

DAVID J. BIROS, Employee/Appellant, v. HOLLENBACK & NELSON and FARMERS INS. CO., Employer-Insurer, and TWIN CITIES BRICKLAYERS HEALTH & WELFARE FUND, Intervenor.

WORKERS' COMPENSATION COURT OF APPEALS
JANUARY 6, 2000

No. [REDACTED SSN]

HEADNOTES

CAUSATION - GILLETTE INJURY. Where the employee testified to 34 years of extremely hard work as a brick and block layer and described the stress placed on his low back by frequent bending and lifting, where his treating physician specifically linked his work with his low back condition and where no expert opinion was to the contrary, the compensation judge was clearly erroneous in finding that the employee had failed to prove the existence of a Gillette injury to his lumbar spine.

CAUSATION - GILLETTE INJURY. Where the medical opinion relied on by the employee to establish a Gillette injury did not specifically identify specific conditions and these conditions did not become materially obvious until after the date of the opinion, the compensation judge was not clearly erroneous in determining that there was inadequate evidence to support a causation finding for those conditions.

Affirmed in part, and reversed and remanded in part.

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

OPINION

STEVEN D. WHEELER, Judge

The employee appeals from the compensation judge's determination that he failed in his burden of establishing a causal relationship between the injuries to his lumbar and cervical spine, to his wrist and to his left femoral cutaneous nerve.

BACKGROUND

The employee, David J. Biros, was hired by Hollenback & Nelson Construction Company, the employer, in January 1995. Early in his career as a bricklayer the employee had worked for Loeffel-Engstrand Construction for approximately 30 years, from 1964 to August 1993. Immediately prior to joining the employer, he worked for three other contractors.¹ At all

¹ The employee testified that from August 1993 until February 1994 he worked for Crossroads Construction, then for Tifmeyer Construction and finally for Martin Benning from July through December 1994.

times the employee worked as a block layer or bricklayer. The employee testified that while block laying he was required to frequently bend and to repetitively lift and carry 60-pound blocks for seven to eight hours per day. Bricklaying required constant bending and laying of 700 to 800 bricks per day, each brick weighing approximately eight pounds. The employee presented a videotape exhibit which accurately demonstrated the work performed by him as a bricklayer. (Pet. Ex. L.)

The employee testified that as a result of his bricklaying activities he first noticed some significant pain in his low back and neck in approximately 1993 and 1994. (T. 35-36.) He did not seek medical treatment for his low back and shoulder symptoms, however, until August 1995. The employee also indicated that he may have had these symptoms on a less frequent basis in the early 1990's, but they were not significant and he simply ignored them. (T. 37.) Dr. Ryan's office notes, from the employee's initial visit on October 6, 1995, the physical therapy notes and the January 30, 1996 report of Dr. Zanich indicate that the employee reported that he had experienced some low back pain associated with his work activities for 10-15 years. (Pet. Ex. B.)

The employee started working as a bricklayer/block layer for Hollenback in January 1995. The employee stated that the bricklaying/block laying work performed there was the same as he had performed for his previous employers. On August 14, 1995, the employee was examined by Dr. Charles H. Moser, an orthopedic specialist at the St. Anthony Orthopaedic Clinic. Dr. Moser indicated that x-rays of the employee's left shoulder "reveal some mild AC degenerative change," and that x-rays of the lumbar spine "show diffuse degenerative changes in the lower lumbar interspaces." He diagnosed impingement syndrome of the left shoulder and a degenerative lumbar disc. The employee was again seen by Dr. Moser on September 19, 1995. At that time the employee continued to complain of symptoms in his lower back but was not having any significant radicular problems. (Pet. Ex. F.)

On September 24, 1995, Dr. Moser referred the employee to Dr. Karen Ryan, M.D., a physical medicine specialist. The employee was first seen by Dr. Ryan on October 6, 1995. Dr. Ryan's office notes from that date contain the following comments:

He reports a gradually progressive history of back pain over the past 14-15 years, with pain, predominately with lifting. He complains of a "toothache" pain in the low back when he stands upright with some discomfort into the L buttocks and in the R lateral lumbar muscles. Getting into his truck at the end of the day and even walking up the hill at his home can be very painful.

He reports his symptoms progress from the morning to the end of the day, with lifting in the midline and are especially bad when he lays block above the 6th or 7th course (42"-56"). He reports that sometimes his back "locks up." The patient denies radiation of pain into the arms or legs, LE numbness or tingling, focal weakness of the arms or legs, problems of balance, incoordination, loss of bowel

or bladder control, and urinary retention. He does report that his L arm falls asleep at night or if held in a flexed position. Sitting does not increase his pain and he is able to drive up to a 100 miles without having pain.

