MOTOR ACCIDENTS AUTHORITY

Medical Assessment Service

Statement of Reasons

in the making of a
Certificate of Determination of a Medical Assessment
in a
Further Assessment
under Part 3.4 of the
Motor Accidents Compensation Act 1999

Matter Number
2007/04/0044HT

Applicant	**Respondent**
Frank Gary Filippetti	GIO General Limited

Claimant's Name:	Frank Gary Filippetti
Claimant's Date of Birth:	06.11.64
Date of Motor Accident:	13.05.04
Assessed By:	Assessor Dr Neal L Thomson
Clinical Specialty:	Orthopaedic Surgery
Assessed At:	Circular Quay
Date of Assessment:	17.04.07
Date of Certificate:	**17.04.07**
Injury Type:	**Physical Injuries**

Dispute Details

The claimant attended at the request of the Motor Accidents Authority of NSW for the purposes of Further Assessment and resolution of the following medical disputes in accordance with Part 3.4 of the Motor Accidents Compensation Act 1999:

- Whether injuries caused by the motor accident have **stabilised**
- The degree of **permanent impairment** of the injured person as a result of injuries caused by the motor accident

This **Statement of Reasons** forms part of the determination in this matter as set out in the accompanying **Certificate of Determination**.

Level 19 1 Oxford Street DARLINGHURST NSW 2010 AUSTRALIA (DX 10 Sydney)
Phone 1300 137 131 Fax 1300 137 707 TTY (02) 8268 1450
www.maa.nsw.gov.au

1. Introduction

I have seen and considered the file relating to the previous MAS assessment, reference 2006/02/2198 and I have seen and considered the MAS Further Application Form and supporting documents and the MAS Further Reply Form and supporting documents.

I have also seen and considered the additional documents that were provided subsequent to the referral of this matter under cover of Medical Assessment Service letter dated

- 10.04.07 - Statement of reasons in a further assessment matter number 2007/04/0044HT prepared by Dr Allan Mears

The Medical Assessment Service has advised that each party has received a copy of the above documentation.

The claimant brought the following relevant imaging studies and/or reports to the assessment:

- 13.05.04 **X-ray right ankle** - Report by John Lim – IAHS Medical Imaging

  The ankle mortise is preserved.
  No fracture visible.
  Multiple corticated ossicles with lucent artefact seen just dorsal to the ankle joint, which may be related to venous phleboliths.

- 13.05.04 **X-ray cervical spine** - Report by John Lim – IAHS Medical Imaging

  Alignment is normal. No fracture. No discrete bony lesion.

- 13.05.04 **X-ray right femur** - Report by John Lim – IAHS Medical Imaging

  Transverse fracture of the distal femur, dorsal fragment is displaced laterally and posteriorly. There is minor overlap of the fragment.

- 13.05.04 **X-ray left ankle** - Report by John Lim – IAHS Medical Imaging

  There is disruption of the ankle mortise. Fracture of the distal tibia noted with displacement.

- 14.05.04 **X-ray chest** - Report by John Lim – IAHS Medical Imaging

  Heart size is at the upper limits of normal on this supine projection. The lungs are clear with no contusion or pneumothorax identified. The lung bases have not been included however, on the film.

- 14.05.04 **X-ray pelvis** - Report by John Lim – IAHS Medical Imaging

  There is no fracture. No discrete bony lesion.

- 14.05.04 **X-ray right femur** - Report by John Lim – IAHS Medical Imaging

  Transverse fracture of the distal femur, dorsal fragment is displaced laterally and posteriorly. There is minor overlap of the fragment.

- 14.05.04 **X-ray right ankle** - Report by John Lim – IAHS Medical Imaging

  There is disruption of the ankle mortise. Fracture of the distal tibia noted with displacement.

- 15.09.04 **X-ray right femur** - Report by Alex Peterson – Whistler Radiology

  A right femoral intramedullary nail is present. This passes through a fracture at the junction of mid and distal thirds. A fracture line is well seen. There is some well defined periosteal response around the fracture, however definite bony union is not demonstrated. No complications appear evident.

  Comment
  Compared to previous x-ray from the 15.07.04 there is evidence of progression of fracture of healing, although bony union is not yet demonstrated.

- 09.11.04 **X-ray right femur** - Report by David Hill – IAHS Medical Imaging

  The postoperative appearances are satisfactory.

- 24.01.05 **X-ray right femur & right knee** - Report by Raymond Lau – Whistler Radiology

  There is an intramedullary nail in position for internal fixation of a fracture of the lower half of the femoral shaft. A considerable amount of new bone

is present around the fracture site but the fracture line is still clearly visible, as such solid bony union has not yet occurred.

