California Orthopaedic Association

Sample Medical-Legal Report

This document is presented as an example of the form and general content of an orthopaedic QME/AME report. The specific diagnoses, conclusions, and opinions expressed herein are those of the author and not necessarily those of the California Orthopaedic Association or every California Orthopedist.

(Put on QME's Letterhead)

(Date of Evaluation)

Department of Industrial Relations
Division of Worker's Compensation
Disability Evaluation Unit
(Address)

Re:	Juanita Patient
SSN:	(Social Security Number)
D/I:	(Date of Injury)
C/N:	(C/N Number)
WCAB:	(Status Before WC Appeals Board)
Emp:	(Name of Employer)
D/Exam:	(Date of Exam)
D/Dict:	(Date Report Dictated)

Qualified Medical Evaluation – Orthopaedic Surgery

The above-captioned patient was seen in this office on March 16, 2007 for an orthopaedic Qualified Medical Evaluation.

This was a Comprehensive Medical/Legal Evaluation involving extraordinary circumstances. More than four hours were spent on a combination of face to face time and record review time by the physician. This is two complexity factors. I have been requested to address the issue of causation regarding body parts other than the originally injured right foot, which is a third complexity factor. Additional complexity involves apportionment between industrial and non-industrial causation. I have also been requested to evaluate this patient by both the old PDRS schedule as well as the AMA Impairment Guidelines. A further complexity was the requirement to perform a detailed analysis of the AMA Guides regarding an evaluation for possible CRPS which was discussed in prior medical reports.

The patient is a 54-year-old, right-handed female who sold women's clothing at a Department store. Her work involved lifting clothes. The heaviest lifting would be multiple items of clothing that weighed approximately 25 pounds at the end of the day and occasionally she would lift this much during the day. This is a full-time job that she started in 1990 and she has had no concurrent employment.

The patient reports that in approximately May 2002 a metal tray fell onto her right foot. She was wearing a flat shoe at the time. There was immediate pain. (This was a closed injury and the skin was not broken.)

She says she could not put weight on it. She reported it and was advised to apply ice. This happened at the end of the work day. She then went home and used ice. The following day she could not put weight on it and she says her foot was discolored. She says she did go to work. (Please note: Although she says she could not put weight on it, she actually did go to work.)

She says she was offered medical care but the patient felt it was only a bruise and she continued at work and was using over-the-counter pain medication.

Finally she did ask for treatment approximately two to three weeks after the injury and she was sent to an urgent care facility as soon as she requested treatment.

X-rays were taken and she was told there were no fractures.

She was prescribed medication and advised to apply ice packs.

She thinks she was given a special boot and she was given a closer parking place at work.

A few weeks later she saw an orthopaedist at the same clinic and was treated with a cortisone injection in the foot. This did not give any relief.

She was still using ice and elevation while she remained at work. She was then started on physical therapy with exercises.

She was feeling progressively worse. At one point she was actually off work for two weeks and she did feel better when she was not weight bearing.

She then, after two weeks, returned to work and asked for fewer hours of work but she did have to stay at full-time work. She then saw Dr. T who prescribed a different type of boot. She says that this boot helped her foot but made her back hurt.

She was also given a home stimulator to use. She was prescribed medication and was started on a pool therapy program.

She was also referred to pain management with Dr. F.

She had x-rays taken of the back and was told that it was fine.

She was seen a few times but received no specific treatment other than continuing on pool treatment. She says the pool treatment helped her mentally.

She says that she was able to continue wearing the boot while she was at work but then she had to stop using the boot after two and one half years of use because of the amount of back pain. (Her back had never been specifically treated.)

During the time that she was under treatment she also was given orthotics. She says she was not limping.

After she stopped using the boot her back pain did not change.

There was no change in the condition of her foot after she stopped using the boot.

She has had no treatment since she stopped using the boot.

She has had an evaluation about six months ago.

Her last treating physician was Dr. T and she last saw Dr. T about a year or more ago. She is still working full time at the Department store. Her only work loss because of her foot condition and injury was for the two weeks of work loss noted earlier in this history. Since then she has continued working full time.

She is currently working full time but she says she does not do the heavy lifting. She says she continues working because of economic needs.

She is currently not seeing a doctor.

PRESENT COMPLAINTS

The patient reports that she gained 60 pounds of weight since this injury because she cannot exercise like she used to.

With reference to the right foot there is pain in the foot only when she is weight bearing. She says that following weight bearing she would have pain that will last for about a half hour after she sits down.

The pain is worse when she walks on hard surfaces and she feels better if she is walking on carpeted surfaces.

She has trouble walking on uneven surfaces.

There is no difference whether she is wearing shoes or walking barefoot.

Currently she wears regular shoes. She occasionally will use orthotics but she says the use of orthotics hurts her back.

She complains of numbness and tingling on the top of the foot.

When the weather is hot she says there is swelling. There is less swelling in cold weather.

She says that when she first starts to walk, the pain will develop after she has been on her feet for a few hours. (This would indicate the patient can go a few hours of walking without pain.)

She says her foot feels unstable and weak.

With reference to her back she states there is constant pain. The foot pain and back pain are equal in severity.

She says she cannot stand in one position for a long time. (She says that after 15 to 20 minutes of standing she has difficulty actually moving.)

The back pain is aggravated by heavy lifting and relieved by taking over-the-counter medication.

Her back pain radiates into the left proximal thigh anteriorly.

There is no numbness or tingling associated with her back pain. There is no aggravation of pain in her back with coughing or sneezing, but then she does indicate that a hard sneeze may jar her back.

She has no other symptoms at this time.

PREVIOUS INJURY HISTORY

The patient notes no previous injury or history of similar symptoms involving the right foot. (She does report that at about age 10 she cut her right foot when she fell off a bike.)

She reports no previous back pain of any kind. She reports no lifetime prior back pains. She says the first time she ever had back pain was when she started using the boot for her foot and the back pain was not bad initially.

She reports no other lifetime injuries prior to or subsequent to the specific injury in May 2002.

PERSONAL HISTORY

The patient is divorced with three children. Tobacco: None. Alcohol: Extremely rarely. Medications: The patient will take three to four over-the-counter medications a day which may include Aleve, Tylenol or ibuprofen. She also takes vitamins. Allergies: None.

PAST MEDICAL HISTORY

The patient has had the usual childhood diseases. Serious Illnesses: None. Surgeries: The patient has had one cesarean section and a tonsillectomy. Her only hospitalizations have been for the delivery of children and the tonsillectomy.

PHYSICAL EXAMINATION

The patient is a well-developed, well-nourished female who gets on and off the examining table rather slowly. She does have a normal gait and shows no evidence of limping. She can walk on her toes but complains of back pain with toe walking. She says she cannot walk on her heels.

She does have a normal stance. She is markedly overweight. She can perform 40% of a full squat but with complaint of low back pain.

Vital Signs: Blood pressure 120/90; pulse 80. Height 5 feet, 3 inches. Weight 211 pounds. Right handed.

Examination of the Lumbosacral Spine:

Inspection: The pelvis is level. The spine is straight. No deformity is evident.

Palpation: There is no muscle spasm. There is no localized tenderness including examination by punch percussion. There is no increase in local warmth.

Motions (R/L): The patient will only forward flex the lumbar spine 30 degrees. Extension is 15 degrees. There is a complaint of pain with flexion and extension. Lateral bending is 20/20 degrees. Trunk rotation is 60/60 degrees.

These motions do not appear to represent a maximum effort. The patient has a marked jerking with motions and she does this jerking spontaneously.

Supine leg raising is 80/85 degrees. There is a complaint of low back pain at the limit of supine leg raising. Fabere test is negative. Fajersztajn test is slightly positive on the right but negative on the left. The reverse Fajersztajn test is markedly positive on the right and negative on the left. (That is, dorsiflexion at the extreme of supine leg raising on the right slightly increases her back pain but plantar flexion, which should actually relieve any stretch irritability, markedly increases her pain which is a nonorganic response.)
The patella shift test is negative.

Motor Testing: Motor function testing reveals less effort to flex and extend her right foot and toes against resistance, although she does have some strength against resistance.

