

**IN THE DISTRICT COURT
AT WELLINGTON**

**I TE KŌTI-Ā-ROHE
KI TE WHANGANUI-A-TARA**

[2021] NZACC 23 ACR 534/11

UNDER	THE ACCIDENT COMPENSATION ACT 2001
IN THE MATTER OF	AN APPEAL UNDER SECTION 149 OF THE ACT
BETWEEN	JILLIAN MUIRHEAD Appellant
AND	ACCIDENT COMPENSATION CORPORATION Respondent

Hearing: 23 November 2020
Heard at: Dunedin/Ōtepoti

Appearances: Mr P Sara for the appellant
 Mr C Light for the respondent

Judgment: 28 January 2021

**RESERVED JUDGMENT OF JUDGE C J McGUIRE
[Work-Related Gradual Process Injury –s 20(2)(e) and s 26(1)(b)
Accident Compensation Act 2001]**

[1] The issue on this appeal is whether the Corporation was correct in its decision of 17 March 2011, whereby it declined to provide cover for the appellant’s claim for a work-related gradual onset condition.

Background

[2] On 23 February 2011, the appellant saw her general practitioner (GP), Dr Leitch, who filed an ACC injury claim form. The injury was described as “increasing upper back and neck pain while working as a sonographer over the past

6-12 months”. Under the heading “Diagnosis 1” was entered “trapezius left” and under “Diagnosis 2” was entered “trapezius right”.

[3] The appellant was referred to a physiotherapist and the claim form listed no restrictions regarding her work. In response to a request from ACC, the appellant completed an ACC272 cover questionnaire form.

[4] In this form dated, 3 March 2011, the appellant confirmed the symptoms she had first noticed were:

Increasing pain and burning through both trapezius muscles when scanning (ultrasound).

[5] The appellant noted that she had worked in this role for 30 years but with an increased workload over the last year. Under the heading “additional information” she said:

Neck and shoulder pain is a documented problem for sonographers. See articles.

[6] In a Medical Practitioner Cover Questionnaire form, Dr Leitch noted the likely cause of the diagnosis as:

Work posture and increased work load.

[7] The Employer’s Questionnaire was completed by Dr James Fulton. He confirmed that in his view the injury was caused by the appellant’s work and the reason he gave was:

Increased work load – scanning and driving.

[8] Dr Fulton also said that the job had been subject to a worksite assessment:

Approx 1995 reports not available.

[9] In his GP consultation notes is an entry, dated 23 February 2011, where Dr Leitch records:

Sore upper back and shoulders.

Increasingly painful over the past 6-12 months. Clearly related to job as a sonographer. Pain increases significantly with a busy season. Burning discomfort across shoulders. Taking daily naproxen for knees anyway. Needs more analgesia. Saw physio this morning and recommended filling in ACC form. Look well ...

[10] The Corporation completed a gradual process claim summary on 16 March 2011, which noted there was no clinical evidence to support a discrete physical injury and therefore s 26 of the Accident Compensation Act 2001 (the Act) could not be met. Additionally, s 30 of the Act was not considered “due to there being no coverable physical injury”.

[11] On 17 March 2011, the Corporation wrote to the appellant confirming it was unable to approve her claim:

Because there is no medical evidence of a physical injury that can be directly attributable to a work task or factor in your work environment. In addition, the work you do and/or your work environment is not recognised as placing workers at significantly greater risk of developing a medical condition.

[12] Subsequently, the Corporation declined an application for additional physiotherapy treatment.

[13] The appellant wrote to her case co-ordinator on 22 March 2011. Amongst other things she said:

I'm very disappointed with this decision and dispute the claim that “the work you do and/or your work environment is not recognised as placing workers at significantly greater risk of developing your medical condition. Should a search of the literature be performed on the research done on the risk of musculoskeletal done on the risk of musculoskeletal injuries amongst sonographers, you will in fact find there is a very high incidence of injuries to sonographers' shoulders, necks, wrists and elbows. This is due to maintaining downward pressure during the ultrasound scan, twisting of the neck and lifting. It doesn't take much of an increase in workload to make this become a chronic injury. ...

I have been scanning for over 30 years. I have maintained a satisfactory level of fitness for my work and have been the same weight for 18 years. My level of fitness has not deteriorated in recent years. My work load has increased considerably over the last year and this is the cause of the injury to my trapezius muscles and neck. This is a gradual onset injury caused by my work.

