Automobile Injury Compensation Appeal Commission

IN THE MATTER OF an appeal by [the Appellant]
AICAC File No.: AC-98-23

PANEL:	**Mr. J. F. Reeh Taylor, Q.C. (Chairperson)** **Mr. Charles T. Birt, Q.C.** **Mr. F. Les Cox**
APPEARANCES:	**Manitoba Public Insurance Corporation ('MPIC') represented by** **Ms Joan McKelvey** **the Appellant, [text deleted], appeared in person**
HEARING DATE:	**October 20th, 1998**
ISSUE:	**Whether Appellant entitled to continued chiropractic care at insurer's expense.**
RELEVANT SECTIONS:	**Section 136(1)(a) of the MPIC Act and Section 5 of Manitoba Regulation 40/94**

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 Appellant], [text deleted] years of age at the time, was the victim of a rear-end collision on the 8th of December 1995, in [text deleted]. [The Appellant] was the driver and sole occupant of her vehicle and was wearing her lap and shoulder belt. Her driver's seat was equipped with an adjustable head rest, but the varying reports reflected on her file make it difficult to determine

whether she actually struck her head; it seems most probable that she did not.

[The Appellant] is a [text deleted] in the employ of [text deleted] on a full-time basis; she has not felt the need to miss any time from work as a result of injuries sustained in her motor vehicle accident.

She first consulted her chiropractor, [text deleted], on December 11th, 1995. [Appellant's chiropractor #1's] report of January 12th, 1996 reflects complaints by [the Appellant] of neck and upper back pain (more to the right side than the left), right wrist pain, low back pain with a referral of numbness, pain and tingling into her legs, all of which was accompanied by restlessness and mood changes. [Appellant's chiropractor #1] prescribed spinal adjustments three times per week. [Appellant's chiropractor #1's] next report results from an examination of April 26th, 1996, in which [Appellant's chiropractor #1] reports that [the Appellant] is experiencing headaches about two to three times per month, decreasing in frequency, duration and intensity. She had indicated relief following a specific spinal adjustment. Neck pain, mid and low back pain had all decreased in severity but were present by the time of the adjustment. He found knee pain associated with lumbosacral injury and slight abnormal gait occurring concomitantly with sacroiliac dysfunction. [Appellant's chiropractor #1] classified [the Appellant's] injuries as a Grade II Whiplash Associated Disorder (WAD 2), prescribed further manipulation at a frequency of once per week for the next eight weeks and recommended light exercises.

[Appellant's chiropractor #1's] next written report bears date October 4th, 1996 and relates to an examination of September 27th of that year. That report indicates "no headaches, neck and lower

back pain are improving. Upper back pain is persistent and easily aggravated". He repeats his diagnosis of a WAD 2, indicates that [the Appellant] is capable of working full duties and again recommends adjustments at a frequency of once per week for eight weeks with a re-evaluation at the end of that time.

By March 19th of 1997, following an examination of that same date, [Appellant's chiropractor #1] again notes that [the Appellant] was experiencing a decrease in headaches both in frequency and duration; she stiffened by the second week after an adjustment and, by one and a half weeks after an adjustment, complained of feeling pain in the L5-S1 region. He recommends adjustments at a frequency of once every two weeks for eight weeks, to be followed by once every three weeks for a further ten weeks and once a month for a further twelve months. Rather strangely, [Appellant's chiropractor #1] now diagnoses [the Appellant] as having sustained a Grade 3a WAD, although he also indicates her capability of performing full functions without symptoms and working full duties. Since all of his earlier diagnoses had indicated a WAD 2 classification and a functional classification of "full function with symptoms", and since his report of March 19th, 1997 clearly indicates major improvements on the part of his patient, we have to assume that his WAD 3a classification was inadvertent and, simply, wrong.

