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Indexed as:
C.L.M. (Re)

IN THE MATTER OF an appeal by C.L.M.
AICAC File No.: AC-98-23

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[1998] M.A.I.C.A.C.D. No. 36

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Manitoba Automobile Injury Compensation Appeal Commission
J.F.R. Taylor, Q.C. (Chairperson), C.T. Birt, Q.C. and
F.L. Cox

Heard: October 20, 1998.
Decision: November 12, 1998.
(28 paras.)

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Issues(s):

Whether Appellant entitled to continued chiropractic care
at insurer's expense.

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Relevant Sections:

Section 136(1) (a) of the MPIC Act and Section 5 of
Manitoba Regulation 40/94.

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Appearances:

Manitoba Public Insurance Corporation ('MPIC') represented by
Joan McKelvey.

The appellant, C.L.M., appeared in person.

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MAIC NOTE: THIS DECISION HAS BEEN EDITED TO PROTECT THE
PERSONAL HEALTH INFORMATION OF INDIVIDUALS BY REMOVING
PERSONAL IDENTIFIERS AND OTHER IDENTIFYING INFORMATION.

REASONS FOR DECISION

[para1] C.L.M., [text deleted] years of age at the time,
was the victim of a rear-end collision on the 8th of December
1995, in Winnipeg. C.L.M. 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.

[para2] C.L.M. is a systems administrator in the employ of the [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.

[para3] She first consulted her chiropractor, Dr. Daniel Schaeffer, on December 11th, 1995. Dr. Schaeffer's report of January 12th, 1996 reflects complaints by C.L.M. 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. Dr. Schaeffer prescribed spinal adjustments three times per week. Dr. Schaeffer's next report results from an examination of April 26th, 1996, in which Dr. Schaeffer reports that C.L.M. 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. Dr. Schaeffer classified C.L.M.'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.

[para4] Dr. Schaeffer'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 C.L.M. 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.

[para5] By March 19th of 1997, following an examination of that same date, Dr. Schaeffer again notes that C.L.M. 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, Dr. Schaeffer now diagnoses C.L.M. 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.

[para6] Since, by early June of 1997, C.L.M. had received 81 adjustments from Dr. Schaeffer over a period of some eighteen months following her accident, MPIC referred her for an independent chiropractic assessment by Dr. Rick Corbett, upon whom she attended on June 24th, 1997. Dr. Corbett's report of June 27th, 1997 reflects complaints by C.L.M. 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. Dr. Corbett reported grip strength as being normal bilaterally, deep tendon reflexes were graded 2+ bilaterally symmetrical and sensation was also normal bilaterally. C.L.M. had reported a pre-existing disability in the form of a "twisted pelvic bone" of which, although Dr. Corbett understood that that problem had been cured some time prior to the motor vehicle accident, the evidence of C.L.M. 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.

[para7] C.L.M. also reported to Dr. Corbett 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 Dr. Schaeffer had been passive, and no active exercises had been prescribed for her other than advice to walk and to work out with light weights.

[para8] After a very thorough series of tests, Dr. Corbett concluded that, as a result of her motor vehicle accident, C.L.M. 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 C.L.M. 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". Dr. Corbett felt that the treatment plan proposed by Dr. Schaeffer was neither reasonable nor necessary and that Dr. Schaeffer 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 C.L.M., Dr. Corbett 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 C.L.M.'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, C.L.M. stated that she felt alright.

[para9] A copy of Dr. Corbett's report was forwarded to Dr. Schaeffer, who was asked to complete a new chiropractic treatment plan report and, after a re-examination of C.L.M. on July 28th, 1997, Dr. Schaeffer provided the requested report, in which he repeats his diagnosis or classification of a WAD 3(a) injury and indicates that C.L.M. 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 Dr. Russell Baron, MPIC chiropractic consultant, from a paper review of all chiropractic reports respecting C.L.M. 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, Dr. Schaeffer goes on to note significant and dramatic neurologic findings. Specifically, Dr. Schaeffer 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 Dr. Corbett. Unfortunately, there is no explanation given in this report as to why there is such a dramatic change in the claimant's reported signs. Dr. Schaeffer 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).

[para10] On November 10th, 1997, either by way of referral from Dr. Schaeffer or on her own initiative, C.L.M. attended upon Dr. Henry Pops, a chiropractor at the Kildonan Park Chiropractic Centre. His report reflects complaints by C.L.M. of headaches, light-headedness, 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. C.L.M. 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 Dr. Pops 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. Dr. Pops 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 "match stick 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 Dr. Russell Baron notes, "these neurological findings are significantly different from those provided by both Dr. Schaeffer and Dr. Corbett". Dr. Corbett essentially provided us with a normal neurologic exam at the end of June 1997. In July 1997, Dr. Schaeffer provides us with a neurologic exam as described above. Neither exam is consistent with that provided by Dr. Pops.

