PURSUANT TO S 160(1)(b) ACCIDENT COMPENSATION ACT 2001 THERE IS A SUPPRESSION ORDER FORBIDDING PUBLICATION OF THE APPELLANT'S NAME AND ANY DETAILS THAT MIGHT IDENTIFY THE APPELLANT

IN THE DISTRICT COURT
AT WELLINGTON

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

[2022] NZACC 189 **ACR 375/14**

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

Hearing: 29 August 2022
Heard at: Wellington

Appearances: Appellant in person (via AVL)
Mr I Hunt for the respondent (via AVL)

Judgment: 28 September 2022

RESERVED JUDGMENT OF JUDGE C J McGUIRE
[Section 32 – treatment injury; proof of injury]

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[1] At issue in this appeal is the correctness of ACC's decision dated 15 January 2014 declining the appellant's claim for a treatment injury on the basis that there is in sufficient evidence of an injury, in particular adhesive arachnoiditis, caused by treatment, which accounts for the appellant's symptoms.

Background

[2] On 5 October 1986, the appellant gave birth to her first child at Queen Mary Maternity Hospital in Dunedin. She gave birth to a healthy baby but required an

epidural anaesthetic during labour. The contemporary notes do not mention any complication with this anaesthetic.

[3] While recovering from the delivery, she complained of chest and rib pain. The doctor was informed, and symptoms improved.

[4] In late 1986 or early 1987, the appellant developed chronic pelvic pain for which she was admitted to Dunedin Hospital in June 1987 for investigations. Prior to that she had had menstrual issues and her IUD was removed.

[5] She had a diagnostic laparoscopy to exclude endometriosis; abdominal X-rays; X-rays of the lumbosacral spine; and MRI imaging of the pelvis, brain and lumbosacral spine. These investigations disclosed no explanation for the pain.

[6] The appellant had two further children in 1989 and 1993 and on 8 December 1993 had a barium enema with the clinical note recording- "7 year history of…cramping abdominal pain". In 1996, a chest X-ray and pelvic ultrasound was undertaken and the latter was repeated in 2000.

[7] In 2005, 2006 and 2008, further ultrasounds of her abdomen were completed and in 2009, a CT scan of the abdomen was taken.

[8] There is a report from physician, Dr Schollum, dated 10 July 2006 in which Dr Schollum says:

> I think that she probably does have chronic fatigue syndrome given her symptomology and the fact that we have essentially ruled out any other significant pathology that could cause her symptoms.

[9] In May 2009, the appellant had an injury where she jumped off a surfboard into unexpectedly shallow water and jarred her body. In the following weeks, her lower back pain intensified. On 10 July 2009, the appellant consulted her GP who filled out the ACC claim form. Her GP thought she had sprained her ribs.

[10] On 6 December 2009, she was admitted to hospital for "acute pain after intercourse".

[11] On 18 December 2009, she again consulted her GP who wrote a letter of referral to the hospital gynaecologist for abdominal pains, concerned that the appellant may have endometriosis. On 24 May 2010 she was admitted to hospital and had an IUD inserted. Also, there was a laparoscopic left ovarian cystectomy and left parafimbrial cystectomy.

[12] Further abdominal X-rays and ultrasound of the pelvis were taken in July 2010.

[13] On 20 October 2010, the Dunedin Pain Clinic at Dunedin Hospital gave a diagnosis of central sensitisation – neuropathic abdominal pain. Dr Jones who assessed her on that occasion stated:

> Given that her earliest presentations of persisting pelvic pain were not too long after the delivery of her first child… One may look for the genesis in those events.
>
> …
>
> This seven year history perhaps implies ongoing symptoms after the October 1986 delivery.

[14] On 11 February 2011, associate professor of obstetrics and gynaecology, Professor Gillet was asked to review the appellant. He noted:

> [The appellant's] chronic pain background is very very complicated…

[15] Professor Gillet recommended that her IUD should be removed.

[16] In May 2011, Dr Macaulay, GP, referred the appellant to neurology services at Dunedin Hospital. In the referral letter, Dr Macaulay stated the appellant had become concerned she had multiple sclerosis. Dr Macaulay also noted she had paraesthesia in the inner thighs and hands as well as constipation, pain in the bladder area and poor response to various treatments to control her pain.

[17] On 31 May 2011 the appellant saw consultant neurologist, Dr Mottershead, who noted a prior history of lower pelvic pain beginning in 1986 with multiple gynaecological interventions, input from the pain clinic; chronic fatigue syndrome diagnosed in 2002; an "eating disorder" in 1999; right facial pain around 2009; onset

of sensory symptoms in upper and lower limbs in 2010; lower back pain recently aggravated by lifting; bladder pain and frequent urinary tract infections.

