EXPERT MEDICAL REPORT OF M.K. SOOD FOR THE COURT

Prepared By Mr. M. K. Sood
Consultant Hand and Plastic Surgeon
PO Box 7191
Ingatestone
Essex
CM4 9WA
Tel: 01277 840140 Fax: 01277 829918
Email: legal@manusood.co.uk

Claimant	:	**Xxxxxxxx**
Dated	:	**9th August 2012**
Specialist field	:	**Hand and Plastic Surgery**
On the instructions of	:	**xxxxxx xxxx xxx**
Reference	:	**xxxxxx**
Subject matter	:	**This report concerns the injuries sustained by Xxxxxxxx on 12th July 2010, the treatment that she received, the present state and a prognosis.**
Examination conducted at	:	**Spire Roding Hospital**
Time of Commencement	:	**1930hrs**
Time of Completion	:	**2000hrs**
Accompanied By:	:	
Proof of Identity	:	

Contents

1. INTRODUCTION

1.01 The writer

I am Manu Sood. My specialist field is Plastic Surgery and Hand Surgery. I am a Consultant Plastic and Hand Surgeon at the St. Andrew's Centre for Plastic Surgery, Broomfield Hospital, Chelmsford, Essex.

St. Andrew's Centre is the Regional Centre for Plastic Surgery and Hand Surgery for Essex and treats approximately 4500 patients with injuries including facial lacerations, leg injuries and hand trauma surgery per year.

My qualifications are: MS (General Surgery), MCh (Plastic Surgery), FRCS (Plastic Surgery), Diplomate of the European Board of Hand Surgery. Full details of my qualifications and experience entitling me to give expert opinion and evidence are in Appendix 1.

I understand that my duty in preparing this report is to the Court and that I have complied with that duty. I am aware of the requirements of part 35 of the Civil Procedure Rules and the Practice Direction 35, the Protocol for Instruction of Experts to give Evidence in Civil Claims and the Practice Direction on Pre-action Conduct.

I understand that this duty overrides any obligation to the person from whom I have received instructions or by whom I am paid. I believe that the facts that I have stated in this report are true and the opinions I have expressed are correct.

1.02 Summary of my Conclusions:

As a result of the injury that Xxxxxxxx has sustained on 12th July 2010 she has been left with a permanent and visible scar on the volar aspect of her right distal forearm and wrist. This will not improve any further with time. She also has the typical appearance of an ulnar claw hand along with wasting of the intrinsic muscles of the hand and hyper-extension and ulnar deviation of the metacarpophalangeal joint of the right little finger. These features will not change spontaneously.

She has symptoms of cold sensitivity in the form of pins and needles and mild discomfort in the hand when it is exposed to low temperatures. Symptoms of cold sensitivity tend to improve gradually over a period of time but may not disappear completely in the long term.

She experiences mild discomfort on activities of daily living and significant discomfort on gripping strongly. This is most likely due to osteoarthritis in the joints of her hand rather than the ulnar nerve injury.

She does however suffer from dysesthesia (an unpleasant sensation when touched) over the ring and little fingers, over the hypothenar eminence and over the dorsum of the hand. This is solely due to injury to the ulnar nerve and will not improve significantly with time.

She has a severe functional loss in her right hand in the form of loss of fine movement, inability to separate her fingers, inability to use her right hand for activities of daily living such as cutting her food, brushing her teeth, brushing her hair and writing normally. These are permanent features and will not improve any further with time.

I have calculated Xxxxxxxx's disability as a result of the injury to her ulnar nerve and her flexor tendons to be as follows:

13% impairment of the upper extremity equating to 8% impairment of the whole person.

This has been calculated with reference to Guides to the Evaluation of Permanent Impairment Fifth Edition, 2005, American Medical Association – pages 438, 439, 463, 492.

1.03 The parties involved:

1. Xxxxxxxx
2. Hospital Plan Insurance Services

2. SUMMARY OF INSTRUCTIONS

(i) Please provide a full list of all the injuries Xxxxxxxx sustained due to this accident.

