ACCIDENT COMPENSATION CORPORATION

Te Kaporeihana Āwhina Hunga Whara

Claim Number: 82737342

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11 September 2007

Mr Trevor Smith
55 Tay Street
Mosgiel
Dunedin

Dear Mr Smith

Referral for a specialist medical assessment

I refer to my previous correspondence to you dated 18 June 2007 on the above subject.

ACC has today received Professor Theis' report dated 4 September 2007, following the interview and examination that took place with you on 15 August 2007. I enclose a copy of that report with this letter.

ACC will now consider the content of this report against the questions posed, seek clarification from Professor Theis where and if required, and advise you of the outcome as soon as practicable.

I acknowledge receipt of your facsimiled letter dated 3 September 2007. I will be responding to this letter in the near future. I also acknowledge and note the content of your facsimiled letter dated 10 September 2007.

If you have any questions, please contact me on ☎(03) 479-6916.

Yours sincerely

Ray Wilson
Technical Claims Manager

Please quote the claim number at the top of this letter when contacting us

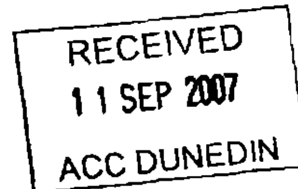
HLR02

Theis Orthopaedics Limited

26A Charlotte St, Roslyn, Dunedin

4 September 2007

Mr R. Wilson
Accident Compensation Corporation
PO Box
Dunedin



Dear Mr Wilson

RE: Trevor John Smith
59 Tay St, Mosgiel
Claim Number 82737342

Thank you for your letter dated 18.6.07 requesting a specialist report on the above.

My report is based on interview and examination of Mr Smith on 15.8.07 together with review of the following information:

- Your 7 page letter to myself dated 18.6.07
- Orthopaedic Outpatient clinic note by Dr A. Campbell dated 22.9.82
- Medical report by Professor Keith Jeffery dated 23.11.82
- Medical report by the late Professor Alan Alldred dated 16.3.84
- Letter by John Matheson to Dr Alex Luke dated 18.3.87
- Medical report by the late Bruce McMillan dated 12.5.88
- Medical report by Andrew Swan dated 22.5.92
- Letter by Bruce Hodgson to Dr Don Watson dated 24.11.92
- Letter by Bruce Hodgson to Dr Don Watson dated 18.2.93
- Copy of x-ray reports CT lumbar spine dated 25.1.93., lumbar spine and pelvis dated 21.2.00, MRI lumbar spine dated 5.3.02
- Letter by Dr Chris Birks to Dr V. Patel dated 12.2.02
- Letter by Bruce Hodgson to Dr Don Watson dated 12.8.02
- Discharge summary Otago District Health Board dated 26.11.04
- Emergency Department Clinical Sheet Dunedin Hospital dated 24.11.04
- Letter by Bruce Hodgson to Dr H. Lloyd dated 9.12.04
- Letter by yourself dated 21.6.07 to myself informing me that Mr Smith has requested that he be allowed to record my assessment

I also reviewed the claimant's Dunedin Hospital notes and x-rays.

At the time of the assessment Mr Smith presented me with a folder of photocopied documents, most of which are listed above but there are a couple which I would like to list:

- Letter by Trevor Smith to myself dated 26.6.07
- Extracts from the previous and current legislation including Section 555 cover under earner's scheme, 115 compensation etc. in case of subsequent accident, 119 compensation for non economic loss related to permanent loss of impairment of bodily function and revision of decisions under former Acts 390 Corporation may revise decisions.
- Review Decision dated 1.5.84 by RA Ayton. Review Officer
- Court Decision by Judge AW Middleton following a hearing on 19.5.95 and issued on 1.6.95
- Memorandum from Ray Wilson to Dean Millar-Coote outlining the background of this claim dated 24.4.07
- Typed comments by Dean Millar-Coote which are undated
- Emergency Department Discharge Summary dated 25.11.04 and addressed to Dr Don Watson
- ACC 18 medical certificate dated 23.12.04
- Letter by Dr Grahame Inglis to Dr A. McKerracher dated 21.4.81
- Copy of Dunedin Hospital notes between 1979 and 1987
- X-ray lumbar spine request dated 1982
- Copies of previous ACC medical certificates
- Copy of GP notes Mosgiel Health Centre between 2.10.06 and 28.9.90
- Letter by Dr V. Patel to the Orthopaedic Consultant, Dunedin Hospital dated 28.11.01
- Letter by Dr AJ Luke to the Surgeon, Orthopaedic Department dated 9.7.82
- Orthotic Requisition Form signed by Dr Campbell and Professor Jeffery dated 22.9.82 for a lumbar brace
- Typed and handwritten fracture clinic notes between 5.5.81 and 7.7.81
- A number of other documents which do not relate to the claimant's back problem
- Ambulance report dated 24.11.04 preceding the Dunedin Hospital admission
- Copy of hospital notes related to an admission on 24.11.04
- Copy of handwritten notes dated 9.4.81 after his forestry accident