Sensory Testing: Sensation in both lower extremities is intact.

Reflexes (R/L): Knee jerks 0/0; ankle jerks 0/0. There is no ankle clonus.

Measurements (R/L inches):

Circumference of thigh	22	21-3/4
Circumference of calf	16-1/2	16-1/2
Circumference of ankle	10	10
Circumference of foot	9-1/4	9-1/4

(Please note: There is absolutely no measurable atrophy in the calf or enlargement of the ankle or foot that would correspond with her history of chronic symptoms involving the right foot.)

Examination of the Right Foot:

The shoes the patient wears to this evaluation are flats that have only a minimal increase in the posterior heel wear of the right shoe compared to the left.

The patient does have a marked metatarsus primus varus bilaterally with bilateral bunions. (The bunions are not tender.) Her feet have symmetrical skin temperature, texture and moisture. She has callus formation on both heels but this is symmetrical. There is no tenderness to light touch anywhere about the foot or ankle, and with firm soft tissue compression there is no tenderness. Subsequently with re-evaluation she reports some tenderness with extremely firm pressure anterior and distal to the medial malleolus. There is no percussion tenderness of the bony prominences. There is no soft tissue swelling anywhere about the ankle or foot.

The patient does have free ankle, subtalar and mid tarsal motion and her range of motion of the involved right foot is symmetrical with the range of motion of the uninvolved left foot.

She does have good active toe motion.

The plantar fascia is neither tight nor tender.

She does have pes planus (flatfoot) bilaterally when she is weight bearing, but again this is symmetrical in both feet.

She does have a slight too-many-toes sign but this is symmetrical bilaterally. There is no heel cord fullness. There is a symmetrical trace of heel valgus.

X-RAY REPORT

X-rays of the lumbosacral spine, pelvis and right ankle and right foot were obtained in this office on March 16, 2007 by Mr. C, Certified Radiological Technologist, Certificate No. (certificate #), and interpreted by the undersigned.
Lumbosacral Spine (5 Views): There is no evidence of fracture, dislocation or other bony injury. Disc and joint spaces are well maintained. There is no arthritic spurring. There is no spondylolysis. There is no spondylolisthesis.

Pelvis (1 View): There is no bony abnormality of the pelvis. The hip and sacroiliac joints are well maintained.

Right Ankle (2 Views): There is no evidence of fracture, dislocation or other bony injury. Joint spaces are well maintained. There is no arthritic spurring. There is no ectopic calcification. There is no evidence of a soft tissue mass.

Right Foot (3 Views): X-rays of the right foot reveal there is a hallux valgus with metatarsus primus varus. There is some associated lateral displacement of the fibula sesamoid under the first metatarsophalangeal joint. There is no disuse osteopenia and there is no evidence of Sildeck's osteodystrophy. There is no evidence of fracture, dislocation or other bony injury. All joint spaces are well maintained. There is no arthritic spurring.

REVIEW OF RECORDS

As noted at the beginning of this report, a number of records have been submitted for review. The records with orthopaedic information will be summarized in chronological sequence for clarity of review.

The earliest entry with any type of orthopaedic information is noted in the records of her family practitioner (Dr. J). She was seen on December 16, 1996. It is hard to read this handwritten note but apparently she had seen her foot doctor because of sharp pains and she needed to lose weight and she wanted a diet. (Which foot was hurting her is not stated.)

Her weight was 193 pounds and if I am interpreting this note correctly she was to lose 60 pounds.

There is no indication of any follow-up after that visit for those problems.

The next note in the records of Dr. J that refer to the parts of the body that currently bother her is a handwritten note of March 31, 1998 indicating she was making a bed and bent down and could not move and her back was very stiff and in pain. The examination revealed that there was some pain on the right side of the lower back. If I am interpreting this handwritten note correctly, the diagnosis was myalgia and she was to use heat and apparently Motrin, and something else that may be Flexeril was prescribed. (Again, there is no follow-up after that visit of March 31, 1998 with reference to that incident when she had some back pain.)

The next available pertinent record is a Doctor's First Report of Work Injury indicating the patient was seen on June 6, 2002 by Dr. X for an injury that is dated May 10, 2002. The patient was picking something up and hit her right foot on a metal tray and an attached report is referred to. The diagnoses are right ankle contusion and she was to be on modified activity and use medication. It was stated she should be at modified work as of June 6, 2002 but the restrictions are not listed.

I do not have another report which was allegedly attached to this First Report.

In sequence the next report is a July 14, 2002 report from Ms. J who apparently is a physical therapist. The diagnosis was an ankle contusion on the right and the patient reported that the leg was injured on May 10, 2002 when she hit her right foot on a metal tray. The patient reported that her condition was worsening. She says she was starting to walk differently and then her hip and back would get sore. It was noted at work she was on modified activity but not tolerating activity well. There is some confusion because the patient reported tolerating previous treatment well with no adverse reaction, but I do not know what type of previous treatment she received. There was lateral foot and ankle tenderness and point tenderness of the lateral malleolus. (At the time of my current examination, very firm pressure anteromedially produces a complaint.)

It was assessed she was getting worse and she was frustrated because she wants to work.

Next there is a narrative report of orthopaedic surgeon Dr. N. who saw the patient at the Medical Center on July 17, 2002 at the request of Dr. X who was listed as her primary treating physician. Her job duties are discussed and it was noted she would be on her feet constantly and lift 15 to 20 pounds at a time.

It was noted that she was injured when an iron tray struck her foot and she reported it and went home at the end of her shift The next day she had increased pain and the foot and ankle was black and blue. She had a large sale coming up and did not want to seek specific treatment but pain persisted and she then saw Dr. X on June 6, 2002. There was some lateral soft tissue swelling. X-rays were taken and the diagnosis was an ankle contusion/sprain and she was treated with ice, medication and an ankle brace and started in therapy. She had not improved and orthopaedic consultation was requested.

There was continued pain in the foot and ankle which was worse after being on her feet for over five hours, and pain increased with walking. Ice and rest helped. The pain was mainly lateral in the ankle and hind foot region and there was no pain elsewhere in the foot. Her prior knee injury that was treated without residuals is noted.

The right ankle and foot examination revealed some mild swelling near the anterior talofibular ligament region. There was slight tenderness near the anterior talofibular ligament and near the calcaneocuboid joint. There was no instability. Neurovascular was intact and there was full foot and ankle motion. (Please note: The pain consistently is on the lateral side of the ankle and foot.)

It was noted the original x-rays showed some soft tissue swelling laterally but were otherwise nremarkable. Repeat x-rays of June 18 showed slightly less swelling, and foot x-rays showed only a mild bunion. The diagnoses were right foot and ankle contusion, rule out occult fracture or deep bone bruise.

The doctor said she should have MRI studies of the ankle and foot because of continued pain at two and one half months since the injury. She was to use a walking boot as needed. She was available for modified work but should avoid prolonged walking.

She was then seen by a different physical therapist A at the Medical Center on July 31, 2002. The same history is noted. The tenderness was still lateral. She was making minimal progress with treatment and she declined to ride a bike and was frustrated with the lack of progress and she was complaining of increased back pain when wearing a walking boot. She was on an exercise program and iontophoresis.

Next from the same facility there is a report stating she was seen by Dr. K. on August 2, 2002. The history is the same. She was on modified work. At the end of prolonged standing she was having swelling and there was moderate pain. In general the pain was at a 2-3/10 level and the MRI was scheduled. She was getting some benefit from therapy and wanted to continue. The examination revealed she was wearing a right ankle brace and had some mild lateral swelling and mild to moderate lateral tenderness. Sensation was intact. The diagnoses were an ankle contusion and sprains and strains of the ankle and foot and she was to continue with medication and therapy and with restricted walking and standing and close parking.

There is a report of an MRI of the right foot and ankle of August 6, 2002. There were findings of peritendinitis of the flexor hallucis longus and some ill-defined decreased signal in the anterior facet of the subtalar joint consistent with bone marrow edema that could be related to trauma.

