Expert Brief Pack: Letter of Instruction

Fictional Example – For Portfolio Purposes Only

Ref: JAA0100134

Prepared For: Expert Physician

Prepared By: Asher Medico-Legal Consulting

Date: 24 June 2025

Plaintiff Name: John Smith

DOB: 03/05/1979

Compliant

46-year-old plaintiff with ongoing lumbar and radicular symptoms following a workplace lifting incident. Despite conservative management and subsequent L4/L5 fusion surgery, the plaintiff reports continuing pain, restricted function, and an inability to return to work

Executive Summary

42-year-old male alleging ongoing lumbar spine symptoms following a workplace lifting incident on 15 March 2023.

Following conservative treatment, the plaintiff sought an orthopaedic opinion. The treating orthopaedic surgeon recommended weight reduction, physiotherapy, and ongoing conservative management. The plaintiff subsequently obtained a second orthopaedic opinion, which recommended lumbar fusion surgery at the L4/L5 level.

The plaintiff elected to undergo fusion surgery in July 2024. Despite surgery, he reports ongoing sciatic pain, restricted lumbar movement, reduced activity tolerance, and an inability to return to his pre-injury employment.

Chronology of Significant Events

On 18 August 2021, Dr Sarah Wilson, General Practitioner, reviewed the plaintiff following an episode of lower back pain after moving furniture at home. The plaintiff described intermittent

lumbar discomfort without radiation below the knee. Examination demonstrated mild paraspinal tenderness with full lower limb power, intact sensation and normal reflexes. Conservative treatment comprising non-steroidal anti-inflammatory medication and a home exercise programme was recommended. Symptoms were noted to have resolved at review approximately three weeks later, and the plaintiff returned to unrestricted employment.

On 15 March 2023, the plaintiff, a 46-year-old warehouse supervisor, reported sustaining an injury while manually lifting a box weighing approximately 30 kilograms during the course of his employment. He described immediate onset of lower back pain with radiation into the right buttock and posterior thigh. The incident report completed by the employer records that the plaintiff ceased work shortly thereafter and was transported home by a colleague.

On 17 March 2023, Dr Sarah Wilson, General Practitioner, examined the plaintiff. The plaintiff reported persistent lumbar pain radiating into the right leg, difficulty bending and discomfort when sitting. Examination identified lumbar paraspinal tenderness, reduced lumbar flexion and a positive straight leg raise on the right at approximately 60 degrees. Motor strength and lower limb reflexes were recorded as normal. Dr Wilson diagnosed an acute lumbar strain with suspected radiculopathy, prescribed anti-inflammatory medication, issued a certificate for total incapacity for work for two weeks and referred the plaintiff for physiotherapy and MRI imaging.

On 24 March 2023, MRI of the lumbar spine demonstrated a right paracentral L4/L5 disc protrusion contacting the traversing right L5 nerve root with mild foraminal narrowing. No fracture, spinal instability or significant central canal stenosis was identified.

On 29 March 2023, physiotherapist Emily Harris completed the initial physiotherapy assessment. The plaintiff reported constant lower back pain rated 7/10 with intermittent shooting pain extending below the right knee. Examination demonstrated significantly reduced lumbar flexion, reduced tolerance to prolonged sitting and guarded movement throughout functional testing. A conservative rehabilitation program comprising manual therapy, graduated strengthening exercises, education regarding activity modification and a home exercise program was commenced.

Between April and August 2023, physiotherapy records document regular attendance. Progress notes record gradual improvement in lumbar mobility and core strength. The plaintiff reported reduced resting back pain but continued episodes of right-sided sciatic pain during prolonged sitting, lifting and household activities. The treating physiotherapist consistently encouraged progression of strengthening exercises, weight management and graded return to normal activities.

On 5 September 2023, Orthopaedic Surgeon Dr Michael Andrews reviewed the plaintiff. Dr Andrews noted MRI evidence of an L4/L5 disc protrusion but considered there was no significant neurological deficit or spinal instability. He recommended continuation of conservative management, including weight reduction, structured physiotherapy, core strengthening and optimisation of analgesia. Dr Andrews advised that lumbar fusion surgery

was not indicated at that stage, noting that many patients with similar imaging findings improve without operative intervention.

