Administrative Appeals Tribunal

DECISION AND REASONS FOR DECISION

Yasmin and Comcare (Compensation) [2019] AATA 15 (10 January 2019)

Division: GENERAL DIVISION

File Number(s): **2017/3163**

Re: **Lubna Yasmin**

APPLICANT

And **Comcare**

RESPONDENT

DECISION

Tribunal: **Dr I Alexander, Member**

Date: **10 January 2019**

Place: **Sydney**

Decision under review is affirmed.

.....[sgd].....

Dr I Alexander, Member

CATCHWORDS

COMPENSATION – injury – ailment -whether the applicant continued to suffer the effects of the accepted injury – whether applicant is entitled to compensation – s 16 and s 19 Safety, Rehabilitation and Compensation Act 1988 (Cth) – repetitive strain injury – chiari malformation and cervico-thoracic syrinx – compensable injury- affirmed

LEGISLATION

Safety, Rehabilitation and Compensation Act 1988 (Cth) ss 5A, 5B, 14, 16 and 19

CASES

Re: The Commonwealth of Australia and Kathleen Beattie (1981) 53 FLR 191
Mellor v Australian Postal Corporation [2009] FCA 504

REASONS FOR DECISION

Dr I. Alexander, Member

10 January 2019

INTRODUCTION

1. Ms Yasmin commenced employment with the Department of Human Services in May 2010. At the time of sustaining the accepted injury Ms Yasmin was employed as a Service Officer (SO4), her main duties being *answering customer service enquiries on processing work using PC.*[1]

2. On 9 February 2015 Ms Yasmin lodged a claim for compensation under the *Safety, Rehabilitation and Compensation Act 1988* (Cth) (the SRC Act). She claimed that in June 2014, while at work, she suffered an injury which was described as "pain in her right arm which later spreaded [sic] to the right shoulder".

[1] Section 37 documents page 20.

3. In a medical report dated 18 February 2015 Dr Saha, general practitioner, recorded a diagnosis of "Repeated strain injury to (R) arm (RSI)" with an initial date of consultation as 4 June 2014.

4. In a determination dated 6 March 2015 Comcare accepted Ms Yasmin's claim under Section 14 of the SRC Act for *sprain of unspecified site of shoulder & upper arm (right).*

5. Following a request for reconsideration by the Department of Human Services, in a determination dated 7 May 2015, Comcare affirmed the initial decision to accept Ms Yasmin's claim. The review officer stated that, although the diagnosis of Ms Yasmin's condition was "not clear", the evidence supported a conclusion that she suffered an "ailment" as defined in the SRC Act and that her work duties had significantly contributed to her claimed condition.

6. In May 2015 Dr Saha referred Ms Yasmin for further investigation with radiological imaging.

7. An MRI of brain and spinal cord performed on 13 May 2015 was reported as showing "intramedullary cystic change" in the spinal cord from C5/6 through to T3/4". This spinal abnormality was subsequently confirmed to be a "Chiari 1 malformation with C5-T3 syrinx".

8. On 25 September 2015, in Royal North Shore Hospital (RNSH), Ms Yasmin underwent an operation described as "Foramen magnum decompression + removal of C1 arch + duroplasty".

9. Following a postoperative complication, a second operation, described as "decompression wound, duraplasty, repair of pseudomeningocoele", was performed on 23 October 2015.

10. In response to a report and recommendation from Allianz Australia Insurance Ltd, dated 28 July 2016, Comcare issued a determination, dated 9 August 2016, stating that Ms Yasmin "had no present entitlement" in respect of medical expenses under section 16 of the SRC Act or to compensation under section 19 under the SRC Act with in respect to her accepted injury.

11. In a reviewable decision dated 12 October 2016 Comcare affirmed the determination of 9 August 2016.

12. In these proceedings Ms Yasmin who was self-represented, seeks review of Comcare's decision of 12 October 2016.

RELEVANT STATUTORY PROVISIONS

13. Section 14 of the SRC Act provides that Comcare is liable to pay compensation in respect of an injury suffered by an employee if the injury results in death, incapacity for work, or impairment.

14. *"Injury"* is defined in subsection 5A(1) to mean:

(a) a disease suffered by an employee; or

(b) an injury (other than a disease) suffered by an employee, that is a physical or mental injury arising out of, or in the course of, the employee's employment; or

(c) an aggravation of a physical or mental injury (other than a disease) suffered by an employee (whether or not that injury arose out of, or in the course of, the employee's employment), that is an aggravation that arose out of, or in the course of, that employment;

but does not include a disease, injury or aggravation suffered as a result of reasonable administrative action taken in a reasonable manner in respect of the employee's employment.

Subsection 5A(2) provides:

For the purposes of subsection (1) and without limiting that subsection, ***reasonable administrative action*** *is taken to include the following:*

(a) a reasonable appraisal of the employee's performance;

(b) a reasonable counselling action (whether formal or informal) taken in respect of the employee's employment;

(c) a reasonable suspension action in respect of the employee's employment;

(d) *a reasonable disciplinary action (whether formal or informal) taken in respect of the employee's employment;*

(e) *anything reasonable done in connection with an action mentioned in paragraph (a), (b), (c) or (d);*

(f) *anything reasonable done in connection with the employee's failure to obtain a promotion, reclassification, transfer or benefit, or to retain a benefit, in connection with his or her employment.*

15. *"Disease"* is defined in section 5B:

(1) In this Act:

***disease** means:*

(a) *an ailment suffered by an employee; or*

(b) *an aggravation of such an ailment;*

(c) *that was contributed to, to a significant degree, by the employee's employment by the Commonwealth or a licensee.*

(2) In determining whether an ailment or aggravation was contributed to, to a significant degree, by an employee's employment by the Commonwealth or a licensee, the following matters may be taken into account:

(a) *the duration of the employment;*

(b) *the nature of, and particular tasks involved in, the employment;*

(c) *any predisposition of the employee to the ailment or aggravation;*

(d) *any activities of the employee not related to the employment;*

(e) *any other matters affecting the employee's health.*

This subsection does not limit the matters that may be taken into account.

(3) In this Act:

***significant degree** means a degree that is substantially more than material.*

16. *"Ailment"* is defined in s 4(1) :

> ***ailment*** *means any physical or mental ailment, disorder, defect or morbid condition (whether of sudden onset or gradual development).*

17. Section 16(1) of the SRC Act provides that "where an employee suffers an injury, the Commonwealth is liable to pay, in respect of the cost of medical treatment obtained in relation to the injury".

18. Section 19 of the SRC Act provides that when an employee is incapacitated for work as a result of an injury the "Commonwealth is liable to pay to the employee in respect of the injury"

ISSUES

19. Ms Yasmin claims that, in 2014, she suffered a "repeated strain injury" to the right upper arm while at work and continues to suffer chronic pain as a result of this injury.