I also had a letter from the claimant after my assessment and this was faxed to me on 20.8.07

Prior to commencing my assessment I explained to the claimant that I had been asked by the ACC to carry out a medical assessment and outlined to him all the information made available to myself. As indicated above he made available additional information and I also made him aware of your letter to myself dated 18.6.07. I gave the claimant the opportunity to ask further questions and clarification regarding my assessment and once I had established that he was fully informed and understood the aim of my assessment my interview started at 2.00 p.m. and finished at 3.50 p.m.

During the assessment Mr Smith was accompanied by a male friend who acted as a support person.

Background

Mr Smith is a 54 year old man who suffered an injury to the middle of his lumbar spine on 9.4.81 whilst cutting down a tree with a chainsaw at work. He was kneeling when he was hit from behind by a tree which had been cut down by one of his mates and it hit him across the middle of the lower back. This was quite a substantial tree measuring 30cm in diameter at its base and it apparently broke because it was half rotten and this is the reason why he was hit. He described himself as being 'winded' but he carried on cutting using his chainsaw and recalls that his mates thought that the tree had missed him. After he had finished cutting the tree he got up and straightened his back. He then had to bend down again to pick up his chainsaw and it was then that he felt quite a sharp pain in the middle of his back. He did not experience any leg pain and there was no numbness or weakness as he was able to walk.

He recalls that his back went into spasm and he was taken to Dunedin Hospital where his back was assessed. X-rays were taken and showed displaced fractures of the transverse processes of L1/L2/L3 on the left side. According to the Dunedin Hospital notes there was no damage to the spinal cord, cauda equina or nerve roots. He was on bed rest for 9 days and was given pain killers. He was then gradually mobilised and discharged without any external support.

According to Mr Smith he was followed up by Professor Keith Jeffery as an outpatient and 6 weeks following discharge he went back to work on light duties. According to Mr Smith there were no light duties in the forestry industry and he continued to suffer from back pain which got worse as the day went on and he recalls that after about 2pm he had trouble moving around. His back did not improve but he continued working and his boss apparently was quite flexible. He claims that ACC did not

compensate him for loss of earnings and that his boss kept paying him until December 1981 when he decided to leave his job. Towards that time there was a question of retraining into a more sedentary type job but this did not happen. At that stage he was 29 years old and as he had some experience in fencing he became a fencing contractor and did some other labouring type jobs. He was self employed and subcontracted some of his work. At that stage he had to work and was unable to do the same amount of work as prior to his accident. Again he mentioned that ACC did not pay him any compensation.

After that he worked as a labourer in the Maintenance Department of the Otago Daily Times but that made his back worse and he left this job after 6 months.

He then got a job as a diesel mechanic which involved putting engines into vehicles. He reported that this involved spending a lot of time in a bent position and according to Mr Smith he was told that he could work in a bent position.

In 1990 he had a hospital admission for recurrence of his back pain. At that stage x-rays were taken which subsequently have been destroyed. There are also apparently no hospital notes in relation to this admission. He eventually recovered from this episode of back pain and went back to the same company but doing a lighter job. Apparently there was some friction between himself and other staff and eventually he left. He had a couple of other labouring type jobs which were temporary and he worked at the Clyde Dam site doing drilling. Apparently ACC stopped his compensation around that time and this went to court in 1995. Around this time there was a question of him going back to forestry work in a management type position. Apparently everything was set up but did not go through. He claims that the ACC would not pay for his retraining. Eventually he ended up on an unemployment benefit in 1998. Subsequently WINZ tried to help get him back into the workforce and got him a job involving heavy labouring. Mr Smith told me that while he was working at this job he 'hurt himself badly' but did not seek any medical treatment because nobody could help him.

Currently he is on an Invalid Benefit and when I asked him how he sees his professional future he told me 'when I finish fighting ACC I will look at all the options'. He was very angry towards the ACC and medical profession because 'they cannot figure out my injuries'.