Since, by early June of 1997, [the Appellant] had received 81 adjustments from [Appellant's chiropractor #1] over a period of some eighteen months following her accident, MPIC referred her for an independent chiropractic assessment by [independent chiropractor], upon whom she attended on June 24th, 1997. [Independent chiropractor's] report of June 27th, 1997 reflects

complaints by [the Appellant] mainly of cervical and thoracic pain and stiffness, with the right side being worse than the left, extending down to approximately the T7 level. She also complained of left sided lower thoracic spine pain and low back pain. [Independent chiropractor] reported grip strength as being normal bilaterally, deep tendon reflexes were graded 2+ bilaterally symmetrical and sensation was also normal bilaterally. [the Appellant] had reported a pre-existing disability in the form of a "twisted pelvic bone" of which, although [independent chiropractor] understood that that problem had been cured some time prior to the motor vehicle accident, the evidence of [the Appellant] was that she did not feel that that problem had been overcome by December 8th of 1995. She had, in fact, continued to receive chiropractic treatments about once every three months.

[The Appellant] also reported to [independent chiropractor] that she had sustained a few falls off horses but, other than fracturing her elbow in a cycling accident, she had had no other fracture prior to, nor after, her motor vehicle accident. All her treatments from [Appellant's chiropractor #1] had been passive, and no active exercises had been prescribed for her other than advice to walk and to work out with light weights.

After a very thorough series of tests, [independent chiropractor] concluded that, as a result of her motor vehicle accident, [the Appellant] had sustained a WAD 2 injury that, by the time of his examination, was almost completely resolved; she had also sustained an "almost corrected thoracic and lumbar strain with mild muscle imbalance; lumbosacral postural stress". He also concluded that [the Appellant] had certain other problems which, in his opinion, were not due to her accident,

namely: "probable left glenoid labrum tear, DDx left bicep tendonitis; patella-femoral arthralgia". He also noted what he refers to as "equivocal illness behaviour". [Independent chiropractor] felt that the treatment plan proposed by [Appellant's chiropractor #1] was neither reasonable nor necessary and that [Appellant's chiropractor #1] should be encouraged to move from passive to more active management, de-emphasizing in-office treatment and emphasizing low-tech home exercise and other active measures. After recommending certain specific forms of exercise for [the Appellant], [independent chiropractor] went on to say that, on implementation of those active measures, treatment frequency should be continued at a rate of once every two weeks for six weeks with the patient being discharged at the end of that period. He felt that [the Appellant's] prognosis was good and that she appeared to have sustained no permanent impairment from her injuries. He reports that, at the end of her examination, [the Appellant] stated that she felt alright.

A copy of [independent chiropractor's] report was forwarded to [Appellant's chiropractor #1], who was asked to complete a new chiropractic treatment plan report and, after a re-examination of [the Appellant] on July 28th, 1997, [Appellant's chiropractor #1] provided the requested report, in which he repeats his diagnosis or classification of a WAD 3(a) injury and indicates that [the Appellant] now complains of neck stiffness and soreness with muscle spasms in the shoulders, cold hands, wrist pain, low back pain, nervousness and restlessness. (What follows is a quotation from a subsequent analysis prepared by [text deleted], MPIC chiropractic consultant, from a paper review of all chiropractic reports respecting [the Appellant] up to June 18th of 1998.)

> After noting some range of motion findings and positive orthopaedic findings, some of which are suggestive of nerve root irritation, [Appellant's chiropractor #1] goes on to note

> significant and dramatic neurologic findings. Specifically, [Appellant's chiropractor #1] notes multi-segmental deficits throughout the cervical and lumbar spine which span multiple neurologic modalities. Specifically, he notes dermatomal deficits at C5-6, C8, T1, L4 and L5, myotomal weakness at C5, C7, T1, L1, L2 and L3, and reflex changes at C5, S1. These dramatic neurologic findings are inconsistent with both his previous reporting and those findings reported by [independent chiropractor]. Unfortunately, there is no explanation given in this report as to why there such a dramatic change in the claimant's reported signs. [Appellant's chiropractor #1] further provides us with 27 risk factors for chronic pain or delayed recovery. He classifies this injury, at this point, as a WAD III(a).

