Automobile Injury Compensation Appeal Commission

IN THE MATTER OF an appeal by [the Appellant]
AICAC File No.: AC-96-71

PANEL:	**Mr. J. F. Reeh Taylor, Q.C. (Chairperson)** **Mr. Charles T. Birt, Q.C.** **Mrs. Lila Goodspeed**
APPEARANCES:	**Manitoba Public Insurance Corporation ('MPIC') represented by Ms Joan McKelvey** **[Text deleted], the Appellant, appeared in person**
HEARING DATE:	**April 14th, 1997**
ISSUE(S):	**Whether victim has permanent impairment and, if so, whether caused by one or both of two motor vehicle accidents.**
RELEVANT SECTIONS:	**Section 127, 129 and 130 of the MPIC Act ('the Act') and Schedule A, Part 1, Section 20 of Regulation 41/94**

AICAC NOTE: THIS DECISION HAS BEEN EDITED TO PROTECT THE APPELLANT'S PRIVACY AND TO KEEP PERSONAL INFORMATION CONFIDENTIAL. REFERENCES TO THE APPELLANT'S PERSONAL HEALTH INFORMATION AND OTHER PERSONAL IDENTIFYING INFORMATION HAVE BEEN REMOVED.

REASONS FOR DECISION

THE FACTS:

[The Appellant],[text deleted] and a teacher of [text deleted], was injured in two accidents while driving a [text deleted] and wearing his seatbelt. The first accident occurred on May 16th, 1994, the second on February 10th, 1995; in each case, [the Appellant's] vehicle was

rear-ended. The first accident involved a heavy impact and resulted in neck pain, particularly on the right side and into his right shoulder, in lower back pain sufficiently serious to cause him difficulty in standing, in muscle spasms and in headaches. His second accident, wherein the Appellant's vehicle was struck from the rear by a 5 ton truck, aggravated the effects of the first. He has undergone chiropractic adjustments, manual traction of his lumbar spine and physiotherapy, including lumbar stabilization classes; he has followed a program of home exercises; he has attended at the [text deleted] clinic of the [hospital #1], where he was treated with epidural steroid injections at L4-5 by [Appellant's pain management specialist] and referred to the pain management program at the [hospital #2]; he has been consuming, and continues to take, 650 milligrams of Aspirin two or three times daily as well over-the-counter strength Tylenol.

Those few facts are matters of common ground between the parties. So, too, is the undeniable fact that, from a CT Scan performed by [Appellant's radiologist] at the Department of Radiology at the [hospital #1] on September 3rd, 1995, it became clear that [the Appellant] had, by that date, sustained central and left posterior L5/S1 disk herniation, causing compression of the thecal sac and of the left S1 nerve root, with bilateral apophyseal joint osteoarthritis at the same level. He has been diagnosed, clinically and radiologically, as having discogenic pain with radiculitis of the S1 nerve root. In his narrative report of November 14th, 1995, [text deleted] (a specialist to whom [the Appellant] had been referred by his family physician, [text deleted]) confirms the forgoing diagnosis and notes that, while the prognosis for functional recovery is fair to good, "unfortunately, tear of the annulus fibers and disk herniation does not heal completely".

[Appellant's rehab specialist] also diagnoses facet joint arthritis, for which he says that the prognosis is "fair to poor. It is unlikely that ([the Appellant]) will be able to continue or participate in any heavy recreational or sports activities" but will be limited to those activities that do "not involve any jumping, pushing, pulling or body contact" - limitations that would seem to restrict [the Appellant] to recreational activities such as chess and tiddlywinks. Those limitations acquire some significance in that [the Appellant], in the course of his work as a teacher, also coached basketball and other sports at the [text deleted].

THE ISSUE:

There seems to be general agreement that [the Appellant] has sustained some measure of permanent impairment, within the meaning of Section 127 of the Act. The primary issue before this Commission is whether that impairment was caused by the accident of February 10th, 1995.