(ii) How do the medical records available to you indicate that this injury occurred?

(iii) What are xxxxx current symptoms and complaints, including any limitations of function and/or movement? Please confirm this for her right arm, hand and fingers.

(iv) What treatment and investigations has Xxxxxxxx received including medications, physiotherapy and rehabilitation? Please comment upon the frequency, the modalities used and the patient's response to treatment.

(v) Are there any previous problems that may have had an effect on Xxxxxxxx's present condition and recovery? Please review their medical history and highlight any pre-existing medical condition that you consider relevant to the current condition e.g. pre-existing degeneration, similar injuries, chronic pain, depression, anxiety.

(vi) Please advise if the claimant has made any previous injury claims and whether they have taken any prolonged time off work or had any previous accidents. Also, state if they are in receipt of any Disability/Incapacity Benefit.

(vii) In your opinion:

(a) What disability would normally have been expected from an injury of this kind? Was this observed?

(b) On examination did the claimant demonstrate any exaggeration in their level of disability? If yes, please provide full details. In your opinion was this exaggeration deliberate?

(viii) Please can you attribute an approximate percentage of the loss of function Xxxxxxxx has sustained to her right arm, hand and fingers separately.

(ix) Has Xxxxxxxx now reached optimum recovery? If not, when can this be anticipated.

(x) Please confirm whether or not the accident on 12th July 2010 is solely and independently and responsible for Xxxxxxxx's ongoing disability. If there has been an exacerbation of a pre-existing medical condition, please provide more details.

(xi) Any additional information, which you may care to submit, would be greatly appreciated.

3. THE ISSUES TO BE ADDRESSED

3.01 The extent and duration of any continuing disability and prognosis.

3.02 Whether or not she will need any surgery.

4. MY EXAMINATION OF THE FACTS

4.01 Documents

The following documents were available to me at the time of preparing the report:

1. A letter of instruction from Hospital Plan Insurance Services dated 6th October 2012.
2. Copies of Medical Record held at Mid Essex Hospitals, Chelmsford.
3. Copies of Medical Records held by her General Practitioner.

4.02 TESTS AND EXPERIMENTS

I carried out specific tests to ascertain the following:

1. Loss of sensation: This was assessed by means of a **moving 2 point discrimination** test.

This test is carried out with an instrument called a **Diskcriminator,** which has pairs of blunt pointed metal pins, which are separated by a fixed distance. They are moved along the pulp of the finger and the patient is asked to state whether they are felt as one point or two points touching the finger. The higher the value in this test, the greater the distance between the two pins which indicates a decrease in the ability to perceive sensation.

2. Power grip: This test is carried out, by asking the patient to grip an instrument called the **Jamar Dynamometer**. When the instrument is gripped a needle moves across the dial of the Dynamometer with greater movement indicating greater grip strength. The test is done with three different settings of the Dynamometer simulate small, medium or large objects.

3. Range of motion of the joints of the fingers: This is measured using a Goniometer which is an instrument that measures the angle between the two bones that form a joint. It shows the extent to which the finger can be straightened and bent.

4. Pinch grip: This is measured using a special instrument for assessing the force that a patient can apply **between the thumb and the side of the index finger *(key pinch)*** and **between the tips of the thumb and the index and middle fingers *(pulp pinch)*.**

The tests and measurements mentioned in this report were carried out by me personally.

4.03 INTERVIEW AND MEDICAL EXAMINATION

Xxxxxxxx was seen at the Spire Roding Hospital, Redbridge on 9th August 2012. She was accompanied by her friend xxxxxxx. The examination lasted for forty five minutes.

OCCUPATION

Retired

HOBBIES

Sewing, knitting, gardening

MEDICAL HISTORY

xxxxxxxx has a history of a small swelling at the base of her left thumb which was scheduled for excision as a day procedure on 7th May 2003. When she presented to the day surgery until the swelling had disappeared and she was therefore discharged.

In February 2005 she was referred to the Orthopaedic Department once again for a back support for symptoms of mechanical back pain and signs of lumbar spondylosis.

