

pounds over the course of two weeks in August 1993.¹ She received Office compensation for periods of disability.

In December 1994 the Office referred appellant to Dr. Michael C. Bidgood and Dr. George P. Delyanis, a Board-certified orthopedic surgeon and neurologist, respectively, for evaluation of her employment-related condition. In a January 6, 1995 joint report, Drs. Bidgood and Delyanis diagnosed marked functional overlay on examination, historical cervicodorsal strain and documented degenerative disc disease of the lumbar spine, preexisting and unrelated to the industrial injury of August 30, 1993. They noted that the findings on examination were primarily functional without objective correlation and represented a normal neuromuscular examination. Drs. Bidgood and Delyanis indicated that, given the nature of appellant's injury, ample time had elapsed for it to resolve itself. They noted that appellant did not require any particular work restrictions.

In February 1995 appellant returned to limited-duty work for the employing establishment on a part-time basis. The job involved sorting mail and inputting data on a keyboard and required lifting up to 35 pounds.²

In a March 1, 1995 decision, the Office terminated appellant's compensation effective that date on the grounds that she had no disability after that date due to her accepted employment injuries. The Office based its opinion on the January 6, 1995 report of Dr. Bidgood and Dr. Delyanis. In a November 9, 1995 decision, the Office affirmed its March 1, 1995 decision.³

On April 4, 1996 Dr. Kenneth Bakken, an attending osteopath, indicated that appellant complained of wide-spread pain, sleep disturbance, fatigue, morning stiffness, anxiety, irritable bowel and bladder, headaches, cold hand and feet, dry mouth and eyes, depression, numbness, tingling, adverse effect of heat, cold and weather changes, cognitive dysfunction, decreased short-term memory, and "recurring family symptoms." Appellant indicated that these symptoms began after she sustained an injury due to lifting and twisting at work on August 30, 1993 and became progressively worse since about November 1995. Dr. Bakken stated that on examination appellant had tenderness in the lower quadrants bilaterally and tenderness in the iliopsoas muscles upon deep palpation. Range of motion in the cervical and lumbar spines was normal although straight leg raising elicited pain in the hips and external rotation of the hips also caused hip pain. Dr. Bakken stated that appellant exhibited multiple areas of "extraordinarily tender +4/4 trigger points" including the suboccipitals, sternocleidomastoids, trapezius, infraspinalis, rhomboids, levator scapula, pectoralis major and minor, deltoids, triceps, upper and lower sacroiliacs, gluteus medius, minimus and maximus, tensor fascia lata, medial collateral knee ligaments, medial and lateral gastrocnemius, soleus, mid extensor mass, and bicipital grooves.

¹ Appellant initially indicated that her injury occurred on August 30, 1993 but she clarified that her injury was caused by performing her work duties during a two-week period around that time.

² Appellant initially worked two hours per day for five days per week and within about month began working five hours per day for five days per week. It appears that at some point in 1997 she began to perform limited-duty work for the employing establishment on a full-time basis.

³ On January 1998 the Office reissued its November 9, 1995 decision in order to preserve appellant's appeal rights. In a March 24, 2006 decision, the Office denied appellant's request for merit review of her claim.

He diagnosed fibromyalgia and chronic myofascial pain syndrome and indicated that appellant was “an obvious classic case of post-traumatic fibromyalgia.”

On April 17, 1996 Dr. Patrick J. Hogan, an attending osteopath, indicated that appellant had cervical dystonia characterized by dystonic contractions which produced tremors and retrocollis (*i.e.*, backwards) movement of her neck. He indicated that appellant also had akathisias or chorea in her legs and stated, “Although cervical dystonia due to cervical trauma is well recognized, the association with her previous spinal strain syndrome and fibromyalgia is less clear. The association would be considered possible rather than probable in this circumstance.”

