Degeneration v Accident

IN THE DISTRICT COURT
AT WELLINGTON

DECISION No. 189 /2009

UNDER	The Injury Prevention, Rehabilitation and Compensation Act 2001
IN THE MATTER OF	an appeal pursuant to section 149 of the Act (Appeal No. AI 106/09)
BETWEEN	MERLENE WILSON Appellant
AND	ACCIDENT COMPENSATION CORPORATION Respondent

Hearing: 28 September 2009

Appearances: Mr A Gibbons advocate for appellant
Mr J Castle for respondent

Judgment: 30 October 2009

RESERVED JUDGMENT OF JUDGE D A ONGLEY

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[1] The appeal concerned a difference of medical opinion as to whether a continuing rotator cuff dysfunction was caused by accident related injury or was caused wholly or substantially by gradual process or age-related deterioration.

Background

[2] The appellant suffered a left shoulder injury on 27 December 2006 when she fell from a bicycle and landed on her shoulder.

[3] The appellant's GP referred her to physiotherapy. After 10 physio treatments, a discharge report on 15 February 2007 recorded *"Fully recovered. Reached all functional goals"*.

[4] Symptoms nevertheless appear to have continued. Radiology in May did not show any abnormality. An ultrasound scan of the shoulder was done on 13 July 2007. The report stated:

> "The subscapularis tendon contains an hypoechoic area consistent with partial thickness tear immediately adjacent to the LHB tendon. The tear appears to extend to the articular surface only.
>
> The supraspinatus tendon is heterogeneous and although no obvious defect is seen, injury seems anteriorly.
>
> The infraspinatus is intact.
>
> Conclusion: There is a small tear of subscapularis adjacent to biceps tendon. Whilst ill-defined strain injury with probable micro tears affects the anterior-most part of subscapularis. No definitive defect has been shown in the structure".

[5] The appellant was seen by Mr Julian Stoddart, orthopaedic surgeon who noted in September 2007:

> "Right hand dominant woman who is very active and was riding her mountain bike when she stumbled and had to hyperextend her left arm as part of a fall. Had discomfort around the shoulder. Some improvement with physiotherapy but has subsequently re-injured it playing soccer. Has had anti-inflammatory medication but no other treatment. Feels the shoulder may have deteriorated slightly over the last 3-4 weeks while she has been incapacitated with the flu."

[6] In November 2007, Mr Stoddart referred the appellant for more physiotherapy with a diagnosis of impingement left shoulder. In February 2008 an MRI scan was reported as showing *"supraspinatus tendinitis without obvious injury. Intra-articular surfaces are otherwise normal."* The report noted bursal thickening of the more distal part of the supraspinatus tendon with the terminal centimetre of the tendon thickened and showing diffuse high signal consistent with inflammatory change but without clear evidence of an actual tear. Moderate fluid was seen in the sheath of the biceps long head. A small amount of high signal was noted in the posterior aspect of the humeral head which may indicated residual bone bruising or possibly an early degenerative cystic process.

[7] In April 2008, physiotherapist Nicole Wilczek applied for ACC funding for further physiotherapy. The Corporation asked for the opinion of its clinical advisor Ms Karen Rasmussen. She is evidently also a physiotherapist. Ms Rasmussen's

opinion was that the condition was a degenerative failure of collagen fibres through repeated micro-trauma or vascular compromise and was a gradual process rather than the result of a specific accident event. There was no evidence of a rotator cuff tear, fracture or dislocation. There was an element of adhesive capsulitis that was of unknown origin and was likely to be idiopathic. Dr Rasmussen advised the Corporation that the need for treatment was likely to be the result of gradual process. The opinion was given without further explaining the medical reasons to ascribe a degenerative cause rather than a traumatic injury cause.

