

CINDY WOLFF, Employee, v. ZERCOM and ST. PAUL FIRE & MARINE INS. CO., Employer-Insurer, and ZERCOM and AETNA/TRAVELERS INS. CO., Employer-Insurer/Appellants.

WORKERS' COMPENSATION COURT OF APPEALS
FEBRUARY 2, 1999

No. [REDACTED SSN]

HEADNOTES

CAUSATION - GILLETTE INJURY; GILLETTE INJURY - DATE OF INJURY. Where the employee's treating physician opined that the employee's condition resulted from repetitive work activities, and the condition was first diagnosed on July 25, 1995, the compensation judge was supported by substantial evidence in finding that the employee had sustained a Gillette injury culminating on July 25, 1995.

CAUSATION - GILLETTE INJURY. Where the employer changed workers' compensation insurers 25 days before the culmination of the employee's Gillette injury, the compensation judge is required to find that the employee's work activities during that 25 days were a substantial contributing cause of the Gillette injury before the new insurer can be held responsible for benefits as a result of the Gillette injury.

Affirmed in part and remanded in part.

Determined by Wheeler, C.J., Wilson, J., and Hefte, J.
Compensation Judge: Carol A. Eckersen

OPINION

STEVEN D. WHEELER, Judge

The employer and its insurer prior to July 1, 1995, Aetna/Travelers, hereinafter Aetna, appeal from the compensation judge's finding that the employee sustained a Gillette-type¹ injury in the nature of right first dorsal compartment tenosynovitis, otherwise known as de Quervain's disease, culminating on July 25, 1995.

BACKGROUND

The employee, Cindy Wolff, commenced working for the employer Zercom on June 11, 1991 as an assembler. At the time the employee was 31 years of age. The parties

¹ Gillette v. Harold, Inc., 257 Minn. 313, 101 N.W.2d 200, 21 W.C.D. 105 (1960).

stipulated that for purposes of calculating the employee's weekly wage that she regularly worked a 36-hour week. All of the positions that the employee engaged in required her to continuously grasp and handle circuit boards on a highly repetitive basis. Prior to May 25, 1993, the employee never experienced any problems, difficulties or symptoms with her right or left upper extremities.

On May 25, 1993, the employee was working in the "lead trimmer job" when her right hand came in contact with an exposed electric wire. The electrical jolt knocked the employee to the ground, may have caused a brief period of loss of consciousness and caused a burn on the back of her right hand. The employee testified that she immediately felt tingling and a "strange feeling" in her right hand.

The employee sought treatment from Dr. Macy at St. Joseph's Hospital in Brainerd on May 26, 1993. Subsequently she was referred to Dr. James M. Smith, an orthopedic surgeon at Midsota Plastic and Reconstructive Surgeons in St. Cloud, hereinafter Midsota. She first was examined by Dr. Smith on June 7, 1993. On examination Dr. Smith found "a five to eight millimeter, slightly raised, very superficial, excoriated area on the dorsal aspect" of the employee's right hand. The employee reported to Dr. Smith that within a few days of the electrocution accident she noted increased swelling and discomfort around "the dorsal aspect of the right hand overlying the index MPC joint area." Dr. Smith's notes indicate that he advised the employee that electrocution injuries are "very unpredictable." He provided the employee with anti-inflammatory medication and indicated to her that surgical procedures would be unnecessary at that point. (Pet. Ex. A, office note of 6/7/93.)

On June 25, 1993, the employee was seen by Dr. Thomas L. Satterberg, also with Midsota, for a plastic surgery consult at St. Joseph's Hospital in Brainerd. Dr. Satterberg prescribed a special protective glove for the employee to wear during her work activities. The employee was seen on follow-up at St. Joseph's on July 23, 1993 by Dr. Paul M. Heath, also with Midsota Plastic Surgeons. On examination the employee complained of some intermittent sharp shooting pain as well as aching pain which was persistent for some days. She indicated that her pain waxed and waned. Dr. Heath recommended that the employee continue to wear the protective glove while at work. (Pet. Ex. C, records from St. Joseph's.)

