Noteworthy Decision Summary

Decision: WCAT-2006-00337-RB **Panel**: Gail Starr **Decision Date:** January 25, 2006

Conflicting Medical Diagnoses – Assessment of Medical Evidence

This decision is noteworthy because it provides an analysis of how to weigh the medical evidence in circumstances where there are conflicting medical diagnoses.

The worker's shoulder and upper limb claim had been disallowed by the Workers Compensation Board, operating as WorkSafeBC.

There was conflicting medical evidence as to the nature of the worker's shoulder and upper limb condition. At one time the condition had been diagnosed as thoracic outlet syndrome and, more recently, it had been diagnosed as an inflammatory brachial plexopathy. The panel addressed the likely correct diagnosis of the worker's upper right extremity and whether this condition was due to the nature of the worker's employment under section 6 of the *Workers Compensation Act*. He preferred the diagnosis provided by a neurologist of an inflammatory brachial plexopathy. Standing at the end of a line of specialist investigators, the neurologist had the benefit of knowing what others had pursued and found or not found. The neurologist's opinion that thoracic outlet syndrome was not the correct diagnosis was forcefully and persuasively expressed; also, there was the clear fact that the surgical treatment for thoracic outlet syndrome had been completely ineffectual. There were also other treating physicians who had not embraced the diagnosis of thoracic outlet syndrome.

With respect to causation, the difficulty was that no medical investigator had offered a reasoned opinion that the work activities were of causative significance in the occurrence of the worker's condition. The worker's appeal was denied.

Workers' Compensation Appeal Tribunal 150, 4600 Jacombs Road, Richmond, B.C. V6V 3B1
Telephone: (604) 664-7800; 1-800-663-2782; Fax (604) 664-7898

WCAT Decision Number: WCAT-2006-00337-RB
WCAT Decision Date: January 25, 2006
Panel: Gail Starr, Vice Chair

Introduction

This is the worker's appeal from an April 2, 2002 decision by a case manager at the Workers' Compensation Board (Board). In this decision, the worker was informed her claim for a bilateral thoracic outlet condition was disallowed. The letter stated the condition had been considered both under the provisions of section 5 of the *Workers Compensation Act* (Act) (compensation for a work-caused injury) and section 6 of the Act (compensation for occupational disease).

This appeal was originally filed with the Workers' Compensation Review Board (Review Board). On March 3, 2003, the Appeal Division and Review 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 transferred to WCAT by operation of law. (See the *Workers Compensation Amendment Act (No. 2), 2002*, section 38.)

The worker's entitlement in this case is adjudicated under the provisions of the Act as they stood prior to changes contained in the *Workers Compensation Amendment Act, 2002* (Bill 49). Policy relevant to this appeal is primarily set out in the *Rehabilitation Services and Claims Manual, Volume I* (RSCM I), which relates to the former (pre-Bill 49) provisions of the Act.

An oral hearing was requested by the worker and this was scheduled for March 23, 2005. In advance of the oral hearing, the worker's representative provided several medical reports which will be discussed below.

There were some procedural peculiarities as this appeal moved toward an oral hearing. Perhaps because of miscommunication, the worker requested deferral of her appeal, while her representative subsequently advised proceeding with it. With the worker's consent, the appeal was reinstated, but then, evidently on receipt of Dr. Hashimoto's August 18, 2003 letter, the worker's representative requested deferral on the basis that the Board would be invited to make a new original decision on the new diagnosis. This was denied in a WCAT letter of November 18, 2004 on the grounds that, under the *Manual of Rules, Practices and Procedures*, sections #26.60 to #26.65 (as they then were), deferral of an appeal could be granted on one occasion only. The matter was again scheduled for an oral hearing, and this did take place, after some further scheduling problems, on March 23, 2005.

At the oral hearing, the worker gave evidence concerning the onset of her symptoms and the course of her medical investigation and treatment. Representatives for the worker and for the employer made submissions on behalf of the respective parties. The employer's representative provided an employee injury/exposure report form concerning the worker's condition in January 2002. This was marked as exhibit #1 and has been added to the claim file.

Issue(s)

Is the worker's shoulder and upper limb condition, at one time diagnosed as thoracic outlet syndrome and more recently diagnosed as an inflammatory brachial plexopathy, compensable? It will be necessary to consider this matter under both section 5 and section 6 of the Act.

Background and Evidence

There is a considerable amount of detail concerning the worker's account of the onset of the symptoms which have led to this claim. There is little controversy concerning the nature of her work. Her accounts of it have been substantially similar on several occasions (to her family physician Dr. Walter on May 25, 2001 and after, to several investigating specialists over time, to the Board's entitlement officer on February 4, 2002, and at the oral hearing before me on March 23, 2005). Her own evidence is also substantially similar to the report of an independent ergonomist who reported on a site visit as her claim was being investigated. I have reviewed all of this abundant workplace evidence and elements of it will be interwoven as necessary.

