IN THE SUPERIOR COURT OF THE STATE OF DELAWARE

IN AND FOR NEW CASTLE COUNTY

SUSAN VON HOELLE,	)	
	)	
Claimant-Appellant,	)	
	)	C.A. No. N10A-12-010 MMJ
v.	)	
	)	
AMERICAN HONDA FINANCE,	)	
	)	
Employer-Appellee.	)	

Submitted: February 20, 2012
Decided: May 17, 2012

On Appeal from the Industrial Accident Board

AFFIRMED

MEMORANDUM OPINION

Donald E. Marston, Esquire, James R. Donovan, Esquire, Doroshow, Pasquale, Krawitz & Bhaya, Wilmington, Delaware, Attorneys for Employee-Appellant

Christian G. McGarry, Esquire, Nathan V. Gin, Esquire, Elzufon Austin Reardon Tarlov & Mondell, P.A., Wilmington, Delaware, Attorneys for Employer-Appellee

JOHNSTON, J.

Susan Von Hoelle ("Claimant") has appealed the November 22, 2010 decision of the Industrial Accident Board ("Board"). The Board denied Claimant's Petition to Determine Additional Compensation Due for her cervical spine and upper left extremity symptoms. The Board found that Claimant did not establish by a preponderance of the evidence that her injuries were caused by her work activities with American Honda Finance Corporation ("AHFC").

Claimant contends that the Board's decision constituted legal error and was not supported by substantial evidence.

FACTUAL AND PROCEDURAL CONTEXT

On June 11, 2009, while working as a customer service representative in AHFC's collections department, Claimant sustained an injury to her right hand related to carpal tunnel syndrome ("CTS"). On July 31, 2009, Claimant underwent a carpal tunnel release surgery on her right hand. AHFC acknowledged that this injury was compensable. Claimant was awarded ongoing total disability benefits at a rate of $506.00 per week.

On December 7, 2009, AHFC filed a Petition for Review of Compensation to terminate Claimant's benefits because she was no longer totally disabled. On March 16, 2010, Claimant filed a Petition to Determine Additional Compensation Due. Claimant claimed entitlement to continued

total disability as to her right upper extremity. Claimant also sought a finding that certain diagnostic testing and treatment related to her right upper extremity symptoms were reasonable, necessary, and causally related to her work injury. Additionally, Claimant requested a finding of compensability for cervical spine and left upper extremity conditions, allegedly related to the original work injury.

On August 25, 2010, the Board held a consolidated hearing on the pending petitions. The Board denied AHFC's Petition for Review of Compensation, finding that Claimant remained totally disabled as a result of her right upper extremity symptoms. The Board, however, denied Claimant's Petition to Determine Additional Compensation Due. The Board ruled that there was no causal relationship between Claimant's cervical spine and left upper extremity conditions and her work activities at AHFC.

Claimant's Condition and Treatment

Claimant first noticed problems with her right hand in 2007. Claimant was experiencing pain, tingling, and numbness in her right hand, which she attributed to her work activities at AHFC. Approximately six to eight months after her right hand symptoms developed, Claimant testified that she began to have similar symptoms in her left hand.

On June 3, 2009, an EMG was performed on Claimant, showing mild right CTS.[1] The EMG showed no evidence of cervical radiculopathy, ulnar neuropathy, or nerve irritation, and was normal as to Claimant's left upper extremity.

On June 11, 2009, Claimant saw Dr. David Sowa, an orthopaedic surgeon. According to Dr. Sowa's records, Claimant complained of pain in her left and right upper extremities, including numbness, tingling, swelling, and limited range of motion. Dr. Sowa examined Claimant and found signs of irritability over the median nerve of the right wrist. Additionally, Dr. Sowa noted a painful range of motion of the left wrist. An x-ray of the left wrist showed no specific bony elements.

Dr. Sowa also observed a painful ganglion cyst of the left wrist that he subsequently treated. Dr. Sowa stated that the ganglion cyst was not related to Claimant's work activities.

On July 31, 2009, Dr. Sowa performed a right carpal tunnel release surgery on Claimant without complication. At her follow-up appointment on August 12, 2009, Claimant indicated that her right hand had improved, but was still painful. Claimant also complained of occasional numbness in her left hand.

[1] Claimant denied the existence of any prior injuries or other conditions that would predispose one to CTS, including lupus, diabetes, smoking or thyroid disease.

Claimant returned to Dr. Sowa on September 9, 2009, and again on October 7, 2009 for follow-up appointments. Claimant stated that she was not using her right hand much due to continued pain and stiffness. Claimant also complained of intermittent tingling in the right hand with intermittent shooting pain in the right upper extremity.