THE APPELLANT'S TESTIMONY:

[The Appellant] testified that the physical problems of which he now complains had been present, in large measure, since the date of his first accident although his symptoms had initially been ascribed to a facet joint strain. It was not until his physiotherapist, [text deleted], suggested to [Appellant's rehab specialist] and to [Appellant's doctor], on May 26th and on June 8th of 1995, that a CT or MIR Scan, or both, might be appropriate, that steps were taken which resulted in an updated diagnosis. [The Appellant] adds that his physiotherapist made that

recommendation because "I wasn't healing properly". [The Appellant] further testified that he has been sleeping very poorly since his first accident, that his general fitness level has dropped materially, due mainly to his inability to do some of the things that he used to do, both at work and domestically. He gave evidence that he cannot shovel snow or work in his garden - indeed, [Appellant's pain management specialist] has specifically advised him to avoid such activities - nor is he able to spend the same amounts of time in physical activities with his children. He expressed grave concern about his future prospects, having been told by his health care providers that his disk problem is not going to go away and that his facet joint arthritis is also something he must learn to live with.

[The Appellant] testified that the bench seat of his car was bent in the second accident. Following that accident, he says, he was called in and warned by his school's principal that his job might be endangered if he were no longer able to cope with its physical demands. He added that his job entails a lot of bending and stretching, especially in his laboratory work. He acknowledges that his chiropractic treatments seemed to do him more good than anything else and that his physiotherapy has helped by teaching him the pelvic neutral position.

[MPIC's DOCTOR'S] EVIDENCE:

[MPIC's doctor], the medical director of the Claims Services Department of MPIC and a specialist in sport medicine, gave evidence for the Corporation at the hearing of [the Appellant's] appeal and, thereafter, offered comments in writing respecting additional reports that the Commission itself had requested from [Appellant's rehab specialist]. After describing the

structure of an intervertebral disk, consisting of the annulus fibrosus (a tough outer skin) surrounding the nucleus pulposus (the gelatinous interior), [MPIC's doctor] added that the disk serves as a cushion between the vertebrae. If the annulus wears, some or all of the interior pulp may escape, impinging upon the root of the spinal nerve and causing pain that, in some cases, can be severe. [MPIC's doctor] emphasized that, in such cases, the pain is usually felt in the leg before back pain becomes noticeable.

[MPIC's doctor] testified that disk herniation does not always produce symptoms; about 20% of patients are asymptomatic. He felt that the prognosis in such cases is usually good, in the absence of neurological problems. Epidural injections can ameliorate the symptoms, thus allowing the patient to undertake back stabilization exercises with a view to restoring spinal function. [MPIC's doctor] emphasized, again, that the most common cause of disk herniation is forward flexion movement and that motor vehicle accidents are not a common cause of disk herniation, in that a shoulder belt will usually impede forward flexion. Symptoms of herniated disk, if in fact caused by a motor vehicle accident, would be expected to become apparent almost immediately. The pulp that escapes from the herniation contains prostaglandins, a highly inflammatory agent of which the chemical reaction with the nerve root can, as noted above, cause considerable pain and often produces a 'list' in the patient's posture.

[MPIC's doctor] went on to summarize the reports of the Appellant's general practitioner, [text deleted], of [text deleted], the chiropractor, and of [Appellant's rehab specialist]. He pointed out that none of the foregoing health care providers had diagnosed any kind of disk herniation until September of 1995 and that even by June of 1995, although [the Appellant] had

started to complain that the pain was radiating into his left leg, there was no real evidence of any nerve root compression or disk herniation; [Appellant's rehab specialist], whenever [the Appellant] attended at his surgery, made all of the recognized, accepted and proper tests which would have disclosed the existence of a herniated disk if one had existed at the time.

[MPIC's doctor] further testified to the effect that:

1. There is little in the health care literature to suggest that motor-vehicle-accident-related-trauma causes lumbar disk herniations in patients who are wearing lap and shoulder restraints and are rear-ended.
2. If an acute herniation of a disk is associated with one specific episode of trauma, then one should expect the symptoms to be felt in the back very early, within one or two days, and that within one or two weeks a substantial component of leg pain, even more severe than the back pain, would be felt by the patient. Those symptoms should also be associated with radiculopathic findings on physical examination.
3. There is a strong probability that [the Appellant's] current pain complaint is, indeed, linked to one or both of his motor vehicle accidents.
4. While it is possible that [the Appellant] has a herniated disk caused by his motor vehicle accident that is currently responsible for his pain symptoms and has always been responsible for them, it is not probable that the accident caused the herniation or that the herniation has caused the symptomatology for the first several months after his accident, given the lack of symptoms or signs consistent with radiculopathy for those first several months.
5. Lumbar disk herniations are typically a consequence of forward flexion with rotation, such

as bending down to pick something up. They are usually associated with relatively minor trauma, superimposed upon internal disk disruption and chronic annular degeneration.

