United States Department of Labor
Employees' Compensation Appeals Board

JUDITH L. CRUMRINE, Appellant	)	
and	)	**Docket No. 04-2110**
	)	**Issued: April 20, 2005**
U.S. POSTAL SERVICE, POST OFFICE, Washington, PA, Employer	)	

Appearances:
Joan E. Lesnock, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Member
DAVID S. GERSON, Alternate Member
MICHAEL E. GROOM, Alternate Member

JURISDICTION

On August 25, 2004 appellant filed a timely appeal of the merit decisions of the Office of Workers' Compensation Programs dated June 22, 2004 and November 6, 2003. The June 22, 2004 decision denied modification of the November 6, 2003 decision. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this termination case.

ISSUE

The issue is whether appellant has established continuing residuals or disability causally related to her November 25, 1997 employment injury.

FACTUAL HISTORY

This is the second appeal in this case. In a July 16, 2001 decision, the Board affirmed the Office's November 29, 1999 decision which terminated appellant's compensation benefits effective December 4, 1999 on the grounds that she no longer had any residuals or disability causally related to her November 25, 1997 employment-related left ankle sprain/strain. The Board accorded special weight to the July 30, 1999 medical report of Dr. Patrick G. Laing, a

Board-certified orthopedic surgeon and impartial medical specialist. He found that appellant did not have any residuals of her accepted employment injury and that she was able to perform her regular duties as a rural letter carrier. The facts of the case are set forth in the Board's decision and are incorporated herein by reference.[1]

By letter dated July 10, 2002, appellant, through her attorney requested reconsideration. She submitted an October 24, 2001 decision from the Social Security Administration, finding that she was disabled under the criteria of the Social Security Act commencing October 1, 1998. Appellant also submitted an April 19, 2002 medical report of Dr. William Mitchell, a Board-certified orthopedic surgeon, who reviewed a history of appellant's November 25, 1997 employment injury and medical treatment. He noted symptoms related to her ankle and his findings on physical examination. Based on his physical findings and normal x-ray results regarding appellant's neck and back, Dr. Mitchell opined that appellant had permanent neuropraxia of the peroneal nerve which arose directly because of its anatomic relationships to the ankle where a very severe sprain occurred to the degree that it required surgery. He further opined that surgery had improved the stability of the ankle but it had contributed nothing to the neuropraxia of the peroneal nerve because there was no treatment for this entity. Dr. Mitchell stated that the neuropraxia of the peroneal nerve which was the damaging factor at that point arose directly from and in connection with the November 25, 1997 employment-related ankle injury and it would give appellant physical limitations to the degree of which she complained. He concluded that she was totally and permanently disabled from returning to her job at the employing establishment.

Appellant submitted a June 21, 2001 medical report of Dr. William W. Frost, Jr., a Board-certified physiatrist, who described the accepted employment injury and appellant's medical treatment. He reported his findings on physical examination and diagnosed chronic "cauda equina-like" syndrome with a lumbar strain and sprain causally related to the November 25, 1997 employment injury. Dr. Frost also diagnosed bilateral lower extremity weakness, abnormal reflexes at the ankle on the left and a history of bladder dysfunction. Further, Dr. Frost diagnosed left ankle dysfunction status post left ankle reconstruction which was performed by Dr. Stephen F. Conti, a Board-certified orthopedic surgeon, on June 10, 1989 with secondary knee pain from ligamentous stress and not from any specific anterior cruciate ligament injury. Lastly, he diagnosed myofascial pain syndrome of the back, hip and calf, depression on Axis I that was work related and chronic pain syndrome. Dr. Frost opined that appellant was permanently and totally disabled for her regular job duties and gainful employment. Appellant also submitted the results of functional capacity tests performed on February 10, 2000 and June 21, 2001 and a summary of her medical treatment.

By decision dated October 10, 2002, the Office denied modification of its prior decisions. The Office found that neither Dr. Mitchell nor Dr. Frost reviewed the statement of accepted facts and all the evidence that was provided to Dr. Laing and, thus, their reports were insufficient to create a conflict with Dr. Laing's medical opinion. Accordingly, the Office found that Dr. Laing's opinion was entitled to special weight.

[1] Docket No. 00-2765 (issued July 16, 2001).

