

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F009901

BYRON E. OWENS, SR.,
EMPLOYEE

CLAIMANT

LENNOX INDUSTRIES, INC.,
EMPLOYER

RESPONDENT

PACIFIC EMPLOYERS INSURANCE,
INSURANCE CARRIER

RESPONDENT

OPINION FILED SEPTEMBER 30, 2004

Upon review before the FULL COMMISSION in Little Rock,
Pulaski County, Arkansas.

Claimant represented by HONORABLE ANDRE K. VALLEY, Attorney
at Law, Helena, Arkansas.

Respondents represented by HONORABLE BETTY J. DEMORY,
Attorney at Law, Little Rock, Arkansas.

Decision of the Administrative Law Judge: Reversed.

OPINION AND ORDER

The claimant petitions the Full Commission to review an administrative law judge's opinion filed July 21, 2003. The administrative law judge found that the claimant did not prove he sustained a compensable injury. After reviewing the entire record *de novo*, the Full Commission reverses the opinion of the administrative law judge. We find that the claimant proved he sustained a compensable injury.

I. HISTORY

The testimony of Byron Owens indicated that he began working for Lennox Industries in about 1990. Mr. Owens testified:

Q. And at the time of your injury, what were your job duties?

A. Well, my specific job was I was running a machine called a Amada, where I run, punch holes in metals and put it back on the thing, but I was also like a rover because I pretty much - had been in fabrication a while and I had run all of the machines and they would take me to different places. When other people didn't show up for work, I would fill in their spots if they needed me to....

Q. What happened on December 21st of 1999?

A. Well, I was at the Amada, I was running what they call top panels, big sheets, and I was running those, and my supervisor come down and told me, he said, "I need to go run some boards for me. The guy on the day shift didn't come in, so I need you to go down there and run them for me," I said, "Okay." So, I went down there and started running them and my hands started hurting, so I done got them all runned up, so I come back and I started running my machine, and I felt like a pope (sic) in it. I looked down and it was a knot on my right wrist. So, I kept on. I went and told my supervisor, and he said, "Well, you go tell the nurse." I went and told the nurse about it.

The claimant agreed on cross-examination that, during a previous deposition, he did not describe a "pop" in the wrist. The claimant essentially agreed that he had

previously described more of a gradual injury. The claimant credibly testified on re-direct examination:

Q. What happened prior to the 21st?

A. Prior to the 21st, whenever I run those blowers, my wrist, you know, I always feel hurt in my wrist, you know, and I was steady going up to the nurse, telling the nurse about it, and she would put a ice pack on it and one time she put some cream on it, some kind of cream they've got, therapeutic cream that they put on there and wrap my wrist with it. Like I say, until the 21st, that's the day when I went out there, and that's when I started going to the doctor.

The claimant testified that the respondent-employer sent him to a doctor. The record indicates that the claimant presented to Stuttgart Medical Clinic on December 21, 1999. The claimant complained of a "knot on R wrist. Pt states he picks up heavy items at work. Pt also states his R hand has been falling asleep." A physician's examination revealed a "6 x 6 x 6 hand cyst" on the claimant's right wrist below the thumb. The physician's impression was "cyst R wrist" and "carpal tunnel syndrome."

The respondents' attorney stated at hearing that the respondents initially accepted as compensable a December 1999 claim filed by the claimant.

The claimant testified, "I started back working, and they had me on the Amada running again, and I was running -

I had a hand splint on my right hand, so I mostly used my left, and then it come down, and I had to run blowers like two or three times, you know, since I got hurt the first time. Then, all of a sudden, my left hand started bothering me, and it kept on and kept on aggravating, so I went up to the nurse and the nurse looked at it and said, 'You need to go to the doctor on this one here, too.'" The claimant testified, "I had ran blowers like two or three different times since I had the first injury because I had to put all my pressure in my left hand. Because when you're running blowers, it's really just all wrist work. You have to squeeze it together and then just turn it like that right there (indicating). You have to put like a hundred spark welds around on each side....I guess I was just doing too much with my left, and it started bothering me."