On November 10th, 1997, either by way of referral from [Appellant's chiropractor #1] or on her own initiative, [the Appellant] attended upon [text deleted], a chiropractor at the [text deleted] Chiropractic Centre. His report reflects complaints by [the Appellant] of headaches, light-headness, dizziness, neck stiffness, thoracic spine pain, numbness in the fingers, cold hands, shortage of breath, low back pain, leg numbness, cold feet, muscle spasms in the legs, mood and behaviour changes, nervousness, restlessness and insomnia. [The Appellant] had estimated her visual analogue pain rating at 95 out of 100 immediately following her motor vehicle accident (100 being the maximum possible pain) and, even at the time of her examination by [Appellant's chiropractor #2] two years later, was still rating her pain at 73. It had been two weeks since her last chiropractic adjustment, and she felt that her symptoms would reduce dramatically after her next chiropractic visit. [Appellant's chiropractor #2] noted bilaterally symmetrical hyporeflexia

in the upper limbs as well decreased sensitivity in the C6 and C8 dermatomes with positive neurovascular compression tests. He also recorded a 25% variation in strength between the left grip and right grip strength, adding that "matchstick testing for dysautonomia revealed positive findings at the fifth cervical dermatome to the right and the sixth cervical dermatome to the patient's left". As [MPIC's chiropractor] notes, "these neurological findings are significantly different from those provided by both [Appellant's chiropractor #1] and [independent chiropractor]". [Independent chiropractor] essentially provided us with a normal neurologic exam at the end of June 1997. In July 1997, [Appellant's chiropractor #1] provides us with a neurologic exam as described above. Neither exam is consistent with that provided by [Appellant's chiropractor #2].

[Appellant's chiropractor #2] diagnosed traumatically induced fibromyalgia, post-concussive sydrome and autonomic concomitants. He recommended ongoing care at levels in excess of what was currently then being provided, with periodic retesting and re-examination of her injuries. He felt that the focus of treatment should be on the inhibition of her chronic pain pathways by specific chiropractic adjustment and a regime of cerebellar stimulation, directed to that end. He had found, on physical examination of [the Appellant], positive response on fourteen of eighteen "tender spots" which led him to diagnose "traumatically induced fibromyalgia".

[Appellant's chiropractor #1], by way of a letter on April 28th, 1998, agreed with [Appellant's chiropractor #2].

Being concerned that [Appellant's chiropractor #2's] and [Appellant's chiropractor #1's] reports seem to indicate the presence of post-traumatic fibromyalgia and other neurological deficits that were still present almost exactly two years following [the Appellant's] automobile accident, this Commission was concerned that her injuries from that accident might be more serious than were first diagnosed. Therefore, in the interests of obtaining a complete picture, we decided to refer [the Appellant] for an independent neurological assessment to [independent neurologist].

[Independent neurologist] notes, in the course of a very thorough neurological report, that [the Appellant] had indicated that she had been reducing her physical activities during the two and a half years that she had been attending [Appellant's chiropractor #1] for chiropractic adjustments. She felt that she had been doing well until about May of 1997 when, having started to increase her physical activities at the suggestion of [Appellant's chiropractor #1], she felt that her symptoms had become worse. We note, here, in passing, that there is a strong suggestion, in a letter of July 6th, 1998 from [Appellant's chiropractor #1], that the deterioration in [the Appellant's] condition was in some way directly related to the independent examination performed by [independent chiropractor]. In our respectful view, that suggestion borders on the ludicrous and is entirely unsupported by any other evidence. Indeed, [the Appellant] herself has stated that her symptoms got worse when she increased her activities - a statement borne out by the reports of [independent chiropractor], [Appellant's chiropractor #2] and [MPIC's chiropractor].

[Independent neurologist] expresses the view that [the Appellant], at least by June 30th, 1998, had made a full recovery from the effects of her motor vehicle accident of December 8th, 1995. She

has tension type headaches as well as musculoskeletal pains that are benign and self-limiting, and there was no reason to believe that, two and a half years after the accident, she had any residual physical damage. She had had a steady course of improvement until the summer of 1997 when she evidently started to have more complaints, as documented in the reports of [Appellant's chiropractor #1]. [Independent neurologist] reported that few, if any, of the complaints reported in [independent chiropractor's] letter of June 27th, 1997 were voiced by [the Appellant], and none of the symptoms documented by [Appellant's chiropractor #2] in his report of December 1st, 1997 was mentioned by [the Appellant], even on direct questioning. [Independent neurologist] added that one would not expect a symptom such as shortage of breath two years following such an injury and the symptom, if present, would not be attributable to the accident.