Current Complaints

When I asked him how his back was he said 'I feel good but I know I've got an injury'. He claims that he has pain in his back all the time. However the intensity can vary depending on what he does. If he looks after his vegetable garden he cannot do a full morning or afternoon. It takes him a week to recover. The pain is localised over the left paravertebral area in the mid-lumbar spine. It then expands from that area proximally and distally. He has difficulty getting from a sitting to standing position. This causes pain in his back. He also has difficulty bending for a prolonged period of time. He told me that he has to do weeding on his hands and knees. When he has to bend for long periods of time this aggravates his back. He can walk on the flat without any major problems for about 30 minutes. However if he does more than that his back gets sore. He has been doing a lot of biking and seems to enjoy it. This allows him to go further afield. He can drive a car but his back gets sore after an average distance of between Mosgiel and Milton. He says that some cars are more comfortable than others. He sleeps well at night but wakes when he turns over.

In the morning his back is a bit sore but eases rapidly. In winter on cold days he gets pins and needles in his legs.

Medication

Currently he is on no medication as he believes that 'pills don't do anything to his back'. He is fit and well and has no other medical problems.

Social

He lives by himself and does all the chores at home. He told me that he started painting the house last year but has not finished yet.

Clinical Examination

When I examined the claimant he was not in any obvious discomfort. He had a straight spine and a normal thoracic kyphosis and a lumbar lordosis. There was no tenderness on palpation of the spinous processes nor paravertebral gutters. He was able to bend forward and touch the front of his ankles. Extension was fine and he was comfortable doing that. Lateral flexion to the left and right was slightly sore. Rotation was full. There was no wasting in his lower limbs and he had well developed muscles. He walked normally. Neurological examination revealed normal sensation, power and reflexes. Hips, knees and ankles had a full range of pain free movement. Pulses were normal. The rest of the examination was normal.

X-rays
Plain films AP and lateral of the lumbar spine dated 24.11.04 showed degenerative changes with narrowing of the disc space at the level of L3/L4 and L4/L5. The rest of the lumbar spine was normal.

MRI scan lumbar spine dated 5.3.02 showed decreased T2 disc signal through the lower three intervertebral discs with mild thecal sac indentation from a mild left paracentral disc protrusion at L4/L5 with some impingement on the left L5 nerve root.

Diagnosis
Mr Smith presents with ongoing back pain and stiffness following an injury at work in 1981 in which he sustained fractures of the transverse processes of L1/L2/L3 on the left side. These fractures have clinically healed and over the last 25 years he has had ongoing pain in his lower back as well as stiffness and a recent MRI has shown loss of signal of the lower three intervertebral discs with a bulging disc at the level of L4/L5 consistent with age related degeneration. The MRI scan has not shown any evidence of abnormal scarring in the soft tissues surrounding the lumbar spine including the transverse processes of L1/L2 and L3 on the left side. Neurological examination was entirely normal which basically means there is no evidence spinal cord, cauda equina or nerve root compression.

In answer to your specific questions:

1. See above.

2. Mr Smith has suffered from chronic low back pain and stiffness for the last 25 years following a work injury in which he suffered fractures of the transverse process of L1/L2/L3 on the left hand side. Over the years Mr Smith has been involved in heavy labouring type jobs and has developed age related degeneration in the three lower intervertebral discs with degenerative type disc bulge at the level of L4/L5.
   It is clear that the claimant's transverse process fractures have healed and there is no medical evidence that there is any abnormal scarring in that area as demonstrated on an MRI scan dated 5.3.02 I therefore do not believe that the claimant's current ongoing back pain is a direct result of his transverse process fractures and that his current back pain is coming from his lower lumbar discs particularly at the level of L4/L5 where there is evidence of a small degenerative disc bulge. It is well recognised that

determining the exact origin of chronic back pain is often not easy but looking at the MRI scan and following my clinical examination I believe that the most likely cause of Mr Smith's back current back condition is on the basis of an age related degenerative disc disease particularly at the L4/L5 level which was not injured in 1981.

3. The claimant certainly had a significant injury to his back which resulted in fractures of the L1/L2 and L3 transverse processes on the left side which led to a haematoma (collection of blood) followed by gradual healing of the fractures over a period of 3-6 months. It is well recognised that fractures heal without scarring.

