**IN THE DISTRICT COURT**
**HELD AT AUCKLAND**

Decision No. 80 [2010] NZACC

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| **IN THE MATTER** | of the Injury Prevention, Rehabilitation and Compensation Act 2001 |
| **AND** | |
| **IN THE MATTER** | of an appeal pursuant to Section 149 of the Act |
| **BETWEEN** | **ADELE BEVERIDGE** |
| | (AI 61/08) |
| | Appellant |
| **AND** | **ACCIDENT COMPENSATION CORPORATION** |
| | Respondent |

**HEARD** at AUCKLAND on 23 April 2010

**APPEARANCES**

Mr M Darke, Advocate for Appellant.
Ms F Becroft, Counsel for Respondent.

**RESERVED JUDGMENT OF JUDGE M J BEATTIE**

[1] The issue in this appeal arises from the respondent's decision of 19 September 2007, whereby it suspended all entitlements to the appellant on the grounds that her ongoing medical condition was not attributable to her back strain injury, being her covered personal injury, but rather her ongoing symptoms were caused by her underlying pre-existing pathology of osteoporosis.

[2] It is the appellant's contention that her ongoing low back pain and other symptoms is in fact a Chronic Regional Pain Syndrome, the cause of which was the back strain injury she suffered in January 2005.

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

- On 20 January 2005, the appellant, then aged 44 years, suffered an injury to her back in the course of her employment.
- The circumstances of that injury, as related by the appellant to Mr Brian Otto, Orthopaedic Surgeon, were as follows:

> Mrs Beveridge was employed for a period of approximately 16 months with Hirequip and was responsible for taking machinery and equipment to different sites for hire. On the day of her injury she was delivering a scissors lift, which is a type of mini crane, to Pacific Steel and she attempted to take the lift off a trailer in a car park and as she did so she slipped on the gravel surface when the trailer moved, and in a twisting turning event, injured both her thoracic and lumbar spine.

- The appellant obtained cover for her injury which was described as *back strain/sprain.*
- From the moment of that injury event onwards the appellant has experienced significant low back pain, on occasions radiating down her legs and she was accepted as being incapacitated as a consequence of her injury.
- A bone density report obtained on 27 January 2005 identified that the appellant did have osteoporosis of her lumbar spine, but that there was no evidence of any compression fractures.
- The first X-rays of the appellant's spine were taken on 25 January 2005 and subsequent X-rays were carried out on 31 August 2007 and an MRI scan was carried out in August 2006.
- The appellant was seen by various specialists from time to time and various reports on her medical condition were provided.
- On 15 August 2007, the appellant was seen and examined by Mr Brian Otto, Orthopaedic Surgeon, at the request of the respondent, and Mr Otto provided a four-page report on his investigation as to the appellant's then current condition.
- It was Mr Otto's opinion that the cause of the appellant's ongoing low back pain was her underlying idiopathic osteoporosis and that the effects of her back strain injury were spent.

- Consequent upon Mr Otto's report, the respondent issued its decision on 19 September 2007 to suspend entitlements, that decision being the decision which is now the subject of this appeal.
- The appellant sought a review of that decision and for the purposes of that review the appellant obtained an independent report from Mr Colin Hooker, Orthopaedic Specialist, and his report was introduced at the review.
- In a decision dated 29 January 2008, the Reviewer, Mr L A Clarke, ruled that the medical evidence identified that the accident had rendered her pre-existing asymptomatic osteoporosis, now symptomatic, but that this medical condition had not been caused by the injury in the accident. The respondent's decision to suspend entitlements was therefore confirmed.
- For the purposes of the appeal to this Court further medical reports have been obtained on the appellant's behalf from Dr R D Wigley, Consultant in Rheumatology and Rehabilitation Medicine, and the respondent has introduced reports from Mr Otto in response thereto.
- For the purposes of the appeal there are now three reports from Mr Otto and two from Dr Wigley.