On 7th February 2002 she was noted to have been discharged from the Orthopaedic Clinic for a fracture of the tip of lateral malleolus of her left ankle three months previously. The fracture was noted to have united satisfactorily and she was advised to continue with ankle exercises and mobilisation.

She has an x-ray report dated 7th November 2007 showing changes of osteoarthritis of her right knee.

There is an entry in her medical records dated 2nd April 2008 which refers to restricted mobility, prescription of significant amounts of analgesia for pain relief and states a diagnosis of osteoarthritis of her right knee and generalised osteoarthritis.

There is an entry in her notes dated 12th November 2008 from the Day Hospital Medical Assessment Rehabilitation Unit Falls Clinic which documents the fact that she has had multiple falls in the past mainly because her right foot tends to give way. She is also noted to have a stocking distribution of anaesthesia due to which her feet have been numb for a couple of years but there was no history of pins and needles or burning.

She gave a history at the time of pain in her back and shoulder but denied any limb weakness.

HISTORY OF THE CASE

12/7/2010
Xxxxxxxx presented to St Andrews Centre for Plastic Surgery, Broomfield Hospital, Chelmsford with a history of an injury to her right wrist as a result of falling while holding a glass. The glass broke resulting in a cut to her right wrist.

She had been referred from Queens Hospital as there was significant bleeding from the wound which could not be easily controlled and there was a suspicion of an arterial and nerve injury.

12/7/2010
She was taken to the operating theatre and the laceration at her wrist was explored under brachial block anaesthesia. The following structures were found damaged and were repaired:

(i) 100% ulnar nerve, 100% ulnar artery

(ii) Left ring finger: Flexor digitorum sublimis muscle 70% division, Flexor digitorum profundus tendon 30% division

(iii) Left little finger flexor digitorum sublimis 100% division

(iv) Flexor carpi ulnaris 100% division.

Following her treatment she was discharged from hospital and attended the outpatient clinic on the following dates:
10/9/10, 13/12/10, 11/3/11, 9/9/11.

4.04 CURRENT PROBLEMS ON DATE OF REPORT

1. Appearance

She is not concerned by the appearance of her hand or of the scar at her wrist.

2. Cold Sensitivity

She complains of symptoms of pins and needles and mild discomfort in her hand when it is exposed to low temperatures. There is no history of change in colour of her palm or fingers.

3. Pain

She does not experience pain at rest. She has mild discomfort in the right hand while carrying out activities of daily living but experiences significant discomfort on gripping strongly.

4. Function

She has difficulty with the following:

(a) Fine movements
(b) Inability to separate fingers
(c) Inability to cut food for which she requires help from her friend, Miss Demain

(d) Inability to use her hand for brushing her teeth, for dressing and for brushing her hair. She now uses her left hand for brushing her teeth and has to have help from her friend to brush her hair.

(e) Her handwriting has now become very poor and borders on the illegible by her own account.

4.05 EXAMINATION FINDINGS ON THE DATE OF REPORT

1. Appearance

She has a well healed scar on the volar aspect of her right forearm and right wrist which measures approximately 6cms in size. She has clawing of her right ring and little fingers.

Her right little finger is hyper extended and abducted at the metacarpophalangeal joint.

She has wasting of the intrinsic muscles of the hand including the first dorsal interosseous muscles, the interossei to the other fingers and to the flexor digitorum brevis muscles leading to wasting of the thenar eminence.

The metacarpophalangeal joints of her right hand are held in an attitude of ulnar deviation.

On examination of the right hand, the right thumb is held with the interphalangeal joint hyper-extended with 10° flexion at the metacarpophalangeal joint.

The index and middle fingers are held in an altitude of 20° flexion of the proximal interphalangeal joint. She has full flexion and roll up of the fingers.

The left thumb shows hyper extension of the interphalangeal joint.

The left middle finger shows radial deviation of 20° at the distal interphalangeal joint which is probably due to osteoarthritis. The left ring finger has radial deviation of 10° at the distal interphalangeal joint which is also probably due to osteoarthritis.