On 18 November 2023, the plaintiff sought a second orthopaedic opinion from Dr Rebecca Chen. Dr Chen recorded persistent radicular pain despite approximately eight months of conservative treatment. Examination demonstrated a positive straight leg raise, diminished sensation in the right L5 dermatome and mild weakness of right ankle dorsiflexion. Having reviewed the MRI and clinical history, Dr Chen considered that the plaintiff had failed conservative management and recommended L4/L5 lumbar fusion after discussing the potential risks, benefits and alternatives. The records note that the plaintiff elected to proceed with surgery.

On 15 July 2024, the plaintiff underwent L4/L5 lumbar fusion. The operative report records successful decompression of the affected nerve root and instrumented fusion without intra-operative complication. Estimated blood loss was within expected limits and satisfactory positioning of pedicle screws was confirmed intra-operatively.

On 15 July 2024, recovery room nursing observations document that the plaintiff was awake, alert and neurologically intact on arrival in the post-anaesthesia care unit. Pain was initially reported as 8/10 and improved following administration of prescribed analgesia. Nursing assessments recorded intact motor function in both lower limbs, stable observations and no evidence of excessive wound drainage or immediate post-operative complication.

On 16 July 2024, ward nursing notes record that the plaintiff mobilised short distances with assistance from the physiotherapy team. The surgical wound remained clean and dry. The plaintiff reported ongoing discomfort around the operative site together with intermittent right leg pain similar to that experienced prior to surgery. There was no documentation of bowel or bladder dysfunction.

On 16 July 2024, hospital physiotherapist James O'Connor assessed the plaintiff following surgery. The plaintiff mobilised approximately 20 metres using a walking frame with supervision. Education was provided regarding spinal precautions, safe transfers, stair negotiation and a graduated walking program. The plaintiff was considered suitable for discharge with outpatient physiotherapy following achievement of mobility goals.

On 30 July 2024, Dr Chen reviewed the plaintiff two weeks following surgery. The surgical wound was noted to be healing appropriately with no evidence of infection. The plaintiff reported improvement in mechanical lower back pain but persistent intermittent sciatic pain affecting the right lower limb. Dr Chen recommended continuation of physiotherapy, gradual increase in walking distance and avoidance of heavy lifting during the fusion healing period.

Between August and December 2024, outpatient physiotherapy records document progressive improvement in walking tolerance, transfers and lumbar stability. The plaintiff demonstrated improved activation of core musculature and reduced reliance on opioid analgesics. However, progress notes consistently record persistent right-sided radicular pain,

particularly following prolonged sitting or repetitive bending activities. Functional lifting remained significantly restricted throughout rehabilitation.

On 15 January 2025, CT imaging of the lumbar spine demonstrated stable instrumentation with satisfactory progression of bony fusion across the L4/L5 segment. No evidence of hardware loosening, screw migration or pseudarthrosis was identified.

On 20 January 2025, Dr Rebecca Chen, Orthopaedic Surgeon, reviewed the plaintiff approximately six months following lumbar fusion surgery.

The plaintiff reported improvement in mechanical lower back pain compared with his pre-operative symptoms but continued to experience persistent right-sided sciatic pain extending into the lateral calf and dorsum of the foot. He reported difficulty sitting for longer than 30 minutes, inability to undertake repetitive lifting and continued absence from work.

On examination, Dr Chen recorded:

- Well-healed surgical incision.
- Mild restriction of lumbar flexion and extension.
- Positive straight leg raise on the right at approximately 50 degrees.
- Mild reduction in sensation over the right L5 dermatome.
- Slight weakness of right ankle dorsiflexion (4+/5).
- No bowel or bladder disturbance.
- No signs of wound infection or hardware-related tenderness.

Dr Chen noted that post-operative CT imaging demonstrated satisfactory progression of fusion with no evidence of instrumentation failure.