He reports that Dr. Moser recently completed back x-rays, with finding of DJD and he was instructed for exercises including pelvic tilts, abdominal strengthening, bridges, side bends and crouching, with no particular improvement. He finds that use of an elastic corset helps decrease his pain when laying brick, but has found nothing to prevent the pain when he lays block. He has been taking Ibuprofen, 800 mg TID, which does decrease his work related shoulder pain, but is unsure of its effect on his back.

Dr. Ryan prescribed a course of physical therapy and an aerobic swimming program.

The employee returned to see Dr. Ryan on November 3, 1995. The employee indicated that the physical therapy program and home exercises had been in effect for approximately two weeks. The employee continued to report that his symptoms became worse at the end of his work day. The employee reported no particular improvement in function or change in his back pain. The employee again saw Dr. Ryan on December 15, 1995. At that time the employee made the following report to Dr. Ryan:

He reports that his pain has increased again and associates it with the fact he has been laying block for the past 2 weeks. He is reporting difficulty with work above the 4th course (32"), and complains of stiffness and clumsiness in his legs, stumbling and a sensation that his legs "won't work." He is having increased discomfort in his shoulders, back and at his knees. He reports the symptoms still progress from the morning to the end of the day and that getting out of his truck at the end of the day is particularly painful. The lumbar cushion did not help. Static standing also increases his back pain.

He denies any neck pain, radiation of pain into the arms or legs, focal weakness or numbness of the arms or legs, loss of bowel or bladder control, and urinary retention. His symptoms do not change much with overhead activity. Neck rotation does not affect his symptoms.

Dr. Ryan made the following assessment concerning the employee's condition:

Mr. Biros' back pain has again increased with the resumption of heavier duties at work. The interventions aimed at the T-L junction

and the anti-inflammatory have had no apparent effect. His prior x-rays have shown low lumbar DJD, and despite the fact that he does not show long tract or clear radicular signs, MRI of the spine, from the T6-low lumbar region is warranted to better access the soft tissue components, to access for a disc herniation, a central canal stenosis or other bony pathology.

An MRI of the employee's thoraco lumbar back from T6 to L4 was completed on December 20, 1995. The conclusion of the radiologist from this MRI was as follows:

1. Multilevel Schmorl's nodes and disc dehydration compatible with thoracolumbar Scheuermann's and/or juvenile discogenic disease.
2. Circumferential annular bulging is seen at L4-5 with minor spondylolisthesis also apparent and mild contact with exiting left L4 nerve root within the intervertebral nerve root canal.
3. There is a mild annular redundancy at several levels in the thoracic spine and mid and upper thoracic levels, most predominately on the right side at T6-7 where there is mild cord contact and flattening.

Flexion and extension x-rays of the lumbar spine taken on December 30, 1995, were interpreted to show moderate narrowing with marginal osteophyte formation at the anterior L4-5, reflecting degenerative changes at this level. There was mild anterior subluxation of L4 on 5, moderate to marked anterior osteophyte formation at L3-4 without frank disc narrowing.² (Pet. Ex. C.)

The next contact the employee had with Dr. Ryan was a telephone call on January 8, 1996, the report of which is set forth in Dr. Ryan's notes as follows:

Received a call from pt. re: increased symptoms with work with 12" block, which weighs 60 lbs. He complains of increased frequency of tingling into the buttocks. I asked him to come in to have an EMG completed to access for radicular changes.

On January 10, 1996, Dr. Ryan administered a lower extremity EMG, which she interpreted to show "bilateral radiculopathy, both acute and chronic, which clinically correlates with his demonstrated L4-5 spondylolisthesis with degenerative changes." Dr. Ryan made the following assessment of the employee's condition:

Mr. Biros has evidence for acute radiculopathy in the lumbar paraspinal muscles, with extremity findings suggestive of

² Similar findings were found in subsequent flexion and extension x-rays taken on November 15, 1996 and April 7, 1997. (Pet. Ex. C.)

involvement of the L5 nerve roots and definitive findings of chronic denervation with reinnervation in the L medial thigh, probably in the L4 root. With these findings, I do not feel that he should continue his present work activity, as it increases his risk of developing a clear cut cauda equina syndrome. It is likely, especially given the giant potentials in the L vastus medialis, that this problem has been developing for at least the last 10, if not 15 years, which coincides with his reported history of back pain. How quickly it might progress is unclear.

I do feel that repetitive lifting of 60 lb. concrete blocks, all day long, as well as the repetitive bending to lay them, will accelerate degenerative changes and promote nerve root compromise for him. I do feel that it is likely that, if he stopped his work as a brick and block layer that he could get satisfactory control of his pain, and likely prevent rapid progression of his radicular symptoms with a conservative treatment program. Similarly, I believe he could get pain control and possibly complete prevention of progression of his radiculopathy at the currently affected levels with a surgical fusion at the L4-5 level, but I am also relatively certain that his post operative restrictions would not allow him to return to his current physically demanding job. However, the only way to be certain about the surgical options in the post-op restrictions would be for him to meet with a spine surgeon.