A full-time pathology attendant in a hospital morgue since 1984, the worker was 51 years of age at the time of her application for compensation. She is right-handed. She describes having previously experienced pain and swelling in her upper extremities, chiefly her right hand, for several years. She attributed this to the aging process for most of that time. She occasionally removed her rings because of the swelling. She continued to work. Although the symptoms usually came on at work, she did not associate her condition with work until some time after she became disabled following an incident at work on May 24, 2001.

On or about May 24, 2001, the worker describes that she was, as part of her regular duties at work, lifting and pouring jugs of liquid. She recalled that she had slept poorly the night before and had awakened feeling stiff and sore in her shoulder; she simply thought she had slept awkwardly and went on about her daily activities, including work. The heaviest jug was a five-gallon jug which needed to be moved from underneath a cupboard to the top of a cupboard; this meant lifting the jug up to around her face level to place it on a counter which was at approximately chest level. This required the use of two hands, but her right hand was doing most of the lifting. On this date, although she had performed this task many times, she experienced an onset of numbness and

Workers' Compensation Appeal Tribunal 150, 4600 Jacombs Road, Richmond, B.C. V6V 3B1
Telephone: (604) 664-7800; 1-800-663-2782; Fax (604) 664-7898

aching in her right hand and, for the first time, numbness in her hands and fingers. She worked the remainder of her shift and also worked the next day. Following that, however, she saw her family physician, Dr. Walter, who considered her then disabled, but he did not report this to the Board until some time after the fact. She says the numbness has never gone away. Various symptom changes and numerous medical investigations later, she has not been able to return to work to this day.

Dr. Walter initially prescribed physiotherapy. This seemed to make the worker's symptoms worse, however, and she discontinued it after three weeks. Then specialist investigation began. It is the worker's evidence she did not think of her work as having caused her symptoms at first, and so she did not initially report a work context to Dr. Walter. Dr. Walter, whose chart notes have been obtained by the Board, recorded the worker's symptoms in some detail on May 25, 2001, but his notes then do not refer to a work context, although they do mention recent lifting. He did not record a diagnosis, but he did plan a neurological referral. He referred the worker to Dr. Chan (neurosurgeon). His chart note for May 28, 2001 shows he had spoken with Dr. Sadowski (neurology and electromyography), but, as it happens, the worker saw Dr. Chan first.

In his June 2, 2001 report to Dr. Walter, Dr. Chan recorded details of his examination of the worker. His clinical impression was of "soft findings of right carpal tunnel syndrome and ulnar neuropathy." However, he thought this did not account for the worker's pain. He recommended a CT scan of the cervical spine, as well as EMG nerve conduction studies, which would be carried out by Dr. Sadowski. The CT scan was undertaken on July 8, 2001 and was read to show no significant pathology, although there were degenerative changes at C4-5 and C5-6.

Dr. Chan had Dr. Sadowski's nerve conduction studies in hand when he saw the worker again July 19, 2001. The nerve conduction studies showed very mild right carpal tunnel syndrome. Such signs as there were in the recent CT scan were noted to be more marked on the left than on the right, but the worker's symptoms were on the right. He thought the C-spine findings had no relationship to the right-hand symptoms. He found no neurological finding to explain the worker's symptoms. He requested an MRI scan and suggested continuing with exercises.

Dr. Sadowski again reported to Dr. Walter on September 13, 2001. He, too, recorded a history and the results of a detailed examination of the worker. He thought the worker's symptoms and findings were likely not neurologically based. They did not correspond to any simple nerve root or peripheral nerve pattern. The fact that she felt more pain with use of the arm suggested a soft tissue problem in the hand. He doubted that the CT scan of the head, proposed by Dr. Chan, or the C-spine MRI, would shed any further light on her symptoms.

Dr. Jaworski (physical medicine and rehabilitation) reported to Dr. Walter on October 17, 2001. (In my reading of the medical reports, this report from Dr. Jaworski is the first to record the worker's occupation or, indeed, anything at all about her work.) He recorded that the worker's symptoms had become greater, although they were intermittent, since the onset some five months previously. Dr. Jaworski reviewed the investigations by Drs. Chan and Sadowski. He was also aware of her trials with physiotherapy, with chiropractic manipulations (not otherwise documented on the file) and a course of NSAIDs, all without clinical benefit. Dr. Jaworski also records a history, as well as details of a physical examination. His impression was of right-sided thoracic outlet syndrome. He was arranging a chest x-ray and a thoracic surgical consultation with Dr. Fry (vascular surgery). He noted, incidentally, a few tender points on the right side of the body in keeping with a component of myofascial pain.

