Automobile Injury Compensation Appeal Commission

IN THE MATTER OF an appeal by [the Appellant]
AICAC File No.: AC-99-61

PANEL:	**Mr. J. F. Reeh Taylor, Q.C., Chairman** **Mrs. Lila Goodspeed** **Mr. F. Les Cox**
APPEARANCES:	**Manitoba Public Insurance Corporation ('MPIC') represented by Ms Joan McKelvey;** **the Appellant, [text deleted], appeared on her own behalf**
HEARING DATE:	**October 8th, 1999**
ISSUE(S):	**(i) Claim for income replacement indemnity ('IRI') - whether qualified;** **(ii) causation - whether symptoms caused by motor vehicle accident ('MVA'); and** **(iii) whether claimant disabled.**
RELEVANT SECTIONS:	**Sections 70(1), 86(1), 106(1) and 110(1)(c) of the MPIC Act, and Section 8 of Manitoba Regulation 37/94.**

AICAC NOTE: THIS DECISION HAS BEEN EDITED TO PROTECT THE APPELLANT'S PRIVACY AND TO KEEP PERSONAL INFORMATION CONFIDENTIAL. REFERENCES TO THE APPELLANT'S PERSONAL HEALTH INFORMATION AND OTHER PERSONAL IDENTIFYING INFORMATION HAVE BEEN REMOVED.

REASONS FOR DECISION

The Appellant, [text deleted], was involved in a MVA on the 10th of July 1996. She sustained a laceration on the left side of her head and contusions on her left arm and shoulder; she also received a slight seat belt burn around the left side of her neck, but no neck trauma.

[The Appellant], who was [text deleted] years of age at the time of her accident, had undergone surgery in 1978 for the removal of a benign brain tumor from the left frontal region, and further surgery in 1983 when, as the result of a MVA, she sustained a fracture of the cervical vertebrae, which was fused operatively.

Following her 1996 accident, [the Appellant] was first seen by [text deleted], a physician at the [text deleted] Clinic, complaining primarily of pain in her left arm. [Appellant's doctor #1] felt that this was a musculoskeletal problem and reported that she could work her full duties and maintain all usual activities yet, in something of an anomaly, he indicated in that same report of August 13th, 1996 that [the Appellant's] classification was "less than full function due to symptoms and/or functional deficit".

On September 17th, 1996 [Appellant's doctor #1] referred [the Appellant] to an audiologist for a hearing test, since [the Appellant] had complained of decreased hearing on the left side following her MVA. The audiologist found no objective signs of any hearing dysfunction.

[Appellant's doctor #1] next referred [the Appellant], on November 14th, 1996, to [text deleted], a neurological consultant in Brandon. The purpose of his referral seems to have been [the Appellant's] continuing complaints of left arm pain following her MVA in July. [Appellant's neurologist #1] reports, on January 3d, 1997, that [the Appellant] is "neurological normal on examination". He expressed the view that the Appellant's left arm symptoms were not neurological in origin. He also indicated "she has absolutely no other neurological symptoms to report, volunteered or on inquiry".

[Appellant's neurologist #1] also reports:

> Cranial nerve examination is entirely normal including her fundi, confrontational visual fields, with no internal or external ophthalmoplegia. Of note, no Horner's Syndrome on the left……

(*Commission's note: Horner's Syndrome is a condition marked by the lagging of the upper lid of one eye, recession or sinking of the eyeball, constriction of the pupil, narrowing the space between the margins of the two eyelids and an absence of perspiration of the face on the side of the affected eye. It is due to a paralysis or destruction of the sympathetic nervous system nerves in the neck sometimes following a neck injury.)*

[Appellant's doctor #1] next, at [the Appellant's] own request, referred her on February 6th, 1997, to [text deleted], the surgeon in [text deleted] who had performed [the Appellant's] neck surgery in 1983. His letter of referral says, in part:

> She was doing rather well until July 10th, 1997 (sic) when she was involved in a MVA and sustained a laceration of her scalp. She has complicated left arm pain and weakness ever since the accident. A neurological consultation……suggested the pain was of non-neurological origin……..The patient wishes to be reassessed by you. I would much appreciate your help.