On January 12, 1996, Dr. Ryan met with the employee and his wife and recommended that the employee not continue in his current work activity of laying block. She did indicate that the employee could lay bricks. In a January 12, 1996 letter to Dr. Moser, Dr. Ryan indicated that she believed that it would be unwise for the employee to continue his present work activities. She stated that she felt the heavy and repetitive lifting would accelerate the employee's lumbar degenerative condition. (Pet. Ex. A.) Dr. Ryan referred the employee to neurosurgeon Mark Fox, who examined the employee on January 26, 1996. The employee's chief complaint to Dr. Fox was "[c]hronic back pain for 10-12 years and right leg pain for approximately four months." Dr. Fox indicated that the employee "likely has a component of degenerative disc disease as a source of his chronic pain." He indicated that a discogram would be needed before any fusion surgery. (Pet. Ex. H.)

At about the same time the employee apparently reported to his employer that he was having difficulties. A first report of injury, filed February 16, 1996, but showing a report of January 25, 1996, and a first day of lost time of January 29, 1996, indicated that the employee had "pain in neck, shoulders, mid back - low back - hip - knees - numbness on R leg - toes - lack of mobility shoulders and knee, mid and low back, lack of sleep due to pain." (Judgment Roll.) As a result, the employer sent the employee to Dr. David Zanich, M.D., at the Airport Medical Clinic, on January 30, 1996. Dr. Zanich diagnosed chronic musculoligamentous lumbar strain with no

evidence of radiculopathy, subject to having an opportunity to review prior diagnostic tests. He restricted the employee to lifting no more than 35 pounds and to avoid repetitive bending. (Judgment Roll.)

The employee was next seen by Dr. Ryan on February 16, 1996. At that time the employee was having significant continued shoulder pain, especially with arm activity, particularly when done overhead and in shoulder extension. The employee denied any neck pain and was indicating he was having somewhat less back pain when he observed his lifting and bending restrictions. Apparently the employee was engaged in lighter duty work at the employer, although he did indicate that when he assisted a coworker in lifting a heavy object he did have increased pain. Dr. Ryan's assessment at that time was as follows:

Mr. Biros has had some improvement of his back pain with the decreased stresses at work, due to following the restrictions suggested by Dr. Zanick.

* * *

I still feel that, if he stops stressing his back with physically demanding work activity, he has a good chance of getting pain control with a program of exercise and possibly a L-S brace or corset.

Because of the employee's continuing difficulties with shoulder pain and limitations of his shoulder and neck movements, Dr. Ryan ordered cervical x-rays. Dr. Ryan continued the restrictions placed on the employee by Dr. Zanick.

On February 20, 1996, Dr. Ryan issued a letter stating that it would be unwise for the employee to continue his "present work activities" because they irritated his shoulders and would accelerate his back problems. On March 14, 1996, Dr. Ryan issued a report commenting on several jobs that were being proposed for the employee. She stated that the employee could not continue in his current job as bricklayer/foreman because of the repetitive lifting. She also opined:

Causation: I do feel that Mr. Biros' work with this employer, in the past 2 years, has been a significant contributing factor to his current condition. I feel that his medical conditions, including the spondylolisthesis and radiculopathy in his back and the tendinitis/bursitis in his shoulders have been caused by his employment as a brick and block layer and are not due to a congenital or non-work related condition. The spondylolisthesis in his lumbar spine is present on a degenerative basis, due to wear and tear through many years and is not congenital.

On March 29, 1996, the employee was given a light duty job as a field supervisor with the employer. His responsibilities include starting jobs, scheduling, personnel problems and

visiting 11 to 12 job sites by truck. The employee has continued in that position, at least until the date of hearing on December 11, 1998.

On April 1, 1996, the employee returned to see Dr. Ryan. She reported that since his last office visit the employee had visited with Dr. Moser who had injected his right shoulder, but with no relief. She stated that the cervical spine x-rays showed mild degenerative disc changes at C4-5 and C6-7. The employee reported that his back was "somewhat better" and he had been avoiding lifting and had not been laying block or brick for the past month. She noted that the employee indicated that after raking leaves recently that he had increased back pain. Dr. Ryan's assessment on April 1, 1996, was as follows:

Mr. Biros has had further improvement of his back pain with a reduction of his work activities and lifting. He now has a normal L ankle jerk, which is a reversal of a loss of ankle reflex seen at his last visit. He continues to have sensory symptoms in the distribution of the lateral femoral cutaneous nerve of the thigh and leg clumsiness, which is worrisome for a smoldering cauda equina compression.