An October 31, 2001 right shoulder x-ray was read to show no significant bony or joint abnormality and no degenerative change related to the AC (acromioclavicular) joint.

When he reported to Dr. Jaworski on December 12, 2001, Dr. Fry described the worker as a "fascinating patient," who was "one of the most dramatic cases of thoracic outlet syndrome, both neurogenic and vasculogenic, that I have seen." He understood, from the history of the worker available to him, that she had simply awakened one day with numbness and pain then went on to "develop fairly typical symptoms." Dr. Fry recorded a number of points concerning his examination of the worker which he took to be strong indicators of thoracic outlet syndrome. He concluded the worker clearly had a "very tight thoracic outlet" with neurogenic and vasculogenic symptoms. He would investigate for a concern he had about possible aneurysms and he recommended proceeding with surgical intervention (first rib resection) as soon as possible; he had put her on the urgent waiting list.

In a December 21, 2000 report, Dr. Jaworski recorded the worker's concern that she was now developing left shoulder pains (which she attributed to compensation for not using the right), but he advised her to carry on with the plan for right-sided surgery.

On January 8, 2002, while the worker still awaited surgery with Dr. Fry, Dr. Walter also recorded in his chart note for that date that the worker was developing left-sided symptoms as well. It was on this date that he provided his first report to the Board. He reported her disabled from work since May 25, 2001. He recorded that diagnosis was uncertain, querying brachial neuritis and describing right hand and arm symptoms. He indicated the worker was under the care of Dr. Fry. The date of injury was shown as May 24, 2001. His report does not indicate what the work relationship with the worker's condition was thought to be; there is no description of an incident, no discussion of her work, and no indication of Dr. Walter's reason for submitting a report to the Board.

A January 11, 2002 bilateral subclavian angiogram was reviewed by Dr. Fry, who reported on this to Dr. Jaworski in a January 21, 2002 letter. He read the arteriogram

as being "quite dramatic" in terms of the compression of the subclavian artery. He proposed to continue with the plan for a first rib resection on the right side. The concluding paragraph of this letter stated the following:

> It is hard to relate this syndrome to anything specific in her case although she does do quite a bit of lifting at work also, of course, using rib shears which might be a factor in provoking symptoms but there doesn't appear to be any discrete history of injury as such. We may learn more about the anatomy when we do her surgery which hopefully will be in the next little while.

Dr. Fry carried out the surgery on February 14, 2002. His operative report is on the file. Dr. Walter reported to the Board on February 22, 2002 that the worker was recovering. This was his second and last progress report to the Board.

On January 11, 2002 the employer submitted a report to the Board and the worker's application for compensation is dated January 20, 2002. At this point the Board gathered the worker's evidence and the medical documentation described above. The entitlement officer requested the opinion of a Board medical advisor concerning causation, and Board medical advisor Dr. A responded by addressing only the possibility that the worker's diagnosed thoracic outlet syndrome might have been caused by trauma. Her claim log entry on March 6, 2002 includes a documented understanding of the mechanism the worker had described when lifting jugs on May 24, 2001. The entry goes on to describe, in a general way, the causes of thoracic outlet syndrome. The opinion is offered that the described work incident on May 24, 2001 did not "sound very injurious. This single incident would not be compatible with causing thoracic outlet syndrome." The entry goes on to acknowledge the worker's belief that years of occupational repetitive activities were significant; however, Dr. A defers to other Board expertise for consideration of the injury as an activity-related soft tissue disorder.

On the same day as the above described medical advisor opinion was provided, the entitlement officer relied on it and recorded a decision that the claim would not be accepted under section 5(1) of the Act. She further indicated the claim was being referred to a case manager for consideration under section 6 of the Act (relating to occupational disease). The new case manager reviewed the file and, in a March 8, 2002 claim log entry, focused particularly on the tasks the worker was required to do as a pathology attendant, both when performing autopsies and otherwise. At this time, it was recorded on the file for the first time that the worker was involved in manual transfers of bodies, the use of rib cutters and Stryker saws. Some of this work was described as very physical, and it was noted that the worker might perform two or three autopsies in a given day. Other, less strenuous duties, some of them apparently involving repetitive activity, were briefly described.

Following this review, an ergonomic intervention report was requested. This was carried out at the work site on March 21, 2002 and reported to the Board in the usual form on March 25, 2002. It was known that the worker's then current diagnosis was bilateral thoracic outlet syndrome, right (the dominant hand) worse than left.