[14] The appellant lodged an application for review.

[15] The Corporation arranged for the appellant to see Dr Yarnall, Occupational Medicine Specialist, on 13 April.

[16] In his report of 15 April 2011, Dr Yarnall stated:

While there was a high prevalence of non specific musculoskeletal problems affecting the upper limbs of sonographers, there is typically non specific pain in the absence of a specific diagnosis or underlying pathology. This appears to be the case with Mrs Muirhead. The specific aetiology of this condition is likely to be complex and multifactorial. ...

Similar musculoskeletal pain syndromes have been described in other occupational groups describing chronic medically unexplained musculoskeletal pain. Typically there is no evidence of any underlying injury as in Mrs Muirhead's case.

...

Although I would not consider that it has been established that this meets the requirement for a gradual process injury, I would consider that Mrs Muirhead's symptoms are related to her occupation and merit further intervention.

[17] In answer to the question whether the appellant had suffered actual damage to the body Dr Yarnall stated:

These types of non specific symptoms are typically linked to musculoskeletal dysfunction, rather than any underlying injury or damage to the body, resulting in dysfunction and pain.

[18] The appellant referred Dr Yarnall's report to Brent Woodley, the physiotherapist who had been treating her. He wrote to the Corporation on 5 May 2011 and stated:

My working diagnosis is that of left C4-6 joint dysfunction secondary to postural overload and thoracic stiffness. This will have initially presented as an acute joint strain on the left C4-6 region which has now developed into more chronic pathology over a 6-9 month period. Her pain is still reproduced when adopting her working posture and intensity is closely related to times spent working.

[19] Mr Woodley confirmed that he felt there was a "definite causal link between her occupation and her current symptoms".

[20] The appellant wrote to the Corporation on 11 May 2011 and said, amongst other things:

Firstly can I say that the physical examination of me performed by Dr Yarnall was at best a gentle prod and in no way examined the injured part of my neck, upper back and upper shoulders. Also Dr Yarnall had no understanding of the progression of pain throughout the working day and he examined me at 9.30 am.

[21] Edie Pont, Occupational Health and Safety Nurse, wrote to the appellant's Case Coordinator on 20 June. She confirmed that in her role as occupational health nurse for Otago Radiology, she had met with the appellant most years since 1999. She noted that she was managing her back and arm pain in 1997.

[22] Ms Pont said:

I have no doubt that Jill's injury is, as she states, work related and caused by the constant repetitive, forceful loading/constrained postures required to carry out the tasks of ultrasound scanning.

[23] Under the heading "history of notes taken from Jill's records", Ms Pont recorded discomfort in the appellant's arm as well as problems with pain in her right Achilles and right knee recorded in 2004. She confirmed her support for the appellant's position.

[24] On 30 June 2011, Dr McLeod, GP, wrote to the Corporation and confirmed that he had seen the appellant in relation to her shoulder pain. He confirmed that the increase in hours and extra driving had led to an increase in her pain. He noted she:

Does have a myofascial pain problem and this is due to her increased work load sitting constantly in the position as described above. In my view this is a gradual onset injury ...

[25] The matter proceeded to review on 6 July 2011 and in a decision dated 2 August 2011, the appellant's application was dismissed. She was referred to Dr Kenneth Orr, Rheumatologist and Musculoskeletal Physician. He examined the appellant and on 16 April 2012 he reported:

My significant findings were:

1. A severe muscle attachment strain at the upper angle of the right scapular at the levator scapulae insertion. In my experience this is the most commonly injured muscle attachment in the whole body and in the last 40 years I have averaged one per day. It is an enthesopathy where some damage to the muscle attachment to the bone has led to some scar tissue formation where the scar catches up some nerve twigs, and whenever it is

pulled on or pushed on or used, produces pain, and as here disappears if it is not stimulated. I treat these as any other enthesopathy, and they respond to low dose corticosteroid ... it is noted that this dose is one tenth of the standard recommended dose. It gives better results, it produces no undesired side effects, no weakening of tendons or muscle attachments, no skin necrosis, with a very low steroid load.

