2018 ONWSIAT 109
Ontario Workplace Safety and Insurance Appeals Tribunal

Decision No. 2942/17

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DECISION NO. 2942/17

R.E. Salisbury V-Chair, S.T. Sahay Member, I. Thompson Member

Heard: September 28, 2017
Judgment: January 11, 2018
Docket: 2942/17

Counsel: J. Johal, for Worker
No one for Employer

Subject: Employment; Occupational Health and Safety; Public
Headnote
Labour and employment law

DECISION UNDER APPEAL: WSIB Appeals Resolution Officer (ARO) dated October 30, 2014

***R.E. Salisbury V-Chair, S.T. Sahay Member, I. Thompson Member*:**

(i) The appeal

1 The worker appeals a decision of the Appeals Resolution Officer (ARO) dated October 30, 2014. The ARO decided that the worker did not have ongoing entitlement for tendonitis and carpal tunnel syndrome, or bilateral wrist surgery, arising out of the worker's compensable January 19, 2012 repetitive strain injury.

2 The issues before the Panel therefore are whether the worker has:

1. Entitlement for bilateral carpal tunnel syndrome and tendonitis arising from the worker's January 19, 2012 repetitive strain injury,

2. Entitlement for bilateral wrist surgery arising from the worker's January 19, 2012 repetitive strain injury.

(ii) Background

3 The worker, now age 53, has been employed with the accident employer since February 1988. As reported on the Worker's Report of Injury Form 6, the worker, on January 19, 2012, while performing her regular work duties of loading beverage cans and bottles into trolley drawers for airline passenger consumption, felt numbness in her fingers and going up her forearms. The worker reported that she was unable to hold on to anything. The worker reported that she had first noticed similar difficulties two to three months prior to January 19, 2012. The worker returned to her job duties and did not lose any time or pay.

4 In Board Memo #4, dated February 14, 2012, the worker was allowed healthcare benefits for a bilateral hand, gradual onset injury. This allowance was based upon consideration of a Health Professional's Report Form 8, dated January 27, 2012, from Dr. Rakesh Uppal, family physician. Dr. Uppal advised the Board by that Form 8 that he had diagnosed the worker on January 27, 2012 as having incurred a bilateral repetitive strain injury to her hands.

5 The accident employer, following the worker's report of injury, provided the worker with modified duties with reduced performance and lifting requirements. The worker commenced physiotherapy treatment twice a week.

6 On April 17, 2012 the worker underwent an assessment at the WSIB Regional Evaluation Center by Dr. Christopher H. Gallimore, orthopaedic surgeon, and Ms. Abbey Thawer, physiotherapist. The opinion of Dr. Gallimore and Ms. Thawer, following their assessment of the worker, was that the worker had incurred a bilateral strain to her hands and that after three more weeks of active rehabilitation, the worker would be able to resume her regular duties in a graduated manner. Dr. Gallimore and Ms. Thawer reported that they did not anticipate that the worker would have any permanent impairment.

7 On May 9, 2012, the worker's Case Manager (CM) advised the worker by letter that it had been determined that the worker would be able to resume full regular duties by May 28, 2012. The worker was deemed by the Board as of June 4, 2012 to have achieved maximum medical recovery with no permanent impairment. The CM advised the worker that her claim file with the Board would be closed as of June 4, 2012.

8 The Board, subsequent to the CM's letter of May 9, 2012, allowed the worker further physiotherapy treatment through June 2012 but denied a request by the worker for compensation for the purchase of compression sleeves. The CM determined that compression sleeves were medically unnecessary for the diagnosed injury of bilateral hand strain.

9 By letter dated June 25, 2012 the worker objected to the CM's decision that the worker had achieved full recovery. The worker stated in part:

> My request for reasonable accommodation from my employer was an attempt to avoid permanent impairment and to have full recovery to continue my employment as prior to the restriction.

10 The worker returned to her regular duties in August 2012 after being accommodated with modified duties from January 19, 2012. The worker was on vacation and did not work for approximately one month during July 2012.