[8] On 13 May 2008, the Corporation issued a decision declining funding of ongoing physiotherapy treatment. On 20 May 2008, Ms Wilczek wrote to the Corporation disputing the possible diagnosis of adhesive capsulitis. She stated that the appellant would have long term problems with her left shoulder through decreased strength of rotator cuff and scapulothoracic muscles. She considered that signs of adhesive capsulitis were only secondary to the movement dysfunction and weakness in the shoulder joint complex, through multiple tears in the subscapularis and supraspinatus tendons as a direct result of the initial injury.

[9] Ms Rasmussen was asked to comment on that letter. She noted that the evidence for multiple tears was the ultrasound scan in 2007, but that on the more recent and more accurate MRI scan there were no definite tears of any of the rotator cuff tendons. Rather, the appellant was noted to have supraspinatus "tendonitis" and thickening of the tendon without obvious injury. Ms Rasmussen concluded that the need for further physiotherapy was not caused by the covered injury.

[10] The Corporation confirmed its decision not to fund further physiotherapy and the appellant lodged a review application. In support of that application, Mr Stoddart wrote on 15 July 2008:

> "I note in one ACC report that adhesive capsulitis is considered not traumatic unless there is underlying shoulder pathology. While I don't think this is the diagnosis in this shoulder, I would disagree with this statement.
>
> I believe when Ms Wilson fell from her bike she crushed the rotator cuff tendon between humeral head and acromion and developed a traumatic tendonitis with associated bursitis. I strongly disagree with the ACC assessment of gradual process injury.

I would support Ms Wilson's claim that her shoulder was injured in the bike accident and has resulted in her current pathology."

[11] The appellant's claim was also supported by a report from Dr Neil Haldane of New Plymouth Chiropractic Clinic. He referred to the MRI report of bursal thickening of the more distal part of the supraspinatus tendon without an actual tear. He said that it would be absolutely normal for the previously noted tears to be healing after 12 months so that no tears would be noted on MRI. However he referred to the evidence of supraspinatus tendonitis, biceps long head inflammation and bone bruising as clear indications of post-traumatic changes. Dr Haldane wrote:

> "I last saw Merlene on 23 June 2008, and have no doubt that her current injury still involves her supraspinatus, subscapularis and biceps long head, as well as the humeral head 'bone bruising', and all are a direct result of her fall from her mountain bike. I can see no evidence whatsoever to consider this a 'gradual onset' injury, and Mrs Wilson has no history of repetitive movement or tasks at work or her pastimes involving the left upper limb. Rather there are typical healing soft tissue findings consistent with the injury as described by Mrs Wilson, and the altered joint physiology is totally consistent with such an injury.
>
> The literature notes that tendonitis, (and adhesive capsulitis also), are likely to occur after a rotator cuff tear, and soft tissue degenerative changes as described above are typical of the injury at this stage of recovery.
>
> I therefore conclude that Mrs Wilson's current injuries are a direct result of her fall and it is most unlikely that there were any pre-existing degenerative changes or that any of Mrs Wilson's current symptoms are likely to have occurred from repetitive movements as per a gradual onset injury."

[12] The Corporation's medical advisor, Dr Austen, then recommended that further advice should be obtained from the radiologist, Dr Feltham. Dr Feltham's response referred to the difficulty of attributing aetiology, but he noted that the acromio-humeral space was barely six millimetres which conceivably pre-disposed to impingement. He stated that the MRI scan was obtained with a closing of the subscapularis against the bicipital groove which would obscure any tear. He considered that the time delay between the ultrasound and the MRI may have allowed for some healing by fibrosis.

[13] Dr Austen then conveyed the comments of ACC's Clinical Advisory Panel. He noted that the appellant had made left shoulder claims in 1991, 1992 and 2003. In line with Dr Feltham's opinion, Dr Austen did not consider that there was

sufficient evidence to support a diagnosis of idiopathic adhesive capsulitis. Dr Austen stated:

> "In CAP's view, with advancing years, rotator cuff tears do not heal. The natural history of partial thickness rotator cuff tears are for them to increase in size over a period of time, and as many as 80% will become full thickness tears within two to three years. Dr Feltham has explained why the MRI scan is not able to be relied on to diagnose a subscapularis tear in this case.
>
> However, Dr Stoddart's treatment is designed to deal with the impingement related problem. That is a condition between the degenerative supraspinatus tendon and the surrounding tissues. While this client may have had an accident, it is clear that the findings within the sub-acromial space are those of client's impingement. Dr Feltham acknowledges that the acromiohumeral interval is only 6 mm and that this provides further suggestion of an impingement related phenomenon.
>
> In summary, then, this client has an impingement related disorder of the left shoulder. The cause of this client's impingement appears to be disease related tendinosis of the rotator cuff. There is no MRI evidence of tendinitis. The role of the accident in this case has at best, caused symptoms of impingement, but has not caused the impingement itself."

[14] Mr Stoddart then responded once again in a letter of 19 November 2008. He wrote:

> "I firmly believe that when Merlene fell from her bike she contused her rotator cuff and caused swelling and inflammation, secondary to this developed weakness of her periscapula muscles and subsequently developed a functional impingement syndrome. This is a very common scenario. With physiotherapy input her scapula muscles have been strengthened, her impingement symptoms have now resolved and she has clinically returned to normal.
>
> If, as ACC states, this was a degenerative condition caused by a very tight subacromial space then we wouldn't expect her symptoms to necessarily improve with physiotherapy. The mere fact that she has improved with physiotherapy would go to support her accident as being the cause for her symptoms.
>
> ACC seems to be taking a line with all injuries to the rotator cuff that these are degenerative in nature. Since everyone's rotator cuff begins to degenerate with age I would be interested to know at what point ACC stops covering people? It seems to be a very ageist policy for this particular condition and seems to be frequently occurring with our applications for shoulder injuries."

[15] Dr Austen then signed another CAP opinion dated 3 December 2008. He took issue with Mr Stoddart's proposition that the improvement with physiotherapy supported the accident related cause, and said that the proposition made no sense

whatsoever because the accepted treatment for degenerative rotator cuff syndromes with or without impingement is a physiotherapy directed exercise and strengthening programme. Dr Austen also suggested that Mr Stoddart may not have been aware that where a condition is substantially gradual process, disease or age-related it does not meet the ACC definition of personal injury. Dr Austen said that the Panel had explained how a narrowed subacromial space with bursal thickening and tendinosis of the supraspinatus are all evidence of gradual process, disease or ageing conditions.

Review

[16] The Corporation's decision not to fund further physiotherapy was then taken to review. The Reviewer traversed the medical reports and put particular reliance on Dr Feltham's report concerning the relationship between impingement and the acromiohumeral interval. The Reviewer's interpretation of the radiologist's report was that the impingement was more likely than not the result of pre-existing pathology within the shoulder. The Reviewer also put weight on the evidence of symptoms being reduced by the initial physiotherapy treatment, concluding that the treatment probably improved the immediate accident damage while the continuing treatment sought by the appellant was a different process.

[17] Mr Gibbons for the appellant submitted that the Reviewer embarked on his own view of a medical question. That submission relates particularly to the inference that the response to physiotherapy suggested that the accident related condition was resolved. That was not a proposition expressly advocated in the medical opinions.

[18] The improvement after physiotherapy seems consistent enough with either theory of the significant cause of the appellant's symptoms. The Reviewer's interpretation of Dr Feltham's comments appears fair. Dr Feltham was not explicit in explaining whether the acromiohumeral interval made a natural degenerative process a more probable explanation, but his comments do seem to bear the interpretation adopted by the Reviewer.

Decision

[19] The difficulty in this appeal lies of course with the opposing opinions of probability. The appellant is supported by the opinions of physiotherapists and Dr Haldane and Mr Stoddart. All those practitioners took the view that the symptoms were consistent with an accident related cause that responded initially to physiotherapy, but eventually persisted and required further physiotherapy treatment. Dr Austen took the view that the imaging results did not provide a useful guide to causation, except the finding that the acromio-humeral space was barely six millimetres.

