

November 2016

# IN HAND



The Newsletter of the RSI and Overuse Injury Association of the ACT  
Supported by ACT Health and the Southern Cross Club

Spring 2016

## News & Events

### RSI & Overuse Injury Association of the ACT AGM

#### Your Comcare Claim: What's happening? *A talk and Q&A with lawyer, David Lander*

When: 12:30pm, Monday 21st November  
Where: The Griffin Centre Room 6, 20 Genge St  
Cost: Free, all welcome—see page 13 for more details

### What To Do When Your Health Care Goes Wrong

*Hosted by the Chronic Conditions Seminar Series*

Speaker: Dr Grant Wilson  
When: 7pm, Thursday 17<sup>th</sup> November  
Where: SHOUT, Collett Place Pearce  
Cost: Free, all welcome

### Helping people with RSI:

- Telephone information service
- Referrals
- Guest speakers
- Events and social gatherings
- Treatment options
- Ergonomic devices
- Voice-operated computing
- Workers' compensation
- Tips and tools for daily life



ANTI-INFLAMMATORY FOODS ... PAGE 6

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# UPCOMING EVENT

## GUIDED SPECIAL ACCESS TOUR OF THE NGA 'VERSAILLES' EXHIBITION

**When:** 3pm, Wednesday, 14th of December

**Where:** The National Gallery of Australia entrance.

This is a wonderful opportunity to have a free guided tour of this exhibition with other members of the Association. Numbers are very limited so please phone or email us to book.



## LETTER TO THE EDITOR

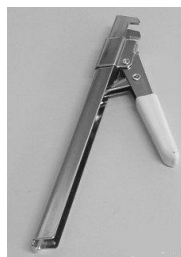
Dear Editor,

I thought I would let members know about some devices I find really useful for opening jars at home.

The Culinare ring pull and bottle opener is really good for bottle caps as well as ring pull cans.



*Culinare*



*Adjustable Jar Opener*

And the adjustable jar opener is really useful for all kinds of jar lids from tiny water bottle lids to big jar lids.

I got the culinare one from Woolworths and the other one from Howard's Storage World, but have seen them in 2 dollar shops as well as the online store <http://www.daily.com.au/adjust-a-jar-bottle-opener-jar1033445.html>.

*The contents of this newsletter do not necessarily represent the opinions of the Association. Whilst all care has been taken in the preparation of the newsletter, we do not accept responsibility for its accuracy and advise you to seek medical, legal or other advice before acting on any of the information within.*

# BITS & PIECES

## The Bamboo spark

The Bamboo spark is a new gadget that brings together the age-old pen and paper and digital note-taking. It combines a graphics tablet with the traditional ink and paper, doing both at once rather than making you choose. When you use it, the pen draws on the paper with ink while simultaneously a digital copy of your work is sent to your smart device and synced with the cloud so you can access it from anywhere.



*The Bamboo Spark*

It isn't perfect, with many reviewers having problems with the pressure-sensor failing to pick up lighter touches, so it isn't ideal for intricate designs or sketches. But if you want to use it to take notes, do rough drawings or just avoid typing on a keyboard, then the Bamboo can give you the feeling of using a pen and paper without sacrificing the convenience of the digital age.

## Does paracetamol work?

According to a recent Cochrane review, paracetamol may not be as effective as we've always thought. Paracetamol is a go-to drug for many chronic conditions; \$151 million was spent on paracetamol for chronic conditions last year in England alone. However, Andrew Moore, the Director of Pain Research at the University of Oxford, says paracetamol simply doesn't work. "So how does paracetamol stack up against what

people with acute back pain want? A Cochrane review is unequivocal – it doesn't work. Not immediately, not later. Nor does the review find any evidence that it works in *chronic* back pain either."

The Cochrane review found that not only is paracetamol no more effective than a placebo at reducing pain, but it could be harmful. "A systematic review of observational studies shows paracetamol is associated

with increased mortality, cardiovascular adverse events, gastrointestinal adverse events, and renal impairment."

"If it were just a few tablets, then maybe we could ignore it, but it isn't. Paracetamol consumption is measured not in kilograms, not even tons, but thousands of tons a year." While Moore urges the medical profession to seriously reconsider the use of paracetamol when treating chronic conditions, others say stronger evidence is needed before taking action.

## Stem Cells

A recent study has found that Australia has the fifth largest number of stem cell clinics per head of population selling questionable treatments directly to consumers. A loophole in regulations has allowed 19 stem cell clinics around Australia to reinject cells from a patient's own fat into a patient's body to treat a myriad of conditions. While there is evidence that stem cells can help treat blood cell disorders and some other types of cancers, the clinics exploit the lack of knowledge

about stem cells to sell them as a treatment for conditions, despite significant evidence that they have no benefit.

## Community Assistance and Support Program

If you live in the ACT and need practical medical help because of your disability, for example gardening or home help, you may be eligible for the Community Assistance and Support Program (CASP). CASP is funded through the ACT Government and services are provided by different organisations. To find out if you are eligible, phone Belconnen Community Service on 6278 8102 or Duo on 6287 2870.

