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1 December 2022

Dr Jeyadinesh Velautham
Tristar Medical Group - West Wyalong
29 Ungarie Road
West Wyalong NSW 2671

Dear Dr Velautham,

RE: MR PAUL J ARCHIBALD - DOB: 26/11/62
51 WOLLONGOUGH STREET, UNGARIE NSW 2669
Claim Number: 4604898

I reviewed **Mr Paul J Archibald** in my Wagga rooms on Thursday, 1 December 2022. Paul continues to report the left-sided low back pain and left lower limb radicular pain. A CT-guided steroid injection in May, 2022 did not give him much benefit.

A repeat MRI lumbar spine shows a previous left L5/S1 laminotomy. The previous acute L5/S1 disc fusion has been resected and there is no recurrent disc protrusion or recurrent left S1 nerve compression seen. There is no ongoing left S1 nerve compression from any epidural fibrosis or epidural collection. There is a shallow central L5/S1 posterior disc bulge and grade 1 L5/S1 retrolisthesis.

Paul suffers ongoing chronic left S1 neuropathic pain, which I think is now an intrinsic chronic pain problem in the absence of any ongoing mechanical compression of the left S1 nerve.

I discussed the treatment options. In the absence of ongoing nerve compression, Paul is safe to persist with conservative treatment and attempt to return to work within his pain tolerance.

Further surgery only has a 50% chance of improving any pain. Further surgery would involve more invasive and aggressive procedures. One option would involve a redo left L5/S1 decompression plus discectomy plus transforaminal interbody fusion plus pedicle screw internal fixation and posterolateral fusion. There is a 50% chance of improving any pain. I specifically discussed risks with the patient ensuring that the patient understood the risks. As with any procedure to alleviate pain, there is the potential outcome of having no response or only a partial response to surgery. There is a 1% risk of nerve injury or CSF leak, a 1% risk of infection, bleeding, DVT or PE, the risk of failure to fuse and the risk of adjacent segment degeneration. As with any surgical procedure, there is a remote risk of catastrophic events such as paralysis or death. New technology using intraoperative CT stereotactic guidance is used to accurately place the pedicle screws.

The other option would involve a trial of spinal cord stimulation. Neuro modulation technology can be used to try to alleviate lower limb neuropathic pain involving a spinal cord stimulator. There is a 50% chance of giving relief of pain. This procedure is performed as an initial percutaneous placement of an epidural electrode as a trial. If the trial fails, then the electrode is simply removed. If the trial is successful, then a further procedure is performed to place a permanent electrode in the appropriate segment at the thoracic spine, which is then connected to a neuro stimulator battery. There needs to be at least a 50% reduction in reported pain prior to proceeding with a permanent placement.

We had a discussion about the management of the workers' compensation claim. The initial goal is one of undergoing medical treatment for the injury with the aim of gradual return to pre-injury work activity. However, if this is not achievable, then one option is to undergo maximal medical treatment to which the patient is willing to consent. Once maximal medical improvement has been achieved, then the patient may undergo a functional capacity assessment and then undergo vocational retraining with the assistance of a rehabilitation supervisor. Sometimes if return to work is not achievable or if there is a dispute, the claim may undertake a medicolegal process. This requires the patient to undergo maximal medical treatment and once maximal medical improvement has been achieved and the condition has stabilized, then the patient's lawyer may refer to a medicolegal specialists to perform a whole person permanent impairment assessment, with a view to seeking financial settlement.

I gave Paul information regarding both the spinal fusion procedure and the spinal cord stimulation procedure. He did not commit to any further procedural treatment at this point time, due to the low probability that any further improvement will be achieved with more aggressive surgical treatment.

It may be acceptable to consider that he has reached the point of maximal reasonable medical treatment and maximal improvement, and the condition may be considered stable. It is safe for him to return to work within his pain tolerance. Paul is aware there is a 5% risk of recurrent disc protrusion and that if he has a significant escalation of pain, then he should return for review with a repeat MRI.

Paul is welcome back for review at any time if he wants to discuss any of the further surgical treatments for the pain.

Yours Sincerely,

DR MICHAEL OW-YANG
MBBS FRACS

cc: Mr Paul J Archibald, 51 Wollongough Street, Ungarie NSW 2669- by Email
cc: Icare WC NSW North Ryde NSW, Icare Workers Insurance, Locked Bag 2099, NORTH RYDE BC NSW 1670- by Email

Dr Ow-Yang consults in Canberra and Wagga Wagga.
Please forward all correspondence and referrals to the Canberra office.

We prefer to receive correspondence via Healthlink (neurospi).