There is no record in the material before us of any report or other response from [Appellant's neurosurgeon] to [Appellant's doctor #1].

In early February of 1997 [Appellant's doctor #2], who appears to have taken over [the Appellant's] care at the [text deleted] Clinic, referred her to the [text deleted] for physiotherapy. [Text deleted], Physiotherapist, reported to MPIC on July 15th, 1997, that:

> This patient was seen on February 11th, 1997 with left shoulder blade and arm pain. She complains of mid-arc abduction discomfort but C-spine and shoulder movements were

> full. Infraspinatus muscle was tight.
>
> No treatment was planned until she was reviewed by her neurosurgeon in [text deleted]……
>
> She was again seen on September 24th, 1997 (*sic*). The findings were: Full passive and active range of motion, normal muscle strength, taut bands in trapezius. A home program of heat and stretching was taught. She was to call for an appointment in three weeks' time for a followup but did not call until June 24th. (*Commission's note: [the Appellant] testified that she had been visiting friends or family in Ontario - hence, the delay in follow-up.)*
>
> She was seen July 15th, 1997 (to-day). She states she is exercising but not always regularly. Exercises were reviewed and are done correctly. She says she feels less pain now.
>
> No further visits were scheduled. This was discussed with [Appellant's doctor #2].

On March 19th, 1997 we find the first mention of facial parasthesia, in a memorandum prepared for the file by [the Appellant's] adjuster at MPIC, who writes:

> [The Appellant] called. She is going to [text deleted], neurologist, in [text deleted] as her face is feeling funny - like dental freezing. [Appellant's doctor #1] is her family doctor. April 9/97 appt.

On March 26th, 1997 [Appellant's doctor #2], who appears to have taken over [the Appellant's] care at the [text deleted] Clinic, referred the Appellant to [text deleted], neurologist, in [text deleted]. [Appellant's doctor #2's] letter of referral makes a very brief note of the Appellant's prior surgical history and says, simply "This [text deleted] year old woman complains of left arm pain for some time now, especially after a MVA in July 1996. Neurological examination was essentially normal." [Appellant's doctor #2] asks [Appellant's neurologist #3] to assess [the Appellant] and advise further management.

[Appellant's neurologist #3's] response of April 13th, 1997 reports, in essence, that the results of his examination of the Appellant were entirely normal "except for reduced appreciation of light touch and pinprick over the left half of the face in the distribution of V1, 2 and 3". In his assessment, [Appellant's neurologist #3] said that [the Appellant] had an acute onset of reduced sensation in the distribution of the left fifth cranial nerve. There were no objective signs other than diminished sensory appreciation. In order to negate any more serious problems, he had arranged for a CT Scan and, meanwhile, had given [the Appellant] a prescription for Tegretol for the neurogenic facial symptoms.

The result of the CT Scan ordered by [Appellant's neurologist #3] showed no abnormalities at all, other than the signs of the previous surgery.

[Appellant's neurologist #2], [text deleted], wrote to [Appellant's doctor #2] on May 6th, 1997, expressing the view that the left arm pain of which [the Appellant] was complaining did not sound like neurologic pain. No sensory component was present and she had not lost any function of the arm. [Appellant's neurologist #2] does not deal with the "recently noticed phenomenon" of numbness of the left side of [the Appellant's] face, since it was being investigated by [Appellant's neurologist #3]. In summary, [Appellant's neurologist #2] advised that "I would go no further in investigating possible stability because I think she is very stable. Certainly physiotherapy could feel free in treating her as they see fit for her muscular complaints.

On May 29th, 1997 [Appellant's doctor #2] referred [the Appellant] to [text deleted], an otolaryngologist in [text deleted], since the Appellant had been complaining of a painful ear and

"She has sensitive hearing and crackling". [Appellant's doctor #2] felt that she had neuralgia.

