

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F504222

ROY G. TIPTON,
EMPLOYEE

CLAIMANT

COLSON MONETTE,
EMPLOYER

RESPONDENT

FEDERAL INSURANCE COMPANY,
INSURANCE CARRIER

RESPONDENT

OPINION FILED NOVEMBER 7, 2008

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

Claimant represented by the HONORABLE JIM R. BURTON,
Attorney at Law, Jonesboro, Arkansas.

Respondent represented by the HONORABLE DAVID C. JONES,
Attorney at Law, Little Rock, Arkansas.

Decision of Administrative Law Judge: Affirmed.

OPINION AND ORDER

The claimant appeals an administrative law judge's
opinion filed March 5, 2008. The administrative law judge
found, among other things, that the respondents were not
responsible for back surgery performed on the claimant.
After reviewing the entire record *de novo*, the Full
Commission affirms the administrative law judge's opinion.

I. HISTORY

The record indicates that Roy Gentry Tipton, age 46, became employed with respondents in October 1997. In October 1998, the claimant was diagnosed with musculoskeletal chest pain after he "coughed hard and something in R chest popped." Medical imaging showed no rib abnormalities. While examining the claimant's left knee, a physician noted in September 2001, "Also left upper quadrant abdominal pain for roughly a year's duration....He did have some injury accidents where he hurt his rib cage....He is having some musculoskeletal type chest pain."

The claimant reported falling off a ladder in June 2003. A medical provider noted in July 2003, "Pt states that he fell off a ladder. He states that his L knee felt like it was pushed in all the way up into his rib cage. He is having pain and swelling in his L knee....He states that his ribs feels like some one has a fist in his ribs. He feels pain up under his ribs." X-rays were "read as normal." The claimant was assessed as having a contusion to his left chest wall.

Dr. Terence P. Braden, III, D.O., stated in August 2003, "The left anterior chest wall will continue to improve with time."

Dr. Brian G. Dickson performed left knee surgery on the claimant in September 2003. Dr. Dickson noted in October 2003, "Mr. Tipton's knee is stable. His ribs are still hurting him. I'm going to get him to see his family doctor to make sure it's not anything else. As far as I'm concerned he can go back to work."

The parties stipulated that the claimant sustained a compensable back injury on February 21, 2005. The claimant testified that he was a process technician and that he programmed machines. The claimant testified that he slipped while climbing down a hopper: "When I did, my left leg went across the bar, my right hip hit the concrete, and my back hit the pipes against the machine that was attached to the machine. The bar went up under my arm, one bar did, and the bars going the other way come back and hit me on my back."

The claimant signed a Form AR-N, Employee's Notice Of Injury, on February 24, 2005. The claimant reported that he had injured his left ankle, knee, right hip, and back. The reported cause of injury was "slip on material on floor when

I came down from hopper." The claimant saw Dr. Michael Lack on February 25, 2005: "Pt states that he fell coming down off of a hopper." Dr. Lack assessed "Contusion, Left Chest Wall."

Dr. Braden saw the claimant on March 28, 2005 and noted, "Mr. Tipton reports that on or about the 22nd of February 2005, he was climbing down from a hopper and his left foot went out from under him and he fell against a bar. He said the bar hit him in his back area in the lower back and the upper back. Since that time he has had left-sided rib pain, interscapular pain, low back pain....I think a bone scan would be appropriate to look for any evidence of fractured ribs in the left side which seems to be his primary area of discomfort as well as the low back area."

The following conclusion resulted from a whole-body bone scan taken March 30, 2005:

1. Increased uptake is noted within the right mid cervical area. This presumably indicates underlying degenerative-type changes. Note that a similar area of increased uptake is noted on the prior comparative bone scan from October 2, 2001.
2. The activity within the skeletal system otherwise appears essentially symmetric. No sites of increased or decreased bone uptake identified to indicate underlying disease. Specifically, I see no areas of abnormal uptake along the lumbar spine area or within the left

ribs, which are apparently the sites of clinical concern per the technologist's notes.