[APPELLANT'S REHAB SPECIALIST'S] EVIDENCE:

The evidence of [text deleted], an orthopaedic surgeon specializing in rehabilitation medicine, consisted of a series of narrative reports rendered to MPIC and to this Commission. He had first examined [the Appellant] on November 18th of 1994 following a referral from [Appellant's doctor], regarding the injuries sustained by [the Appellant] in his first accident of May 16th, 1994. [Appellant's rehab specialist's] initial impression was that [the Appellant] clinically had lower lumbar spine interspinous ligamentous strain and right L4/5 and L5/S1 joint strain resulting from that accident. [The Appellant] was instructed to apply moist hot packs to the back for half an hour, followed by paraspinal and abdominal muscle stretching and strengthening exercises. He was to start doing regular flexion exercises of the spine but to avoid any extension strain on the spine that might aggravate his right L4/5 facet joint pain.

[The Appellant] was seen again by [Appellant's rehab specialist] on December 9th, 1994, and on February 3rd of 1995; on neither of those visits did [Appellant's rehab specialist] detect any evidence of disk herniation or spondylosis of cervical and lumbar spines. The Appellant was advised to continue with his then current physiotherapy treatments, to continue with his home exercise program and to start on a conditioning program to improve his sitting, standing and working tolerance.

Following [the Appellant's] second accident on February 10th, 1995, he attended again upon [Appellant's rehab specialist] on February 17th. He complained, at that time, of pain in the lumbosacral region and reported that any prolonged sitting or standing activities aggravated that pain. Range of motion of the lumbar spine was noted at 25% below normal, with forward flexion and extension both being painful. [Appellant's rehab specialist] also noted that the February 10th accident had caused exacerbation of [the Appellant's] facet joint strain (arthritis) and that the Appellant had developed myofascial and soft tissue pain syndrome. He was given a local injection of Xylocaine and Cortisone and given further instruction in an exercise program. From his February 17th, 1995, examination of [the Appellant], [Appellant's rehab specialist] concluded that:

1. The 1994 accident had caused flexion/extension and possibly rotation injuries to the Appellant's cervical and lumbosacral spines, the cervical injury being complicated by musculoligamentous strain and myofascial pain syndrome.
2. The lumbosacral spine injury caused facet joint strain and degenerative changes, although [Appellant's rehab specialist] goes on to note that he cannot tell how much of the degeneration predated the motor vehicle accident nor whether the accident caused the facet joint injury - an ambivalence that, it must be said, creates difficulty for this Commission.
3. There was no evidence that he could then (February 17th, 1995) discern of spinal fracture of dislocation nor of disk herniation causing nerve root compression.
4. The examination did reveal tenderness of interspinous ligaments and of facet joints at L5/S1 level, with 25% restriction of movement of the lumbar spine.
5. [The Appellant's] facet joint arthritis is permanent and may get worse. For that reason, although the Appellant should be able to continue the sedentary aspects of his work he

should avoid any heavy manual or recreational activities which may cause extension strain and loading on the lumbar spine and aggravate the facet joint arthritis.

6. Cortisone injection would give temporary relief of the pain "and a lumbosacral flexion belt or arthrosis (sic) may prevent the extension loading or strain of the facet joints."

On September 5th, 1995 and (so far as can be determined from the material before us) primarily as the result of the urgings of the Appellant's physiotherapist, [text deleted], in consecutive reports to [Appellant's rehab specialist] and [Appellant's doctor] in May and June of 1995, [Appellant's rehab specialist] arranged for [the Appellant] to undergo a CT Scan on September 3rd, with the result described on page 2 of these Reasons.

On November 14th, 1995, in response to a request from the insurer, [Appellant's rehab specialist] submitted a further, detailed, narrative report. In it, he touches briefly upon his February 17th, 1995 examination of [the Appellant] and says that the February 10th, 1995 accident may have caused disk injury but that, at the time of the examination, he found no evidence clinically of any nerve root compression or irritation. [Appellant's rehab specialist] then reports upon a further examination that he conducted of [the Appellant] on June 12th, 1995, when the Appellant stated that he had continued to experience pain in the lumbosacral region after any prolonged activity or sitting or standing posture or heavy work. "Over the past two months, on two occasions, the pain has gone to the legs particularly in the left popliteal region. The pain has been sharp and is aggravated on coughing and sneezing." There had been no noticeable weakness or numbness in his left leg. Noting that "surprisingly, he has not responded favourably to the appropriate treatments for his mechanical and facet joint pain syndrome", [Appellant's rehab

specialist] surmises at this time (June 12th, 1995) that [the Appellant] "may have injured his disk particularly the tear of the fibers which may have caused bulging of the disk causing some irritation of the L5/S1 nerve root on the left side".