2. The second lesion I found was in the mid portion of the right trapezius insertion, where I found a similar lesion in the middle part of the spine of the scapula. My experience of trapezius enthesopathies are much less common than levator scapulae, probably because the muscle attachment is very much larger. With her concurrence it also was infiltrated with low dose steroid.
3. A third soft tissue problem in the area which was contributing to her problem was a muscle attachment strain in the occipital muscle attachments to the base of the skull on the right side just lateral to the mastoid process. This would contribute to her neck tension, and probably triggers her headaches, and it too was infiltrated with steroid.

[26] Dr Orr also added:

In my experience there is no such thing as “non specific musculoskeletal pain”.

Every pain has a cause, and it should be possible to elucidate that cause and having found it, it is usually possible to do something about it.

[27] Following clarification was sought by Mr Sara, Counsel for the appellant.

Dr Orr responded on 24 May 2012 and said:

... enthesopathy are readily palpable because of their extreme tenderness.

They are always traumatic in origin, and represent the residuum of a repair process after a muscle attachment that has been partly detached from the bone. A blood clot becomes scar tissue, and it catches up some nerve twigs that are richly endowed in such a junction, and thereafter there is a tender area which is stimulated whenever the lesion is pressed on, or pulled on by the muscle.

A common example of this sought of lesion is the so called tennis elbow, which can be bad enough to take all the power out of the forearm, because no muscle will contract fully into pain.

The levator scapulae and trapezius are the two suspensor muscles for the shoulder blade, and therefore the whole arm, and as I indicated they are frequently damaged in lifting strains. They do not occur in any way than as a result of trauma.

The problem I found in her right knee was not related to the shoulder girdle problems, and represented the residuum of a different older injury, which now is hopefully cleared up. After I dealt with the residual tenderness in a ligament attachment of a similar nature to an enthesopathy.

[28] A further report was obtained from Dr Walker, a specialist in occupational and environmental medicine and director of Workhouse Christchurch.

[29] He was asked to provide comment on Dr Orr's report and amongst other things, said:

Firstly on the plausibility front, I am not convinced that Dr Orr's levator scapulae insertion or trapezius insertion enthesopathies actually occur in human beings. Enthesopathies occur where tendons attach at the tips of long bones. The attachment are at sites of traction where there is either a bony pit or bony protuberance. Recognised enthesopathy sites are limited and generally restricted to those of tennis elbow, golfers elbow, jumper's knee, plantar fasciitis and achilles insertional tendinopathies. I have worked at ACC for over 11 years and have considered thousands of cases but have never heard of a case of trapezius or levator scapulae enthesopathy. I am not convinced of the diagnosis, the sites of pain here do not have a long bone anatomy and the implicated muscles attached over broad areas.

... secondly, it is necessary to consider to what extent the clinical features are consistent with enthesopathy. However, given what is, essentially an implausible condition and unreported in the medical literature, it is difficult to consider how likely it is that the clinical features are consistent with Dr Orr's diagnoses. ...

Thirdly it is important to consider the extent to which other conditions are more or less likely. The differential diagnosis would also include myofascial pain, fibromyalgia, cervical spondylosis, pain due to sustained muscle activity, rotator cuff pathology, and a chronic pain condition but such conditions cannot be ruled out given that a copy of Dr Orr's clinical assessment has not been provided. ...

[30] Dr Walker's opinion was referred to Dr Orr who responded on 28 September 2013 as follows:

...

Dr Walker is not the first occupational medicine specialist to say he has not heard of enthesopathies involving the levator scapulae insertion.

In all previous cases I have backed up my diagnosis by presenting them with a cured patient, but in this case I have no knowledge of the end result.

My principle regret is in using the term "enthesopathy". I had always previously called these "muscle attachment strains", which they are, but this year I attended a lecture by Professor Dennis McGonagle, professor of investigative rheumatology at the University of Leeds, who has made a particular study of the enthesis, that is the junction of tendon or ligament to bone, and its reaction to mechanical stress, and he pointed out in this lecture and any of the multiple entheses to be found in the body could be strained, and produce a painful lesion, and that there are hundreds of these.

... I am essentially a doer rather than a talker or writer, and have not published any of my findings, but I have given several presentations, mostly to rheumatologists, particularly the rheumatologists in the Auckland area. ... over the last 40 years I have cleared up literally thousands of these problems. I'm sorry that Dr Walker has not heard of them, and worse, implied I have spent those 40 years treating non-existent conditions – with a success rate of better than 90%.

[31] Dr Orr saw the appellant again and reported on 4 December 2013. Amongst other things, he said:

[the appellant] told me she had been virtually symptom free for between 3 and 4 months, but then some of her right shoulder discomfort started to recur, but it was never as bad as when I first saw her.