In assessing repetitive work, the ergonomist focused on job tasks which involved neck and shoulder repetitions or arm movements which might affect the shoulder and neck. A few tasks, such as filling racks with slides, filing slides and scraping slides, were acknowledged to be somewhat repetitive for other areas of the body, but they were not thought significant for the neck and shoulder. Weights and sizes of material and equipment are noted (but not necessary to describe here) as was the fact that there was vibration with use of the Stryker saw. Static pressure or force for up to 5 to 15 minutes per occasion of use was noted.

Documentation contained in the ergonomic intervention report is extensive and highly detailed, broken down by each task performed. As both the worker and the employer (and their respective representatives) are thoroughly familiar with this report, it is not necessary to provide a detailed summary here. From the worker's evidence at the oral hearing (and as provided to the entitlement officer), it is clear that she regards the lifting and pouring activities and the duties performing autopsies as the most significant features of her work in relation to her diagnosed condition. The following excerpts from the report are sufficient for purposes of this appeal:

> …There is,…some forceful (high force) bilateral abduction of the arms > 60 degrees when using the Stryker saw to cut the cranium and medium force when cutting the ribs. It should be noted that these activities account for 10-15 minutes average to 30 minutes maximum for the saw and 5-10 minutes (12 repetitions) for the ribs. These duties are performed every other week, up to 3 times a day, daily for that week.
>
> Although I have detailed the specific postures and forces for each task, the following is a summary of the shoulder postures and frequencies averaged throughout the entire workday:
> Left/ Right shoulder abduction < 60 degrees; frequent dynamic light to medium force.
> Left/ Right shoulder flexion < 60 degree; frequent dynamic light to medium force.
> Bilateral shoulder flexion < 60 degrees; occasional dynamic high force.
> Right shoulder adduction; occasional dynamic light to medium force.
> Right/ Bilateral shoulder flexion > 60 degrees; occasional dynamic light to high force.
> Right shoulder abduction > 60 degrees; occasional dynamic medium to high force.

Right shoulder internal rotation; occasional dynamic medium to high force.

…

TASK 3: once a day or once a week duties.
Right shoulder abduction and adduction (turning crank); occasional dynamic light force.
Bilateral shoulder flexion <> 60 degrees (lifting/lowering box); occasional dynamic medium force….
…

Right shoulder abduction > 60 degrees (pouring); occasional dynamic medium to heavy force….

…

Right shoulder flexion 90 degrees (lifting container out of machine); occasional dynamic light force (1.87 pounds)….

…

TASK 7: Morgue duties.
Bilateral push/pull; occasional dynamic high force.
Right / left shoulder abduction < 60 degrees; frequent dynamic medium force.
Right / left shoulder flexion < 60 degrees; frequent dynamic medium to high force.
Bilateral shoulder flexion > 60 degrees; occasional dynamic high force.
Bilateral pull

TASK 8: Autopsy
Bilateral shoulder flexion > 60 degrees; occasional dynamic medium to high force.
Right/left shoulder abduction; occasional dynamic medium to high force.
Right Internal rotation of shoulder; occasional dynamic medium to high force.
Right shoulder adduction; occasional dynamic medium to high force.
Right shoulder flexion < 60 degrees; occasional dynamic medium force.

[reproduced as written]

On review, it was reported there was no aspect of the worker's duties which was unaccustomed. The work was self-paced and there was task variability.

Workers' Compensation Appeal Tribunal 150, 4600 Jacombs Road, Richmond, B.C. V6V 3B1
Telephone: (604) 664-7800; 1-800-663-2782; Fax (604) 664-7898

Consistently with the worker's evidence at the oral hearing, this report notes that she was required to manually move bodies in her morgue duties. Some of this was assisted by hand pedals and cranks. (More modern, automated equipment has replaced some of this since the worker became disabled.) In her autopsy duties, it was noted that when placing a body on the table (39 inches high) she was required to pull the body a minimum of two repetitions, involving bilateral shoulder flexion greater than 60 degrees. When cutting the cranium, the worker was required to stand on a foot stool and to work from 10 to 30 minutes in this position, bent over the body and using the Stryker saw. As the saw only cuts in one direction, it was necessary to stop half-way through and change hand/arm positions to cut the other half of the cranium. Cutting ribs was also quite physical. Each rib is cut separately, using both hands to pull the cutter closed. The clavicle is usually cut with a machine, being too difficult to cut with the rib cutters.

As is usual with such reports, the ergonomic intervention report carried the caveat that, as only occupational risk factors have been considered, no opinion regarding causation of the diagnosed condition is stated or implied.