On July 19, 1996 Dr. Hogan indicated that appellant reported that in August 1993 she began to have increased back pain after repetitively lifting mail packages at work over “a matter of days.” Appellant indicated that this pain progressed such that she had pain throughout her entire spine and that she later began to have “involuntary muscle activity” which produced involuntary positions of the neck. Dr. Hogan indicated that when he saw appellant on April 17, 1996 she demonstrated an irregular dystonic tremor of predominantly retrocollis nature and that palpation of her cervical spine revealed dystonic activity in the upper trapezius, latissimus and splenius capitis. He indicated that cervical dystonia disorder does arise sporadically without any apparent provocation and stated:

“However, it has been well recognized that trauma can activate a cervical dystonia disorder. It is felt that a person would have to have a predisposition toward the development of this type of disorder which is a disturbance in the circuitry in the movement control centers of the brain. The disturbed feedback from an injured spine is then felt to activate this underlying dystonic disorder. Thus, on a more probable than not basis, her trauma is related to her current condition by an underlying dystonic disorder.”

On August 2, 1996 Dr. Bakken stated that appellant’s work-related injury in August 1993 precipitated post-traumatic fibromyalgia syndrome, a nervous condition affecting the limbic, hypothalamic, neurological, immune, endocrine, and psycho-emotional systems which is characterized by areas of inflammation and spasm called tender or trigger points. He indicated that appellant could be “observed objectively” with lower extremity akathisias, cervical dystonia, weakness, multiple areas of trigger point tenderness, myofascial pain, decreased range of motion, and biomechanical dysfunction including poor movement and posture. Dr. Bakken stated:

“It is clear that she had no symptoms of fibromyalgia or the cervical dystonia as diagnosed by Dr. Patrick Hogan prior to the incident in August 1993. On a more-probable-than-not basis there is a clear correlation between the patient’s injury and the subsequent medical problems which she has experienced. These are exacerbated by on-going work. The patient has two clear post-traumatic diagnoses: (1) fibromyalgia syndrome, (2) cervical dystonia, producing dystonic tremor and retrocollis.”

In numerous reports, dated between August 1996 and July 1997, Dr. Hogan described his treatment of appellant's medical condition which included period injections of Botox in her cervical spine. He indicated that appellant continued to have symptoms of cervical dystonia as well as involuntary muscle activity in the rest of her spine and legs. Dr. Hogan generally indicated that the Botox treatments seemed to produce good results until the medication wore off.

On November 11, 1996 Dr. Bakken indicated that appellant continued to complain of tenderness in various muscles, including the upper and lower sacroiliac, gluteus medius and minimus, right quadratus lumborum, and bilateral suboccipitals, trapezius, levator scapula and rhomboids. On June 29, 1997 Dr. Karl J. May, a Board-certified surgeon who served as an Office medical adviser, stated that Dr. Bakken did not present sufficient objective findings to show that appellant had fibromyalgia syndrome and cervical dystonia.⁴

In late 1996 appellant claimed that she sustained fibromyalgia syndrome and cervical dystonia due to her accepted employment injuries which caused continuing disability, but it does not appear that she filed a formal claim for these conditions at that time.⁵

On May 23, 1997 Dr. Hogan stated that appellant reported that she was initially injured in August 1993 when she frequently lifted mailbags and boxes weighing in excess of 70 pounds for a two-week period. Appellant began to have progressive back pain which eventually involved the entire spine and months after the initial injury she began to experience involuntary extension movements and tremors of her cervical muscles. Dr. Hogan stated that appellant was diagnosed with cervical dystonia and treated with Botox injections. He indicated that appellant could perform limited-duty work with no lifting more than 30 pounds and noted, "It can be stated that on a more probable than not basis the consequence of the injuries in August 1993 did result in her chronic pain state and movement disorder."

In an August 4, 1997 decision, the Office affirmed its prior decisions. The Office found that the medical evidence appellant submitted after March 1, 1995 did not show that she had residuals of her accepted employment injuries after that date. It also found that she had not shown that she sustained employment-related fibromyalgia or cervical dystonia.⁶

On August 8, 1997 Dr. Bakken discussed medical literature regarding fibromyalgia syndrome and cervical dystonia and stated that there is a "clear and consistent correlation in the literature and medical research regarding a work-related injury and the diagnosis of post-

⁴ Dr. May indicated that the diagnosis of fibromyalgia syndrome was frequently associated with cases of secondary gain.

