IN THE DISTRICT COURT
HELD AT WELLINGTON

Decision No. [2010] NZACC 209

IN THE MATTER of the Accident Compensation Act 2001

AND

IN THE MATTER of an appeal pursuant to Section 149 of the Act

BETWEEN **STEPHEN CLEGG**

(AI 7/08)

Appellant

AND **ACCIDENT COMPENSATION CORPORATION**

Respondent

HEARD at WELLINGTON on 26 August 2010

APPEARANCES
Ms H Williams, Counsel for Appellant.
Ms A J Douglass, Counsel for Respondent.

RESERVED JUDGEMENT OF JUDGE M J BEATTIE

[1] The issue in this appeal concerns the correctness of the respondent's decision of 19 June 2007, whereby it declined to approve funding for surgery described as L5/S1 discectomy, nerve root decompression and posterior lumbar interbody fusion.

[2] The respondent's decision letter advised that the surgery was required to treat a gradual process degenerative condition which had been rendered symptomatic by the injury accident.

[3] The background facts relevant to the issue in this appeal may be stated as follows:

- On 21 April 2007 the appellant, then aged 45 years and a builder by occupation, suffered a lumbar sprain injury whilst attempting to lift a

heavy door frame. The appellant immediately began to experience lower back pain.

- Cover was granted to the appellant for a lumbar sprain injury and sciatica.

- The pain did not resolve and therefore the appellant's GP, Dr Crighton, referred him to Mr J A Bonkowski, Neurosurgeon, for assessment.

- For the purposes of Mr Bonkowski's assessment, both x-rays and an MRI scan of the appellant's lumbar spine were obtained.

- Mr Bonkowski examined the appellant on 1 June 2007 and again on 13 June 2007. Mr Bonkowski's advice was that the appellant required surgery and that this was the only way he would be rid of the pain in his lower back and leg.

- Mr Bonkowski made application to the respondent for approval of funding for the proposed surgery in a request dated 13 June 2007.

- The request for funding was referred to Mr P Medlicott, Orthopaedic Surgeon, of the respondent's Clinical Advisory Panel, and it was his advice that the need for surgery was predominantly due to gradual process multi-level degenerative spine.

- Consequent upon Mr Medlicott's advice the respondent issued its decision of 19 June 2007 declining to fund the proposed surgery for the reason given by Mr Medlicott.

- The appellant sought a review of that decision and for the purposes of that review Counsel for the Appellant introduced a report from Mr Mark Sherwood, Orthopaedic and Spinal Surgeon, and the respondent introduced an expanded opinion from its Clinical Advisory Panel in response thereto.

- In a decision dated 14 December 2007, the Reviewer, Ms Vicki Thomson, ruled that she had not been persuaded that the L5/S1 disc protrusion was caused by the accident even if it did initiate the appellant's symptoms, and she found on balance that the condition for which the appellant required surgery was caused wholly or

substantially by a gradual process condition. She therefore confirmed the respondent's decision.

- For the purposes of the appeal to this Court a further report from Mr Sherwood has been introduced on behalf of the appellant and a further opinion from the respondent's Clinical Advisory Panel has been introduced on behalf of the respondent.

[4] The relevant medical evidence which has been introduced for the purposes of this appeal is as follows:

1. Letter from Dr Crighton dated 25 May 2007 to Mr Bonkowski.

This was Dr Crighton's letter requesting Mr Bonkowski to assess the appellant. This letter stated as follows:

> Thank you for seeing this man who had a low back injury on 21/4/07, ACC No.FW 21321.
>
> He has been having severe pain down the R leg to the foot in the L5 distrib such that he has needed oxycontin to control it.
>
> On this he has excellent pain control but the severe pain recurs if he stops it.
>
> He has had tingling and numbness also.
>
> ? needs surgery as he is an active self employed person.

2. MRI scan report of lumbar spine dated 6 June 2007.

The clinical details advice to the radiologists were: "Lifting injury one month ago. Severe right sciatica."

All lumbar discs were examined. The reports on L4/5 and L5/S1 were as follows:

> L4/L5: There is minimal loss of disc height and disc desiccation together with a minor broad-based poster disc protrusion extending into both neural foramina. Minor to moderate facet joint arthropathy with some anterior buckling of the ligament flava is present. There is some narrowing of both neural foramina inferiorly and indentation o f the thecal sac but no significant central canal or foraminal stenosis is demonstrated.
>
> L5/S1 There is loss of disc height and disc desiccation together with predominantly fatty type and plate change. A broad-based post disc protrusion is present most marked in the neural foramina and more marked on the right which does result in displacement and some flattening of the exiting right L5 nerve root. Mass effect on the left L5 nerve root is less marked. There is no significant central canal stenosis or mass-effect on S1 nerve roots bilaterally. Minor facet joint arthropathy noted.