## The cost of musculoskeletal disorders

How much do musculoskeletal disorders (MSD) cost employers? Up to 70% of workers report having a MSD and this leads to significantly diminished productivity. A recent study in Australia worked out exactly how much MSDs are costing businesses in productivity losses. To establish the cost, office workers were asked to rate pain in various body regions. Researchers concluded that "annually productivity loss due to MSDs was valued at \$3,612 AUD per worker, or approximately 4.15% of individual yearly salary." It also found that for each additional region in which the worker had symptoms of MSD, an average of \$638 was lost annually.

*Pereira M., Johnston V., Straker L., Sjøgaard G., Melloh M., O'Leary S., Comans T.*

*The monetary value of productivity losses due to musculoskeletal disorders in office workers.*

# RESEARCH IN BRIEF

## DOGS WITH RSI

Supraspinatus tendinopathy is a common problem for agility dogs. These dogs run obstacle courses in competitions and can be any breed from poodles and jack russells to golden retrievers and border collies. Experts think the repetitive strain of constantly turning could be the cause of the injury.

A recent study investigated using “adipose-derived progenitor” cells and platelet-rich plasma therapy to help injured agility dogs. Adipose-derived progenitor cells are similar to stem cells and are taken from fatty tissue. They found that some dogs improved significantly and ultrasound showed a major reduction in tendon size for all treated dogs. While the study doesn’t mention the possibility of using similar treatments for humans, these results are certainly encouraging.

*Canapp S., Canapp D., Ibramhim V., Carr B., Cox C., Barrett J. (2016). The use of adipose derived progenitor cells and platelet rich plasma combination for treatment of supraspinatus tendinopathy in 55 dogs: A retrospective study*

## SICKNESS BEHAVIOURS

If you think your overuse injury has been making you feel anxious, depressed, and foggy, you may be right. A recent study investigated the connection between sickness behaviours in rats with overuse injuries and their level of inflammation. Sickness behaviours are symptoms and effects of illnesses that go beyond physical symptoms and responses. Such illness responses include lethargy, depression, anxiety, loss of appetite, sleepiness, and failure to concentrate.

The rats with higher levels of inflammation showed increased sickness behaviours over the whole 12 weeks of the study, including being less socially active and more aggressive. Rats are very sociable animals!

Half of the rats were either given ibuprofen, a nonsteroidal anti-inflammatory drug, or anti-TNF-alpha treatment which inhibits TNF, a pro-inflammatory. In the treated rats, both treatments reduced sickness behaviour, with the anti-TNF-alpha treatment being more- effective. The study concludes that sickness behaviours occurring from work-related overuse – “behaviours that may equate with increased sickness absence in humans” – are a result of increased levels of pro-inflammatories.

*Barbe M., Xin D., Hadrevi J., Barr-Gillespie A. (2016) The Association between sickness behaviours in a rat model of overuse and systemic inflammatory cytokines and anti-inflammatory drugs*

## TENDON-TO-BONE HEALING

One of the major challenges of rotator cuff repair surgery is the tendon-to-bone healing that needs to occur. Tendon repair is an incredibly complicated process and surgery can only create circumstances which give the tendon the best possible chance to repair. An important stage of the healing is reattaching the tendon to the bone.

Currently, the failure rate can be as high as 94%, so increasing the success rate has been a high priority for researchers. One promising candidate is increasing vitamin D levels in patients. A recent article reviewed recent research on vitamin D and tendon-to-bone healing. It found that “Vitamin D plays a significant role in the tendon-to-bone healing process by increasing the bone mineral density and strengthening the skeletal muscles ... [and] stimulating growth and proliferation.” The researchers conclude that vitamin D may play a promising role in improving the success rate of surgery, but as usual, more research is needed.

*Doughert K., Dilisio M., Agrawal D. (2016). Vitamin D and the immunomodulation of rotator cuff injury*

# Is RSI INFLAMMATORY?

This has been a big question in research into overuse injuries for many years. Up until the 1990s, the accepted view was that these injuries were primarily inflammatory, and this was shown in all the *'itis'* names that were used like tenosynovitis, tendinitis and epicondylitis for example.

Then, in the early 1990s, a group of researchers challenged this view, saying that these conditions were mainly degenerative, renaming them 'tendinopathy' or 'tendinosis'.

Now the question has been reopened, with a paper by Dr Benjamin Dean and his colleagues at the University of Oxford's Institute of Musculoskeletal Sciences, entitled 'Are inflammatory cells increased in painful tendinopathy? A systematic review.' He concludes "The existing evidence supports the hypothesis that increased numbers of inflammatory cells are present in pathological tendons. The lack of high-quality qualitative studies in the area demonstrates a clear need for future research to better understand the role of inflammation in tendinopathy."

Dr Jonathon Rees is a Consultant in Rheumatology and Sports Medicine who was physician to the Great Britain 2008 Paralympic Team in Beijing and to the 2012 London Olympics. He recently published a paper entitled "The role of inflammatory cells in tendinopathy: is the picture getting any clearer?" He writes that the role of inflammation in chronic tendinopathy is 'controversial and highly debated.....to think of chronic tendinopathy as purely a degenerative condition is an oversimplification.'