She has mild swannecking of the left middle and ring fingers.

2. Sensation

She complains of a sensation of numbness and tingling in her right hand in the distribution of the ulnar nerve. This includes the right ring and little fingers on the palmar aspect and also the hypothenar eminence and the dorsum of the right hand. These areas are uncomfortable to touch.

3. Function

Sensory Deficit:

The result of the moving 2 point discrimination test are shown in mm below:

Digit	Thumb		Index Finger		Middle Finger		Ring Finger		Little Finger	
	Radial	Ulnar	Radial	Ulnar	Radial	Ulnar	Radial	Ulnar	Radial	Ulnar
Right	2	3	4	5	4	4	4	8	8	8
Left	2	2	4	4	3	3	3	4	4	4

There is a significant decrease in the quality of sensation on the ulnar half of the right ring finger and on the right little finger as compared to the left side.

The Tinel's sign is positive at the right wrist crease.

Allen's test indicates that the hand is predominately supplied by the radial artery. It is quite likely that the ulnar artery is no longer patent.

Motor Deficit:

Power Grip: The power grip has been measured using the Jamar Dynamometer. The readings are in kg per square cm. pressure and three readings are taken on each occasion.

		Right			Left		
1	Equivalent to gripping pipe 3cm in diameter	0	0	0	2	4	4
2	Equivalent to gripping pipe 5.5cm in diameter	0	0	0	4	6	4
3	Equivalent to gripping pipe 8cm in diameter	0	0	0	4	4	4

The Froment's sign is mildly positive in the right hand indicating that adductor pollicis muscle (of the thumb) is either very weak or is not functioning.

There is a very severe loss of grip strength in the right hand. She has a significant loss of strength in the uninjured left hand as well.

Pinch Grip:

Three readings were taken for pulp and key pinch and the values expressed as kg per square cm. The pulp pinch is measured as 3 point pinch with the thumb opposing against the tips of the index and middle fingers.

		Right			Left		
1	Pulp pinch	1.0	0.5	0.5	5	4.5	4.0
2	Key pinch	0.5	1.0	0.5	4	5	5

There is a very significant decrease in the strength of both pulp and key pinch in the right hand as compared to the left side.

Range of Motion:

Digit	Thumb		Index Finger		Middle Finger		Ring Finger		Little Finger	
	Right	Left	Right	Left	Right	Left	Right	Left	Right	Left
MCP	-10/30	10/60	0/85	0/75	0/85	0/80	-20	0/85	-30	0/90
PIP	10-50	-20/60	20/90	0/105	20/90	0/95	45/80	0/95	55/80	0/100
DIP			0/20	0/70	0/10	0/80	0/20	0/85	20/30	0/55

She has independent flexor digitorum sublimis and flexor digitorum profundus function in the right index and middle fingers.

The flexor digitorum sublimis function is present in her ring and little fingers but she has very weak function of the flexor digitorum profundus muscles in the ring and little fingers.

She experiences pain when the right distal ulnar is balloted suggesting that there is laxity of the distal radial ulnar joint capsule and ligaments.

She has stiffness and restriction of movement of both shoulders.

5.0 MY OPINION

In this section each of the issues which are listed on page 5 will be addressed.

5.01 The extent and duration of any continuing disability and prognosis.

1. Appearance

As a result of the injury sustained by Xxxxxxxx on 12th July 2010 she has been left with a permanent and visible scar which will not improve any further with time

She also has a deformity of the right hand which includes the following features:

Clawing of the ring and little fingers, wasting of the intrinsic muscles of the hand and hyperextension/ulnar deviation of the right little finger. These are also permanent features which will not improve spontaneously with time.

2. Cold Sensitivity

As a result of the injury that Xxxxxxxx has sustained on 12th July 2010 she has symptoms of cold sensitivity in the form of pins and needles and discomfort on exposure to low temperatures.

Symptoms of cold sensitivity tend to improve gradually over a period of time but may not disappear completely in the long term.