The employee returned to see Dr. Smith on August 30, 1993, at which time she complained of discomfort and pain in the area of the electrocution. Also on that date Dr. Smith prepared a permanency rating, indicating that the employee had a zero percent permanent partial disability (PPD) rating as a result of her electrocution burn. (Pet. Ex. A, office notes from Midsota.)

The employee testified that after returning to work in May 1993 she was given a light duty job working on the "Ragen" machine. This work did not involve heavy lifting or handling vibrating tools or objects. It did, however, require frequent grasping of parts to be placed for the assembly process. The employee testified that even on the Ragen machine she continued to have intermittent tingling, pain and weakness in her right wrist which affected her ability to perform her work for the employer. Although she did not miss any time from work, she indicated

that work activity aggravated the pain in her hand which continued to increase in frequency and intensity over time. She stated she frequently reported her difficulties to her supervisor, Mary, at the employer.

The employee did not seek additional medical treatment until April 22, 1994, when she again saw Dr. Heath at St. Joseph's Hospital. Dr. Heath's notes reflect the following history from the employee:

[C]ontinued to have discomfort in her hand and now in the upper forearm, at least as much, if not more, than she did when she was seen last August. She indicates that most of the pain is over the metacarpals, particularly the second and third. This is made worse when she dorsiflexes or flexes her wrists, or grasps anything very heavy. She occasionally has a shooting pain up her forearm. She describes that pain as sharp type pain that comes and goes, but may last for up to half an hour at a time.

Dr. Heath indicated that he would discuss the employee's situation with his partners, Dr. Smith, who had seen the employee in the summer of 1993, and Dr. Paul W. Schultz. Thereafter the employee was scheduled for a bone scan and an EMG, both of which were accomplished on May 6, 1994 at St. Joseph's Hospital in Brainerd, and both of which proved to be within normal limits. On May 20, 1994, the employee was again seen in consultation at St. Joseph's Hospital by Dr. Heath. His consultation report indicates that the purpose of the meeting was for "a recheck and further discussion regarding her chronic arm pain." They discussed several treatment options and the employee opted for a referral to Dr. L. Michael Espeland at Anesthesia Pain Clinic in St. Cloud. (Pet. Ex. C.)

During June and July 1994 the employee underwent a series of stellate ganglion block injections at Dr. Espeland's pain clinic. The employee testified that these injections gave her very little relief. (Pet. Ex. D., T. 60-61.)

The employee testified that she continued to work at the Ragen machine and experienced difficulties. She stated that her hand became weak and more painful at the end of her work day and that she reported these symptoms to her supervisor. The employee was referred for an independent medical examination, by the employer's workers' compensation insurer, the St. Paul Companies, hereinafter St. Paul, to Dr. Mark E. Holm, who specializes in orthopedic surgery of the upper extremities. Dr. Holm examined the employee on October 25, 1994. Dr. Holm's report and deposition testimony indicate that the employee advised him that immediately after the electrocution incident of May 25, 1993 she felt numbness and tingling in her right hand and that since the injury her hand had felt tired. She advised Dr. Holm that her symptoms continued to worsen over time. On the date of the examination the employee complained of pain on the back of the right hand which occasionally radiated to the back of her right forearm. She stated that the pain worsened with activity. Following his examination and a review of the medical records from Dr. Espeland and Dr. Heath, Dr. Holm indicated that the employee's chief problem is "carpal

tunnel-like symptoms that have developed since her electrical injury.” He recommended a repeat EMG. He stated that the employee’s current condition was “in part directly related to the injury of 5-25-93 and also, in part, due to her repetitive gripping and grasping activities in the workplace since 5-25-93.” He indicated that the employee’s work activities should be restricted so that she should avoid repetitive firm grasping, grasping or pinching with her right hand and the use of vibrating power tools. He imposed a lifting restriction of five pounds on her right hand. He stated that these restrictions should be considered as permanent. In his October 25, 1994 report Dr. Holm stated that “there was no pain with manipulation of the right thumb CMC joint. Finkelstein’s test was negative, ruling out de Quervain’s tendinitis.”