The overall comment made by the radiologist was:

Widespread discogenic changes described. A broad-based poster disc protrusion is associated with a signifcant right foraminal stenosis at L5/S1.

3. Report and request for surgery from Mr Bonkowski dated 13 June 2007.

This previously fit and healthy forty six year old builder, who is self employed and does a lot of heavy lifting work, injured himself on 21st April: he was lifting a heavy door frame and felt a strain in his back and developed initially soreness in his back, which then became a leg pain and for the last fortnight he has had severe leg pain, which has become so critical that he is having to take fairly regular strong narcotics to keep it under control.

The pain goes down the right leg as far as the foot and is associated with a feeling of numbness in the sole of the right foot. There have been no left sided symptoms and no bowel nor bladder symptoms.

...

Recent x-rays of the lumbar spine show that the L5/S1 disc is quite collapse but there is still gas within the disc space, suggesting that there is some residual material and movement at that level.

An MRI of the lumbar spine was carried out on the 6th June: this shows that there is quite advanced collapse of the L5/S1 disc with what looks to be a more focal disc protrusion in an extra-cannalicular location, almost certainly distorting the right L5 nerve root. Over and above the collapse of the disc has resulted in quite marked stenosis of both L5 vertebral foraminae.

I met with Mr Clegg again on the 13th June and relayed these results to him. I have told him that the only surgical mechanism for ridding him of his pain would involve removing what is left of the L5S1 disc and carrying out a posterior lumbar interbody fusion, as well as a nerve root decompression.

He says that he is in constant pain and taking Morphine to try and control it. I have therefore told him that surgery is really his only option and application is therefore being made to the ACC to cover the cost of an L5/S1 discectomy, nerve root decompression and a posterior lumbar interbody fusion with instrumentation.

Mr Bonkowski answered "not sure" to the question whether the surgery was required to treat a condition which was the result of personal injury caused by accident.

4. Comment from Mr P Medlicott, Orthopaedic Surgeon, dated 19 June 2007.

Mr Medlicott was the respondent's Clinical Advisory Panel member asked to consider the request for funding and his advice was that the appellant's condition was one of pre-existing degenerative change. He then stated:

Multi-level degenerative changes with disc bulges obviously present prior to 2007. Need for surgery predominantly due to gradual process multilevel degenerative spine.

5. Medical Report from Mr Mark Sherwood, Orthopaedic and Spinal Surgeon dated 18 September 2007 to appellant's counsel.

Mr Sherwood did not see or examine the appellant but had all the medical notes for reference. He was asked questions and his answers to the relevant questions are as follows:

Q *What is your diagnosis of Mr Clegg's condition?*

A The diagnosis is most likely disc prolapsed. Mr Clegg has degenerative changes in his lumbar spine, significant disc collapse at the lumbosacral disc in association with either disc bulge or disc prolapse. This is causing compression of the exiting L5 nerve root and is likely to be causing compression of the traversing S1 nerve root. A significant external force could have lead to his injury and his symptoms.

Q *Are Mr Clegg's current symptoms causally linked to the personal injury he sustained on the 21st of April 2007?*

A The patient is reported to be previously fit and healthy. He then suffered an injury which has caused him significant pain and dysfunction. It is my opinion that his current symptoms are strongly causally linked to the personal injury he sustained on the 21st April 2007.

Q *Are Mr Clegg's current symptoms wholly or substantially caused by a non-injury factors?*

The only non-injury factors present are degenerative changes which are commonly seen in the imaging of asymptomatic individuals of his age. Therefore, degenerative changes should not be assumed to be the cause of pain and dysfunction following an injury in a patient who did not have symptoms prior to the injury.

Q *If you consider Mr Clegg's symptoms are caused by degeneration, do you consider that the degeneration would have remained asymptomatic if it were not for the injury he sustained on 21 April 2007?*

A This question can never be answered with certainty. However, there is a very high likelihood that his back would have remained asymptomatic if it were not for the injury he sustained on 21 April 2007.