There is mild degenerative disease involving the patellofemoral articulation where there is slight osteophytic lipping. The bones are slightly porotic. The tibiofemoral compartments are not significantly narrowed. No other bony abnormality is seen.

- 03.02.05 **Bone scan** - Report by Phil Monaghan – Illawarra Nuclear Imaging

  Opinion
  Abnormal bone scan of the right distal right femur.
  There are findings for reactive non-union.
  A labelled white cell/bone marrow study has been arranged for evaluation regarding complicating infection.

- 10.02.05 **Bone scan** - Report by Phil Monaghan – Shoalhaven Nuclear Imaging

  Opinion
  The labelled white cell study is against the presence of complicating focal infection involving the reactive non-union of the right distal femur.

- 27.06.05 **CT lumbar spine** - Report by Dr Adrian Gale - Rayscan Imaging – Liverpool

  At the L5/S1 level, there is minor circumferential bulging of the disc annulus associated with a small right posterolateral disc protrusion.
  However, there is no direct encroachment on neural structures.
  Osteoarthritic changes are noted in the apophyseal joints at this level, slightly more marked on the right than the left.
  The remaining discs are intact.
  The remaining neural structures are normal in appearance.
  No discrete soft tissue mass to suggest the presence of a haematoma is seen at this time.
  No radio dense foreign body is demonstrated.
  No other abnormality is seen.

- I reviewed an X-ray left ankle dated 15.07.04

Vertical fracture lower end of left tibia with a large separate segment including the medial malleolus. The fracture has been fixed with plate and screws. Three separate screws transfix the lower part of the fracture. There is a step in the articular surface of the tibia of the ankle mortice.

Details of Who Attended the Assessment

The claimant attended unaccompanied.

List of Injuries as Submitted by the Parties

The following injuries as listed in the referral letter were assessed in relation to the above medical dispute:

- **Left ankle – closed tibial plafond fracture**
- **Right femoral – grade 11 open distal fracture**
- **Right knee – medial collateral ligament injury / anterior cruciate ligament injury**
- **Lumbar spine injury**

Summary of Additional Information Provided since the Previous Assessment

I reviewed the following documents:

Reports by Dr Bodel to Nagle & McGuire dated 20.11.06, 20.11.06 & 05.12.06.
Report by Dr Searle to Nagle & Maguire dated 19.08.06
Reports by Dr Janson to GIO dated 02.11.04, 23.11.04, 07.01.05, 27.01.05.
Notice of claim form
Reports of Dr Lau dated 25.01.05 & 20.07.05
Report Ambulance Service of NSW dated 13.05.04
Report by Dr P Whistler dated 03.11.05
Report by Dr A Peterson dated 13.12.05
Report by Dr R Walker dated 11.01.06
Clinical notes Shoalhaven District Memorial Hospital dated 01.03.06.
Clinical notes Sydney Southwest Private
Report of Dr A Gale dated 12.04.06

2. History as Given by the Claimant

Brief Medical History and Relevant Personal Details

Mr Filippetti stated that he was fit and healthy prior to the motor accident.

He stated that he was not under treatment.

He did use a Ventolin puffer for occasional asthmatic attacks.

He also reported that he had a previous operation on his left ankle for removal of spur at the back of the lateral side of the left ankle. The operation was performed in 1990.

Mr Filippetti is divorced. He has 3 children and since 2005 has custody of 2 of the children, a son aged 6 and a daughter aged 8 years.

He lives in a house, which is rented. His economic status is poor.

He smokes about 3 – 4 cigarettes a day and does not drink alcohol.

Brief History of Education and Employment

Mr Filippetti does not have any trade certificates.

The nature of his duties at the time of the motor accident was plant operator for Druce DP Pty Ltd.

His hours of work were 38 hours per week. He did approximately 6 – 8 hours overtime.

The equipment used was driving a 40 tonne excavator.

Mr Filippetti states that he has been unable to work since the accident.

History of the Motor Accident

Mr Filippetti stated that on 13.05.04 he was riding a motorbike. He was wearing a helmet, steel capped boots, and work gear with a vest over the top of the gear.

He was riding with his light on.

There was a collision with motorcar. He stated that the car had stopped to do

a right hand turn into a driveway and suddenly the car turned in front of his motorbike. He said that he cannoned straight into the car at about 40KPH.

Mr Filippetti states that he was thrown off his bike and went over the top of the car landing about 3 – 4 metres behind the car. He was not knocked unconscious.

Police attended the scene of the accident and an ambulance arrived after about a 30 minute delay.

Mr Filippetti was transported to Shoalhaven Hospital. He is unsure whether x-rays were performed at the hospital but he was stabilised at Shoalhaven Hospital and then transported to Wollongong Hospital.

History of Symptoms and Treatment Following the Motor Accident

Mr Filippetti was admitted to the Wollongong Accident and Emergency Department. X-rays were performed there.