[18] Dr Mottershead noted the appellant had had an MRI scan of the lumbosacral spine which was "apparently unremarkable".

[19] Dr Mottershead described his full neurological examination of the appellant as normal. His conclusion was that she was unlikely to have a significant organic neurological disorder. He organised an MRI brain scan which showed no sign of multiple sclerosis. He also ordered nerve conduction testing which were reportedly normal. There were referrals to Dr Jones, pain specialist, Dr Birmingham, psychiatrist and later, in October 2011, to Professor Wilson, urogynaecologist, after which the appellant underwent a cystoscopy hydrostatic distension, and ladder biopsy.

[20] Further assessments by associate Professor Gillett, Mr East, and Dr Alchin followed in 2012 and 2013.

[21] On 23 September 2013, Dr Morris, GP, submitted an ACC 45 injury claim form on the appellant's behalf. In it the appellant's injury was diagnosed as "FO23.00 left and right".

[22] Under the heading "Accident and Employment Details – Description", Dr Morris wrote:

> In labour with first child, given epidural with Marcain, as needle went in intense pain from sight shooting down right leg.

[23] In October 2013, Dr Morris submitted clinical notes and an ACC 2152 treatment injury claim form on the appellant's behalf. Under the heading "list the injury caused by the treatment", Dr Morris wrote "arachnoiditis".

[24] Under the heading "What treatment gave rise to the injury", Dr Morris wrote:

> Epidural injection 05/10/1986.

[25] Dr Morris noted that the appellant had had multiple treatments by various doctors over the years which had not helped at all.

Appellant's submissions

[26] The appellant told the Court that prior to the epidural injection on 5 October 1986, she was extremely fit and healthy involving herself in gymnastics surfing and cricket at a high level.

[27] She said that when she had the epidural there was a "blinding light pain for one to two seconds". She was aged 17 at the time.

[28] She said the actual birth was fine, but she was extremely nauseous and had ongoing pain in her chest and sternum over the next two days. She said that over the month she developed bladder and bowel issues and that intercourse was painful.

[29] She said that as no doctor was able to find the cause of her pain, she just had to put up with it.

[30] She spoke of the incident whilst surfing in 2009 where she jarred her lower back, jumping off her board in unexpectedly shallow water. She says that from then on, she had chronic pain and chronic neurological symptoms.

[31] Endometriosis was investigated as was nerve entrapment.

[32] During her own researches, she came across adhesive arachnoiditis and she endeavoured to get a diagnosis of this to make a treatment injury claim. She refers to the file review then conducted by Dr Wallis which notes that she had chronic neuropathic pain associated with her previous similar diagnosis and that it is not possible to know whether this is related to her radiological arachnoiditis.

[33] In 2017, she sent her MRI scans of 2011 and 2013 to Professor Thurnher in Austria and on 17 October 2017 received a report with the following conclusion:

> MR imaging findings of two exams (2011 and 2013) are consistent with lumbar arachnoiditis (clumping, thickening and peripheral adherence of the cauda equina nerve routes with empty sac appearance).

[34] Professor Thurnher's report includes still images from the MRI scans with comments in support of her conclusions.

[35] On 4 March 20, the appellant obtained a report from Dr Moriarty relating to the MRI that was performed on 27 May 2019. She refers to what Dr Moriarty said in his report namely:

> This study included thin axial T2 images of the cauda equina, with sagittal and coronal reconstructions.
>
> These show an ambulating appearance to the caudal equina nerve routes in the mid-lumbar region. On coronal views, some of these nerve roots show focal lateral/medial deviation, contacting adjacent nerve roots. There is also possibility non-neuro material linking some nerve roots on axial images. In addition, the right S1 and left S2 nerve routes contact and probably adhere to the postero-lateral margins of the thecal sac.
>
> Whilst there is no definite nerve route "clumping" or "empty sac" typically seen in adhesive and arachnoiditis, I believe the findings noted above are sufficient to make a diagnosis of arachnoiditis.

Respondent's submissions

[36] Mr Hunt acknowledges that this file contains a great deal of medical documentation. He says that ACC's position is that the evidence does not satisfy a conclusion that the appellant suffers arachnoiditis.

[37] He refers to the *Ambros*[1] test in support of ACC's position. He says there is insufficient evidence of a causal link between the epidural injection in 1986 with her presentation since.