Following receipt of this report, the case manager required Board medical opinion. Board medical advisor Dr. N replied in a claim log entry of April 2, 2002. Dr. N advised, in pertinent part, as follows:

> Occupational risk factors for thoracic outlet syndrome are thought to be related to working with the arms held in greater than 60 degrees of abduction or flexion or heavy lifting causing excessive downward traction on the shoulder, where such activities constitute a significant part of the work day.
>
> This woman's work activities have been analyzed on Mar 21/02. Forceful abduction of the shoulders greater than 60 degrees of abduction is limited to 10-15 minutes 3 times per day. Moderately forceful abduction of the shoulders greater than 60 degrees is required 5 - 10 minutes 3 times per day. There are no activites which cause forceful downward traction on the shoulders. The work is highly variable and self-paced. The vast majority of activities are low to medium force and utilize neutral shoulder postures. From a medical point of view, the occupational risk factors in this case do not appear to be significant for right thoracic outlet syndrome.
>
> [reproduced as written]

With this advice in hand, the case manager issued the April 2, 2002 letter which is here appealed. In the letter, he clarified for the worker that there were two possible routes under which a condition such as thoracic outlet syndrome could be accepted as compensable. Where the condition was traceable to a personal injury, it might be compensable under section 5 of the Act. Where it was considered due to the nature of

the employment, it would be considered an occupational disease and, if compensable, compensation would be under section 6 of the Act. The letter summarizes the opinions of both Board medical advisors (Dr. A and Dr. N) and states that the case manager cannot conclude that the worker's condition was either caused by or significantly aggravated by her work activities. Thus, it would be compensable neither under section 5 nor section 6 of the Act. That was the decision which is here appealed.

There is some new medical evidence concerning the worker's condition, and I turn to that now.

Approximately six months after her surgery, the worker saw Dr. Jaworski again and he reported to Dr. Walter in a July 24, 2002 letter. The worker's symptoms at that time (shortness of breath and ongoing numbness and pain, as well as weakness, in the hand) led him to order a chest fluoroscopy. This showed right hemidiaphragm paralysis, "presumably due to phrenic nerve damage during the recent surgery."

The worker was referred again to Dr. Sadowski, who saw her August 19, 2002. His report at that time reveals that, not only did the February 14, 2001 surgery produce no change in the worker's symptoms, but also that Dr. Fry had performed a scalenotomy on April 4, 2001, and this again produced no improvement in her symptoms, although she had gone on to develop the right phrenic nerve paralysis and shortness of breath. Dr. Sadowski again examined the worker and reviewed studies previously described here. He was unable to explain the numbness in the fourth and fifth digits. There was still a suggestion of mild carpal tunnel syndrome, "perhaps more prominent now than it used to be." He would further investigate with an MRI scan.

On September 6, 2002, Dr. Jaworski saw the worker in follow-up. She still had difficulty with shortness of breath on exertion and her right upper limb symptoms continued to bother her. The MRI study ordered by Dr. Sadowski was still awaited. Investigations would continue.

No further reports from Drs. Jaworski, Sadowski or Fry have been received on the claim file. However, the worker was seen by at least two more specialists. On May 28, 2003 she was seen by Dr. Hashimoto (neurology), who reported to Dr. Walter on the same day. Dr. Hashimoto recorded the worker's account of her work activities and her reports of symptoms. He also recorded her lack of success with surgery. He did not think her problems were related to a thoracic outlet syndrome, but he would investigate further, as he thought that she did have a brachial plexus problem.

At Dr. Hashimoto's request, further assessment and electromyography were undertaken by Dr. Gibson (neurologist) and she reported on this in a letter of June 20, 2003. Her investigations showed "definite and very significant chronic neurogenic change in a right C8 distribution." These findings were felt to be more in keeping with a right C8 radiculopathy than with neurogenic thoracic outlet syndrome. Review of the

worker's cervical MRI was expected to be helpful. When the MRI of the cervical spine and brachial plexus was read by the radiologist, the impression was as follows:

1. Mild canal narrowing in the mid cervical spine in relation to disc/osteophyte complexes. Neural foraminal narrowing at multiple levels, most marked on the right at C4/5 and bilaterally at C6/7.

2. The right C8 nerve root is not impinged at the C7/T1 level.

3. No evidence of right brachial plexus abnormality.

When the new investigations were available, Dr. Hashimoto saw the worker again and reported to Dr. Walter on January 15, 2004. He found the MRI results basically unhelpful and noted the worker continued to be "a diagnostic problem." He interpreted all the studies as negative and stated he did not believe this was a thoracic outlet syndrome but he was left in no doubt the worker did have some kind of brachial plexopathy, which might be an inflammatory problem. He would review her again in six months. When he did so he recorded that the worker reported painful numbness in the forearm and hand, the thumb being spared. She had difficulty accomplishing fine tasks and doing anything that required use of the hand repetitively; she reported that doing something a second or third time leaves her with an arm that feels weak and more painful and she has to stop. Dr. Hashimoto went on to provide his impression as follows:

> Her examination again reveals the slightly wasted triceps on the right side with reduced triceps, brachial radialis, and biceps reflexes, all on the right side compared to the left. She has decrease to light touch over the dorsal aspect of her forearm and extending down into her hand but sparing the thumb….
>
> It would appear that she has involvement of C8 as well as, to a lesser extent, C6 and C7. This would imply to me that the problem is within the brachial plexus and that the involvement is greater lower than higher but this certainly is not the type of problem one would see with a thoracic outlet syndrome….much more in keeping with an inflammatory brachial plexopathy and at the present time there really is not much to do except to continue symptomatic treatment. There is no question with respect to disability as especially repetitive activity increases discomfort markedly….There is a mild concern in my mind with respect to her disability status because the assumption has been made that she has a thoracic outlet syndrome which I believe has long since been disproved.
>
> [reproduced as written]

Dr. Hashimoto did not mention or record any opinion concerning causation in any of his three letters; nor had Dr. Gibson.

With her September 10, 2004 written submission, the worker's representative provided a form concerning patient disability, which was completed and signed by Dr. Hashimoto without the document being dated, except that it shows it was faxed by Dr. Hashimoto on September 2, 2004. Dr. Hashimoto's notes on this form include his opinion that the Board medical advisor's opinion underlying the April 2, 2002 Board decision is irrelevant because the diagnosis (thoracic outlet syndrome) considered there is not reflective of the worker's actual condition. He is emphatic the worker does not have thoracic outlet syndrome. Again, Dr. Hashimoto expresses no opinion concerning occupational causation. He emphasizes his belief that the worker's condition is an inflammatory brachial plexopathy with likely C7 and C8 involvement.

When the worker's representative received Dr. Hashimoto's latest letter, she moved to defer WCAT consideration of the appeal and to obtain a new Board decision on the worker's claim for compensation with the new diagnosis as a basis for the claim. As described in the introduction to this decision, WCAT could not accede to this request. On receipt of the request to the Board for a new decision, a new case manager requested another medical opinion. In an October 6, 2004 claim log entry Board medical advisor Dr. F provided a response. Dr. F explained the nature of brachial plexopathy. She also stated she had reviewed Dr. Hashimoto's report as well as the October 2003 MRI. She reviewed several possible causes of adult brachial plexopathy, including downward pressure on the shoulder stretching the nerves, a fracture of the collar bone, infiltration by malignant cells, or radiation therapy. She stated clearly that the condition was not related to the worker's job activities as they had been described on the file. She thought the previous opinion by Dr. N regarding causation was unaffected by the new information.

On receipt of this advice, yet another case manager reviewed the matter. This case manager decided that, since the original decision to deny the claim had been made more than 75 days previously, she could not reconsider the decision. The previous denial of the claim would stand.

Law and Policy

At the oral hearing, representatives of the worker and employer agreed that no serious issue arises in this appeal under section 5 of the Act. I agree with this. As the initial decision on the claim was set out by the entitlement officer, and as advised by Dr. A, there was no serious evidence supporting a traumatic cause of the worker's upper extremity condition. I think this holds true without regard to the diagnoses which are contended for in the medical evidence. The worker did not, in her application for compensation or otherwise, describe trauma to her upper extremity which could likely be causative, under general medical understanding, of a thoracic outlet syndrome. This

is reflected in all medical opinion on the file which addresses the question. I find it unnecessary to describe at any greater length the law and policy which might relate to the claim if it were advanced on the basis of section 5 of the Act.

Section 6 of the Act is directed at compensation for occupational disease. Thoracic outlet syndrome has been recognized by the Board as an occupational disease (under authority conferred by section 1 of the Act and RSCM I item #26.03). A condition listed as "disablement from vibrations" has also been recognized under this authority. Brachial plexopathy has not been recognized, but RSCM I item #26.04 allows recognition of particular conditions as compensable occupational disease, following mandated standards of enquiry, when dealing with a specific case.

Chapter 4 of RSCM I, generally, contains most of the Board's published policy concerning occupational diseases. Much of that material, by volume, simply sets out current medical understanding of a number of conditions which have been recognized as occupational diseases. Risk factors for activity-related soft tissue disorders of the limbs are considered at length and, generally, these factors have been addressed in the ergonomic intervention report available in this case.

RSCM I item #27.35 is addressed to "unspecified or multiple-tissue disorders." Briefly summarized, this statement of policy clarifies that, while diagnostic terms and opinions related to these types of conditions may differ, "even though a clinical entity familiar to the Board has not been diagnosed," a claim must be considered on its own merits.

With reference to thoracic outlet syndrome and disablement from vibrations, *inter alia,* it is highlighted that there is no evidentiary presumption in favour of causation. Thus, as stated in RSCM I item #27.30:

> These diseases are compensable only if the evidence establishes in the particular case that the disease is due to the nature of any employment in which the worker was employed.

