Noteworthy Decision Summary

Decision: WCAT-2005-01331-RB **Panel**: Guy W. Downie **Decision Date:** March 17, 2005

Occupational Disease – Activity-Related Soft Tissue Disorder (ASTD) – Evidence Required to establish that ASTD was Due to Nature of Employment - Section 6 of Workers' Compensation Act – Schedule B - Tendonitis –Occupational Disease Recognition Regulation – Epicondylitis - Risk Factors – Policy items #27.20 and #27.31 of the Rehabilitation Services and Compensation Manual, Volume I

This decision is an example of the analysis used to determine whether a worker's Activity-Related Soft Tissue Disorder is caused by the nature of the worker's employment. It emphasizes the importance of determining whether there exist significant causative factors in the worker's employment activities which meet the criteria set out in Workers' Compensation Board (Board) policy. The fact that a worker experiences physical problems while at work is not determinative.

In this case, the worker's physician diagnosed the worker with bilateral flexor tendonitis and bilateral medial epicondylitis. The worker was a hotel clerk. The Board had found that the worker's condition was not caused by the worker's employment and rejected the claim under section 6 of the *Workers Compensation Act*. The only issue on appeal was whether these conditions were due to the nature of the worker's employment. The WCAT panel confirmed the Board's decision and found that they were not.

The WCAT panel evaluated the worker's occupational and non-occupational activities to identify relevant risk factors for the worker's diagnosed conditions. Relying upon an assessment done by the Board case manager, who was an ergonomic evaluation specialist, the WCAT panel found that none of the worker's employment activities met the occupational disease thresholds set out in Board policy for the diagnosed conditions. The worker's employment activities required essentially no or minimal force, and were not sufficiently repetitive to qualify as risk factors. In addition, the worker engaged in non-occupational activities that were risk factors for the diagnosed conditions. These included recreational mountain biking, home renovations, gardening, smoking, and being on birth control medication. The WCAT panel accepted the Board medical advisor's opinion that these were significant risk factors. The WCAT panel thus concluded that it was not likely that the worker's employment activities caused the diagnosed conditions.

In support of the claim, the worker had obtained additional opinions from her general physician, occupational therapist, neurologist, and rheumatologist. The WCAT panel, while acknowledging the support provided for the worker's appeal from the various doctors, concluded that none of their opinions were relevant because none of their reports identified any significant causative factor in the worker's employment activities which meet the criteria set out in Board policy.

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Introduction

The worker, now 33 years old, was employed as the front desk clerk in a hotel. In an application for compensation to the Workers' Compensation Board (Board), she said that over a period from June 19, 1991 to the present, she had experienced a gradual worsening of problems in her left and right hands, wrists, and arms including elbows. She experienced aching and difficulty carrying, holding, and lifting objects. Her limbs were constantly sore. She ascribed her problems to continuous repetitive motions, keyboarding, telephone and credit card machine use, writing, stapling, etc. She said she had not missed time from work.

In a letter of October 16, 2001 a Board case manager, who is an R.N. and an ergonomic evaluation specialist, told the worker she was providing a decision as follow-up to a site visit on September 28, 2001. The site visit was in relation to a diagnosis provided by the worker's physician of bilateral flexor tendinitis and bilateral medial epicondylitis. The worker had confirmed that approximately two years earlier, while working with the same employer, she became aware of symptoms in her wrist and these became consistent and worse for the next two years, and in the last eight months she had noticed the symptoms in both elbows. The worker had had a previous motor vehicle accident in 1994 resulting in whiplash. Other non-work-related risk factors included birth control medication and tobacco intake of one package per day of cigarettes. The worker was also involved in home renovations. She had been at her present job for ten years, with no changes in her job duties, although there had been some additional machines added, and the worker felt that this increased the amount of keyboarding she had to do. She worked Monday to Friday, from 7:00 a.m. to 3:30 p.m., took regular breaks, and had a variety of duties at the front desk. The case manager described these duties. She had observed the worker at the computer terminal and doing her other duties.

The case manager said that under section 6 of the *Workers Compensation Act* (Act) risk factor guidelines for tendinitis included repeated motions of more than ten per minute (excluding keyboarding) and incorporating greater than 30 degrees of flexion, 45 degrees of extension, or 30 degrees of ulnar deviation and forceful exertion reasonably perceived by the worker to be high or a pinch grip of greater than two pounds. She said she was unable to see this happening during the check in, the check out, or when the worker was using the phone. Other risk factors included repetition with force and these were not evident, there was no evidence of force and awkward posture, and no intensive keyboarding and/or awkward posture when keyboarding. The tasks were varied, and while there might be repetition with the check out time in the first four

hours, approximately ten per day at four minutes each, this did not meet the criteria for repetition. She said the job was busy, but also varied and this limited repetition and frequency.