Mr Filippetti states that an operation was carried out on the evening of the day of the motor accident on 13.05.04.

The operation was for intramedullary pinning of the right femur, which was compounded and insertion of pin and plates into the left ankle.

Mr Filippetti remained in hospital for 6 – 8 weeks and was discharged on a wheel chair home to Sanctuary Point Jervis Bay.

I obtained the history from the supplied documentation by Dr Stuart Jansen Orthopaedic Surgeon Escarpment Orthopaedics and Sports and Dr M O'Carrigan Orthopaedic Surgeon Sydney Bone and Joint Clinic

I note in Dr Jansen's report of 07.01.05 that Mr Filippetti underwent internal fixation of his left ankle and retrograde intramedullary nailing of the right femur. These were performed on 14.05.04 at Wollongong Hospital.

Diagnosis: A significant fracture of the left tibial plafond, which was displaced and a femoral fracture grade 2 compound injury.

It was noted that the femoral fracture was debrided at the time of original surgery.

Dr Jansen did review Mr Filippetti on 20.07.04 some 9 ½ weeks post surgery.

He noted that here had been benefit from physiotherapy but Mr Filippetti was still non-weight bearing. He examined Mr Filippetti's right knee and considered that there was laxity of the anterior cruciate ligament grade 2 and medial collateral ligament laxity grade 3.

There was also a restricted range of movement.

X-rays at that time showed the fracture with internal fixation without any signs of significant union.

He advised that Mr Filippetti may require ligament reconstruction at a later time.

It is also noted that Dr Jansen requested removal of the locking screws from the proximal end of the femur to be done at Figtree Private Hospital. These requests were apparently sent on 26th July and 1st November to GIO Insurance.

It is noted on 05.11.04 Mr Filippetti underwent further surgery at Wollongong Hospital. It was noted at operation that the intraoperative findings were broken screws with the protrusion of the nail approximately 4mm into the knee. There was deep groove in the central ridge of the patella. There was a widespread early osteoarthritis in the rest of the right knee in both medial and lateral compartments. The nail and screws were removed. The femur was reamed up to 13mm and a size 13 X 340mm nail was re-inserted. Dr Jansen states that the fracture at that time was rotationly stable and it was only locked at the knee.

He was discharged from hopsital weight bearing as tolerated with crutches.

I note a report of 23.11.04. Dr Jansen reports significant failure of the fractured to advance with healing.

There was also a suspicion that there may be an infection at that time.

The report of 16.02.05 Dr Jansen states he elected to refer Mr Filippetti to Dr Tim O'Carrigan.

Report of 27.04.05 by Dr Tim O'Carrigan Orthopaedic Surgeon Sydney Bone and Joint Clinic.

Dr O' Carrigan states under discussion. There is established hypertrophic

non-union of the right femur. Mr Filippetti therefore needs surgical intervention in the form of removal of the intramedullary nail, debridement of the fracture site, excision of about 2cms of bone at this level and to get back to bleeding healthy bone.

He will also require a lengthening osteotomy proximal to the reach of the previous nail in the sub-trochanteric region and to stabilise the femur we will need to apply and EBI rail fixateur.

A report 26.07.05 by Dr O'Carrigan indicates that on 21.06.05 operative treatment was carried out on Mr Filippetti's right femur with resection of his non-union and an EBI external fixateur was applied. It is stated that the cultures were negative but he did have a period of intravenous antibiotics.

On 05.07.05 he was taken back to theatre and further fixation devices were added to the EBI external fixateur and screws were inserted across the osteotomy site to improve stability.

There are numerous other reports by Dr O'Carrigan.

An operative reported dated 13.09.05, adjustment of EBI external fixateur right femur.

18.10.05 problems with pain and pin tract infection.

04.11.05 Dr O'Carrigan made the comment that Mr Filippetti's circualtion in his right leg had suffered and significant disturbance because of the previous trauma and multiple surgery. I think that this is the main factor regarding swelling in the right leg.

A report of 11.01.06 Dr O'Carrigan reported Mr Filippetti is having difficulty walking with pain and also feels that the knee and leg is generally more swollen.

X-rays at that time compared with a month ago showed significant consolidation of his osteotomy and regeneration site.

The 14.02.06 further operation report dated 06.02.06 modification of external fixateur right femur.

07.03.06 Dr O'Carrigan reports flare up of pin tract infection and pain. Mr Filippetti was admitted to hospital for intravenous antibiotics and analgesia.

Operation reprot dated 08.03.06 removal of EBI external fixateur right femur.

11.04.06 Dr O'Carrigan reported that Mr Filippetti required an arthroscopy of his right knee.

Operation report dated 01.05.06 right knee arthroscopy partial medial meniscectomy and chondroplasty.