3. Pain

She experiences pain on carrying out activities of daily living and on gripping strongly with the right hand. The pain is likely to be due to associated osteoarthritis which affects the joints of her fingers and wrist.

4. Function

She has significant functional loss in her hand as a result of the following features:

(i) Loss of fine movements
(ii) Inability to separate her fingers
(iii) Inability to use her fingers for activities such as cutting food, brushing her teeth, brushing her hair and writing
(iv) Loss of sensation in the ring and little fingers
(v) Significant loss of strength in her right hand for power grip
(vi) Inability to straighten the joints of her right ring and little finger as compared to the left side
(vii) Significant loss of pulp and key pinch grip

5.02 Whether or not she will need any further surgery.

The situation with regard to Xxxxxxxx's right hand can be improved by addressing some of the issues that have arisen from the injury to the ulnar nerve. The loss of function in her right hand as a result of the ulnar nerve injury and the resulting ulnar claw can be improved by tendon transfer surgery. In particular the claw deformity of her right ring and little fingers and possibly the strength of her side to side pinch between the thumb and index fingers can be improved by carrying out procedures called tendon transfers. The procedure of tendon transfer is carried out under regional block anaesthesia and can potentially be done as a day case. It will result in the hand being placed in a splint for a period of at least eight weeks and possibly up to twelve weeks during which she will not be able to use the hand for activities of daily living including personal care.

However, the result of tendon transfers in the hand will be correction of the claw deformity but not necessarily an improvement in the overall function of the upper limb which has probably been affected by secondary changes arising from cervical spondylosis, possible osteoarthritis in her shoulders and wrist and osteoarthritis in the joints of her fingers.

However the outcome of this surgery is not entirely predictable due to the fact that she also has osteoarthritis in the joints of her fingers.

The accident on 12th July 2010 is responsible for Xxxxxxxx's ongoing problems with the hand resulting from division of the tendons and the ulnar nerve. However it is not solely responsible for her disability as she also has osteoarthritis in the joints of her hand and wrist.

She also complains of pain in her neck and both shoulders. A more accurate assessment of the problems with her neck and shoulder can be obtained with an MRI scan of the neck to assess any disc involvement or foraminal stenosis causing compression of the cervical nerves.

The shoulder can be better assessed by x-rays but she may also need and MRI scan for assessment of the soft tissues. An opinion from a Consultant Orthopaedic Surgeon will need to be sought for this.

The situation with regard to her wrist and hands can be better assessed following x-rays of the hands and wrists if required.

5.03 Whether the Claimant has made any previous injury claims or are they in receipt of an disability/incapacity benefit.

From the medical records that are available to me Xxxxxxxx does not appear to have made any previous injury claims. I do not have any data to suggest that she is in receipt of disability/incapacity benefit.

The disability in her hand in terms of loss of nerve function is commensurate with an injury of the nature that she suffered on 12th July 2010.

Xxxxxxxx did not demonstrate any exaggeration in her level of disability.

The loss of function in Xxxxxxxx's hand is due to two factors:

(i) The injury to her right wrist and forearm resulting in a division of the tendons to her wrist and fingers and also to the ulnar artery and ulnar nerve.

(ii) Osteoarthritis which appears to affect her shoulder, wrist and hand. More accurate assessment of the shoulder, wrist and hand is possible after x-rays. Assessment of the shoulder will require an opinion from a Consultant Orthopaedic Surgeon with a special interest in shoulder surgery.

Xxxxxxxx has now reached an end point in terms of her recovery as two years have elapsed from her injury.

The accident on 12th July 2010 is responsible for Xxxxxxxx's symptoms resulting from an injury to her ulnar nerve and due to the loss of function due to division of the tendons to her ring and little fingers and to her wrist flexor.

Xxxxxxxx has osteoarthritis of her wrist, thumb and fingers which is responsible for pain and loss of movement in her fingers especially in the distal interphalangeal joints.

I have calculated Xxxxxxxx's disability as a result of the injury to her ulnar nerve and her flexor tendons to be as follows:

13% impairment of the upper extremity equating to 8% impairment of the whole person.