On June 5th, 1997 [Appellant's otolaryngologist] responded to [Appellant's doctor #2]. His letter of that date reports, in part:

> ……([the Appellant]) is a very pleasant [text deleted] year old lady whose main complaint is that of troubles with her left ear…..July 1996…..she was involved in a motor vehicle accident. She hit her head on the window and received an ulceration to the left parietal region. (*Commission's note: this seems to be the first and only mention of this kind of problem; we believe [Appellant's otolaryngologist] probably dictated 'laceration'.)* She noted that there was a slight pain which started subsequent to that. The pain actually started in February, 1997, and has been present on a continuous basis since then. She describes the sensation of the pain slowly increasing in its scope. It now extends into the region of the eye as well as up to the oral commissar in the left side of the face. She has seen a neurologist in this regard. She apparently has had a CT Scan although I do not have the results of this. She now presents for further evaluation in this regard.

[Appellant's otolaryngologist], after a full otolaryngologic examination, reported no abnormalities of any kind, except that there was some temporomandibular joint ('TMJ') dysfunction with crepitus in the right joint. He was unable to document any particular otologic pathology other than the subjective symptoms noted above. He recommended an audiogram and a brain stem evoked response. As well, he referred [the Appellant] to [Appellant's orthodontist] with respect to her TMJ dysfunction.

[The Appellant] next sought help from [text deleted], chiropractor, whom MPIC authorized to treat her for six weeks, three times in each of the first three weeks and twice in each of the remaining three. [Appellant's chiropractor] felt that series of treatments would be quite inadequate, expressing the view that [the Appellant's] upper cervical spine was very unstable and that she was suffering from facial numbness stemming from the fifth cranial nerve (the

trigeminal nerve) and fatigue. He felt that the Appellant needed ongoing treatment at the C2/C3 levels with a view to reducing the trigeminal nerve problem. In the event, [the Appellant] received 27 spinal adjustments from [Appellant's chiropractor] between October 1st, 1997, and February 4th, 1998, both inclusive.

Prior to her accident, having worked as a medical office assistant and then as the operator of a day care centre from 1990 to 1994, [the Appellant] had moved to Manitoba where she had been employed for a while at a [text deleted] store in [text deleted]. In the spring of 1996 she had decided to take some time off work in order to be with her [text deleted] children. She was therefore classified as a 'non-earner' at the time of her accident, but recommenced working at the [text deleted] some time in or about early November 1997, working six hours a day from Monday through Friday and eight hours a day on Saturdays.

[Text deleted], the orthodontist in [text deleted], gave his report and recommendations to MPIC on December 18th; his recommendations were eventually accepted, subject to the reservation that MPIC was not necessarily admitting that the need for an orthopaedic appliance and other orthodontic treatments had been brought about by the MVA. Rather, the insurer agreed to pay for certain orthodontic costs because the Appellant's adjuster had given that commitment before receiving the views of the insurer's in-house medical/dental team.

MPIC then referred [the Appellant] to [text deleted], neurologist with the [text deleted] Clinic, who saw the Appellant on March 2nd, 1998. He was provided with copies of most of the earlier medical reports. [Appellant's neurologist #4], in a very thorough report bearing date March 4th,

1998, expressed the opinion that

> ……A good deal of her sensory complaints may well be explained on the basis of local myofascial pain in the tender areas…..and in particular the distribution of the parasthesia that occur with the sternocleidomastoid muscle fit well with some of her history. In particular, the history of the fact that the sensory complaints change from time to time would fit much better with a muscular origin than a focal neurologic complaint. I also find it difficult to convince myself that there is a major degree of sensory abnormality, given the preserved corneal reflex. Having said that, the degree of involvement of the face and the involvement of the tongue as well is somewhat concerning and, despite the lack of evident neurologic abnormality on exam, I would be uncomfortable, given her past neck surgery, to attribute her sensory complaints simply to muscular tightness. For that reason I have taken steps to arrange an MRI of her neck and brain to make sure there is no nerve root or spinal cord compression at a neck level and no evidence of a brain stem lesion as a result of the most recent motor vehicle accident.
>
> I suspect……the main treatment for this patient's complaint firstly is to reassure her…..that there is no reason to be excessively concerned about her current symptomatology…….I have encouraged her to become more aggressive with regard to stretching, particularly of the sternocleidomastoid but the neck in general, as well as the pectoralis, biceps and brachioradialis trigger points that are quite evidently symptomatic on the left side.
>
> She may be left with some sensory changes but I don't think she will ever be significantly disabled by them.
>
> I feel that the main problems the patient is currently complaining of relate to muscular strain at the time of …..accident and a persistent focal myofascial pain syndrome with associated paresthesiae. I am not convinced clinically of any other associated neurologic abnormality, but am not comfortable enough given her marked complaints that I am willing to avoid investigating her further.

