Can a needle-stick injury cause chronic fatigue syndrome?

Patricia Worthy, Canberra

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According to three professors, eminent in the field, and a three-member tribunal of the Administrative Appeals Tribunal, the answer is "yes".

Facts

On 29 April 1985 in the early hours of the morning, our client, ("the applicant") who was a member of the Australian Federal Police, was instructed to attend to removing a large number of used syringes from a road in suburban Canberra. The syringes were scattered on the roadway and a desk drawer was found nearby. The applicant collected the syringes and placed them in the drawer. As the applicant was carrying the drawer into the police station, he held the drawer with his left hand to open a door, after which he replaced his right hand on the drawer and immediately felt a pain in his right hand. He looked down to see a syringe sticking into the top of his right fifth finger; as he withdrew his hand he noticed a very small drop of blood.

The incident was recorded in the applicant's notebook and he attended the Accident & Emergency section of the local hospital where the wound was cleaned and a Hepatitis B injection administered. The injury was such that no puncture wound was visible to the attending doctor. Hepatitis B tests proved negative and other tests did not reveal any disease.

The applicant later gave evidence that within 7 to 10 days after the incident he experienced a range of symptoms including abdominal cramps and a gastric attack, fever, fatigue, headaches, muscle pain and general tiredness. His symptoms continued, worsening towards the end of 1985 and running into 1986. He continued to work until 6 July 1985 when he took his first time off work as a result of the incident. His evidence was that he had consulted the police doctor on a number of occasions on an informal basis.

On 7 December 1987 the applicant lodged a workers' compensation claim, at that stage believing he had suffered hepatitis because of discomfort he had experienced on the right side of his lower rib cage which he thought had commenced shortly after the needle-stick incident. The claim was rejected in February 1988 on the basis that the medical specialist was unable to state, on the balance of probabilities, that the applicant's condition was a result of the needle-stick incident.

The applicant had a major absence from work in March 1988 during which he received gamaglobulin injections to no effect. He commenced a graduated return to work in December 1992 and increased his hours to eight hours per week in 1993 until he went off work on 10 November 1993. At that stage he was referred to Professor D. Wakefield. He tried to resume work again but his health deteriorated further.

The matter finally went before the AAT on 24 October 1997. Various lay witnesses gave evidence in relation to the applicant's good health and zest for both living and his career prior to the incident. They also attested to the dramatic deterioration in his health after the incident.

Medical Evidence

Professor D. Wakefield, immunologist with extensive experience of Chronic Fatigue Syndrome ("CFS") became the applicant's treating physician in 1994. He diagnosed "a needle-stick injury that led to a viral-like infection and subsequently a post-infective fatigue syndrome". He conceded that the cause of CFS is not known and that it does not always follow a viral illness. Despite this, he stated that there is good evidence that CFS can follow viral infection.

Professor J. Dwyer, immunologist and specialist in CFS, saw the applicant on 26 March 1997. He found himself agreeing with Professor Wakefield: "In essence, it is highly probable that a viral infection that occurred following a needle-stick injury... caused an acute infection that subsequently subsided but triggered a chronic fatigue or post infection fatigue syndrome." Interestingly, both professors thought that the ongoing stress at work may have worsened the symptomatology.

Professor P. Gatenby, immunologist with extensive experience with patients with CFS (on behalf of Comcare) accepted that the applicant was suffering from CFS. The Tribunal found his views to be largely in line with Professors Dwyer and Wakefield but his views as to causation differed. He believes that the cause of CFS is not yet known. He believes that the connection between CFS and viral illnesses may be pure coincidence. He conceded that it was possible that a virus could trigger CFS but was not willing to go as high as probable.

Conclusion

From the beginning of the hearing it was conceded by Comcare that the applicant had suffered the needle-stick injury and that he was now suffering from CFS. The matter in issue was whether or not the incident could lead to the condition.

