Arthur Saffold v. Palmieri Roofing Inc. (June 21, 2011)

STATE OF VERMONT
DEPARTMENT OF LABOR

Arthur Saffold	Opinion No. 15-11WC
v.	By: Phyllis Phillips, Esq. Hearing Officer
Palmieri Roofing, Inc.	For: Anne M. Noonan Commissioner
	State File No. H-22526

OPINION AND ORDER

ATTORNEYS:

David Williams, Esq., for Claimant
Robert Cain, Esq., for Defendant

ISSUE PRESENTED:

Is Claimant's lumbar spine condition since 2006 compensable as a direct and natural consequence of his September 1994 work-related injury?

EXHIBITS:

Joint Exhibit I:	Medical records
Joint Exhibit II:	Medical summary
Claimant's Exhibit 1:	Workers' Compensation Rule 14.9240
Claimant's Exhibit 2:	Operative procedure, November 30, 1994
Claimant's Exhibit 3:	Operative report, June 30, 2006
Claimant's Exhibit 4:	Dr. McLellan office note, July 3, 2008
Claimant's Exhibit 5:	Letter from Dr. Ross, December 15, 2008
Claimant's Exhibit 6:	Letter from Dr. Ross, February 19, 2010
Defendant's Exhibit A:	Medical records reviewed by Dr. Ross
Defendant's Exhibit B:	Radiology report, March 17, 1997
Defendant's Exhibit C:	*Curriculum vitae*, Victor Gennaro, D.O.

CLAIM:

All workers' compensation benefits to which Claimant proves his entitlement as causally related to his lumbar spine condition since 2006
Costs and attorney fees pursuant to 21 V.S.A. §678

FINDINGS OF FACT:

1. At all times relevant to these proceedings, Claimant was an employee and Defendant was his employer as those terms are defined in Vermont's Workers' Compensation Act.

2. Judicial notice is taken of all relevant forms contained in the Department's file relating to this claim.

Claimant's 1994 Injury and Subsequent Treatment

3. Claimant worked for Defendant as a general laborer and roofer. On September 30, 1994 he injured his back while carrying a heavy roll of roofing paper.

4. Claimant presented to Littleton Orthopaedics on November 8, 1994 with complaints of low back and right-sided radicular pain. A subsequent myelogram revealed findings suggestive of an L4-5 disc herniation.[1] On November 30, 1994 Claimant underwent a laminectomy and discectomy at that level.

5. Initially Claimant recovered well from the November 1994 surgery. His low back pain lessened significantly, and the pain, numbness and tingling in his right lower extremity abated as well.

6. Claimant underwent physical therapy in early 1995, during which he made steady progress but continued to complain occasionally of numbness in his thigh and/or foot. His therapy was interrupted for a time after he suffered a heart attack in March 1995. After his recovery from that event, Claimant continued to experience some residual low back pain, as well as radicular symptoms into his right lower extremity.

7. In December 1996 Claimant's treating physician, Dr. Howard, determined that he had reached an end medical result and rated him with a 20% whole person permanent impairment. Even at that time, Claimant continued to experience symptoms in his low back and right leg, particularly with prolonged standing or sitting. Claimant also complained of ongoing weakness, numbness and tingling from his right leg down into his foot.

8. At Defendant's request, in February 1997 Claimant underwent an independent medical examination with Dr. Jennings, who rated his permanent impairment at 10% whole person. Subsequently, the parties executed an Agreement for Permanent Partial Disability Compensation (Form 22) that reflected a compromise of the two impairment ratings, which the Department approved in July 1997.

[1] Claimant has six lumbar vertebrae, which can lead to some confusion when counting disc levels. Early radiological studies and operative reports referred to the lowest (most inferior) lumbar disc level as L5-6; this corresponds to what later is referred to as the L4-5 level.

9. Despite having reached an end medical result, Claimant continued to experience both low back pain and radicular symptoms down his right leg. For the most part, for the nine-year period between early 1997 and April 2006 he opted not to seek medical treatment for these symptoms. While always somewhat problematic, furthermore, they did not preclude him from working.