The claimant followed up with the initial treating physician on January 4, 2000. The claimant reported reduced swelling on the right wrist, but that he was getting a knot on his left wrist. The physician's examination indicated that medication had "helped cyst not numbness." The physician's impression was "cysts wrist," "carpal tunnel syndrome," and "neuropathy." The claimant testified that his medical treatment included steroid injections.

The record contains a Physician's Report dated on or about January 20, 2000. The claimant was diagnosed with "right volar wrist ganglion" and "bilateral carpal tunnel syndrome." The physician's report stated, "Bilateral volar wrist ganglions over radial side. Right anterior shoulder goes numb. Pain was intermittent, now all the time."

In a Physician's Report dated February 10, 2000, the claimant was diagnosed with "right volar wrist ganglion" and "bilateral carpal tunnel syndrome."

The claimant testified that he noticed a temperature change in his hands, "around in February after my hands had swollen from the steroid injections. That's when they swole up and they got real, like cold on me."

An electrodiagnostic examination was carried out on February 28, 2000, with the following impression:

1. Normal nerve conduction studies of the right and left median nerves, both motor and sensory, including the anterior interosseus branches. There is no evidence for a carpal tunnel syndrome on either side by standard techniques.
2. Normal palmar stimulation of both the right and left median and ulnar nerves.
3. Electromyographic studies are normal of the muscles examined.

CONCLUSION: The electrodiagnostic studies are normal. There is no electrodiagnostic evidence for a carpal tunnel syndrome on either side. There is no evidence of cervical nerve root irritation on either side. There is no evidence

of anterior interosseus involvement on either side. This is a normal examination.

The claimant testified that he continued to work, but the parties stipulated that the claimant was paid temporary total disability compensation from March 8, 2000 to April 11, 2000. On May 3, 2000, the claimant was diagnosed with "bilateral hand pain & weakness - unclear etiology - atypical carpal tunnel symptoms."

A hand surgeon, Dr. Michael M. Moore, examined the claimant on May 22, 2000 and noted that the claimant's fingers were cold on his left hand. Dr. Moore stated:

[I]t is my opinion Mr. Owens presents with a difficult problem. His clinical history and physical examination do suggest a possible carpal tunnel syndrome. However, the NCV/EMG study was normal. In addition, Mr. Owens' clinical history and physical examination may be consistent with a Raynaud's phenomena, or vasospastic disease....At this time, I do not feel Mr. Owens is a candidate for surgical treatment....

Dr. Moore arranged additional diagnostic testing and consultation with Dr. Reginald J. Rutherford. Dr.

Rutherford reported on May 31, 2000:

Mr. Owens reports that in December, 1999 he began to experience numbness of his hands. This after onset spread up the arms to the region of the neck accompanied by neck and low back pain. He subsequently noted coldness of his hands and has noted that on cold exposure his hands will turn blue....

The hands were noted to be ice cold to touch there being marked temperature difference in comparing temperature of the hands vs. temperature of the feet....Small ganglions were noted over the volar aspect of each wrist....

Mr. Owens' clinical picture is considered most consistent with a vasospastic disorder. This is supported by current diagnostic testing which serves to rule out accompanying or associated entrapment neuropathy. Further laboratory studies are recommended to ascertain whether or not there is evidence of an underlying systemic process or illness....

Dr. Rutherford also authored an EMG Report on May 31, 2000:

The nerve conduction study does demonstrate prolongation of all sensory latencies and to a lesser degree motor latencies. There is no asymmetry on side to side comparison and no asymmetry on internal comparison in evaluating median versus ulnar, motor and sensory function. Present study is clearly different from that previously recorded by Dr. Miles but the changes as noted are felt adequately explained by temperature effect. There is no evidence in the present study to suggest carpal tunnel syndrome or other focal abnormality on the peripheral nervous system.

The respondents' attorney indicated at hearing that the respondents controverted the claim after the reports from Dr. Moore and Dr. Rutherford.