20. The Respondent contends that, as at 9 August 2016, Ms Yasmin was not entitled to compensation under sections 16 or 19 of the SRC Act in relation her accepted injury.

21. Therefore, the definitive issue in this matter is whether as at 9 August 2016 Ms Yasmin continued to suffer the effects of her accepted injury and, if so whether she is entitled to compensation under section 16 and/or section 19 of the SRC Act.

EVIDENCE

Ms Yasmin

22. In an undated written submission received by the AAT on 10 September 2018 Ms Yasmin stated the following:

> *As I have already informed AAT in my previous letter, despite the 'Syrinx' operation my right arm pain continued as it was before the operation. Comcare is also aware of it. Comcare arranged different doctors to assess the reason for my pain. The findings of different doctors recommended by Comcare failed to provide any definite opinion that my current condition is specifically related to neurological issue. …. The latest report from Comcare referred Dr McGill indicates that the pain is most likely related to Syrinx. But the current MRI report (13/7/18) and treating specialist neurosurgeon's opinion (9/8/2018) shows that I do not have Syrinx and therefore, my arm pain is not related to Syrinx.*

23. At the hearing much of Ms Yasmin's oral evidence was somewhat confused. She had great difficulty in answering specific questions and was unable to provide a coherent account of her symptoms over the four-year period from the claimed date of injury in June 2014.

24. Ms Yasmin claimed that she has suffered constant pain since 2014 and that the pain is always located in the distal third of the right upper arm, adjacent to the triceps muscle. She described her pain as "constant at night, aggravated when at work, varies during the week, sometimes goes down the forearm" but provided little clarity as to the nature and severity of her symptoms with respect to her significant spinal pathology, complicated surgery and the extended period where she was away from work.

25. Ms Yasmin stated that in the five to six months after her operation the "pain was not there" because she was on "strong medication" but came back again "with my work" and frequently insisted that the pain had not changed since 2014.[2]

26. Ms Yasmin confirmed that she has been back at work on full duties since April 2017, albeit with some workplace modifications. She explained that she is able to use *Dragon* software which helps her to reduce the amount of typing.

27. Ms Yasmin stated that currently "this pain never ends" but "actually I can manage it" with medication which includes *Panadol Osteo* up 8 tablets per day and occasional *Lyrica*.

TIME LINE OF EVENTS [3]

28.

- 30.06 2014 -Ms Yasmin provides medical certificate advising that she is suffering from right arm and elbow pain …..workstation assessment is recommended.
- 03.07.2014 – Ms Yasmin advised …**first experienced intermittent pain in right elbow 1 month prior** …. symptoms progressed to her right wrist and up the arm into her right shoulder ……symptoms further increased with pain travelling into the

[2] I note that this claim is inconsistent with the documentary evidence before the Tribunal.
[3] Section 37 Documents page 30.

right side of the neck ….workstation assessment was performed with appropriate education and ergonomic adjustments to Ms Yasmin's desk.

- 07.07.2014 - …. since the workstation assessment performed ……pain has reduced significantly ..
- 21.07.2014 – Ms Yasmin….my condition improved but still some pain.
- 05.09. 2014 – Ms Yasmin has been having issues again ….receiving physio treatment ….**appears to be alleviating pain.**
- 21.11.2014 – Ms Yasmin completed Report of injury … "repetitive strain injury".
- 24.11 2014 – Lubna left work early due to sore right upper arm.
- 25 .11.2014 – 5.12 2014 – certified unfit for work.
- 09.12.2014 – **2 weeks absence** …**reported her arm 80% better** …cleared to return to work no restrictions.
- 12.12.2014 – Further workstation assessment by Occupational therapist …..5 session of physiotherapy …..**pain "almost gone**".
- 31.12.2014 – ultrasound of right elbow …normal.
- 19.01.2015 – Ms Yasmin called to advise ….she is unwell due to pain from physio session on the weekend.
- 27.01.2015 – 24.02.2015 – ***certified unfit for work.***
- 9.02 .2014 – Ms Yasmin submits Worker compensation case… "repeated strain injury in right arm".
- 16.03.2015 – Section 36 …to be assessed by Dr Matthew Paul, occupational physician.

MEDICAL EVIDENCE

Dr A. K. Saha – General Practitioner (GP)

29. In a medical certificate dated 18 February 2015 Dr Saha stated that Ms Yasmin suffered a medical condition which he diagnosed as "repeated strain injury to (R) Arm (RSI)" caused by "Repeated use of computer keyboard".

30. Dr Saha indicated that the first consultation for the condition occurred on the 4 June 2014 but provided no details with respect to clinical signs or symptoms to support the diagnosis.

31. In a Care Plan Summary dated 7 March 2015 Dr Saha noted "PAIN RT ARM RSI RT ARM" as principal diagnoses but provided no other relevant clinical details.

32. Dr Saha provided three medical certificates for compensation dated 19/06/2015, 17/06/2016 and 26/08/2016. In each certificate he stated that the clinical diagnosis was "RSI RT ARM" which was caused by "repeated use of rt hand in computer" and "typing'. In each certificate he recorded that medication included an opiate and or Lyrica.

33. In a report dated 27 November 2018 Dr Saha stated, inter alia, the following:

> *Mrs Lubna Yasmin first consulted me on 4/6/2014 for pain in the right arm. The pain increased with typing. The examination was carried out no physical sign was detected and CT scan was done on 6/6/2014 and reported as normal. Also, ultra sound on right shoulder was done on 16/8/2014 and found normal. She was diagnosed RSI and was given 2-3 weeks rest at home without typing. The pain completely disappeared but recurred when she went back to work.*
>
> *She was referred for physiotherapy without much improvement. She was referred to hand specialist Dr Edmunds who could not find anything wrong …..she was seen by a neurologist ….nerve conduction study was carried out which was also normal.*
>
> *MRI was carried out on 8/5/2015. Lesion (Syrinx) in cervical spine was detected …..Initially the treating doctors of RNSH thought that her arm pain would be gone after the treatment of the Syrinx….But still she has been suffering from her right arm pain..*
>
> *Initially the treating doctors of RNSH thought that her arm pain would be gone after the treatment of the Syrinx…..follow up MRI/CT Scan shows complete resolution of the Syrinx. But still she has been suffering from her right arm pain…*
>
> *….Lubna went back to full time and this created excess pressure on her health to perform her job. Now Lubna experiences on going arm pain at work which increases most on Friday after working for five days. After resting for two days in weekend, she feels better to resume her work on Monday….*
>
> *To my opinion, this issue have been created from work related as Lubna had to continue full time duty to the fact that Comcare discontinued their support by ceasing her work cover claim on 9/8/2016……Therefore, I am still of the opinion that her right arm pain was originated from work and she has RSI.*

Dr Ian Edmunds – Hand and Wrist Surgeon

34. In a letter dated 13 October 2014 Dr Edmunds noted that Ms Yasmin presented with "pain and burning in her right mid-forearm over the dorsal aspect and also pain and tenderness

over the distal triceps region" On examination he noted "no weakness or numbness and Tinel's sign is negative over the radial and ulnar nerves".