10. Claimant held a variety of jobs during this time, though none after March 2004. From July 1996 until some time in 1997 he worked at Hitchener's, a golf club manufacturing company. For approximately two years thereafter, he owned and operated a small coffee shop; that business closed in 2000. From 2001 until 2004 he worked as a lathe operator at NSA Industries.

11. Following triple-bypass surgery in September 2001, Claimant was disabled from working at NSA Industries for six months. Upon returning to work he continued to experience cardiac symptoms. As a result, in March 2004 his doctors again advised him to stop working, which he did.

12. There is no credible evidence that Claimant's work activities from 1997 through 2004 either caused or aggravated his low back pain or radicular symptoms.

13. In addition to his cardiac condition, which has required fairly constant medical vigilance since 2001, in 2004 Claimant also began experiencing pain in his upper extremities. These were diagnosed as repetitive stress injuries, arguably related to his employment at NSA, and for which he underwent multiple surgeries in 2005. Claimant testified that during the periods when these other medical conditions were requiring active treatment, his low back and leg pain "took a back seat." I find this testimony credible.

14. Claimant has not worked since March 2004. He has been receiving social security disability benefits since that time, primarily due to his cardiac condition.

Claimant's 2006 Surgery

15. In April 2006 Claimant experienced the spontaneous onset of low back pain with radicular symptoms down his right leg. Contemporaneous medical records reflect that Claimant was "simply walking along" when he felt a "spasm" in his back, followed by worsening pain, tingling, numbness and weakness down his right lower extremity. The symptoms were exactly the same as those he had experienced prior to his 1994 surgery.

16. Claimant testified that although he had never been symptom-free since his original injury in 1994, the pain he felt in April 2006 was significantly worse. Contemporaneous medical records corroborate this testimony, which I find credible.

17. A May 2006 MRI revealed a right-sided disc herniation at L4-5, the same level as had been operated on in 1994. There also was evidence of scar tissue at the site. Upon reviewing the MRI, Dr. Sengupta, the orthopedic surgeon to whom Claimant had been referred, observed that the disc herniation "appears to be moderate in size, but it appears that because of the scar tissue around the right L5 nerve root it is producing significant symptoms on the right leg."

18. As treatment for Claimant's symptoms, Dr. Sengupta recommended a repeat L4-5 discectomy, which Claimant underwent on June 29, 2006. In his operative findings, Dr. Sengupta reported "scar tissue identified from prior surgery." Dr. Sengupta removed some of this scar tissue in order to better release the nerve root.

19. The medical records reflect that after the June 2006 surgery Claimant initially experienced good relief of his symptoms, but by the following year his radicular complaints had returned. A June 2007 MRI study showed disc degeneration at both L4-5 and L5-S1, but no evidence of disc herniation at either level. In addition, once again there was significant scar tissue around the L5 nerve root.

20. Claimant's symptoms still persist. Having failed to realize significant relief from two prior surgeries, it is unlikely that a third surgery will prove successful.

Expert Medical Opinions

(a) Dr. Gennaro

21. At Defendant's request, in October 2006 Claimant underwent an independent medical examination with Dr. Gennaro, an orthopedic surgeon. In addition to personally examining Claimant and taking his history, Dr. Gennaro also reviewed Claimant's entire medical record and his deposition testimony as well. The question put to him was whether Claimant's June 2006 surgery represented a recurrence causally related to his 1994 work injury and subsequent disc surgery or alternatively, whether it reflected an unrelated aggravation or new injury.

22. Dr. Gennaro concluded that Claimant's 2006 surgery reflected neither an aggravation nor a recurrence. As Claimant had not identified any specific work or other activity that might have provoked a disc herniation, Dr. Gennaro discarded the possibility of an aggravation or new injury. Given the number of years that had passed since Claimant's original surgery, furthermore, Dr. Gennaro deemed it unlikely that the 2006 surgery would have been caused by a recurrent disc herniation, as those typically occur within a relatively short period of time (6 to 36 months) after the original injury and surgery.[2]

[2] Dr. Gennaro acknowledged his use of the term "recurrent disc herniation" referred to its medical definition – a reherniation of disc material at the same level and the same side as previously. As discussed *infra*, Conclusion of Law No. 5, the term "recurrence" as defined in Workers' Compensation Rule 2.1312 has a somewhat different legal meaning.