On August 14, 2002 Dr. N reports ongoing pain and having trouble after a long work day and she felt better after she had been off work a few days. The MRI report was reviewed and the diagnosis at this time was a right foot and ankle contusion that was healing more slowly than expected.

She was treated with a local injection and if pain persisted she might need a bone scan. On August 28, 2002, Dr. N notes the injection did not help, the symptoms were the same and the patient was concerned about a possible nerve injury. There was still tenderness over the sinus tarsi. The diagnosis was the right ankle and foot contusion that was healing more slowly than expected with a questionable neuroma of the

sensory branch of the peroneal nerve. A bone scan was recommended as well as a referral to a foot and ankle specialist.

A total body bone scan with technetium was performed and there was mild increased activity in the right tarsal region.

Next there is a report of a consultation by podiatrist Dr. B who saw the patient on September 24, 2002. The patient's pain was on the top of the right foot and outer aspect of the ankle which would begin after she was on her feet for about four hours. The more she was on her feet the pain would get worse and cause her to limp. She was working full time at regular duty. She came to the examination fully weight bearing and wearing regular shoes. The history of injury and subsequent treatment is briefly reviewed. On examination the skin and vascular findings were all normal and the neurological examination as described was normal. There was slight tenderness of the lateral aspect of the ankle, but no other areas of tenderness. Range of motion was normal. Pes planus and a bunion were noted bilaterally. The lower extremity foot and ankle measurements were symmetrical and ranges of motion were symmetrical on the right and left sides. X-rays showed no reported abnormalities. Records were reviewed and by history, it was felt she was status post contusion with secondary tenosynovitis of the right ankle. It was felt she had a localized tenosynovitis of the right ankle which was compatible with the reported mechanism of injury. The MRI substantiated her symptoms. A short course of physical therapy with modality and exercises was prescribed along with medication. It was felt she could continue working full time without limitations.

A handwritten progress note from Dr. B of October 28, 2002 notes the patient was still doing the same. Apparently the doctor was awaiting a report of a CT scan, but I cannot read the rest of this handwritten report.

There is a report of a CT scan of the right ankle of November 12, 2002 that was ordered by Dr. B. There was no bone or joint abnormality. The tendons were difficult to evaluate and it was noted an MRI would be a better study. The CT was negative.

The patient was seen in orthopaedic consultation by Dr. P. on January 27, 2003. Her history of injury and treatment was reviewed and it was noted that she had used several different types of ankle support. At one point she used a walker boot with pain relief but developed back pain from the walker boot and she stopped using the walker boot. There was no history of complaints referable to the right ankle or foot before May 10, 2002.

Examination revealed an antalgic gait with limping. There was no apparent deformity but there was some swelling and tenderness. Range of motion was symmetrical with the other side and there was no sign of instability. There was a trace of weakness of the ankle and foot and there was pes planus. The metatarsus primus varus was described and there were some hammertoes. Prior x-rays were reviewed and the only abnormalities were the hallux valgus and hammertoes. The bone scan showing mild increased activity in the right tarsal region was reviewed, and the MRI showed no apparent bone or joint abnormalities. The diagnosis was right ankle and foot pain that was chronic status post contusion. It was noted she had already had extensive treatment and had not improved with all of the treatment but her pain had actually increased. A short leg cast was suggested but it was noted she might not tolerate the cast because of her unfavorable experience with a walker boot. It was stated, "Ms. Patient has more subjective complaints than objective findings." It was noted the x-rays, bone scan and MRI had not shown any specific abnormalities. She was to be reexamined in one week and she was to remain at modified work with limited walking and closer parking.

Dr. P saw the patient again after re-evaluating her on February 12, 2003. Her complaints were of a lot of pain and swelling at the end of the work day but not as bad some days as others. The examination noted severe limping and the right foot was essentially "frozen" in inversion and plantar flexion position. There was diffuse tenderness dorsolaterally and in the hind foot. Because of guarding there was no passive motion

of the ankle or foot. The diagnosis was still a right ankle and foot pain that was chronic status post contusion.

The doctor stated there was no explanation of her severe ankle and foot complaints based on clinical findings. It was noted she had had an extensive workup which had not shown evidence to explain her ankle and foot pain. It was stated she might benefit from alternative medicine treatment such as acupuncture which would be prescribed on a trial basis.

Next there is a Doctor's First Report of Work Injury prepared by Dr. T (orthopaedic surgeon). A First Report of Work Injury is incomplete but there is a corresponding narrative report indicating the patient saw this orthopaedist on May 5, 2003. The comp1aints of pain, burning and swelling in the dorsolateral right foot that were worse at night were reviewed.

The history is very briefly reviewed. Treatment is very briefly reviewed. It was noted that an MRI was done but he did not have the results. Her job duties are discussed. Her symptoms were worse at the end of the day but not very noticeable in the morning. At night it bothered her when even the sheets touched her foot. There were no prior injuries. On examination it was noted she had a moderate flatfoot with a rather significant hallux valgus. She could get up on toes and heels and had good pulses and there was no point tenderness of the bones but there were dysesthesias in the dorsolateral foot.

It was felt there had been an injury to the superficial peroneal nerve and that she probably had a complex local pain syndrome, i.e. sympathetic dystrophy.

A nerve test and a bone scan were recommended and then appropriate doctors to treat her would be chosen. She would be seen when the studies were done. She was allowed to continue at work with restrictions.

Electrodiagnostic studies are reported by Dr. G. Studies were done on July 2, 2003 of the right lower extremity that included an EMG and nerve conduction study. These were completely normal studies with a normal EMG and nerve conduction study. There was no evidence of a radiculopathy or a peripheral nerve injury.

A supplemental report from Dr. T of February 23, 2004 notes that her diagnosis was dystrophy of the foot. She wanted to continue working but wanted to work on a part-time basis. A request to work no more than four days in a row was suggested and she was going to see Dr. F for workup of the dystrophy of the right lower extremity. (I have no reports between the nerve study of July 2003 and this follow-up report of February 2004 and I do not know what Dr. T's impression was after the electrodiagnostic studies were performed that were normal.)

The patient was re-evaluated by Dr. T on March 22, 2004 and it was noted she was being seen by Dr. T, although she was supposed to be seen by Dr. F who is a physiatrist.

She was working with a boot and had received no new treatment and nothing had changed. She was complaining of weakness in the back and her foot gave out when walking and it was felt this was due to calf muscle weakness which was immobilized in the boot which did control her swelling and pain.

The next report comes from Dr. T indicating she was seen on April 19, 2004. It was noted the doctor had been following her for quite some time with the diagnosis of "mild dystrophy to her right foot." It was noted she was working with limited duty because when she was on it for a long time there would be swelling and the swelling would cause nerve irritation and increasing pain. When on her foot for a limited time the swelling was down and she could "cover it." She was given a new type of walking boot.

It was noted her treatment had been conservative. Because of the chronicity problem it was felt she needed to see a pain specialist and she had been referred to Dr. F but this had not been authorized.

On May 24, 2004 Dr. T reports it was now about two years since the injury and she still had the same amount of symptoms. There was swelling and a limited amount of work time she could tolerate. There was cramping in the calf. It was noted that x-rays never showed any fracture. It was noted the diagnosis of dystrophy had been made and it was two years and she still had the same discomfort. She could work with the boot on and do limited work but was a Qualified Injured Worker. It was felt before she was permanent and stationary she should see a pain specialist and she did have an appointment to see Dr. F who is a physiatrist who deals with chronic pain. (Please note: Dr. F is in the same medical group as Dr. T.)

Another narrative report from Dr. T of August 9, 2004 notes that it had been nearly two years since injury, she was using a walking boot and had modified hours but was still having pain and the back was starting to bother her increasingly. The back was getting worse, especially when wearing a boot. The doctor felt he would consider her permanent and stationary from his treatment within six weeks but he did again request that she see Dr. F for further treatment. The doctor felt she was a candidate for vocational rehabilitation. She was, however, continuing at work. She was on medications.

Next there is a report from Dr.F. who saw the patient initially on August 23, 2004. The history of injury and ongoing increasing pain in the right foot is noted and her treatment and diagnostic studies were reviewed and it was noted the diagnostic studies did not reveal any specific pathology. It was stated that in the last seven months with using a cam walker she had low back pain, strain, discomfort and achiness.