In a September 29, 2003 letter, appellant, through her attorney, requested reconsideration. Appellant's attorney submitted Dr. Mitchell's October 7, 2003 medical report in which he provided a history of his treatment of appellant beginning on April 19, 2002. Dr. Mitchell listed the medical records he reviewed and provided a detailed review of them. He also reviewed the Office's statement of accepted facts and addendums. Dr. Mitchell noted his April 19, 2002 report and explained that appellant still suffered from continuing residuals and disability due to her accepted employment injury because her injury was significant as it was not the usual simple ankle sprain or soft tissue injury as referred to by Dr. Laing and based on the findings of her treating physicians. He stated that, both Dr. Laing and Dr. Robert Yanchus, a Board-certified orthopedic surgeon and second opinion physician, neglected the literature which confirmed that a severe ankle sprain can pull the adjacent peroneal nerve and tendon to the degree that a stretch force is exerted up to the level of the peroneal bone neck and with this sprain neuropraxia and even neuropathy, as shown on a December 15, 1998 electromyogram (EMG) test, can develop. Dr. Mitchell related that, since the peroneal nerve is a very delicate one, potential for permanent damage is present immediately when injury occurs. He stated that Dr. Laing did not perform many tests that would elicit pathologic findings. Dr. Mitchell noted Dr. Laing's omissions and normal reflex and range-of-motion findings regarding appellant's knees. He stated that the fact that appellant sustained an ankle injury and its secondary ramifications to the peroneal nerve and tendon showed a specific causal relationship to her residuals. He stated that the bridging symptoms which never abated and the bridging findings which always existed between the current condition and the accepted employment injury supported a finding of causal relation.

On November 6, 2003 the Office issued a decision denying modification of the October 10, 2002 decision. The Office found that Dr. Mitchell's October 7, 2003 report was insufficient to create a conflict in the medical opinion evidence and again accorded special weight to Dr. Laing's impartial medical opinion.

In a letter dated March 20, 2004, appellant, through her attorney, requested reconsideration. Appellant submitted Dr. Mitchell's January 9, 2004 report in which he noted a review of the February 22, 1999 EMG report of Dr. Jeffrey D. Lemberg, a Board-certified physiatrist, Dr. Yanchus' February 8 and March 4, 1999 medical reports and Dr. Laing's July 30, 1999 medical report. He further noted his October 7, 2003 opinion. Dr. Mitchell stated that the December 8, 1998 finding of Dr. David A. Stone, a Board-certified physiatrist, that appellant had a positive Tinel's sign at the peroneal nerve as it wound around the neck of the fibula was significant in explaining her injury and ongoing problems which had been overlooked by most of the impartial medical examiners. He also stated that the February 22, 1999 EMG findings showed some abnormalities that should not be dismissed as if the complete report was within normal limits. Dr. Mitchell explained:

> "The mechanism of injury results from the fact that the left peroneal [nerve] winds around the neck of the fibular, just below the knee, travels down the outside of the ankle and under the ankle ligament. This nerve has sufficient elasticity or laxity anatomically so that normal walking does not bother it. However, when the ankle was inverted, or turned in, in a sudden sprain-like movement, this jerks the

peritoneal nerve with it. All of the slack is taken up and the nerve tightens up at its fixed point, which unfortunately is around the bony neck of the fibula.

"Therefore, when the ankle pull stretches this nerve, it becomes compressed at the fixation point along the bone and the nerve itself is stretched because there is no longer any looseness, or play, available in the nerve. Since it is a delicate nerve, the injuries can range all the way from the foot drop to one that simply gives the patient mild weakness and subjective symptomatology. The EMG scan shows [sic] changes all the way from complete absence of motor function to minimal or no absence of motor function."

Dr. Mitchell quoted an article concerning the development of a peroneal nerve injury from electrodiagnostic medicine. He stated:

"The reason this explanation is necessary is that a small accessory nerve could explain the confusion to the physicians who are not familiar with the problem. I note in reviewing Dr. Laing's report that he never even considered the possibility that this situation could be present. He simply diagnosed a soft tissue injury to the lateral collateral ligament, completely ignoring the nerve that was underneath that ligament. Most of the early literature that reflects this anomalous condition, occurred around the late 1970s and early 1980s. I have not seen much in the literature lately about this problem.

"In reviewing the various records, I note that some physicians were aware of one part of the problem and some aware of the other component to [appellant's] problem but none of them really tied it together as a complete unified syndrome. The extensive studies and opinions that have already been offered, in my opinion, rule out any other injury that could have occurred and established support only for this particular syndrome.

"It is my professional opinion within a reasonable degree of medical certainty that the ankle sprain [appellant] sustained was not only sufficient to tear the ligament ultimately but put a stretch mechanism on the peroneal nerve, which was fixed around the neck of [the] fibula and resulted in a neuropraxia, which was supported by EMG evidence only if one takes into consideration additional accessory peroneal nerve in explaining the EMG abnormalities.

"Although, these were not evident with one gross electrophysiolgic abnormality, they were evident when all of the small changes are put together and in view of the fact that many of these injuries have occurred only with small changes, it is not unusual that someone unaccustomed to subtle change would miss the picture completely. It is my opinion, therefore, based on these findings, that [appellant] did sustain an injury to her peroneal nerve at the time she sprained her left ankle."