... as I have stated before, these enthesopathies are always of traumatic origin, which can be a single considerable lift, or many repeated lesser strains.

She brought a page of 9 photos taken at work, and I note that in the bottom right corner is one where she appears to be lifting or positioning a patient, leaning over the patient with her right arm, and to my mind this would be quite adequate to produce the sort of strain we are looking at in the scapular suspensors.

... she had her initial treatment at the end of March, and all was well for 3 months and some discomfort started again.

If this is not a new strain, it is quite possible that with all pain gone, she could forget about ever having a problem around her shoulder, and be in danger of putting rather more power into a lift to position a patient than she had been while conscious of the problem.

[32] On 16 September 2014, Dr Richard Wigley, a consultant in rheumatology and rehabilitation medicine, examined the appellant and reported on 25 October 2014. His report included the following:

Diagnosis:

- (1) Levator scapula enthesopathy bilaterally caused by her work as sonographer.
- (2) Previous De Quervain's disease has almost recovered but this was probably also work induced.
- (3) Transient left tennis elbow (epicondylitis), also attributable to her occupation.
- (4) There is some evidence that she is developing a secondary neuropathic pain syndrome.
- (5) Myofascial pain syndrome. This diagnosis is not confirmed.

...

Questions:

- (1) Is there a physical injury?

Yes. As detailed by Dr Orr the tenderness insertion of the levator scapulae and upper trapezius muscles are damaged causing local inflammation and so a physical injury which takes time to heal.

...

Conclusions:

I am satisfied that she has bilateral strain of the levator scapulae insertion induced by constantly straining over patients while applying considerable force repeatedly turning the neck to see the screen and operating the keyboard over many years. Relief from local injection confirms this diagnosis. Symptoms are unlikely to resolve if she continues her work at the present intensive level. Changing her work hours and intensity may avert or delay the onset of a disabling neuropathic pain syndrome reflecting damage to the central nervous system.

[33] The Corporation obtained a further report from Craig Ball, shoulder and elbow specialist, dated 21 December 2014. While not having had the opportunity to examine the appellant in person, he undertook a literature search and reviewed the earlier reports. He said, in the course of his report:

So in summary there has clearly been a failure to agree on a diagnosis in Mrs Muirhead's case and there appears to be two camps, one believing that she is suffering from a traumatic levator scapulae enthesopathy, the other a more general pain disorder with some myofascial pain attributed to overuse but did not feel that there was a specific injury related to her gradual process claim. Aside from providing my own thoughts on the literature clearly I am not going to be able to come up with a specific diagnosis myself but I think it is important to appreciate in this lady that one documented pathology she does have is cervical spondylosis and we know that in many patients secondary trapezial pain with cervical spondylosis is common, as initially alluded to by her physiotherapist. In addition the clinical examination findings have differed between the treatment providers so clearly there has not been one single site of maximal pain and tenderness. We also know that the literature does suggest that sonographers are pre-disposed to pain problems with the upper with the upper extremity but without specific pathological basis or injury being proposed. Obviously I fully accept that the onset of her symptoms correlated directly to her increase in work load and that is not in question, but with what I have read in documentation so far it is not clear to me that a specific injury has actually occurred and I will discuss this further with my thoughts on the literature.

...

None of the literature I looked at however were disorders primarily related to a physical injury but related to poor posture and the repetitive nature of tasks, often in a bad position. In the case of Mrs Muirhead this has clearly been the case as demonstrated in the series of photographs that were included with the documentation. I think that that is certainly related to the onset of her symptoms but from the documentation provided and from my assessment of the literature I can not find a physical injury to whatever one would like to call Mrs Muirhead's pain and dysfunction. It is I suppose a non specific musculoskeletal pain disorder. Some would call it levator scapulae syndrome, some would call myofascial pain predominantly involving the levator scapulae and trapezius and others obviously may and have called it an enthesopathy.

...

Clearly the problem has been caused by her work as a sonographer and associated with poor posture and the increased work load that she has undertaken and her current pain and dysfunction is directly related to that.

[34] Since Mr Ball raised the possibility of cervical spondylosis being the cause of her symptomology an opinion of Dr Fraser Burling, Rheumatologist was obtained.