23. Having discarded both aggravation and recurrence as likely causes, Dr. Gennaro concluded that the symptoms Claimant began experiencing in 2006 most likely represented the manifestation of longstanding chronic degenerative disc disease in his lumbar spine. The natural progression of this disease is evidenced not only by worsening degeneration at the L4-5 disc level (the site of Claimant's 1994 surgery), but also at other levels as well.

24. Degenerative disc disease is an evolving process. As a disc begins to degenerate, the jelly-like central portion, or nucleus pulposus, becomes less elastic and begins to flatten out. This causes the harder exterior covering, or annulus, to bulge. As the process continues, the annulus may weaken and crack, allowing disc material to herniate through the opening.

25. When a disc herniates, enzymes are released, which irritate the nerve root. This chemical irritation is the primary cause of most nerve root, or radicular, symptoms. Once irritated, the nerve root becomes inflamed and is less able to tolerate a smaller space within the spinal canal. Scar tissue from a previous surgery can make this small space even smaller, but does not itself cause the nerve root to become irritated or inflamed.

26. It is quite typical for patients with degenerative disc disease to experience episodic flare-ups and remissions. According to studies cited by Dr. Gennaro, furthermore, disc surgery does not alter the natural progression of the condition. That is, over the long term patients who have undergone disc surgery are just as likely to experience recurrent symptoms as those who have not had surgery. The presence or absence of scar tissue from a prior surgery appears not to be a relevant factor, therefore.[3]

27. To summarize, Dr. Gennaro concluded that Claimant's condition since 2006 has been the consequence solely of "aging and time." Notwithstanding some residual symptoms over the years, his 1994 surgery was successful – his condition markedly improved from its pre-surgery state, and then stabilized to the point where he was able to return to work and resume normal activities for many years thereafter. The degenerative disease in his spine continued to progress naturally, however, until worsening symptoms attributable entirely to that condition led to repeat surgery in 2006.

(b) *Dr. McLellan*

28. At Dr. Sengupta's referral, in July 2008 Claimant underwent an evaluation with Dr. McLellan, a physician at Dartmouth Hitchcock Medical Center. Upon reviewing Claimant's June 2007 MRI Dr. McLellan remarked that it revealed evidence of a disc herniation and post-operative changes at L4-5, and also "considerable scar tissue around [the] right L5 nerve root."

[3] Claimant correctly notes that one of the studies cited by Dr. Gennaro, published by Drs. Cinotti and Roysam in 1998, may have limited applicability to patients whose symptoms recurred as shortly after surgery as Claimant's did. Dr. Gennaro cited additional studies as well, but these were not made available for the hearing officer's review.

29. Absent a more comprehensive review of Claimant's medical records, Dr. McLellan declined to issue a final opinion as to the causal relationship, if any, between Claimant's 1994 surgery and the symptoms that led to his 2006 surgery. Speaking "in a more generic way," however, Dr. McLellan stated:

> [Claimant] clearly had a disc herniation back in 1994. Individuals who have had disc herniations are at high risk of recurrence. In the absence of an intervening injury, recurrent symptoms on the same side at the same level are more probably than not related to the original injury. Given insidious onset of [symptoms] in the same dermatomal pattern as before and given the MRI results, the current radicular symptoms are also more probably than not related to the original injury.

30. Dr. McLellan did not conduct any further review of Claimant's medical records, did not issue a final opinion specific to Claimant's case and did not testify at the formal hearing. I find it difficult, therefore, to accord much weight to his generic statement as to the cause of Claimant's recurrent symptoms.

(c) *Dr. Ross*

31. At the request of Claimant's attorney, Dr. Ross, an orthopedic surgeon, conducted a medical records review in December 2008. Although his initial report was somewhat confusing, ultimately Dr. Ross concluded that Claimant's 2006 disc herniation, subsequent surgery and current condition most likely were causally related to his 1994 injury and surgery. Dr. Ross testified to this effect at the formal hearing.

32. From his review of a select portion of Claimant's medical records, Dr. Ross gleaned that Claimant never fully recovered from the 1994 surgery, that his pain began to recur within a matter of weeks, and that his clinical course for years thereafter was punctuated by frequent exacerbations and only temporary remissions. From this, Dr. Ross concluded that the 1994 surgery had been unsuccessful. Thus, he would have advocated for repeat surgery to more fully relieve the L5 nerve root compression much sooner, certainly well before 2006.