By decision dated June 22, 2004, the Office again denied appellant's request for modification based on a merit review of her claim. The Office found that, although

Dr. Mitchell's January 9, 2004 opinion was well rationalized, it was insufficient to overcome the weight accorded to Dr. Laing's impartial medical opinion.

LEGAL PRECEDENT

After termination or modification of compensation benefits, clearly warranted on the basis of the evidence the burden for reinstating benefits shifts to the claimant.[2] In order to prevail, the claimant must establish by the weight of the reliable, probative and substantial evidence that he or she had an employment-related disability which continued after termination of compensation benefits.[3]

ANALYSIS

The Board's July 16, 2001 decision affirmed the Office's November 29, 1999 termination of appellant's compensation. Therefore, the burden shifts to appellant to establish reinstating benefits. Appellant submitted additional medical evidence to establish that she has residuals of her employment-related left ankle sprain/strain. In a January 9, 2004 report, Dr. Mitchell opined that appellant had a peroneal nerve injury causally related to her November 25, 1997 employment-related left ankle sprain/strain. He reviewed appellant's medical records and provided detailed physical and objective findings on examination. Dr. Mitchell analyzed these findings and reached a conclusion regarding appellant's condition which comported with this analysis.[4] He provided extensive medical rationale to support his conclusion that appellant's peroneal nerve injury was causally related to the November 25, 1997 employment injury. Dr. Mitchell stated:

> "The mechanism of injury results from the fact that the left peroneal [nerve] winds around the neck of the fibular, just below the knee, travels down the outside of the ankle and under the ankle ligament. This nerve has sufficient elasticity or laxity anatomically so that normal walking does not bother it. However, when the ankle was inverted, or turned in, in a sudden sprain-like movement, this jerks the peritoneal nerve with it. All of the slack is taken up and the nerve tightens up at its fixed point, which unfortunately is around the bony neck of the fibula.
>
> "Therefore, when the ankle pull stretches this nerve, it becomes compressed at the fixation point along the bone and the nerve itself is stretched because there is no longer any looseness, or play, available in the nerve. Since it is a delicate nerve, the injuries can range all the way from the foot drop to one that simply gives the patient mild weakness and subjective symptomatology. The EMG scan shows [sic] changes all the way from complete absence of motor function to minimal or no absence of motor function."

[2] *Howard Y. Miyashiro*, 51 ECAB 253 (1999).

[3] *Talmadge Miller*, 47 ECAB 673, 679 (1996); *see also George Servetas*, 43 ECAB 424 (1992).

[4] *See Melvina Jackson*, 38 ECAB 443 (1987).

Dr. Mitchell quoted an article about the development of a peroneal nerve injury and stated that appellant's treating physicians were not familiar with the problem. He noted that Dr. Laing's report did not consider the possibility that the injury could be present as he ignored the nerve that was underneath the ligament while some other physicians had some awareness of the problem but failed to tie it together as a complete unified syndrome. Dr. Mitchell opined that appellant's employment-related ankle sprain was not only sufficient to tear the ligament ultimately but put a stretch mechanism on the peroneal nerve which was fixed around the neck of the fibula resulting in a neuropraxia as demonstrated by EMG abnormalities that were not evident alone but when small changes were put together. Based on these findings, Dr. Mitchell concluded that appellant sustained an injury to her peroneal nerve at the time she sprained her left ankle.

The Board finds that the opinion of Dr. Mitchell is sufficient to create a conflict in the medical opinion evidence with Dr. Laing, the impartial medical specialist, as to whether appellant has any residuals causally related to the November 25, 1997 employment injury.[5] Dr. Mitchell's conclusion that appellant suffers from residuals due to her accepted employment injury is supported with medical rationale and based on a complete and accurate factual and medical background.

CONCLUSION

As a conflict exists in the medical opinion evidence between Dr. Laing, the independent medical examiner and Dr. Mitchell, appellant's treating physician as to whether she has any continuing residuals causally related to her November 25, 1997 employment injury.

[5] With respect to the evaluation of the medical evidence, section 8123(a) of the Federal Employees' Compensation Act provides in pertinent part: "If there is a disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination. 5 U.S.C. § 8123(a).

ORDER

IT IS HEREBY ORDERED THAT the June 22, 2004 and November 6, 2003 decisions of the Office of Workers' Compensation Programs are set aside; the case is remanded for further proceedings consistent with this decision.

Issued: April 20, 2005
Washington, DC

Colleen Duffy Kiko
Member

David S. Gerson
Alternate Member

Michael E. Groom
Alternate Member