Having regard to the plaintiff's ongoing radicular symptoms, Dr Chen requested repeat MRI imaging to assess for persistent nerve root compression, recurrent pathology or post-operative scar formation. The plaintiff was advised to continue physiotherapy, maintain a graduated exercise programme and remain under pain management pending further investigation.

On 22 February 2025, MRI of the lumbar spine was performed following the plaintiff's ongoing complaints.

The radiologist reported:

- Stable post-operative appearance following L4/L5 fusion.
- No recurrent disc herniation.
- Mild epidural fibrosis surrounding the exiting right L5 nerve root.
- Mild residual foraminal narrowing at L4/L5.
- No central canal stenosis.
- No hardware complication identified.

The report concluded there was no significant recurrent compressive lesion requiring further surgical intervention.

On 5 March 2025, Dr Chen reviewed the plaintiff after receipt of the MRI findings.

Dr Chen advised that the imaging demonstrated satisfactory fusion with no evidence of recurrent disc prolapse or hardware failure. She explained that mild epidural fibrosis was a recognised post-operative finding and that its relationship to the plaintiff's ongoing symptoms was uncertain.

Dr Chen considered there was no indication for revision lumbar surgery at that time.

Recommendations included:

- Continued physiotherapy with emphasis on conditioning and flexibility.
- Ongoing weight management.
- Review by a pain medicine specialist for optimisation of symptom management.
- Functional Capacity Evaluation to assist with assessment of work capacity.
- Graduated return to suitable duties if tolerated.

On 10 March 2025, Dr Wilson reviewed the plaintiff for ongoing symptoms. The plaintiff continued to report persistent right-sided sciatic pain, reduced tolerance for prolonged sitting and standing, disturbed sleep and inability to return to warehouse duties. Examination recorded restricted lumbar flexion, positive straight leg raise on the right and mild sensory alteration within the L5 dermatome. Dr Wilson continued analgesic medication and referred the plaintiff for an independent functional capacity assessment.

On 2 April 2025, occupational therapist Karen Lewis completed a Functional Capacity Evaluation. The plaintiff demonstrated independence with personal care and light domestic tasks but experienced increased symptoms during repetitive lifting and sustained bending activities. The assessment concluded that the plaintiff retained capacity for sedentary work with opportunities to alternate between sitting and standing but was not considered capable of returning to heavy manual employment.

Summary

The records demonstrate radiological evidence of a technically successful fusion, with stable instrumentation and no recurrent disc prolapse.

Despite these findings, the plaintiff continues to report persistent right L5 radicular symptoms including persistant sciatic pain, reduced lumbar mobility, restricted activity tolerance.

Objective clinical findings include: Positive straight leg raise on the right at approximately 50 degrees, mild weakness of right ankle dorsiflexion (4+/5) documented on two occasions,

reduced sensation over the lateral aspect of the right calf in an L5 distribution, reflexes generally symmetrical throughout follow-up.

Repeat MRI demonstrates mild epidural fibrosis adjacent to the right L5 nerve root without evidence of a significant recurrent compressive lesion. No hardware loosening or implant failure identified, and no recurrent disc herniation.

Dr Chen did not recommend further surgical intervention and instead advised ongoing rehabilitation, pain management and assessment of functional capacity.

The plaintiff has not been able to return to work and requires ongoing physiotherapy and analgesia. Occupational therapy records indicate the plaintiff is independent in personal care but reports difficulty with vacuuming, gardening, carrying groceries, repetitive lifiting, prolonged driving. A Functional Capacity Evaluation concludes the plaintiff demonstrates capacity for sedentary duties with the ability to change position regularly, while heavy manual work is not recommended.

We would be most grateful for your opinion on the following issues:

- Is the plaintiff's current presentation causally related to the workplace incident?
- What significance, if any, should be attributed to the plaintiff's documented pre-existing lumbar complaints?
- Was lumbar fusion clinically indicated having regard to the differing orthopaedic opinions?
- Is the plaintiff's persistent radicular pain explained by the available clinical and imaging findings?
- Are the plaintiff's reported functional restrictions consistent with the objective medical evidence?
- Has maximum medical improvement been achieved?
- What work capacity, if any, is supported by the available evidence?