He still has marked shoulder pain, again, mostly in the central 60° arc of motion, aggravated by activity, consistent with a rotator cuff tendinitis/sub deltoid bursitis, but the R shoulder injection had no apparent effect on the pain. He does have improvement of shoulder motion and of his neck motion. He does have degenerative disc changes on his C-spine x-rays and the pain may still represent a cervical radiculopathy. The current sensory findings are more consistent with ulnar compression at the elbow, than they are of radiculopathy, but UE EMG may still be of use to assess for any evidence of radiculopathy or myelopathy.

Restrictions placed by Dr. Ryan on the employee were that he was "to continue to avoid lifting more than 35 lbs, and is not to lift anything repetitively. He is to do no repetitive bending below knee level and no prolonged sitting or static standing."

The employee returned to Dr. Ryan on April 29, 1996, with continuing complaints of shoulder pain with activity, pain above the medial aspect of the elbow bilaterally and continued occasional left greater than right fourth and fifth finger pain, as well as numbness, but no radiating pain from the neck to the arms and no weakness. The employee reported that his low back pain increased with activity and driving. He stated that he had difficulty walking on rough ground and has problems with right foot weakness after walking, when his back pain is worse. He continues to have intermittent right leg parasthesias and numbness. Dr. Ryan's assessment after the examination was as follows:

Mr. Biros has stable back pain with continued limitation of his work activities and lifting. He has no further symptoms or findings to suggest any progression of his radiculopathy or a cauda equina syndrome. . . .

He still has marked shoulder pain, with bilateral arm pain to suggest the pain may still represent a cervical radiculopathy. . . .

On May 1, 1996, the employee returned to Dr. Ryan for an EMG in connection with his continuing shoulder pain, intermittent neck pain and dysesthetic sensation in the fourth and fifth fingers of both hands. The employee had a cervical MRI on May 9, 1996. Dr. Ryan indicated that the MRI showed mild disc bulging at C3-4 and C6-7, but with no disc herniation or evidence of neural compromise.

The employee was seen by Dr. Ryan again on May 10, 1996. At that time he was complaining of shoulder pain, bilaterally, which increases with activity. He was reporting no radiating pain from the neck to the arms, that his back pain was still “noticeable” and that he felt clumsy on rough ground and up inclines. Dr. Ryan’s assessment at that time was as follows:

Mr. Biros still has marked shoulder pain, with EMG documented cervical radiculopathy but no findings of disc herniation or neural compression on his MRI. Presumably he has had some nerve root compromise, from an unclear source, perhaps from phospholipase A2, as described by Saal, et al from the discs,^{1 2} which has changed the muscular control of the rotator cuff muscles and subsequently developed a rotator cuff tendinitis. His scan does not, however, show any apparent annular tears. He has not been doing any neck exercises and may benefit from a program to address neck strength. Perhaps with increased control of his head and neck motions, after neck strengthening, he will have fewer difficulties with his shoulders.

His EMG also documented bilateral medial neuropathy at the wrist and that may be contributing to his shoulder pain, as CTS pain can be referred to the shoulder. He does not have particular complaints to suggest an active CTS, however his increased shoulder pain at night might reflect carpal tunnel involvement. . . .

He has relatively stable back pain which he has managed by volitional continued limitation of his work activities and lifting. . . .

1 Saal, Joel; Franson, Richard, Dobrow, Robert; Saal, Jeffrey; White, Arthur; and Goldthwaite, Noel; High Levels of Inflammatory

Phospholipase A2 Activity in Lumbar Disc Herniations, Spine 15 (7):674-678, 1990.

2 Franson, Richard; Saal, Joel; and Saal, Jeffrey; Human Disc Phospholipase A2 is Inflammatory, Spine, 17 (6 Suppl.): S129-S132, 1992.

The employee returned to see Dr. Ryan on June 7, 1996. At that time the employee displayed “classic signs of rotator cuff tendinitis.” His lower back pain and radiculopathy were stable to slightly improved. Also on June 7, 1996, the employer and insurer filed a Notice of Denial of Liability, indicating that the employee suffered from a preexisting degenerative condition and his problems were not work related. Thereafter the employee continued to treat with Dr. Ryan on an almost monthly basis until June 13, 1997. During this time the employee’s complaints were primarily of low back pain and shoulder pain. There was some evidence of complaints of neck pain and tingling in his fingers. During this time the employee was treated with medications for pain control and to assist him in sleeping. The employee continued to work in his field supervisory position, which he apparently tolerated, with some occasional difficulties associated with walking on frozen ground and driving his truck from site to site. Dr. Ryan’s notes from June 13, 1997 contain the following history:

Mr. Biros returns to the office in follow-up of his bilateral lumbar radiculopathy, meralgia paresthetica, L4-5 spondylolisthesis, mid body weakness, pain, bilateral cervical radiculopathy, and bilateral shoulder pain with rotator cuff tear/tendinitis. Since last seen he reports a stable course, with continued problems with constant, low grade back pain, with soreness in the mornings, mid body weakness with compensation into a lumbar extension posture, and stinging and tingling in the R lateral thigh. He denies focal LE weakness and although he still has occasional bladder and bowel urgency, he has had no bladder or bowel incontinence.