The claimant presented to another orthopaedist, Dr. Charles A. Clark, in February 2001. Dr. Clark ordered additional diagnostic studies. The record indicates that

electrodiagnostic studies were performed on or about February 21, 2001, with the following impression, "Severe bilateral CTS and left ulnar nerve entrapment at Guyon's canal." Dr. Clark reported in March 2001:

This is a f/u for persistent pain in both upper extremities. We obtained NCVs. There is no question that he has severe carpal tunnel syndrome on both sides with ulnar involvement at Guyon's canal on the L side as well, indicating that both nerves to the L hand are involved. The most common etiology of severe carpal tunnel syndrome is rapid repetitive motion over-use. I suspect this is related to his job at Lenox (sic)....

At this point in time, he has filed under his regular insurance, but he is going to require bilateral carpal tunnel releases and probably going to be out of work for 8-12 wks. I recommended that since this has been confirmed now as carpal tunnel syndrome, that he consider filing this under WC. Regardless of whether it is approved under WC or not, he certainly needs to have these fixed....

Dr. Clark diagnosed "Bilateral carpal tunnel syndrome, severe."

Dr. Clark performed a carpal tunnel release of the claimant's right wrist on March 30, 2001. Dr. Clark reported, "the transverse carpal ligament was released in its entirety under direct visualization with Stevens tenotomy scissors. After complete release, the contents of the canal were evaluated. The median nerve was somewhat

atretic and compressed at both ends, consistent with carpal tunnel syndrome."

Dr. Clark noted on April 30, 2001 that the claimant "has pretty good use of his R hand now....His sensation has returned in its entirety. He is sleeping at night....He has reached enough healing at this stage that we can go ahead and pursue his L side."

Dr. Clark performed a carpal tunnel release of the claimant's left wrist on June 15, 2001. Dr. Clark reported, "After complete release the contents of the carpal canal were evaluated. The median nerve had signs of carpal tunnel syndrome with compression proximally and distally, so called hourglass configuration. It was traced out to the recurrent branch which was intact."

The claimant reported "multiple complaints" to Dr. Clark on June 29, 2001, including "recurring paresthesia over a medial nerve distribution on the R." Dr. Clark's impression included "S/p carpal tunnel release R with recurring paresthesia." The claimant subsequently reported improvement on the right but continued numbness and tingling on the left. Electrodiagnostic studies were carried out on or about July 3, 2001, with the impression, "Clinical and electrodiagnostic evidence of improving carpal tunnel

syndrome after surgery." Additional diagnostic testing was carried out on or about July 30, 2001, with the impression, "No electrodiagnostic evidence of peripheral neuropathy, ulnar nerve entrapment or carpal tunnel syndrome in any of the upper extremities. Tenosynovitis, both wrists, with irritation of median nerve with sign/symptoms consistent with carpal tunnel syndrome. Tennis elbow, left upper extremity." Dr. Clark stated on August 20, 2001, "When you examine him, he has triggering of both thumbs. I think this is probably the source of his discomfort, as I have reviewed his NCVs which indicate significant improvement on the L. It has returned to normal latency of the median nerve at the wrist and I think clinically it looks quite good."

Dr. Clark's diagnosis on September 19, 2001 was "1) Carpal tunnel syndrome bilaterally, s/p releases, doing well with nerve conduction velocities indicating steady improvement. 2) Bilateral trigger thumbs." Dr. Clark testified that he returned the claimant to work on October 1, 2001. The respondents' attorney cross-examined the claimant:

Q. After the surgery that you've talked about Doctor Clark performing on your right wrist and your left wrist, you still had problems, did you not?

A. Not at first, I didn't.

Q. But eventually, you starting (sic) to go back to Doctor Clark telling him about pains and problems with your wrists, is that right?

A. After I went back to work, yes.

More electrodiagnostic testing was carried out after the claimant's return to work, with the interpretation on November 21, 2001, "Bilateral moderately severe carpal tunnel syndrome."

Dr. Clark reported on November 28, 2001:

Byron is a f/u for bilateral carpal tunnel syndrome, s/p releases. He now has confirmed bilateral moderately severe carpal tunnel syndrome bilaterally.