Dr. Braden noted on April 5, 2005, "Mr. Tipton continues to complain of left rib discomfort. I reviewed with him his bone scan that does not reveal any evidence of rib fractures. No evidence of abnormal uptake. I am going to institute him in a therapy environment. I'll see him back in this office in 2-1/2 weeks. If he is not distinctly improved, he will have reached maximum medical improvement from the injury that he reports to have sustained. I will be releasing him back to his regular work duties."

A CT scan of the claimant's chest on April 25, 2005 was normal. A CT scan of the claimant's abdomen and pelvis on April 25, 2005 was normal.

Dr. James F. Murrey reported on April 26, 2005, "On February 22nd he had a fall at work and hurt primarily his upper chest. He has been off work to see if rest will help....He did have a CT of his chest and abdomen. He has had a negative bone scan. The etiology of his pain is undetermined....At this time he had a fall and has been hurting in his chest now for two months. No signs of any serious injury and not improved with rest." Dr. Murrey planned additional diagnostic studies and noted, "Should

these tests look fairly normal, I would probably not recommend further work up. If he does not seem to be responding with rest, then it would probably be okay to return to work. We will give him off one more week and see how he does. But if this does not seem to be resolving, he may be better off returning."

A Radiology Report, Left Rib Series, taken May 23, 2005 showed "Normal left ribs."

A lumbar spine series on May 23, 2005 showed the following: "Minor anterior spurring present anteriorly at L4 and L5 and L1 and L2. Vertebral body heights, alignment, and disc spaces are within normal limits. No paraspinous soft tissue abnormalities." The Opinion was "1. Minor anterior endplate spurring. 2. No fracture." A thoracic spine series taken May 23, 2005 showed "Minor anterior endplate spurring is present at several levels. Vertebral body heights and alignment and disc spaces are normally maintained. No paraspinous soft tissue abnormalities." The Opinion was "1. Minor anterior endplate spurring. No fracture."

The following opinion resulted from a thoracic spine MRI done May 25, 2005: "1. Thoracic spine intervertebral

osteochondrosis and spondylosis as described. 2. Thoracic spinal cord lesion - indeterminate. This lesion is concerning for primary spinal cord glioma. Metastasis also possible. This lesion is not well defined typically seen of syringomyelia. However, there was some motion degradation on this examination, which may be a factor. Therefore, recommend contrast examination to further evaluate this area."

Dr. Murrey noted on June 6, 2005, "Roy Tipton saw neurosurgery for an abnormal MRI of his thoracic spine. He has what appears to be a syringomyelia. It has been recommended repeating this in 4-6 months to assess any progression. No further treatment being necessary. It is at least unlikely that this is related to his back pain and he had recommended pain management as well....At this time have given him a neurosurgical appointment in Memphis for a second opinion."

Dr. Badia Adada, UAMS Medical Center, reported on July 6, 2005, "The patient was seen today at the neurosurgery outpatient clinic for consultation. He is a 43-year-old patient who suffered a fall at work a few weeks ago. Since, he has been having back pain and pain around the chest

area....An MRI scan of thoracic spine demonstrates an anomaly in the T3 to 6 area, possibly a syrinx versus a spinal cord lesion....It is hard to tell if this is related to his work injury. We would like, however, to obtain an magnetic resonance imaging scan of the spine with and without contrast to rule out any tumor causing his anomaly."

The following impression resulted from an MRI of the thoracic and lumbar spine taken July 19, 2005:

1. Abnormal central cord edema in the thoracic level from T1 through T5 level, more prominent from T3 through T5 level with significant cord extension at T4 and T5 level. There appears to be small syrinx at T2 and T3 level within the thoracic cord. No enhancement is seen. d?d would include traumatic, viral or demyelination process. MRI brain may be helpful for further workup if indicated clinically.
 2. Mild superior endplate compression deformity of T6 and T7 vertebral bodies.
- Findings were discussed with Dr. Adada.