This has been calculated with reference to Guides to the Evaluation of Permanent Impairment Fifth Edition, 2005, American Medical Association – pages 438, 439, 463, 492.

6.0 Statement of truth

I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true. The opinions that I have expressed represent my true and complete professional opinions on the matters to which they refer.

7.0 Statement to the Court

I understand that my overriding duty is to the Court, both in preparing reports and in giving oral evidence. I have complied, and will continue to comply with the duty. I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert are required.

I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters which I regard as relevant to the opinions I have expressed.

All of the matters on which I have expressed an opinion lie within my field of expertise.

I have drawn to the attention of the Court all matters, of which I am aware, which might adversely affect my opinion.

Wherever I have no personal knowledge, I have indicated the source of factual information.

I have not included anything in this report which has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter.

Where, in my view, there is a range of reasonable opinion, I have indicated the extent of that range in the report.

At the time of signing the report I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I subsequently consider that the report requires any correction or qualification.

I understand that this report will be the evidence that I give under oath, subject to any correction or qualification I may make before swearing to its veracity.

I have attached to this report a statement setting out the substance of all facts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.

That I know of no conflict of interest or any kind, other than any which I have disclosed in my report.

That I do not consider that any interest which I have disclosed affects my suitability as an expert witness on any issues on which I have given evidence.

That I will advise the party by whom I am instructed if, between the date of my report and the trial, there is any change in circumstances which affect my answers to either of the above two points.

M.K.Sood M.S., M.Ch.(Plast)

APPENDIX I

Curriculum Vitae

Personal Details

NAME: Mr Manu Sood

ADDRESS FOR CORRESPONDENCE:
PO Box 7191
Ingatestone
Essex CM4 9WA

TELEPHONE : 01277 840140

FAX : (01277) 829918

E – Mail : legal@manusood.co.uk

QUALIFICATIONS :

Degree	Year of Award
Diploma in Hand Surgery (Federation of European Societies for Surgery of the Hand)	1999
FRCS (Plastic Surgery)	1997
M.Ch.(Plastic Surg.)	1990
M.S.(Gen.Surg.)	1988
M.B.B.S.	1983

PRESENT APPOINTMENT:

Consultant Hand and Plastic Surgeon
St. Andrew's Centre for Plastic Surgery
Broomfield Hospital
Chelmsford CM1 7ET

Regional Advisor for East Anglia
Diploma in Hand Surgery
British Society for Surgery of the Hand/
University of Manchester

Elected to Council of British Society for Surgery of the Hand, 2007 – 2010.

LECTURES AND COURSES

April 1999	**Pain and the Peripheral Nerve: A Surgeon's Viewpoint** Guest Lecture to the European Society for Hand Therapy
September 1999	**1.The Management of Reflex Sympathetic Dystrophy** **2. Surgery for the Spastic Upper Limb** Invited Speaker to the Continuing Medical Education Programme of the Association of Plastic Surgeons of India
March 2000	**Replantation in the Upper Limb** Invited Speaker, North East Thames Hand Meeting
September 2001	**Functional Anatomy of the Hand** Instructional Course, British Association of Hand Therapists.
5 April 2003	**Plastic Surgery and the Management of Skin Cancers** PGEA Masterclass
1 May 2003	**The Management of Hand Injuries in the NHS** Essex Medicolegal Society
13 June 2003	**Upper Limb Spasticity, Syndactyly**, **Thumb Duplication** Invited Speaker, Trent Region Orthopaedic Training Course
30 Jan 2005	**Fingertip Injury with or without bone exposure** Invited Speaker, BSSH Course in Advanced Hand Surgery
31 Jan 2005	**Free Vascularised Bone / Joint Transfer in the Upper Limb** Invited Speaker, BSSH Course in Advanced Hand Surgery
14 April 2005	**Extensor Tendon Tethering** Invited Speaker, Anglo Spanish Hand Meeting, Vallodolid
13 May 2006	**The Management of Carpal Tunnel Syndrome** Invited Speaker, Essex Regional Neurophysiology Meeting
22 November 2006	**Advanced Course in Hand Surgery, Royal College of Surgeons:** The Degenerative Hand - Invited Faculty Lectures Delivered Tendon Transfers for Radial Nerve Palsy Flexor Tendon Synovectomy and Reconstruction Finger Fusion
5-6 October 2007	**Hand Surgery Examination** **British Society of Surgery for the Hand (BSSH)** Examiner
27 November 2007	**Human Factors in Risk Management** Partnership for Change Programme