On August 9th, 1995, [Appellant's rehab specialist] conducted another examination of [the Appellant]. Its results were very similar to those of the June 12th examination, showing no improvement in the Appellant's condition - indeed, if anything there was a deterioration, since there was now "persistent left posterior lumbosacral pain with radiation to the left leg". [Appellant's rehab specialist's] notes from that examination indicate that he "would like to rule out disk herniation", and that he therefore ordered the CT Scan of the L3-S1 spine, of which [Appellant's radiologist] reported the results referred to on page 2 above.

On September 22nd, 1995 [Appellant's rehab specialist] met with [the Appellant] again, explained the results of the CT Scan and made the diagnosis referred to earlier, namely: discogenic pain with radiculitis of the S1 nerve root, with no significant compression of that nerve root but accompanied by L5/S1 bilateral facet joint arthritis. (We note that [Appellant's radiologist's] report does speak of an apparent nerve root compression, and we must therefore conclude that, as between these two experts, the matters is one of degree.)

In the summary to his general report of November 14th, 1995, [Appellant's rehab specialist] includes these opinions:

> "[The Appellant], as a result of motor vehicle accident of February 10th, suffered flexion/extension and possibly rotational injury to his lumbosacral spines (sic). This

injury aggravated his pre-existing facet joint arthritis and may have caused annulus fibrous tear leading to disk herniation at L5/S1 level. (There follows a sentence apparently intended to deal with the May 16th, 1994 accident but which, due to an hiatus rendering it meaningless, is omitted here.) ....On February 10th, 1995 he suffered further flexion/extension and possibly rotational injuries to his lumbar spine and this aggravated his pre-existing facet joint arthritis and may have aggravated the tears of the annulus fibers or fresh injury to the L5/S1 disk causing annulus tears and disk herniation."

In replying to a specific question asked of him by MPIC's adjuster, [Appellant's rehab specialist] makes the following statement:

"[The Appellant] indeed suffered a herniated disk with radiculitis of the S1 nerve root on the left side and most likely it is related to the accidents of May 16th, 1994 and February 10th, 1995. Historically and clinically he did not have any symptoms and signs of left leg radiculitis until the accident of February 10th, 1995 so keeping in view his history and my clinical findings most likely he suffered disk herniation in the accident of February 10th, 1995. There has been no previous CT Scans done and we cannot be absolutely sure that whether the disk herniation was caused by the May 16th, 1994 or February 10th, 1995 accidents or it was a combined cause and effect of both accidents."

A memorandum from [Appellant's pain management specialist] at the [text deleted] clinic of the [hospital #1], dated November 9th, 1995, contains the following, unequivocal statement:

"[The Appellant] has been suffering from the chronic low back pain due to disk herniation

> at lumbar vertebrae L5 and sacral 1 (S1). Lifting, snow shovelling et cetera should be avoided."

[MPIC's doctor] states, in a memorandum of April 24th, 1997, that "there is a strong probability that [the Appellant's] current pain complaint is linked to the motor vehicle accident in question". However, in [MPIC's doctor's] view, while it is possible it is not probable that [the Appellant's] accident caused his disk herniation or that the disk herniation has caused the symptomatology in [the Appellant] for the first several months after his accident.

After receiving a copy of [Appellant's rehab specialist's] letter of July 17th, 1997 [MPIC's doctor] makes the following comment in a memorandum of August 6th, 1997:

> "I would state that [Appellant's rehab specialist's] letter does not refute my opinion, but indeed supports it. The key supporting statement from [Appellant's rehab specialist] in this case is on page 6 (*he appears to mean page 5*) under his point number 2. [Appellant's rehab specialist] states that in [the Appellant's] case there was no one specific episode which caused the disk herniation. If no one specific episode caused the disk herniation, then the motor vehicle collision could not be responsible for causing the disk herniation, therefore, on the balance of probability, the patient is not entitled to an impairment award for it..... Furthermore, to document that a patient has a disk herniation being responsible for their pain, multi-level discography is required. This has not been performed on [the Appellant] to my knowledge. In the absence of neurologic findings as in [the Appellant's] case, only speculation regarding the relationship between radiographically identified disk herniations and the patient's pain complaint can take place."