11 On September 11, 2013 the worker wrote to the Board and stated in part:

> I am enclosing a letter from Doctor Glynis Koponen indicating that I need an operation for both hands. I am waiting for a date for the surgery. I am requesting WSIB financial assistance during the period that I will be away from work and recovering.

12 On December 10, 2013, the worker's representative contacted the worker's CM and advised that the worker was scheduled for a right wrist carpal decompression surgery on January 8, 2014, with left wrist surgery pending.

13 The CM wrote to the worker on December 31, 2013 and advised that the worker's claim for ongoing entitlement was denied. The CM stated, in part, that the reasons for this decision were:

> This letter is to confirm that a review has been undertaken in your claim and an opinion has been obtained from our medical consultant. It has been determined that after reviewing the Physical Demand Information Form (PDA) and all the medical information on file, there is not sufficient evidence to indicate your current diagnosis of tendinitis and CTS [Carpal Tunnel Syndrome] is compatible with the job duties or the injury which occurred on January 19, 2012, nor is the current diagnosis compatible with the original diagnosis of bilateral wrist tendinitis and repetitive use.

14 The ARO, as noted, denied the worker's objection to the denial of her claim. In response to a request by the worker for clarification regarding the ARO's determination, the ARO advised by correspondence dated December 14, 2016 that the allowance of the worker's claim was accepted only for a bilateral hand strain. The ARO confirmed that he found no ongoing entitlement for the worker for carpal tunnel syndrome, tendinitis or for bilateral hand surgery.

(iii) The medical evidence

15 Following the Board's recognition of the worker's claim for entitlement for bilateral wrist strain occurring on January 19, 2012, and the Board's closure of the claim in June 2012, the worker underwent an MRI on June 16, 2012. That MRI was interpreted as indicating that the worker exhibited right wrist ECU (extensor carpi ulnaris tendon) tendinosis and tenosynovitis at the level of the wrist and that the worker's left wrist exhibited a dorsal ganglion cyst which communicated with the radiocarpal joint.

16 On June 18, 2012, Dr. Jogindra Singh, physical medicine, absent any reference to the worker's MRI of June 16, 2012, reported that an Electrodiagnostic Study performed by Dr. Singh was interpreted as:

> The motor and sensory distal latencies of both median nerves were significantly prolonged to support the diagnosis of carpal tunnel syndrome of a mild degree, left side being worse than the right.

17 Dr. Singh further reported that on June 18, 2012:

> I injected 1cc of Depo-Medrol with 0.5cc 1% Xylocaine without adrenaline into the left carpal tunnel [of the worker] close to the median nerve which hopefully will be quite helpful in getting rid of the pain with numbness and tingling in her hand. She was advised to apply ice locally on the injected area for 10 minutes once or twice daily, and wear a wrist brace all of the time if possible for a few days.

18 On June 25, 2012 Dr. Singh reported that following the injection of Depo-Medrol and Xylocaine into the worker's left wrist a week previously, the worker had become free of numbness and tingling in her left hand. Dr. Singh advised that if the worker started complaining again of numbness and tingling in her left hand after returning to work, that the worker could be referred to a surgeon for surgical decompression of the median nerve on the left side.

19 On September 9, 2013, Dr. Glynis Koponen, neurologist, reported her diagnosis that the worker suffered from tendonitis, carpal tunnel, and soft tissue pain from work-related issues. Dr. Koponen further advised that the worker would be required to be off work for approximately one month following surgery for carpal tunnel syndrome.

20 On November 4, 2013, Dr. Vivek Panchapakesan, surgeon, confirmed a diagnosis of bilateral carpal tunnel syndrome for the worker and proposed to operate on the worker's right hand first, followed by the worker's left hand two to three months later. Dr. Panchapakesan reported in part:

> [The worker] was seen today for assessment of bilateral carpal tunnel syndrome. There have been symptoms of numbness and tingling in both hands for months, equal in both hands. She is right hand dominant. Her work entails loading and unloading beverage carts for airplanes. The numbness is occurring in the median nerve distribution. The numbness is intermittent and there is a history of night waking. Previous interventions have included night splinting as well as steroid injections.