Dr. Sowa examined Claimant and found that she had a limited range of motion in her right wrist. An x-ray of the right hand and wrist showed no specific abnormalities.

Due to Claimant's limited use of her right hand, Dr. Sowa became concerned that she was developing reflex sympathetic dystrophy ("RSD"). Dr. Sowa, however, noted that Claimant was not suffering from excessive swelling or color changes in her hand – symptoms that are indicative of RSD. Dr. Sowa recommended that Claimant be restricted to light duty work.

On October 13, 2009, Claimant was evaluated by Dr. Robert Smith, an orthopaedic surgeon, for a defense medical examination. Claimant stated that she suffered from tingling in her right hand which was related to CTS. Claimant did not indicate at that time that she was suffering from any neck or left upper extremity pain.

Dr. Smith examined Claimant and noted that Claimant's right carpal tunnel release surgery scar was healing well. Dr. Smith detected no deformity or atrophy of the right hand, and he noted that Claimant had full range of motion of her right wrist and finger joints. Claimant was able to grip, pinch and oppose her right thumb.

Because Claimant's clinical examination was normal, Dr. Smith stated that no additional testing was necessary as Claimant had reached the point of "maximum medical improvement." According to Dr. Smith, Claimant was capable of part-time work, gradually increasing to full-time work without restrictions within two months.

Claimant returned to Dr. Sowa on November 4, 2009 for a follow-up appointment. Claimant complained of tingling and burning in her right hand, as well as pain and numbness in both arms. Claimant also indicated that she was suffering from neck stiffness and trapezius muscle tenderness, especially on the left side.

Based on Claimant's complaints, Dr. Sowa ordered an x-ray of her cervical spine. The x-ray revealed significant straightening of the cervical spine and slight foraminal narrowing between the third and fourth cervical vertebra. According to Dr. Sowa, straightening of the cervical spine is

indicative of cervical muscular spasms which could cause cervical nerve root irritation.

On December 2, 2009, December 30, 2009, and January 27, 2010, Claimant returned to Dr. Sowa for treatment. Claimant complained of burning and tingling in her right hand as well as significant coldness in both hands. Claimant also complained of significant left-sided neck pain and radicular-type aching in the left upper extremity. Claimant stated that if she extended her neck, she experienced symptoms in the upper left extremity, and if she elevated her arms, she experienced tingling in both arms.

Dr. Sowa examined Claimant and noted ulnar nerve irritability in her elbows. According to Dr. Sowa, if Claimant raised her arms above her head, she developed severe symptoms of pain into the ulnar aspect of both forearms. Dr. Sowa also noted diffuse symptoms in Claimant's right and left upper extremities, pain with motion of the right shoulder, and left paracervical neck tenderness.

Due to the diffuse symptoms in Claimant's right upper extremity, Dr. Sowa remained concerned that she was developing RSD. Dr. Sowa also was concerned that the symptoms in Claimant's left upper extremity represented either a cervical radiculopathy or a thoracic outlet syndrome.

Dr. Sowa scheduled a cervical MRI to determine whether Claimant's increased symptoms were due to a significant cervical disk herniation. The MRI, performed December 2009, showed only evidence of age-related degenerative disease.[2]

On March 18, 2010, Claimant was seen by Dr. Kim, a physiatrist who specializes in non-surgical treatment of back and neck problems. Claimant indicated that her neck pain, which was worse on the left side than on the right side, radiated into her shoulder and down her arm toward her left hand fingers. Claimant also complained of sensitivity in her right hand.

Dr. Kim examined Claimant and found normal cervical motion except for flexion as well as a mild decrease in lateral bending toward the left and right. Dr. Kim also noted tenderness on Claimant's right and left sides, diffuse tenderness of both scapular regions, and tenderness along the left shoulder.

Dr. Kim recommended cervical injections for Claimant's right-sided symptoms. Additionally, Dr. Kim recommended an EMG to evaluate Claimant's upper extremities. The EMG, performed on April 7, 2010, was normal as to Claimant's left side. On the right side, the EMG showed only

[2] Specifically, the MRI showed evidence of a mild cervical spondylosis and bone spur formation, some osteoarthritis of her facet joints, and some foraminal narrowing on the left side between the third and fourth vertebra and between the sixth and seventh vertebra on the right side.

mild residual slowing of the median nerve conduction after carpal tunnel release. The EMG showed no evidence of nerve root involvement or thoracic outlet syndrome.