The claimant consulted with Dr. Reginald J. Rutherford on August 4, 2005:

Mr. Tipton fell injuring (sic) his mid to upper back at work. He came under the care of the neurosurgical department at UAMS. MRI imaging of the thoracic spine revealed extensive edema of the thoracic spinal cord. He was to be seen by neurology at UAMS but subsequently learned that the neurology department at UAMS would not accept worker's compensation patients prompting evaluation here. Mr. Tipton's principal complaint at this juncture is pain....

Mr. Tipton's neurological examination is unremarkable. This is surprising considering the report of abnormality on thoracic MRI. The radiologist indicated diffuse edema T1 through T5 with a small syrinx T2/T3 level. This may be related to trauma but alternative diagnoses are possible. He requires current MRI imaging of the thoracic spinal cord with contrast enhancement to follow his previously documented lesions specifically to ascertain whether or not there has been improvement or progression. In conjunction with this he requires contrast enhanced MRI imaging of the brain and cervical spinal cord....

Dr. Rutherford noted on August 29, 2005, "His MRI studies have been reviewed with radiology. There is no interval change between the first and third referable to abnormal signal in the thoracic spinal cord. There is no contrast enhancement in the most recent study. There is no evidence from review of all studies to suggest underlying malignancy."

A Functional Capacity Evaluation was done on September 13, 2005: "Mr. Roy Tipton is referred to Functional Testing Centers, Inc. for a comprehensive functional capacity evaluation aimed at determining his current functional abilities as it relates to a complaint of on-going back pain that originated as a result of a work related accident....Mr. Roy Tipton underwent functional evaluation this date with unreliable results and inappropriate pain

behaviors. Overall, Mr. Tipton is able to perform wok (sic) at least at the Sedentary work category over the course of an 8 hour workday."

Dr. Rutherford noted on September 16, 2005, "In view of the fact that he has a normal neurological examination in spite of the changes noted on his MRI of the thoracic spine and his complaints are entirely subjective in nature which are now of dubious credibility based upon his FCE, he will be released to return to regular work duties. The only further medical attention required from my perspective is a repeat MRI study of the thoracic spine with contrast enhancement in three months time to compare with the present study to insure that the changes noted on MRI imaging do not represent an underlying spinal cord tumor. Mr. Tipton was given an unrestricted release to work. He will be seen in follow up upon completion of the thoracic MRI."

Dr. Rutherford signed a slip returning the claimant to work at full duty on September 16, 2005.

The parties stipulated that the respondents paid temporary total disability through September 20, 2005, and that the respondents controverted medical treatment and indemnity benefits after September 20, 2005.

Dr. Murrey referred the claimant to Dr. Rodney T. Routsong, D.O., who began treating the claimant on October 12, 2005.

Dr. Murrey noted on November 14, 2005, "The etiology of his pain was determined to be rib head somatic dysfunction. He did have a repeat MRI in July that did not show any swelling of his spinal cord. His pain is still present. He does have a difficult time even doing his light duty walking and bending and stooping....We have talked with Dr. Routsong per phone, who recommended a repeat MRI to make sure there is not any change in his spinal cord, suggestive of tumor, etc. and asked to see him back as far as his work restrictions are concerned."

An MRI of the claimant's cervical spine and thoracic spine was taken on November 22, 2005, with the following impression:

1. No evidence of an intramedullary tumor or other significant intramedullary lesion to explain the syringomyelia.
2. The syrinx extends from the C7-T1 level down to the T6-T7 intervertebral disc level.
3. Minimal posterior disc bulging at T6-T7 without significant spinal canal stenosis.

Dr. Routsong informed Dr. Murrey on December 9, 2005, "This patient's neurological examination remains unchanged.

