STACE F. KROOK, Employee/Appellant, v. GAUTHIER INDUS. and AM. COMP. INS., Employer-Insurer, and MN DEP'T OF HUMAN SERVS., Intervenor.

WORKERS' COMPENSATION COURT OF APPEALS
FEBRUARY 10, 1999

No. [REDACTED SSN]

HEADNOTES

CAUSATION - SUBSTANTIAL EVIDENCE. Where the employee's doctor's testimony was equivocal regarding whether a specific work incident caused both a ganglion cyst and a ligament tear and the IME opined that it did not, the compensation judge was supported by substantial evidence in finding that only the cyst was caused by the work incident.

Affirmed.

Determined by Wheeler, C.J., Johnson, J., and Hefte, J.
Compensation Judge: Peggy A. Brenden.

OPINION

STEVEN D. WHEELER, Judge

The employee appeals from the compensation judge's determination that the lunotriquetral ligament tear injury to his left wrist was not causally related to any work activity with the employer. We affirm.

BACKGROUND

The compensation judge made the following findings of fact which are not contested by either party:

> 1. Prior to March 1996, the employee had no symptoms or limitations associated with the functioning of his left wrist.[1]
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> 2. On or about March 13, 1996, while in the course of carrying a bundle of steel bars weighing approximately 100 pounds, the employee experienced a "giving way" of his left wrist. At the time the incident occurred the employee's left wrist was in a flexed and pronated position.

[1] In March 1996 the employee was 23 years of age and had a weekly wage of $326.66.

3. The employee experienced immediate pain and swelling in the area of his left wrist following the incident on or about March 13, 1996.

4. As a result of the work incident on or about March 13, 1996, the employee sustained a post-traumatic synovial cyst. (See Employee Exhibit B: 11/15/96 note and Employee Exhibit G: 7/3/97 note.)

The employee did not seek immediate medical assistance for the injury that he sustained on March 13. The employee testified that after the March 1996 incident the swelling eventually went down but a lump remained below his thumb on his left wrist. (T. 81-82.) The first medical care he received was from Dr. David Lundberg, a specialist in family medicine at the Olmsted Medical Group, on November 6, 1996. At that time the employee indicated that he had injured his left hand/wrist on three separate occasions within the prior seven months - - at work while lifting, in a fist fight and while falling face first on his driveway.[2] Shortly thereafter, on November 15, 1996, the employee was seen by Dr. Robert Kurland, an orthopedic specialist also at the Olmsted Medical Group. The employee gave Dr. Kurland a similar history of three recent traumas to his left hand/wrist.[3] Dr. Kurland's diagnosis was post-traumatic synovial cyst. Following an ultrasound diagnostic examination to determine the size of the cyst, excision surgery of the ganglion cyst was performed on November 27, 1996 by Dr. Kurland.

Following the surgery the employee continued to complain of problems with his left wrist. Eventually, in May 1997, the employee was referred by Dr. Kurland to the Mayo Clinic for examination. He was first seen on May 5, 1997 by Dr. M. L. Jurisson. Thereafter, he was referred to Dr. Allen T. Bishop, an orthopedic surgeon specializing in hand surgery. On May 16, 1997, a left wrist arthrogram with Lidocaine was performed which disclosed a tear of the lunotriquetral ligament. During the procedure, when the Lidocaine was injected, the employee reported almost immediate complete left wrist pain relief. This relief, however, lasted for only two hours. As a result of the findings from the arthrogram Dr. Bishop recommended a diagnostic wrist arthroscopy, which was performed on June 18, 1997. During this procedure, Dr. Bishop

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[2] At the time of the examination Dr. Lundberg noted that the employee was 68" tall and weighed 253 pounds. (Pet. Ex. B.) A later report indicates that the employee was 6' and 265 pounds. (Resp. Ex. 1, Tountas Depo. Ex. 1, 10/10/97 report of Dr. Tountas.) At trial the employee testified that he was then 6' and 300 pounds. (T. 40.)

