**BOB SOIN  
MB BChir (Hons) MA (Cantab) FRCS MD**

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Castle Cavendish Works Dorking Road Nottingham NG7 5PN

**MEDICAL REPORT ON**

**Mr XXXXX XXXXX**

**XX/XX/XXXX**

**FOR THE ATTENTION OF THE COURT**

**SINGLE INSTRUCTION REQUESTED BY**

**Premier Medical CMRXXXXX/101**

**For: Motor Insurance Bureau Claims ref:** XXXXX/PIO

**In accordance with the Personal Injury Pre-Action Protocol**

**DATE OF EXAMINATION XX/XX/20XX**

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Report to the Court

**Report compiled by Mr Bob Soin MA, MB BChir (Hons), FRCS (Eng) MD.**

**XXXX XXXX**

Date of birth: XX XXXX 19XX  
Age at date of injury: 51  
Date of report of injury : XX/XX/XXXX

Occupation at time of incident: Care Assistant

For the purposes of this medical report, I examined Mrs XXXX XXXX, at XXXXhrs on the XXth XXXXX 20XX, at the Princess Margaret Hospital, Windsor. She presented a passport and bank card as identification. I have notes from his hospital specialists, particularly relating to her emergency admission, abdominal surgery and GP notes. This is a report focussed on her abdominal injuries. I note previous report from Dr XXXX, GP from his examination dated XX XXXX 20XX.

This report is based upon my clinical experience as a Consultant General Surgical Surgeon and as a fellow of the Royal College of Surgeons of England and the articles listed below:  
A Textbook of Surgical Practice – Bailey & Love.

Principles of Surgery – S. I. Schwartz 8th Edition.  
UpToDate- Management of duodenal and pancreatic trauma in adults. 2016. Maggio P & Clark D. Wolters-Kluwer.  
Velmahos GC, Tabarra M, Gross R et al. Blunt pancreatoduodenal injury: a multicentre study of the research Consortium of New England Centres of Trauma (ReCONECT). Arch Surg 2009 144:413.

**PRESENT COMPLAINTS**

Mrs XXXX reports no on-going or limiting abdominal pain or problem. She returned to full-time work as a care assistant after 3 months from the date of the accident. She has reduced her hours from 65-70 hours of work a week to approximately 50 hours a week because of fatigue.

She has, since resuming her job, restricted her work practices because of her concern about the strength of her abdominal wall. She avoids lifting and turning and client and finds herself relying on her arms rather than her core muscles.

She has not needed to see her GP with regard to any on-going abdominal issues and does not use any painkillers for her abdominal wall.

She is able to do all her activities of daily living independently from approximately 3 months after the accident. She does not need to wear an abdominal support or corset.

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Mrs XXXX does not have any modifications to equipment in the house or car as a result of her injuries following the accident.

She is aware of the cosmetic appearance of her scar. She no longer wears a bikini but otherwise wears normal clothing including belts.

She has not restarted running, but is now able to go for long walks without restriction to keep fit.

**HISTORY OF THE ACCIDENT**

Mrs XXXX was in an accident at approximately XXXX on the night of XXXXXX. She was the seat-belted driver, when her car was hit from the passenger side at approximately 30mph. She recalls being thrown from side to side and having immediate abdominal discomfort in the area of her belt.

She was triaged at XXXX Hospital Emergency Department at XXXX hrs. She was assessed, resuscitated and a CT scan performed. This demonstrated evidence of a bowel perforation with free intra-abdominal gas but no other abdominal, chest or pelvic injury.  
She underwent an immediate operation (laparotomy) where a perforation of the duodenum was found and repaired. There was leakage of bile into the abdominal cavity (termed ‘peritoneal soiling’), which was cleaned out and a drain placed.

Mrs XXXX was moved to the intensive care unit where she was treated with further fluids and antibiotics. Her gut did not function immediately, as is not uncommon following these injuries, so was fed intravenously with total parenteral nutrition.

She had post-operative symptoms of pain, fever and abdominal distension. She had repeat CT scans on the XXXXX and a barium meal on the XXXXXXX. These confirmed no leak from the repair or intra-abdominal abscesses. The second CT showed post-operative constipation only.

Mrs XXXX developed a superficial wound infection and was discharged on painkillers and requiring daily wound dressings, which continued for approximately six weeks after the operation. During this time she required help with her activities of daily living including dressing and bathing from her family. She was unable to do her house cleaning activities for approximately eight weeks. A friend moved in to live with her and support her through this time.

**PAST MEDICAL HISTORY**

Prior to the accident the patient rarely saw her GP and had no pre-existing medical conditions. She had not previously had any abdominal operations.