On December 2, 1994 the employee was first seen by Dr. Paul W. Schultz, also of Midsota, at its clinic in St. Cloud. From this point through the date of hearing Dr. Schultz remained the employee’s primary physician. On the occasion of the initial examination, the employee’s complaints were noted to include:

Sharp aching pain over the dorsum of the right hand. No complaints of significant fingertip numbness. She notes generalized aggravation with any type of use of the hand. It is generally improved with rest. She does wear a splint for comfort. For nighttime sleep she is using Amitriptyline.

On examination Dr. Schultz noted positive results on a Phalan’s test and a mild positive Tinel’s on the right upper extremity. He noted that the Finkelstein’s test was negative bilaterally. Dr. Schultz indicated that the employee would be seen in occupational therapy for application of a TENS unit and that she could continue working subject to her currently outlined restrictions. Dr. Schultz again saw the employee on December 20, 1994. At that time the employee noted that her TENS unit was intermittently helpful. Dr. Schultz stated in his office notes that he had “no further recommendations for therapy and no surgical recommendations.” (Pet. Ex. A.)

In early January 1995 the employee met with representatives of the employer and a qualified rehabilitation consultant (QRC), Judy Gaub, to assist her in her efforts to maintain a full work schedule subject to her restrictions. At that time the employee was still working on the light-duty Ragen machine, as she had been since May of 1993. Some time after this meeting the employee was apparently transferred to the night shift where she worked three 12-hour shifts. The employee indicated that this shift was satisfactory. The employee testified that the work on the Ragan machine, while better than the wave machine or the lead trimmer machine, did cause her some aggravation of her hand/wrist symptoms. (T. 66-67.) The employee also saw Dr. Schultz on January 12, 1995. The employee reported that “overall she has noted significant improvement with the use of her TENS unit.”

The employee was examined by Dr. Schultz on February 24, 1995, at which time she complained of some mild tenderness in her right hand and wrist. The employee reported that “the TENS unit has improved her pain.” On April 6, 1995, the employee apparently telephoned the Midsota Plastic Surgeons reporting that over the weekend she had experienced recurring right

dorsal hand pain sometimes lasting five minutes at a time.

The employee was again seen by Dr. Schultz on April 27, 1995, at which time she continued to complain of pain over the back portion of her right hand and wrist. Dr. Schultz's office notes indicated that it was his "impression that Cynthia Wolff has chronic hand pain S/P electrical injury" and that he had no further recommendations for treatment or therapy at that time. On June 2, 1995, the employee returned to see Dr. Schultz. At that time she complained of "persistent pains over the dorsum of the hand near the site of the injury. She has recently noted some paresthesias on the pad surfaces of the radial side fingers."

The log sheets from Midsota indicate that on July 5, 1995 that the employee called and stated that "she has had increasing pain over the last week or so because the machine she normally operates has been sent out for repair. She has been clipping & bending wires which makes her pain increase as well as some soreness at the base of her thumb" (Pet. Ex. A.) On July 25, 1995, Dr. Schultz again examined the employee. His office note from that visit states as follows:

The patient is seen for a new problem. She has been complaining of pain at the base of the right thumb for about two weeks. She is working with her TENS unit satisfactorily which was reportedly purchased. She is taking objects out of bins and placing them on boards.

Physical examination demonstrates tenderness over the right first dorsal compartment. Finkelstein's is positive. No significant complaints of increased hand paresthesia. Full finger flexion and extension and full thumb flexion to the fifth distal metacarpal.

It is my impression that the patient has right de Quervain's disease.

I have recommended anti-inflammatories, thumb spica splint, and consideration of a Aristospan injection. . . .