However, with respect, we are of the view that [MPIC's doctor] omits the more cogent passage from [Appellant's rehab specialist's] letter of July 17th, 1997. True, [Appellant's rehab specialist] does say that there was no one specific episode which caused the disk herniation, but he goes on in the next sentence to say:

> "In my opinion it was the first accident which caused disk strain and facet joint injury which lead to further degeneration of the disk over the weeks and months related to daily activities and the second motor vehicle accident caused addition injuries in the form of mechanical forces on the disk causing further increase in interdiscal pressure and herniation. In [the Appellant's] case it was not one episode but it was more than one episode of injury which caused disk herniation."

[Appellant's rehab specialist] also went on to comment that [the Appellant's] disk herniation did not cause significant compression of the nerve root but, rather, caused irritation of the nerve root only which, in [Appellant's rehab specialist's] view, explained the absence of significant radiculopathy in the form of sensory motor and reflex abnormalities. [Appellant's rehab specialist's] July 17th, 1997 report, although seeming to differ from his earlier report, does go on to say that [the Appellant's] "symptoms of discogenic pain and radicular pain came obvious after the second motor vehicle accident and in my clinic notes of February 17th, 1995 he stated that coughing and sneezing aggravated the pain and occasionally the pain radiates to his right knee and leg. On straight leg raising beyond 65 degrees there was aggravation of the lumbo sacral and leg pain. This clinical picture which was not present on examinations of 18 November 1997, December 9, 1994 and February 3, 1994."

In the decision of this Commission respecting the appeal of [text deleted] bearing date May 8th, 1997, we had to deal with a situation not totally dissimilar from the present one, in the context of a disk injury that did not produce low back pain symptoms until some time after the motor vehicle accident, and a consequent denial of benefits by MPIC. In [text deleted's] case, we referred to a decision of Scott, ACJ, QB, as he then was, in the case of Payjack v Forkheim and Olinyk, reported at 54 Manitoba Reports (2nd edition) at page 263. In the Payjack case, the victim did not even begin to experience low back pain until some time after her motor vehicle accident. The orthopaedic surgeon called to give evidence for the plaintiff, had concluded that her low back injury, resulting in an acute lumbar disk protrusion, was probably caused by the automobile accident in the absence of any previous history of low back pain or any other trauma that could have caused the injury. The medical evidence emphasized that "The onset and increase in pain and discomfort was not an abrupt, but rather a gradual, process and that it was quite possible that there might be no back pain at the beginning, or minimal symptoms, but as time went on.....the symptoms would begin to impact upon the plaintiff." The Associate Chief Justice heard further testimony that "Sometimes the symptoms of a disk injury are delayed, especially if the original injury is a small tear to the annulus fibrosis, and this then progresses over time to a significant tear and, ultimately, a protrusion.....Trauma can be an initiating factor to a disk protrusion if there is some degenerative process already present....It is sometimes the case that the initial tearing thereafter progresses to a point where a prolapse or protrusion takes place....".

THE LAW:

The relevant portions of the legislation are to be found in Sections 127, 129 and 130 of the Act and in Schedule A, Part 1, Section 20 of Regulation 41/94, copies of which are annexed hereto and form part of these Reasons.

DISPOSITION:

As is not infrequently the case in matters coming before this Commission, we are confronted with the divergent opinions of medical specialists, each expert in his field and whose bona fides are unquestioned. After much careful consideration, we find that a reasonable balance of probabilities favours the proposition that [the Appellant] suffered some disk weakening in his first accident, that the condition which resulted was almost undoubtedly accentuated by the normal demands of [the Appellant's] work and domestic chores - even more, perhaps, by the exercise regimen that he followed on professional advice - during the intervening months, and that his second accident led to the eventual herniation of his L5/S1 disk.

[The Appellant's] facet joint degeneration or arthritis seems almost certainly to have been caused or, at the very least, made more severe, by the trauma of his two accidents, there having been no indications of such pathology pre-dating his first accident.

We therefore find that [the Appellant] is entitled to an award of 4% for permanent disability under Section 20(b)(ii) of Schedule A to Regulation 41/94, adjusted pursuant to Sections

164(2) and 165(3), with interest at the statutory rate from November 14th, 1995, the date when [Appellant's rehab specialist] first rendered his opinion as to the likelihood of disk herniation resulting from the accident.

Dated at Winnipeg this 8th day of January 1998.

J. F. REEH TAYLOR, Q.C.

CHARLES T. BIRT, Q.C.

LILA GOODSPEED