Of major import, in our view, is that [Appellant's chiropractor #2] recorded that [the Appellant] had suffered "head injuries" which, as [independent neurologist] points out, clearly is not the case. [Independent neurologist] goes on to say;

> She did not complain of difficulty in movement and I cannot support his (i.e. [Appellant's chiropractor #2's]) diagnosis of "traumatically induced fibromyalgia" nor the diagnosis of "post traumatic headache". He ([Appellant's chiropractor #2]) states that she has the "hallmark signs" of alcohol intolerance indicative of a "closed head injury" which, in fact, never occurred.

[Independent neurologist] describes certain electrodiagnostic tests apparently performed by [Appellant's chiropractor #2] as being impossible to interpret and holding no credibility as far as

any disease process is concerned.

[Independent neurologist], further, agrees with [independent chiropractor] that home exercises would be sufficient as well as activities of daily living. He expresses the view that [the Appellant] does not require ongoing chiropractic manipulations which, in fact, coincided with the subjective worsening of the patient as documented by [Appellant's chiropractor #1] and [Appellant's chiropractor #2]. [Independent neurologist] completely agrees with [MPIC's chiropractor] in the comment that soft tissue injuries improve over time and often take place with or without treatment, although in the early stages treatment does help. At this point, two and one-half years following the injury, it is [independent neurologist's] view that [the Appellant] needs no ongoing therapy but, rather, reassurance that she does not have any residual physical damage. [Independent neurologist] believes, as does this Commission, that [the Appellant] is honest and forthright, but, as he puts it, ".....unfortunately her symptoms are propagated by a very supportive therapist who is advising her that she should continue with more treatment and thereby propagating her complaints which she probably feels represent residual physical damage."

In his letter of July 6th, 1998 [Appellant's chiropractor #1] expressed the view that [the Appellant] had sustained "neural trauma" and was now suffering from what he called "classical symptoms of a concussion". [Independent neurologist's] supplemental report of October 1st, 1998 refutes both those conclusions quite forcefully.

We must deal with the diagnoses offered by [Appellant's chiropractor #2]:

(a) *Traumatically Induced Fibromyalgia*

We note, firstly, that [Appellant's chiropractor #2] is the only one of the professional caregivers who have examined [the Appellant] and have come to that diagnosis. Secondly, we know of no reliable literature that enables us to draw a conclusion that fibromyalgia syndrome can, in fact, be caused by the trauma of a motor vehicle accident. As is well known, fibromyalgia syndrome is not a disease but, rather, is a label attached by the medical profession to a bundle of symptoms whose cause cannot be determined by any standard, objective, clinical tests. The etiology of fibromyalgia syndrome is unknown. A consensus report on fibromyalgia and disability in the Journal of Rheumatology, 1996, at pages 534 to 539, emanating from a conference of eminent specialists in the field who gathered in Vancouver, concludes that there is insufficient evidence to establish a causal link between trauma and the symptoms of fibromyalgia syndrome.

Dr. D. L. Goldenberg, in an article headed "What is the future of fibromyalgia?" published in the Rheumatic Disease Clinics of North America, Volume 22, Number 2, in May of 1996 (pages 393 to 406) says that the syndrome of fibromyalgia overlaps with chronic fatigue syndrome, irritable bowel syndrome, irritable bladder and migraine headache. He adds that there is likely no single cause for these syndromes and that they best fit into a psychosocial, rather than a biomedical, model. While it is true that, following the results of a study prepared by the American College of Rheumatology in 1990, two of the primary criteria for diagnosing fibromyalgia syndrome became, firstly, unusual tenderness at at least eleven of eighteen specific tenderpoint sites on the body and, secondly, wide-spread

pain, it has to be noted that even those criteria are by no means objective since, of course, pressure at each tenderpoint calls for a subjective reaction from the patient.

In sum, then, we are of the view that [the Appellant] did not sustain "traumatically induced fibromyalgia", even if such a thing exists - a concept which, in our respectful view, is extremely doubtful.