He reports continued bilateral shoulder pain, usually R > L. Even turning his steering wheel can bother his shoulders. He has had an occasional “catch” in his neck, but no radiation of pain from the neck to the arms. He has no new numbness or tingling in the UE, reporting continued hand tingling with driving, which he believes is associated with the vibration of the steering wheel. It still resolves if he changes position. He denies night time tingling.

In a report dated June 23, 1997, Dr. Ryan indicated that the employee had reached maximum medical improvement and that he had permanent partial disability ratings totaling 47.0% impairment of the body as a whole. She arrived at this level of permanency by stating that the employee had the following ratable conditions and ratings: (1) Grade I lumbar spondylolisthesis, with bilateral lumbar radiculopathy, for a combined value of 20.6%; (2) cervical strain with EMG

documented bilateral cervical radiculopathy, a combined value of 15.7%; (3) meralgia paresthetica as a result of impaired function of the right lateral femoral cutaneous nerve, 4%; (4) bilateral partial rotator cuff tears, 4%; (5) for loss of range of motion and flexion and abduction at the right shoulder, 6%; (6) bilateral median neuropathy at the wrist, as documented on EMG, 6%; and (7) right ulnar neuropathy at the wrist, as documented on EMG, 3%. In addition to the above ratings, Dr. Ryan indicated that the employee suffered from headaches and chronic pain. She indicated that the employee would require periodic ongoing medical follow-up and medication. She suspected that his condition would continue to deteriorate and may require surgical intervention. Dr. Ryan's records do not reflect that she treated the employee after June 13, 1997. Dr. Urban's notes indicate a referral of the employee from Dr. Ryan following an examination in mid August 1997.³ At the hearing, the employee testified, however, that he did consult with Dr. Ryan in the summer of 1998 and was examined by her in December 1998.

On August 14, 1997, the employee was examined by Dr. Paul Wicklund, an orthopedic surgeon, at the request of the employer and insurer. At that time the employee gave a history of commencing work at Hollenback & Nelson in January 1995 as a bricklayer. He advised Dr. Wicklund that in September of 1995 he started to have trouble lifting blocks and that by the end of September he had significant pain in his shoulder and low back. As a result, he had to stop performing the bricklaying position and returned to work as a field supervisor. The employee related that he had not had a specific injury in his work at Hollenback & Nelson. On the date of examination the employee indicated that his pain is less severe in the morning and worsens as the day goes on. The employee stated that he has bilateral shoulder pain, all of the fingers in both hands tingle and he feels weakness in his hands. He also complained of low back and neck pain. As a result of his examination and review of the various medical reports and records, Dr. Wicklund made the following diagnosis: (1) multi-level degenerative disc disease, cervical spine and lumbar spine; (2) bilateral impingement syndrome, shoulders; and (3) right carpal tunnel syndrome. Dr. Wicklund provided the following opinion concerning the employee's conditions:

Based on my history, physical, and review of the medical records, it's my opinion to a reasonable degree of medical certainty that there is no specific injury that Mr. Biros sustained at Hollenback & Nelson. In my opinion his condition is stabilized and therefore he has reached maximum medical improvement. If it is assumed that he had some form of injury at Hollenback & Nelson, then he would have a 10% permanent partial disability of the body as a whole because of multi-level degenerative disc disease in the lumbar spine. In my opinion he can continue working full-time as a supervisor. The only restrictions I would place on him are no lifting more than 40 pounds and no repetitive use of his hands. The only further treatment may be release of his right carpal tunnel. This is going to be evaluated by Dr. Tountas.

³ It is possible that the exhibits do not contain all the treatment records from Dr. Ryan after June 13, 1997.

Dr. Wicklund again examined the employee on September 18, 1998. As a result of this examination and review of the medical records since his last examination, Dr. Wicklund provided the following diagnosis: (1) bilateral impingement syndrome, right and left shoulder, left treated surgically with an average result; (2) multi-level degenerative disc disease, cervical spine; and (3) juvenile diskogenic disease, lumbar spine. Dr. Wicklund provided the following opinion concerning the employee's condition:

Based on my history, physical, and review of the medical records, it's my opinion to a reasonable degree of medical certainty that Mr. Biros has reached maximum medical improvement from any and all injuries that he has claimed including his shoulder problems. In my opinion he has permanency, 2% for each shoulder, based on Section 5223.0450, Subpart 3A(1). In my opinion he can continue working full-time in his supervisory job. His restrictions should include no brick or blocklaying. He shouldn't do overhead work. He shouldn't lift more than 20 pounds to waist level, otherwise there are no restrictions on his job. I would recommend a decompression of his right shoulder if right shoulder symptoms worsen.