He sets out four reasons why the role of inflammation in tendinopathy is a hot topic:

1. Chronic tendinopathy is extremely common, It is often career-threatening to the athlete and causes enormous morbidity in the general population.
2. We have few effective treatments. The fact that there are so many treatments advocated, with each treatment having its own proponents and detractors confirms one thing – it confirms none of our treatments are good enough. If there was one very effective treatment for tendinopathy then this would be used ubiquitously and this is definitely not the case.
3. Our understanding of chronic tendinopathy is inadequate and this lends itself to debate. While our models of chronic tendinopathy are helpful, they are all incomplete and all have unanswered questions.
4. There is no universal agreement on a definition for inflammation."

Dr Jill Cook, one of the main proponents of the 'mainly degenerative' school of thought, interviewed Dr Rees recently in a podcast for the British Journal of Sports Medicine. Dr Rees emphasized that "the wheel has definitely not turned full circle" and he is not advocating a purely inflammatory model.

He thinks that inflammation is definitely part of the picture, but, in his own practice, rarely uses traditional anti-inflammatory treatments such as cortico-steroid injections or non-steroidal anti-inflammatories (NSAIDS) medicines. Dr Cook, by the way, advocates the use of an NSAID, ibuprofen – not other NSAIDS – early on in the treatment of tendon overuse injuries.

Dr Cook agrees that inflammation is part of the tendinopathy picture but says "inflammation is not creating the pain or driving the problems".

So could an anti-inflammatory diet help RSI? The answer is that scientists disagree and we don't know. However, because it's a diet that has many positive health effects, it's very unlikely to do you any harm.

*Ann Thomson*

# ANTI-INFLAMMATORY FOODS

There is growing evidence that diet is an important factor in fighting inflammation. An article from the Journal of Biomedical Science concludes “further study” is warranted “to determine whether appropriate food selection may help patients suffering from chronic inflammatory conditions.”

Exactly how diet affects inflammation is unclear, but according to an article from the European Society of Cardiology, the benefits of an anti-inflammatory diet are proven: “both epidemiological studies and intervention trials support an important role of diet in reducing the risk of a variety of chronic diseases, including cardiovascular disease, and overall mortality.” We’ve compiled a list of some of the most effective foods that you can add to your diet to help fight inflammation.

## Tomato:

Tomato is a great addition to your diet. According to a study from the University of Maastricht in the Netherlands, it has three compounds - lycopene, ascorbic acid and  $\alpha$ -tocopherol - which all act together to inhibit inflammation. The researchers say they complement each other because they “diminish the process of inflammation differently on different levels.” Lycopene has also been shown to have various other health benefits, including preventing cardiovascular diseases and helping reduce the risk of cancer.

## Green Leafy Vegetables:

Green leafy vegetables are high in quercetin, as well as having many other helpful compounds. As we mentioned in our last newsletter, quercetin is a flavonol with powerful anti-inflammatory properties. They also have a lot of vitamin E, which helps fight inflammation as well as phytonutrients that are a strong antioxidant.

## Fatty Fish:

There is a lot of research to back up the benefits of including fish in your diet. They contain omega-3 fatty acids, which prevent inflammation in several ways, reducing both inflammation and pain as well as preventing more. If you aren’t a fan of fish, then fish oil

tablets are another great way of getting omega-3 into your diet. They are strongly recommended by the American Heart Association for preventing vascular disease due to inflammation.

## Fruits:

Many fruits have been shown to have anti-inflammatory and anti-oxidant effects. Two particularly good fruits to include in your diet are cherries and pomegranates. Cherries are high in cyanidin, which is found in many other berries as well. Cherries act as a strong antioxidant and inhibitor of COX-2 – an enzyme responsible for inflammation and pain. Pomegranate contains Granatin B, an anti-inflammatory that isn’t found in many other foods. Pomegranate is also said to help prevent cancer and cardiovascular diseases.



However, it’s important to aim for variety, rather than relying on one specific super food. Because different compounds work in different ways to fight and prevent inflammation, including as many different anti-inflammatory fruits and foods in your diet as possible will help keep inflammation down.

## Dietary Fibre:

Fibre is an important part of a good diet and among its many benefits is protecting your bowels from inflammatory diseases. A study on rats found that taking fibre supplements increased the production of short-chain fatty acids. These are very powerful inhibitors of pro-inflammatory mediators. Increasing the amount of fibre in your diet is very easy and is definitely worth doing!

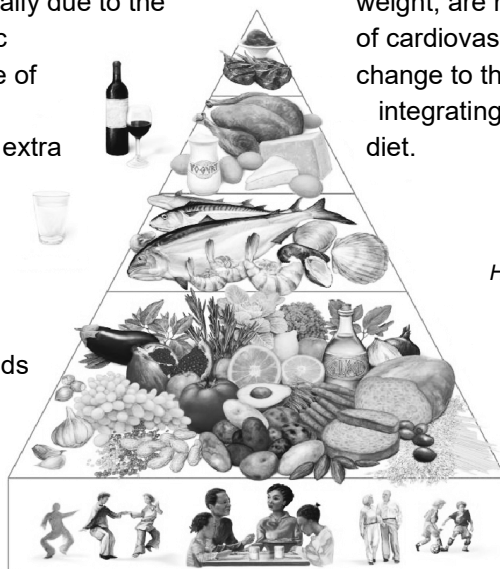
## Mediterranean Diet:

Making a few small changes and including some of the foods we’ve mentioned in your diet while swapping out some fattier alternatives can make a big difference. However, Cheryl Orlansky of the Laureate Medical Group says there is also a benefit if you “remove those fats that turn on inflammatory processes, such as saturated fat from meats, butter, cream sauces, fried foods and trans fat found in many processed foods.”