[3] The employee testified that he told both Dr. Lundberg and Dr. Kurland that he had injured his left hand/wrist in three separate incidents, as reported in the physicians' notes. On reflection, however, he stated that he never injured his left hand/wrist in a fist fight. (T. 34-35, 65-66.) He did injure his <u>right</u> hand in a fight in May 1995. (T. 35-36; Pet. Ex. C, Mayo Clinic records of 5/14/95.)

found "a large amount of inflamed synovium and cartilage or ligamentous tissue attached to the lunate and triquetrum." The loose tissue was debrided using a shaver device. An arthroscopic inspection of the lunotriquetral ligament disclosed that it was "moderately unstable from the radiocarpal side" while the "dorsal and palmar ligamentous portions appeared to be intact." All other areas of inspection apparently were found to be normal. The operative report indicates that Dr. Bishop "felt that the [employee's] mechanical symptoms were to a large extent due to the flap of lunotriquetral ligament within the joint and the reactive synovitis rather than the lunotriquetral ligament instability which was mild to grade 2 based on Geissler's classification theme." As a result, Dr. Bishop indicated that it was not necessary at that time to proceed with a "lunotriquetral ligament reconstruction or lunotriquetral fusion," which could be attempted at a later date if the debridement itself did not alleviate the employee's symptoms.

On July 21, 1997, the employee filed a claim petition indicating a date of injury of approximately March 25, 1996. The petition indicated that the employee claimed a synovial cyst on his left wrist and requested temporary total disability from October 1, 1996 through May 25, 1997, and temporary partial disability from May 25, 1997 to the present and continuing, plus medical expenses. Attached to the claim petition was a July 3, 1997 letter report from Dr. Kurland indicating that the employee's work activity for the employer was consistent with the development of a synovial (ganglion) cyst in the employee's left wrist.

On July 30, 1997, Dr. Bishop issued a letter report in which he indicated that when he had last seen the employee on July 3 he continued to complain of "dislocations" of his wrist, but that these could not be reproduced clinically. Dr. Bishop stated that "it was felt this sensation may have been a locking or catching phenomenon from an unstable lunotriquetral tear. This problem should have been resolved by the arthroscopy, however, and I am currently uncertain as to the cause of his persistent symptoms." The employee was seen on several other occasions by Dr. Bishop and other physicians at the Mayo Clinic in the latter part of 1997. On his last visit, on October 23, 1997, the employee continued to complain of a feeling of instability in his left wrist and persistent right ulnar-sided wrist pain. Dr. Berger's notes from that date indicate that the employee "states that he is debilitated in the sense of an assembly line labor type job that he has, but he continues to work as a bouncer at a local nightclub establishment." Dr. Berger's notes indicate that he was unable to find any evidence of synovitis and that all other tests performed on the hand and wrist were negative. He stated that he "performed a lengthy examination with Dr. Bishop flouroscopically and we were not able to demonstrate any instability at that time either." Dr. Berger's impression was "chronic ulnar sided wrist pain, specifically localized to the ulnar and dorsal aspect of the mid carpal joint, uncertain etiology." Dr. Berger's notes contain the following observations:

> I reviewed my findings with the patient with Dr. Bishop. It is conceivable that this patient may have a Zancolli type lesion to the dorsal ulnar triquetral hamate ligament that but this is largely a diagnosis of exclusion, and there are no specific provocative maneuvers other than tenderness and no specific imaging studies that help to define this lesion. We explained this to the patient,

> realizing that surgical intervention could be carried out, but is relatively unpredictable, given the nonspecific status of his complaints currently. We have offered him the option of conservative management, particularly in light of the fact that we do not see anything currently ongoing that will specifically predispose to any further pathologies such as degenerative disease. We offered him a cock-up splint, and if he finds that this is comfortable, he may benefit with an ulnar sided custom splint or a leather gauntlet. He will return to Dr. Bishop on a p.r.n. basis. He was pleased with the work up.

Dr. Bishop's note of October 23, 1997 indicates that the employee's future course was to "continue to treat his wrist symptomatically with protection and avoidance of activities that exacerbate his sense of instability." As of the date of hearing the employee had not returned to the Mayo Clinic following his last visit on October 23, 1997.