Thereafter the employee continued to be treated by Dr. Schultz on several occasions in the latter part of 1995. She was again seen in July 1996. At that time the employee also exhibited a positive Finkelstein's test.

On January 10, 1997, the employee was re-examined by the St. Paul Companies' independent medical examiner, Dr. Holm. As a result of that examination and a review of medical records, Dr. Holm indicated that the employee's diagnosis was "status post electrical injury, right hand (resolved) and chronic de Quervain's tenosynovitis, right wrist. The first diagnosis is a direct result of the May 25, 1993 work injury. The second diagnosis is a new condition as of July 1995 that is probably related to her work activities but is not related to the May 25, 1993 work injury." Dr. Holm indicated that no work restrictions were required as a result of the electrical

injury but that as a result of her “new problem” she should be limited to a 40-pound lift on an occasional basis and repetitive lifting of 10 pounds or less. He also recommended that she continue to wear a wrist brace at work. He further stated that if the employee’s de Quervain’s tenosynovitis condition worsened in severity the employee would probably require a surgical release of the first extensor compartment.

In early February 1997 the employee returned to see Dr. Schultz. Dr. Schultz reconfirmed his diagnosis of de Quervain’s tenosynovitis disease based on another positive Finkelstein’s test and “a firm feeling of the first dorsal compartment.” For the first time he recommended that the employee consider a surgical release procedure. When seen by Dr. Schultz again on March 19, 1997, the employee indicated that she was off work because of her pain and that she had significant tenderness over her “first dorsal compartment.” She reported mild tenderness “over the region of the supinator” and “very mild central dorsal wrist tenderness.” The employee continued to see Dr. Schultz on numerous occasions throughout 1997. On each occasion she continued to complain of pain in her right hand and wrist. In his most recent report, dated March 31, 1998, Dr. Schultz stated that the employee had two separate work injuries, the first being an electrical injury to the back of her right hand on May 25, 1993 and the second being de Quervain’s disease “which dates from 1995.” The doctor anticipated that the de Quervain’s disease could be satisfactorily treated with a surgical procedure but that he would anticipate that the pain related to the 1993 electrical injury would be “chronic and unchanging.” He further stated that “it is my impression that her chronic dorsal hand pain is related to her electrical injury of May 25, 1993. Ms. Wolff’s current work capacity is currently complicated and limited by her ongoing de Quervain’s disease.” He further indicated that the recommended surgery is not directed for management of the employee’s electrical injury but as treatment for the tenosynovitis. (Pet. Ex. A.)

On July 10, 1997, the employee was examined by Dr. William Call at the request of the insurer, Aetna/Travelers. Based on his examination and the medical reports reviewed, Dr. Call opined that the employee “demonstrates a history and physical examination consistent with a long-term radial and dorsal wrist pain syndrome from an electrical injury occurring on 5-25-93. I don’t find specific focal evidence of de Quervain’s disease objectively supported. The patient did not respond to first dorsal compartment injections.” He further stated that if the employee in fact “does have de Quervain’s disease, then I would feel it is a result of her original electrical injury as a result of degenerative changes in the first dorsal compartment.” Essentially Dr. Call indicated that all of the employee’s current problems are directly related to the electrical injury of May 1993. (Aetna/Travelers Ex. A.)

The employee filed a claim petition on October 18, 1996, seeking permanent partial disability benefits under Minn. Stat. § 176.101, subd. 3t(b), based solely on an injury to her right upper extremity sustained on May 25, 1993. This claim petition was subsequently amended on March 5, 1997, at which time an injury date of July 1, 1995 was added, as was a claim for a second opinion and approval of a surgical procedure. The matter came on for hearing before Compensation Judge Carol A. Eckersen at the Office of Administrative Hearings on April 29, 1998. In addition to other issues decided by Judge Eckersen, which are not appealed herein, the

compensation judge determined that the employee had sustained a Gillette-type injury which culminated on July 25, 1995 in the nature of de Quervain's tenosynovitis. She approved the proposed surgery for that condition and indicated that the Aetna/Travelers Insurance Company was solely responsible for the effects of the Gillette injury. The employer and Aetna/Travelers appeal from that decision.