We have reviewed his recent MR studies. The cervical MR scan is normal. The thoracic MR scan with and without contrast, again demonstrates the syrinx extending from approximately C7 down to T7. This is a non-enhancing lesion and the radiologist reports that this does not have the appearance of neoplasm."

Dr. John D. Brophy examined the claimant on July 3, 2006:

Mr. Tipton reports he was doing well with no history of back or leg symptoms until 21 February, 2005 when he slipped and fell on the last stair at work falling against a railing and an adjacent machine. He was able to walk away from the fall and in fact continued to work. At that time he reported the onset of thoracic and lower back pain....An internal medicine evaluation included a thoracic MRI demonstrating an abnormality in the thoracic spinal cord. He was evaluated by a neurosurgeon in Jonesboro, Arkansas, Dr. Abraham, and was diagnosed with a thoracic syrinx at that time....In December, 2005 he underwent another neurosurgical opinion with Dr. Routsong who repeated the thoracic MRI demonstrating the syrinx and suggested that he remain on an off work status....Currently, his chief complaint is interscapular pain. His second complaint is lower back pain and his third complaint is related to left anterior inferior rib pain which also began at the time of his injury in February, 2005....

IMPRESSION:

1. The thoracic MRI studies were reviewed with neuroradiology and are considered most consistent with a thoracic syrinx. In my opinion this finding is unrelated to the work injury described by Mr. Tipton 21 February, 2005.

2. Mr. Tipton has complained of anterior rib pain intermittently since 1998. Evaluation for this rib pain has included multiple bone scans and chest CT with no definitive etiology determined, it is possible that his rib pain could be related to his thoracic syrinx.

3. Chronic back pain which could be related to his syrinx or potentially myofascial in etiology....

With regard to his syrinx, I agree with previous other neurosurgical opinions that there is no definite evidence of tumor. However, given its atypical features follow-up studies are recommended through his personal insurance. With regard to his work injury 21 February, 2005 I would consider him at maximum medical improvement with a PPI rating of 0%. It is possible that his symptoms could improve with a serious weight loss and gradual home walking endurance exercise program. I agree with other neurosurgical opinions that he would not be considered an operative candidate unless he developed a progressive neurologic deficit or there was MRI evidence of possible tumor. We also discussed the fact that it is possible that chronic heavy lifting and Valsalva could increase the size of the syrinx over time resulting in a progressive neurologic deficit. This issue is considered somewhat controversial. Given his ongoing complaints with minimal strenuous activity, clearly alternative employment should be considered. From the standpoint of his work injury there is no objective reason why he could not return to his preinjury activity level.

An MRI of the claimant's brain, cervical spine, and thoracic spine was taken on July 20, 2006, with the following impression:

1. Unremarkable MRI of the brain.

2. Slight superior extension of the thoracic syringomyelia now extending to approximately C7 level in the right hemicord. Slight enlargement of the syrinx involving the left thoracic hemicord.

The claimant followed up with Dr. Adada on September 13, 2006:

He is known for a severe pain problem that started after a work-related injury. At that time, he was found to have severe swelling of his thoracic spinal cord. Since that time, his pain has been gradually deteriorating. He has had several medical treatments that did not help. Lately, he has been complaining also of pain radiating down both arms....

[S]can of the cervical and thoracic spine performed in July 2006 was reviewed and shows a spinal cord cavitation compatible with a syrinx. It also shows a mild irregularity of a disc at the C5-C6 level just where the syrinx started....

We discussed with the patient that most probably his syrinx is post-traumatic in origin. We discussed with him the treatment options at the time being that are surgical and they include a laminectomy to explore the area of the start of the syrinx and to release any arachnoid adhesions that might be seen....We will start by exploring the T5-T6 area as discussed with him and we will release any arachnoid adhesions seen....

Dr. Routsong stated on September 19, 2006, "I initially evaluated Mr. Roy Tipton in regard to injuries and neurological problems in October/November of 2005. This patient sustained significant injuries from his fall on February 21, 2005 while he was at work. I have already

listed his injuries and previous significant neurological problems in my previous reports. His problems did not start until the date of that injury and his clinical problems are directly related to that work injury."