On October 10, 1997, at the request of the employer and insurer, the employee was examined by Dr. Chris Tountas, an orthopedic surgeon specializing in the treatment of the hand and upper extremity. At the time of his examination the employee complained of pain at "the mid dorsal aspect of the left wrist," in the "anatomical snuff box, as well as the volar and dorsal aspects of the wrist and the dorsal ulnar aspect of the hand." He also complained of pain when pressure was directly applied to the "tubercle of the navicular as well as the pisiform." He had no numbness or tingling and no positive signs on any testing. There was no atrophy of the intrinsic musculature. The employee had full range of motion of his forearms. Dr. Tountas indicated that he reviewed the medical records from the Olmsted Medical Group and the Mayo Clinic. As a result of his examination, the history obtained from the employee and from the medical records, Dr. Tountas issued the following diagnosis and opinion:

> 1. Diagnosis is post excision, synovial cyst and lunotriquetral ligament tear, left wrist.
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> 2. Prognosis is guarded because of the presence of the lunotriquetral tear.
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> 3. In my opinion, I do not believe that the diagnoses occurred as a result of his work related injury. I do not feel that either mechanism, that is lifting the bundle of steel with his arms wrapped around, nor with the left hand and wrist in the position described [by the employer], was of sufficient force and magnitude, or in the direction usually associated with a tear of a lunotriquetral ligament tear. In addition I do not feel that it produced the synovial cyst or ganglion. It is more likely that the lunotriquetral tear has occurred as a result of a forceful blow to the hand either in a fist fight or when falling in his driveway.

On November 14, 1997, Dr. Kurland issued a letter opinion, after having received a copy of Dr. Tountas' October 10, 1997 report. Dr. Kurland stated as follows:

> Certainly, repetitive work activity with heavy lifting of steel could cause damage to the soft tissues in the wrist and lead to the formation of a synovial cyst, as well as perhaps a lunotriquetral tear. However, the latter would be a little more difficult to explain. I would believe that the tear in the ligamentous tissue is most likely surgical in nature and may have been caused at the time of the excision of the mass due to the broad based nature of the synovial cyst. Otherwise, the only other cause would be the fall onto the hand that was documented in the record. Either of these could be a responsible event.

Dr. Kurland went on to state that,

> I apologize for not giving you a "100% response." I do believe, though, that the patient's work activity can certainly be responsible for both the diagnosis and condition now seen. I believe that the ligamentous disruption noted by Dr. Bishop at the time of arthroscopy and with the arthrogram could be post surgical in nature as well as post traumatic.

(Pet. Ex. G.)

On January 7, 1998, the employee was seen for a consultation examination by Dr. Dennis J. Callahan, an orthopedic surgeon. Following his examination and review of the employee's medical records Dr. Callahan made the following observations:

> With regard to Mr. Krook's symptoms and treatment options, I would, in essence, be in agreement with Dr. Chris Tountas' opinion the way I understand it from reading his report. It would appear to me that there is an instability problem with the wrist from a ligamentous wrist injury.
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> With regard to how and when this injury occurred, it is impossible for anyone to say with a 100% certainty when such an injury did, in fact, occur. It is very unlikely that it occurred during Dr. Kurland's surgery since Dr. Kurland was operating on the opposite side of the wrist. In fact, I would be inclined to believe that the synovial cyst was a result of the wrist injury rather than the wrist instability being the result of the synovial cyst surgery. Based on Mr. Krook's history, he did not have any trouble with his wrist before the injury

> of April 1996. It is, therefore, my opinion that the episode of April 1996 was the cause of his injury. However, if it is determined that this episode did not, in and of itself, cause that injury then it is my opinion that the episode resulted in the pre-existing injury becoming symptomatic which necessitated treatment. If the injury was, in fact, pre-existing, it was not of any disability, did not need any treatment prior to the episode of April 1996. If [sic] would, therefore, be my opinion that the need for surgery, treatment and the resulting disability would be a result of the injury of March or April 1996.

Dr. Callahan repeated this diagnosis and opinion in his deposition of May 13, 1998. (Pet. Ex. A.)

The matter came on for hearing before a compensation judge at the Office of Administrative Hearings on May 21, 1998. In her Findings and Order, issued on June 11, 1998, Compensation Judge Peggy A. Brenden determined that on or about March 13, 1996 the employee did injure his left wrist while working for the employer. She found that the only injury the employee sustained, however, was a post-traumatic synovial cyst. She determined that the "preponderance of the evidence fails to establish the lunotriquetral tear for which the employee had surgery in June of 1997 is causally related to the employee's work injury on or about March 13, 1996." (Finding 6.) It is from this latter finding that the employee appeals.