[4] Essentially, the competing contentions of Mr Otto and Dr Wigley are firstly, on Mr Otto's part, that the appellant's ongoing pain is attributable to her now symptomatic pre-existing osteoporosis, whereas Dr Wigley contends that the appellant is suffering from a Chronic Pain Syndrome caused by the back strain injury, and that the osteoporosis condition is not a cause of her back pain.

[5] The medical evidence which has been presented to the Court in this appeal, in chronological order, is as follows:

**1. Two reports from Dr P Frengley, Endrocrinologist.**

The first report from Dr Frengley was on 27 January 2005. The actual report was not introduced in evidence but is referred to in the Review Decision, and it identifies that the X-rays showed that the appellant's vertebra were demineralised. Dr Frengley identified the appellant's condition after a bone density scan as being that of osteoporosis of the spine.

In his second report of 15 February 2005 he confirmed the diagnosis of osteoporosis and advised that there was no sign of any vertebral deformation. He then gave advice on treatment for her condition.

## 2. Report from Dr E W Dryson, Occupational Medicine Specialist, dated 24 August 2006.

Dr Dryson had been requested to conduct an Initial Medical Assessment and for this purpose he obtained an MRI scan and his report of 24 August 2006 was a report of the result of that MRI scan. He stated as follows:

> This shows a tiny central disc bulge at the lumbosacral junction with a small focus on peripheral high signal consistent with an annular tear. Overall, this disc is of reduced signal consistent with degenerative change. There is no encroachment of the central canal or neural foramina at this or any other level. The other discs are normal in their signal and height. No bony or paravertebral soft tissue abnormality.
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> Comment:
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> The MRI scan has clearly not shown the cause of Adele's persisting low back pain. The changes on MRI scan are consistent with a minor degenerative change only and do not represent injury.
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> The cause of the underlying pathology producing Adele's back pain is therefore not known.

## 3. Report from Dr K Laubscher, Pain Specialist, dated 5 December 2006.

Dr Laubscher reported to the respondent after examining the appellant and also reviewing the previous medical reports and the MRI scan. He identified the appellant as being tender to deep palpation at L4/5 and L5/S1, but there was no brush allodynia. Her tenderness extended to the paravertebral areas and sacroiliac regions left more than right with associated skin drag. His assessment was that in his opinion the appellant's low back pain was consistent with demonstrated disk lesion at L5/S1 and that there were neurogenic features. He considered that her paravertebral pain in the thoracic region was probably a reflection of myofascial pain with paravertebral muscle tightness/spasm. He further stated *"The nociceptive focus is most likely to be an L5/S1 disc."*

## 4. Report from Mr Brian Otto, Orthopaedic Surgeon, dated 15 August 2007.

Mr Otto obtained a full history and carried out an examination. He commented on previous medical reports, including that of Dr Laubscher, and he stated as follows:

> She has been seen and examined by Dr Laubscher of the Pain Clinic and had an MRI scan completed, and emphasis was placed on the fact that there was an annular tear at L5-S1 and a minor central disc bulge, but it is well noted that the L5-S1 space is a large and forging space, and the MRI scan report on the 9th August 2006, is in my opinion, within normal limits for a woman of 48 years of age, and the tiny central disc bulge and annular tear are not the symptom producing issues in this case. She has clearly defined discomfort over the S1 joint in a pelvis that has demineralisation and softening of the bone, and the changes are more in keeping with the effects of a strain on that joint, than any disc pathology in the lumbar spine.
>
> Likewise, the mid thoracic pain which she complains of is a noted feature in osteoporosis. There has been no scintogram completed, but it was likely following the injury event that there may have been increased uptake in that area, reflecting the underlying osteoporosis of the bone and micro fractures occurring with the said injury event.

He further commented:

> The changes are now more representative of the underlying osteoporotic problems than the effects of the injury, which are essentially spent. It is difficult to justify ongoing entitlement in this case, based on the paucity of clinical findings, and the minimal interruption in functional activity, and the time interval between the stated injury and the current review, is sufficiently long for any effect of injury to be spent, and to represent the underlying pathological change in the bone of inherited or idiopathic osteoporosis, which is the primary cause for her symptoms at this review.