[Appellant's neurologist #4] also noted that, at the time of her examination on March 2nd, 1998, [the Appellant] felt that the range of motion of her left shoulder, which had been quite limited early on, had since returned to full range.

[Appellant's neurologist #4] also said that an examination of [the Appellant's] cranial nerves "revealed slight diminution in pinprick sensation in all three divisions of the trigeminal nerve.

Testing the scalp sensation, there did not seem to be much asymmetry once one got past the hairline when comparing the left to the right. Temperature sense was reasonably symmetric on the face". At the risk of possible oversimplification, we think it fair to say that the remainder of [Appellant's neurologist #4's] examination of the Appellant disclosed no abnormalities of any real consequence, other than that, when palpating for tender muscles and anatomically described trigger points, "It was possible to identify a trigger point in the upper left sternocleidomastoid muscle which when irritated by palpation created an alteration of the sensory complaints in the left face. In fact, for a brief period of time things actually improved but then came back again." Interestingly enough, [Appellant's neurologist #4] also noted that the range of motion in [the Appellant's] shoulder (while he does not say so, we assume he means her left shoulder) was slightly restricted, particularly when trying to elevate her arm with a flexed elbow, although [the Appellant] herself had expressed the view that she had regained full range of motion of her shoulder. However, we recognize that these conditions can vary slightly from one day to the next, so this finding does not represent any significant anomaly.

On March 16th, 1998 [the Appellant], in speaking with her adjuster at MPIC, said that she wanted to quit work and make a claim for income replacement indemnity (IRI). She apparently said that [Appellant's neurologist #4] had given her new medication which was giving her a lot of headaches and, as well, she was experiencing swelling and numbness of her face.

Although [Appellant's neurologist #4's] report does not say so, he apparently prescribed an intensive physiotherapy plan for [the Appellant]; this was supported by [Appellant's doctor #2], who recommended that the Appellant take one month off work in order to concentrate on the

physiotherapy.

It was not until early August of 1998 that MPIC finally received a copy of the CT Scan of [the Appellant's] brain that had been requisitioned by [Appellant's neurologist #3]. It showed no abnormalities, save only for evidence of the 1979 surgery.

The magnetic resonance imaging procedure that had been requisitioned by [Appellant's neurologist #4] was eventually performed at [hospital] on November 5th, 1998. [Appellant's neurologist #4's] report of November 27th did not demonstrate any cervical or brain abnormality related to the MVA. When reassessed on November 19th, [the Appellant] had reported to [Appellant's neurologist #4] that the physical activity required at the [text deleted], when stocking shelves and going up and down 20 stairs to get to the supply area, simply aggravated her symptoms to too great a degree. She had therefore decided to take time off work and concentrate on using her prescribed medication and exercises. Having done so, she had noted marked improvement. [Appellant's neurologist #4] reported that

> Her ongoing complaints include the sensory distortion of the left side of her face and hyperacusis associated with sonophobia with the left ear……A new symptom that developed over the summer was numbness in the right hand with prolonged positioning.

[Appellant's neurologist #4] concluded his report of November 27th, 1998 by saying:

> From a neurologic point of view, I think she has a degree of trigeminal neuralgia as a result of the head injury associated with the accident and as well the hyperacusis is a neurologic symptom as a result of the head injury. I think the majority of the other symptoms involved here are more related to a muscular injury at the time of the accident.