PLAN: At this point in time, we had started treating this about a yr ago. At that point in time, we documented bilateral carpal tunnel syndrome. He underwent procedures on both sides, with documented good responses. He underwent FCEs, which indicated that he could do moderate work, and he was returned to his previous job. Since he has been in his previous job, he has had a recurrence of his symptoms and recurrence of his problems. These have been confirmed again on NCVs....

I would suggest to Byron that we consider repeat nerve conduction releases, with neurolysis as indicated; that we cast each individually following the surgery for a period of 4-6 wks; and that he strongly consider not returning to the same job description that he has been in previously, as I think that this will probably create the same problems over again....

The claimant followed up with Dr. Clark on March 4, 2002:

He said is he awaiting a court date on the 21st for WC, to try to determine his current status. He is on his regular job right now. He has persistent pain and weakness in both hands and nighttime awakening, worse on the L than the R.

We have confirmed that he has recurrent carpal tunnel syndrome that is probably worsening. There is a question of multiple etiologies that needs to be considered, but considering the type of work that he does, I think this probably plays a major role in his recurrence....I have recommended an extended carpal tunnel release.

Dr. Clark diagnosed "carpal tunnel syndrome, bilateral, moderate."

Dr. Clark reported on April 22, 2002, "R side is doing quite well at this point in time. He has good sensation in his fingers. He is sleeping at night....I recommended carpal tunnel release on the L."

The parties deposed Dr. Clark on April 29, 2002. Dr. Clark testified that diagnostic studies he had reviewed showed "marked bilateral carpal tunnel syndrome as well as ulnar nerve involvement of the left wrist - at the left wrist." Dr. Clark agreed that he had diagnosed "severe" carpal tunnel syndrome. The claimant's attorney questioned Dr. Clark:

Q. What was your basis for stating that he had severe?

A. Based on the nerve conduction studies....The delay at the carpal canal was significant and I believe the latency at the - on the right side was over seven.

Q. What date are you looking at in your notes?

A. I'm just looking at the nerve conduction velocities that were conducted by Dr. Verma on February 21, 2001....I usually wait till they're moderate or moderately severe before I consider operating. Once they get to severe, you cannot predict the degree of recovery that they're going to get. So, it's not wise to wait until they get to be severe. But, when they're severe, you really don't have much choice about it, because then you're trying to prevent further damage as well as correct the problem....

Q. Mr. Owens had a recurrence.

A. Uh-huh. Both sides.

Q. When did you discover his recurrence?

A. He came back to see me back in November of 2001, and at that time he had the same signs and symptoms again. At that time we had sent him back to work, and he came back with numbness and tingling in both hands in the median nerve distribution. I repeated the nerve conduction studies again, and at this point in time they were not quite as bad as they were previously, but they were still not normal again. Whereas, they had been at one time....

Q. Based on moderate carpal tunnel, what is your recommendation for Mr. Owens' course of treatment.

A. Extended carpal tunnel release with a neurolysis....

Q. Based on your opinion and reviewing their records and your history of treating Mr. Owens, do you feel at that time he had carpal tunnel?

A. I think he did. I think he had sub-clinical disease and think that was reflected in the letters that they attached to their findings. Sub-clinical carpal tunnel means you have the problem, you have the symptoms, but his nerve conduction velocities do not reflect the degree of involvement.

The respondents' attorney cross-examined Dr. Clark:

Q. And were there anything in his diagnostic tests that would indicate from an objective standpoint the etiology of Mr. Owens' carpal tunnel syndrome that you revealed back in February 2001?

A. In think the most likely etiology is overuse.

Q. And that's based upon his history to you.

A. Based on history, based on the findings from nerve conductions, based on my physical exam....

Dr. Rutherford provided an EMG report for the respondents on June 20, 2002:

Mr. Owens is known to me having previously been seen in 2000. At that juncture he was felt to suffer from a vaso spastic disorder. Testing at that time did not support a diagnosis of carpal tunnel syndrome. Mr. Owens has since undergone right carpal tunnel release times one and left carpal tunnel release times two. He reports lack of benefit from the above procedures. He presents today for re-evaluation at the request of Ms. Demery (sic). This is limited to electrodiagnostic testing to ascertain whether or not there is objective evidence for carpal tunnel syndrome, ulnar neuropathy or other abnormality of the peripheral nervous system....