Marked damage to the femoral sulcus and retropatella surface presumably from the retrograde nail.

There was a large area of fibrocartilage in the femoral sulcus but no loose flaps.

Fimbrillation of the retropatella chondral surface, which was debrided to stable cartilage.

Dr O'Carrigan considerd the anterior cruciate ligament was intact. The medial compartment showed some grade 3 medial femoral condylar early cartilage wear. There was a small tear of the posterior horn of the medial meniscus, which was resected back to stable cartilage. There was a small area of fimbrillation in the lateral tibial plateau cartilage.

A final report of Dr Tim O'Carrigan dated 16.08.06 indicated that Mr Filippetti was getting some pain around the right lower back and right buttock.

It is stated that his pain was not improving or getting worse.

He was taking pain medication. Mr Filippetti considered that his leg lengths were equal.

It was noted that he walked with an antalgic gait. He was noted to have reduced flexion of his right hip. There was extreme irritabilty of the right knee.

It was felt that there was a good range of movement of the left ankle.

It was suggested that Mr Filippetti attend Dr Henry Lam Pain Management Specialist for his ongoing chronic pain and psychological coping mechanism.

Mr Filippetti stated that he recevied physiotherapy in his home by Theo Bokor Physiotherapist once per week.

Mr Filippetti also had to look after his 3 children and he managed to cope with

his household duties as he had good upper body strength and was able to move from the bed to the wheel chair and to the toilet.

He had difficulty with bathing. He spent a lot of time resting in bed and the lounge room

He received home care nursing and also attended the Medical Centre at Sanctuary Point to visit Dr Stonovich Family Physician.

He received analgesic tablets from Dr Stonovich.

Mr Filippetti stated that after 7 – 8 months he was advised that a screw had slipped in the nail and the pin had shifted into his knee and he related damage to the patella.

He said that the physiotherapist considered that there was a complication in Mr Filippetti's right knee.

Mr Filippetti reported that he suffered from ongoing swelling in his left ankle, which he felt was getting worse but he did not receive any treatment for the left ankle.

He said that he had x-rays for his back but these were reported on as being normal.

Details of Any Relevant Injuries or Conditions Sustained Since the Motor Accident

Mr Filippetti does not report any other injuries or accidents since the motor vehicle accident.

Current Symptoms

- **Left ankle – closed tibial plafond fracture**

  Mr Filippetti reports continuing pain and swelling in his left ankle with poor circulation in his left leg. He says that he suffers significant discomfort with cold weather with pain and stiffness in the ankle.

  He says that he cannot swivel from right to left now that he is ambulant and has restricted range of movement in the ankle joint.

- **Right femoral – grade 11 open distal fracture**

  Mr Filippetti reports continuing pain in the region of the fracture. He says that his muscles have deteriorated in the right leg and there is wastage and weakness in the musculature.

  He feels that he does not have a full range of movement in his hip or his right knee.

- **Right knee – medial collateral ligament injury / anterior cruciate ligament injury**

  Mr Filippetti says that he has to use his stick almost all the time. His walking distance is very restricted and he finds that if he is not using his stick he has a feeling of instability in the right knee.

  He states that his right knee has let him down on occasions. He cannot go down stairs carrying anything and has fallen attempting to go down stairs on one occasion.

  He continues to have a very irritable knee and complains of swelling in his knee and stiffness in the knee.

- **Lumbar spine injury**

  Mr Filippetti states that he has increased stiffness in his back and he said that the back tends to lock up. He has been lying down a lot and while sitting in a car he finds that his back tends to stiffen and lock up.

  He has some pain radiating to his right buttock area and pain on twisting to the right.

  He uses a cane to ambulate.

Current and Proposed Treatment

Mr Filippetti said that he understands that there is no further treatment of the fracture of the femur or the ankle being considered.

His physiotherapy has stopped and he feels that things are getting worse.

He continues to look after his 2 children and his domestic nursing has been cut back.

He is irritable because he cannot stand for long periods of time and has to sit on and off during meal preparation. .

3. Findings on Clinical Examination

Clinical Examination

- **Left ankle – closed tibial plafond fracture**

  It is noted that there is some swelling around the left ankle region and there is a restricted range of movement with some pain and discomfort at the extremes of movement.

Ankle Measurements: AMA 4 Table 42 (Page 78)

	Measurement RIGHT	Measurement LEFT
Plantar Flexion	40°	30°
Extension (Dorsiflexion)	10°	0°

Ankle Measurements: AMA 4 Table 43 (Page 78)

	Measurement RIGHT	Measurement LEFT
Inversion	15°	10°
Eversion	10°	0°

Ankle Measurements: AMA 4 Table 44 (Page 78)

	Measurement RIGHT	Measurement LEFT
Varus	nil	nil
Valgus	nil	nil

- **Right femoral – grade 11 open distal fracture**

  Thigh measurements 10cms above the patella were 54cms on the right

and 56cms on the left.