On December 9th, 1998, [Appellant's doctor #3], who had now taken over the care of [the

Appellant] following [Appellant's doctor #2's] departure from the [text deleted] Clinic, referred the Appellant back to [Appellant's neurologist #3] in [text deleted], this time for the assessment of possible carpal tunnel syndrome. He found none. His examination of the Appellant revealed full range of neck motions, absence of Horner's Syndrome, no signs of radiculopathy, symmetric reflexes, normal hand strength and intact sensation (we presume, bilaterally, although [Appellant's neurologist #3's] report does not specifically say so). [Appellant's neurologist #3] says he assured the Appellant that clinically she had no neurologic deficit, either originating in the spine or the peripheral nerves although, he noted, "She presents with numbness affecting both hands for several months.

Having been refused IRI, [the Appellant] applied for an internal review and, on May 18th, 1999, MPIC's Internal Review Officer upheld the decision of the adjuster. It is from the Internal Review Officer's decision that [the Appellant] now appeals to this Commission.

Following the filing of her Notice of Appeal, [the Appellant] arranged for [Appellant's doctor #3] to refer her to [text deleted], a neurologist in [text deleted], whom she saw on July 27th, 1999. She presented to [Appellant's neurologist #5] with complaints of numbness, pain and paresthesiae affecting the left side of her face, with the center of pain being located within the left ear, "a neuralgic type pain, spreading out into the remainder of the trigeminal distribution". She also complained of pain in the left elbow, left leg, left foot, with intermittent swelling. In addition, she had been complaining of pain in the left hip region. [Appellant's neurologist #5's] report of July 27th, 1999 concentrates primarily upon the medications that [the Appellant] was already taking, and upon his recommendations for the appropriate dosages. He also suggested

two or three other, alternative medications for [Appellant's doctor #3's] consideration. [Appellant's neurologist #5] concluded by saying that, while surgical intervention with respect to [the Appellant's] facial symptoms was also a possibility, he did not think it an option at that stage. The installation of glycerin around the trigeminal ganglion might also be considered, although [Appellant's neurologist #5] was unsure that this would provide relief from this type of distribution pain. He deferred to [Appellant's neurologist #2], who "would be more of an expert on this than I am". [Appellant's neurologist #5] does not suggest any particular causation for the symptoms of which [the Appellant] complained.

MPIC then referred all of the medical evidence on file to [text deleted], another medical specialist in neurology, with the request that he review the conclusions of [Appellant's neurologist #4] and of [Appellant's neurologist #5], as well as certain views expressed by MPIC's inhouse medical team.

[Appellant's neurologist #6] points out that:

- [the Appellant] had no documented complaint of left facial sensory abnormality until [Appellant's neurologist #3] obtained a history of numbness in the left face on April 2nd, 1997 (this is not quite correct since, as we have noted on page 3 of these Reasons, [the Appellant's] adjuster recorded facial parasthesia on March 19th, 1997, but [Appellant's neurologist #6] did not have that memorandum when preparing his report.)
- [Appellant's otolaryngologist] had found no evidence of hearing loss nor other abnormality.
- None of the earlier examinations by [Appellant's doctor #1] (the Appellant's family physician) or [Appellant's neurologist #1] (neurologist) disclosed any mention of facial numbness.

- A hearing test in October 1996 had been normal.
- [Appellant's neurologist #2] had documented a normal neurologic examination in his report of April 9th, 1997 in spite of [the Appellant's] complaint of numbness in the left face.
- There was nothing else documented in terms of symptomatology until [Appellant's neurologist #4's] assessment of March 2nd, 1998. Then, and apparently for the first time, the Appellant had given a history of numbness spreading from the left ear to the cheek, nose and then the lips. Also, for the first time, a complaint of abnormal sensation in the tongue had been reported. Again, for the first time, the Appellant had given a history of left hip pain with radiation of the discomfort down the back of the left leg as far as the calf.
- [Appellant's neurologist #4's] report of diminished pinprick sensation in all three divisions of the Appellant's trigeminal nerve had also stated that the diminished pinprick sensation stopped at the hairline.