The nerve conduction study and needle examination are normal. There is no evidence of cervical radiculopathy, brachial plexopathy, ulnar neuropathy or median neuropathy either upper extremity. Regarding the diagnostic possibility of carpal tunnel syndrome, this has been addressed by both routine and internal comparative techniques which have proven uniformly normal. Based on present electrodiagnostic testing, I remain of the opinion that Mr. Owens' complaints are best ascribed to vaso spastic disorder.

Dr. Clark wrote after a follow-up visit with the claimant on July 10, 2002, "My best clinical guess at this point in time is that he would be available for light use R-handed work only, except for the fact that this would probably exacerbate his carpal tunnel on the R side again." Dr. Clark diagnosed "Bilateral carpal tunnel syndrome s/p recurrence on L, s/p second release, healing well." The last report of record from Dr. Clark appears to have taken place on September 18, 2002, when he wrote, "My recommendation with respect to work is that he be allowed to RTW, but that in a different capacity than he was previously, that did not require rapid, repetitive motion of his hands or heavy repetitive motion of his hands."

The parties deposed Dr. Rutherford on August 20, 2002. Dr. Rutherford agreed that he had seen the claimant on two occasions. Dr. Rutherford described vasospastic disorder as "abnormal reactivity of the blood vessels, the arteries, in

the hands, and it results in coldness, color change, and accompanying neurological symptoms, pain, numbness, tingling." He testified that the causes for this disorder "can either be idiopathic, which means it occurs without known association, or it can be a component of collagen vascular disease or autoimmune disease."

On examination by the claimant's attorney, Dr. Rutherford described carpal tunnel as "a problem with the median nerve at the wrist[.]" The claimant's attorney asked Dr. Rutherford:

Q. Do you feel in this case that surgery was necessary?

A. I don't think the diagnostic studies support surgery in Mr. Owens' case, and I don't think the surgeries have been of any clinical benefit.

Q. So, is it your opinion that the surgeries were a misdiagnosis?

A. Well, I don't think carpal tunnel syndrome is a substantiated diagnosis, and I've said that several times today....

A pre-hearing order was filed with the Commission on November 18, 2002. The parties agreed to litigate the following issues:

- (1) Whether the claimant sustained a compensable bilateral carpal tunnel injury;
- (2) Whether the claimant was entitled to temporary total disability compensation;

- (3) Whether the claimant was entitled to permanent partial disability;
- (4) Whether the claimant was entitled to medical benefits from June 14, 2000; and
- (5) Attorney's fee.

Hearing before the Commission was held on May 8, 2003. The claimant testified that he had returned to his regular job. The claimant's attorney requested to "reserve" the issues of temporary total disability, permanent disability, and medical benefits. The claimant essentially requested to adjudicate "the question of compensability only." The respondents agreed with the administrative law judge that their "primary defense" was "no objective findings."

The administrative law judge found, "The preponderance of the evidence reflects that the claimant did not sustain a specific time and place of occurrence bilateral carpal tunnel syndrome injury which arose out of and in the course of employment with the respondent employer. The claimant has not sustained her (sic) burden of proof by a preponderance of the evidence. A.C.A. 11-9-102 (Repl. 2000.)"

The claimant appeals to the Full Commission.

II. ADJUDICATION

The claimant on appeal cites Ark. Code Ann. §11-9-102(4)(A), which defines "compensable injury":

(ii) An injury causing internal or external physical harm to the body and arising out of and in the course of employment if it is not caused by a specific incident or is not identifiable by time and place of occurrence, if the injury is:
(a) Caused by rapid repetitive motion. Carpal tunnel syndrome is specifically categorized as a compensable injury falling within this definition[.]