It may be worth trying a switch to a Mediterranean Diet. increased inflammation.

"The Mediterranean diet reduces the incidence of coronary heart disease partially due to the protective role of its phenolic components, including those of extra virgin olive oil." This diet includes more nuts and extra virgin olive oil in your diet, both of which have a powerful anti-inflammatory effect. Mediterranean herbs and vegetables are also particularly high in compounds that help fight inflammation.

The other main advantage of the Mediterranean diet is that it contains far fewer fatty foods and processed carbohydrates than Australian diets. Processed carbohydrates increase insulin, which contributes to inflammation and fatty foods have also been linked to



People who stick to a Mediterranean Diet also lose weight, are more active and have significantly lower risk of cardiovascular diseases so it could be worth making a change to the Mediterranean diet rather than just integrating a few elements from it into your normal diet.

Joseph Penington

References:

Huang C., Wu M. Differential effects of foods traditionally regarded as 'heating' and 'cooling' on prostaglandin E2 production by a macrophage cell line

Esposito K., Giugliano D. Diet and Inflammation: a link to metabolic and cardiovascular diseases

Hazewindus M., Haenen G., Weseler A., Bast A. The anti-inflammatory effect of lycopene complements the antioxidant action of ascorbic acid and  $\alpha$ -tocopherol

Bogani P., Galli C., Villa M., Visioli F. Postprandial anti-inflammatory and antioxidant effects of extra virgin olive oil

## LOW-LEVEL LASER THERAPY

In the search for safe, non-invasive treatments for chronic pain with minimum or no side-effects, laser therapy—known as photobiomodulation—is now shown to be an effective treatment for a range of pain conditions.

Dr Roberta Chow, a GP and member of the RACGP special interest group in pain medicine who is a world-leader in the research and application of laser therapy, says there is a body of evidence that shows it can be helpful for patients with musculoskeletal pain, migraine, fibromyalgia, nerve pain and neuropathies including shingles and trigeminal neuralgia.

With experience spanning almost 30 years, Dr Chow is a firm advocate of the treatment.

"Photobiomodulation offers GPs a nonpharmacological way of helping patients, and because light has a broad spectrum of effects on tissue, it has application across an equally broad range of clinical conditions," said Dr Chow.

Known as Low-Level Laser Therapy (LLLT), it uses LED light to reduce pain and promote tissue healing, by blocking pain nerves and reducing inflammation, leading to a reduction in central sensitisation and improved circulation.

Dr Chow's systematic review of 16 randomised controlled trials including a total of 820 patients, published in The Lancet, showed LLLT reduces pain immediately after treatment in acute neck pain, and for up to 22 weeks after completion of treatment in cases of chronic neck pain.

The British Medical Journal clinical recommendations for tennis elbow include LLLT and the International Association for the Study of Pain finds strong evidence for the use of LLLT in myofascial pain syndrome, while the American Physical Therapy Association guidelines recommend LLLT for Achilles tendonitis.

Thanks to PainAustralia for their permission to republish this article from their newsletter, Issue 66, October 2016 . This is an abridged version.



# WHAT DETERMINES THE LIKELIHOOD OF A GOOD OUTCOME WITH RSI?

*This is an edited and abridged version of an article by Sandra Oudshoff published in the Dutch RSI Association Newsletter March 2016. We are very grateful to Annemarie Calnan for her translation.*

"All animals are equal, but some animals are more equal than others" is a famous line from George Orwell's satirical book 'Animal Farm'. But does this also apply to people with RSI? Do all symptoms progress in the same way or are there different effects within groups? Researchers at the Health Innovation Knowledge Centre at the University of Rotterdam investigated these questions to improve the management and treatment of RSI.

## How was the research set up?

Participants for the study were recruited over a year through general practitioners in the Rotterdam area; they were patients who had newly-reported arm, neck or shoulder pain. The participants had to be between 18 and 64 years old, able to fill out questionnaires in Dutch and prepared to participate over the entire study. Nearly seven hundred participants were followed up for two years. Every six months, participants were given five questionnaires to complete, providing a good picture of the timing of the symptoms and their effects within a large group of people.

At the start of the investigation, each participant was asked not only about the duration, location and severity of their symptoms, but also about their work and personal data. Standardised questionnaires were used to provide reliable data about, for example, participants' overall health and the severity of the complaints.

## What factors were included in the survey?

Firstly, demographic characteristics such as age, sex, education level, having paid work and participating in a sport for one or more hours per week were analysed. Secondly, characteristics of the RSI such as the region in which they occurred: neck-shoulder, elbow-arm, wrist or hand. Other factors included how long the symptoms had been present when first consulting the GP, the distribution of the complaints over the body, whether they were specific or widespread and the severity of the symptoms in the previous week.

Thirdly, other physical characteristics such as general health, earlier injury in the neck or upper body, the presence of other musculoskeletal disorders such as low back pain, and the presence of other chronic diseases such as cardiovascular disease were measured.