Calf measurements 10cms below the patella were 43cms on the right and 41cms on the left.

It is noted that there is swelling of the right leg suggesting some circulatory insufficiency.

Hip Measurements: AMA 4 Table 40 (Page 78)

	Measurement RIGHT	Measurement LEFT
Flexion	70°	120°
Fixed flexion	Nil assessable	0°
Internal Rotation	10°	20°
External Rotation	40°	50°
Abduction	50°	50°
Adduction	30°	30°

There was no fixed flexion assessable but Mr Filippetti holds his hip somewhat flexed because of his flexed knee.

Knee Measurements: AMA 4 Table 41 (Page 78)

Knee measurements	Measurement RIGHT	Measurement LEFT
Flexion	To 70°	°
Extension	Minus 30° with a fixed flexion contracture	°
Varus	nil	°
Valgus	Nil	°
Flexion Contracture	30°	°

It is noted that there is multiple scarring of the right limb and scarring of the left leg.

There has been assessment by a Plastic Surgeon of the scarring of the right and left legs as a result of the motor accident.

- **Right knee – medial collateral ligament injury / anterior cruciate ligament injury**

  The right knee is particularly irritable. There was a mild effusion in the right knee joint with a fixed flexion contracture. The knee had to be supported with a roll when Mr Filippetti was lying on the couch.

  It is noted that there is significant limitation of range of movement with significant irritability in the right knee and some hamstring spasm.

  The patella was painful to movement.

  Review of instability signs of the right knee revealed a reasonably stable knee although the knee was very painful.

  One was unable to elicit the jerk test for anterior cruciate ligament insufficiency although I noted that Dr O'Carrigan did state that the anterior cruciate ligament was normal at arthroscopy.

  I note that it has been previously reported that there was apparent laxity to the Lachmans test and there may have been damage to the posterior cruciate ligament by the intramedullary nail, which would lead to a positive Lachmans test. I cannot confirm this finding.

  I note that other reports do suggest that there was ligament laxity in the right knee. It was difficult because of significant irritability in the right knee to examine for laxity of the ligaments. I would have to accept statements of the treating Orthopaedic Surgeons.

  I believe that the only way to establish exact ligament laxity would be to carry out an examination under anaesthesia of the right knee joint.

- **Lumbar spine injury**

  I did not detect paraspinal muscle spasm but there is detectable dysmetria in the lumbar spine. Mr Filippetti had significant difficulty crossing the room without the use of his walking stick. He is reliant on the walking stick for walking from place to place and about the house and also outdoors.

Lumbar Spine Measurements: AMA 4 Tables 82 & 82 (Pages 129 & 130)

LUMBAR SPINE MOVEMENTS	Measurement
Forward flexion	40°
Extension	20°
Side bending left	30°
Side bending right	10°
Rotation right	10°
Rotation left	20°

I did not detect abnormal neurological signs in the lower limbs.

There are areas of sensory alteration due to scarring of the right lower leg and right knee area.

4. Review of Documentation

Summary of Relevant Documentation Provided in the Initial Assessment

I noted a report by Dr James Bodel dated 20.11.06.

There is some variation in the physical findings in Dr Bodel's report when compared to my report, but this may well be due to time of the assessment and the fact that Mr Filippetti at my review appeared to be suffering from more significant pain about his right knee and his hip area, which could be accounted for by increased inactivity.

I note Dr Bodel's assessment rating and I note that in his report he estimated final Whole Person Impairment as 21%WPI.

I noted the report of Dr Allan Searle dated 19.08.06.

Dr Searle did note that there was a degree of dysmetria in the lumbar spine.

He considered that range of movement in the ankles was normal and I considered that this differs to my report and to the report of Dr Bodel.

He noted some diminution in sensation in the lateral aspect of the right calf,

which may be due to the scarring, although he does not mention that finding.

He does say that the movements of the left ankle were slightly restricted.

He also found varying degrees of movement in the right knee to my assessment and to Dr Bodel's assessment and he suggested that there was an excessive range of extension, which would be consistent with possible posterior cruciate ligament damage.

Dr Searle did not mention the right hip lack of movement.

He did note that Mr Filippetti had a marked right limp and was using a walking stick in his left hand.

I note that Dr Searle gave an assessment for the lumbar spine DRE Category 11 – 5% WPI and also assessed Mr Filippetti's impairment under Table 36 - routine use of a cane – 20% WPI.

I do not believe that Table 72 and Table 36 can be combined. I would conclude that his assessment should be 20% WPI.