A compensable injury must be established by medical evidence supported by objective findings. Ark. Code Ann. §11-9-102(4) (D). Ark. Code Ann. §11-9-102(4) (E) provides:

The burden of proof of a compensable injury shall be on the employee and shall be as follows:
(ii) For injuries falling within the definition of compensable injury under subdivision (4) (A) (ii) of this section, the burden of proof shall be a preponderance of the evidence, and the resultant condition is compensable only if the alleged compensable injury is the major cause of the disability or need for treatment.

The respondents on appeal do not contend that the claimant cited an inapplicable statutory provision. Instead, the respondents argue that the claimant did not prove he sustained a compensable injury. The respondents specifically argue that the claimant did not prove by a preponderance of the evidence that he suffers from carpal tunnel syndrome.

The Full Commission finds that the claimant proved he sustained a compensable injury. The claimant began working for the respondents in 1990. In 1999, his "hands started

hurting" as a result of running the machines for the respondents. The claimant testified that he was "steady going up to the nurse." The claimant sought company medical treatment after feeling a "pop" on his right wrist on or about December 21, 1999. The initial medical records corroborated the claimant's testimony, and a large cyst was noted on the claimant's right wrist. The respondents initially accepted compensability.

The claimant returned to work, and his left hand began hurting. The claimant's description of his work, which description was corroborated by the record, indicate that the claimant's symptoms arose out of his employment. A physician's impression, not Dr. Clark or Dr. Rutherford, was "cysts wrist, carpal tunnel syndrome, neuropathy." The record includes at least three substantially-similar diagnoses by an initial treating physician. The claimant testified that his hands became cold, which fact was corroborated by Dr. Moore in May 2000. Dr. Moore stated, "His clinical history and physical examination do suggest a possible carpal tunnel syndrome." The claimant began treating with Dr. Clark in February 2001. The Full Commission recognizes Dr. Rutherford's opinion that the claimant did not sustain carpal tunnel syndrome.

Nevertheless, we attach greater weight to the impression of Dr. Clark, the treating orthopaedic surgeon, who diagnosed "severe bilateral carpal tunnel syndrome and left ulnar nerve entrapment." Dr. Clark's impression was based in part on objective electrodiagnostic findings. Dr. Clark's reports also indicate that the claimant's symptoms arose out of his employment. Dr. Clark eventually performed two surgeries on the claimant's left wrist and one on the right. The Full Commission notes that Dr. Clark's surgical report in March 2001 revealed an "atretic" and compressed median nerve consistent with carpal tunnel syndrome. An abnormal "hourglass" configuration, consistent with carpal tunnel syndrome, was seen in the claimant's left wrist in June 2001. Even Dr. Rutherford recognized carpal tunnel syndrome as "a problem with the median nerve at the wrist." In addition to the repeated objective electrodiagnostic testing, the documented cysts on the claimant's wrists bilaterally, and bilateral cold hands, all objective findings, Dr. Clark's surgical reports constitute patent objective medical findings establishing a compensable injury.

The Full Commission notes that the claimant's symptoms improved following surgery but later recurred. The claimant

testified that his symptoms returned after he returned to his work. Nevertheless, an argument that the claimant purportedly did not "benefit" from surgery is not pertinent in adjudicating whether the claimant sustained a compensable injury pursuant to the provisions of Act 796 of 1993. Dr. Clark testified at deposition that the "most likely etiology" of the claimant's condition was "overuse" of his extremities. Dr. Clark recommended in September 2002 that the claimant seek work that did not require "rapid, repetitive motion of his hands or heavy repetitive motion of his hands." The preponderance of evidence in the record demonstrates that the claimant sustained bilateral carpal tunnel syndrome which arose out of and in the course of the claimant's employment with the respondents. The claimant established an injury with objective medical findings. The Full Commission also finds that the compensable injury was the major cause of the claimant's disability and need for treatment.