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**DRUG HISTORY**

No current medication. After the accident she was discharged with paracetamol and required only this for more than two months after discharge. She was still using this regularly up to 4 times a day when she returned to work.

**PSYCHOLOGICAL SYMPTOMS**

Mrs XXXX has a lack of confidence in the strength of her abdominal wall. This has prevented her returning to running and resuming lifting duties at work.

**SOCIAL HISTORY**

Mrs XXXX is married and lives in a house but lives on the ground floor.  
She returned to normal socialization about 4 months after the injury.  
She returned driving after 3 months but still is apprehensive when driving, particularly, when driving on the same roundabout.  
Her sleep pattern took 6 months to return to normal, uninterrupted sleep.  
She is a non-smoker who drinks less than 2 units of alcohol per week.She has never been involved in previous claims or compensation litigation.

**ON EXAMINATION**

Mrs XXXX is XXXcm tall and weighed XX.Xkg with a BMI of 30. She moved without restriction or aid around the room and on to the couch.

There is a well-healed 13cm scar with a maximum width of 1.5cms in the upper abdomen extending below the umbilicus. There is no sinus, fistula or hernia associated with the scar. The scar has no keloid but has marks from the skin clips used to close the wound. There are drain holes either side of the umbilicus, which are well healed without hernia.

**OPINION AND PROGNOSIS**

Mrs XXXX sustained injuries consistent with the mechanism of injury caused by the impact. Her recovery was typical given the severity of injury suffered and relatively rapid because of

her preceding good health. She has made a good recovery and has no long-term limitations at this time due to the physical injuries. She has a relative reluctance to risk damaging her abdominal wall and developing an abdominal hernia. I reassured her during the consultation that the wound has healed well and is unlikely to deteriorate with normal lifting activity. The risk of hernia development remains, but is independent of physical activity.

Her psychological response to the accident appears neither excessive, nor prolonged and should dissipate further over the next six months.  
There remain potential risks of further complications that may result from her injuries and the treatment required. In terms of long-term complications related specifically to the injuries to the duodenum, it is not anticipated that there will be any long-term sequelae or on-going disability.

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However, adhesions (internal scars between tissues) often follow emergency open surgery particularly when there has been peritoneal soiling/contamination. There is a long-term risk of problems such as bowel obstruction necessitating (emergency) surgery. This surgery is likely if needed to be open and complex surgery with significant risk of morbidity and a smaller risk of death. The incidence of adhesion related obstruction is approximately 5% but not possible to predict particular at risk patients with any accuracy. Some of these cases may be managed without operation but approximately a third of these will require operation.

There is an approximate 10-20% risk of incisional hernia after an emergency laparotomy that is increased by post-operative infection, which complicated Mrs XXXX’s recovery. Most of these would appear within three years after the index operation (i.e. by mid 2019). There is a continued risk of emergency surgery being required due to hernia &/- obstruction of approximately 3% per year.

Further surgery would be a major procedure that may require a prolonged hospital stay and recovery. The risk of a recurrent hernia would be up to 20% after this.

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**STATEMENT OF TRUTH**

I confirm that insofar as the facts stated in this report are within my knowledge, I have made clear which they are and I believe them to be true, and the opinions I have expressed represent my true and complete professional opinion.

I understand that my overriding duty in preparing this report and giving evidence is to the Court rather than the party who engaged me.

I have endeavoured in my report and in my opinion to be accurate and cover all relevant issues concerning the matters stated, of which I have been asked to address.

I have endeavoured to include within this report those matters of which I have knowledge or of which I have been made aware, which might adversely affect the validity of my professional opinion.

I have indicated within this report all sources of information used in its completion.

I have not, without forming an independent view, included or excluded any information that has been suggested to me by others.

I will notify those who have engaged me immediately in writing of any reason my existing report require any correction or qualification.

I understand that my report, subject to any correction before swearing as to its correctness, will form the evidence to be given under oath or affirmation.

I confirm that I have not entered into any arrangement between the parties whereby the amount of payment in respect of my fee is dependent upon the outcome of the case.

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I confirm that my report contains a comprehensive summary of the conclusions reached and includes any relevant pre-accident medical information and history, treatment received and present condition, dealing in particular with the capacity for work (where appropriate) and giving a full prognosis. I have fully assessed the claimant’s injuries to establish the extent and duration of any continuing disability and impact on daily living in my opinion.

Bob Soin MB BChir (Hons), MA(Cantab), FRCS, MD.

CONSULTANT GENERAL SURGEON

XXth XXXXX 20XX.

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**Administration, Appointments & Queries:**

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