On August 15, 1997, the employee was examined by Dr. Chris Tountas, an orthopedic surgeon. His examination was primarily for the employee's shoulder and upper extremity difficulties. Dr. Tountas examined the employee, reviewed the medical records of Dr. Ryan and the various x-rays, MRIs, and EMG reports. He provided the following diagnosis:

1. Tendonitis of the right shoulder with partial rotator cuff tear. Tendonitis, left shoulder. There is no evidence on MRI of the cervical spine to support nerve root compression resulting in cervical radiculopathy. Neurologically upper extremities are intact.
2. In addition, the clinical findings do not support a diagnosis of carpal tunnel syndrome and therefore clinical correlation is lacking relative to the EMG. The same conclusion is relative to any evidence for an ulnar neuropathy. In my opinion, the shoulder changes noted on x-ray and/or MRI are pre-existent to his employment at Hollenback and are degenerative. In my opinion Mr. Biros did not sustain an injury to his neck, shoulders or upper extremities as a result of work activity at Hollenback and Nelson.
3. In my opinion, Mr. Biros has reached maximum medical improvement.

4. As a result of employment at Hollenback and Nelson, there is no basis for any residual partial permanent impairment.

* * *

6. Restrictions are to limit heavy lifting and carrying at or above shoulder level. There are no restrictions relative to the use of the head and neck, or his hands. There is a lifting restriction for the shoulders of 40 pounds.

(Resp. Ex. 2.)

On August 29, 1997, the employee was seen at Orthopaedics Surgeons, Ltd. by Dr. Mark A. Urban. This examination was primarily in connection with the employee's shoulder difficulties. Dr. Urban initially diagnosed advanced bilateral impingement syndrome which he believed would require acromioplasty. In a follow-up visit on October 2, 1997, Dr. Urban confirmed that as a result of his review of the June 1996 MRI of the employee's right shoulder that the employee had a partial thickness rotator cuff tear. An MRI of the left shoulder was ordered by Dr. Urban and completed on October 2, 1997. This MRI indicated some partial thickness tearing of the left rotator cuff, displacement of the biceps tendon with marked degeneration and also hypertrophy of the AC joint. Dr. John Anderson, an orthopedic surgeon at the same group, saw the employee on October 21, 1997. It was his opinion that the employee's shoulder pain was due to his brick and block laying activities and he advised him to undergo surgery. This surgery on the left shoulder was completed by Dr. Edward M. Szalapski, M.D., on February 11, 1998. The post-operative report indicates that "the rotator cuff is grossly intact and does not appear to be substantially thinned," which was noted to be inconsistent with the MRI findings. (Pet. Ex. E.)

In a report dated June 30, 1998, Dr. Szalapski indicated that the acromioplasty performed on February 11, 1998 to decompress the employee's shoulder and allow rotator cuff healing was not particularly successful. As a result, surgery on the right shoulder was not planned. He indicated that as a result of the employee's shoulder problems he had a 4% permanent partial disability rating of the whole body. (Pet. Ex. D, E.)

On February 25, 1997, the employee filed a claim petition alleging entitlement to permanent partial disability and medical expenses as a result of an injury in the nature of "[m]ulti-level disc degeneration, bulging disc at L4-5 with compression spondylolisthesis, multi-level thoracic annular redundancy with compression at T6-7, tendonitis of right shoulder." The date of claimed injury was January 29, 1996. The matter came on for hearing before a compensation judge at the Office of Administrative Hearings on December 11, 1998. In her findings and order of February 9, 1999, the compensation judge determined that the employee had sustained injuries to his right and left shoulders, primarily as a result of the admission of this injury by the employer and insurer.⁴ She awarded medical expenses related to those shoulder injuries and a 4% permanent

⁴ The judgment roll contains a January 28, 1998 letter from counsel for the employer and insurer apparently admitting liability for the shoulder injury and an agreement to pay for the shoulder surgery which was done on February 11, 1998.

partial disability rating. The compensation judge denied the employee's claim for any permanent partial disability or medical expenses related to any of the other alleged injuries sustained at the employer. 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

In denying the employee's claims for medical expenses and permanent partial disability, the compensation judge stated that the employee "did not sustain Gillette injuries to his lumbar spine, cervical spine, wrists and left femoral cutaneous nerve arising out of and in the course of employment." (Conclusion of Law, No. 1.) The compensation judge did find that "the employee has a 2% permanent partial disability of each shoulder. The employee does not have permanent partial disability causally related to a work injury for any of the remaining alleged injuries or conditions." (Conclusion of Law, No. 2.) She also stated that, "The employee is entitled to payment of medical benefits related to treatment of his bilateral shoulder condition. He is not entitled to payment of medical care for any of the other alleged conditions which have not been found to be causally related to a work injury." (Conclusion of Law, No. 3.) In her findings the compensation judge recited the reports of Dr. Tountas and Dr. Wicklund but did not specifically indicate that she adopted their opinions.