⁵ Appellant had filed occupational disease claims on July 10, 1996 and July 11, 1997 asserting that her fibromyalgia and cervical dystonia conditions were "triggered" by the performance of her work duties around August 30, 1993. The Office determined that these claims were actually claims for continuing disability due to her accepted employment injuries and combined the files for these claims with the present case record. Appellant filed a claim for an employment-related emotional condition but this claim was denied by the Office on April 28, 1998.

⁶ In a December 10, 1998 decision, the Board reversed the Office's termination of appellant's compensation effective March 1, 1995. In a July 24, 2000 decision, the Board found that the Office had justified its termination of appellant's compensation effective March 1, 1995.

traumatic fibromyalgia syndrome and/or cervical dystonia. He indicated that appellant did not have the symptoms described in his previous reports prior to “the injury which she reported on August 30, 1993.”

Dr. Hogan continued to produce, reports dated between August 1997 and February 2006, in which he discussed his treatment of appellant’s cervical condition.

On February 10, 2006 appellant filed a claim alleging that she sustained a recurrence of total disability for periods beginning April 17, 1996 due to her accepted employment injuries.⁷ She indicated that after she returned to limited-duty work for the employing establishment in February 1995 she experienced extreme neck and back pain, headaches, and “violent shaking and numbness in my face and arms.”⁸

On February 24, 2006 Dr. Hogan stated that appellant was being treated for a post-traumatic type of cervical dystonia which “arose associated with an industrial injury in 1993.” He indicated that appellant reported that in 1993 she engaged in repetitive turning and lifting in order to move mail and that she developed the onset of cervical pain through this process. Appellant reported that within two weeks she developed involuntary cervical extension and tremors.

In an August 2, 2006 decision, the Office denied appellant’s claim on the grounds that she did not submit sufficient medical evidence to establish that she sustained a recurrence of disability on or after April 17, 1996 due to her accepted employment injuries.

Appellant requested a hearing before an Office hearing representative. At the December 20, 2006 hearing, Dr. Hogan testified that appellant sustained a cervical subluxation/strain in at work in 1993 and that she developed cervical dystonia due to this injury. He stated that post-traumatic cervical dystonia occurs when the brain receives impulses from the injury site and then responds by sending excessive impulses back to the neck. Dr. Hogan indicated that there was “no chemical or scan test” which could show that this type of abnormal activity comes from the basal ganglia of the brain.

In a March 29, 2007 decision, the Office hearing representative affirmed the Office’s August 2, 2006 decision.⁹

LEGAL PRECEDENT

When an employee, who is disabled from the job she held when injured on account of employment-related residuals, returns to a light-duty position or the medical evidence of record

⁷ The Office had only accepted that appellant sustained employment-related cervical and lumbar subluxations around August 1993.

⁸ It appears that appellant regularly performed limited-duty work since February 2005 and only periodically stopped work for brief periods.

⁹ Appellant submitted additional evidence after the Office’s March 29, 2007 decision, but the Board cannot consider such evidence for the first time on appeal. See 20 C.F.R. § 501.2(c).

establishes that she can perform the light-duty position, the employee has the burden to establish by the weight of the reliable, probative, and substantial evidence a recurrence of total disability and show that she cannot perform such light duty. As part of this burden the employee must show a change in the nature and extent of the injury-related condition or a change in the nature and extent of the light-duty job requirements.¹⁰

ANALYSIS

The Office accepted that appellant sustained cervical and lumbar subluxations due to lifting parcels and mailbags weighing up to 70 pounds over the course of two weeks in August 1993. In February 1995 appellant returned to limited-duty work for the employing establishment on a part-time basis. The job involved sorting mail and inputting data on a keyboard and required lifting up to 35 pounds.¹¹ On February 10, 2006 appellant filed a claim alleging that she sustained a recurrence of total disability for periods beginning April 17, 1996 due to her accepted employment injuries.¹²