Summary of Relevant Additional Documentation provided Since the Previous Assessment

I have listed the documents reviewed and have also referred to many of the documents already in this report.

Relevant Imaging Studies and Other Investigations

See under Section 1 of this document.

5. Conclusions

Consistency of Presentation

I found that Mr Filippetti was suffering from significant irritation arising from his right knee. There would appear to have been some deterioration in his right knee since previous examinations and this may be contributing to some of the loss of range of movement of his right knee.

I found that Mr Filippetti was distressed and somewhat angry about the length of his treatment and recovery and the fact hat he was being denied assistance with the children that he is looking after.

He seemed forthright and very determined to continue to be the carer of his family and was attempting to carry out all the requirements of his duties as a father.

I did not consider that there were any inconsistencies in Mr Filippetti's medical history and no inconsistencies in his physical findings except the assessment of his right knee impairment, which would have to assessed with the help of previous investigations and the information supplied by other specialists

Diagnosis and Causation

- **Left ankle – closed tibial plafond fracture**

  Mr Filippetti suffered a closed fracture of the lower end of the left tibia with displacement of the articular surface of the ankle joint, which has been fixed with plates and screws.

  There is a step deformity in the articular surface.

  Mr Filippetti has residual swelling in the left ankle and restricted range of movement with associated pain.

  The fracture was caused by the motor accident.

- **Right femoral – grade 11 open distal fracture**

  Mr Filippetti suffered a fracture of the mid and lower thirds of the right femur, which was compound and mildly comminuted.

  This fracture required intramedullary fixation with an intramedullary nail inserted in a retrograde fashion.

  The fracture passed onto non-union and has required further operative treatment.

  There has also been damage to the intraarticular area of the knee joint due to the intramedullary nail damaging the retropatella surface and also the intercondylar area of the right knee joint. Mr Filippetti underwent a partial medial meniscectomy of the right knee.

Mr Filippetti has required an upper femoral osteotomy and transport of the middle third of the femur downwards to produce union at the fracture site after excision of the pseudoarthrosis.

The fracture has passed onto sound union.

There has been transport of bone to accommodate for shortening of the right femur and treatment of the non-union.

The fracture of the right femur was caused by the motor accident.

- **Right knee – medial collateral ligament injury / anterior cruciate ligament injury**

There has been damage to the right knee and the current clinical findings are clouded by acute irritation of the right knee joint but review of the supplied documentation indicates that may well have been damage the posterior cruciate ligament and medial ligament damage.

There is restricted range of movement of the right knee and significant ongoing impairment of the right knee joint with the development of osteoarthritic change.

The right knee injury has been caused by the motor accident.

- **Lumbar spine injury**

There has been increasing irritation of the lumbar spine by abnormal gait patterns and the requirement of the use of crutches and then a stick for ambulation.

Mr Filippetti was noted to suffer from dysmetria of his lumbar spine and restricted range of movements.

He does have some radiation of pain to his buttock and right leg but there are no abnormal neurological signs associated with the lumbar spine or radiculopathy.

The lumbar spine injury was reported at the time of the motor accident and has been aggravated by Mr Filippetti's gait.

The lumbar spine condition has been caused by the effects of the motor accident.

Some of the 'injuries' submitted by the parties did not describe diagnostic entities (for example, signs, symptoms, disabilities, handicaps, complaints etc.). These have been considered and are incorporated into the injuries listed below.

Injuries Listed by the Parties and Caused by the Accident

After reviewing the list of injuries as submitted by the parties, examining the claimant, and reviewing the accompanying documentation, it is determined that the following injuries **WERE** caused by the motor accident:

- **Left ankle – closed tibial plafond fracture**
- **Right femoral – grade 11 open distal fracture**
- **Right knee – intraarticular damage and ligament damage**
- **Lumbar spine injury**

Injuries Not Listed by the Parties But Caused by the Accident

After reviewing the list of injuries as submitted by the parties, examining the claimant and reviewing the accompanying documentation, it is determined that the following injuries **WERE NOT** listed by the parties but **WERE** caused by the motor accident:

Nil

Injuries Listed by the Parties But Not Caused by the Accident

After reviewing the list of injuries as submitted by the parties, examining the claimant and reviewing the accompanying documentation, it is determined that the following injuries **WERE NOT** caused by the motor accident:

Nil

5. Determinations

Stabilisation

Determination and Reasons Regarding Stabilisation of Injuries

- **Left ankle – closed tibial plafond fracture**

  The fracture has united with a step in the articular surface and restricted ankle movements. The ankle is considered to be stable in its recovery.

- **Right femoral fracture– grade 11 open distal fracture**

  Mr Filippetti's right femoral fracture has required multiple operative treatments and has now achieved union at the fracture site and at the osteotomy site at the upper part of the femoral shaft. There is muscle weakness and there is muscle atrophy. There is restricted range of hip movement but no loss of leg length.