Based on our *de novo* review of the entire record, the Full Commission find that the claimant proved that he sustained a compensable injury pursuant to Act 796 of 1993. The Full Commission therefore reverses the opinion of the administrative law judge. We note that the claimant

expressly reserved the issues of temporary total disability, permanent partial disability, and reasonably necessary medical treatment. For prevailing on appeal to the Full Commission, the claimant's attorney is entitled to a fee of two-hundred fifty dollars (\$250). Ark. Code Ann. §11-9-715 (Repl. 1996).

IT IS SO ORDERED.

OLAN W. REEVES, Chairman

SHELBY W. TURNER, Commissioner

Commissioner McKinney dissents.

DISSENTING OPINION

I must respectfully dissent from the majority opinion reversing the opinion of the Administrative Law Judge and finding that the claimant has proven that he sustained a compensable injury, namely carpal tunnel syndrome.

The claimant asserts that he sustained a work-related, specific incident of carpal tunnel syndrome to both wrists on December 21, 1999. See, Claim for Compensation Form AR-C, filed on June 13, 2001.

Because the claimant asserts a specific incident carpal tunnel injury, the claimant must satisfy all of the

requirements set forth in A.C.A. §11-9-102, as amended by Act 796, in order to establish the compensability of his alleged injury. This means that the claimant must prove by a preponderance of the evidence that he sustained an accidental injury as a result of a specific incident identifiable by time and place of occurrence, which caused internal or external harm to the body, which arose out of and in the course of his employment, and which required medical services or resulted in disability or death. A.C.A. §11-9-102(4) (A) (i) and A.C.A. §11-9-102(4) (E) (i). The statute further requires that a claimant establish a compensable injury by medical evidence supported by objective findings as defined by A.C.A. §11-9-102(16). Finally, medical opinions addressing compensability must be stated within a reasonable degree of medical certainty. If the claimant fails to establish by a preponderance of the evidence any of the requirements for establishing the compensability of the injury, he fails to establish the compensability of the claim and compensation must be denied.

The claimant testified that he felt a sudden pop in his right wrist on December 21, 1999, and thereafter noticed swelling of that wrist. In his deposition, however, the claimant stated that his condition had gradually gotten

worse before he finally reported it as a work related injury. Furthermore, the claimant's wife testified that both of the claimant's wrists were swollen when he arrived home from work on the afternoon of the alleged incident. In contradiction to his wife's testimony, however, the claimant testified that he injured and received treatment only for his right wrist as a result of the incident of December 21, 1999. The claimant further testified, and medical records confirm, that it was not until January of 2000 that he first began experiencing problems with his left hand.

It is well established that questions concerning the credibility of witnesses and the weight to be given to their testimony are within the exclusive province of the Commission. White v. Gregg Agricultural Ent., 72 Ark. App 309, 37 S.W.3d 649 (2001). When there are contradictions in the evidence, it is within the Commission's province to reconcile conflicting evidence and to determine the true facts. Id. I find that the inconsistencies and contradictions presented by this claimant make him an unreliable witness.

Furthermore, the totality of the objective medical evidence presented in this claim fails to support a finding that the claimant sustained a work related specific incident

of carpal tunnel syndrome. In fact, the objective medical evidence presented herein fails to support a finding that the claimant suffers from carpal tunnel syndrome, period. For example, in a letter to the claimant's referring physician, Dr. Noble Daniel, dated May 22, 2000, hand specialist, Dr. Michael Moore, wrote as follows:

Dr. Daniel, it is my opinion Mr. Owens presents with a difficult problem. His clinical history and physical examinations do suggest a possible carpal tunnel syndrome. However, the NCV/EMG study was normal. In addition, Mr. Owens' clinical history and physical examination may be consistent with a Raynaud's phenomena, or vasospastic disease. (Emphasis added)