In RSCM I item #27.33, it is stated that these conditions:

> …typically result in numbness and tingling, pain, and weakness of the upper limb(s). They may be caused or aggravated by occupational or non-occupational activities, particularly in an individual who by virtue of their specific anatomical makeup is susceptible to these disorders….Medical research does not clearly relate any of these peripheral nerve entrapments…to any particular employments and accordingly each claim must be determined according to its own merits.

Finally, as to law, policy and general principles, I would note that it is not uncommon in an appeal for there to be new evidence which suggests that an uninterrupted condition

should receive a different diagnosis than it had received previously. I consider that it requires the citation of no authority to say this evidence is acceptable and must be considered in an appeal. This is true, at least, where substantially the same signs and symptoms are being interpreted by different diagnosticians over time. Where, on the other hand, a condition is gradually understood to involve fundamentally different signs and symptoms or, for example, to affect another or other parts of the body, the line might have to be drawn differently. Here, however, I consider that the worker's upper right extremity condition, as manifested in her upper right limb, shoulder, right neck and thoracic and brachial plexus, is before me.

Decision and Reasons

It is argued on behalf of the worker that her claim should be accepted under section 6 of the Act on the basis of the medical opinion of Dr. Fry. On this view, the worker's disabling activity lifting and pouring on May 24, 2001 was the "last straw." Leading up to that, she had a history of untreated symptoms. Her work should be accepted as including the risk factors for thoracic outlet syndrome. Drawing on the ergonomic intervention report, the worker's representative argues that 45 minutes out of a 7.2-hour day is, contrary to the opinion of Board medical advisor Dr. N, significant force as contemplated by the policy. Dr. Fry's reports are also relied on for his attention to the worker's lifting and use of rib shears in provoking her symptoms. It is emphasized that these were actions and activities she would never have undertaken except at work. This worker's particular physical make-up should be accepted, in the light of Dr. Fry's description of her condition, as putting her at greater risk for development of the condition from which she suffers than other workers.

It is the employer's representative's position that there is no clear link between the worker's condition and her work activities. She argues that, despite Dr. Hashimoto's characterization of it as irrelevant, Board medical advisor Dr. N's review of the worker's condition is still valid; she states the Board medical advisor's opinion would still be valid, even after Dr. Hashimoto's opinion, no matter which diagnosis is being considered.

It is urged by the employer's representative that the numerous consultation reports of specialists on the file contain no medical evidence to relate any diagnosis of the worker's condition to her work activities. She contends the Board medical advisors had all the evidence that matters in providing the advice they did to the adjudicators.

In deciding this appeal, it is not necessary to tarry long over the question of whether the worker's condition is compensable under section 5(1) of the Act. As indicated above, both representatives agreed rather readily that there was no serious contention there had been the kind of trauma that would be required to consider the worker's condition the result of a personal injury. No fall, wrench or blow or other form of immediate insult occurred. While the worker's description of lifting and pouring on May 24, 2001 might, under some circumstances, be considered a specific incident, it was not an incident of

the type which would be suggestive of causation of thoracic outlet syndrome. The work performed on May 24, 2001 was, in the strongest view of the worker's evidence most favourable to her, simply the "last straw" in a long build-up of conditions which are argued to be positive. None of these amounts to an "injury" as it is understood under the relevant law and policy applicable to compensation under section 5(1) of the Act. On this point, the worker's appeal cannot succeed.

With respect to the contention the worker's condition should be accepted as compensable as an occupational disease, I find that very little of the evidence is at all supportive of the worker. I will deal first with the sometime diagnosis of thoracic outlet syndrome. Then I will turn to the more recently suggested diagnosis of brachial plexopathy.

Meaning no disrespect, having reviewed all the medical evidence, I find I am unable to rely on the opinion of Dr. Fry with respect either to the proper diagnosis of the worker's upper right extremity condition or to its causes. Looking first at Dr. Fry's views on causation, I note that, at first, his expressed opinion was that work would not have been causative. Later, although he does not reveal why or how his opinion changed, he expressed a contrary view referring to only two elements of the worker's duties. I do not find his opinion to be supported either by full familiarity with the worker's duties or by persuasive reasoning. I find the April 2, 2002 claim log entry by Board medical advisor Dr. N has considerably greater explanatory power; it also has the virtue of directly addressing the worker's activities in the context of relevant guidelines set out in chapter 4 of RSCM I.

In view of the relative persuasiveness and aptness of medical opinion available, I am unable to find that, if the worker ever suffered from thoracic outlet syndrome, her work was likely of causative significance so as to make it compensable under section 6 of the Act.