## 5. Report of Mr Colin Hooker, Orthopaedic Specialist, dated 14 December 2007.

Mr Hooker examined the appellant for the purposes of his report and he commented, inter alia, as follows:

> In my opinion, it is more likely than not that the injury of 20 January 2005 is a significant causative factor in Mrs Beveridge's continuing back pain. It must be pointed out that the "pathology" cannot be stated with certainty. Although there is undoubtedly underlying osteoporosis, this in itself could not be stated, in my opinion, to be the sole and exclusive cause of her continuing symptoms. The effects of the superimposed injury of 20 January 2005 must be considered to be an important additional factor.
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> On the balance of probabilities, in my opinion, it is more likely than not that the cause of the pain has been injury superimposed on osteoporosis. Again, it is pointed out, that the word "pathology" is perhaps wrongly used in this question; the question should be perhaps "that this pain was caused substantially by". Ageing, in my opinion, is not a factor.
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> In my opinion, it is more likely than not that the accident has been a significant factor in Mrs Beveridge's condition, as detailed above.
>
> This perhaps is the most pertinent question; it is, in my opinion, most likely that the accident caused a pre-existing asymptomatic condition to become symptomatic.

## 6. Report from Dr R D Wigley dated 29 July 2009.

Dr Wigley examined the appellant on 15 May 2009 for the purposes of his report, and he had reference to all previous medical reports, including those of Mr Otto and Mr Hooker.

Dr Wigley considered the history of the appellant's condition and he then stated as follows:

> She has gone on to develop a chronic nociceptive pain syndrome. This can be triggered off by any injury, sometimes quite minor injuries, and it frequently complicates back strain. Continued nociception from the mid-dorsal, lower lumbar and possibly the sacroiliac joints is sufficient explanation for her continuing pain problems. These sources of pain all arose out of her injury.
>
> I do not think that the osteoporosis has caused her earlier or current symptoms. It should not cause symptoms in the absence of a fracture or loss of vertebral height. The treatment Fosamax and calcium for more than four years may well have brought her bone density back into the normal range but she still has the pain.

Dr Wigley had been asked questions and his answers were as follows:

Q *Is it likely that she had any degenerative condition affecting her L5/S1 disc before the accident?*

A No, not in my opinion. She had no pain before the injury and the changes on MRI are best explained by an injury at that time causing internal disc disruption. She also has sensory changes suggesting root pressure at L5 and/or S1. These changes were noted by Drs Adams, Callaghan and Dryson and myself but may not have been adequately tested on other examinations. Presumably this has been present throughout. The protrusion was minor at the time of the MRI but it may have receded since the accident. Protrusion would be less lying down for the MRI than it would be with a spine under load. Standing MRI scans, done at some centres in the USA, are not available here.

Q *On balance what is the predominant cause of her current incapacity?*

A Chronic nociceptive pain syndrome induced by disc injury and possible spinal strain and left sacroiliac strain. These factors may contribute to the continuation of the chronic pain syndrome.

Q *What is the substantial cause of the continuing pain in the mid dorsal spine?*

A The osteoporosis does not explain the pain at this level as no fracture was found. Presumably there was soft tissue damage at the time of the fall. Continuing nociceptive pain at all these sites would explain the hypersensitivity and so contribute to her chronic neuropathic pain syndrome.

Q *On what basis would you disagree with the opinion of Mr Brian Otto, Orthopaedic Surgeon?*

A Mr Otto did note the sensory changes recorded by Drs Callaghan, Adams, and Dryson and later by me. He did not consider the MRI changes in the L5/S1 disc sufficient to cause her symptoms. I do not agree that there is sufficient evidence that the osteoporosis causes her symptoms. The evidence of sacro-iliac joint strain is more convincing. Mr Otto did not note the hyperesthesia over the dorsal and lumbar spine and did not diagnose the chronic neuropathic pain syndrome. Indeed he made no comment on her chronic pain syndrome which is the main cause of her continuing pain and disability.

> Mr Hooker did note the diffuse tenderness and recognised the "injury factor in the causation of her pain". He does not name what he considers to be the "pre-existing asymptomatic condition.