Claimant returned to Dr. Sowa on May 6, 2010, complaining of hand pain. Specifically, Claimant described swelling and color changes in her right hand. Claimant also indicated that she was suffering from neck pain and headaches.

On May 18, 2010, Claimant was again seen by Dr. Smith. Claimant complained of an electrical-type pain shooting from her neck into both upper extremities, with alternate hot and cold sensations in her arms. Claimant also stated that she suffered from severe headaches. Dr. Smith examined Claimant and found no objective evidence to support her claims of neck pain.

Dr. Kim saw Claimant again on June 8, 2010. Claimant stated that she underwent an injection on the right side which gave her some degree of relief in the right hand. Although she was not as sensitive in the right hand as she had been previously, she still experienced color changes in her hand. Claimant also complained of continued neck pain and symptoms in the left shoulder and upper extremity, radiating into the hand. Claimant stated that she continued to suffer from headaches.

Based on Claimant's complaints, Dr. Kim diagnosed Claimant with RSD and left cervical radiculopathy. Dr. Kim recommended that Claimant repeat the injection on the right side, and receive an epidural steroid injection for the left-side cervical radicular symptoms.

Claimant was again seen by Dr. Sowa on June 10, 2010. Dr. Sowa diagnosed Claimant with RSD in her right upper extremity and neck pain with a left-side cervical radiculopathy or bilateral thoracic outlet syndrome.

Claimant's Work Experience

Claimant has been out of work since July 30, 2009, the day before her carpal tunnel release surgery. In September 2009, Claimant contacted AHFC to inquire about the availability of light duty work. Claimant contends that she was informed that no light duty was available. Claimant made no further efforts to contact AHFC.

Claimant began working for AHFC in 2001 as a customer service representative. Claimant moved to several departments within AHFC before her ultimate placement as a customer service representative in the collections department. Notwithstanding these internal transfers, it appears that Claimant's job responsibilities remained largely the same during her time at AHFC. The record establishes that the bulk of Claimant's job duties at AHFC entailed data entry and making telephone calls.

While at AHFC, Claimant's work hours varied. A typical work day for Claimant could range anywhere between 9 to 11 hours, with overtime occasionally required.

The August 25, 2010 Hearing

Claimant's Testimony

Claimant testified that at some point in 2007, she experienced tingling and numbness in her right hand. Claimant stated that her right hand would swell and change colors.[3] Approximately six to eight months after her right hand symptoms developed, Claimant testified that she began to have similar symptoms in her left hand. Claimant later developed a stiff neck from sitting all day, which she claims affected her left hand.

Claimant testified that as of August 2010, she had received two injections for her right hand. Claimant stated that the injections decreased the sensitivity in her right hand and that the swelling was less frequent and less severe.

At the August 2010 hearing before the Board, Claimant testified that she still was experiencing neck pain that radiated into her fingers, burning pain in her elbow, and headaches – all of which she attributed to her work activities at AHFC. Claimant testified that based on her current symptoms,

[3] Drs. Smith, Kim and Sowa never observed a change of color in Claimant's hands.

she did not believe that she could work at all. Claimant was hopeful that she will be able to return to AHFC in the future.

Claimant's husband, Tim Von Hoelle, testified that he personally had observed Claimant's right hand symptoms, including color changes, swelling, and temperature changes.

Claimant's Medical Expert

Dr. Sowa testified by deposition that Claimant developed right-sided CTS as a result of work activities. Additionally, Dr. Sowa opined that Claimant developed neck pain with a left-sided cervical radiculopathy or bilateral thoracic outlet syndrome as a result of her keyboarding activities at work.[4] According to Dr. Sowa, sustained neck flexion and poor posture while sitting in front of a keyboard caused cervical muscle spasms and aggravate cervical nerve roots, resulting in Claimant's left upper extremity complaints.

Dr. Sowa acknowledged that the June 2009 and April 2010 EMGs were normal as to Claimant's left upper extremity, but testified that cervical nerve root irritation and thoracic outlet syndrome typically do not show up on an EMG. Dr. Sowa testified that Claimant's x-ray showed straightening

[4] Dr. Sowa testified that Claimant's neck symptoms were wholly unrelated to her right CTS.

of the cervical spine that is indicative of cervical muscular spasms which could cause cervical nerve root irritation.

Dr. Sowa further opined that after Claimant's right carpal tunnel release surgery, she developed RSD. Dr. Sowa believed that additional diagnostic testing was unnecessary in light of Claimant's history and the physical examinations. Dr. Sowa opined that an injection, used both to diagnose and treat RSD, was a safer alternative than using a bone scan to diagnose.