STANDARD OF REVIEW

In reviewing cases on appeal, the Workers' Compensation Court of Appeals must determine whether "the findings of fact and order [are] clearly erroneous and unsupported by substantial evidence in view of the entire record as submitted." Minn. Stat. § 176.421, subd. 1 (1992). Substantial evidence supports the findings if, in the context of the entire record, "they are supported by evidence that a reasonable mind might accept as adequate." Hengemuhle v. Long Prairie Jaycees, 358 N.W.2d 54, 59, 37 W.C.D. 235, 239 (Minn. 1984). Where evidence conflicts or more than one inference may reasonably be drawn from the evidence, the findings are to be affirmed. Id. at 60, 37 W.C.D. at 240. Similarly, "[f]actfindings are clearly erroneous only if the reviewing court on the entire evidence is left with a definite and firm conviction that a mistake has been committed." Northern States Power Co. v. Lyon Food Prods., Inc., 304 Minn. 196, 201, 229 N.W.2d 521, 524 (1975). Findings of fact should not be disturbed, even though the reviewing court might disagree with them, "unless they are clearly erroneous in the sense that they are manifestly contrary to the weight of the evidence or not reasonably supported by the evidence as a whole." Id.

DECISION

The employee argues that the compensation judge's decision is not supported by substantial evidence in the record and is clearly erroneous. Specifically, the employee contends that the compensation judge was improper in accepting into evidence and relying on the opinion

and report of Dr. Tountas. It is the employee's contention that Dr. Tountas' report lacked adequate foundation because Dr. Tountas based his opinion on a totally inaccurate version of the facts surrounding the incident which produced the injury on March 13, 1996. (EE brief at pp. 3-4.) The employee contends that Dr. Tountas' assumption concerning how the employee had placed his hands around the stack of steel did not accurately reflect the positioning of the employee's hands and wrists at the time of the incident. As a result, the employee contends that Dr. Tountas' opinion should not have been accepted by the compensation judge.

We note that there is much testimony by the employee, by Drs. Callahan and Tountas in their depositions and evidence in the medical records concerning the weight of the steel bars and the placement of the employee's hands on or about the bars at the time of the injury. These various pieces of evidence and testimony are subject to multiple interpretations. It is the responsibility of the compensation judge to review these differing and sometimes confusing pieces of evidence and determine by a preponderance of the evidence what was most likely to have occurred. In this particular case the compensation judge made a determination with respect to the employee's hand positioning at the time of the injury. The employee argues that Dr. Tountas based his opinion on causation of the ligament tear on circumstances other than that found by the compensation judge. A careful review of Dr. Tountas' testimony, and especially his report of October 10, 1997, shows that the compensation judge was reasonable in concluding that Dr. Tountas' opinion was based on an accurate understanding of the mechanism of the injury. We note in Dr. Tountas' report that he was given two different versions of how the incident occurred. In his report he stated that,

> The history in your narrative of October 9, 1997 indicates that [the employee] was asked to move a two foot high stack of steel shanks weighing between 300 and 400 pounds. The narrative stated that he wrapped his arms around the stack and lifted them. The history I obtained [from the employee] is somewhat different in that he describes a certain positioning of the right and left hands and wrists to lift the shanks which were apparently about 18 inches long. I would question the positioning of the hands and wrists as reported to me as being reasonably able to lift the amount of weight reported as being 300 to 400 pounds.

In his report of October 10 Dr. Tountas indicated in his opinion that either mechanism, that described by the attorney's referral letter or the employee's statements at the time of examination, would not put the employee's left hand and wrist in a position which would have applied sufficient force or have been in the direction usually associated with a tear of the lunotriquetral ligament. Based on this statement, which was predicated on several different possible ways in which the incident of March 13, 1996 occurred, including the one adopted by the compensation judge, Dr. Tountas' opinion was based on adequate foundation and the real question for the compensation judge was the weight to which his opinion was entitled.

It is the responsibility of the compensation judge to resolve differences between

medical expert opinions. As pointed out by the compensation judge, she interpreted Dr. Kurland's report as indicating that he found it "difficult to explain" the causal connection between the ligament tear and the work injury. She observed that Dr. Callahan could offer no explanation of how he came to the conclusion that the ligament tear was related to the work incident. She noted that Dr. Tountas maintained that the employee's condition was not work-related and explained his condition in some detail. Based on this review she found Dr. Tountas' opinion to be more persuasive. Under the circumstances of this case, we cannot fault the compensation judge's choice between medical expert opinions. Nord v. City of Cook, 360 N.W.2d 337, 37 W.C.D. 364 (Minn. 1985).