[38] Mr Hunt submits that the reports on file from gynaecologist Michael East dated 24 January 2013 do not support the appellant's position as the majority of the pain that she complained of at that time started in 2009 as a surf board accident and a further injury occurred on 14 February 2011 when jolting on a step while carrying a barbeque.

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1 *Accident Compensation Corporation v Ambros* [2007] NZCA 304, [2008] 1 NZLR 340.

[39] Mr Hunt refers to comments in the comprehensive pain assessment report of 4 April 2013 to the effect that the appellant self-diagnosis of adhesive arachnoiditis is seen as being the latest in the series of self-diagnoses.

[40] Mr Hunt notes that the report that the appellant obtained from Antonio Aldrete MD of 9 July 2013 was carried out without a face to face consultation with the appellant. Mr Hunt refers to ACC's Treatment Injury cover decision tool from January 2014 and notes that this report refers to a proposed definition of adhesive arachnoiditis as including "some neurological abnormality on examination, most commonly hyporeflexia".

[41] He notes that the author, Dr Wallis, concludes that:

> There is no convincing evidence that [the appellant] has adhesive arachnoiditis or that a spinal anaesthetic in 1986 caused such a problem.

[42] He next refers to Dr Chamley's treatment injury advice of 30 June 2020 in which the doctor concludes:

> There is no doubt that [the appellant] has significant chronic neuropathic pain, however, on the basis of the information available to me, in my opinion, it is probably not an injury caused by her obstetric epidural in 1986.

[43] Dr Chamley did however confirm his original advice:

> If there was indeed an injury, (which I do consider probable), then it was not an ordinary consequence of treatment.

[44] Mr Hunt comments on the report obtained by the appellant from Dr Matthews of 21 December 2020. He says that Dr Matthew's report is unusual because it appears to suggest how to argue for a diagnosis of arachnoiditis and it provides pointers to support that argument, rather than just purely medical conclusions.

[45] He refers to a report obtained by the appellant from consultant neurosurgeon Mr Finnis dated 21 October 2021 noting that Mr Finnis said:

> Although the diagnosis clinically is sound for an arachnoiditis, there is very little objective evidence for this.

[46] Dr Finnis requested conduction studies or EMG. The study was carried out by Dr Taylor, clinical neurophysiologist, on 11 January 2022.

[47] Doctor Taylor noted that there was no neurophysiological evidence of L5-S1 nerve route injury on either side of lumbosacral plexopathy…

[48] Dr Taylor concluded by saying:

> I know of no neurophysiological manifestation of arachnoiditis so these findings do not contradict that diagnosis.

[49] Mr Hunt submits that this is not a diagnosis of arachnoiditis, and he notes the caution that must be observed when considering what the appellant in this case, as a lay person, puts forward in support of their own appeal.

[50] Mr Hunt refers to Judge Ongley's decision in *Dally*.[2] Judge Ongley emphasised the importance of those offering medical opinions to first qualify themselves as having sufficient skill and expertise in the process of diagnosis that is required in the particular case.

[51] He submits that the evidence in this case is insufficient to warrant a diagnosis of adhesive arachnoiditis and there is insufficient evidence that the appellant's presentation was caused by the epidural that she received in 1986.

Appellant's reply

[52] In replying, the appellant said that commencing in 2009 (following the surfboard incident) her pain symptoms were suddenly more powerful than they were before.

[53] She says she was told to "get on with her life" and she had endeavoured to do so.

[54] The appellant also dismisses the criticism of Dr Aldrete's report saying he is an adhesive arachnoiditis specialist, so he knows what he is looking for when

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[2] *Dally v Accident Compensation Corporation* [1997] NZACC 60.

considering MRI scans. She repeats that none of ACC's experts have examined her either.

[55] She again refers to Dr Moriarty's report of 20 March 2020 as being a diagnosis of arachnoiditis.

[56] The appellant refers again to the evidence relating to causation and said that in her lay person's experience, before the epidural she was fit and healthy, enjoying intercourse and after that her world was shattered.

[57] She again said that her symptoms were consistent all the way through and that "you cannot manufacture symptoms to match a diagnosis."

Decision

[58] When she was 17 in 1986, the appellant was on the 4 October admitted to hospital to have her first child. There, in the course of labour, she received an epidural with a bolus of marcain at 0.5%.

[59] She says that what is not recorded in the medical notes is that she screamed upon the insertion of the epidural. She said:

> I experienced an intense 10 plus scale burning white intensely sharp shooting pain my lower back through my perineum and down my right leg to my foot. Like a lightning bult lasting about 1-2 seconds. I figure this was the "pain upon insertion" and I didn't make a fuss.