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 employer and its insurer, Aetna/Travelers, appeal only from the compensation judge's finding that the employee sustained a Gillette injury in the nature of de Quervain's tendinitis, which culminated on July 25, 1995, shortly after Aetna had commenced coverage for the employer. Aetna makes four arguments on appeal: (1) the employee's de Quervain's tendinitis problem was a direct and proximate result and consequence of the 1993 electric shock injury and there was no Gillette injury to the employee; (2) in the alternative, if the employee sustained a Gillette de Quervain's injury, that injury should have been found to have been in existence prior to July 1, 1995, when Aetna became the employer's workers' compensation insurer; (3) in the alternative, if the employee sustained a Gillette de Quervain's injury on July 25, 1995, responsibility for the injury could not be charged to Aetna as there was no showing or finding that the work activity between July 1 and July 25, 1995 was a substantial contributing cause of the Gillette injury; and (4) in the alternative, if Aetna were responsible then its exposure should be lessened by apportioning responsibility for the Gillette injury between the May 25, 1993 electrical injury and the repetitive trauma work activities prior to July 25, 1995.

A Gillette injury is a result of repeated trauma or aggravation of a pre-existing condition which results in a compensable injury when the cumulative effect is sufficiently serious to disable an employee from further work. Gillette v. Harold, Inc., 257 Minn. 313, 321-22, 101 N.W.2d 200, 205-06, 21 W.C.D. 105 (1960); Carlson v. Flour City Brush Co., 305 N.W.2d 347,

350, 33 W.C.D. 594, 598 (Minn. 1981). In order to establish a Gillette injury, an employee must “prove a causal connection between [his] ordinary work and ensuing disability.” Steffen v. Target Stores, 517 N.W.2d 579, 581, 50 W.C.D. 464, 467 (Minn. 1994). While evidence of specific work activity causing specific symptoms leading to a disability “may be helpful as a practical matter,” determination of a Gillette injury “primarily depends on medical evidence.” Id. A Gillette injury occurs when “it becomes reasonably apparent to the employee that the injury has resulted in, or is likely to cause, a compensable disability.” Isaacson v. Minnetonka, Inc., 411 N.W.2d 865, 867, 40 W.C.D. 270, 274 (Minn. 1987). The date of disability may be determined by considering other ascertainable events in addition to only considering the last day the employee worked. Schnurrer v. Horner-Waldorf, 345 N.W.2d 230, 233, 36 W.C.D. 504, 508 (Minn. 1984). It is not mandatory that an employee be disabled from work activity or suffer wage loss in order to determine that a Gillette injury has occurred. Johnson v. Lakeland Bean Co., 39 W.C.D. 884, 888 (W.C.C.A. 1987).

Aetna’s first argument is that the employee did not sustain a Gillette injury. While Aetna does not dispute that the employee has an injury in the nature of de Quervain’s tendinitis, it argues, based primarily on the opinion of its medical expert, Dr. Call, and several office notes by Dr. Schultz, that a substantial contributing cause of her condition was the electrocution injury sustained in May 1993. As of the date of hearing the final opinions of Dr. Holm, the St. Paul Companies’ expert, and Dr. Schultz, the employee’s treating physician, were that the employee sustained two distinct injuries to her right hand and wrist. Both doctors concluded that the pain and disability which was first identified on July 25, 1995 as de Quervain’s tendinitis was the result of repetitive work activities by the employee at the employer prior to July 25, 1993. We note that the primary test for the existence de Quervain’s disease is the Finkelstein’s test. In October 1994, Dr. Holm noted that the Finkelstein’s test was negative as to the employee’s right upper extremity and he specifically ruled out a diagnosis of de Quervain’s disease. Dr. Holm testified that the basis for his decision to rule out a causal relationship between the electrical injury and de Quervain’s disease was that there was no sign of de Quervain’s present for several years after the electrocution. The first occasion on which the employee exhibited a positive Finkelstein’s result was July 25, 1995. Dr. Schultz’s notes state that this condition was seen as a “new problem.” Both Dr. Holm and Dr. Schultz indicated that her condition was associated with her repetitive work activities for the employer. We find that Dr. Schultz’s and Dr. Holm’s latest opinions provide substantial support for the compensation judge’s determination that the employee sustained a Gillette injury in the nature of de Quervain’s tendinitis. The compensation judge was permitted to select their opinions rather than that of Dr. Call or Dr. Schultz’s earlier comments. Nord v. City of Cook, 360 N.W.2d 337, 37 W.C.D. 364 (Minn. 1985).²