[Appellant's neurologist #6] comments that "We know from normal anatomy that the trigeminal nerve distribution extends well above the hairline, approximately to the top of the head, and [Appellant's neurologist #4] clearly comments on the fact that scalp sensation was normal. [Appellant's neurologist #6] goes on to say

> Without pronouncing it, he (i.e. [Appellant's neurologist #4]) is implying……that the distribution of the sensory loss was in fact not in an anatomical distribution as the trigeminal nerve cannot stop supplying sensation at the exact hairline. I would not consider this finding to represent an anatomic or organic abnormality. [Appellant's neurologist #4] on the other hand speculates that this may be due to an underlying muscular problem and I believe he is also implying that this may be a numbness complaint secondary to underlying myofascial pain syndrome. The latter opinion is based on his finding of tenderness in the left upper sternomastoid muscle with trigger point tenderness.
>
> The issue of causation is the underlying question, and I believe that the motor vehicle accident resulted in a scalp laceration and head trauma without any residual neurologic

> abnormalities. Even the facial sensation is impossible to explain on an anatomical basis and, as clearly outlined, the symptom wasn't even voiced until several months later, after the accident.

[Appellant's neurologist #6] expresses the view that there is nothing in any of the medical reports to support a diagnosis of trigeminal neuralgia. As he puts it "This condition refers to severe, lancinating, lightning-like pains in the trigeminal nerve branch distribution, usually the second or the first branch of the trigeminal nerve. Neither [Appellant's neurologist #4] nor any of the other examiners mentioned pain as a symptom, hence trigeminal neuralgia cannot possibly be a diagnosis." He concludes that, based on the information given, he could not consider the Appellant to be impaired to a degree that she would be unable to perform her clerical duties that she had performed in the past. (We have to note that [the Appellant's] duties at the [text deleted] store were not confined to clerical ones; she was also required to restock shelves and, generally, move merchandise around, in addition to less physical demanding duties.)

[Appellant's neurologist #6], in a second, separate letter touching upon [Appellant's neurologist #5's] report, expresses the view that both [Appellant's neurologist #5's] report and the personal record of [the Appellant] "only underline and support my conclusions……that there is no evidence of any organic pathology and furthermore no evidence of any relationship between the car accident and subsequent physical problems that would explain her symptomatology that was later obtained by others.

DISCUSSION

When reviewing all of the evidence presented to us in connection with [the Appellant's] appeal, we are confronted, as is frequently the case, with a sharp difference of opinion between highly qualified medical experts. While expressing the respect of this Commission for the competence and, therefore, the views of [Appellant's neurologist #4], we are conscious of the fact that he did not see [the Appellant] until March 2nd, 1998, some 20 months after her motor vehicle accident. The same must be said, of course, for [Appellant's neurologist #6] and [Appellant's neurologist #5], neither of whom saw the Appellant until quite some time after [Appellant's neurologist #4's] first assessment. Nevertheless, none of [the Appellant's] earlier medical examiners - [Appellant's doctor #1], [Appellant's neurologist #1] and [Appellant's doctor #2] - makes mention of the facial paresthesia. When [Appellant's doctor #2] referred the Appellant to [Appellant's neurologist #3] on March 26th, 1997 he mentioned only her complaint of left arm pain; [Appellant's neurologist #4's] report of his initial assessment on March 2nd, 1998 is the first clinically noted reference to "decreased pinprick sensation in all three divisions of the trigeminal nerve". Even then, not even [Appellant's neurologist #4] is able to diagnose any neurological deficit; [Appellant's neurologist #4] was of the view that the main problems of which the Appellant was complaining related to muscular strain from her MVA and a persistent, focal myofascial pain syndrome.