The fourth group included the so-called psychosocial

features: somatisation, social support, catastrophising, fear of movement and the degree to which a person believes that their own behaviour affects their health. Somatisation is the phenomenon that psychological distress, such as tension or stress, manifests itself in

Two-thirds of the study participants recovered and one quarter recovered to some degree. Only a small group - 9% - didn't recover at all.

physical symptoms. Catastrophising is the tendency to believe that physical complaints and expected future changes in them are worse than the reality.

Finally, participants were asked about their work: sick leave in the past six months, any presumed work-related nature of the symptoms, physical workload and work pressure.



## Which groups were found?

This research specifically looked at the outcome 'severe restrictions'. Three groups of participants emerged with broadly similar patterns. The first and largest group comprised two-thirds of the participants in this study, those whose limitations reduced very quickly.

A second group of nearly a quarter of the participants had some recovery in limitations: their symptoms reduced after six months, but then hardly reduced any further or changed much in severity. A final small group with nine percent of participants had severe limitations, a continuous high score on symptom severity and barely improved at all in two years.

The good news is that most people who had arm, neck or shoulder complaints and reported to the GP recovered relatively quickly, and then had few or no further restrictions. A third of the participants still had severe limitations, even after two years. It is important, then, to examine if there are certain prognostic factors for groups which predict the different outcomes.

## What determines who falls into which group?

According to the researchers, a high degree of somatisation is the most important predictor for the least favourable complaints gradient. Furthermore, the prevalence of poor general health and multiple sites of symptoms in the arm, neck and shoulder area are both important.

A number of other factors impacted on the group with limited recovery:

- complaints of symptoms for more than three months,
- other musculoskeletal disorders,
- being female,
- previous injury in the neck and arm shoulder area,
- low education,
- low social support,
- higher intensity of the symptoms.

There are three further factors which influence limited recovery: older age, fear of movement and catastrophising.

## How can we use the results?

The researchers say that psychosocial factors, such as somatisation, does not mean that the complaints are psychological or that the patient is to blame. These factors reflect only how a person is inclined to think of their complaints, or respond to tension or stress. If these factors are considered in the treatment as well as information about the origin and the severity of the symptoms and the actual expected progress, then there is a higher likelihood of good treatment results.

*Sandra Oudshoff (Dutch RSI Association)*

*Reference: Miedema H., Sita A., Hoekstra B., Burdorf A., Koes B. "Disability trajectories in patients with complaints of arm, neck and shoulder (CANS) in primary care: a prospective cohort study.*

**Somatization** is defined as the "normal, unconscious process by which psychological distress is expressed as physical symptoms. For example, a person with clinical depression may complain of stomach pains that prove to have no physical cause. It's a concept which evolved as a way for doctors to think about and classify symptoms they couldn't otherwise explain.

However, it's not accepted by all clinicians as useful or valid. Dr John Quinter writes disparagingly of somatization: It 'in fact only reflects the medical observer's "psychologization" of the clinical problem.'

It could be argued that it's particularly problematic to diagnose in people with overuse injury, as at least 4 of the 14 symptoms in a commonly-used questionnaire to diagnose somatization are often associated with an overuse injury: tingling in the fingers, painful muscles, neck pain and back pain.

# THE MEDICOLEGAL INTERVIEW

*“Every now and then (the insurer) will send you all for a review and that is when you live in fear, because it depends on what kind of doctor you get. There are doctors who don’t think there is a real problem. We all live in fear of these reviews. I understand the need for them but it’s very stressful. You feel you’re living under a shadow.”*

Medicolegal interviews can cause a lot of anxiety and stress. Unlike other medical interviews, the purpose is not to help you get better or to recommend a treatment, but to determine whether your claim is justified or not. Some medicolegal doctors have a good understanding of overuse injuries and are sympathetic and helpful. Others are just in the business to make money and provide a report that will ensure more well-paid work for them in the future by telling the insurer what they want to hear.

So one of the first things you can do before the interview is to try to find out as much as you can about the doctor who will be interviewing you. Ring up the insurer and ask for the name of the doctor you will be seeing and what specialty they have. Use a search engine to find out everything you can about them and have a look at *rate my doctor* to read any reviews that might be there. Give us a ring – we have a list of medicolegal practitioners whose reports are reliably unsympathetic. You can also get information about them by searching the database of AAT cases at the common-law website to see if they have given evidence in any cases at the AAT (<http://www.austlii.edu.au/au/cases/cth/AATA/>).

If you have reason to think that a particular doctor will not be fair, ring up the insurer and ask if you can see someone else. It's always worth asking!

Because the experience of having RSI can be a very painful one, both physically and emotionally, "reliving" your experiences by having to tell a complicated story in a short period of time can be difficult. To try and lessen the stress of the whole process, remember that you don't have very much control over it. Okay, I realise this sounds odd! But if you recognise that you don't have control over something, you will also realise that worrying or getting anxious about it will not achieve anything. This is a procedure that you have to go through and how the doctor behaves or what they write is not up to you. They will do what they generally do and you will do your best to be honest and cooperative.

However, there are a few things you can do that will help. It's definitely a good idea to write down your story before you go. Make sure it includes everything important, including a clear timeline and:

- what you were doing at work when you first got RSI
- the symptoms you experienced
- what treatments you've been given
- the effect of treatments
- what you can and cannot do most of the time, particularly at work. Be specific! What tasks can you do for how long? What symptoms do you get if you do particular tasks?
- what you are currently doing at work and the effect on you, including pain levels.