² Aetna’s fourth argument, requesting partial apportionment of the responsibility for the de Quervain’s Gillette injury to the “St. Paul Companies’ 1993 injury” must be rejected on the same bases that we affirm the compensation judge’s finding that the employee sustained a Gillette injury on July 25, 1993, which was a separate and distinct injury, not substantially caused or contributed to by the 1993 electrocution incident.

In the alternative, Aetna argues that if the employee sustained a de Quervain's Gillette injury that this injury culminated before July 1, 1995, when it came on the risk at the employer. Aetna cites the deposition testimony of Dr. Holm, the St. Paul Companies' expert, in support of its position. Aetna points to Dr. Holm's agreement that the employee showed evidence of a Gillette injury as early as October 1994. Dr. Holm agreed that at that time there was some "physical damage" that was "a result of some repetitive work activity since the electric burn injury." (Resp. Ex. 1 at p. 21.) Aetna contends that the employee's activity on the Ragen machine, which did not allow her a variety of activities and which required a highly repetitive use of her right hand, caused a Gillette injury as early as October 25, 1994. Aetna argues that the employee's testimony concerning her symptoms, which were ongoing and increasing from 1993 through the period prior to July 1, 1995, establish that she had developed a severe disability directly related to her work activities after the electrocution incident.

The determination of the exact timing of the culmination of a Gillette injury is a question of fact for the compensation judge. In the case at hand, the first diagnosis of de Quervain's tendinitis was made on July 25, 1995. On all prior examinations, from May 1993 through June 1995, no evidence was found, either in subjective complaints by the employee or as a result of objective testing, that the employee had this disorder. The findings on examination subsequent to July 25, 1995 until the date of hearing confirmed that the employee continued to exhibit symptoms and have test results consistent with the July 25, 1995 diagnosis. We cannot fault the compensation judge for determining that this disorder did not culminate until after July 1, 1995 based on the medical records in evidence. It appears that the Gillette-type injury which Dr. Holm was referring to as being present in October 1994 was a suspected carpal tunnel syndrome problem, which he found to have subsequently abated. The employee did not make a claim for a Gillette injury in the nature of carpal tunnel syndrome and as a result the compensation judge was not unreasonable in ignoring Dr. Holm's testimony and Aetna's argument with respect to the finding of an earlier Gillette injury.

Aetna also argues that the employee's work activities during the 25 days from July 1 to July 25 were insufficient to be a substantial contributing cause of the de Quervain's disease. They argue that the compensation judge failed to make a finding that the work activity during this period was at all contributing to the employee's injury. Aetna points out that there is no evidence concerning the employee's work activities during this 25-day period and that it therefore cannot be held responsible. We agree that in a Gillette case, the compensation judge must find that the work activity after a change in coverage has been a substantial contributing cause of the injury which culminated after the change. Crimmins v. NACM No. Central Corp., 45 W.C.D. 435 (W.C.C.A. 1991); see also Tannahill v. Mid-American Lines, 40 W.C.D. 726 (W.C.C.A. 1987). In this case, the compensation judge failed to make such a specific finding. As this court cannot make factual determinations, this matter is remanded to the compensation judge for a specific finding on this issue.