General medical examination was performed. Apparently her posture was normal and she had good motion, if I am reading this note correctly. The Achilles and patella reflex were 1+ on the right but not elicitable on the left. (It was the right side that was symptomatic.) Strength was normal and she could toe and heel walk and her gait was overall normal “with a walker.” (I am not sure if this was a walking boot or an actual pickup walker that is referred to since no one has prescribed a walker that I have seen reported.)

X-rays of the lower back were normal and the final diagnosis of this doctor was unspecific foot pain that might be a variant of a complex regional pain along with her back sprain secondary to wearing a mechanical device.

It was felt she needed progressive mobilization and weight bearing activities without the brace. It was stated the longer she wears the brace, the weaker she would become, and she had been advised to stop using it for 30 minutes a day initially and she would then be weaned from it. New x-rays would be obtained and there was a consultation for orthotics because she was flatfooted and had valgus toes. The prior imaging studies were to be obtained and there would be consideration for sympathetic blocks and different medications.

On September 7, 2004, Dr. F reports ongoing symptoms aggravated by flexion and long walking. She was currently not wearing a support and had only a mild antalgic gait. There was very minimal swelling and full motion. There was tenderness dorsally. X-rays showed no specific pathology and the assessment was that she had nonspecific dorsal foot pain and she was to see a podiatrist for orthotics and she was to begin physical therapy. It was suggested she be seen in the P.M. to accurately assess her pain.

The next report comes from Dr. M. Although this report is stated to be a physician’s initial orthopaedic report it was prepared by a podiatrist. (Dr. M is in the same office as Drs. T and F.)

The history of injury is noted. Her previous treatment is not stated but it was noted her current complaint was of ongoing right foot pain. Under the review of systems, it was noted she had a history of back pain. The podiatric evaluation revealed no skin changes. The neurological examination states that the reflexes were symmetrical and normal and sensation was normal. The vascular examination was normal. There was marked pronation bilaterally with reproducible pain in the right foot.

It was noted she had had nerve conduction studies but it was stated they did not include the foot. (Please note: The EMG did include the flexor digitorum longus and the extensor hallucis longus and the nerve conduction studies did include the superficial peroneal nerve and the sural nerve.)

It was noted the x-rays and MRIs had been nonconclusive.

It was noted that the patient stated in a supportive cast she was relatively asymptomatic. (Please note: She had never been actually in a cast but rather had been in various boot-type supports.)

She was currently treated with supination strapping which decreased her symptoms, and it was felt a supportive device should help with orthosis. It was suggested that she stay strapped until an orthosis could be fabricated. If that did not totally eradicate symptoms, a functional ankle/foot orthosis would be considered.

On October 4, 2004, Dr. T reports that she had been followed for quite some time and she was currently getting pool therapy which seemed to strengthen her ankles and she was feeling better. She was to continue on her medications suggested by Dr. F.

On January 31, 2005, Dr. T states that she had a chronic neuropathy of the right foot and ankle. (Please note: No objective description of neuropathy has been reported thus far.) It was noted the doctor was planning to do a permanent and stationary evaluation but she still required medication and was wearing a boot and required limitations at work. It was noted the doctor was looking for a way to cure the problem but this might not be an answer. It was noted the previous nerve test was “inconclusive because of too much swelling in her foot.” (Please note: The electrodiagnostic studies that I have reviewed of July 2003 were quite clearly stated to be normal.) Nerve conduction studies were to be repeated to see if there was something compressing the nerve which could then possibly be released.

Dr. F reports on February 8, 2005, that Dr. T re-evaluated her and noted there were no fractures. Dr. M had provided orthotics and prescribed better footwear but she was still wearing loafer-type shoes which she had been told were poor for her feet. Pain was on the right anterior dorsum of the foot aggravated by prolonged weight bearing. It was noted she was putting on weight despite insistence that she lose weight.

The examination revealed normal posture and she had full motion of the lumbar spine. The foot had mild lateral swelling and was tender, sensory examination was normal and reflexes were intact.

It was felt she had nonspecific foot pain that was possibly neuropathic. Dr. F felt there was not much more that he could provide but she would start an additional water-based therapy program because she thought it was helpful. She was going to be sent to a different doctor (Dr. S) for evaluation of continued treatment for her right foot pain. There was a consideration that possibly her symptoms could be handled through a nerve block.

The next report is a QME report from Dr. B (who was a previous treating physician). This examination took place on June 6, 2005 and notes she was having pain from the top of the right foot traveling to the outer aspect of the ankle which was related to weight bearing activities. The pain was not constant. It was noted she could also not sit for prolonged periods of time because it causes the foot to swell and numbness in the right big toe. She was using a cam walker daily at work which helped control swelling. She would wear the boot during non-work activities if she would be sitting or walking a lot. It was stated there had been low back pain since wearing the boot. She was currently working modified duty three days a week but at her regular job. She however was not returning merchandise at the end of the work day. On current examination she was wearing regular shoes with custom-made orthotics and there was no change in the status of the right foot over several years. The treatment she had received since she was last seen by Dr. B on November 18, 2002 was reviewed. There are some mistakes because it was stated Dr. T had x-rays taken and diagnosed nerve damage. (He suspected nerve damage but nerve damage does not show on x-rays.) Various medications she had gotten are noted and it was noted she had a cam walker, but did not

know how long she had been using it. She did not know how long she had received therapy. It was noted she had seen Dr. F.

The history is somewhat inconsistent because after it was stated she did not know how long she used a cam walker it was stated she had been wearing it for about one and one half years.

Examination of the right foot and ankle showed no soft tissue edema or effusion. Skin temperature, texture and color were normal and symmetrical, there was no diaphoresis, there was no sensory loss, and neurovascular status was intact. There was only mild tenderness with firm palpation of the anterolateral ankle and the ankle was stable. The lower extremities were symmetrical regarding size and strength with good muscle tone. On initial attempted motion, there was splinting but with encouragement she demonstrated full range of motion. The bunion and pes planus were noted that were symmetrical. (Please note: The doctor is describing a totally normal examination with the exception of pes planus and a bunion which were symmetrical.) Lower extremity measurements were symmetrical. Lower extremity range of motion of the ankle and foot were symmetrical. X-rays including weight bearing x-rays were taken and there were no gross findings suggesting previous fracture or dislocation. There was no obvious bone or soft tissue abnormality other than for the large bunion deformity with the metatarsus primus adductus angulation. The joint spaces were well maintained. A small plantar calcaneal spur was noted. Previous records were reviewed and the diagnosis was a history of a contusion of the right ankle and foot.

It was noted it was now a little more than three years since the injury and the various treatments she had received were reviewed. It was noted she had received extensive conservative treatment and was in her pre-injury job although there was a restriction of limited walking at the end of the work day. She was complaining of pain and swelling in the foot and she was wearing a “removable cast primarily while working.” (Please note: It was a removable boot.) It was noted the clinical examination of the foot and ankle was essentially unremarkable except for mild tenderness. There was no soft tissue swelling, increased skin temperature or atrophy, there was no sensory loss, range of motion was full, and there was no instability or weakness. The x-rays showed no bone or joint pathology relative to the foot or ankle. The doctor stated from his current examination, “I find essentially nothing wrong with her right foot or ankle.” He felt there was “symptom magnification” and the subjective complaints were out of proportion and not substantiated by objective x-ray findings. It was noted this was the general consensus in light of the absence of any specific abnormal findings or definitive diagnosis stated in previous reports. The doctor felt she had had more than ample treatment and had reached maximum medical improvement. Based on her present status it was felt there was no further medical care or treatment that would be indicated or anticipated to change her condition. The doctor found no need to use the cam walker and he felt it was not medically indicated. It was noted the patient was scheduled for nerve studies and if they became available the doctor would review them and make further comment. The doctor himself however felt there was no need for a neurological test. It was also noted the previous EMG and nerve conduction studies of July 2003 were unremarkable. It was felt she was permanent and stationary regarding the foot injury of May 10, 2002.