Before you go, read through this statement to remind yourself of all the facts of your case. Most people find these interviews pretty stressful, so learn some simple stress-relieving breathing techniques that you can practice beforehand. It could be helpful to download a stress-relief app to your smartphone.

Give your written account to the doctor, whether they want it or not. Then there can be no disagreement about what you said or didn't say about your injury and its effect on you.

While you should try to answer all questions, it's perfectly okay to say that you need a minute to think about something. It's also all right to go back and amend a previous answer if you need to do so. You can ask for a short break if you need one, although it will be brief because these guys' time is very expensive!

It's essential to take a friend with you for support if you possibly can. Ring the insurer as soon as you get notice of the interview and ask if you can take a support person with you. Generally, they will agree. The rules are that the person who goes with you cannot talk during the medicolegal interview unless they are asked to do so. They can be asked to leave the room during a physical examination, but if you are comfortable with them being there, by all means have them stay. However they can take notes and it's a good idea for them to do so. You might like to arrange to have a cup of coffee together afterwards and go over the interview, with your friend writing down the main points.

“Because the experience of having RSI can be a very painful one, both physically and emotionally, "reliving" your experiences by having to tell a complicated story in a short period of time can be difficult.”

Not only will you feel more confident and relaxed if you have a friend with you, you also have a witness in case of a disagreement about what happened at the interview. For example, one of our members recently received a medicolegal report in which she was described as having been "hostile" and "uncooperative" during the interview. Her friend was able to write a short report disputing this account and attesting to the fact that she had willingly answered all questions and cooperated fully.

It's also a good idea to arrange to see a specialist in the same area as the medicolegal doctor and ask them to write a report. Your lawyer or your GP can suggest a suitable specialist. If their report arrives in time, give it to the medicolegal doctor and say "I want you to take this in evidence".

Receiving the medicolegal doctor's report can be just as stressful as the actual interview.

*“That's devastating – to get a report that says there's nothing wrong with you when you know you've had your life just crippled!”*

*“He wrote a very negative report with remarks about my character saying, for example, that I was a hostile person, that I was pretending—even though I hadn't taken time off work. I felt completely devastated. I suppose, looking back now that I am more used to medicolegal systems, my reaction seems extreme but I think it's typical of a lot of people that I just felt that someone had struck a very strong blow at my integrity. I couldn't sleep for thinking about the report; I just felt absolutely sick.”*

The medicolegal doctor may write the same report for you as he or she has written for many other people – just changing the name and a few details! Don't take it personally if you get a negative report – you are one of thousands of honest workers with real injuries in the same situation. Just do what you can to minimise harm to your own health and well-being throughout the process.

*Ann Thomson*

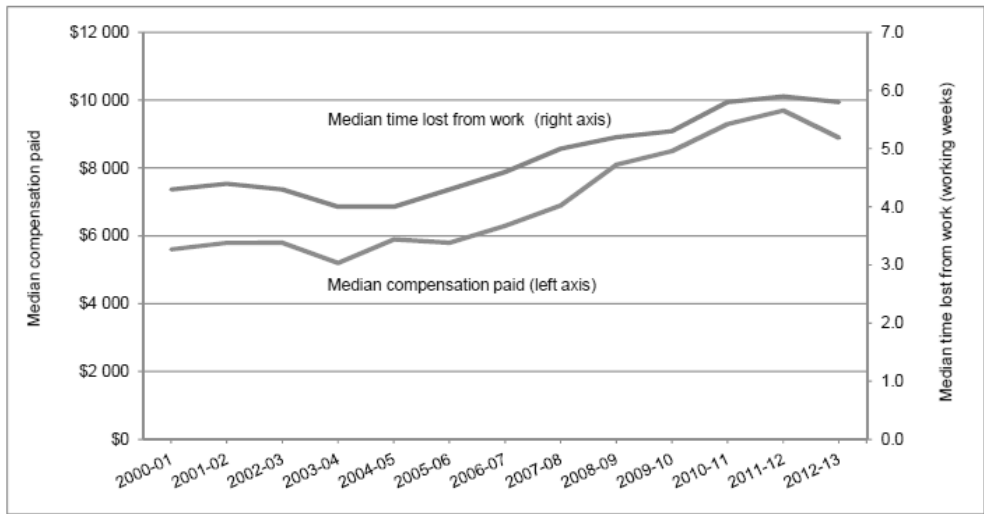
# AT A GLANCE: MSDs IN AUSTRALIA

Safe work Australia recently published a compendium ‘Statistics on Work-Related Musculoskeletal Disorders’. There are some interesting facts that emerge from the statistics.