Dr. Sowa noted that after receiving the injection, Claimant experienced some degree of relief in her right hand. Dr. Sowa opined that Claimant's positive response to the injection suggested that Claimant did, in fact, have RSD. Therefore, in Dr. Sowa's opinion, the initial injection was reasonable as well as the administration of subsequent injections.

With regard to Claimant's work restrictions, Dr. Sowa testified that following the July 2009 carpal tunnel release surgery, Claimant was totally disabled. By September 2009, Dr. Sowa recommended that Claimant be restricted to light duty work. However, in November 2009, after Claimant complained of neck and left upper extremity symptoms, Dr. Sowa testified that Claimant was totally disabled. Nevertheless, Dr. Sowa opined that

Claimant's right hand symptoms, alone, were sufficient to place her on total disability.

Employer's Medical Expert

Dr. Smith testified by deposition that based on the June 2009 EMG, Claimant had a mild case of right-sided CTS. Dr. Smith opined that although "there's no clear evidence that [keyboard work] causes carpal tunnel," there was "probably a loose association between keyboard work and the development of carpal tunnel…."

Dr. Smith opined that as of October 2009, Claimant had reached the point of maximum medical improvement following the carpal tunnel release surgery. Therefore, Dr. Smith believed it was reasonable for Claimant to return to work part-time and gradually transition into full-time work with no restrictions by January 2010.

As to Claimant's neck and left upper extremity symptoms, Dr. Smith opined that they were not related to Claimant's right-sided CTS. Dr. Smith noted that although individuals with severe CTS can experience pain radiating up the arm all the way to the neck, Claimant had a mild case of CTS.

Dr. Smith testified that he was unable to find an objective basis for Claimant's neck and left upper extremity symptoms. Neither the June 2009

EMG nor the April 2010 EMG showed evidence of cervical radiculopathy, thoracic outlet syndrome, or other nerve root irritation. Additionally, the December 2009 MRI showed no evidence of a herniated disc, stenosis, or a prior injury. Dr. Smith opined that Claimant's complaints were the result of "symptom magnification" as opposed to any work activity.

Dr. Smith further testified that there were no clinical findings to support a diagnosis of RSD. Claimant exhibited none of the physical findings indicative of RSD,[5] and no diagnostic tests were ever performed by Dr. Sowa. According to Dr. Smith, more diagnostic testing – *i.e.*, a bone scan – should have been performed to confirm that Claimant had RSD before she received the injection.

Vocational Testimony

Carol Esing, a senior disability vocational specialist, prepared a labor market survey that identified twelve jobs which met Dr. Smith's recommendations. The average weekly wage of these twelve positions was between $240 and $600 with a median wage of $348.97 per week.

Jim Stevens, a regional manager at AHFC, testified that Claimant's position in the collections department had been held for her since July 2009.

[5] Such clinical findings include: changes in skin, sweating pattern, hair growth, fingernails; atrophy; and joint ankylosis.

Stevens testified that if Claimant returned to AHFC, accommodations would be made for Claimant's work restrictions.

The Board's Opinion

Considering Claimant's cervical spine and left upper extremity symptoms, the Board found Dr. Smith to be more persuasive than Dr. Sowa. Relying on Dr. Smith's opinion, the Board concluded that there was no causal relationship between Claimant's cervical spine and left upper extremity symptoms and her work activities at AHFC. The Board noted that Dr. Sowa's opinion was based primarily on Claimant's report that her work activities caused her symptoms, rather than on objective findings. According to the Board, neither the MRI nor the EMGs showed evidence that would validate Claimant's neck and left upper extremity complaints. Moreover, and perhaps most significantly, the Board noted that Claimant's neck and left upper extremity complaints did not begin until five months after Claimant ceased working at AHFC. Therefore, the Board denied Claimant's petition for benefits for her neck and left upper extremity symptoms.

The Board, however, accepted Dr. Sowa's opinion that Claimant remained totally disabled due to her right-sided symptoms alone. The Board noted that Claimant's right-sided symptomatology, which Dr. Sowa believed

to be progressing into RSD, was a "large component" of Dr. Sowa's opinion that Claimant was totally disabled.[6]

The Board further found that the injections related to Claimant's right-sided symptoms were reasonable, necessary and causally related to the work injury. In reaching this conclusion, the Board accepted Dr. Sowa's testimony that a bone scan is not a requirement to diagnose RSD; rather, injections may be used to both diagnose and treat. Noting Claimant's positive response to the first injection, the Board found the injections reasonable, and therefore, compensable.