I turn now to address, insofar as I can, the likely correct diagnosis of the worker's upper right extremity condition and, crucially, whether the condition might yet be due to the nature of her employment so as to be compensable under section 6 of the Act. On this point, I find Dr. Hashimoto's views compelling as to diagnosis. Standing at the end, so to speak, of a line of specialist investigators, he had the benefit of knowing what others had pursued and found or not found. His opinion that thoracic outlet syndrome was not the correct diagnosis is forcefully and persuasively expressed; also, there is the clear fact that last resort treatment for thoracic outlet syndrome (the first rib resection carried out by Dr. Fry) was completely ineffectual. Further, considering the possibility that the condition might have been caused by repetitive activity, there is the fact that the worker's condition has not improved at all (indeed, it appears to have grown more serious) since she laid off work. Although for a time Dr. Jaworski concurred in the diagnosis of thoracic outlet syndrome, I note that on seeing the worker in post-surgical follow-up, he did not persist in that diagnosis. I do not read Dr. Sadowski's reports as

indicating he subscribed to the diagnosis. Nor does family physician Dr. Walter ever seem to show enthusiasm for that diagnosis. Indeed, interestingly, the ultimate diagnosis (so far) by Dr. Hashimoto is remarkably similar to that of Dr. Walter before specialist investigation began.

There is not a great deal in all this evidence to unify it into a clear diagnostic picture. Being qualified neither to give nor to confirm a diagnosis, my role is simply to assess the evidence in the context of applicable law and policy. It seems, from my layperson's perspective, that Dr. Hashimoto's diagnosis of an inflammatory brachial plexopathy is the most likely to be correct. Assuming for the moment that that is how the worker's condition should be considered, I must ask myself whether that condition is likely due to the nature of the worker's employment.

The chief difficulty here, for the worker's appeal, is that no medical investigator has offered a reasoned opinion that work has been of causative significance. Nor has any secondary medical opinion been presented tending to support such an argument. While it is suggested by the worker's representative that some important features of the risk factors (recognized in chapter 4 of the RSCM I) are present in the worker's duties, and while I agree that the workplace evidence tends to support that much, the only reasoned medical opinion available on that point in relation to thoracic outlet syndrome (Dr. N's) is negative.

When I consider other diagnoses in the alternative, I must note that, while Dr. N was directly addressing thoracic outlet syndrome, his claim log entry shows he was mindful of the activities known to be risk factors for activity-related soft tissue disorders generally. Thus, while his opinion does not directly address other diagnoses, it comes closer to embracing them generally than does any other opinion available on the question of causation. Similarly, although to a lesser degree, when Dr. F offered the only direct medical opinion on causation with respect to brachial plexopathy, that opinion was also based on awareness of the diagnostic puzzle the worker's condition presented. Thus, even acknowledging that Dr. Fry also mentioned some potentially relevant risk factors for other activity-related soft tissue disorders, no reasoned medical opinion supports work causation here, and such reasoned and direct medical opinion as there is would deny it. I cannot find that the evidence supports the worker in relation to compensability for the diagnosed brachial plexopathy.

I must also find that, should the worker's condition, as presently understood, be properly considered (under the language of RSCM I item #27.35) simply as "an unspecified or multiple-tissue disorder," there is still insufficient medical evidence (including opinion evidence) to support compensability. Again, Dr. Fry's brief opinion is the only one supportive of the worker's appeal, and I find it insufficiently reasoned to prevail over the fuller and more contextual opinion of Dr. N and the further opinion (after further review) of Dr. F.

In short, I find that such evidence as might support the worker's position in the appeal is insufficient to do so.

Cases such as this are difficult and sometimes frustrating for the parties, often especially for the worker. While personal experience and "common sense" may often seem to suggest that work was a factor in the onset of a condition, established medical principles cannot be made to do so. This is frequently the case where there is an immediate temporal relationship between some event or series of events and the onset of a condition. It is often difficult for a layperson to see, where this is the case, that medical science does not support that the relationship is causative. While it is frustrating for a worker so affected to hear or to read that "work only served to call attention to the condition" or that "it would be speculative" to argue that work was causative, that is the reality so far as medical knowledge is concerned. And I find that to be the case here.

Having considered all the evidence, I do not find it sufficient to support that the worker's upper right extremity condition (once diagnosed as thoracic outlet syndrome and more recently diagnosed as inflammatory brachial plexopathy) either arose out of and in the course of her employment (section 5 of the Act) or was due to the nature of her employment (section 6 of the Act) so as to be compensable.

Conclusion

For the reasons indicated, the worker's appeal is denied and the April 2, 2002 decision here appealed is confirmed. No costs or expenses were requested and none are awarded.

Gail Starr
Vice Chair

GS/gl/ln