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US Expert Medical Opinion, Inc. 1625 SE, 3rd Avenue Suite 723. Fort Lauderdale, FL 33316. USA

Date: April 10th, 2020

Reference: Mr.

DOB:

Dear Mr.

The following is a report prepared for Mr. based upon my review of the available medical records provided in your MyUSADr. Medical opinion request.

#1 Office notes from Mr. P dated April 2, 2015.

These records state that Mr. had undergone a 2-stage revIsion left-sided internal hemi-pelvectomy and hip reconstruction. He was 7 months post op. He was having neuropathic pain from a partial sciatic nerve injury. He was walking with a short leg gait because of a 3 cm limb length discrepancy. X-rays at that time state that the implant remains in place with no evidence of loosening or infection. He had nerve conduction studies performed. There is still evidence of a partial lesion of the sciatic nerve, and this is mainly sensory. Mr. Pollack states that laid has full power in dorsiflexion and 4 out of 5 power of ankle plantarflexion. He has pins and needle sensation in the L5 and S1 distributions.

#2 Repeat EMG and nerve conduction studies from March 9, 2016.

This report states that there is a partial left sciatic nerve lesion, axonopathy, affecting peroneal greater than the tibial nerve segments. There are no features of ongoing left lumbosacral radiculopathy. Significant left common peroneal neuropathy at or across the fibular head or knee is less likely.

#3 Office notes from Mr. P dated March 10, 2016.

The records state that Mr. is now 20 months since his 2-stage revision left internal hemipelvectomy and hip reconstruction. It also states that he has undergone gastric band and has lost a significant amount of weight. He walks unaided with a short leg gait as well as a left-sided foot drop. It states that his left leg is approximately 5 cm shorter than the right. He has good active plantar flexion of the foot. He has reduced sensation on the dorsum of the foot. He has no power of ankle and toe dorsiflexion of ankle eversion. The x-rays report states that everything is satisfactory with no signs of loosening. A bone scan shows no evidence of

metastatic disease. The nerve conduction studies confirm a partial left sciatic nerve lesion affecting the peroneal more than the tibial nerve segments. Mr. P recommended a

combination of a foot drop splint and a heel raise.

#4 Medical report from Mr. M, Consultant Orthopedic Surgeon from the peripheral nerve injury unit.

The records state that Mr. is a survivor of pelvic Ewing sarcoma. It states that he had a previous hemipelvectomy and subsequent infection in the prosthetic replacement and excision and further prosthetic replacement in 2014. The hemipelvic replacement operation cleared him of the infection and there was no sign of metastatic disease.

He states that there was aa sciatic nerve lesion affecting his peroneal more than his tibial nerve resulting in a foot drop and pain.

Mr. M felt that Mr. would be an excellent candidate for tibialis posterior tendon transfer.

#5 Report from the orthopedic department from the Kuwait Oil Company ---- Hospital.

This report summarizes that Mr. developed cancer in his left hip bone in 2004. He had been operated upon for a hemipelvectomy and a custom-made prosthesis. This became infected in 2014. In May 2014 he had removal of the prosthesis, traction, and medical management. He underwent another prosthesis surgery in July 2014. He developed immediate postoperative foot drop. He underwent another surgery with shortening. His foot drop did not return back to normal. EMGs performed August 20, 2014 were consistent with sciatic nerve lesion. He had an MRI scan done of the lumbar spine which was normal. EMGs done in October 2016 demonstrated sensory nerve conductions to be normal. The EMG findings were compatible with chronic neurogenic changes involving the peroneal nerve distribution. Examination demonstrated wasting of the calf and thigh muscle and ankle drop. There is ankle plantar flexion but no dorsiflexion. The toes moved freely. There is markedly diminished sensation at the dorsum of the first webspace and the muscles were all weaker compared to the other side.

#6 Letter to the employer from May 23, 2017.

This letter was prepared by Mr. Michael Fox. It states that Mr. underwent multiple tendon transfers about the left foot and ankle. It states that the tendon transfers were required as a consequence of a history of Ewing sarcoma, a hemipelvectomy, and a previous sciatic nerve injury. It states that he recovered well from the initial operation. He was requesting physiotherapy. It states that he will require a period of 6-8 weeks of physiotherapy before he is

able to return to work.

#6 MRI of the left leg from February 11, 2019.