[35] In a letter dated 25 March 2015, Dr Burling said, amongst other things:

With regards to commenting on the note of Dr Ball, orthopaedic surgeon, that he is not "able to come up with a specific diagnosis", I think that satisfies the answer to his question that he does not have the training in soft tissue nor the success with soft tissue that has been obtained by Dr Orr, whereas I would expect his dealing with bone injuries to be excellent.

...

I will not go over all the literature as it has already been discussed, but at this clinic the results of our treatments and the response to treatment is much more supportive of the literature done by Professor Dennis McGonagle, which was well summarised by Dr Ball. I disagree with Dr Ball in the opinion that Professor McGonagle's descriptions of enthesopathies do not apply in this situation as the patient's response to treatment would disprove that statement quite emphatically.

In summary, it is one issue to make a diagnosis, but it is another issue entirely to make a diagnosis supported by the outcome of treatment. To put it differently, who is right? The person who makes a diagnosis and successfully treats the patient or the person who theorises but does nothing for the patient. The response to Dr Orr's treatment that Jillian Muirhead is reported to have in the notes was sufficiently dramatic.

[36] Mr Sara obtained a medical report from Tipu Aamir, Pain Medicine Specialist, dated 8 February 2017. Dr Aamir concluded that the appellant fulfilled the criteria of suffering from myofascial pain which he described as:

Aris[ing] from a primary dysfunction of the muscle, which can be a strain or sprain and then becomes associated with local and central sensitisation.

[37] He noted that there was an abundance of evidence in the literature that pointed towards a high prevalence of myofascial pain in sonographers.

[38] He concluded:

In my opinion there is a clear link between her work as a sonographer and development of chronic myofascial pain, which is supported by literature. The current scientific evidence highlights, that work as a sonographer leads to acute sustained overload leading to muscle injury which in turn leads to a cascade of peripheral tissue changes at the muscular level and dysfunction of the central nervous system leading to development of chronic myofascial pain.

[39] Mr Light, Counsel for the Corporation, obtained a further report from Dr Yarnall, on 6 August 2017, primarily focused on Dr Aamir's conclusions.

[40] Dr Yarnall agreed with Dr Aamir that acute or chronic muscle strains/dysfunction resulted in pain, which in turn, could result in central sensitisation and ongoing problems with chronic pain. These outcomes are also influenced by other risk factors such as poor ergonomics, inability to take rest breaks or other psychosocial risk factors.

[41] He agreed with the diagnosis of a myofascial pain problem and that sonographers had a greater prevalence of pain symptoms affecting upper limbs, neck and shoulder girdle.

[42] However, he disagreed that work as a sonographer means acute or sustained overload "leading to muscle injury".

[43] He said:

I disagree that there is evidence of a specific injury in Mrs Muirhead's case (while noting that the literature does note evidence of changes at the cellular level in cases of myofascial and other chronic pain problems). I would characterise Mrs Muirhead's problem as a disorder of muscular dysfunction, resulting in pain and central sensitisation, but without any history of a specific physical trauma, i.e. that this is a primary rather than a secondary pain problem.

[44] He concluded:

I agree that her work as a sonographer is a relevant risk factor for this problem; however the current evidence on the pathophysiology of this condition suggests that this is a primary pain problem, rather than pain which is secondary to a specific physical injury (and it is my understanding that this is the basis upon which ACC declined Mrs Muirhead's claim).

[45] Dr Aamir was asked to respond and provided a report on 15 November 2017. He did not agree that the appellant's pain problem was secondary rather than primary. He was also asked to clarify his opinion concerning the pathopsychological cause of her pain problem, and in particular, what he meant by the term "biological changes in the musculoskeletal subsystem".

[46] It was also put to Dr Aamir that:

In other words Dr Yarnall is saying Mrs Muirhead has a pain problem without there being any physical injury at all.

[47] Mr Aamir referred to 2014 research of Fernandes De Las Penas and Dommerholt who wrote:

Development or activation of TRP (trigger points – cardinal features of myofascial pain) can result from a variety of factors, including repetitive muscle overuse, acute muscle overload, repetitive minor muscle trauma.

[48] Referring to the study of Gurdle, B and others, 2014, that reviewed microdialysis studies to look at changes in muscle in myofascial pain, Dr Aamir said:

They have reviewed literature from 1999 to 2014 and conclude that several studies showed elevated levels of 5-HT, glutamate, lactate and pyruvate indicating peripheral muscle alteration in the case of myofascial pain.