Dr. Adada performed the following surgical procedure on October 12, 2006: "T5, T6 and T7 laminectomy. Microsurgical resection of arachnoiditis and scar tissue for syringomyelia." The pre- and post-operative diagnosis was "Thoracic syringomyelia."

Dr. Adada noted on November 1, 2006, "He is known for posttraumatic syrinx that occurred after an injury he suffered at work. Since his surgery, he still is complaining of the same pain he was having. He also is having some soreness at the area of the surgical site. Otherwise, he has been stable....We would like to obtain an MRI scan of the thoracic area to evaluate the surgical site and see if his syrinx has changed. Will formulate further treatment once his MRI is obtained."

An MRI of the claimant's thoracic spine was taken on September 5, 2007, with the impression, "Status post laminectomy from T4 to T6 following decompression of a known syrinx. No evidence for any residual hydromyelia on this

present study specifically with no evidence for any abnormal areas of enhancement on contrast study."

A pre-hearing order was filed on September 27, 2007. The claimant contended, among other things, that he was entitled to additional medical treatment after September 20, 2005, which treatment included surgery by Dr. Adada. The claimant contended that he was entitled to temporary total disability beginning September 21, 2005 and continuing until on or about September 6, 2007, at which time he was released by Dr. Adada.

The respondents contended, among other things, that they had paid all appropriate benefits in regard to the claimant's compensable injury of February 21, 2005, and that the claimant's continued problems were not related to the compensable injury. The respondents contended that the claimant was not entitled to temporary total disability following his release to return to work as of September 16, 2005.

The parties agreed to litigate the following issues:
(1) The date claimant's healing period ended; (2) Claimant's entitlement to additional temporary total disability; and

(3) Respondent No. 1's responsibility for additional medical treatment.

A hearing was held on January 25, 2008. The claimant testified regarding the surgery he underwent, "The syrxinx is no longer there....But the spinal cord is damaged from the syrxinx, and there is a lot of scar tissue....The pain goes from the very same spot every time. In movement, when I get up in the morning, the pain is down, but the more movement I do, the worse it hurts. Then it starts burning, and if I try to do much with my arms or any kind of bending or anything like that, the pain radiates on around the entire rib cage and up into my chest. And if I push myself too hard, it gets very severe."

An administrative law judge found, among other things, that the respondents were not responsible for the claimant's medical treatment after July 3, 2006, and that the respondents were not responsible for surgery performed by Dr. Adada. The claimant appeals to the Full Commission.

II. ADJUDICATION

The employer shall promptly provide for an injured employee such medical treatment as may be reasonably necessary in connection with the injury sustained by the

employee. Ark. Code Ann. §11-9-508(a) (Repl. 2002). The claimant must prove by a preponderance of the evidence that he is entitled to additional medical treatment. *Wal-Mart Stores, Inc. v. Brown*, 82 Ark. App. 600, 120 S.W.3d 153 (2003). What constitutes reasonably necessary medical treatment is a question of fact for the Commission. *Dalton v. Allen Eng'g Co.*, 66 Ark. App. 201, 989 S.W.2d 543 (1999).

In the present matter, the Full Commission finds that the claimant did not prove medical treatment provided after July 3, 2006 was reasonably necessary in connection with the compensable injury. The claimant did not prove surgery performed by Dr. Adada was reasonably necessary.

The parties stipulated that the claimant sustained a compensable back injury on February 21, 2005. The claimant wrote on a Form AR-N that he injured his left ankle, knee, right hip, and back. The claimant was diagnosed with a contusion to his left chest wall on February 25, 2005. A bone scan on March 30, 2005 showed presumed degeneration in the claimant's cervical spine but no structural abnormalities to the claimant's thoracic or lumbar spine. It was specifically noted following the bone scan, "I see no areas of abnormal uptake along the lumbar spine area or

within the left ribs, which are apparently the sites of clinical concern per the technologist's notes." Dr. Murrey reported on April 26, 2005 that the etiology of the claimant's pain was undetermined and that there were no signs of a serious injury.