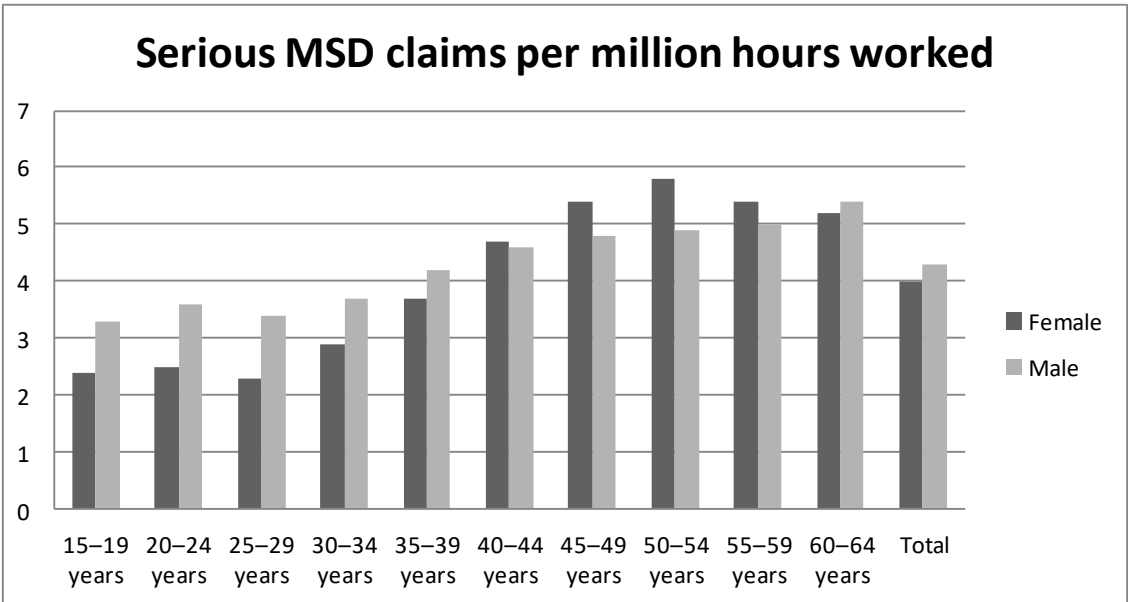
Firstly, prevention isn’t working. The percentage of serious claims involving MSDs has hardly changed over 14 years. It’s stayed at around 60% of all serious claims since 2000.

Secondly, over the same period, the median time lost from work for serious MSD claims increased by 35%. In 2001, it was just over four working weeks, and it’s now almost six.

Figure 3: Median time lost from work and median compensation paid for serious MSD claims, 2000–01 to 2012–13



The next table shows that younger employees are less likely to claim compensation for MSDs than older employees. It also shows that women’s rate of claims for MSDs increases as they get older, so that they overtake men’s rates when they reach 40 and then stay higher until they reach the age of 60.



‘Statistics on Work-Related Musculoskeletal Disorders’, Safe Work Australia

## YOUR COMCARE CLAIM: WHAT'S HAPPENING?

After a year of horror losses in 2012, Comcare is now back in the black through a “get-tough policy on claims” and a “crackdown on dubious claims for pharmaceuticals and treatments that have no proven therapeutic benefits” according to an article in The Canberra Times. The AAT appears to be backing Comcare in its effort to cut costs and reduce access to therapies.

David Lander, the speaker at our forthcoming AGM, has been a passionate and effective advocate for Comcare clients over many years, winning many cases for our members. He will talk about what's happening with Comcare and the AAT – there will be plenty of time for your questions.



**When:** 12:30pm Monday, November 21<sup>st</sup>

**Where:** Room 2.06, Griffin Centre, 20 Genge St, Canberra City

*Tea, coffee and refreshments will be provided.*

## CAUTIOUS STEP FORWARD FOR INJURED WORKER COMPENSATION CASES

A Victorian Ombudsman investigation has found the state's workers compensation scheme should be amended to ensure complex claims are resolved in a fair and timely manner—shedding light on a process hampered by red tape and confusion not just in Victoria, but across Australia and around the world.

The Investigation into the management of complex workers' compensation claims and WorkSafe oversight, recently tabled in the Victorian Parliament, calls for a review of dispute resolution processes and improvements in oversight of complex claims by WorkSafe, which underwrites the compensation scheme.

It found cases where agents worked the system to delay or deny seriously injured workers the financial compensation to which they were entitled, by cherry-picking evidence to support a decision or reject a claim and supplying Independent Medical Examiners with selective, incomplete or inaccurate information.

It also saw evidence of decisions being influenced by financial incentives to terminate claims.

Rosemary McKenzie-Ferguson was injured in the workplace more than 20 years ago and is now an

Injured Worker Advocate.

“One of the ways in which claims agents achieve their targets, is by creating confusion with industry jargon, which alienates people and makes them think they are not eligible for compensation.

“In some cases injured workers are forced to stop treatments even though they are only part-way through a program, and by the time they chase legal action, they have become significantly deconditioned.”

Change is also being demonstrated in the implementation of a new protocol that ensures early intervention after injury to prevent the onset of chronic pain. This is proving to benefit not only the injured worker, but also employers and insurers.

The WISE study led by Professor Michael Nicholas, showed days off work could be halved, when applying early intervention strategies to injured workers at high-risk of long-term pain, demonstrating cost savings of 22 percent per worker.

*Thanks to PainAustralia for their permission to republish this article from their newsletter, Issue 66, October 2016 . This is an abridged version.*

# TIPS & TOOLS

Robot vacuum cleaners are one of the next steps in the ongoing mission to automate household chores. In the past decade or so, they've come a long way, especially with the introduction of the Dyson 360 Eye and iRobot's Roomba 980. Dyson has spent upwards of \$50,000,000 in the past eighteen years researching and developing their first entry in the robot vacuum cleaner market.