The Board finds that appellant did not submit sufficient medical evidence to show that she sustained a recurrence of total disability on or after April 17, 1996 due to her accepted employment injuries. In support of her claim, appellant submitted numerous reports of Dr. Bakken and Dr. Hogan, both attending osteopaths. Dr. Bakken and Dr. Hogan collectively determined that appellant had a fibromyalgia syndrome and cervical dystonia related to the employment injuries she sustained in August 1993.¹³ The reports of Dr. Bakken and Dr. Hogan, however, are of limited probative value on the relevant issue of the present case in that they did not provide adequate medical rationale in support of their conclusions on causal relationship.¹⁴

On April 4, 1996 Dr. Bakken indicated that appellant complained of experiencing numerous symptoms, including wide-spread pain, fatigue, morning stiffness, numbness, tingling, cognitive dysfunction and emotional problems. He noted that appellant indicated that these symptoms began after she sustained an injury due to lifting and twisting at work on August 30, 1993 and became progressively worse since about November 1995. Dr. Bakken stated that on examination appellant exhibited areas of “extraordinarily tender +4/4 trigger points” in numerous muscle groups throughout her body. Dr. Bakken diagnosed fibromyalgia and chronic

¹⁰ *Cynthia M. Judd*, 42 ECAB 246, 250 (1990); *Terry R. Hedman*, 38 ECAB 222, 227 (1986).

¹¹ Appellant soon began working five hours per day for five days per week. It appears that at some point in 1997 she began to perform limited-duty work on a full-time basis.

¹² Appellant regularly performed limited-duty work since February 2005 and only periodically stopped work for brief periods after April 17, 1996.

¹³ Dr. Bakken primarily treated appellant for fibromyalgia and Dr. Hogan primarily treated her for cervical dystonia.

¹⁴ See *Leon Harris Ford*, 31 ECAB 514, 518 (1980) (finding that a medical report is of limited probative value on the issue of causal relationship if it contains a conclusion regarding causal relationship which is unsupported by medical rationale).

myofascial pain syndrome and indicated that appellant was “an obvious classic case of post-traumatic fibromyalgia.”

Although Dr. Bakken suggested that appellant had fibromyalgia which was related to the employment injuries she sustained in August 1993 he did not provide adequate medical rationale supporting this conclusion. He did not describe appellant’s employment injuries or her job duties in August 1993 in any detail, nor did Dr. Bakken explain the mechanism through which appellant could have sustained fibromyalgia due to the accepted employment factors such that she experienced a recurrence of total disability on or after April 17, 1996.

On August 2, 1996 Dr. Bakken stated that appellant’s employment injury in August 1993 precipitated post-traumatic fibromyalgia syndrome and cervical dystonia and indicated that she could be “observed objectively” with various symptoms including cervical dystonia, lower extremity akathisias, weakness, multiple areas of trigger point tenderness, myofascial pain, decreased range of motion, and biomechanical dysfunction including poor movement and posture. Dr. Bakken stated that it was clear that appellant had no symptoms of fibromyalgia or cervical dystonia prior to August 1993 and noted on a more-probable-than-not basis that there is a clear correlation between appellant’s employment injury and these two conditions. On August 8, 1997 Dr. Bakken discussed medical literature regarding fibromyalgia syndrome and cervical dystonia and stated that there is a “clear and consistent correlation in the literature and medical research regarding a work-related injury and the diagnosis of post-traumatic fibromyalgia syndrome and/or cervical dystonia. He indicated that appellant did not have the symptoms described in his previous reports prior to “the injury which she reported on August 30, 1993.”