6. Report from Clinical Advisory Panel dated 12 October 2007.

The Panel was requested to consider Mr Sherwood's report and it responded as follows:

> In CAP's view Mr Sherwood's report provides little or no information as to causation and the questions asked of Mr Sherwood appear to be legal questions dressed up medically that reflect a legal test rather than a medical test. In fact, it would appear that the claimant has disc protrusion at 4 different levels in his lumbar spine. It could be axiomatic to presume that a significant external force (as referred to be the cause here) would have caused all 4 protrusions. This is clearly an absurdity.
>
> Disc disease caused bulges and protrusions. Disc disease is not an ACC matter unless the accident causes that disc disease. It is totally unlikely that the accident described has caused the disc disease and associated protrusions. What the accident has caused is symptoms referable to the lumbosacral disc. These symptoms are caused by a degenerative L5/S1 disc, part of which degeneration includes the protrusion. It is extremely likely that the claimant's back would have become symptomatic at some stage.

7. Report from Mr Sherwood dated 17 July 2009 to appellant's counsel.

Mr Sherwood gave this report after examining the actual MRI scan which had been obtained on 6 June 2007. He then stated as follows:

> There are multilevel degenerative/aged related changes present in this gentleman's lower back. These are clustered around the thoracolumbar junction and also at the lumbosacral disc. There is desiccation of the L4-5 disc. There is significant collapse and degeneration of the L5/S1 disc. There are osteophytes present anteriorly at the L5/S1 disc. These have been there for a long time and this disc has not been normal for a long time. This does not mean that it has to be painful.
>
> If one looks very closely at slice 15/18 and slice 35/44 of the sagittal T2 and axial T2 scans respectively, there is an acute disc prolapse in the far lateral zone on the right hand side of the L5/S1 level which would correlate with his symptoms. I am confident that this is an acute disc prolapsed because it is light grey, compared to the residual degenerate annulus.

Mr Sherwood then answered the following questions:

Q In your initial opinion, you identify that Mr Clegg has pre-existing degeneration as well as a disc prolapsed. Do you consider, on the balance of probabilities, that the disc prolapsed was a continuation of the degeneration or was the disc prolapsed caused by the injury he sustained on 21 April 2007?

A On the balance of probabilities, the disc prolapse was caused by the injury he sustained on 21 April 2007.

In addition to that answer, Mr Sherwood answered "yes" to the question as to whether the need for surgery was causally linked to the personal injury sustained on 21 April 2007.

8. Further opinion from CAP dated 23 July 2010.

The Panel was asked to consider Mr Sherwood's further report including his analysis of the MRI Scan. The Panel sought the opinion of Dr Quinten Reeves, Musculoskeletal Radiologist, to review the images and comment. He stated as follows:

> ...I agree that there is a right foraminal protrusion of the L5/S1 disc. It is difficult on these images to determine the size of any far lateal component, although on the most lateral image there does appear to be a small far lateal component, although his does not appear to be as significant as the foraminal component. It is often difficult to differentiate between disc and osteophyte in far lateral situations on axial scans without corresponding coronal scans. For this examination, no coronal scans were performed.
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> ...
>
> As previously stated, I am unable to estimate the age of the disc protrusion on this scan.
>
> I do not believe it is possible to reliably estimate the age of the disc protrusion, except in cases where the disc protrusion is uniformly black and small with secondary signs such as osteophytes or calcification which indicates a chronic aetiology. The vast majority of protrusions are of indeterminate age being of intermediate signal intensity on T2 weighted imaging, indicating some water content.

The Panel then stated:

> In this case there is clear evidence of significant degenerative pathology affecting the level to be treated as well as the adjacent lumbar spine. The L5/S1 disc is degenerative and has collapsed producing foraminal stenosis. The disc protrusion is likely to reflect this degeneration as it does at the more cephalad levels.
>
> The proposed procedure involves removing the disc material, decompressing the nerve roots and stabilising the disc space by fusing it.
>
> There is an option to remove the disc protrusion only, but this is not appropriate in this case because the disc has collapsed and the disc space requires stabilisation in order to relieve the nerve root compression and relieve the symptoms caused by the disc space degeneration.
>
> The degenerative pathology, by definition, is longstanding and clearly existed at the time of the covered event, so there is no causal relationship between it and the event.

DECISION

[5] For a claimant to be entitled to funding for elective surgery as a treatment entitlement under the Act, it must be established that the need for surgery is to treat a medical condition or injury caused by the accident for which the claimant has cover under the Act.

[6] In the present case, the appellant has cover for a lumbar sprain and sciatica, but as this Court has noted on a number of occasions, the generalised statement of injury which may involve internal injury is not to be treated as all-embracing and it is open to the Court to identify, based on the medical evidence, precisely what the nature and extent of the covered injury may be.