33. From his review of Dr. Sengupta's surgical findings in 2006, Dr. Ross concluded that the scar tissue that resulted from Claimant's 1994 surgery was itself compressing his L5 nerve root. To a reasonable degree of medical certainty, therefore, in his opinion the 1994 surgery was a "major factor" in causing the symptoms for which Claimant underwent surgery in 2006.

34. Dr. Ross acknowledged that there was no radiological evidence that Claimant's 1994 surgery had failed to decompress his L5 nerve root adequately. Rather, his conclusion in this regard was based on his understanding of Claimant's clinical presentation in the weeks, months and years thereafter. Dr. Ross never reviewed Claimant's entire medical record, however, which is voluminous, nor did he ever interview Claimant personally or read his deposition. Given these omissions, it is difficult to understand how Dr. Ross was able to appreciate Claimant's clinical course and pattern of recurrent symptoms accurately. I find that his conclusions are rendered less credible as a result.

35. Dr. Ross disagreed with Dr. Gennaro's assertion that a patient who has undergone prior disc surgery is no more likely to suffer a recurrent herniation than one who hasn't. According to Dr. Ross, both because a prior surgery is likely to cause scar tissue to form and because an annulus that has torn once is more likely to tear again, recurrent symptoms are more prevalent in the surgical population.

36. Dr. Ross also disagreed with Dr. Gennaro as to the expected progression of Claimant's degenerative disc disease. In his opinion, there was no basis from which to conclude that the natural history of Claimant's disc degeneration would have caused his symptoms to recur in 2006 had the 1994 surgery not predisposed him to further deterioration. At the same time, however, Dr. Ross admitted that he had no specific knowledge or opinion as to whether Claimant's 1994 surgery actually accelerated the progression of his degenerative disc disease in any way.

CONCLUSIONS OF LAW:

1. In workers' compensation cases, the claimant has the burden of establishing all facts essential to the rights asserted. *King v. Snide*, 144 Vt. 395, 399 (1984). He or she must establish by sufficient credible evidence the character and extent of the injury as well as the causal connection between the injury and the employment. *Egbert v. The Book Press*, 144 Vt. 367 (1984). There must be created in the mind of the trier of fact something more than a possibility, suspicion or surmise that the incidents complained of were the cause of the injury and the resulting disability, and the inference from the facts proved must be the more probable hypothesis. *Burton v. Holden Lumber Co.*, 112 Vt. 17 (1941); *Morse v. John E. Russell Corp.*, Opinion No. 40-92WC (May 7, 1993).

2. The disputed issue in this claim is one of causation. Claimant asserts that his condition since 2006 represents a recurrence of symptoms causally related to his compensable 1994 injury and subsequent surgery. Defendant asserts that Claimant's condition has resulted from the natural progression of his degenerative disc disease, and that his symptoms are not causally related at all to his 1994 injury and surgery.

3. When a primary injury is determined to be compensable, all of the medical consequences and sequelae that flow from it are deemed compensable as well. 1 *Larson's Workers' Compensation Law* §10.01 at p. 10-3 (Matthew Bender, Rev. Ed.). Thus, once the work-connected character of an injury or condition has been established, its subsequent progression remains compensable, so long as the worsening is not shown to have been produced by an independent nonindustrial cause. *Id.*, §10.02 at p. 10-3.

4. For the purposes of determining workers' compensation liability, it is critical to distinguish between a condition that has worsened as a direct and natural result of a compensable primary injury and one that has worsened independently from any work-related event. In the first instance, the causal link back to the primary injury remains intact, and the employer on the risk at the time remains responsible for whatever treatment and/or disability results from the worsening. *See, e.g., Jackson v. True Temper Corp.*, 151 Vt. 592 (1989). In the second instance, the causal link is severed, and the employer is no longer liable. *See* 1 *Larson's Workers' Compensation Law*, *supra* at §10.02D, n.9 and cases cited therein.