   It is clear that the claimant suffered a significant injury to his back which resulted in fractures of the transverse processes but this did not result in significant scarring as the fractures healed completely over a period of 3-6 months.

   I could not detect any obvious scarring on the MRI scan dated 5.3.02 in the area of the previous fractures and there was no tenderness on palpation of the previously injured area. I therefore believe that there is no scarring present today in this particular case.

4. May I point out that the x-rays taken in 1981 are no longer available and probably have been destroyed and therefore I cannot comment on these films but can only base my opinion on other doctor's interpretation of those films. According to the clinical notes by Dr A. Campbell dated 22.9.82 the disc spaces in the lumbar spine 'were preserved'. According to a letter by Mr John Matheson dated 18.3.87 he was of the opinion that at the time of the injury there was some narrowing of the lumbosacral junction with some slight increase in the narrowing in recent radiographs. According to Professor Keith Jeffery in his report dated 23.11.82 he did not comment on the disc spaces but simply noted the fractures of the transverse processes of L1, L2 and L3. The late Bruce McMillan in his report dated 12.5.88 again did not comment on the intervertebral disc spaces and Mr Andrew Swan in his report dated 20.5.92 noted that serial x-rays up to 1991 over a period of 10 years showed progressive decrease in the lumbosacral disc space with some evidence of instability but he did not comment on the appearances of the disc spaces in relation to the original x-ray taken in 1981. From the information made available

to myself it appears that there is some uncertainty about the state of the lumbosacral disc at the time of the injury but it appears that Mr Smith developed increasing disc space narrowing at the lumbosacral junction over a period of 10 years following the injury.

In response to your questions I cannot establish whether the lumbosacral disc space narrowing predated the accident of 9.4.81 nor can I determine whether the accident on 9.4.81 caused damage to the lumbosacral disc. I can confirm that according to the information made available to myself it appears that the claimant developed gradual disc space narrowing over a period of 10 years after the 1981 accident.

5. a.

Mr Smith's original pain following the injury was related to the fracture of the transverse processes up to the point where bony healing had occurred. As indicated above I have not been able to identify any evidence of post fracture scarring there I do not believe that this would be a cause of his ongoing pain. The most common cause of back pain in New Zealand is age related disc degeneration which is often referred to as mechanical back pain and I believe that Mr Smith's current back pain is most likely to be a result of age related disc degeneration.

b.

i. As the transverse process fractures have fully healed and in the absence of ongoing scarring as demonstrated by the MRI scan it is most likely that the ongoing back pain in this case is due to age related disc degeneration in the three lumbar discs as demonstrated by the MRI scan.

ii. As already indicated there is no evidence of scarring and the transverse process fractures of L1 L2 and L3 have fully healed.

iii. Clinically and radiologically the fractures of the transverse processes of L1 L2 and L3 have fully healed and there is no radiological evidence of non union of these fractures which would explain the ongoing pain.

iv. I could not detect any other cause explaining the pain in this case although it is well recognised that determining the exact cause and site of low back pain is often not possible despite extensive medical investigation.

c.
Mr Smith's initial pain was of an acute nature on the basis of fractures of the transverse processes between L1 and L3 and his subsequent more chronic type back pain is more likely to be related to age related disc degeneration as documented on the MRI scan.

6.

a.
I did not see any x-rays of the pelvis nor left or right hip but from a clinical point of view there was no evidence of a fracture of either the left or right hip.
b.
As far as I can tell I have not been able to identify any pelvic fracture in this case.

7. As a result of back pain patients often lose the normal hollow in their lower back which is called a lumbar lordosis and this is a normal reflex mechanism secondary to spasm of the paravertebral muscles. Once the pain disappears the lumbar lordosis is restored unless there is stiffness in the lumbar back on the basis of degenerative disease. Similarly, a lateral curvature (scoliosis) of the lumbar spine in acute back pain is often on the basis of nerve root compression following a disc prolapse and again this will disappear once the pain has settled down.

8. Overall, having extensively reviewed the information made available to myself I strongly believe that there is no causal relationship between Mr Smith's current symptoms of back pain and the accident on 9.4.81. The transverse process fracture between L1 and L3 is healed and there is no evidence of scarring and the MRI of the lumbar spine has shown evidence of age related degenerative disease of the lumbar spine which is the most common cause of back pain in New Zealand in a patient of Mr Smith's age.

Don't hesitate to contact me if you need any further information.

Yours sincerely

J-C. Theis
Associate Professor of Orthopaedic Surgery