The case manager said that under section 6 of the Act she had then reviewed risk factors for medial epicondylitis. These included repetition with force, forearm pronation or wrist flexion greater than ten times per minute and exerting a high hand force as perceived by the worker or exerting more than ten pounds of force. She said that when looking at the check in procedure as related to medial epicondylitis, there was no force noted in any of the tasks. This was similar for check out actions. Phone calls were intermittent through the day, and there were no risk factors related to epicondylitis. She concluded that she was unable to find any risk factors for bilateral wrist/forearm tendinitis or bilateral elbow medial epicondylitis.

The case manager said that as a part of the adjudication process, a Board medical advisor had reviewed the claim and his comments had been taken into consideration.

She said that although the worker was busy at work, there were just not the risk factors for bilateral wrist and forearm symptoms and elbow symptoms, and she was unable to make any recommendations for the workplace other than the one change in moving the card swipe closer to the worker, and relocating the key maker card to the far side. She said the claim was disallowed and there was no entitlement to wage loss or health care benefits. She suggested that the worker follow-up with medical investigations to rule out any systemic causes for her symptoms.

The worker appealed this decision.

Issue(s)

Was the worker's diagnosed bilateral flexor tendinitis and bilateral medial epicondylitis causally related to her employment activities?

Jurisdiction

This appeal was filed with the Workers' Compensation Review Board (Review Board). On March 3, 2003 the Review Board and the Appeal Division of the Board were replaced by the Workers' Compensation Appeal Tribunal (WCAT). As this appeal had not been considered by a Review Board panel before that date, it has been decided as a WCAT appeal. (See the *Workers Compensation Amendment Act (No. 2), 2002*, section 38.)

Background and Evidence

The first medical report from the worker's family physician, Dr. Slobodian, was dated August 16, 2001. Dr. Slobodian said that the worker told him that last fall she had noticed aching in the lateral aspects of both arms. She said that her work involved using both hands constantly for credit card machine, telephone keypad, and writing. She had aching in both arms all the time - during weekends as well, as she had to stay active with her hands. On holidays for two weeks, with less arm activities, there had been less pain, but the pain returned on her return to work. She had started dropping things. She said symptoms were progressing. Her elbows were now aching. On examination the doctor found full range of motion of the wrists and elbows, with mild tenderness of the flexor tendons at the wrists bilaterally, with pain on flexion against resistance. There was marked tenderness of the medial epicondyles bilaterally. He diagnosed bilateral wrist flexor tendon repetitive strain injury and bilateral medial epicondylitis. The worker was not disabled.

The claim file contains a form recording the worker's history with respect to activity-related soft tissue disorders (ASTD), dated September 28, 2001, and taken from the worker by the case manager. The worker had first noticed her symptoms about two years earlier. These became constant and worse over the next two years, and in the last eight months had involved the elbows. She had no known systemic medical conditions, other than allergies to some drugs. She had been in the same job with the same employer, with no changes for ten years, although there had been some increase in keyboard work. Non-occupational activities included gardening, mountain biking, speed boating, house renovations, and volunteer work with children once a week. The work activities were listed in some detail.

The file also contains forms listing risk exposure factors for tendinitis and for medial epicondylitis. These analyzed the worker's work activities in relation to the risk factors. Both analyses concluded that there were no risk factors for these conditions.

Dr. Slobodian's next report, on January 3, 2002 noted that the worker had started physiotherapy in September. She had been advised to take some time off work, but had not been able to afford this. She continued to have pain in both arms. When she was off work for two weeks in the Christmas period, there had been a significant reduction in pain. Her own activities were limited and she could not mountain bike or lift heavy objects. He said the physiotherapist had recommended four weeks off work, and he concurred with this recommendation. His next report, on February 14, 2002 said the worker had not been at work since January 11, and was feeling generally better and working better. She was having physiotherapy twice weekly. He said the worker was now not medically capable of working full duties full time. There were no further medical reports on the file.

In a claim log entry of October 31, 2001 a Board medical advisor said he had re-reviewed the file. As noted by the case manager, there were no specific risk factors contained within this individual's tasks that would place stress on the wrist or the elbows to a significant level sufficient to cause a pathophysiological change in the tissue resulting in tendinitis. He said:

> …She has significant non-occupational risk factors that provide a much more forced repetition and excessive posturing including recreational mountain biking, home renovations and gardening. Smoking a pack of cigarettes a day is a relative risk factor.
>
> As I pointed out to you whenever someone presents with bilateral complaints particularly involving joints, a comprehensive medical work-up to identify potential underlying connective tissue disorders amongst other medical causes needs to occur. Particularly in light where the work is neither forceful, significantly repetitive and/or involving prolonged duration of posturing. As you are aware the risk factors require moderate to major force in combination with repetition to amount to a major risk factor. These are not present in this particular situation and therefore she deserves a medical work-up in a comprehensive fashion rather than someone just speculating that it's got to be work-related and ending the journey there....