The current literature indicates that micro trauma due to repetitive muscle overuse can lead to changes at a microscopic level in the muscles which lead to production of chemicals which are algogenic (pain inducing) and stimulate pain receptors peripherally.

In my opinion Mrs Muirhead's work as a sonographer has involved micro trauma due to repetitive muscle overuse which in turn has led to known pathophysiological changes which are properly classified as a physical injury.

[49] Given the importance of the issue, a panel of specialists was convened. The panel comprised of Professor Des Gorman (physician), Dr Tipu Aamir (psychiatrist and pain specialist), and Dr John Cullen and Dr Stewart Walsh (orthopaedic surgeons). They reported through Professor Gorman on 1 September 2019.

[50] The panel considered nine questions:

1. Does the subject currently suffer from a physical injury and if so what is it?

Answer: With the exception of one panellist who thought any aetiological argument to be speculative, the panel was otherwise unanimous that the subject suffered a physical injury.

As to what the injury was there appeared to be two answers:

1. Cervico-scapular dysfunction.
2. Myofascial pain disorder.

2. Is the pain the subject experiences a consequences of a physical injury that has either resolved or developed into a pain condition?

The panel's response to this question was aligned to that for question 1. Other than the panellist who regarded any aetiology as speculative, the panel was unanimous in their opinion that the subject's pain is a consequence of a physical injury.

Panellists' comments regarding this included:

Repetitive biomechanical overload to cervical facet joints through repetitive work and poor ergonomics leading to neural irritation and secondary muscle spasm and trigger points.

And from another panellist:

The subject has worked as a sonographer for over 30 years. There is a history of very high work load. There are a number of risk factors that have likely predisposed her to develop the condition. These include:

High scan frequency, habitual arm abduction and applying pressure to transducer.

And another commented:

The likely pathophysiological mechanism is repetitive muscle overuse which has likely led to microtrauma leading to change in the electrolyte balance and shortening of muscle fibres.

3. Is it probable that the subject suffers from a pain condition without there being any antecedent physical injury at all?

The panel response was consistent with that of the first two questions – the panel view is that the answer to this question is that the subject's pain syndrome is highly unlikely to have arisen de novo.

In regard to question 3 Professor Gorman says:

A detailed response from one of the panellists well summarises the view and is cited below.

In my opinion, even though there is the absence of one single incident where force was applied leading to disruption of the tissue, the subject was exposed to microtrauma over a sustained length of time which initiated the process of a disorder of central pain modulation as described below.

- 4. If someone satisfies the clinical criteria of a myofascial pain syndrome, does this indicate that at some time or stage they had muscle damage?**

The panellists' views were again consistent with their earlier responses; antecedent muscle damage is almost certain in this context.

- 5. If the subject of this consideration satisfies the clinical criteria for a myofascial pain syndrome, what is the likelihood that this condition is caused by the subject's work process – implausible and highly unlikely, plausible but unlikely, plausible and likely, or almost certain.**

In answer to question 5 the panel were unanimous in the view that the subject's pain condition is an almost certain result of her work process.

- 6. Given the literature cited here, should myofascial pain syndromes be considered as an occupational disease of sonographers?**

The unanimous panel view is that myofascial pain syndromes should be considered an occupational disease of sonographers.

- 7. If the subject of this consideration satisfies the clinical criteria for a levator scapulae (or other) enthesopathy, does this indicate that at some time or stage the subject had damage to a tendon or ligament insertion into bone?**

The panel's response was that:

If the diagnostic criteria for a enthesopathy are met then the panel response was that some antecedent trauma was highly likely. One panellist considered that any aetiological discussion was speculative.

All panel members however attributed the subject's health problem to her work.

- 8. If it is assumed that the subject satisfies the clinical criteria for a levator scapulae (or other) enthesopathy what is the likelihood that the subject's condition is caused by her work process?**

The panel agreed that the subject's condition was highly likely to have been caused by her work process.

- 9. Given the literature cited here should levator scapulae (or other) enthesopathies be considered as occupational disease of sonographers?**

The panel was unanimous in the view that levator scapulae (or other) enthesopathies should be considered an occupational disease of sonographers.

The Appellant's Submissions

[51] Mr Sara, Counsel for the appellant, took the Court through the saga of medical reports in this case from 2011 until 2019.