[7] In the present case, the appellant's then employment as a builder was one which would have involved significant physicality and it is the case that other than a short period in 2003 when he suffered some back pain, his back, and in particular his lumbar spine, had not caused him any problems. Up to the occasion of the injury event under consideration he had been able to engage in all the physical activities that would be involved as a builder.

[8] On 21 April 2007, he suffered a lumbar sprain injury whilst lifting a heavy door-frame and experienced the immediate onset of back pain, and which pain progressed down his right leg to his right foot. It is presumably for that aspect of the appellant's condition that the appellant's GP identified that he was suffering from sciatica on his right side consequent upon the back strain injury.

[9] It is evident from the MRI scan and the interpretation thereof, by the radiologist, Mr Bonkowski, and Mr Sherwood, that at the L5/S1 level there was nerve root entrapment, that is the sciatic nerve, and that this was causing the pain.

[10] It was the assessment of Mr Bonkowski that an L5/S1 discectomy was required in order to carry out nerve root decompression, and that decompression would involve a posterior lumbar interbody fusion. This is a surgical procedure which is well-known to the Court from countless cases where this particular surgical procedure has been the focus of attention.

[11] Indeed, there does not seem to be any disagreement on this point from the Panel, who identify that the surgical procedure intended involved removing the disc material, decompressing the nerve roots and stabilising the disc space by fusing it.

[12] For the sake of completeness, I note that Mr Sherwood gave the same diagnosis, he described it as being a compression of the exiting right L5 nerve root and which was likely to be causing compression of the traversing S1 nerve root.

[13] The factual circumstances are that from the moment of the accident the appellant commenced to experience severe lumbar pain on his right side down into his right leg. I find that there can be no other explanation for that pain and discomfort other than he now was experiencing a compressed nerve on the right side of L5/S1.

[14] Much has been made by the respondent's Panel of the fact that the appellant was displaying multilevel disc degeneration in his lumbar spine, and as is their won't the Panel simply places every problem at the door of degeneration and contends that the proposed surgery is simply to treat and repair a degenerative condition which is evident. The present case is another example.

[15] In the present case, the Panel identify that the appellant's pre-existing degenerative condition has now become symptomatic, and it is of course the case that there is accepted legal determination that the mere fact of a previously asymptomatic degenerative condition becoming symptomatic, does not give rise to a finding of causation of personal injury.

[16] In the present case I find that the facts establish that this appellant's circumstances are far more than merely his asymptomatic degenerative lumbar spine becoming symptomatic. It is clear that he had an L5/S1 disc which was badly affected

by degeneration, but it is not simply that degenerative disc that was rendered symptomatic, but rather that disc further collapsed, no doubt because of its precarious nature, and caused the onset of nerve entrapment.

[17] This Court can identify that nerve root entrapment is not a medical condition which can remain asymptomatic and suddenly produce symptoms of severe pain, such as is the case with this appellant. It is the case that when the act of entrapment occurs, there is the immediate onset of pain and that this is what happened when the appellant suffered his lumbar sprain, that action caused the disc to further collapse bringing about entrapment and giving rise to the need for surgery to treat that nerve root entrapment.

[18] In the circumstances, I find that the pre-accident state of the appellant's lumbar disc is simply a state of affairs which made it more likely that the trauma of an accident event such as occurred with this appellant, would be likely to cause some further disintegration of that shaky disc and bring about the entrapment that did in fact occur. The fact that if the appellant was a young, fit "buck" with a degeneration-free lumbar spine and that the injuring event would not have caused any such injury to a fit, younger person is not relevant. The claimant must be accepted as he is found to be, and in the case of this appellant the physical trauma of the strain injury on his degenerative affected lumbar spine at L5/S1 was the activity which brought about the nerve root entrapment.

[19] As earlier noted, it is accepted by all the specialists who have considered the matter that the proposed surgery is to treat the nerve root entrapment caused by the disc collapse and the surgical procedure is to create a state of affairs where there is no longer that nerve root entrapment, and which state of affairs is achieved by way of lumbar fusion and nerve root decompression.

[20] Accordingly, therefore, I find that the surgical procedure proposed by Mr Bonkowski was to treat a medical condition/personal injury sustained by the appellant in the accident of 21 April 2007, and as such the surgical treatment for same is something which the appellant is entitled to have funded by the respondent under the Act.

[21] Accordingly, the respondent's decision is quashed and substituted by a decision that the appellant is entitled to funding for the surgical treatment proposed.

[22] The appellant being successful I allow costs in the sum of $2,500 together with any qualifying disbursements.

DATED this 22nd day of November 2010

M J Beattie
District Court Judge