These reports would not establish that appellant had fibromyalgia or cervical dystonia related to her accepted employment injuries which caused total disability on or after April 17, 1996 because the Board has held that the fact that a condition manifests itself or worsens during a period of employment¹⁵ or that work activities produce symptoms revelatory of an underlying condition¹⁶ does not raise an inference of causal relationship between a claimed condition and employment factors. Moreover, Dr. Bakken did not provide any opinion regarding appellant’s ability to work for any period on or after April 17, 1996. Therefore, the reports of Dr. Bakken do not show that appellant sustained employment-related total disability as alleged.

On July 19, 1996 Dr. Hogan, an attending osteopath, indicated that appellant reported that in August 1993 she began to have increased back pain after repetitively lifting mail packages at work over “a matter of days.” Appellant indicated that this pain progressed such that she had pain throughout her entire spine and that she later began to have “involuntary muscle activity” which produced involuntary positions of the neck. Dr. Hogan stated that when he saw appellant on April 17, 1996 she demonstrated an irregular dystonic tremor of predominantly retrocollis nature and that palpation of her cervical spine revealed dystonic activity in the upper trapezius, latissimus and splenius capitis. He indicated that cervical dystonia disorder does arise

¹⁵ *William Nimitz, Jr.*, 30 ECAB 567, 570 (1979).

¹⁶ *Richard B. Cissel*, 32 ECAB 1910, 1917 (1981).

sporadically without any apparent provocation and stated that it had been recognized that trauma can activate a cervical dystonia disorder.¹⁷

Dr. Hogan concluded that on a more-probable-than-not basis that appellant's August 1993 "trauma" was related to her current condition of cervical dystonia. However, Dr. Hogan did not provide adequate medical rationale in support of his conclusion. He did not describe the nature of appellant's August 1993 "trauma" in any detail or explain the mechanism through which she could have sustained cervical dystonia due to the accepted employment factors such that she experienced a recurrence of total disability on or after April 17, 1996. Dr. Hogan indicated that cervical dystonia involved impulses sent between the brain and the neck but he did not provide an adequate basis, such as the results of diagnostic testing or clinical findings, to explain why this process had occurred in appellant's case.

On May 23, 1997 Dr. Hogan stated that appellant reported that she was initially injured in August 1993 when she frequently lifted mailbags and boxes weighing in excess of 70 pounds for a two-week period. He noted that appellant reported that months after the initial injury she began to experience involuntary extension movements and tremors of her cervical muscles. Dr. Hogan indicated that appellant could perform limited-duty work with no lifting more than 30 pounds and noted, "It can be stated that on a more probable than not basis the consequence of the injuries in August 1993 did result in her chronic pain state and movement disorder." The Board notes that Dr. Hogan did not provide any additional explanation of why he felt that appellant sustained cervical dystonia in August 1993 that caused a recurrence of total disability on or after April 17, 1996.¹⁸ It should be noted that this report contains the only instance that Dr. Hogan discussed appellant's ability to work and that the restriction he recommended was within the limited-duty work appellant performed on and after April 17, 1996. Therefore, the reports of Dr. Hogan do not show that appellant sustained employment-related total disability as alleged.

CONCLUSION

The Board finds that appellant did not meet her burden of proof to establish that she sustained a recurrence of total disability on or after April 17, 1996 due to her accepted employment injuries.

¹⁷ Dr. Hogan stated that a person would have to have a predisposition toward the development of cervical disorder which was a disturbance in the circuitry in the movement control centers of the brain.

¹⁸ In a February 24, 2006 report and in testimony at a December 20, 2006 hearing, Dr. Hogan provided a similar discussion of his belief that appellant sustained cervical dystonia due to her accepted employment injuries. However, he did not provide medical rationale explaining the basis for this opinion.

ORDER

IT IS HEREBY ORDERED THAT the Office of Workers' Compensation Programs' March 29, 2007 and August 2, 2006 decisions are affirmed.

Issued: February 14, 2008
Washington, DC

Alec J. Koromilas, Chief Judge
Employees' Compensation Appeals Board

David S. Gerson, Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board