STANDARD OF REVIEW

On appeal from the Industrial Accident Board, the Superior Court must determine if the Board's factual findings are supported by substantial evidence in the record.[7] "Substantial evidence" is less than a preponderance of the evidence but is more than a "mere scintilla."[8] It is "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion."[9] The Court must review the record to determine if the evidence

[6] The Board declined to make a specific finding that Claimant, in fact, suffers from RSD.

[7] *Histed v. E.I. DuPont deNemours & Co.*, 621 A.2d 340, 342 (Del. 1993).

[8] *Richardson v. Perales*, 402 U.S. 389, 401 (1971).

[9] *Histed*, 621 A.2d at 342 (citing *Olney v. Cooch*, 425 A.2d 610, 614 (Del. 1981)).

is legally adequate to support the Board's factual findings. The Court does not "weigh evidence, determine questions of credibility or make its own factual findings."[10] If the record lacks satisfactory proof in support of the Board's finding or decision, the Court may overturn the Board's decision. On appeal, the Superior Court reviews legal issues *de novo*.[11]

DISCUSSION

Claimant's Neck and Left-Sided Complaints Were Not Work-Related

The Board denied Claimant's Petition for Additional Compensation Due as to her neck and left upper extremity symptoms, finding that these complaints were not related to Claimant's work activities at AHFC. In reaching this conclusion, the Board rejected the testimony of Dr. Sowa, noting the absence of any objective evidence to validate Claimant's subjective complaints. According to the Board, Dr. Sowa's diagnosis was based primarily on Claimant's report that her complaints were caused by work activities. Further, the Board noted that the onset of Claimant's neck and left-sided complaints began approximately five months after Claimant ceased performing work at AHFC.[12]

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[10] *Olney*, 425 A.2d at 614.

[11] *Person-Gaines v. Pepco Holdings, Inc.*, 981 A.2d 1159, 1161 (Del. 2009).

[12] Though the Board miscalculated the length of time between Claimant's last day at AHFC and the onset of her neck and left-sided symptoms, that error is harmless. The

Dr. Sowa opined that Claimant developed neck pain with a left-sided cervical radiculopathy or bilateral thoracic outlet syndrome as a result of her keyboard activities at AHFC. According to Dr. Sowa, sustained neck flexion and poor posture while sitting in front of a keyboard could cause cervical muscle spasms which could aggravate the cervical nerve roots. Dr. Sowa acknowledged that although an EMG typically does not show evidence of cervical radiculopathy or bilateral thoracic outlet syndrome, Claimant's x-rays indicated cervical muscle spasms. Dr. Sowa further opined that Claimant's left upper extremity complaints were the result of cervical nerve root irritation.

Dr. Smith testified that neither the EMGs nor the MRI showed any objective evidence to substantiate Claimant's subjective complaints concerning her neck and left upper extremity symptoms. Dr. Smith first noted that the initial EMG showed only a mild case of right CTS and was normal as to Claimant's left upper extremity.

As to Claimant's neck, Dr. Smith testified that the cervical MRI showed only age-related degenerative disease and nothing traumatic in nature

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record establishes that Claimant first complained of left-sided symptoms in June 2009, while she still was working at AHFC. In November 2009, approximately three months after Claimant's last day at AHFC, she first complained of neck pain.

indicative of an injury. Further, during his examination of Claimant's neck, Dr. Smith was unable to detect any spasms, atrophy, rigidity, or deformity.

With no objective findings to support Claimant's subjective complaints, Dr. Smith opined that Claimant's symptoms were the result of "symptom magnification." According to Dr. Smith, simply sitting at a desk using a keyboard would not cause Claimant's alleged cervical herniation or cervical radiculopathy. Therefore, Dr. Smith found no causal relationship between Claimant's neck and left upper extremity complaints and her work activities at AHFC.

The Court finds the Board's denial of benefits for Claimant's neck and left upper extremity complaints to be free from legal error. The Board was presented with conflicting medical testimony. Both opinions were supported by substantial record evidence. As the trier of fact, the Board is free to accept one expert opinion and reject the other.[13]

CONCLUSION

The Court finds that the Board properly considered all of the record evidence in finding Appellee's expert opinion more persuasive than Appellant's expert. The Court finds that the Board's factual findings are

[13] *Opalach v. Diagnostic Imaging, P.A.*, 2007 WL 2758773, at *4 (Del. Super.).

supported by substantial evidence, and that the Board's decision is free from legal error.

THEREFORE, the November 22, 2010 decision of the Industrial Accident Board is hereby **AFFIRMED.**

IT IS SO ORDERED.

/s/ *Mary M. Johnston*
The Honorable Mary M. Johnston