35. Dr Edmunds concluded that Ms Yasmin's symptomatology was "not particularly diagnostic but may possibly be due to "**mild thoracic outlet syndrome**"[4] and recommended that she continue with physiotherapy "including improving her shoulder posture **to take any pressure off her brachial plexus**". [emphasis added]

Dr Jane Oliver – Consultant Rheumatologist

36. In a letter to Dr Saha, dated 27 January 2015, Dr Oliver stated, inter alia, the following:

> *Thank you for referring Lubna …..She developed **fairly sudden onset of pain in the right forearm in June 2014.** She described a burning sensation in the right arm and over the right scapula. She also has pain in the ulna and dorsal aspect of the right hand and wrist. …. There was no history of trauma. She was initially managed with paracetamol and had a CT cervical spine and ultrasound of the right shoulder. There was no pathology demonstrated. She liaised with her manager at work who arranged an ergonomic review of her desk set up and modifications, and she was commenced on stretching exercises which helped her for a couple of months**. She took 2 weeks off work and avoided doing any housework in December 2014,** and her symptoms significantly improved. She returned to work for 2 weeks and her pain recurred……She wakes up at night due to pain. [emphasis added]*
>
> *Lubna had quite extensive pain. The examination did not really help pin-point any localised source for he her pain. It was unclear to me whether her pain was in fact coming from rotator cuff or the thoracic spine. I asked for an MRI of her upper limb as this is more sensitive than the ultrasound. [emphasis added]*

Dr Matthew Paul – Consultant Occupational Physician

37. In a report dated 26 March 2015 Dr Paul stated, inter alia, the following:

> *Ms Yasmin's symptom onset was **very vague in nature**. She stated that around April or May 2014 she noticed the **slow onset of pain** from her neck on the right side into her right shoulder blade and then shoulder down into right arm and right elbow into the right forearm, right wrist and 4th and 5th fingers with an unusual sensation which was described as burning ….There was no trauma associated with the onset of the pain, but she did notice that the **pain increased with keyboarding and mousing** ……She had five sessions of **physiotherapy which led to some improvement**. She stated that by November 2014 her symptoms increased significantly ……**she had 15 days off work … during this time she improved.** [emphasis added]*

[4] Note explanation by Dr McGill in his oral evidence at para 22 below

38. Dr Paul did not provide a formal diagnosis but noted that he had had discussed the case with Ms Yasmin's GP and had recommended further investigation including an MRI of the cervical spine.

39. In a report dated 23 March 2016 Dr Paul confirmed that prior to the diagnosis of cervical spine condition Ms Yasmin had "attempted to continue at work but her **symptoms persisted despite treatment and they remained present whether or not she was at work or at home but were made worse by manual activity**".

40. Dr Paul noted that **Ms Yasmin was currently not working and that following surgery she was left with "ongoing pain in her right upper limb** from the shoulder down into the hand and 4th and 5th fingers". Her current medications included Lyrica[5] 75 mg at night and 25 mg occasionally in the morning, occasional Endone and paracetamol.

41. Dr Paul concluded that Ms Yasmin has a "non-work related neck condition" described as **"**chronic right upper limb pain secondary to neuropathic pain in the C6 dermatome distribution secondary to an Arnold Chiari malformation and syrinx." He also that the following the required surgery she had "ongoing chronic pain in the same distribution/area".

MRI

42. An MRI of the spinal cord performed 13 May 2015 is reported as showing "a 7.5 cm elongated area of intramedullary change with some expansion of the spinal cord from C5/6 though to T3/4" which was considered to "represent a syrinx". Also reported was, "cervical spondylosis" at the adjacent C5/6 and C6/7 levels but with only minor encroachment on the central canal structures.

43. An MRI cervico-thoracic spine performed on 23 June 2015 is reported as showing:

- Large syrinx extending from approximately the midbody of C5 to the midbody of T2 with maximal diameter at T1/2…Minor disc bulges in the cervical spine.

[5] Department of Health TGA – Lyrica (pregabalin) is indicated for the treatment of neuropathic pain in adults

- Chiari 1 malformation with the cerebral tonsils lying approximately 8mm below the foramen magnum.

Dr Sally Preston – Consultant Rheumatologist (Michael J Cousins Pain Management and Research Centre RNSH)

44. A In a letter to Dr Saha dated 17 July 2015 Dr Preston noted that Ms Yasmin had been referred from the Emergency Department of RNSH and stated, inter alia, the following:

> *Ms Yasmin is 48 years of age …. She reports onset of pain in the right arm in 2014 which was initially diagnosed as being due to "RSI". She has had adjustments to her hours and duties and reports that her symptoms improved after a period of leave …. She has been referred to see either the neurosurgery or Neurology department at this hospital and has an appointment for further review in August…… She presented to the Emergency Department at Royal North Shore Hospital on the 15th May 2015 and was commenced on Lyrica at that time. It has been very helpful and she is taking 75 mg at night. ….She takes regular paracetamol and may take up to 2 Panadeine Forte a day. Other treatment has included physiotherapy and adjustments in her work station.*
>
> *Ms Yasmin reports improvement in her symptoms but persistent pain in the right arm. She has virtually constant pain in the right arm above the right elbow.* ***Symptoms are worse with any sort of activity and particularly noticeable after a day at work or after typing for prolonged periods****. She occasionally has more spread of pain down into the medial aspect of the right forearm and hand. She is not troubled by neck or upper back pain and has no paraesthesia ….*
>
> *Ms Yasmin reports that her sleep is disturbed, although it has improved since the introduction of Lyrica …. Although managing with work she finds that her symptoms are worse after she has been at work ….****the pain has restricted all her household activities.***
>
> *Reference to an MRI of the cervical spine (not available for review today) which report syrinx in the C%/6 to T3/4 spinal cord.*
>
> *In summary, Mrs Yasmin presents* ***with right arm pain in a C6 dermatome which is consistent with a neuropathic process.*** *Further advice from the Neurolgy or Neurosurgical department is awaited.*

Ms Jessica Wilkinson, Exercise Physiologist, Carfi

45. In an email dated 2 September 2015 Ms Wilkinson provided a summary of a conversation with Dr Saha and stated, inter alia the following:

> *Dr Saha advised that he had not received the letter from the Specialist whom Lubna consulted with following the MRI. He had however received notification from the hospital (Presumably RNSH) that Lubna was on the waiting list for an operation due to the new medical condition……surgery was expected to occur within three months. Dr Saha made changes to the comcare medical certificate*

> *including neurological condition in the diagnosis.*[6] *He also reported that he was unsure as to whether this new condition was the cause of Lubna's symptoms, and has ticked uncertain on the medical certificate. Dr Saha advised that the impression he got from Lubna regarding the feedback from the specialist was that after the operation, her pain would cease…..Dr Saha advised that there had been conflicting opinion as to whether this condition was related to her symptoms ….he believed confirmation could not be obtained in this regard until the outcomes of Lubna's surgery.*

Professor A Krishnan – Consultant Neurologist

46. In a report dated 19 January 2016 Professor Krishnan noted that in 2014 Ms Yasmin "began to notice right arm and forearm pain that was made worse with exertion" and that subsequent investigation revealed a Chiari malformation and cervico-thoracic syrinx.