Dr Wigly then gave his conclusions as follows:

> The osteoporosis would have preceded the injury but would only cause back pain if there were fractures and none were shown. The disc changes at L5/S1 would be consistent with internal disc disruption, which would explain the low back pain. There is no evidence that this preceded the injury, only speculation. There is no convincing evidence that a pre-existing condition was aggravated by the accident. The chronic nociceptive pain followed the injury and continues, so clearly the effect of the injury is not spent.

> I conclude that the accident damaged the L5/S1 disc, and probably strained the sacroiliac joint and her lower thoracic spine leading to the chronic nociceptive pain syndrome, which is now the main cause of her disability.

## 7. Second medical report from Mr Otto dated 1 September 2009.

Neither Dr Wigley nor his report are referred to by Mr Otto in this report, and it must therefore be assumed that he had not seen it at the time he was asked to make further comment on the appellant's condition.

Mr Otto advised that the appellant had two established pathologies which were capable of producing the pain symptoms of which she complained, firstly, the osteoporosis and secondly, the degenerative disc at the lumbosacral junction. He further stated:

> That disc was demonstrated to be reduced in height and to have a reduced amount of proteoglycan with a tendency for the annular wall to bulge as a consequence of that, and would have mechanical changes from the altered segmental motion, enough to produce back pain if injudiciously loaded.

He further commented as follows:

> I note that there has been a tendency to use the term "chronic regional pain syndrome" but this denies the underlying pathology that is so capable of producing pain because of the structural loss of integrity and it still remains my concern that it is the osteoporotic change within the bone and in addition the changes in the lumbosacral disc, which are the main contributors to her continuing complaints of pain.
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> . . .
>
> In this instance the disc degenerative disease at the lumbosacral disc in retrospect is the most likely cause for the pain in the buttock and referred to the left sacroiliac joint, and it would account for her stiffness and discomfort in her back lying for any period of time.
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> . . .
>
> I am of the opinion that the lumbosacral disc is most likely causing her lower lumbar spine pain and that is an established degenerative change at the L5-S1 level, and it is well known that discs that have established degenerative changes within them, do not withstand loading or extra st4esses, and can become symptom producing, noting that even minor trauma can unmask those underlying change.

...

To label her complaints of pain from the thoracic region particular as part of a "chronic regional pain syndrome" is essentially a statement by a physician which indicates that he has no knowledge of the cause of the underlying pain, and is denying the existence of the primary pathologies which have the potential to account for all those symptoms.

## 8. Report from Dr R D Wigley dated 2 February 2010.

Dr Wigley was asked to respond to Mr Otto's report of 1 September 2009. Comments made by Dr Wigley are as follows:

Mr Otto again assumes that there was pre-existing "degenerative change." He does not give reasons for excluding acute injury as the sole or major cause. The MRI showed an annular tear. This supports my view that the injury was the substantial if not the sole cause of her continuing pain and disability.

...

Accepting that there was pre-existing osteoporosis there was no demonstrated fracture so I have to conclude that the injury was the sole or at least the predominant cause of the ongoing pain and disability.

...

The statement that *"the surprising feature was the paucity of findings"* is a surprising statement as it is well known that chronic pain syndromes can follow even minor injuries. The pain can be prolonged and disabling, as a chronic nociceptive regional pain syndrome, or in its most severe form, complex chronic pain syndrome (sympathetic dystrophy) (Ref 1). A feature of such pain syndromes is hyperaesthesia which Ms Beveridge shows over the lumbo-sacral junction area. I routinely check for this in chronic back pain cases.

...

*"The term chronic regional pain syndrome denies the underlying pathology..."* I cannot agree with this statement as chronic pain states are frequently caused by acute physical injuries as in Ms Beveridge's case.

*"The disc degenerative disease in the lumbosacral disc in retrospect is the most likely cause for the pain in the buttock and referred to the left sacro-iliac joint."* The disc change, including an annular tear could also be due to injury so again the word *degenerative* is misleading. Mr Otto no longer considers the sacro-iliac joint as the source of her pain as suggested in his initial report.