The Tribunal accepted lay evidence both in relation to the applicant's good health prior to the incident and in relation to the dramatic deterioration, including severe weight loss, following the incident. The Tribunal accepted all three professors as being experts in their field and in its Decision handed down on 6 November 1997, went on to say:

"Given the current state of medical knowledge with respect to CFS the Tribunal cannot make an equivocal statement as to the causation of the applicant's condition. However, in taking the history of the onset of symptoms in connection with the medical evidence, the Tribunal finds that, on the balance ▶

of probabilities, there is a link between the needle-stick injury and the development of viral-like symptoms within 20 days of the incident. Both Professor Dwyer and Professor Wakefield believe that this would be sufficient to connect the applicant's development of CFS to the incident. Professor Gatenby also conceded that this history would provide a plausible link. Therefore while the Tribunal reiterates that it cannot be unequivocal about this, in view of the present limited state of relevant medical knowledge, it finds that a causal link between the applicant's apparent viral illness and his subsequent development of CFS is probable."

Concluding note

This case note is a very brief summary of a huge case involving 516 pages of "T" documents containing many medical reports and learned papers on CFS. This note does not purport to cover all issues but is submitted to assist other practitioners who may find themselves with clients with similar problems. ■

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Communicating with the disabled

Thurgar v Singh & Ors, NSW District Court, April 1997.
Catherine Henry, Sydney

Catherine Henry

A medical negligence case run to trial but which settled on day 2 shows that there is still a significant way to go before medical practitioners understand the special needs of deaf clients. The case demonstrates the importance of medical practitioners (and lawyers) being aware of the communication resources available in the community and how to use them appropriately.

Allegations of negligent treatment.

The facts of the case were as follows. The plaintiff, a 59 year old profoundly deaf woman from Sydney sought advice in 1994 from her general practitioner, Dr Singh, in relation to vaginal bleeding. The communication between Ms Thurgar and Dr Singh was by handwritten notes. In late July 1994, Ms Thurgar was referred to a urogynaecological specialist, Dr Biswas, whom she had not consulted previously. Dr Biswas was the principal defendant.

A referral letter was written by Dr Singh, GP to Dr Biswas, but despite the client's deafness, no Australian Sign Language ("Auslan") interpreter was booked for the appointment and very little of her medical history or presenting symptoms were included in the referral letter. At the appointment with Dr Biswas, Ms Thurgar was forced to communicate through written notes as she did not use lip reading. Some of the notes which became available during the case revealed a very minimal level of communication and Dr Biswas, himself, indicated that he found it difficult to obtain a full medical history because of the absence of effective communication. Ms Thurgar was given written advice and a prescription.

A further consultation between Dr Biswas and Ms Thurgar was held at which no interpreter was present. Eventually, in September 1994, Ms Thurgar organised a hearing friend who could use Auslan to attend an appointment with her so that she could act as an interpreter. The friend who acted as an interpreter thought Dr Biswas was more interested in her ability to sign than Ms Thurgar's condition.

In September 1994, Ms Thurgar was referred to Blacktown Hospital for a curette and hysteroscopy. On admission a professional interpreter had been organised to gather information for admission. At the conclusion of the procedure Ms Thurgar was advised by a staff member that she should make an appointment with Dr Biswas six weeks after the surgery. She was not told that as a result of the hysteroscopy, a carcinoma on the lining of the uterus had been found.

About four weeks later Ms Thurgar still had vaginal bleeding. She again attended Dr Biswas' rooms for a consultation with a friend to interpret for her. That friend remembers remarks being made by the specialist's staff to the effect that Ms Thurgar could lip read but was pretending not to be able to. Again the specialist exhibited an unusual level of interest in the friend's ability to sign. Still, the plaintiff was not told she had cancer of the endometrium. Rather, when questioned by the plaintiff as to the cause of the continued bleeding, Dr Biswas replied that Ms Thurgar had a large bladder and should limit the amount of coffee she drank!

Towards the end of 1994 and as the symptoms continued, Ms Thurgar consulted other medical practitioners who were advised that uterine cancer had been detected as a result of the earlier procedure at Blacktown Hospital. As indicated, this had not been communicated to Ms Thurgar. As a result, Ms Thurgar was immediately scheduled for a radical hysterectomy. By the time this was to be performed the cancer had spread and she had to undergo radiotherapy which was not successful. Ms Thurgar died in June 1998.

Medical evidence presented at the hearing of the matter in the District Court was that had the cancer been treated