21 On December 21, 2013, a Board Medical Consultant, Dr. A.D. Kanalec, advised that following his review of the available clinical information regarding the worker he found:

> 1. In summary based on review of the PDA and all the clinical information imaged for my review I cannot relate the diagnosis of tendinitis and CTS specifically with job duties but there may be some soft tissue pain associated with any full-time work activity at the end of the day but this would most likely be transient and not permanent.
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> 2. I do not believe the diagnosis of tendinitis, carpal tunnel syndrome is compatible with the original diagnosis dated January 27, 2012 of bilateral wrist tendinitis and repetitive use. Laborers can typically suffer from soft tissue discomfort after work day which is transient and not permanent. There appear to be some generalized soft tissue findings noted by Dr. Gallimore during his regional evaluation center report which tends to support a degree of reporter bias.

3. I do not believe that the bilateral CTS surgery is in order for this injury based on the very nature of her job and review of the PDA.

22 On January 8, 2014 Dr. Panchapakesan performed a right open carpal tunnel release and right median nerve block on the worker. There was moderate inflammation of the median nerve found in the worker's right wrist as it passed through the carpal tunnel.

23 The worker has not undergone carpal tunnel surgery on her left side. On March 24, 2017 Dr. Koponen reported that she could find no consistent electrical signs for carpal tunnel syndrome on the worker's left side and questioned whether the worker's reported continued discomfort might be due to arthritic or soft tissue pain.

(iv) The worker's testimony

24 The worker testified that she started working with the accident employer in 1988. She stated that her current job was that of "bar builder." The worker testified that she has been performing her bar builder duties since 1990. In her role as a bar builder the worker is responsible for loading trolley tray drawers at her work station with beverages that include cans and bottles of pop, beer, wine and water. These trolley tray drawers are in turn loaded into a trolley which is taken aboard an aircraft where flight attendants access the trolley drawers to deliver drinks to passengers.

25 The worker testified that her role in the trolley tray drawer loading process involves taking the full beverage containers and loading them into trolley tray drawers, and then lifting the loaded drawers into a trolley. The worker then pushes the full trolley to a doorway where it will be retrieved by another worker for delivery to an aircraft. Occasionally the worker is required to clean out the trolley tray drawers.

26 The worker confirmed that her workload is varied and depends upon the number of flights that have to be replenished during an eight hour shift. The worker stated that for the largest aircraft, 36 drawers of beverages are required. Each trolley tray drawer holds 20 cans of pop or beer. Water and juice is supplied in larger containers, and the worker testified that 15 of the larger bottles are loaded into a trolley. The worker estimated that she would cover 15 flights in a shift with on average five trolleys per flight.

27 In describing the pulling and pushing required to load trolley tray drawers into a trolley, the worker testified that five to six years ago the trolleys were loaded with metal drawers which sometimes got stuck. The worker stated that sticking trolley drawers had not been a problem for five to six years as the trolley system had been switched over to the use of plastic tray drawers.

28 The worker testified that on January 19, 2012 she was working early in the morning loading trolley tray drawers with beverage containers and she felt pain in her fingers. She had difficulty picking up beverage cans.

29 The worker recalled that she saw her family doctor in January 2012, Dr. Uppal, and told him about the pain in her fingers. The worker recalled that she was told by Dr. Uppal that she might have arthritis.

30 The worker recalled that after seeing her family doctor in January 2012, she was given pain medication and started going for physiotherapy. The worker recalled that she attended physiotherapy for two or three months. The worker stated that she found the pain medication difficult to take. The worker confirmed that she was given modified duties by the accident employer but found that neither the medication or the physiotherapy improved her condition.

31 The worker recalled that she saw her family doctor again who sent her to Dr. Singh in June 2012. Dr. Singh gave the worker an injection in her left hand and told her to stay home from work for one week. It was the worker's recollection that she went on vacation for one month after Dr. Singh's injection and that she returned to work at her regular duties in August 2012.