On May 25, 2005, a thoracic spine MRI showed an indeterminate spinal cord lesion. Dr. Murrey reviewed the MRI and noted that the claimant "has what appears to be a syringomyelia....It is at least unlikely that this is related to his back pain" Dorland's Illustrated Medical Dictionary, 28th Edition, defines "syringomyelia" as "a slowly progressive syndrome in which cavitation occurs in the central segments of the spinal cord, generally involving the cervical region, but the lesions may extend up into the medulla oblongata (*syringobulbia*) or down into the thoracic region; it may be of developmental origin, arise secondary to tumor, trauma, infarction, or hemorrhage, or be without known cause." The record does not demonstrate that the finding of syringomyelia was causally related to the February 21, 2005 accidental injury. Dr. Adada first examined the claimant on July 6, 2005 and noted a possible

syrinx in the thoracic spine but stated, "It is hard to tell if this is related to his work injury."

An MRI of the claimant's thoracic and lumbar spine was taken on July 19, 2005 at which time it was noted, "There appears to be a small syrinx at T2 and T3 level within the thoracic cord." The preponderance of evidence does not show that the syrinx described on July 19, 2005 was causally related to the February 21, 2005 accidental injury. Dr. Rutherford noted the thoracic abnormality and stated, "This may be related to trauma but alternative diagnoses are possible." An expert opinion based on "may" lacks the definiteness required to prove a causal connection. *Frances v. Gaylord Container Corp.*, 341 Ark. 527, 20 S.W.3d 280 (2000). We note Dr. Rutherford's subsequent opinion on September 16, 2005 that, despite the changes noted on MRI, the claimant's neurological examination was normal. Dr. Rutherford stated, "The only further medical attention required from my perspective is a repeat MRI study of the thoracic spine with contrast enhancement in three months time to compare with the present study to insure that the changes noted on MRI imaging do not represent an underlying spinal cord tumor."

Dr. Murrey stated on November 14, 2005, "The etiology of his pain was determined to be rib head somatic dysfunction." The record does not show that this condition was causally related to the February 21, 2005 accidental injury. According to an MRI study on November 22, 2005, it was noted that "2. They syrinx extends from the C7-T1 level down to the T6-T7 intervertebral disc level." The preponderance of evidence before the Commission does not demonstrate that this syrinx was caused by the February 21, 2005 accidental injury. Dr. Brophy examined the claimant on July 3, 2006 and stated among other things, "1. The thoracic MRI studies were reviewed with neuroradiology and are considered most consistent with a thoracic syrinx. In my opinion this finding is unrelated to the work injury described by Mr. Tipton 21 February 2005."

The Full Commission recognizes Dr. Routsong's opinion that the claimant's clinical problems were "directly related to that work injury." Dr. Adada opined, "most probably his syrinx is post-traumatic in origin." The Commission has the duty of weighing medical evidence and, if the evidence is conflicting, its resolution is a question of fact. *Green Bay Packaging v. Bartlett*, 67 Ark. App. 332, 949 S.W.2d 695

(1999). In the present matter, the Full Commission finds that the opinions of Dr. Murrey, Dr. Rutherford, and Dr. Brophy are entitled to more probative weight than the opinions of Dr. Routsong and Dr. Adada. Dr. Murrey, and Rutherford, and Dr. Brophy did not causally attribute the claimant's syringomyelia or syrinx to the February 21, 2005 accident. We find that the opinions of Dr. Murrey, Dr. Rutherford, and Dr. Brophy are supported by the record before the Commission. The Commission also notes, based on Dr. Adada's post-surgery findings and the claimant's testimony, that the claimant did not report any genuine post-surgical improvement. Post-surgical improvement is a relevant consideration in determining whether or not an operation was reasonably necessary. *Winslow v. D&B Mech. Contractors*, 69 Ark. App. 285, 13 S.W.3d 180 (2000).