(b) *Post-traumatic Headache Syndrome, also know as Post-concussive Syndrome*

The evidence to support such a diagnosis is, in our view, slender in the extreme. Firstly, [the Appellant] is on record with the statement that she did not strike her head on any part of the interior of her vehicle at the time of the accident. Secondly, although it is true that the symptoms of concussion can be produced by the sudden displacement of the brain within the skull cavity, and even in the absence of direct, physical impact, [independent neurologist] expresses the view that, if she had had a portion of her brain slipping through the foramen magnum, as was suggested by [Appellant's chiropractor #1], one would have expected serious neurologic damage, which is in fact not the case. We concur

(c) *Autonomic Concomitants*

We must be frank to say that we are puzzled by this expression, whose meaning has yet to be made clear to us. Using those words in their every-day meaning, we take this to be a reference to indications of pathological effects upon some one or more nerve centres in the brain or spinal cord which regulate involuntary movement and which are concomitants of, or accompany, post concussive syndrome. However, [Appellant's chiropractor #2's] reasoning that leads him to that conclusion escapes us. His report says that "testing for dysautonomia (that is, an abnormality in the function of the autonomic nervous system)

> revealed blood pressures average over five separate tests to be well within the margin of errors for the testing equipment". He adds that "Near to Far Gaze testing revealed deficiencies to the patient's left. Heel to toe challenge resulted in a deficiency to the patient's left. Match stick testing resulted in deficiencies to the patient's left." With deference to [Appellant's chiropractor #2], we are unable to draw the same conclusion that he apparently does from the data presented to us. [Appellant's chiropractor #2] also draws the conclusion that [the Appellant] had suffered brain trauma that had precipitated a traumatic fibromyalgia syndrome which, in turn, resulted in what he calls "maladaptive neural plasticity". Since we have already found, as a fact, that [the Appellant] did not sustain any closed head injury at the time of her motor vehicle accident, it necessarily follows that we cannot accept this further diagnosis by [Appellant's chiropractor #2].

DISPOSITION:

[The Appellant's] appeal arises from a decision of her adjuster at MPIC, bearing date September 4th, 1997, whereby the Corporation terminated payments for any further chiropractic care for injuries sustained in her motor vehicle accident of December 8th, 1995. That decision was confirmed by MPIC's internal review officer in his letter of January 30th, 1998. [The Appellant] seeks the reinstatement of those payments from the date of their termination up to the 28th of April 1998.

We find that [the Appellant] did, indeed, sustain a Grade II Whiplash Associated Disorder as a

result of her accident. She was able to resume her full duties at work and all normal activities, except for a fairly sharp reduction in some of her outdoor activities. In light of the absence of almost all of the recognized high-risk factors in [the Appellant's] history and her condition at the time of the accident, one would have expected her to have reached maximum therapeutic benefit after approximately sixteen weeks of chiropractic treatment. [The Appellant] had started to increase her physical activities, upon [Appellant's chiropractor #1's] advice, prior to her examination by [independent chiropractor]; we find that [independent chiropractor's] examination was totally unconnected with the quite sudden and dramatic increase in her reflex changes and in the neurological deficits recorded by [Appellant's chiropractor #1] in his treatment plan report of July 28th, 1997. By the same token, we can find no support in the evidence for a finding of any head injury, nor any neurological deficits of the kind suggested by either [Appellant's chiropractor #1] or [Appellant's chiropractor #2]. The recommendations of [independent chiropractor], [MPIC's chiropractor] and [independent neurologist] are, in our respectful view, all in keeping with the clinical guidelines for chiropractic practice in Canada, published as a supplement to the Journal of the Canadian Chiropractic Association, Volume 8, Number 1, in March of 1994.

We find, therefore, that MPIC was justified in terminating payments for further chiropractic care in September of 1997. The need for that continuing care, if it exists at all, does not in our view find its roots in [the Appellant's] motor vehicle accident and the present appeal must, therefore, be dismissed.

Dated at Winnipeg this 12th day of November, 1998

J. F. REEH TAYLOR, Q.C.

CHARLES T. BIRT, Q.C.

F. LES COX