...

Mr Otto comments that it is difficult to explain her ongoing pain for three years as the thoracic pain would be expected to have improved as bone injury would have healed. *"That this has not occurred is somewhat surprising."* He apparently does not accept the well established concept of nociceptive pain due to neural sensitisation. I agree with Dr Laubscher, a pain specialist, that she has *"nociceptive pain associated with central sensitisatiion."*

...

He states "*To label her complaints as of pain from the thoracic particular (sic) of a chronic plain syndrome is essentially a statement by a physician which indicates that he has no knowledge of the cause of the underlying pain and is denying the existence of the primary pathologies which have the potential to account for all those symptoms."*

Here Mr Otto misquotes my opinion. I did not deny the existence of primary pathologies and I did not say that the pain syndrome could cause the initial and continuing thoracic and low back pain. My opinion remains that the pain, originally caused by the thoracic

> and low back injuries, has led to chronic nociceptive pain sensitisation, which is the major continuing cause of her pain and disability. This can continue whether or not the original source of the pain has ceased.

**9. Third report from Mr B Otto dated 29 March 2010.**

This was a response to Dr Wigley's report of 2 February 2010. He commented, inter alia, as follows:

> Pain, of itself, is not a diagnosis, and is only a symptom and it is the responsibility of the clinician to exclude the obvious pathologies and their likely contribution to this (sic) symptoms, when they are present in an individual. To use the term "Chronic Pain Syndrome" is to deny the "likely contribution of either of these pathologies, to the pain that is being expressed by this patient.
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> In osteoporosis it is the integrity of the bone which is in question, and not infrequently there may be minor implosion of the disc into the endplate producing pain and changes in that area, and that situation reflects the lack of structural integrity that is implied by the term osteoporosis. It is in my opinion, at the top of the list of differential diagnosis in the likely explanation for the cause for her mid thoracic pain.
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> The lumbosacral pain associated with the degenerative L5-S1 disc, is an established pathology perfectly capable of producing the pain that was noted at the clinical review, and the issue in this case is whether or not the clinician appropriately carries the investigations a step further, as in carrying out discography, as this would help to evaluate the contribution of the pain from the L5-S1 disc.
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> ...As the disc looses (sic) its integrity and pressure which is calculated at around 90 lbs per square inch in the ordinary individual , the hinging quality, which is guided by the facet joints posteriorly, changes to be a more translational motion and is reflected often in traction spurs at the margin of the disc, wear in the fact joints posteriorly, inflammation around those facet joint capsules, and their proximity to the root canal and the emerging nerve root, may produce low grade neurological symptoms.

Mr Otto concluded by stating:

> At this point in time I have no confidence that the two basic pathologies that exist in this patient, have been totally excluded as generators of her pain, and there is no additional information that has been supplied that give me confidence that the pain is coming from elsewhere than those sites that are seen to be altered and capable of accounting for her clinical symptoms.

[6] In his submissions, on behalf of the appellant, Mr Darke stated that the particular ongoing condition which was causing the appellant's continued incapacity was that of a Chronic Pain Syndrome which had arisen from the physical injury she had suffered in January 2005. Mr Darke submitted that there was no evidence that the osteoporosis *per se*, or indeed any degenerative condition at L5/S1 was the cause of pain, and he submitted that Dr Wigley, supported as he was by Dr Laubscher, had identified the ongoing pain as being that of nociceptive regional pain syndrome.

[7] Ms Becroft, for the respondent, submitted that Mr Otto had correctly identified the ongoing cause of pain, and that there is clear medical opinion which identifies that the

degenerative discs and osteoporosis are respectively pathologies which can cause ongoing pain. Ms Becroft also referred to Mr Hooker's report and said that his report was in large measure consistent with that of Mr Otto.

## DECISION

[8] The decision of the respondent which is now the subject of this appeal was a decision made by it pursuant to Section 117 of the Act, namely that it was not satisfied, on the basis of the information in its possession that the appellant was entitled to continue to receive entitlements in respect of her covered injury.