With her notice of appeal - part 2 the worker requested an oral hearing of her appeal. In a letter of May 5, 2004 she was notified that based on WCAT criteria the appeal would proceed by way of written submissions. I have reviewed the file and submissions, and am satisfied that on the basis of the documentary evidence and of the arguments and submissions, this appeal can be dealt with fairly through the read and review process.

On the notice of appeal - part 2 the worker requested that the claim should be accepted, a pension allowed, that she should be provided with vocational rehabilitation benefits, and that she should be provided with health care. She requested a correction in wage rate, she requested wage loss benefits, and all related expenses. Of this list, only the issue of acceptance of the claim is before this panel.

With the notice of appeal the worker provided a letter from herself dated May 1, 2003 in which she argued against the decision. Her principal argument was that when she was off work in 1999 for an unrelated reason her symptoms improved, but when she returned to work the symptoms returned after a short time. However, she also noted that the symptoms affected her ability to continue outside activities such as golf, gardening, and mountain biking. She said that she had engaged an occupational therapist to provide recommendations with regard to improvements in her workplace.

She provided a copy of this report dated November 16, 2001. The report outlined her activities in great detail. It said that, in summary:

> The ergonomic assessment was conducted with [the worker] present. Job demands result in need to use the computer almost continuously, and speak on the telephone, write and use various pieces of equipment frequently, for short periods of time. The following is a list of recommendations to help improve the ergonomic of the workstation, as well as suggestions for changes in body mechanics to help reduce stress on the upper extremities.

The accompanying recommendations included:

- provision of an alternate removable surface for the worker's keyboard, about 9 1/2" high, to allow the worker to maintain optimal position when keying.
- this would necessitate raising the computer monitor about 2 inches.
- the worker should raise the surface on which she writes, to the right of the keyboard, by 2 ½"
- the telephone should be raised about 2 inches to improve the wrist position when using the buttons.
- the worker was encouraged to keep her elbow close to her body when holding the telephone.
- the worker was encouraged to avoid applying force to the stapler with her wrist extended. She would benefit from an automatic stapler.
- the worker might benefit from a pen grip which would increase the diameter of the pen, and thus reduce the grip force required.

In her letter the worker disagreed with a number of the observations of the case manager in her role as an ergonomic analyst. She said that her activities of in house renovation were minimal. She said that the regular breaks which she got during the day were minimal. She said that the evaluator had not witnessed her working. She said that she had been asked to estimate the amount of time each task took on an average day. She now said there were inaccuracies in the guesses she made, and provided a new list. She described each of her activities, which she seemed to think were very demanding. She said she had had blood tests, as recommended, and all were negative. She said that she had discontinued her work in January 2002 and taken medical leave. In May 2002 she had been able to return to work gradually, and in a modified position in a different workstation which required less intense and less frequent keyboarding. She had left his job, in January 2003, on a three-month leave of absence to work at a different job. Her condition, while still a real problem, was decreasing in intensity. She had returned to her regular position on April 20, 2003, and already had experienced an increase in pain and a return of symptoms.

With her submission the worker provided a letter of May 1, 2003 from Dr. Mark

Sherman. He said the worker had continued to work through much of the time up to the present, and had been engaged in no other repetitive activities, recreationally or domestically, that could better explain her symptoms. He said she had suffered both personal and financial hardship, and deserved proper compensation, which he supported.

The worker provided a letter from Dr. F. Kemble, neurologist, addressed to Dr. C. Atkins. Following examination Dr. Kemble said that:

> Neurologically and electrodiagnostically, she is normal. She is probably one of those individuals who have sensitive ulnar nerves without any significant compression and I have discussed this with her.