Dr. Reginald Rutherford, a neurologist, examined the claimant on more than one occasion throughout the course of his treatment, and he diagnosed the claimant with vasospastic disorder. Dr. Rutherford based this diagnosis primarily upon repeatedly normal results of nerve conduction studies, neurological examinations of the claimant, and the claimant's symptoms, including frequently cold hands. In support of his diagnosis, the results of two EMG nerve conduction studies showed no focal abnormality of the median nerve which, as Dr. Rutherford explained, is critical to a diagnosis of carpal tunnel syndrome. Certain variations

shown on the readings of the second EMG nerve conduction study performed in February of 2000, were, according to Dr. Rutherford, "fully and adequately explained" by the effect of temperature on the claimant's vasospastic disorder. Dr. Rutherford testified as follows:

In the sense that you are trying to make a diagnosis for carpal tunnel, you'd want to show that the median response was significantly slower than the ulnar response, and there are internal comparative techniques that you can employ to try to bring this out and there's an expected range of difference, normal and abnormal. So, when you're looking at differences in sensory latency, you want to show that the difference between median and ulnar for internal comparative techniques over short distances of comparison is in excess of .5 milliseconds, ..., which is what you're looking at when you're measuring the speed at which the impulse travels across the wrist, and that's not present. They [the claimant's] were identical. So, you can't make an argument that there's a problem with the median nerve at the wrist in the form of carpal tunnel. All you can do is say that both responses are slow and they're slowed equally; so, that implies that there's a generalized disturbance of the nerve function, and there are different reasons why that can occur.

In establishing a claim for carpal tunnel syndrome, the majority relies primarily upon the medical opinion of his surgeon, Dr. Charles A. Clark. During the

claimant's respective wrist surgeries, Dr. Clark observed what he described as "signs" of carpal tunnel syndrome in both wrists. However, during his deposition of April 29, 2002, Dr. Clark admitted that the symptoms associated with carpal tunnel syndrome, some such as seen in the claimant, will often mimic those of a vasospastic disorder. The primary difference, explained Dr. Clark, is that, unlike carpal tunnel syndrome, vasospastic disorders are not well localized in one area. Dr. Clark conceded that nerve conduction velocities are "probably" the best aid in determining whether someone has carpal tunnel or a vasospastic disorder, with electro-myographic studies "probably" being the second best method. Dr. Clark admitted that he is not an expert in nerve conduction velocities and that he would defer to a neurologist, such as Dr. Rutherford, in that regard.

Dr. Rutherford opined that had carpal tunnel been a valid diagnosis in the claimant's case, even if diagnostic studies presented a "false negative" (were consistently negative but the claimant really had the condition), then "surgery or Cortosone injections or both should have worked" to correct his condition. That neither surgery nor injections have resolved the claimant's ongoing problems

further supports the conclusion that the claimant's condition is vasospastic. Furthermore, Dr. Rutherford stated that vasospastic disorders can be caused by a number of different things, including disease processes, or they can be completely idiopathic in nature.

The Commission has the duty of weighing the medical evidence as it does any other evidence, and the resolution of any conflicting medical evidence is a question of fact for the Commission to resolve. CDI Contractors v. McHale, 41 Ark. App. 57, 848 S.W.2d 941 (1993). Despite Dr. Clark's surgical observations, and especially in light of his admission that he is not an expert in nerve conduction velocities and that he must defer to a neurologist in that regard, more weight must be assigned to Dr. Rutherford's and Dr. Moore's opinions in this matter. In addition, although the claimant has displayed certain symptoms associated with carpal tunnel syndrome, the testimony of both Dr. Clark and Dr. Rutherford concerning the characteristics of carpal tunnel and vasospastic disorder reveals that the claimant's condition is, more likely than not, vasospastic.

It is undisputed that the claimant suffers from a wrist condition for which he has received medical treatment.

However, upon considering the evidence in this case I find that it is highly unlikely that the claimant sustained a specific incident carpal tunnel injury to his right wrist on December 21, 1999, and it is absolutely unbelievable that the claimant sustained a specific incident injury to his left wrist on that date. The totality of the objective medical evidence presented in this claim preponderates in favor of the claimant suffering from a non-work related vasospastic disorder rather than carpal tunnel syndrome.

Therefore, for all the reasons set forth herein, I respectfully dissent from the majority opinion.

KAREN H. MCKINNEY, Commissioner