[52] He says that the Corporation's position that the appellant has not suffered any injury is in effect, a policy decision. However, the position is now clarified in the appellant's favour by virtue of the weight of the medical reports that have been obtained.

[53] Referring to the Act, Mr Sara submits that the appellant satisfies the test for a personal injury caused by a work-related gradual process.

[54] He refers to s 26(1)(b), namely that a physical injury has been suffered by the appellant.

[55] Mr Sara refers to s 30 relating to personal injury caused by work-related gradual process and submits that the personal injury suffered by the appellant was caused by a gradual process; that in terms of s 30(2) the appellant performed an employment task that had a particular property or characteristic and the particular property or characteristic caused or contributed to her personal injury and for the purposes of s 30(2)(c) the risk of suffering personal injury is significantly greater for persons who perform the employment tasks of the appellant than for persons who do not perform it.

[56] He notes it is the emphatic view of Professor Gormon's panel that the appellant has suffered a physical injury. He also notes that the panel was of the view that the antecedent muscle damage was almost certainly caused the development of her myofascial pain syndrome.

[57] Mr Sara notes that the panel also went on to say that the alternative physical injury diagnosis offered by Dr Burling of levator scapulae enthesopathy was also work-related.

[58] Mr Sara refers to what the Chief Justice said in the Supreme Court decision of *Allenby v H*:¹

If a “sprain or strain” amounts to personal injury, impregnation (with its profound impact on the physiology of the woman) is properly seen as a physical injury for the purposes of the definition of “personal injury” adopted by the legislation. It must be interpreted in the light of the purposes of the Act which are concerned with establishing entitlements for impairment, rehabilitation, and treatment.

[59] Mr Sara says in light of that approach, the line of cases which have suggested that changes at a cellular level cannot amount to a physical injury, can no longer be regarded as authoritative.

[60] Mr Sara submits that there is unanimity amongst all the medical experts that the appellant’s work as a sonographer had the requisite noxious tasks that resulted in her suffering a pain condition. Therefore, the issue of causation is put beyond doubt.

The Respondent’s Submissions

[61] Given the fact that there have been substantial reports addressing the issues in this case over eight years, the issues have narrowed.

[62] Mr Light refers to the decision in *Teen v Accident Compensation Corporation*.²

Mr Light submits:

The factual background in *Teen* is similar to the factual background in this case, namely that Ms Teen’s work for Telecom involved keying in data. A diagnosis was also made of a myofascial pain syndrome, although there were also references to fibromyalgia or a chronic pain syndrome. The claim for cover was also made as a work related gradual process injury. Wild J dismissed the application for special leave to appeal to the High Court, upholding Judge Beattie’s decision that ACC had correctly revoked Ms Teen’s cover. Judge Beattie had held that a physical injury was required for cover for a work related gradual process injury. With reference to Dr Wigley’s opinion, a cellular change induced as part of fibromyalgia condition did not constitute a physical injury.

[63] Mr Light also referred to the judgment of Blanchard J in *Allenby* where he said:³

¹ *Allenby v H* [2012] NZSC 33, [2012] 3 NZLR 425, at [18].

² *Teen v Accident Compensation Corporation* [2002] NZACC 244.

[56] As the illustration provided by s 26(1)(b) indicates, “physical injuries” are those suffered by the claimant which have some appreciable and not wholly transitory impact on the person but which are not necessarily long-lasting or ones that cause serious bodily harm.

[64] He also referred to *Studman v Accident Compensation Corporation*.⁴ In that case, Ellis J said:⁵

Although both pain and stiffness may well be symptomatic of an underlying (and potentially qualifying) physical injury, that is not necessarily so. Most obviously, I suppose, pain could just as easily be caused by disease, for which (in general terms) coverage is not extended. It is for that reason that it is, in my view, necessary separately to identify the underlying physical injury with some precision.

[65] Mr Light states that as pain, per se, is not a physical injury, the appeal should be dismissed.

Decision

[66] This is an important case. The fact that almost 10 years has elapsed since the appellant saw Dr Leitch, with increasing upper back and neck pain while working as a sonographer is entirely regrettable. However, in fairness to both the appellant and Corporation, the case posed several challenges. These challenges have included the looseness with which various medical descriptors have been used in medical reports. There were also sincere attempts from both sides to identify all the important durable issues by accurately and sustainably diagnosing the condition that the appellant has. They then needed to determine the interface of that diagnosis with the Act as literally read and as interpreted progressively by the courts.