The instant claimant did not prove that the diagnosis of syringomyelia or the finding of a thoracic syrinx was causally related to the February 21, 2005 accidental injury. Nor did the claimant prove by a preponderance of the evidence that the surgery performed by Dr. Adada was reasonably necessary in connection with the compensable injury. The Full Commission affirms the administrative law

judge's decision denying these benefits. The Full Commission affirms the administrative law judge's finding that the respondents were not responsible for any medical treatment, including surgery, provided after July 3, 2006.

IT IS SO ORDERED.

OLAN W. REEVES, Chairman

KAREN H. MCKINNEY, Commissioner

Commissioner Hood concurs, in part, and dissents, in part.

CONCURRING AND DISSENTING OPINION

I must respectfully concur, in part, and dissent, in part, from the majority opinion. After a de novo review of the record, I find that in addition to the medical treatment awarded by the majority, the claimant has also proved entitlement to benefits after October 23, 2005, as the preponderance of the evidence of record indicates that the claimant's need for surgery, including treatment for syringiomelia, was related to his on-the-job injury, and therefore, I must

respectfully dissent from the majority's limited award of benefits.

On September 19, 2006, Dr. Routsong, a neurosurgeon, stated:

I initially evaluated Mr. Roy Tipton in regard to injuries and neurosurgical problems in October/November 2005. This patient sustained significant injuries from his fall on February 21, 2005 while he was at work. I have already listed his injuries and previous significant neurological problems in my previous reports. His problems did not start until the date of that injury and his clinical problems are directly related to that work injury.

On October 23, 2006, the claimant underwent a laminectomy and microsurgical resection of arachnoiditis and scar tissue. In a postsurgery note, Dr. Adada, the claimant's treating physician attributed the syringomyelia to "posttraumatic syrinx" which occurred after the claimant's compensable work injury.

The only doctor to opine that the syrinx injury was unrelated to the claimant's work injury was the IME doctor, Dr. Brophy. On July 3, 2006, Dr. Brophy stated:

IMPRESSION:

1. The thoracic MRI studies were reviewed with neuroradiology and are considered most consistent with a thoracic syrinx. In my opinion this finding is unrelated to the work injury described by Mr. Tipton 21 February, 2005.
2. Mr. Tipton has complained of anterior rib pain intermittently since 1998. Evaluation for this rib pain has included multiple bone scans and chest CT with no definitive etiology determined, it is possible that his rib pain could be related to his thoracic syrinx.

The majority states that it has based its determination on Dr. Brophy's opinion that the claimant's syrinx is somehow related to his rib pain. However, as noted by the respondent, Dr. Brophy, and the Administrative Law Judge, the claimant had extensive testing regarding rib and back pain before his February 21, 2005 work injury. None of the tests performed prior to the claimant's on-the-job injury indicated a syrinx or syringomelia. For the majority to conclude that the syrinx was pre-existing, based on the evidence of record

requires impermissible speculation and conjecture, particularly in light of the fact that tests before the on-the-job injury are void of mention of syringiomeia, while those after the on-the-job injury, including those performed by Dr. Rutherford, indicate that the condition is now present. Furthermore, as noted above, Dr. Adaba, the claimant's treating physician and Dr. Routsong, both relate the claimant's need for surgery to the claimant's compensable on-the-job injury, while Dr. Brophy only states that the pre-existing rib pain could "possibly" be related to a pre-existing syrinx. The majority's conclusion that the claimant's syrinx is related to a pre-existing condition is not supported by the evidence of record, and should be reversed.

For the aforementioned reasons I must respectfully concur, in part, and dissent in part.

PHILIP A. HOOD, Commissioner