5. Both parties here have framed their arguments at least partially as a dispute as to whether Claimant's 2006 surgery and current condition should be characterized as a "recurrence." Workers' Compensation Rule 2.1312 defines a recurrence as "the return of symptoms following a temporary remission." This term most often is distinguished from an "aggravation," which Rule 2.1110 defines as "an acceleration or exacerbation of a pre-existing condition caused by some intervening event or events."

6. I do not consider the issue presented by this claim as one involving either a recurrence or an aggravation. Although Claimant credibly testified that he suffered from residual symptoms continuously from the time of his 1994 surgery forward, he also testified that they did not worsen to the point of requiring medical treatment until 2006. I cannot characterize these facts as a "return" of symptoms following a "temporary" remission.

7. Nor can I characterize Claimant's worsening symptoms in 2006 as the type of intervening "event" that would trigger an aggravation analysis. The more appropriate question, therefore, is simply to determine whether Claimant's condition since 2006 has flowed directly from his compensable 1994 injury, or whether it has resulted from some entirely independent cause. *See Pacher v. Fairdale Farms*, 166 Vt. 626, 628 (1997) (finding of new injury, distinct from prior injury, does not have to be either aggravation or recurrence).

8. Each party here presented its own expert testimony on this issue. Dr. Ross concluded that scar tissue from Claimant's 1994 surgery was a "major factor" in causing the symptoms for which he underwent surgery in 2006, and from which he continues to suffer currently. Dr. Gennaro concluded that the 1994 surgery was irrelevant to the process, and that Claimant's degenerative disc disease worsened independently to the point where the 2006 surgery became necessary.

9. Where expert medical opinions are conflicting, the Commissioner traditionally uses a five-part test to determine which expert's opinion is the most persuasive: (1) the nature of treatment and the length of time there has been a patient-provider relationship; (2) whether the expert examined all pertinent records; (3) the clarity, thoroughness and objective support underlying the opinion; (4) the comprehensiveness of the evaluation; and (5) the qualifications of the experts, including training and experience. *Geiger v. Hawk Mountain Inn*, Opinion No. 37-03WC (September 17, 2003).

10. The first factor does not favor either expert, as neither was a treating provider. The fifth factor is also neutral, as both experts are well-qualified to render opinions on the causation issue presented here.

11. The second and fourth factors favor Dr. Gennaro. He reviewed Claimant's entire medical record, read his deposition and most importantly, interviewed Claimant personally as to the history of his injury and the progression of his symptoms from 1994 forward. In contrast, Dr. Ross reviewed only a portion of Claimant's medical record. From this he determined that Claimant's 1994 surgery had failed completely, that he never fully recovered and that his symptoms were almost as troublesome in the years thereafter as they became in 2006. From the records Dr. Ross reviewed, I cannot discern how he could have reached these conclusions.

12. The third factor weighs in Dr. Gennaro's favor as well. His opinion was clear, thorough and objectively supported. It adequately accounted for the presence of disc degeneration at other levels in Claimant's lumbar spine at the same time that it discounted scar tissue as a contributing factor. The fact that Dr. Gennaro's conclusions were consistent with findings reported in the medical literature, while by no means determinative, also lends support to his opinion. *See, e.g., Kurant v. Sugarbush Soaring Association, Inc.*, Opinion No. 17-10WC (May 4, 2010).

13. I conclude that Dr. Gennaro's opinion was more persuasive than Dr. Ross'. I also conclude, therefore, that Claimant has failed to establish the required causal link back to his compensable 1994 injury so as to render either his 2006 surgery or his current condition compensable. Claimant's current condition is not the direct and natural result of his compensable primary injury. It is the result of degenerative disc disease, which has progressed independently from any work-related injury or sequelae of treatment.

14. Claimant having failed to prevail on his claim, he is not entitled to an award of costs or attorney fees.

ORDER:

Based on the foregoing findings of fact and conclusions of law, Claimant's claim for workers' compensation benefits causally related to his 2006 surgery and subsequent condition is hereby **DENIED**.

DATED at Montpelier, Vermont this 21st day of June 2011.

_____
Anne M. Noonan
Commissioner

Appeal:

Within 30 days after copies of this opinion have been mailed, either party may appeal questions of fact or mixed questions of law and fact to a superior court or questions of law to the Vermont Supreme Court. 21 V.S.A. §§670, 672.