14th April 2008	**Intercollegiate Speciality Boards Examiners' Induction Course** Edinburgh
1-2 May 2008	**Spring Scientific Meeting BSSH** Chairman
22-23 May 2008	**Tendon Transfers and Nerve palsy** Invited speaker, British Association of Hand Therapists
6-7 June 2008	**Nerve Injury & Compression, Pain, Anaesthesia** Instructional Course, BSSH
2-3 October 2008	**Hand Surgery Examination** **British Society of Surgery for the Hand (BSSH)** Examiner
11 October 2008	**Hand Surgery in Rheumatoid Arthritis, British Rheumatology Association** Invited Speaker
6-7 February 2009	**Tendon Injury, Paralysis, Rehabilitation** Instructional Course in Hand Surgery, BSSH, Manchester Invited speaker
1-2 October 2009	**Hand Surgery Examination** **British Society of Surgery for the Hand (BSSH)** Examiner
12 November 2009	**Autumn Scientific Meeting – BSSH** Convener of Symposium on "Microsurgical Reconstruction of the Upper Limb" <u>Lectures Delivered</u> Microsurgical reconstruction of long bones defects in the upper limb Vascularised bone grafting for established scaphoid non-union Immediate toe transfer for reconstruction of single digit amputations.
25 November 2009	**Hand and Wrist Arthroplasty Course** Royal Liverpool University Hospital Instructional Course
4-5 December 2009	**International Symposium for Plastic Surgeons** Occuloplastic Surgery, Munich
5-6 February 2010	**The Child's Hand and Tumours, BSSH** Instructional Course
9 February 2010	**Tendon Transfers in the Hand and Upper limb** Royal Society of Medicine Invited Speaker

27 May 2010 **Degenerative Disorders of the Hand**
Invited Speaker

7 September 2010 **Hand Surgery for General Practitioners**
The Mid Essex Medical Forum
Invited Speaker

20 October 2010 **Mastering your Risk Workshop - MPS**
Royal College of Physicians

8 February 2011 **FRCS Plast Revision Course**
Invited Faculty and Examiner

28 February 2011 **FRCS Plast Revision Course**
Invited Faculty and Examiner

1 March 2011 **Mastering Adverse Outcomes Workshop**
Royal College of Physicians

11-12 May 2011 **Advanced Skills in Hand and Wrist Surgery**
Royal College of Surgeons London
Lectures Delivered
Cubital Tunnel Release and Variations
Tendon Transfers for Ulnar Nerve Palsy
Rheumatoid Arthritis: Replacement and Realignment of MCP Joint
Correction of Finger Deformities
Fusion of Finger Joints for Arthritis and Trauma

8 September 2011 Medicolegal Expert Witness Course

29 September 2011 **Cadaveric Hand Trauma Course**
Invited Faculty
Lectures Delivered
(1) Flap cover for the Hand and Forearm including Microsurgical Reconstruction
(2) Paediatric Hand Fractures

29-30 Sept 2011 **Cadaveric Hand Trauma Course**
Guy's and St Thomas' Hospital

23-24 Feb 2012 **XI Surgery of the Hand**
Frontiers in Hand and Upper Limb Reconstruction

24 April 2012 **Mastering Difficult Interactions with Patients Workshop**
Royal College of Physicians

25 April 2012 **Mastering Professional Interactions Workshop**
Royal College of Physicians

15-16 May 2012 **Advanced Skills in Hand and Wrist Surgery**
Royal College of Surgeons London
Lectures Delivered
Cubital Tunnel Release
Tendon Transfers of ulna nerve palsy
MCPJ realignment and replacement
Correction of finger deformities and joint fusion
ARPE Joint Replacement

19-21 June 2012 **Core Skins in Hand Surgery**
Lectures Delivered
Nerve Anatomy and Access
Nerve Repair plus Grafting (Part 1)
Nerve Repair plus Grafting (Part 2)

PUBLICATIONS

Lim EH, Sood M K, Dziewulski P D (2006) Unilateral palmar and axillary hyperhidrosis post electrical flash burn. Burns. 2006 May;32(3):389-90.