If doing the vacuuming is a pain and you're prepared to spend quite a lot, then either of these robots is worth considering as a substitute. They'll both clean your floor quite effectively as long as there aren't any stairs in your house and both can be told to clean whenever you want and will put themselves back on to the charger when they're done. They are unlikely to get stuck and need you to help them.

The two robovacs use slightly different technology to navigate around your house but either will make sure that they reach every corner of their floor and clean it thoroughly. Both robovacs come with an app that will let you check up on your robovac's progress or even start a clean while you're out.



Neither of these robot vacuums is perfect, though. You have to remember to pick up everything off your floor beforehand and if you do leave clothes on the floor, the vacuum may try and pick them up and do the clothes some damage.



Furniture is also an issue, as both will be unable to get underneath low furniture. The Roomba has a slight advantage here, being an inch shorter and able to get into more places. But as long as you remember to tidy your floor thoroughly before your robot is scheduled to do a clean, you should be able to go out and come home to a clean floor.

There aren't many differences between the Dyson and the Roomba, but the main three are cost, battery life, and size. The Dyson costs around \$1400 while the Roomba is only \$900. The Roomba also has a longer battery life so it doesn't have to go back and charge as often, resulting in a faster vacuum and is also around an inch shorter; so the Roomba 980 is probably the way to go.

## Introducing the Robo-Mop

Robotic cleaning doesn't stop with vacuums - Robomops are now also on the market. For \$599, the iRobot Braava floor-mopping robot can mop the floor with rewashable microfiber pads. However it might be worth sticking to your old mop for now. The Choice Magazine review says "Perhaps a crawling toddler wearing damp microfiber kneepads could have done the job quicker", after it took half an hour to sweep the kitchen floor. It also failed to effectively clean the tougher stains on the floor. The review wasn't entirely negative, though. If you use it every day on a regular-shaped floor, and are prepared to spend nearly six hundred dollars, it'll save you from a difficult chore. But we think we'll wait until better designs for a robot mop come along.



## Information Sheets Available:

A New Approach to Pain  
 Assistance through Medicare  
 Clickless Software  
 How to Win and Keep a Comcare Claim  
 Hydrotherapy  
 Injections for RSI  
 Managing Stress in Your Life  
 Managing Your Finances  
 Massage  
 Medical & Medico-Legal Appointments  
 You don't have to live with depression  
 Neck Pain  
 Pillows & RSI  
 Sewing & RSI  
 Member's Story — Studying with RSI  
 Swimming with RSI  
 Treatments for Carpal Tunnel Syndrome  
 Voice Overuse  
 Member's Story — Invalidity Retirement

## Helping Hand Sheets Available:

Driving	Getting on top of your emails
Sewing	Gadgets to help with medicines
In the Laundry	Writing and Pens
Handles	In the Garden
Book Holders	Sitting at the Computer
Cycling	Choosing a Keyboard
Holidaying	In the kitchen
Break software	Heat therapy for pain
Clickless software	Which keyboard?

***To order an electronic copy of any of the above info sheets, please email us***

***Save with our two year membership for just \$40.00***

## Booklets Available:

### **The RSI Association Self-Help Guide** **\$25**

Really useful and practical information on treatments, medico-legal matters, maintaining emotional health and managing at home and at work.

### **Moving on with RSI** **\$10**

Stories of people who have learnt to live with serious RSI, with many ideas on how to survive emotionally and successfully manage the condition.

### **Pregnancy & Parenting with RSI** **\$20**

Information designed to help parents with an overuse injury to manage the specific challenges they face.

***Booklets can be purchased online ([www.rsi.org.au](http://www.rsi.org.au)), requested by email, or ordered by mail using the form below.***

## Renewal for Membership & Order Form

*Please make cheques or money orders payable to the RSI and Overuse Injury Association of the ACT, Inc.*

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

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*I would like to receive my newsletter by email:* ☐

Annual Membership:	I want to renew for 1 Year	Save money and renew for 2 years
Low Income	\$15 <input type="checkbox"/>	\$25 <input type="checkbox"/>
Standard Income	\$25 <input type="checkbox"/>	\$40 <input type="checkbox"/>
Organisation*	\$60 <input type="checkbox"/>	
<b>Booklets Available:</b>	<b>Cost:</b>	
Self-Help Guide	\$25 <input type="checkbox"/>	
Moving on with RSI	\$10 <input type="checkbox"/>	
Pregnancy & Parenting	\$20 <input type="checkbox"/>	

### **I enclose:**

Donation (tax-deductible): \$ \_\_\_\_\_

**Total:** \$ \_\_\_\_\_

*\*Organisational membership is open to organisations sharing our aims.*



# COMING SOON

TIPS 'N TOOLS—KITCHEN LIFESAVERS

MEMBER'S STORY:

SETTING UP MY OWN BUSINESS

EMPLOYERS AND THE COMPENSATION  
SYSTEM

QUITTING — THE WHEN, THE HOW AND THE  
WHY



*Preventing overuse injury, reducing its impact*

**RSI & Overuse Injury Association of  
the ACT, Inc.**

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## Contact Us

Give us a call for more information about our services or drop in to our office during our opening hours.

Opening Hours: Mondays and Thursdays,  
10.30am to 2.30pm

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