47. Professor Krishnan stated that despite two surgical procedures Ms Yasmin reported that "she still has ongoing right arm pain which is similar to what she experienced prior to the surgery" and that there has been "no significant change in the intensity of the pain compared to her preoperative level" He noted that Ms Yasmin was still being treated with Lyrica, Targin [7] paracetamol and anti-inflammatory medication.

48. On neurological examination Professor Krishnan was unable to "demonstrate any focal abnormality" and suggested that Ms Yasmin's symptoms may be "musculoskeletal in origin". He declined to make any comments in respect of the syrinx on the basis of limited experience with this condition but added that Ms Yasmin description of the pain in her right arm which is "relieved by rest and increased with exertion" is not typical of neuropathic pain and suggests musculoskeletal pain.

Dr U K Dias – Consultant Occupational Physician

49. In a report dated 8 July 2016 Dr Dias stated, inter alia, the following:

> *Ms Yasmin was diagnosed with a congenital cervicothoracic spinal cord syrinx stretching from the level of C5 to T4 associated with chronic non-specific pain in her right upper limb. She underwent surgery for decompression of the spinal canal syrinx in September 2015. Presently Ms Yasmin continues to suffer non-specific*

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[6] Section 37 Documents T17- Medical Certificate for Compensation 19/06/2015- *Current Diagnosis: RSI RT ARM Pain rt hand, forearm ,upper arm …after using computer for certain period of time…..Caused by repeated use of rt hand in computer [sic]……Treatment: Panadol, Panadine Forte, Lyrica*

[7] Targin (oxycodone) – opioid analgesic

neuropathic pain affecting her right upper limb at approximately nine months post-surgery.

Ms Yasmin took approximately six months off work following surgery, before commencing a graduated return to work in March 2016. Since surgery, she has been treated with physiotherapy, hand therapy, analgesia, home exercises and topical ointment. She reports that her that her cervical spine pain has resolved following surgery; however, she continues to experience chronic non-specific neuropathic pain in her right upper limb.

She currently manages her symptoms by taking Endone[8] on a nightly basis and frequently throughout the day. Ms Yasmin has been progressing slowly since commencing her return to work program in March 2015. She is currently certified as fit to work six hours per day, four days per week, with additional restrictions on performing phone shift duties and keyboarding duties.

In opinion Ms Yasmin appears to be suffering from chronic non-specific neuropathic pain affecting her right upper limb. Her symptoms cross the C7, C8 and t1 dermatomes but do not conform to a specific dermatomal distribution pattern. She may potentially benefit from a repeat nerve conduction study ….to exclude any objective peripheral neurological dysfunction in her right limb. She also reports an increase in symptomatology since the cessation of her Lyrica medication on 21June 2016. This has led to a n increase in reliance on Endone on a nightly basis. I would recommend re-introducing Lyrica at 75 mg on a nightly basis, and reducing the reliance on Endone, with the aim of gradually weaning down the dosage of Lyrica over the next two to three months.

In my opinion Ms Yasmin is fit to continue on a graduated return -to -work program. She should be slowly upgraded back to her pre-injury hours and duties.

50. With respect to the question of a specific diagnosis Dr Dias added the following:

> *My diagnosis of chronic non-specific neuropathic pain in Ms Yasmin's right upper limb is different from the diagnosis put forward by her treating GP, Dr Saha, who has diagnosed her with a 'repetitive strain injury'.* ***I do not believe that Ms Yasmin's condition is "repetitive strain injury". Her symptoms are neuropathic in character*** *(burning, dsysaesthesias, intermittent pins and needles and numbness) and do not conform to a specific muscle group in her upper limb. Indeed her symptoms do not conform to a specific dermatomal distribution either…****I believe that her symptomatology in her right upper limb is of a chronic non-specific neuropathic nature.*** *[emphasis added]*

Dr R Gurgo - Neurosurgeon

51. In a relatively brief report dated 5 October 2017 Dr Gurgo noted current complaints as "right sided upper limb pain in the region of the triceps about 10 to 15 cm superior to the elbow' but "no shooting pain" the right arm an no pain in the "right shoulder or right elbow".

[8] Endone (oxycodone) – opioid analgesic

52. On examination he noted "some tenderness when palpating the right triceps area about 10cm superior to the elbow", finds no other abnormality and makes a diagnosis of "right-sided" upper limb pain of unknown cause'.

53. In response to specific questions from Comcare Dr Gurgo opined that the cause of Mr Yasmin's "condition" is "uncertain" and that it is "unlikely" that she suffers "repetitive strain injury" given the amount of time that has elapsed since 2014.

54. Dr Gurgo states that "it is quite possible" that Ms Yasmin's employment did contribute to her symptoms "given the repetitive nature of the work" but does not provide any other reasons to support his opinion.

Dr N W McGill – Consultant Rheumatologist

55. In a report dated 16 April 2018 Dr McGill stated, inter alia, the following:

> *In February or March 2014 she experienced pain on the posterolateral aspect of the right arm at approximately the junction of the proximal two thirds of the arm (the being the section between the shoulder and the elbow)…..her duties at work involved keying but no elevation of the shoulders. Her sleep was disturbed. The pain was "constant" and "bad" at night. She explained that that her general practitioner decided that the pain must have derived from her work.*
>
> *She had surgery to her spine in September 2015 and a further procedure in October 2015. She returned to restricted work duties in about March 2016. She was away from work for about six months. The pain persisted throughout that period … .she confirmed continued to experience pain although she thought it was less troublesome than when she was working. …She felt that she had returned to her full duties by April 2017.*
>
> *Over the last twelve months her symptoms have changed only a little …..she feels better a the beginning of the working week and worse as the week progresses ….The pain remains localised to the junction between the proximal two thirds and the distal third of the right arm on the posterior and posterolateral aspect.*
>
> *She has pain in the proximal right upper arm for which a certain cause cannot be identified. On the basis of probabilities,* ***I think her spinal cord pathology (syrinx) is likely to have initiated the pain****. With respect to the hypothesis that her keying and other work duties caused the pain, the distribution of the symptom was not consistent with excessive keying and the persistence of the symptom throughout the six month period that she was away from work argues strongly against her work duties having been causative. Imaging studies looking for tendinitis or tenosynovitis were negative.* ***She does not have repetitive strain injury or any other diagnostic label that is applicable to repetitive physical activity with the upper limb.*** *In that she has experienced pain for about four years it is reasonable to deem that she a chronic pain condition. There are no diagnostic criteria for "chronic pain condition"…..She reported that her symptoms*