[20] Mr Stoddart questioned whether a claim should be decided on the basis of the Panel's view that rotator cuff deterioration is such a natural part of the ageing process that there is nothing to distinguish an accident related cause in a case like the present, and that the onus on this appellant is not discharged because the evidence of symptoms and imaging is equivocal.

[21] The Court is not qualified to draw any independent medical conclusions. The question for the Court concerns the weight to be given to medical professional opinions for or against the appellant's claim. That enquiry may be guided by the persuasive reasoning of a particular opinion, the skill and experience of the practitioner, the recital of authoritative sources, the first hand examination of the patient or observation of the development and progress of symptoms, and possibly by a level of agreement between a number of practitioners.

[22] In this case there is no clear guide to the cause of the appellant's continuing symptoms. It is the continuing symptoms that require further physiotherapy, not the initial symptoms that were more naturally associated with accident trauma.

[23] The ultrasound in July 2007 suggested a partial thickness tear. That did not show up on the MRI in February 2008. The difference was attributed to possible healing over that period, or to obscuring in the MRI of a possible tear because of the position of the shoulder at the time of the scan. The opinion of Dr Feltham was restricted to the conclusions that could be drawn from radiology alone, without reference to the history and symptoms observed by treating practitioners.

[24] The nature of the symptoms were described by the physiotherapist, Ms Wilczek, in May 2008 as movement dysfunction and weakness in the shoulder joint as a direct result of the initial injury. The diagnosis and cause were described by Mr Stoddart as a crushing of the rotator cuff tendon with resulting tendonitis. The ultrasound scan showed evidence of a tear in July 2007, five months after the accident. That supported the opinions of the practitioners who had diagnosed a rotator cuff tear on the basis of physical examination of the appellant.

[25] In February 2008 a tear was not apparent on an MRI scan. If a tear had not occurred, or even if a tear had healed, the continued symptoms could have been caused by underlying pre-injury pathology.

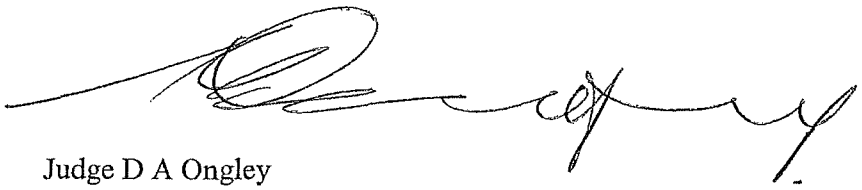
[26] Weight should of course be given to the CAP opinion that the ageing process is accompanied by micro-tearing damage to the rotator cuff tendons and that those tears eventually do not heal, for reasons expressed by Dr Austen. The Panel did not comment on the ageing process with particular reference to the age of the appellant herself who was aged 49 at the time of her accident.

[27] In this case, I consider that greater weight should be accorded to the opinion of Mr Stoddart who had examined the patient and whose view of a continued injury related condition was supported by the opinion of physiotherapist Ms Wilczek and chiropractor Dr Haldane. Whilst there may well have been underlying deterioration, the opinions supporting a continuing accident related condition requiring ongoing physiotherapy within eighteen months from the date of the injury were given by medical professionals who had treated the appellant. They are not easily discounted. The problem of deteriorating through ageing does not appear to be a complete answer. It does not take account of the supervening effect of trauma. In the various opinions concerning rotator cuff degeneration, there is no information concerning the period of time that the healing process might take following a traumatic shoulder injury to a 49 year old woman. It remains credible that the appellant's left rotator cuff, possibly affected by age-related micro tears, suffered a crushing injury causing tendonitis and associated bursitis, and that the injury persisted as a significant cause of weakness and movement dysfunction at April 2008 when an application was made

for funding for further physiotherapy. On balance, I consider that Dr Stoddart's opinion should be preferred.

[28] The appeal is allowed. The Reviewer's decision is quashed and the claimant will be entitled to funding for the treatment for which Ms Wilczek applied in April 2008.

[29] The appellant will have costs of $1,800 and reasonable disbursements.



Judge D A Ongley
District Court Judge