S. Papanastasiou, M.K. Sood (2004) Aberrant position of the ulnar nerve within the carpal canal. Microsurgery. 2004;24(1):24-5.

S. Papanastasiou, M.K. Sood (2002) Double-level replantation of the upper extremity with microvascular pulp transfer onto an intermediate macroreplant segment. Plast Reconstr Surg. 2002 Oct;110(5):1294-7.

M.K.Sood, D. Elliot (2000) Primary Amputation of the Middle Ray in the Treatment of Severe Injuries of the Central Hand. Plastic and Reconstructive Surgery, 106:1 115-118

M.K.Sood, D.Elliot. (1998) Relocation of Sensory Neuromas of the Hand into Pronator Quadratus. British Journal of Hand Surgery 23B: 2: 214-219.

D.Elliot, M.K.Sood,B.Swain, A.F.S.Flemming. (1997) A Comparison of Replantation and Terminalisation of Distal Amputation of A Single Digit. British Journal of Hand Surgery, 22B: 523 - 529

M.K.Sood, F.D.Burke. (1997) Anterior interosseous nerve palsy : a review of 16 cases. British Journal of Hand Surgery, 22B:64-68.

M.K.Sood, D.Elliot. (1996) A new technique for distal attachment of flexor tendon grafts to the the distal phalanx. British Journal of Hand Surgery, 21B: 629 - 632.

Kangesu T., Ho Asjoe M., Sood M.K., Myint T. And Frame J.D.(1995)
Replantation of testis and penis in a child. Lancet 345 (8961): 1368-9.

R.L.Thatte, M.K.Sood, P.K.Uppal (1987)
A combination of unusual abnormalities of the lacrimal apparatus and nostril in a case of bilateral cleft with choanal atresia. British Journal of Plastic Surgery,40:645-6.

MEMBERSHIPS

British Society for Surgery of the Hand	Member
British Association of Plastic Surgeons	Member
British Medical Association	Member
Medical Protection Society	Member

PROFESSIONAL INTERESTS

I am a Consultant Plastic and Hand Surgeon at the St Andrew's Centre for Plastic Surgery where approximately 4500 patients with injuries including facial lacerations, leg injuries and hand trauma are treated every year. In addition to over 800 patients per year with hand trauma of varying complexity (which includes tendon injuries, fractures and joint injuries, injuries to nerves and blood vessels and skin loss).

I also treat patients with elective hand problems such as osteoarthritis, rheumatoid arthritis, Dupuytren's contracture and nerve compression syndromes. I have a special interest in microsurgical reconstruction of major injuries, nerve surgery, surgery for congenital anomalies of the hand and foot and surgical reconstruction of the upper extremity in patients with strokes and cerebral palsy. I have an interest in clinical research and have published articles on Hand Surgery in peer reviewed journals.

I am actively involved in postgraduate teaching and I am currently responsible for the training of the Senior Registrar in Hand Surgery attached to the Regional Plastic Surgery Unit.

I maintain my accreditation for Continuing Medical Education by attending national and international conferences, visiting centres with an international reputation, remaining up to date with published literature in hand surgery and participating in postgraduate education and audit.

I am the Regional Advisor of East Anglia for the Hand Surgery Diploma which is administered by the British Society for Surgery of the Hand / University of Manchester.

I was a Council Member for the British Society of Surgery of the Hand 2007 – 2010.

I have been the Plastic Surgery Representative on the Medical Advisory Committee at the BUPA Roding Hospital, Ilford for the last three years.