Subjectively it was stated she had intermittent minimal/slight pain, and objectively there were no abnormalities. It was stated that as per Chapter 18 of the AMA Guides she had 1% whole person impairment (pain impairment). It was felt she could remain at full work with no limitations or restrictions, and there was no limitation of pre-job capacity. There were no factors of apportionment and her condition was consistent with the injury of May 10, 2002. Provisions for future care with medications and follow-up evaluations for exacerbations of symptoms were recommended.

Following that permanent and stationary evaluation by Dr. B on June 6, 2005 there is a permanent and stationary report of Dr. T of August 23, 2005. It was noted her diagnoses have been a soft tissue injury to the foot with dystrophy/ neuropathy. (Please note: This patient has never demonstrated the findings of dystrophy or neuropathy.) It was noted she had had multiple treatments and seen multiple doctors. She was currently working four eight-hour days a week and would wear a boot that made the foot feel better. The pain was moderate to severe at times but relieved by medication. She was taking Neurontin for her dystrophy pain.

Her examination was unchanged. It was stated she had a non-antalgic gait at this time and was wearing regular loafers. There was no atrophy or lost motion. There was some numbness in the dorsum of the foot in the distribution of the deep peroneal nerve. The diagnosis was a chronic dystrophy/neuritis of the right foot. It was stated she was permanent and stationary regarding the industrial injury. The doctor does not rate her disability. He just states she was permanent and stationary and that her injuries and symptoms were related to the injury. It was stated if her problems got worse, future care would be indicated. (Please note: The doctor does not describe any specific type of future medical care, he does not describe any work restrictions, and he does not discuss subjective complaints or objective findings.)

Records then skip to a Qualified Medical Evaluation prepared by orthopaedic surgeon Dr. C, M.D. who examined the patient on January 9, 2006.

The history of injury of May 10, 2002 is noted and her subsequent evaluations and treatment are reviewed including the diagnostic studies that have been performed. From the specificity of some of this history it would appear that a great deal of the history was obtained from a record review.

Her current complaints were of constant numbness in the ankle and tingling in the afternoons in the ankle, and there was swelling, especially in hot weather, and the pain would increase with prolonged standing or walking and there was a feeling of instability.

In the foot there was pain rated as 1-2 on a scale of 10 (this is very minimal pain) that would increase at the end of the day after being on the foot all day. The pain was on the top of the foot and would extend to the toes and was associated with numbness and swelling. It was noted she was currently working regular duties even though she was given modified duties with restrictions. (The nature of the restrictions is not stated.)

It was noted there had been a prior left knee injury at work which was self treated, then had conservative treatment, and there were no residual problems. All other types of injuries are denied. Her job duties were reviewed. On examination it was stated that since the injury she has gained 45 pounds. It was also stated however that her current weight was approximately 200 pounds. (Please note: In the notes of Dr. L of 1996 and 1997 her weight was 193 and 198 pounds on different visits.)

Examination revealed she had an antalgic gait with a slight limp on the right. There was slight tenderness of the anterior ankle but no instability. There was slight tenderness about the dorsum of the foot. There was a mild pes piano valgus and hallux valgus and bunion. There was slight weakness of right great toe extension.

There was no deltoid ligament or lateral ligament tenderness. There was no medial or lateral swelling. There was no ecchymosis. Sensation was intact and there were no trophic changes. Pulses were present and there was no atrophy.

It was stated she could stand on heels and toes with difficulty and pain and could stand on the right foot with difficulty and pain. She stood on the left foot without difficulty and without pain. Range of motion of the ankles revealed a 10 degree loss of inversion and a 5 degree loss of eversion of the right compared to the left. There was however absolutely no measurable discrepancy in the circumference of the calves or the ankles. The x-rays of the foot showed a hallux valgus and bunion but were otherwise normal, and the ankle x-rays showed no acute abnormalities and normal alignment. Multiple records were reviewed which included the same records that were available to the undersigned. The doctor also had an Application for Adjudication of Claim that was filed on June 25, 2004 stating the parts of the body that were injured were the right foot and resulting low back, left foot and left leg. (Please note: I have not seen a single reference to any left leg problems in any report reviewed thus far. The patient does not report any left leg symptoms to the undersigned and has not reported any to Dr. C.

The diagnoses of Dr. C were that she was status post contusion of the right ankle and foot and had a probable complex regional pain syndrome/reflex sympathetic dystrophy, improved. (Please note: The

doctor's own physical examination reveals not a single factor or objective sign that would be utilized in diagnosing a complex regional pain syndrome.)

It was also noted that the entire report of Dr. C is completely silent regarding any back symptoms or an examination of the back.

In the discussion Dr. C states that on the basis of the information available she did have an injury at work involving the right foot and ankle on May 10, 2002. (He does not describe any other injuries or parts of the body involved.)

He felt she was permanent and stationary and had reached maximum medical improvement and had been permanent and stationary when considered so by Dr. F. (Please note: The undersigned has not seen a permanent and stationary report prepared by Dr. F and in reviewing the records that are summarized by Dr. C there is no mention of a permanent and stationary report by Dr. F and he may be referring to the permanent and stationary report prepared by Dr. B.)

Dr. C also states her condition was industrial from her work injury of May 10, 2002. He rates her subjective disability as being frequent slight pain increasing to moderate with vigorous activities, and the objective findings are slight weakness of right great toe extension and slight restriction of inversion and eversion of the right ankle. It was noted she did have flexible flatfeet that was not disabling or contributing to disability. He noted she had a hallux valgus and a bunion involving the right great toe which was pre-existing but was asymptomatic and not contributing to disability. (Please note: The contusion she had was in the ankle area and any weakness of the extensor of the great toe would most likely be related to the deformity with a metatarsus primus varus with a hallux valgus which alters the mechanics of that tendon.)

Dr. C however states apportionment was completely due to the industrial injury. He felt she should have future medical care with evaluations and treatments and may need various medications, orthotics with replacements and short courses of therapy and additional diagnostic testing. (Please note: This report is prepared nearly four years after the industrial injury and all of that type of evaluation and treatment thus far had not led to any improvement.)

The doctor recommends a prophylactic work restriction from repetitive heel and toe raising, prolonged walking on uneven terrain, prolonged climbing, crawling, running and jumping, and a prophylactic restriction from heavy lifting and carrying.

It was noted that she had returned to her previous occupation and was not a Qualified Injured Worker.

Dr. C then performed an AMA impairment rating and says the mild inversion and eversion was a 2% lower extremity and 1 % whole person impairment. It was stated the mild gait was present and there were some findings consistent with causalgia or complex regional pain syndrome Type II. (He does not describe any findings consistent with that condition in his own report or examination.)

It was felt that the severe contusion caused injury to the superficial nerves on the dorsum of the foot and ankle and he therefore recommended Chapter 13 be used to rate impingement and he recommends that Table 13-15 should be used. Table 13-15 does not refer to CRPS but rather refers to a gait disorder, and to be in the Class I category described by Dr. C a person can rise to a standing position and walk but had difficulty with elevations, grades, stairs, deep chairs and long distances, and none of those difficulties are described by Dr. C and I therefore do not believe that that is an appropriate table to use in evaluating the patient. Dr. C states that it was his opinion that she had 9 % whole person impairment as a result of the causalgia/RSD/CRPS involving the right foot or ankle. (Please note: The doctor does not describe a single finding of that condition in his own physical examination.)

The final comments are that she had a significant injury to the foot and ankle and had about three years of treatment and used a cam walker for a long time that helped her get back to work. (Please note: She had

minimal loss of work.) It was noted Neurontin was the medication used for causalgia, neuralgia and complex regional pain syndrome. (Please note: It is also used for a number of other conditions.)

It was noted Dr. P felt she probably had a complex local pain syndrome, i.e. sympathetic dystrophy. (Please note: Dr. P does not describe any of the objective findings of that condition.) Dr. F in August 2004 felt she may have a variant of complex regional pain. (Dr. F did not describe any of the findings of that condition.)