> *are worse when she is at work……physical activity can cause someone to experience more discomfort at the time of doing the activity.*
>
> *I think on the basis of probability, her arm pain is due to an underlying condition (syrinx) with residual pain despite improvement in the underlying condition as a result of surgery.[emphasis added]*

56. Dr McGill was asked to provide a supplementary report with respect to additional documents provided by Ms Yasmin. The documents included a letter from Ms Yasmin's treating neurosurgeon, Dr Sergides, and the report of an MRI of the cervical spine performed on the 13 July 2018.

57. The MRI was reported to show cervical spondylosis with posterior disc bulge and osteophytes with moderate right exit foraminal narrowing at C4/5 and 5/6 levels.

58. In the supplementary report dated 16 November 2018 Dr McGill stated, inter alia, the following:

> *In my initial report I concluded that it was likely that her spinal cord pathology had initiated her pain. I accept the views of Dr Sergides that the degenerative changes in her cervical spine, particularly the changes the disc bulge at C5/6 which causes significant foraminal stenosis compressing the exiting C6 nerve root, may be responsible.*
>
> *I confirm my views that the distribution of her symptoms has not been consistent with excessive keying as a cause. Persistence of her symptoms throughout the six month period. that she was away from work argues strongly against her work duties as a causative factor…..Pain can persist following removal of the initiating cause. The statement of by Dr Sergides that "given the symptoms have been present for four or five years, it is unlikely that this (the perineural block) will result in permanent relief, reflects the potential for the pain to continue.*

59. Dr McGill attended the hearing by telephone and was able to provide the Tribunal with informative oral evidence. Relevant extracts of the oral evidence are noted as follows:

- *The syrinx can cause pain…..I think it remains very possible, that that was the initiating of her pain. The fact that it was successfully surgically treated and the pain didn't go away, doesn't prove that it's not the cause of the pain……I thought the syrinx was the probably initiator of her pain and that she had continued to experience pain thereafter, despite the successful surgery.*
- *She had further imaging which showed significant foraminal stenosis compressing the exiting C6 nerve root. Dr Sergides thought that that might be the explanation of her persistent pain and, you know, I think that's a very reasonable possibility.*

- *I think she has two proven pathologies, both of which can cause pain in the right arm, that is she had a syrinx and she has foraminal narrowing with potential compression of one of her cervical nerve roots….., both of which can cause pain in the area that she continues to have pain. But I would still favour the syrinx as the most likely major cause of her pain.*
- *People can continue to - once they've suffered pain due to a problem, some people will continue to experience pain, even when the problem has been cured. So, the successful surgery does not prove that the pain was not due to the syrinx……When pain has been present for a long time, sometimes treatments that you would expect to be able to relieve the pain don't have the degree of success that you'd expect, because the pain pathways are established.*
- *she reported to me that when she was typing and doing other physical activities that her pain was worse and I have no reason to doubt her. I have no way of judging that so I just accept it as a true statement, just as someone who has an arthritic knee might feel worse when they're walking, the walking makes the pain worse, it doesn't cause the arthritic knee, it doesn't change the underlying pathology, it doesn't change their susceptibility to experiencing the pain. But when they are doing the activity, they may feel more pain and that's what I think the relationship between her work and her pain has been. She says it only happens when she's at work without other physical activities, like - I can't understand the rationale of that, but that wasn't what she told me. You know, if keying was the cause of the pain you would expect her pain to be in the structures that are being moved when you're keying, that is in the hand and wrist. They normally get it much more distally. Secondly the fact that she was off work for about six months at the time of her surgery and her pain persisted is strongly against the work as being a primary cause of the pain.*
- *And so do you have any comment about …..the specific location for such a long period of time?---Well, I think it does not reflect local pathology at the site of the pain. I think when a pain persists and is the focus of that person's attention - part of what's happening here today is inadvertently focusing attention again on that - then people can continue to experience and report pain in a localised area. But it doesn't fit with a local pathology, nor does it fit with the typical location of right C5-6 foraminal narrowing pain. But I think it's a reflection that her pain pathways are*

switched on, and due to ongoing concern about it and this whole process, it has become fixed.

- *One other question I have is when she was first seen, she saw her GP initially and then in 2014 she was seen by a hand surgeon, Dr Edmonds…… He expressed the opinion in the end that it was not particularly diagnostic, but he referred to a possible mild* ***thoracic outlet syndrome****. Are you able to explain what you understand by that? - Sure. I think what he's saying is that he can't find any local pathology to explain the e symptomatology and that it may be referred from somewhere more proximal. He had noted that the CT of the cervical spine didn't show nerve root compression, so he thought, "Well, if it's not happening in the cervical spine, where else could it be happening? It could be happening with compression over the brachial plexus." At that stage he wasn't aware of her syrinx.*

  But his comments simply reflect that this is a pattern of pain that seems to be referred from somewhere proximally. It is not explained on local pathology. Being a hand and wrist surgeon? he would be very familiar with tendinitis, tenosynovitis, a whole range of local pathologies in the forearm and hand and wrist region. And it's clear from his letter that he didn't find evidence of one of those disorders. But his comments simply reflect that this is a pattern of pain that seems to be referred from somewhere proximally. It is not explained on local pathology. Being a hand and wrist surgeon, he would be very familiar with tendinitis, tenosynovitis, a whole range of local pathologies in the forearm and hand and wrist region. And it's clear from his letter that he didn't find evidence of one of those disorders….

  So the fact that you've just said that he would be very experienced at assessing forearm injuries and so on, does that have any sort of - does it sway you in any way in terms of consideration of the possibility of the type of activities that Ms Yasmin was doing would be related to those sorts of activities? ……I think, you know, the keying activities involves the use of the hands, wrist and forearms in terms of the muscles, and if those activities were responsible for the pathology, then you would expect to find something in the hands, wrist and forearms. And at that time someone who spends his life looking after those areas didn't find any pathology in those areas, so I think it fits very well with my conclusion that her pain has come from more proximal structures, of which I think the syrinx is the more

likely of the two possibilities; the syrinx and her cervical spine being the two possibilities.