[67] Although the matter has taken an inordinate period of time to come to Court, the various reports obtained have honed the issues to be determined. During that time, there have been significant advances in the medical understanding of such conditions - exemplified by successive reference to the medical literature as more research data and studies have become available. Indeed, I note that in Professor Gormon’s report on behalf of the panel members of 1 September 2019, reference is made to a publication from January 2018. Therefore, in this case, I have taken more

³ *Allenby*, above n 1, at [56].

⁴ *Studman v Accident Compensation Corporation* [2013] NZHC 2598.

time and care to set out the conclusions of the reports that have been obtained since 2011.

[68] With this approach, the path towards determining this appeal is much helped as something of an inquiry into the relevant matters that have followed from it. The result is that, with the report of the Independent Doctors Assessment Services of 1 September 2019, the path to the conclusion of this appeal becomes relatively straight forward.

[69] It is common ground that the work of sonographers is shown to put them at high risk of myofascial pain. These factors include long scan duration, high scan frequency, use of manually propelled devices, high number of obstetrical scans, habitual arm abduction and isometric static loading, forceful gripping, applying pressure to transducer and habitual rotation of the upper spine.

[70] The appellant in this case attended her GP on 23 February 2011 complaining of increasing upper back and neck pain while working as a sonographer over the previous 6-12 months. She noted in her cover questionnaire that she thought her symptoms were due to “increased work load” and driving.

[71] In her letter to the Corporation of 22 March 2011, the appellant said:

My work load has increased considerably over the past year and this is the cause of the injury to my trapezius muscles and neck. This is a gradual onset injury caused by my work.

[72] As to the central issue of whether there had been an injury caused rather than just pain, the Independent Doctors Assessment Services report said:

Yes cervico-scapular dysfunction.

[73] The next question asked of the panel was:

Is the pain the subject experiences a consequence of a physical injury that has either resolved or developed into a pain condition?

The majority answer of the panel (except for one panellist) was that the subject’s pain is a consequence of a physical injury.

⁵ At [26].

[74] The third question asked of the panel was “is it probable that the subject suffers from a pain condition without there being any antecedent physical injury at all?” The same majority answer to this question was that the subject’s pain syndrome was highly unlikely to have arisen de novo.

[75] The following detailed response from one of the panellists summarises the majority view:

In my opinion, even though there is the absence of one single incident where force was applied leading to disruption of the tissue, the subject was exposed to micro trauma over a sustained length of time which initiated the process of a disorder of central pain modulation, as described above.

It is a combination of hypersensitivity of the nervous system (central sensitisation) and impairment of the brain mechanisms to modulate the pain, i.e. dampen down the pain. This phenomena used to be known as diffuse noxious inhibitory control (DINC); the terminology has been changed to conditioned pain modulation (CPM). It is well known that CPM is impaired during a disorder of central pain modulation.

[76] I refer to what Blanchard J said in *Allenby* concerning s 26(1):⁶

[56] As the illustration provided by s 26(1)(b) indicates, “physical injuries” are those suffered by the claimant which have some appreciable and not wholly transitory impact on the person but which are not necessarily long-lasting or ones that cause serious bodily harm.

[77] I conclude that what has occurred to the appellant squarely meets the “illustration” provided by Blanchard J.

[78] I conclude, therefore, that for the purposes of s 26(1)(b), the appellant has suffered a personal injury, meaning physical injury suffered by her. Likewise, I find for the purposes of s 30 of the Act, this personal injury suffered by the appellant was caused by work-related gradual process. For the purposes of s 30(1) the injury was caused by a gradual process in circumstances where she performed employment tasks with characteristics (as earlier described) that has caused or contributed to the cause of her personal injury. For the purposes of s 30(2)(c), the risk of suffering the personal injury was significantly greater for persons who performed her employment tasks than for persons who did not perform them.

⁶ *Allenby*, above n 1, at [56].

[79] Accordingly, the appeal is allowed and the decision of the Corporation of 17 March 2011 is quashed. Cover is provided for the appellant's claim for a work-related gradual process injury.

[80] Should there be any issue as to costs counsel have leave to file memoranda in respect thereof.



Judge C J McGuire
District Court Judge

Solicitors: Mr P Sara, Barrister and Solicitor, Dunedin for the appellant
Young Hunter, Solicitors Christchurch for the respondent