Dr. C agrees she had a variant of a complex regional pain syndrome or causalgia involving the right foot or ankle. (Please note: She does not have the subjective complaints of complex regional pain syndrome and she does not have the physical findings of complex regional pain syndrome; not a single one of the findings of that condition is identified on the examination of this patient who has normal skin temperature, texture and moisture. She has absolutely no atrophy. She does not have the severe tenderness associated with that condition. She does not have any of the other objective findings of that condition.)

Dr. C disagreed with Dr. B and felt there was no evidence of symptom magnification and records showed "evidence of probable complex regional pain syndrome and causalgia." (I would strongly disagree with Dr. C and a careful review of the records indicates that no one has ever identified a single objective finding of that condition.)

A rating analysis of the January 9, 2006 report of Dr. C notes his diagnoses and ratings of subjective complaints and findings and work restrictions and the analysis was that the restriction of heavy lifting was a 20% standard and the other restrictions added a 5% for 25 % standard overall with a final PD of 28%. (Please note: This is an analysis of the disability rating.) Under the discussion of factors of impairment it was stated the use of CRPS causalgia seemed appropriate with a final permanent disability being 13%. (I would disagree with the rating analysis. This analysis is based upon accepting the diagnosis but I definitely do not believe that that diagnosis is appropriate for this patient.)
(Please see my own comments regarding the diagnosis of complex regional pain syndrome in my discussion which follows my review of records.)
In sequence there is a supplemental report prepared by Dr. C dated April 3, 2006 at which time he reviewed a deposition transcript of Ms. Patient. This is the deposition of June 23, 2004. He does not comment upon the content of this deposition other than to state that after reviewing it there were no changes to his opinions.

Dr. C did re-examine the patient on September 25, 2006. It was noted she had previously been seen in January and since then had seen no other physicians for her work-related injuries. It was stated today she was complaining of the low back pain which started in 2002 soon after the treatment for the right foot and ankle, and had not previously been treated for low back pain but wanted to see a chiropractor for her back. (Please note: It is interesting that Dr. C in September obtains information from the patient about low back pain that she says started in 2002, yet he does not have a single word about low back pain in his own report of January 2006.)

It was noted that the patient told Dr. C she did not have back problems until she wore the orthotic boot which helped the foot but caused her to have low back pain, and it became so great she stopped wearing the boot after January 2006. (Other reports indicate she stopped wearing the boot before January 2006 and Dr. C himself when he examined her in January 2006 does not describe any type of boot that she was wearing.)

At the time of this report in September 2006 Dr. C states that with reference to the lower back she had pain in the low back radiating into the left leg that would increase with lifting, bending, stooping, squatting, prolonged standing or walking and varied throughout the day. There was also right ankle pain on the outer aspect of the ankle and there was swelling of the ankle and pain would increase after prolonged standing or walking and the ankle felt unstable at the end of the day. There were also symptoms in the right foot, great toe pain at the top of the foot radiating into the large toe associated with numbness tingling and swelling in the foot and increased pain with movement of the foot and toes by the end of the day and she walked with

an uneven gait. (Please note: These symptoms of swelling were not confirmed by the measurements performed by Dr. C himself.)

It was noted she was currently taking over-the-counter medication. She was working at the same company in the same position since she was seen in January. Under the lower back examination it was stated she had an antalgic gait with a "very slight limp on the right." Her posture was normal. There was slight lumbar paravertebral tenderness but no spasm. She could squat without difficulty but with pain in the back. There was no pain or tenderness with palpation of neither the sacroiliac joints nor the sciatic notches. She could flex her fingers to 8 inches from the floor with moderate increased pain in the back but no spasm. Flexion was 70 degrees. Extension was 20 degrees with increased pain but no spasm. Lateral bending was 35 degrees with increased pain but no spasm, and rotation was 65 degrees with increased pain but no spasm. (Please note: The doctor is describing some self limitation of range of motion with subjectively reported pain but no spasm.)

Straight leg raising was 50 degrees bilaterally without pain or tenderness in the back. All special tests for the lower back were negative and even ankle clonus testing was negative. (Please note: With ankle clonus testing there is no mention of any symptoms arising in the ankle itself.)

Motor testing revealed no motor weakness in either lower extremity. (This would contradict his previous statement that there was some weakness of the right great toe extensor.) Sensation in the lower extremities was not impaired. Vascular testing was normal and reflexes were equal and active. The hip examination and the knee examinations were normal. The right foot and ankle examination revealed an antalgic gait with a slight limp and slight tenderness of the anterior ankle but no instability and there was slight tenderness diffusely of the dorsum of the foot. There was no tenderness of the ligaments of the ankle; there was no medial or lateral swelling and no ecchymosis. The mild pes plano valgus deformity was bilateral and the hallux valgus and bunion were present. It was stated there was very slight weakness of right great toe extension. (Please note: When examining the foot it was stated there was weakness of right great toe extension, but when examining the back it was stated that motor testing showed no weakness in either lower extremity.) Sensation was intact. The patient could stand on the right foot with difficulty and pain and could stand on the left foot without difficulty and pain. Measurements were the same as those in January and again it is noted there is absolutely no measurement discrepancy of the circumference of either the calves or the ankles. Lumbosacral x-rays showed moderate degenerative disease at L5-S1 with no acute abnormalities. Once again the diagnoses were status post contusion right ankle and foot and complex regional pain syndrome that were improved. (Please note: I would definitely disagree with the diagnosis of complex regional pain syndrome on the basis of the reported physical examination findings of Dr. C with not a single objective finding of that condition being identified.) A new diagnosis is listed of a lumbosacral sprain and strain that was chronic, lumbar degenerative disc disease L5-S1 and lumbar radiculopathy. (Please note: The doctor does not describe any findings on his own examination of a neurological abnormality consistent with a lumbar radiculopathy. He describes straight leg raising without pain, all special tests were normal, motor testing was normal, sensation was intact and reflexes were equal and active and there were no physical findings of a radiculopathy.) The lumbar degenerative disc disease is an imaging study finding only.

In the discussion Dr. C states that she had the injury when the heavy object fell on her right foot and ankle and she had treatment for several years and "she appears to have developed complex regional pain syndrome as a result of this severe injury." (Throughout this current discussion and in my comments which follow it is noted that I strongly disagree that she has developed complex regional pain syndrome.)

Dr. C refers to his previous evaluation of January 9 and states that none of those opinions have changed other than for an error in his rating of the whole person impairment. (Please note: None of his opinions have changed but he now for the first time discusses a lower back condition.)

Regarding the lower back it was stated there was evidence of a degenerative disc disease at L5-S1 but she was asymptomatic before having the right foot injury and it was felt the altered gait mechanics aggravated her lumbar spine condition, causing it to become symptomatic, and there was evidence of industrial

aggravation. (As I will discuss subsequently, there is nothing in the medical literature that I am aware of that confirms that a gait abnormality can produce a lumbar spine condition.)

It was felt the lower back condition was permanent and stationary. It was felt her causation was industrial as a result of the injury of May 10, 2002 and he now rates the lower back as having occasional slight pain that would become moderate with more vigorous activities and there was occasional slight radiating pain to the left lower extremity. The objective findings were paravertebral tenderness, slight restricted motion and x-rays showing moderate degenerative disc disease and facet arthropathy at L5-S 1. (Please note: The range of motion and tenderness are subjective findings during examination, not objective manifestations of impairment.)

Dr. C discusses apportionment and notes there was moderate degenerative disease at L5-S1 with facet arthropathy that was contributing to the lumbar radicular symptoms and her present level of disability and impairment. He stated her altered gait mechanics, prolonged limping and walking with a cam walker aggravated the condition, and absent the altered gait mechanics and limping it was not clear or possible to determine if or when she would have become symptomatic regarding the lumbar spine. He then does apportion 50% of her back condition as being a compensable consequence of the injury to the right foot and ankle and 50% to the natural progression of degenerative disc disease in the lumbar spine. He discusses future medical care with short courses of therapy and medications and additional diagnostic testing should be available and she might require pain management including epidural cortisone injections. (Please note: She had absolutely no findings that would warrant any of that type of treatment.)