  The femoral fracture is considered to have stabilised

- **Right knee – Intraarticular damage and ligament damage**

  Mr Filippetti is suffering from significant irritation in his right knee with restricted range of movement and flexion contracture of his right knee.

  He is having difficulty with ambulation and appears to have deteriorated since the last assessments of his permanent impairment.

  I consider that it is not possible to say that his condition is stabilised at the present time because there has been significant deterioration in comparison to the previous reports concerning his right knee joint.

  I would be hesitant to state that Mr Filippetti's condition has stabilised to a stage where he could be considered to be static and well stabilised and not likely to change by more 3% within the next 12 months.

  Review of this injury could be considered in 9 months time to assess if the condition is stabilised.

- **Lumbar spine injury**

  Mr Filippetti continues to have ongoing symptoms of pain in relation to his lumbar spine. He continues to be incapacitated, as he has to walk with a stick to ambulate within the house and outside of the house.

Impairment

Injuries That Give Rise to a Permanent Impairment

- **Left ankle – closed tibial plafond fracture**
- **Right femoral fracture – grade 11 open distal fracture**
- **Right knee**
- **Lumbar spine injury**

Injuries that give rise to no permanent impairment

- **Nil**

Degree of Whole Person Impairment (WPI) of Injuries that are PERMANENT

Explanation of assessment:

MAA Guides September 2005 and American Medical Association Guides to the Evaluation of Permanent Impairment, 4th Edition

Left ankle

Chapter 3. 2i, Diagnosis based estimates – Table 64 – Page 85 & 86.

Ankle – Intraarticular fracture with displacement – 8% WPI

8% WPI

Right femur fracture

Hip Impairment

Chapter 3.2e – Range of motion – Table 40 – Page 78

Only one range of movement can be accepted for impairment.

Flexion - 70° - assessed as less than 80° - moderate impairment – 4% WPI

Knee Impairment

Range of motion – Chapter 3.2e Table 41 – Page 78

Flexion - Less than 80° - moderate - 8% WPI

Flexion contracture is 30° - (20° + 14% WPI plus 1% per 10° over 20°, which gives 15% WPI

Right knee

Ligament Laxity
Assessed under Chapter 3.2i - Page 84 –Diagnosis based estimates –Table 64-page 85

Cruciate and collateral ligament laxity – moderate – 10% WPI

Meniscectomy - medial – partial – 1%

Lumbar spine

Lumbosacral spine Chapter 3, Section 3g, Page 101, Table 70 Page 108 and Table 72 Page 110

Page 102 DRE Lumbosacral Category 11: minor impairment.

The history and findings are compatable with a specific injury and include muscle guarding, non-uniform loss of range of movement (dysmetria, differentiator 1, Table 71, p. 109), or nonverifiable radicular complaints. There is no objective evidence of radiculopathy.

The assessment is DRE Category 11- **5% WPI**

Right leg

Assessment of muscle atrophy

Chapter 3.2c – Table 37 for the thigh 2cm wasting – moderate impairment – 4% WPI

Combining the assessments - muscle atrophy cannot be combined with any other assessment.

Assessment gait derangement –

Chapter 3.2b – Table 36

I consider that Mr Filippetti fulfils the requirement that state – requires routine use of a cane, crutch or long leg brace – moderate severity – 20% WPI.

Range of motion or ankylosis cannot be combined with other impairments that are appropriate; therefore the use of range of motion or ankylosis is inappropriate.

Final determination of WPI

Diagnosis based estimates for the right leg:

Cruciate and collateral ligament laxity 10%.

Meniscectomy - medial – partial – 1%
Combining = 11%

Combining Left ankle impairment
Intraarticular fracture with displacement – left ankle – 8%

Using the Combining Values Chart Page 322 gives 18% WPI.

This would have to be combined with the lumbar spine impairment of 5% WPI giving 22% WPI.

Using Range of motion

Flexion contracture 15%, Combined with left ankle 8% and Lumbar spine 5%

Combining tables Page 322 = 26% WPI

As this is higher than the assessment as determined by abnormal gait or range of movement I consider that the Whole Person Impairment be assessed at 26% WPI.

	Body Part or System	AMA Guides/ MAA Guidelines References (chapter/ page/table)	Stabilised (YES/NO)	Current %WPI*	%WPI* from pre-existing OR subsequent causes	%WPI* due to motor accident

1	Left ankle	Chapter 3.2i Diagnosis based estimates Table 64 Pages 85 & 86	Yes	8%	**0%**	**8%**
2	Right Knee	Chapter 3.2e Table 41 – Page 78	No	15%	0%	15%
3	Lumbar spine	Chapter 3 Section 3g Page 101 Table 70, Page 108 Table 72, Page 110 DRE Category 11	Yes	5%	**0%**	**5%**
4						
5						
6						

* %WPI = percentage whole person impairment

Determination Regarding the Degree of Whole Person Impairment of the Injured Person as a Result of the Injuries Caused by the Motor Accident
The total percentage whole person permanent impairment for assessed injuries caused by the motor accident is 26%.