- *She hasn't had a repetitive strain injury identified at any stage, and the pattern of pain has never been consistent with a repetitive physical injury of the hands and wrists and forearms as cause of pain. The reason I think that her pain was from her syrinx and not from her work, I've gone through on several occasions, but to recap, the location of the pain didn't fit; the pain persisted which was not working; a whole range of activities make her pain worse according to the history that she provided and has confirmed today; and she has very definite proof of pathology. So she had a syrinx for which she had two operations, and she has degenerative change in her cervical spine. So to suggest that pathology that can't be identified despite her seeing an experienced hand and wrist surgeon at the time her symptoms were bad in 2014, having imaging of the forearm with and ultrasound, I think there is no evidence of pathology there, and yet there was very clear evidence of pathology more proximally. It just doesn't seem plausible to base her symptoms on her keying activity*.

Dr Sergides –treating neurosurgeon

60. In a letter to Dr Saha dated 9 August 2018 Dr Sergides stated, inter alia, the following:

> *Lubna's complaint is of pain in her right harm which has had since 2014. This prompted her initial MRI scan which demonstrated a syrinx and a Chiari 1. It was hoped that treating this would help her right arm pain, but unfortunately it has not. ….The pain is primarily in the right deltoid/trapezius area and also in the right scapular tip. It is constant. Over the last few weeks it has been particularly troublesome for her……She takes Lyrica, Nurofen or Panadol all on an as required basis.*
>
> *On examination she appeared fit and well. She had normal posture and gait. There was no winging, wasting or fasciculations in her upper limbs and the neurological examination was normal.*
>
> *Her MRI scan performed at PRP on 13 July 2018 demonstrates resolution of the syrinx and satisfactory appearance around the foramen magnum. There is moderate spondylotic change with disc bulges maximal at C5/6 and C6/7. The disc bulge at C5/6 causes significant foraminal stenosis compressing the exiting C6 nerve root and this may well account for Lubna's symptoms. I have suggested we perform a perineural block, as much for diagnosis as treatment. Given the symptoms have been present for four years, it is unlikely that this will result in permanent relief.*

61. In a letter dated 28 September 2018 Dr Sergides stated, inter alia, as follows:

I saw Lubna following her right C5/6 foraminal block. This made her symptoms a bit worse for a week or so and they improved for a week or so. They are now back to baseline.

I had a discussion with Lubna about a way forward. Her symptoms are manageable with a Lyrica tablet which she takes two or three times per week at night and we both agree that continuing conservative management is the best way forward. Should Lubna's symptoms deteriorate in the future I's be happy to see her again to discuss thins further. We discussed laminoforaminotomy.

RNSH Medical Records - extracts

62.

- 15.05. 2015 - ED : right upper limb pain …MRI 2 days ago … cystic change ….syrinx …started on Lyrica …allodynia in the C6 dermatome on the right side … referred to chronic pain clinic.
- 25.09.2015- surgery: Foramen Magnum decompression + removal of C1 arch + duraplasty.
- 09.10.2015 -ED: pain and stiffness in her occiput neck and back.. pain has increased in severity 10/10…8/10 after 10 mg morphine CDA.
- 12.10.2015 - Discharge note:….1 day history of pain across her shoulders and nape of the neck…..pain and numbness in her upper limb has improved since surgery …sutures removed …discharged on 2.5-5mg Endone QID PRN and weaning dose of Dexamethasone.
- 19.10.2015 - ED: neck pain ….in distress…requiring morphine for analgesia.
- 23.10.2015 -surgery: Duraplasty and repair of pseudomeningocoele.
- 30.10 .2015 - Discharge home.
- 9.11.2015 - ED: increasing occipital swelling…frontal headache.. no increased R arm pain ..

Clinical notes: Lyrica 75 mg mane; Targin 5mg bd; Panadol 6 hourly; Endone 5 mg PRN – 4x/day.

Neurosurgery Clinic RNSH- extracts from letters to Dr Saha

63.

- **8 July 2015- Dr S G Thomas (neurosurgery fellow)** – I had the pleasure of reviewing Ms Yasmin today…..she is a 46 year old lady who presents with right-sided upper lib pain for the last one and a half years. The pain is of a dull diffuse nature along the medial aspect of the arm and forearm to the medial two fingers. The pain has been better over the last couple of months since she has been on Lyrica. She also complains of right-sided hand weakness. On examination she has right hand grip weakness…. decreased sensations in the C8-T1 dermatomes ……two MRIs of the spinal cord with contrast May and June 2015 shows evidence of a Chiari 1 malformation ….with C3 to T3 level syrinx.

  Lubna's symptoms are explained by the syrinx which is probably caused due to the Chiari malformation. [emphasis added]

- **19 August 2015- Dr S G Thomas** – I am **quite certain that Lubna's symptoms are explained by the syrinx** which is probably caused due to the Chiari 1 malformation. I have explained the nature of the disease to Lubna and her husband. What we would suggest at this point in time is that it is best treated with surgical decompression ….forum magnum decompression, removal of the arch of C1 and a duraplasty. [emphasis added]

- **9 December 2015 - Dr P Rao (neurosurgery registrar)** - As you are aware Lubna Yasmin is a lady with Chiari malformation with extensive cervical syrinx. She was operated on 25 September 2015 with Chiari decompression. She re-presented with ongoing symptoms and pseudomeningocoele for which she had a reopening of the wound and re-do duraplasty and repair of the pseudomeningocoele under Dr Assad on 23 October 2015. Postoperatively she gradually improved although the recurrence of the pseudomeningocoel reoccurred but she was much better symptomatically.

  On seeing her today she is well **with improving numbness and hand function**. She also has reduced pseudomeningocoele both clinically and on the CT scan done today. She has reduced her analgesic medications and currently is on

Ocycontin 5 mg bd and Lyrica 75 mg bd. I reassured her that she can return to her work gradually with short hours initially.[emphasis added]

- **2 March 2016 – Dr L Yang (neurosurgery registrar)** -As you are aware Lubna had a posterior fossa decompression for her Chiari malformation associated with extensive cervicothoracic syringomyelia. ……Today in clinic she was well. **She still has mild ongoing pain over the lateral aspect of her upper limbs bilaterally which is expected**. Her MRI scan demonstrated marked improvement of the cervicothoracic syringomyelia. [emphasis added]
- **1 March 2017- Dr A Pahwa (neurosurgery registrar)** -……. As you are aware Lubna had a posterior fossa decompression for a Chiari malformation associated with extensive cervicothoracic syrinx back in late 2015. Since then, she has progressed really well with follow up scans which demonstrate resolution of the syrinx. Clinically Lubna has remained symptom-free with no headaches. She does however have some right lateral upper arm pain which she feels is associated with her work settles down over a period of rest. She occasionally takes simple analgesia for this. On examination today, Lubna has no myotomal deficits and her wound has healed nicely with no evidence of psueudomeningocoele. My feeling at the moment is that this right lateral arm pain is not related to her original pathology of her cervicothoracic syrinx or Chiari.