Regarding the lower back, prophylactically it was recommended she have a work restriction from repetitive bending, stooping, pushing, pulling and heavy lifting. It was noted however that she had returned to her previous occupation and was not a Qualified Injured Worker.

Dr. C now gives an AMA impairment rating for the lower back and felt she would be in DRE Lumbar Category II. (Please note: Lumbar Category II in the DRE system requires findings compatible with a specific injury. She did not have a specific injury to the back.) Findings may include significant guarding or spasm. (He does not describe any spasm.) There would be asymmetric loss of motion (which is not described by the doctor). There would be non-verifiable radicular complaints which would be radicular pain without objective findings. (Please note: No radicular pain is clearly described.) (Please note: I definitely believe that Dr. C's own evaluation would place her in DRE Category Lumbar I.)

There is a rating analysis by a rater of the report of Dr. C of September 25, 2006. The diagnoses are listed as per the report and the subjective and objective findings are listed noting that the patient's apportionment was 50% industrial and it was felt that the evaluation was correct and there were no errors and the final permanent disability would be 14% but there is no comment about the rating of impairment by the AMA Guides in this analysis of the rating.

This concludes the review of the submitted medical records.

The final material to be reviewed is a transcript of the deposition of Ms. Patient that was taken on June 23, 2004.

In the initial portion of the deposition it is noted she had never been in an automobile accident. It was noted that when she was little she fell off a bike and hurt the left side of her left foot. She then corrected it to the right foot. She could not recall the treatment she received and was seen only in an emergency room.

It is noted she had had a prior injury at the Department Store involving her left knee and this was about seven years ago and she was examined at the request of the employer, although she did not want to go, and she had fully recovered from that injury.

She could not recall ever having seen a podiatrist or a chiropractor in her entire life. (Regarding her current injury, the first podiatrist she saw was Dr. M, but she was seen by Dr. M after the date of this deposition.)

Her past medical history and education were reviewed and her previous employment history was reviewed.

At the time of this deposition she was still being seen by Dr. T and was wearing a boot on her right foot that had been prescribed by Dr. T and she had been using it for about six months. She would use it only when working or doing a lot of walking. She also used it when she would have to sit for a long time but did not generally wear it at home. She felt better sitting and standing with the boot on rather than off.

It was noted that the boot would help control swelling when she was sitting. She had been taking numerous medications.

There had been no injury since May 10, 2002. There had been no employment since her injury other than at the Department Store.

It was noted the patient was unhappy that Dr. T had not been able to find a “miracle cure” for her foot condition. It was noted that Dr. T had suggested she see Dr. F for pain management but she had not yet been seen.

The electrodiagnostic testing with neurological testing was reviewed but she did not know the results. The patient testified that Dr. T said that the foot was too swollen to do the actual testing. (Please note: The report indicates that the foot was adequately tested.)

It was noted her amended claim adds her left leg and back.

The patient indicated that the left leg and foot started hurting a few months after the original injury. She had mentioned this to her earlier doctors but all of those doctors told her that the low back and left lower extremity condition were not due to the industrial injury.

The patient was asked about the people at work that she discussed her symptoms with.

The various treatments she had received were reviewed. There was a further discussion about the childhood injury to the foot which she stated was a small cut. It was noted that before May 10, 2002 she never had any spinal complaints or any diagnostic studies of the lower extremities or back.

It was noted that a number of years before the industrial injury she would do some running for exercise but had not been doing that at the time of the industrial injury.

She did testify that in the past she saw an acupuncturist about 25 years ago for weight loss but not for injuries that she could recall. She did not know if any doctor had diagnosed flatfeet.

It was noted that she had been on restrictions since the injury of no ladders and no climbing up and down stairs and she was to park closer to her work place. She no longer returned merchandise to the departments at the end of the day and she was working four days on and three days off. She indicated her current pain medication did not completely relieve her symptoms. The patient testified that the medication would reduce her pain from a level 10 to a level 5 on a scale of 10. (Please note:
This pain scale is obviously very inaccurate and this patient could not be working with pain at the most severe pain imaginable.)

She was further asked about her ongoing symptoms at the time of the deposition and she reports she had gained about 20 pounds since the injury. This concludes the information in the deposition.

This concludes the review of all of the submitted records.

COMMENT

After a review of the history as obtained directly from the patient and the voluminous records that have been submitted, my physical examination and the x-rays available, it is my opinion that the above-captioned patient has the following industrially related orthopaedic conditions:

1. History of a contusion right ankle and foot.
2. History of back pain.

It is now nearly five years since this patient's industrial injury and she still has similar complaints to those that were present soon after the industrial injury. I believe her condition has been permanent and stationary for quite some time. It is noted there has been virtually no change in her overall condition since one year after the industrial injury. Although she has had numerous diagnostic studies and numerous evaluations and attempts at treatment through August 2005, it is noted that none of this treatment has had any beneficial influence on her foot or ankle condition. I therefore believe that she most probably could be considered to have reached maximum medical improvement by one year after the industrial injury.

There are, however, no permanent and stationary reports prepared prior to January 2005, and therefore an AMA impairment rating would be appropriate.

I have been requested to evaluate this patient by both the old permanent disability rating schedule as well as the AMA impairment method.

With reference to her right foot and ankle, at the current time I would rate her residual subjective complaints in the category of intermittent minimal to slight pain that might become constant slight pain with prolonged (many hours) of weight bearing. Permanent factors of residual objective disability referable to the right foot and ankle are actually limited to the tenderness with very firm pressure both anterior and distal to the medial malleolus. (In the past all of her symptoms were on the lateral side of the ankle.)

She does have a bilateral, very marked metatarsus primus varus and hallux valgus with a bunion deformity; however, this is symmetrical on both sides and this has absolutely nothing to do with her industrial injury.

It is noted that at the current time she has full symmetrical range of motion of the ankles and feet, she has free motion, there is no bone tenderness, there is no ligamentous instability, and at the time of my examination she did have a normal gait. Her shoes do show a minimal increase in posterior heel wear on the right which may indicate that she does have a periodic slight gait abnormality.

The patient has continued working at her regular job and I see no indication of any condition in her foot that would require any type of job modification or work restriction. I believe she could be working full time and do not believe that her hours need to be varied because of her foot condition. I believe she can wear any type of shoe that she finds comfortable and she does not require any type of special shoes. It is noted that more than a year ago she stopped wearing the special boot she had and there has been no change in her symptoms since she stopped wearing that boot.

As noted in the beginning of this discussion, this patient has had an extraordinarily protracted program of evaluations and treatment by various doctors. She has had almost every conceivable diagnostic study that could be performed. She has had an MRI study, she has had a CAT scan, she has had a bone scan, and she has had electrodiagnostic studies. None of these diagnostic studies have revealed any evidence of an impairment or disability or treatable condition.

She has seen numerous orthopaedists, multiple podiatrists and a pain management physician, none of whom have been able to come up with a clear diagnosis of a condition that could be treated and resolved. I do not believe that further diagnostic studies or further medical care are indicated or necessary or will be likely to be of any benefit to this patient in the future.

This patient does report a childhood minor cut on her foot but this has nothing to do with her current foot condition. Although her subjective complaints are not substantiated by objective findings, there is no history of any other injury or condition involving the right foot that would be responsible for her current condition. Although she does have the flatfoot and bunion problem, she has this in both feet but only the right foot is symptomatic. I therefore believe that all of her current right foot subjective complaints should be considered apportionable to the specific industrial injury of May 10, 2002.

It is also noted that the injury in question could not have been an extremely severe injury since she went nearly one month before she agreed to seek medical care for this injury and there has been minimal work loss from her work that does involve prolonged standing and walking as a result of the injury. I therefore believe and would concur with previous evaluators who felt that her subjective findings are out of proportion to her injury and her objective evaluation.

For completeness of this evaluation I will review her foot condition for an impairment rating as per the AMA Guides.

As per Table 17-1, Page 525, various methods to evaluate impairments to the lower extremities include anatomic, functional or diagnostic based conditions. In reviewing that table, it is noted the patient has none of the anatomic conditions of impairment.