The worker provided a letter of February 19, 2002 from Dr. Christopher Atkins, rheumatologist. In his report Dr. Atkins said:

> She has had a clunk in the left hip with slight intermittent pain here ever since she was a child. This has not bothered her but two years ago she started to notice the onset of pain in her wrists, elbows and hands. Her symptoms are activity dependent; they are made better by rest and ice. In the last 18 months she has noticed some tingling in the ring finger and little fingers of both hands. This seems to be related to activity and occasionally occurs at night when she is sleeping with her hands above her head.
>
> She has undergone physiotherapy since September of 2001, which included ultrasound, stretches, whirlpool, ice and weights.
>
> She comes out in hives with Robaxisal, ASA and Advil. She also gets hives with food preservatives. She smokes one pack of cigarettes a day and drinks alcohol on a social basis. She has had psoriasis, particularly on her elbows, since the age of 19. 7 years ago she had fairly well defined areas of alopecia on her scalp....
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> ... She is 5' 6 ½", weighs 156 pounds. There was pain on palpating the medial epicondyles of both elbows but no synovitis was noted, no lack of extension. Tinal [*sic*] sign was equivocal over the carpal tunnels and produced pain shooting up proximally. There was slight pain on full forcible flexion of the wrist. No synovitis was noticed in the wrists of the MCP or PIP joints of the fingers of either hand....

> ... She probably does have repetitive strain syndrome with medial epicondylitis; possibly a carpal tunnel syndrome and tardy ulnar palsy. I am having her seen by Dr. Kemble to check for these conditions.... Her positive rheumatoid factor is not significant in this clinical context.

The worker provided several photographs of her workstation.

The worker provided excerpts from a Board publication.

The worker made no further submissions beyond these attachments to her notice of appeal.

The employer was notified of the appeal, but did not participate.

Board policy with respect to tendinitis is outlined in policy item #27.20 of the *Rehabilitation Services and Claims Manual, Volume I* (RSCM I). This described the risk factors to be considered, which include:

- the relative frequency, intensity, and duration of exposure to risk factors encountered in connection with the worker's employment compared to those encountered in non-occupational activities;
- whether the intensity of the forces placed on the affected tissues in connection with the worker's employment activities are likely to produce injury (such as a sudden stretching of tendinous tissues) when compared to such likelihood arising from the intensity of forces encountered in connection with the worker's non-occupational activities;

…

- whether the worker has previously suffered injuries, inflammation, or infections associated with the affected tissues, and if so the likely cause of the prior conditions;

…

- whether the worker has suffered from any degenerative or systemic disorders (including but not limited to degenerative arthritis, rheumatoid arthritis, gout, systemic lupus erythematosus, connective tissue disease, or inflammatory rheumatological disorder), and if so whether such underlying disorder is the likely cause of the subject inflammatory disorder, or alternatively has had the effect of rendering the worker more susceptible such that shorter, or less frequent, or less intense exposure to risk factors may initiate the subject disorder;

- whether the worker is taking prescription medications, is undergoing any therapy or treatment for any other condition, or is pregnant, and if so whether this is a likely cause of the subject disorder or alternatively has had the effect of rendering the worker more susceptible.

With respect to epicondylitis, Board policy item #27.31 of the RSCM I provides that:

> The Board recognizes that where the worker was occupationally performing frequent, repetitive, forceful and unaccustomed movements (including forceful grip) of the wrist that are reasonably capable of stressing the inflamed tissues of the arm affected by epicondylitis, and in the absence of evidence suggesting a non-occupational cause for the worker's epicondylitis condition, a strong likelihood of work causation will exist....

Reasons and Findings

Having considered the evidence and the arguments, I confirm the Board's decision. I deny the worker's appeal. In reaching this decision, I acknowledge the support provided for the worker's appeal from the various doctors listed. However, none of their reports identify any significant causative factor in the worker's employment activities which meet the criteria set out in Board policy. The most significant factor which is absent from the worker's work activity is force. Her employment activity requires essentially no or minimal force. The absence of this factor means that her work is not capable of significantly stressing the tissues affected by her condition. Also absent from her employment activity is repetition, in the sense used in evaluating ASTD. Her activities, while busy, provide a great deal of variety and so eliminate the factor of repetition. The Board medical advisor considered that the worker's non-occupational risk factors were significant, and included recreational mountain biking, home renovations and gardening. Smoking was also a risk factor. I accept his opinion in this regard.

Having reviewed and analyzed all of the reports provided, I find that it is not likely that the worker's diagnosed bilateral flexor tendinitis or her bilateral medial epicondylitis were caused by her employment activities. Certainly, when these problems are present, her work activity, or any activity, would call them to her attention. The worker herself noted that in addition to work activity, many of her other activities also had to be curtailed because of the problem.

Conclusion

For the reasons outlined I confirm the Board's decision. I deny the worker's appeal. No costs were identified in connection with the appeal, but if there was a cost to the worker in securing the letter of support of May 1, 2003 from Dr. Sherman, this cost should be reimbursed at the Board's regular tariff.

Guy W. Downie
Vice Chair

GWD/hb