CONSIDERATION

Did Ms Yasmin suffer a repetitive strain injury of the right upper arm in 2014?

64. Ms Yasmin submits that in 2014 she suffered an injury at work that was compensable under the SRC Act. She claims that she suffered a “repetitive strain injury” that was caused by her work duties which included typing.

65. The difficulty for Ms Yasmin is that, in my view, the weight of the evidence before the Tribunal does not support her claim.

66. There is no dispute that shortly after she lodged her claim for compensation, in 2015, she was found to suffer a congenital medical condition relevantly described as a ‘Chiari malformation and cervico-thoracic syrinx’. At that time, this condition had been undiagnosed and Ms Yasmin had been asymptomatic prior to 2014. The condition

required a corrective operation which was performed in September 2015 at RNSH. As a result of postoperative complications, a second operation was performed in October 2015.

67. In support of Ms Yasmin's claim for compensation Dr Saha provided a brief report, dated 18 February 2015, in which he diagnosed Ms Yasmin as suffering from "Repeated strain injury to the (R) arm (RSI).

68. Dr Saha noted the date of first consultation as 4 June 2014 and stated that the injury was sustained because of "Repeated use of Computer keyboard" but provided no other clinical details or any explanation to support the diagnosis.

69. As noted above Dr Saha provided three medical certificates for compensation, dated 19/06/2015, 17/06/2016 and 26/08/2016, in which he confirmed that clinical diagnosis as "RSI RT ARM" caused by "repeated use of rt hand in computer" and "typing'.

70. Dr Saha provided these certificates notwithstanding the fact that in May 2015 he was aware of the MRI reports which confirmed that Ms Yasmin suffered significant cervico-thoracic spinal pathology.

71. Furthermore, in letters provided by Dr Thomas, neurosurgery fellow RNSH, dated 8 July 2015 and 19 August 2015, Dr Saha was informed that Ms Yasmin's symptoms could be explained by the "syrinx" which was caused by the "Chiari malformation" and that corrective surgery was recommended.

72. Dr Edmunds in his letter of 13 October 2014 suggested the possibility of "mild thoracic outlet syndrome" with no mention of a repetitive strain injury.

73. Dr Paul in his report of 26 March 2015 noted 'non-specific upper limb pain" that required further assessment and investigation.

74. Dr Preston in her report of 17 July 2015 noted 'right arm pain in a C6 dermatome which is consistent with a neuropathic process".

75. Dr Dias in his report of 8 July 2016 expressed the opinion that Ms Yasmin did not suffer a "repetitive strain injury" of the right arm and, in my view, provided persuasive reasons for his opinion.

76. Dr McGill expressed the opinion that Ms Yasmin did not have a "repetitive strain injury" or any other diagnostic label that is "applicable to repetitive physical activity with the upper limb". He supported his opinion with a logical analysis of the available evidence and, in my view, cogent and balanced reasoning.

77. Dr Sergides, the treating neurosurgeon, in his letters of 9 August 2018 and 28 September 2018, provided no support for a conclusion that Ms Yasmin had suffered a "repetitive strain injury' of the right arm and raised the possibility of second explanation for her persisting symptoms.

78. On consideration of the available evidence I am satisfied that in 2014 Ms Yasmin did not suffer a "repetitive strain injury of the right arm".

79. In deciding I have preferred the evidence of Dr Dias and Dr McGill because their evidence was consistent with the weight of the other medical evidence before the Tribunal and because their opinions were supported by sound reasoning.

80. I found Dr Saha's evidence unhelpful because it was incomplete, not consistent with the weight of other evidence and not supported by convincing reasons.

Did Ms Yasmin suffer a compensable injury under the SRC ACT in 2014?

81. I accept that in June 2014 Ms Yasmin suffered increased pain in her right arm while at work and that her work duties, at that time, had contributed to the increased pain such that she suffered some incapacity for work.

82. The available evidence, however, clearly supports a conclusion that the pain in her right arm was caused by her pre-existing cervical cord pathology that was subsequently diagnosed as "Congenital Chiari malformation and cervico-thoracic syrinx".

83. There is no clear explanation as to why Ms Yasmin had been asymptomatic prior to June 2014 and, for present purposes, I accept that it is likely that her work duties had contributed to exposing the underlying pathology by precipitating pain.

84. However, I am not persuaded that there is sufficient evidence to support a conclusion that Ms Yasmin's work duties were solely responsible for her increasing pain.

85. There is evidence that other activities, also contributed to her increasing pain while she was not at work. For example, a report of being "unwell due to pain" from physiotherapy session on the weekend, a report of increased pain after "Australia day long weekend", Dr Preston's recorded note that "symptoms are worse with any sort of activity" and Dr Dias' recorded note that her "symptoms remained present whether or not she was at work or at home but were made worse by manual activity".

86. Relevantly, however, there is no evidence to support a conclusion that Ms Yasmin's work duties contributed to the cervical cord pathology or any change to that pathology.

87. Therefore, the question that arises is whether "pain itself," that does not cause any pathology or any pathological change, can constitute an Injury for the purposes of the SRC Act.

88. Relevantly In *Re: The Commonwealth of Australia and Kathleen Beattie* (1981) 53 FLR 191 (*Beattie*) the Full Federal Court was asked to address two questions:

    (i) Does pain doing no pathological harm constitute an injury within the meaning of the Compensation (Commonwealth Government Employees) Act 1971?

    (ii) Does pain doing no pathological harm constitute an aggravation of a pre-existing injury caused in non-compensable circumstances within the meaning of the Act.

89. This was a case in which an employee had suffered an injury while on leave and returned to work while still suffering pain from the injury. While at work her duties were such that suffered increased severity of pain which resulted in an incapacity work. However,

although the employee had suffered increased severity of pain, there was no evidence that the work activities had caused any further pathological change.

90. The Court considered the first question inappropriate because "the notion of pain itself being the cause of pathological injury is not one that can be readily comprehended".

91. The Court reformulated the second question as, "can incapacitating pain brought on by activity undertaken in the course of employment constitute an aggravation of a physical injury, not-withstanding that such pain is not brought about by any further pathological change".

92. After considering relevant past authorities, the Court decided that "incapacitating pain" brought on by activity in the course of the employment **may** constitute an "aggravation of a physical injury", notwithstanding that pain was associated brought about by any pathological change. The Court emphasised, however, that "Such pain may do so. Whether it does or not will usually be a question of fact to be decided by the Tribunal or Prescribed Court whose decisions on questions of fact are not the subject of appeal."