[para11] Dr. Pops diagnosed traumatically induced fibromyalgia, post-concussive syndrome 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 C.L.M., positive response on fourteen of eighteen "tender spots" which led him to diagnose "traumatically induced fibromyalgia".

[para12] Dr. Schaeffer, by way of a letter on April 28th, 1998, agreed with Dr. Pops.

[para13] Being concerned that Drs. Pops's and Schaeffer's reports seem to indicate the presence of post-traumatic fibromyalgia and other neurological deficits that were still present almost exactly two years following C.L.M.'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 C.L.M. for an independent neurological assessment to Dr. Andrew Gomori.

[para14] Dr. Gomori notes, in the course of a very thorough neurological report, that C.L.M. had indicated that she had been reducing her physical activities during the two and a half years that she had been attending Dr. Schaeffer 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 Dr. Schaeffer, 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 Dr. Schaeffer, that the deterioration in C.L.M.'s condition was in some way directly related to the independent examination performed by Dr. Corbett. In our

respectful view, that suggestion borders on the ludicrous and is entirely unsupported by any other evidence. Indeed, C.L.M. herself has stated that her symptoms got worse when she increased her activities - a statement borne out by the reports of Dr. Corbett, Dr. Pops and Dr. Baron.

[para15] Dr. Gomori expresses the view that C.L.M., 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 Dr. Schaeffer. Dr. Gomori reported that few, if any, of the complaints reported in Dr. Corbett's letter of June 27th, 1997 were voiced by C.L.M., and none of the symptoms documented by Dr. Pops in his report of December 1st, 1997 was mentioned by C.L.M., even on direct questioning. Dr. Gomori 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.

[para16] Of major import, in our view, is that Dr. Pops recorded that C.L.M. had suffered "head injuries" which, as Dr. Gomori points out, clearly is not the case. Dr. Gomori goes on to say;

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

[para17] Dr. Gomori describes certain electrodiagnostic tests apparently performed by Dr. Pops as being impossible to interpret and holding no credibility as far as any disease process is concerned.

[para18] Dr. Gomori, further, agrees with Dr. Corbett that home exercises would be sufficient as well as activities of daily living. He expresses the view that C.L.M. does not require ongoing chiropractic manipulations which, in fact, coincided with the subjective worsening of the patient as documented by Dr. Schaeffer and Pops. Dr. Gomori completely agrees with Dr. Baron 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 Dr. Gomori's view that C.L.M. needs no ongoing therapy but, rather, reassurance that she does not have any residual physical damage. Dr. Gomori believes, as does this Commission, that C.L.M. 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."

[para19] In his letter of July 6th, 1998 Dr. Schaeffer expressed the view that C.L.M. had sustained "neural trauma" and was now suffering from what he called "classical symptoms of a concussion". Dr. Gomori's supplemental report of October 1st, 1998 refutes both those conclusions quite forcefully.

[para20] We must deal with the diagnoses offered by Dr. Pops:

(a) Traumatically Induced Fibromyalgia

[para21] We note, firstly, that Dr. Pops is the only one of the professional caregivers who have examined C.L.M. 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.

[para22] 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.

[para23] In sum, then, we are of the view that C.L.M. 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

[para24] The evidence to support such a diagnosis is, in our view, slender in the extreme. Firstly, C.L.M. 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, Dr. Gomori expresses the view that, if she had had a portion of her brain slipping through the foramen magnum, as was suggested by Dr. Schaeffer, one would have expected serious neurologic damage, which is in fact not the case. We concur.

(c) Autonomic Concomitants

[para25] 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, Dr. Pops' 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 Dr. Pops, we are unable to draw the same conclusion that he apparently does from the data presented to us. Dr. Pops also draws the conclusion that C.L.M. 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 C.L.M. 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 Dr. Pops.

DISPOSITION:

[para26] C.L.M.'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. C.L.M. seeks the reinstatement of those payments from the date of their termination up to the 28th of April 1998.

[para27] We find that C.L.M. 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 C.L.M.'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. C.L.M. had started to increase her physical activities, upon Dr. Schaeffer's advice, prior to her examination by Dr. Corbett; we find that Dr. Corbett's examination was totally unconnected with the quite sudden and dramatic increase in her reflex changes and in the neurological deficits recorded by Dr. Schaeffer 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 Dr. Schaeffer or Dr. Pops. The recommendations of Dr. Corbett, Dr. Baron and Dr. Gomori 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.

[para28] 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 C.L.M.'s motor vehicle accident and the present appeal must, therefore, be dismissed.

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