The impression is extensive signal abnormality in the tibialis posterior, flexor digitorum longus, flexor hallucis longus and peroneal muscles as well as in the distal lateral gastrocnemius

muscle. Differential diagnosis includes an inflammatory etiology/denervation edema. Suggest follow-up. There is also a small round area of marrow signal abnormality in the proximal metaphyseal diaphyseal area of the tibia. 2 small to characterize. Follow-up in bone scan suggested.

#7 MRI of the left ankle from February 11, 2019.

The impression is deltoid ligament sprain. Focal marrow edema/contusion in the posterior lateral aspect of the body of the talus. Diffuse edematous signal in the visualized flexor hallucis longus muscle. Pre-Achilles fat pad edema.

#8 Plain x-ray of the left hip from February 11, 2019.

The findings reveal a total hip replacement. Multiple radiopaque shadows are seen lateral aspect of the thigh suggesting calcifications.

#9 CT scan of the left hip from February 11, 2019.

The impression is postoperative changes. Slight widening of the lucency along the bone cement interface in the intertrochanteric region, having a maximum diameter of 2.8 mm. Suggested follow-up to look for interval progression. Bone fusion of the left sacroiliac joint. Few subcutaneous nodular calcific foci in the proximal thigh.

#10 MRI scan of the left foot from February 11, 2019.

Impression is minimal internal or metatarsal bursitis at the third webspace. Otherwise unremarkable study.

#11 Medical report from Mr. P from May 9, 2019.

This report states that Mr. is struggling with several issues including a significant leg length discrepancy with shortening of the left leg as well as weakness in his left foot due to a partial sciatic nerve lesion. He had already undergone tendon transfers which have helped. On exam, there is some active ankle dorsiflexion and plantarflexion. A PET scan was reviewed showing no

evidence of recurrent disease or distant metastasis. A CT scanogram was carried out to measure the leg length discrepancy and he had approximately a 3 cm shortening on the left side from the femur. The report states that Mr. F says there is no more he can do in terms of tendon transfers to improve his ankle function. The question arises as to whether he would be a candidate for lengthening procedure of his femur. He has been referred to DG for evaluation.

#12 Medical report from Mr. P to Mr. D from June 6, 2019

Asking that Mr. be evaluated to see if he is a candidate for a lengthening procedure to equalize

limb lengths.

Impression:

#1 Ewing sarcoma

#2 Status post left hemipelvectomy and left hip reconstruction

#3 Status post infected left hip reconstruction

#4 Status post revision left hip reconstruction

#5 Partial sciatic nerve lesion with an associated foot drop

#6 Status post tendon transfers

#7 Limb length discrepancy of approximately 3 cm

Response to questions from Mr.

Overall I feel that considering his initial diagnosis of a Ewing sarcoma, Mr. has done fairly well. There is no obvious recurrence of the tumor or metastatic disease. The hip reconstruction appears to be doing well. It seems that the tendon transfers helped some but not help completely. I don't feel that any further tendon transfers should be recommended.

From a surgical standpoint, an ankle fusion could be carried out but I think that would be a last resort. I feel that a foot drop brace, AFO, would be a better option at this time because it would still allow plantar flexion.

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With regards to the nerve pain, it is difficult to determine if the pain is coming from the nerve, foot drop, or previous surgeries. Therefore the results of any treatment may not show significant improvement or results. I would therefore recommend continuing medical management and potentially as a last resort to consider a trial of a nerve block and or radiofrequency ablation of the symptomatic nerves.

I feel the biggest question is a limb lengthening procedure. Wearing a 3 cm shoe build up and using an AFO brace is not ideal in light of the foot drop. Limb lengthening procedures are successful, but they do carry potential complications. In light of his previous nerve injury, the biggest concern would be exacerbating his neurogenic pain. However, a limb lengthening procedure is done gradually over time and the risk of further neurogenic pain or injury would hopefully be minimized. I feel that a limb lengthening procedure would give him the best

improvement overall to improve the limb length discrepancy and improve his gait. The limb

lengthening procedure would have to be carried out distal to the cemented femoral stem. It would either have to be done with an external ring system or possibly over a short intramedullary rod. This would depend on the distance between the cemented femoral stem and the remaining diaphyseal portion of the femur.

Thank you for allowing me to assist you with your medical concern. I hope this review supplies the information desired. Please feel free to contact me if you have any further questions

Sincerely,

Bruce Janke, MD

Diplomate American Board of Orthopedics