[60] Shortly thereafter the appellant experienced pelvic pain.

[61] In a report dated 17 July 1987, Dr Williamson registrar in obstetrics and gynaecology recorded that following her recent admission to hospital to have her IUD removed:

> Her pain has settled down greatly but it is still present as a vague ache which was worst during her last period which occurred last week.

[62] The report went on to say:

> We obviously still haven't got to the bottom of her problem, the possibilities being constipation, pelvic inflammatory disease and endometriosis.

[63] The next report is dated 14 August 1987 from the out-patients department which notes:

> Pulling discomfort –in lower abdomen most of the time. Relieved by rest…dyspareunia remains a problem.

[64] On 19 October 1987, she was admitted to hospital for laparoscopic investigation of her pelvic pain.

[65] The next report produced by the appellant is a radiological report from Dunedin Hospital dated 8 December 1993 which again notes a seven-year history that includes cramping pain.

[66] The appellant mentioned in her oral submissions that she was basically told to get on with her life and she did so.

[67] The next report produced by her is dated 10 July 2006 from Dr Schollum, who noted:

> [The appellant's] symptoms remain much the same. She has fatigue, essentially every day. She does persist with her activities including her amateur photography although she freely admits that this takes far longer than she would like. Her fatigue also limits her ability to manage around the home.
>
> …
>
> I have had a long discussion today with [the appellant]. I think she probably does have chronic fatigue syndrome given her symptomology and the fact that we have essentially ruled out any other significant pathology that could cause her symptoms.

[68] The appellant jarred her back while surfing in 2009 in the process of jumping off her surfboard into what she thought was reasonably deep water, but which was extremely shallow.

[69] She was referred back to Dunedin Hospital by her GP on 18 December 2009. Her GP wrote:

> Thank you for seeing [the appellant] who has been admitted to hospital recently for abdominal pains which have been escalating to the point of admission.

[70] The stance taken by ACC on this appeal appears to be that her pain commenced in 2009 after the surfboard accident. That derives from, in part, what urogynaecologist Michael East wrote in his report of 24 January 2013 where he says:

> The majority of the pain of which she now complains started in 2009 as a surf accident and a further injury occurred on 14 February 2011 when jolting on a step while carrying a barbeque.

[71] Given what I have recorded earlier in this judgment relating to the years before 2009, I do not accept ACC's submission that her pain commenced in 2009.

[72] It needs to be acknowledged that the appellant was an extremely fit and healthy person and she excelled in the sports she loved including cricket, surfing and gymnastics. Likewise, it is not surprising that the three professionals, Dr Alchin, occupational physician, Jane Hunter, physiotherapist, and Diane Wood, pain therapist described her to be "very pleasant, cooperative, clearly intelligent, and thoughtful".

[73] Mr Hunt also relies on a comment in the same report:

> She recently (since your referral letter) Googled "neurological pain" conditions, and found that her symptoms fitted arachnoiditis exactly. She believes this diagnosis (arachnoiditis) that she contracted it from the October 1986 epidural, and that arachnoiditis was lying dormant since then until reactivated by the 2009 surfboard episode.

[74] Once again, in the context of her history and her attitude to life I do not find this reported comment of her as contradicting her narrative of injury commencing in 1986.

[75] The appellant has been criticised from time to time over the many years since 1986, for a series of self-diagnosis. This is unfair. No one has at any time suggested that the appellant has in any way dreamed up or imagined her symptoms. What was plain was that various possible diagnosis were considered over time including

endometriosis, sacroiliac joint dysfunction, chronic fatigue and chronic pain. Her correct diagnosis has proved to be equally elusive for those whom she consulted.

[76] The appellant has likewise been criticised for obtaining "diagnoses" from overseas medical professional who has no opportunity to examine her in the face to face.

[77] This too is unfair. Most of the medical professionals she consulted in New Zealand were reliant on her previous medical notes and in particular her MRI scans. In such circumstances, the advantage of a face to face consultation falls away.

[78] Likewise, it is unfair to conclude in the appellant's case that if the condition were adhesive arachnoiditis it would have been diagnosed before now. The evidence shows that for a long time her condition essentially baffled the medical experts, hence the testing over the years for a variety of other conditions.

[79] It appears from the medical information before me that arachnoiditis, although postulated in medical circles as a discreet diagnosable injury condition from at least 1986 when her injury occurred, is still a diagnosis that is relatively rare. But from the medical information and studies placed before the court there is now consensus in medical circles that it is a discreet and diagnosable injury condition that may follow from the administration of an epidural injection.