[9] The leading case on how this particular statutory provision is to be interpreted and implemented is that of a decision of Her Honour Justice Mallon in ***Ellwood v ACC*** (Wellington Registry CIV 2005-485-536). In that decision Her Honour identified that the onus is on the Corporation to establish that it has a sufficient basis before terminating entitlements and that if the position is uncertain then there cannot be a sufficient basis for such termination.

[10] Applying that principle to the present case, there are the two competing contentions, firstly there is the contention by the Corporation that the appellant's ongoing lower back pain condition is being caused by either or both the pathologies of the appellant's underlying osteoporosis in her spine, and/or the lumbosacral pain associated with the degenerative disc at L5/S1.

[11] The appellant, in contrast, contends that the condition is that of a Chronic Pain Syndrome which is the ongoing consequence of her back strain injury and that there is no evidence that either her underlying osteoporosis or degeneration at L5/S1 is in fact causing pain.

[12] The respondent has in large measure relied upon the advice it received from Mr Otto, and in the final analysis of his assessment he simply says that to consider the condition as being that as a Chronic Pain Syndrome is to ignore the obvious pathologies associated with the appellant's pre-existing conditions

[13] I have formed the clear view that Mr Otto is not prepared to acknowledge that there is such a condition as a Chronic Pain Syndrome and he has simply said that if there are these pre-existing degenerative conditions then *ipso facto* they must be the source of the appellant's ongoing pain.

[14] On the other hand, this Court has received evidence from a respected specialist in Mr Wigley, that it is a well-known and accepted medical fact that Chronic Pain Syndromes can follow even minor injuries, and this Court can take judicial notice of that being a medical fact, and the Court has heard evidence of that circumstance on countless occasions. As identified by Dr Wigley, the pain in such circumstances can be prolonged and disabling. It is significant, I find, that Dr Laubscher, back in December 2006, came to the view that the appellant's low back pain had neurogenic features and he also referred to the fact of nociceptive focus being on the L5/S1 disc. He went on to state that it was more likely that the appellant had persistent nociceptive pain and associated central sensitisation rather than nerve root irritation.

[15] In his final response to Dr Wigley, Mr Otto does explain in general terms how degeneration in a disc can be a generator of symptoms, but I find that there is no evidence that that generality does apply to the particular pathology that the appellant displayed.

[16] As Mr Otto put it ...

> "As the disc looses (sic) its integrity and pressure which is calculated at around 90 lbs per square inch in the ordinary individual , the hinging quality, which is guided by the facet joints posteriorly, changes to be a more translational motion and is reflected often in traction spurs at the margin of the disc, wear in the facet joints posteriorly, inflammation around those facet joint capsules, and their proximity to the root canal and the emerging nerve root, may produce low grade neurological symptoms."

[17] There is no evidence that has been presented to this Court of traction spurs, wear in the facet joints or inflammation at those facet joints, and therefore, whilst I accept what Mr Otto says as a general proposition, nevertheless I do not find on the evidence that it does apply to this appellant. As was noted by Dr Dryson after he had obtained the MRI scan, his advice was that the changes were consistent with a minor degenerative change only and do not represent injury. He therefore advised that the cause of the underlying pathology producing the appellant's back pain was therefore not known. This was, of course, before the identification by Dr Laubscher of a Chronic Pain Syndrome as being the likely cause.

[18] In all the circumstances I find that in this case the competing assertions by the respondent and the appellant are such that the matter is too finely balanced for the Court to determine that the respondent was able to be satisfied that the appellant was not entitled to continue to receive entitlements, and in line with the principles enunciated in ***Ellwood***, I find that the "not satisfied" test cannot be met and therefore

the appellant was entitled to continue to receive entitlements as of the date of the decision to suspend them.

[19] Accordingly then, the respondent's decision is quashed and the appellant is thereby established as continuing to have entitlements in respect of her covered injury from the date of suspension for however long thereafter it can be shown that there is no basis for the respondent being not satisfied of her continued entitlement.

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

**DATED** this 10 day of June 2010

M J Beattie
**District Court Judge**