Statement about Permanent Impairment
The determination as to permanent impairment is made in accordance with the American Medical Associations Guides to the Evaluation of Permanent Impairment (Fourth Edition) and/or the Motor Accident Authority's Impairment Assessment Guidelines.

Permanent impairment ratings take symptoms into account, however the percentage whole person permanent impairment is not a direct measure of disability. A finding of zero percent whole person impairment indicates that there was an injury caused by the motor accident and that there may be continuing symptoms but that relevant guides rate the associated impairment at 0% WPI.

7. Summary

The following determinations are made in relation to this matter.

Stabilisation

The following injuries caused by the motor accident **HAVE STABILISED**:

- **Left ankle – closed tibial plafond fracture**
- **Right femoral – grade 11 open distal fracture**
- **Lumbar spine injury**

The following injuries caused by the motor accident **HAVE NOT STABILISED**:

- **Right knee**

Permanent Impairment

I decline pursuant to Section 132(3) of the Motor Accidents Compensation Act 1999 to make an assessment as to the degree of permanent impairment of the injured person as a result of injuries caused by the motor accident as I am not satisfied that the right knee injury has stabilised.

Signed _____

Name **DR NEAL L THOMSON - MAS MEDICAL ASSESSOR**

Date **20.03.07**

MOTOR ACCIDENTS AUTHORITY

Medical Assessment Service

Further Certificate of Determination of Assessment

made under Part 3.4 of the
Motor Accidents Compensation Act 1999
as to the
DEGREE OF PERMANENT IMPAIRMENT
OF THE INJURED PERSON
AS A RESULT OF THE INJURY CAUSED BY THE MOTOR ACCIDENT

Matter Number
2007/04/0044HT

Applicant	**Respondent**
Frank Gary Filippetti	GIO General Ltd

Claimant's Name:	Frank Gary Filippetti
Claimant's Date of Birth:	06.11.64
Date of Motor Accident:	13.05.04
Assessed By:	Assessor Dr Neal L Thomson
Clinical Specialty:	Orthopaedic Surgery
Assessed At:	Circular Quay
Date of Assessment:	17.04.07
Date of Certificate:	17.04.07

THE DETERMINATION MADE IN RELATION TO THIS DISPUTE IS AS FOLLOWS:
I decline pursuant to Section 132(3) of the Motor Accidents Compensation Act 1999 to make an assessment as to the degree of permanent impairment of the injured person as a result of injuries caused by the motor accident as I am not satisfied that the right knee injury has stabilised.

Details of the assessment and reasons for my determination are set out in the attached Statement of Reasons, which forms part of my determination.

Signed Neal Thomson

Name **Dr Neal L Thomson - MAS MEDICAL ASSESSOR**

Date **17.04.07**

RECEIVED
1 MAY 2007
MOTOR ACCIDENTS ASSESSMENT SERVICE

MOTOR ACCIDENTS AUTHORITY

Medical Assessment Service

Further Certificate of Determination of Assessment

made under Part 3.4 of the
Motor Accidents Compensation Act 1999
as to
WHETHER AN INJURY HAS STABILISED

Matter Number
2007/04/0044HT

Applicant	**Respondent**
Frank Gary Filippetti	GIO General Limited

Claimant's Name: Frank Gary Filippetti
Claimant's Date of Birth: 06.11.64
Date of Motor Accident: 13.05.04

Assessed By: Assessor Dr Neal L Thomson
Clinical Specialty: Orthopaedic Surgery
Assessed At: Circular Quay
Date of Assessment: 17.04.07
Date of Certificate: 17.04.07

THE DETERMINATION MADE IN RELATION TO THIS DISPUTE IS AS FOLLOWS:

The following injuries caused by the motor accident have stabilised:

- **Left ankle – closed tibial plafond fracture**
- **Right femoral – grade 11 open distal fracture**
- **Lumbar spine injury**

The following injuries caused by the motor accident have NOT stabilised:

- **Right knee -**

Details of the assessment and reasons for my determination are set out in the attached Statement of Reasons, which forms part of my determination.

Signed Neal Thomson

Name **Dr Neal L Thomson - MAS MEDICAL ASSESSOR**

Date **17.04.07**

RECEIVED
MAY 2007
MOTOR ACCIDENTS ASSESSMENT SERVICE