[80] What is not questioned by any of the medical experts is that the appellant has chronic neuropathic pain which she did not have prior to her admission to hospital for the birth of her first child and which involved an epidural injection.

[81] In support of the appellant's case is a diagnosis of arachnoiditis by Professor Thurnher dated 17 October 2017. Professor Thurnher is based overseas and was supplied with, amongst other things, the appellant's MRI scans of 15 May 2011 and 8 August 2013. Professor Thurnher concluded:

> MRI imaging findings of two exams (2011 and 2013) are consistent with lumbar at arachnoiditis (clumping, thickening and peripheral adherence of the cauda equina nerve routes with empty sac appearance).

[82] In her report, Professor Thurnher demonstrates her conclusions by reference to still photographs of the actual MRI scans.

[83] In a report dated 4 March 2020, Mr Moriarty, neuroradiologist reviewed more recent MRI of the appellant's lumbar spine from 27 May 2019. He said the images:

> Show an undulating appearance to the caudal equina nerve roots in the mid-lumbar region. On coronal views, some of these nerve roots show focal lateral/medial deviation, contacting adjacent nerve roots. There is also possibly non-neural material linking some nerve roots on axial images. In addition, the right S1 and left S2 nerve roots contact and probably adhere to the postero-lateral margins of the thecal sac.
>
> Whilst there is no definite nerve root "clumping" or "empty sac" typically seen in adhesive arachnoiditis, I believe the findings noted above are sufficient to make a diagnosis of arachnoiditis.

[84] Consultant neurosurgeon Mr Finnis in a report of 21 October 2021 was of the view that her many MRI scans were "essentially normal". He also said:

> Neurophysiology studies, some by myself, have largely been normal with the exception of some irritation of the nerve in one of the studies.

[85] He then said:

> Although the diagnosis clinically is sound for arachnoiditis, there is very little objective evidence for this.

[86] He then asked that necessary nerve conduction studies or EMG be redone.

[87] This occurred on 11 January 2022 by Dr Taylor, clinical neurophysiologist, He noted that he had previously seen the appellant on one occasion in 2011.

[88] Referring to that occasion, he said:

> I made a comment in my report that "a degree of nerve root irritation in the lower lumbosacral spine is not excluded". Not that I found evidence of this. Nerve irritation as opposed to nerve injury does not manifest neural physiologically and is therefore a conclusion based on symptoms in the absence of detected pathology.

[89] Under the heading “Summary/Recommendations”, he says this:

> There is no neurophysiological evidence of L5 or S1 nerve root injury on either side nor of lumbosacral plexopathy. There is also no evidence of peripheral neuropathy in the lower limbs which excludes this as a possible cause of [the appellant’s] distal sensory symptoms. I know of no neurophysiological manifestation of arachnoiditis so these findings do not contradict that diagnosis.

[90] Mr Hunt submits that the Court in this case is left in a position where it may not in accordance with *Ambros*[3] draw robust inferences of causation and that it cannot draw valid inferences based on facts supported by evidence but must rely on supposition or conjecture.

[91] I disagree.

[92] Dr Taylor says, in his report, nerve irritation does not manifest neurophysiologically and is therefore a conclusion based on symptoms in the absence of detected pathology. He excludes peripheral neurapathy and says that his findings do not contradict a diagnosis of arachnoiditis. In the appellant’s case the symptoms have been ongoing and documented for 34 years.

[93] Notwithstanding Dr Taylor’s comment on nerve irritation, Mr Finnis acknowledges “irritation of the nerve” in one of the MRI studies. He also acknowledges that “the diagnosis is clinically sound for arachnoiditis.”

[94] I find in this case that I can, on the balance of probabilities, make a robust conclusion that the appellant suffered a treatment injury as a result of the epidural injection in 1986, and that the injury caused is adhesive arachnoiditis. There is no doubt whatever that the appellant, since 1986, and especially from 2009, has suffered the lumbosacral pain that she describes. Indeed, none of the medical professionals has suggested that the pain she experiences is not real.

[95] Accordingly, the appeal is allowed and ACC’s decision of 15 January 2014 declining the appellant’s claim for a treatment injury is reversed.

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3 See *Ambros* n1.

[96] Should there be any issue relating to costs, the parties have leave to file memoranda in respect thereof.

Judge C J McGuire
District Court Judge

Solicitors: Young Hunter, Christchurch