93. Relevantly, in *Mellor v Australian Postal Corporation* [2009] FCA 504 (19 May 2009) Her honour, Justice Bennett considered the decision of the Full Court in *Beattie* and appeared to approve this decision as authority for the proposition that "Pain may constitute an aggravation of an ailment or injury".

94. Ms Yasmin's pre-existing cervical cord condition is clearly an "ailment" within the meaning of the SRC Act.

95. On consideration of the evidence, and, in accordance with the above cited authorities, I am satisfied that that Ms Yasmin's "increased right arm pain" can be considered to have been an aggravation of an ailment that was contributed to, to a significant degree by her employment.

96. Therefore, in 2014 Ms Yasmin did suffer an injury for the purposes of the SRC Act.

Did Ms Yasmin continue to suffer the effects of her compensable injury in August 2016

97. Ms Yasmin claims that in August 2016 she continued to suffer the effects of her compensable injury, which she suffered in 2014, and submits that the 9 August 2016 decision to deny further compensation under section 16 and 19 of the SRC Act should be set aside.

98. Ms Yasmin also claims that she currently continues to suffer the effects of that injury on the basis that she still has the same pain in the distal third her right upper arm which she had in June 2104.

99. Ms Yasmin submits that her "syrinx", which has now been fully treated and resolved, can no longer be considered to be the cause of her pain.

100. In support of her claim Ms Yasmin relies primarily on the opinion of her GP, Dr Saha, with some support from the opinions expressed by Dr Pahwa and Dr Gurgo.

101. The difficulty for Ms Yasmin is that, in my view, the weight of the available evidence does not support her claim.

102. The RNSH medical records indicate that following her surgery in September/October 2015 Ms Yasmin had significant problems with severe pain that required treatment with considerable amounts of opiate analgesic medication.

103. The available evidence also indicates that she continued to suffer symptoms including pain in both her upper limbs for some months after the surgery. During this time, she was not at work and her pain was clearly associated with her spinal cord pathology and side effects of the surgery.

104. In a letter to Dr Saha dated 9 December 2015 Dr Rao noted that Ms Yasmin "was well with improving numbness and hand function" and that her current daily analgesic medication included Oxycontin 5 mg 5mg bd and Lyrica 75mg.

105. In a letter to Dr Saha dated 2 March 2016 Dr Yang noted that Ms Yasmin had "ongoing pain over the lateral aspect of **upper limbs bilaterally which is expected**".

106. In his report of 8 July 2016 Dr Dias confirmed that Ms Yasmin continued to experience "non-specific neuropathic pain symptomatology in her right upper" and noted her symptoms had increased after she had stopped taking Lyrica resulting in an increased reliance on "strong opiate analgesic medication".

107. In a letter to Dr Saha dated 1 March 2017 Dr Pahwa, noted that Ms Yasmin reported some "right lateral upper arm pain which she feels is associated with her work and settles down over a period of rest. She occasionally takes simple analgesia for this." He expressed the opinion that 'this right lateral arm pain is not related to her original pathology of cervicothoracic syrinx or Chiari".

108. In his letter of 5 October 2017 Dr Gurgo stated that Ms Yasmin's current condition was "uncertain" and that it was "unlikely" that she suffers "repetitive strain injury" given the amount of time that has elapsed since 2014. He expressed an opinion that that that "it is quite possible" that Ms Yasmin's employment did contribute to her symptoms "given the repetitive nature of the work".

109. Dr Sergides, treating neurosurgeon, in his letters of 9 August 2018 noted that the most recent MRI showed "significant foraminal stenosis compressing the exiting C6 nerve root" and suggested that "this may well account for Lubna's symptoms".

110. In his letter of 27 November 2018 Dr Saha asserts when Ms Yasmin's was rejected Comcare had stated that her right arm pain was correlated to syrinx "which was later proved wrong" and that in his opinion "her right arm pain was originated from work and she has RSI".

111. In his oral evidence Dr McGill confirmed his opinion; the most likely cause for Ms Yasmin's persisting right upper limb pain was the "syrinx". He explained that the successful treatment of the "syrinx" did not exclude this pathology as the cause of the pain, particularly, as pain that has been present for a long time may not be fully relieved following surgical treatment because of the development of "pain pathways".

112. However, Dr McGill did concede that it was possible that the C6 foraminal stenosis described by Dr Sergides could be a second contributing factor causing Ms Yasmin's current right upper limb pain.

CONCLUSION

113. In my view, the available evidence demonstrates that in the six months following Ms Yasmin's first operation in September 2015, when she was not at work, her symptoms including her right upper pain were caused by the cervico-thoracic pathology and the effects of the surgery.

114. In July 2016 Dr Dias was clearly of the opinion that Ms Yasmin's continuing upper arm symptoms, at that time, were caused by her cervico-thoracic pathology and not contributed to by her employment.

115. The cause of Ms Yasmin's current right upper arm pain remains unclear.

116. Dr Saha's opinion that the "RSI" she suffered in 2014 is the cause of her current pain is, in my view not consistent with the weight other evidence and is not supported by reliable reasons. I have placed little weight on his opinion.

117. The somewhat superficial opinions of Dr Pahwa and Dr Gurgo are also not supported by satisfactory reasons and, therefore, I find they are of little value.

118. Dr Sergides raises the possibility of an alternative cause of Ms Yasmin's pain but does not lend any support to Ms Yasmin's claim that her employment had significantly contributed to her persisting symptoms.

119. In my view, the most persuasive opinion on this issue has been provided by Dr McGill. He has clearly addressed the relevant evidence in a balanced manner and provided plausible reasons in support of his opinion.

120. Therefore, in consideration of the available evidence I am satisfied that Ms Yasmin's work duties during 2014 and 2015, prior to her first operation, did not make a contribution, to a significant degree to her symptoms following her surgery or her current symptoms.

121. I am satisfied that the compensable injury Ms Yasmin suffered in 2014 is best characterised as an aggravation of her pre-existing spinal pathology in the form of "increased pain" while performing her duties at work and which caused only a temporary incapacity for work.

122. I am also satisfied that that the effects of the compensable injury had ceased at the time of Ms Yasmin's first operation in September 2015.

DECISION

123. For reasons set out above I find that, as at 9 August 2016, Ms Yasmin no longer suffered the effects of her compensable injury and, therefore, had no present entitlement to compensation under section 16 or 19 under the SRC Act.

124. Decision under review is affirmed.

I certify that the preceding 124 (one hundred and twenty four) paragraphs are a true copy of the reasons for the decision herein of Dr I Alexander, Member

.....[sgd].....

Associate

Dated: 10 January 2019

Date(s) of hearing:	**11 and 12 December 2018**
Applicant:	**In person**
Counsel for the Respondent:	**Anella Bortone**
Solicitors for the Respondent:	**Geoff Wilson, Comcare**