In her memorandum the compensation judge explained her denial of benefits for the claimed injuries to the lumbar spine, cervical spine, bilateral wrists and left femoral cutaneous nerve by stating "the employee has failed to meet his burden of proof in that he has not offered credible medical evidence that his work activities were a substantial contributing cause or aggravation of the conditions he claims." The compensation judge goes on to state,

Dr. Ryan gave a blanket statement that the employee's work for the past two years with Hollenback and Nelson was a substantial

contributing factor to his current condition in her March 14, 1996 report. She fails to support his [sic] opinion with an explanation in her reports. Her clinical records are, as Dr. Urban notes, “lengthy and difficult to follow.” Her assessments at times suggest more diagnoses to be considered. I do not find her opinions credible. The employee has not met his burden of proving that his work activities were a substantial contributing cause or aggravation of the conditions he claims.

On appeal the employee contends that the compensation judge’s determination is not supported by substantial evidence in the record and is clearly erroneous. The employee recites the evidence which supports his position that he sustained a Gillette injury which culminated during his employment at Hollenback and Nelson. This evidence includes the follows:

1. The employee’s testimony concerning the specific work activities he engaged in at Hollenback and Nelson as a brick and block layer and the attendant pain which occurred during and immediately following his work activities.
2. The employee’s testimony that he did have prior difficulties with his low back but that those problems never prevented him from doing his work and did not cause him to seek any medical attention until after eight months of working with Hollenback and Nelson.
3. Dr. Ryan clearly opined that the employee’s low back and shoulder conditions were causally related to his work activities at Hollenback and Nelson.
4. Her March 14, 1996 report, while not specific as to the neck, cutaneous nerve and wrist difficulties, did encompass all conditions the employee suffered at that time.
5. Dr. Ryan’s office notes, which were voluminous, clearly showed that the employee provided a history to Dr. Ryan of work activities after October 6, 1995 which were very specific, and which the employee tied to specific symptoms caused by that activity.
6. The opinions of Dr. Wicklund and Dr. Tountas do not state that the employee did not suffer a Gillette injury while working for the employer.

As a result, the employee argues that while Dr. Ryan’s notes are “lengthy and difficult to follow” they clearly establish that it was her considered opinion that the employee’s permanent injuries, which she detailed in her report of June 28, 1997, were caused by the cumulative effects of many

years of work activities, which culminated with a requirement for medical care and a loss of time in January 1996.

The employer and insurer, in response to the appeal, cite this court's decision in Reese v. Northstar Concrete, 38 W.C.D. 63 (W.C.C.A. 1985), give passing reference to Steffen v. Target Stores, 517 N.W.2d 579, 50 W.C.D. 464 (Minn. 1994), and cite Nord v. City of Cook, 360 N.W.2d 337, 37 W.C.D. 364 (Minn. 1985). With respect to Reese, the employer and insurer contend that there was insufficient specific information connecting the work activities at Hollenback and Nelson to the employee's problems. With respect to Steffen and the supreme court's pronouncement therein that determination of a Gillette injury is primarily a question of medical evidence, they contend that the compensation judge has made a choice between medical experts and that decision should therefore be relied upon based on our decision in Nord. The employer and insurer contend that the compensation judge relied on the opinions of Drs. Wicklund and Tountas to find that Dr. Ryan's opinion was inadequate.

The compensation judge did not specifically cite Nord or indicate that her decision was based on the selection of the opinions of Drs. Wicklund and Tountas over that of Dr. Ryan. The compensation judge stated that her decision was based on the failure of the employee to produce "credible" evidence sufficient to establish a prima facie case that he had sustained a Gillette injury. She stated that he failed to "meet his burden of proof." In her memorandum she stated Dr. Ryan's opinion was not "credible" because it was "a blanket statement," her clinical notes were "lengthy and difficult to follow," she did not provide an explanation to support her opinion and suggested that "more diagnoses be considered." Essentially the compensation judge dismissed the employee's claim for lack of any medical support. She found Dr. Ryan's reports and notes, standing alone, did not persuade her that the work activity at the employer caused the employee to sustain a Gillette injury to any part of his body. As a result, it was unnecessary for the compensation judge to weigh Dr. Ryan's report against those of Dr. Wicklund or Dr. Tountas.