32 In answer to a question from the Panel regarding her activities during the period August 2012 to August 2013, the worker stated that she did not miss any shifts due to her hand and wrist condition during this period. The worker recalled that her family doctor referred her to Dr. Koponen during this period. The worker was sent for blood tests, checked for arthritis and had an EMG. The worker recalled that after all the testing, Dr. Koponen told her she had a muscle strain in her hands and carpel tunnel.

33 The worker testified that she underwent surgery on her right arm for carpel tunnel in January 2014. The worker stated that she was absent from work following her surgery for 10 weeks and qualified for Employment Insurance benefits during this absence.

34 The worker testified that following recovery from her surgery on her right hand that the numbness has gone away but the strain in her right hand remains the same. The worker is using a lotion which she rubs on her hands and has not gone ahead with surgery for her left hand.

(v) Submissions of the worker's representative

35 It was submitted on behalf of the worker that the Board and the ARO in denying the worker benefits had incorrectly concluded that the worker's duties were not sufficiently forceful and repetitive to have contributed to the worker's onset of carpal tunnel syndrome or the necessity for corrective bilateral wrist surgery. The Panel's attention was directed to the Physical Demands Information Form contained in the Case Record as well as the worker's testimony regarding the repetitive nature of the work that required the worker to place hundreds of beverage containers into trolley tray drawers during an eight hour shift. The worker's representative pointed out that the worker's attending physicians had attributed the worker's conditions and need for surgery as being work related.

(vi) Law, policy and medical discussion paper

36 Since the worker was injured in 2012, the *Workplace Safety and Insurance Act, 1997* (the "WSIA") is applicable to this appeal. All statutory references in this decision are to the WSIA, as amended, unless otherwise stated.

37 Pursuant to sections 112 and 126 of WSIA, the Appeals Tribunal is required to apply any applicable Board policy when making decisions. Pursuant to WSIA section 126, the Board has identified certain policies applicable to this appeal. We have considered these policies as necessary in deciding this appeal. In particular, we have considered Board Policy packages: 1; 38; 300.

38 Dr. B. Graham prepared a Medical Discussion Paper on carpal tunnel syndrome for the Tribunal in February 2000 (revised in May 2001, Illustrations added March 2003). This paper was included in the case materials. Dr. Graham describes the epidemiology of carpal tunnel syndrome as follows:

> Carpal tunnel syndrome is widely held to be a very common clinical condition... However, the exact prevalence of this condition in industrialized economies like Ontario, has not been reliably established...Recent studies of local populations in Scandinavia documenting symptoms confirmed by physicians as due to carpal tunnel syndrome, indicate that the prevalence is no higher than between 2 and 4%. The literature also suggests that the prevalence among working individuals in somewhat lower, about 0.5%. This suggests that the majority of cases occur in the non-working population and this reflects the experience of most experienced clinicians.
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> While it is possible that different work activities may expose workers to a variable risk of developing symptoms of carpal tunnel syndrome, an assessment of the independent effect of the workplace as an etiologic factor is hampered by wide variations in the diagnostic criteria used it identify carpal tunnel syndrome.

39 Dr. Graham comments about workplace conditions and their potential contribution to the development of carpal tunnel syndrome as follows:

> Where the relationship between exposure to repetitive hand use and carpal tunnel syndrome has been carefully studied, no significant increase in the risk of developing this condition can be identified. In rare circumstances, where a clear temporal linkage between the development of symptoms and their relief, in relation to a given exposure, can be reliably and repeatedly identified, then a major criterion for causality may be met. Other issues which should have an impact on establishing causality include a dose response relationship and a plausible biologic basis, both of which are largely lacking in most, though not all, instances where there is held to be a work-related etiology for carpal tunnel syndrome.
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> **Repetitive movements and exacerbation of a pre-existing or intermittently symptomatic state of carpal tunnel syndrome**
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> The role of repetitive movements has been alluded to above. The data available on this subject suggests little if any relationship between this type of exposure and carpal tunnel syndrome. The exception would be in instances where the repetitive activity requires both frequent and forceful movements. Guidelines for defining a critical frequency and degree of force can be inferred from these reports. Where there is a pre-existing diagnosis of carpal tunnel syndrome which is claimed to be exacerbated by a work activity, the same issues in establishing causality pertain as in establishing work-relatedness in general. Carpal tunnel syndrome is known to be a condition that is characterized by both exacerbations and remissions and so the effect of modified work, absences from work and ergonomic modifications to the workplace are difficult to measure. Similarly, the status of an individual who has apparently been successfully treated for carpal tunnel syndrome and is contemplating a return to employment that may be thought to be a risk factor for carpal tunnel syndrome is unclear.
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> **Tenosynovitis and carpal tunnel syndrome**
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> Although an inflammatory condition affecting the tendons is frequently diagnosed, in most cases, there is little or no evidence to support the presence of this type of condition and it essentially represents a diagnosis of exclusion. It is difficult to link the diagnosis of carpal tunnel syndrome to an inflammation of the tendons except in the context of conditions known to cause an extreme degree of inflammation like rheumatoid arthritis. This is rare in the context of carpal tunnel syndrome encountered in the workplace and is usually unambiguous when it does occur.

(vii) Analysis

40 As was commented upon in *Decision No. 1842/09*, the Tribunal has generally found the commentary in the Medical Discussion Paper prepared for the Tribunal by Dr. Brent Graham, entitled, *Carpal Tunnel Syndrome*, to provide a useful context for determining in an individual case whether workplace activities have significantly contributed to the onset of a worker's carpal tunnel syndrome. The Tribunal has generally found that there must be evidence of "forceful and repetitive movements" which contributed to onset.

41 As was also noted in *Decision No. 1842/09*, there is no specific Board policy that addresses the adjudication of carpal tunnel and related surgery claims.

42 The Board allowed the worker's claim for healthcare benefits given the symptom onset on January 19, 2012 and the diagnosed repetitive strain injury. This was the diagnosis provided for the worker by her family physician in January 2012 and described on the Form 8 he submitted to the Board. This diagnosis was confirmed at the WSIB Regional Evaluation Center in April 2012. The CM in allowing the worker's claim for a repetitive strain injury was satisfied that the worker's duties as a bar builder required extensive and repetitive use of the worker's hands.

43 The Panel notes that the diagnosis of the worker's carpal tunnel syndrome was initially made in June 2012 by Dr. Singh. This diagnosis was made after the worker had been on lighter modified duties and had engaged in physiotherapy to address her diagnosed repetitive strain injury for approximately six months. The worker also suggested in her testimony that the month-long vacation she took in July 2012 after being diagnosed with bilateral carpal tunnel syndrome, and her absence from her bar building work duties had had little impact on her symptoms. While not stated directly in her testimony, the Panel was left with an impression that the worker's carpal tunnel symptoms progressed from mid-2012 until surgery was recommended by Dr. Koponen in September 2013. The worker did not describe any changes to her work duties as a bar builder during this period.

44 The Case Record contains a Physical Demands Information Form (PDA) for the work performed by the worker as a bar builder. While that PDA was prepared in August 2005, there was no evidence or submissions before the Panel to suggest that there are any inaccuracies in this document or that the PDA does not reflect the nature of the worker's duties at the time of her claimed injury. The worker's testimony about her work as a bar builder was consistent with the PDA. In describing the work of a bar builder, the PDA states that the general physical demands for the worker's elbow, forearm, wrist and hand are frequent and continuous movement. The forces exerted for gripping are described as light (<2 lbs.), pushing forces are described as medium, and pulling forces are described as light/medium. There are no torqueing or vibratory forces described in the PDA as occurring when performing the work of bar builder. It was noted by the Panel that the January 2012 onset of numbness, as testified by the worker, mostly affected her ability to grip the beverage containers the worker was required to place in the trolley tray drawers. This is an effort which the PDA described as requiring a light force.