[The Appellant] testified that she had had pain in her left arm for quite some time prior to her MVA (this is borne out by [Appellant's doctor #2's] referral to [Appellant's neurologist #3] on March 26th, 1997); she thought that it might have stemmed from her prior surgery. That left arm

pain certainly seems to have been exacerbated by her MVA, but [Appellant's doctor #2], [Appellant's neurologist #3] and [Appellant's neurologist #2] do not seem able, between them, to have determined any cause other than a form of muscular strain, for which [Appellant's neurologist #2] recommended physiotherapy.

Following her accident, and whether caused by it or not, [the Appellant's] primary complaints were of facial paresthesia and pain in her left arm. Each of those symptoms calls for two inquiries: firstly, was it caused by her motor vehicle accident; secondly, was it sufficiently debilitating to prevent her from continuing her employment.

With respect to the numbness on the left side of [the Appellant's] face, the time span between the date of her accident and the emergence of that paresthesia, combined with the reports of [Appellant's doctor #1], [Appellant's neurologist #1], [Appellant's doctor #2], [Appellant's neurologist #3] and [Appellant's neurologist #2], persuade us that this particular problem did not have its origin in [the Appellant's] MVA and that, even if we are mistaken in that finding, the symptoms were not severe enough to prevent the continuance of [the Appellant's] employment.

The question of the pain in her left arm is more difficult to assess. There was, as we have already noted, a pre-existing left arm pain, although that does not seem to have inhibited [the Appellant's] activities to any major extent. Following her MVA, there is comparatively little evidence on her file pointing to any serious injury to her left arm. [Appellant's neurologist #2], for example, in his report of May 6th, 1997 to [Appellant's doctor #2], says "…..she has not lost any function of the arm". Similarly, the report of [text deleted], physiotherapist, on July 15th,

1997 reflects full passive and active range of motion, normal muscle strength, "…..she says she feels less pain now", and the only area of concern was a complaint of mid-arc abduction discomfort, with taut bands in the Appellant's trapezius.

[The Appellant] herself felt well enough to go back to work in early November, 1997. Apparently, in December of that year when attempting to pick up a basket of laundry, [the Appellant] found herself unable to do so because she could not clasp her hand. [The Appellant] testified that, in her view, it was this latter incident that caused her adjuster to refer her initially to [Appellant's neurologist #4] but, when we examine the adjuster's letter to [Appellant's neurologist #4], it makes passing reference to the Appellant's initial complaints of pain in her left arm and neck, but concentrates primarily upon the facial numbness referred to above. Despite the incident with the laundry basket, [the Appellant] did continue working until the end of April of the following year. She testified that she had quit "because I had the incident with my hand (i.e. the laundry basket) and had been referred to [Appellant's neurologist #4] who gave me exercises, Amitriptyline and analgesics". It is noteworthy, also, that [Appellant's neurologist #4's] report of March 4th, 1998 says:

> When testing the left hand with the pinprick she did have some sensory loss in a C6 distribution compared to other areas on that arm, but I suspect this is something that results from the prior, known C6 root entrapment that she experienced with the previous accident. There is no evidence of muscle wasting distally in either hand and intrinsic power was normal.

[The Appellant] does not say that she quit working because of pain. Rather, she was concerned that there might be a recurrence of the laundry basket incident, despite the reassurances given her by all of her caregivers. It is difficult to say, with any certainty, whether the problems with her

left hand and arm of which [the Appellant] complained were due to her motor vehicle accident of July 10th, 1996; in our view, the stronger probability is that those symptoms had some other etiology. In either event, we are not able to find on a reasonable balance of probabilities that [the Appellant] was prevented from continuing her employment by pain in her left arm. Whatever had caused the sudden and unexplained weakness in her left hand seems to have vanished from the scene completely by the time she saw [Appellant's neurologist #4].

In sum, therefore, we find that, on a reasonable balance of probabilities, [the Appellant] did not sustain injuries in her MVA on July 10th, 1996 of sufficient severity to prevent the continuance of her employment at the [text deleted] after April 30th, 1998. It follows, therefore, that her appeal must be dismissed.

Dated at Winnipeg this 1st day of December, 1999.

J. F. REEH TAYLOR, Q.C.

LILA GOODSPEED

F. LES COX