Although a peripheral nerve injury has been suggested by some doctors, this has never been confirmed by either electrodiagnostic testing or detailed clinical examination with no specific motor or sensory loss from any peripheral nerve injury.

Later in this discussion I will indicate why I definitely do not believe this patient has ever had either causalgia or reflex sympathetic dystrophy (CRPS) and therefore the anatomic assessment of her lower extremity would not be appropriate. Under the functional impairment, range of motion, gait derangement and strength with manual muscle testing are methods of evaluation.
This patient has full symmetrical range of motion when compared with the opposite foot, and she does have normal muscle strength with manual muscle testing. The only abnormality she may have would be a gait derangement which I will discuss after completing this review of Table 17-1.

The final method to evaluate lower extremity impairments would be diagnostic based and this patient does not have any fractures or ligament injuries. She has not had meniscectomies. She does have a foot deformity in the form of a pes planus and a metatarsus primus varus with hallux valgus and a significant bunion. However, she has this condition in both feet and these are completely unrelated to her industrial injury. Hip and pelvic bursitis and lower extremity joint replacements are not appropriate to evaluate this patient.

The final and only remaining condition in her foot that can be evaluated by the AMA Guides would be the gait derangement.

Gait derangements are discussed in the AMA Guides in Section 17.2C starting on Page 529. A mild gait impairment would represent an antalgic limp with a shortened stance phase and evidence of moderate to advanced arthritic change of the hip, knee or ankle. (Please note: This patient does not have any change in her stance phase and she does not have any moderate or advanced arthritic change.) She therefore would have less than a mild type of antalgic limp which itself is a 7% whole person impairment. Under mild, a positive Trendelenburg sign or moderate to advanced arthritis of the hip would be included, which this patient does not have. A 15% impairment because of a mild gait abnormality would require part-time use of

a crutch or cane which this patient has never used. A mild impairment at the 15% level would also require the routine use of a short leg brace or an ankle/foot orthosis. (Please note: Although this patient has had an AFO discussed in the past and has used a cam walker in the past, she has not used any type of apparatus on her foot for more than a year, indicating this is not a routine finding and therefore she does not fit into this category.) The other moderate and severe categories of gait derangement are much more than anything that this patient would have. I therefore believe that she falls into the antalgic limp which is not even a constant finding and therefore requires a less than 7% whole person impairment. Being very generous I believe that this patient would have at most a 3% whole person impairment with reference to her foot condition. This is based upon the intermittent gait impairment which is slightly confirmed by the discrepancy in heel wear on her shoes.

In summary I believe that this patient's right ankle and foot condition which is the only area of impairment that I consider industrial on this patient would be rated at a 3 % whole person impairment based upon primarily her level of subjective complaints and by an intermittent gait impairment.

As noted at the beginning of this discussion, I believe that the only industrial injury this patient has sustained has involved her right ankle and foot.

Although a claim has been made for a back problem and she has mentioned low back pain to numerous physicians, no physician examining her has identified any significant pathology in her lower back other than Dr. C who discusses lumbosacral degenerative disease and lumbar radiculopathy when he saw her for a second visit in September 2006, although he makes no mention of any involvement of the back when he first saw her in January 2006, long after all of her treatment had ended.

With reference to her lower back condition, I am unaware of any specific medical literature that supports the contention that any type of footwear or gait abnormality will produce a lower back radiculopathy or degenerative disc disease. There is no indication that back pain is a sequela of any type of foot problems and it is noted that lower extremity amputees do not develop back pain as a consequence of their lower extremity problems.

Dr. C apportioned 50% of her lower back condition to non-industrial causation.
It is the undersigned's opinion that all of her lower back condition should be considered non-industrial in origin. This patient did have an episode of back pain for which she saw Dr. J in the past but I do not believe that that isolated episode of back pain, for which there is no indication of any follow-up visits in 1998, is responsible for her current condition. It is noted that in the past Dr. J has discussed weight reduction with the patient and his own records indicate that her weight as far back as 1996 was 193 pounds which is not very much less than her current weight in 2007.

I believe that it is most medically reasonable that her current back complaints and findings are the result of the aging processes combined with her obesity. I do not believe that her back condition should be considered a compensatory consequence of the time when she had a contusion of her foot nor any gait abnormality or use of any type of boot that was applied for her back condition. I therefore believe that her back condition is completely non-industrial.

For completeness of this report I would rate her current residual subjective complaints referable to her lower back at most in the category of intermittent and minimal. There is no objective evidence of an impairment or disability referable to her lower back. No doctor who has examined her back has identified any neurological abnormality related to the back. At the time of my current examination she has no spasm and no tenderness including examination by punch percussion. She does have limited motion but this does not appear to be a maximum effort and her motion is performed with a marked jerking movement X-rays at the time of my examination are normal. If there is any degenerative disc disease it is not sufficient to be identifiable.

Utilizing the AMA impairment guidelines her back condition would most appropriately fall into the Lumbar Category I (Table 15-3, Page 384) with no significant clinical findings. This would rate out as a 0% whole person impairment referable to her back.

Finally with reference to the lower back condition, I see no evidence of any condition that would require further diagnostic studies or medical care now or in the foreseeable future.

There is no evidence of any condition in her lower back that would require any type of job modification or work restriction.

Another condition that has been mentioned by various physicians in the past is the possibility of her having a complex regional pain syndrome.

This patient has never demonstrated any of the findings of complex regional pain syndrome. In the AMA Guides there is a detailed discussion of complex regional pain syndrome. There is actually a table of the objective diagnostic criteria for CRPS which includes RSD and causalgia on Page 496. Table 16-16 which is self-explanatory indicates there have to be vasomotor changes such as problems with skin color which would be mottled or cyanotic, skin temperature which would be cool and/or edema. The patient has never had any of those types of changes other than the initial black and blue discoloration when she had the original injury.

Sudomotor changes of the skin being either dry or overly moist have never been identified by any physician and are not present at the current time.

Trophic changes that could include skin texture which would either be smooth and non-elastic have not been described. Soft tissue atrophy has never been identified. Joint stiffness and decreased passive motion have never been clearly identified. There are no nail changes. There are no hair growth changes.

She does not have radiographic changes of osteoporosis or trophic bone changes, and her bone scan is not consistent with CRPS.

It is therefore quite evident that this patient does not now have and in the past did not have CRPS.

I believe that the doctors who have mentioned this syndrome are looking for something that can explain her pain which has not been otherwise clearly identified on the basis of her examination findings or her history.

In summary, I do not believe that this patient has any type of lower back condition that can be considered to be a consequence of her industrial injury. I do not believe she has ever had a complex regional pain syndrome. She does have a history of a right ankle and foot contusion which I have rated. These conditions are not sufficient to require future medical care or a job modification or work restriction. Her foot and ankle condition is fully apportionable to the specific industrial injury of May 2002.

This has been a very complicated case to evaluate. If there are any questions regarding these opinions, please do not hesitate to call upon me.

Please note, obtaining a history directly from the patient (with the assistance of an interpreter, if needed), reviewing and summarizing all records (if any), performing the entire physical examination and all measurements, reviewing x-rays (if any), and the preparation and dictation of this entire report were entirely and solely performed personally by the undersigned. The only exceptions were the measuring of vital signs and transcription of my personally dictated findings onto an office work sheet which were done by (office manager), who has been my office manager and back office assistant for 20 years and has been instructed and monitored in these activities by me. The time spent in connection with this evaluation was in compliance with any available guidelines.

Re: Juanita Patient
Date

Face to Face Time with Patient = _____hours
(History and Physical Examination)

Record Review Time =_____ hours
(Sorting, Reading, Summarizing)

Report Preparation Time = _____hours
Dictation and Proof Reading

_____Total Hours

I declare under penalty of perjury that there has not been a violation of Labor Code Section 139.3, that the contents of the report are true and correct to the best of my knowledge, and any statements concerning any bill for services are true and correct to the best of my knowledge.

I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true.

Dated _____ at County of _____

Sincerely,

Dr. QME, M.D.
Qualified Medical Evaluator
Diplomat, American Board of Orthopaedic Surgery

CC: Adjustor
Defense Attorney
Applicant Attorney