The issue before us is whether the compensation judge's summary dismissal of the employee's claim was appropriate. In part, as to the existence of a Gillette injury to the lumbar spine, we believe she was clearly erroneous. There was sufficient evidence, even without Dr. Ryan's opinion, to establish that the employee sustained a Gillette injury. The employee testified in detail about his work activities lifting blocks and bricks for over 30 years. He stated that he had a gradual onset of low back pain which increased in severity until August 1995, when he first sought medical help. He indicated that he first asked for relief from work in late January 1996, when he told his employer of his difficulty. He stated that in late March 1996, he had to change jobs to a light-duty supervisory position. The videotape, Petitioner Exhibit L, demonstrated that the employee's work involved very heavy lifting and repetitive bending under stress. The diagnostic tests, x-rays and an MRI, demonstrate that the employee has multilevel degenerative disc disease to his lumbar spine. This view was shared by the employer's IME, Dr. Wicklund when he stated that the employee had a 10% permanent partial disability rated as a result of a multi-level degenerative condition in his lumbar spine. There can be no question that the employee has an injury to his lumbar spine related to his work activity. In addition, the first

time he received treatment, the first time he had to work under restrictions, his first change of jobs and first lost time occurred after he had worked for the employer for at least eight months.

We agree that while Dr. Ryan's office notes are lengthy and may be difficult to follow, they are very clear concerning the employee's lumbar spine condition. Her March 14, 1996 opinion specifically connects the employee's spondylolisthesis condition to his work activities. She states that the condition is degenerative, "due to wear and tear through years" and is not the result of congenital difficulties. This seems to be a sufficient explanation for a fairly obvious connection between a significant amount of heavy work for the employer and a degenerative condition. Dr. Ryan's office notes clearly show that she was aware of the employee's specific work activities, such as lifting blocks to specific heights and having more symptoms later in the workday, which led to specific low back symptoms. (See Pet. Ex. B, notes of 10/6/95, 12/15/95, 1/10/96.) It is hard to imagine a more compelling case for the finding of a Gillette injury to the employee's lumbar spine culminating while working for the employer and contributed to by work for the employer.

It is unnecessary to remand the issue of whether an application of the principles in Nord would be appropriate in this case. There is no evidence which contradicts a finding that the employee's work for the employer was a substantial contributing cause of a Gillette injury to the employee's lumbar spine. Dr. Wicklund's opinion does not address the issue of whether the employee sustained a Gillette injury. He only states that the employee did not sustain a specific injury at the employer. We note, with interest, Dr. Wicklund comments that "[i]f it is assumed that he [the employee] had some form of injury at Hollenback & Nelson, then he would have a 10% permanent partial disability of the body as a whole because of multi-level degenerative disk disease in the lumbar spine." (Emphasis added.)

Having found a Gillette injury to the lumbar spine, related to the employee's work at the employer, we remand for a finding by the compensation judge of the date the injury culminated and a finding of the amount of permanent partial disability to attribute to the injury.

With respect to the employee's alleged Gillette injuries to the neck, wrists and left femoral cutaneous nerve, however, we believe the compensation judge's assessment is not clearly erroneous. First, Dr. Ryan's March 14, 1996 causation opinion, upon which the employee relies, does not specifically refer to any of these conditions. Second, Dr. Ryan's clinical notes do not make any material reference to concerns about these conditions until after March 14, 1996. From August 1995, when the employee first sought treatment, until March 14, 1996, the primary focus of the employee's complaints, physicians and physical therapist's treatment and diagnostic testing was the employee's lumbar spine and shoulders. There is some reference to numbness in the employee's right thigh and some question concerning whether there might be some range of motion problems with the employee's neck which may have been caused by his shoulder problems. Her notes specifically reflect that the employee was not complaining of neck pain as late as February 20, 1996, the date of the employee's last evaluation prior to the March 14, 1996 opinion letter. Cervical tests were not done until May 1996. The first suggestion of material problems with the employee's wrists came in connection with the employee's shoulder problems, but not

until after March 14, 1996. The first mention of the left femoral cutaneous nerve appears in Dr. Ryan's April 1, 1996 office note. An EMG of the employee's upper extremities was not completed until May 1, 1996. We note that the first opinion by Dr. Ryan which specifically mentions these three conditions was her June 23, 1997 report. In that report she merely gave opinions concerning the appropriate permanent partial disability ratings for the conditions but did not indicate what had caused the conditions.

Since Dr. Ryan's causation opinion in March predated any suggestion of material problems with the employee's left femoral cutaneous nerve, neck or wrists and the opinion did not specifically mention them, it was not inappropriate for the compensation judge to find the opinion to be insufficient evidence to support the employee's claim. The compensation judge did not err in finding that the employee had failed to satisfy his burden of proof concerning causation of a claimed Gillette injury to the employee's neck, wrists and left femoral cutaneous nerve.