45 Based on the evidence, the Panel finds that while the work of a bar builder was certainly repetitive, it cannot be said that the movements described by the worker in her testimony or the measured movements described in the PDA require forceful repetition.

46 The initial diagnosis of bilateral carpel tunnel syndrome for the worker was made in June 2012 by Dr. Singh. That diagnosis was made some six months after the diagnosis in January 2012 by Dr. Uppal that the worker had suffered a bilateral repetitive strain to her hands. Dr. Gallimore, in April 2012, confirmed that the worker's onset of symptoms on January 19, 2012 were due to a bilateral repetitive strain. On February 8, 2013, Dr. Koponen opined on examining the worker that, "Its sounds like CTS [carpal tunnel syndrome] or arthritis pain." On August 23, 2013 Dr. Koponen reported that the worker had "increasing bilateral CTS." A diagnosis of tendonitis and soft tissue pain first appear in Dr. Koponen's report of September 9, 2013 in relation to the reported need for the worker to undergo carpal tunnel surgery.

47 The Panel understands from Dr. Graham's discussion paper that a repetitive strain wrist/hand injury, carpal tunnel syndrome, tendinitis and soft tissue pain are each a distinct diagnosis as are the etiological factors for each diagnosis. It is notable that some of the medical reports in the Case Record do not clearly identify the determined etiology for a given diagnosis. This makes it difficult to ascertain what work related conditions are being attributed as causal to a diagnosed condition. Examples include Dr. Uppal's report dated February 18, 2014 that provides, in part:

> [The worker] had repetitive strain injury to her wrist, which is work related. Her diagnosis is soft tissue injury, tendonitis and carpal tunnel syndrome...

And Dr. Koponen's report dated February 11, 2014 that provides, in part:

> [The worker] has been diagnosed with tendonitis, carpal tunnel, and soft tissue pain from work related issues. She also has repetitive strain which made the pain of the former issues worse.

48 The Panel finds that there is insufficient evidence of substance that the worker was engaged in forceful and repetitive work activities that significantly contributed to the onset of her carpal tunnel syndrome when diagnosed in 2012 or the subsequent diagnoses of accompanying tendinitis and soft tissue pain diagnosed in 2013. The Panel finds that the evidence indicates that the worker's regular job duties were modified in January 2012, to accommodate the worker's

compensable condition of bilateral strain injury and were unlikely to have significantly contributed to the condition of carpal tunnel syndrome as diagnosed in June 2012. Given that the worker testified that following a month's vacation in July 2012 her symptoms remained largely unaffected by this absence from work, this provides further reason to doubt that the worker's work activities were significantly contributing to her diagnosed condition of carpal tunnel syndrome and its progression.

49 The worker performed her regular work duties from August 2012 through to September 2013 without absence at which time she was advised by Dr. Koponen that bilateral surgery for carpal tunnel syndrome was recommended. As noted, Dr. Singh had found in June 2012 that carpal tunnel syndrome was more evident on the worker's left side. The worker underwent surgery in 2014 on her right side but testified that while numbness has been alleviated she still feels a strain on that side. Absent any surgical intervention or change in working conditions for the worker, in 2017 Dr. Koponen reported that there was no consistent evidence for carpal tunnel syndrome on the worker's left side and Dr. Koponen raised a suspicion of arthritic or soft tissue pain.

50 The Panel finds therefore that it has not been established that the worker's work duties which were found to have caused the worker's compensable January 19, 2012 repetitive strain injury made a significant contribution to the development of the worker's bilateral carpal tunnel syndrome as first diagnosed in June 2012 by Dr. Singh and the condition of tendonitis diagnosed as a related condition to carpal tunnel syndrome by Dr. Koponen in September 2013. Accordingly, the worker is not entitled for bilateral carpal tunnel syndrome and tendonitis arising from the worker's January 19, 2012 repetitive strain injury, and the worker is not entitled for bilateral wrist surgery arising from the worker's January 19, 2012 repetitive strain injury. The worker's appeal is denied.

DISPOSITION

51 The appeal is denied.