United States Department of Labor
Employees' Compensation Appeals Board

L.H., Appellant	)	
and	)	**Docket No. 10-550**
	)	**Issued: December 17, 2010**
U.S. POSTAL SERVICE, POST OFFICE, Raleigh, NC, Employer	)	

Appearances:
Daniel F. Read, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On December 22, 2009 appellant filed a timely appeal from decisions of the Office of Workers' Compensation Programs dated August 17 and November 5, 2009. Under 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUES

The issues are: (1) whether the Office met its burden of proof to terminate appellant's compensation benefits; and (2) whether appellant met his burden of proof to establish that he developed an abdominal aortic aneurysm and an embolic condition in the performance of duty.

FACTUAL HISTORY

On December 30, 2006 appellant, a 55-year-old mail expeditor, was struck in the back and left leg by a heavy mail bin. He filed a claim for benefits, which the Office accepted for back contusion; abrasion or friction burn of the left leg, not including the foot, with no infection.[1]

On January 23, 2007 Dr. Joseph M. Falsone, a Board-certified family practitioner, noted that he examined appellant on January 5, 2007 and diagnosed an abdominal aortic aneurysm. He indicated that this condition was related to the December 30, 2006 work incident in which appellant was struck in the back of his lower leg.[2]

On May 21, 2007 Dr. Falsone related that appellant had begun to experience severe pain in his right leg and calf three days prior after walking one-half mile. Appellant also developed an ingrown toe nail.

In a May 21, 2007 report, Dr. Lawrence Sichel, Board-certified in internal medicine, stated that appellant had experienced pain in his right great toe due to an ingrown toe nail and had developed severe pain in his right leg after walking one-half mile. The medial edge of appellant's right great toe had turned purple. Dr. Sichel recommended that appellant do only limited walking. On May 24, 2007 he indicated that appellant had bilateral leg pain and that his legs stiffened after walking for two hours. On examination appellant was unable to squat more than two inches due to pain in his right calf and right thigh and was unable to sleep due to right leg discomfort. On May 29, 2007 Dr. Sichel noted severe pain in both calves and the right great toe, which was purple. On June 1, 2007 he reiterated his findings.

Appellant underwent an abdominal aortogram on June 12, 2008 which showed an abdominal aneurysm. He was referred to Dr. Stanley G. Crossland, a specialist in vascular surgery. In a June 12, 2007 report, Dr. Crossland advised that appellant had developed an abdominal-iliac aneurysm with emboli in both lower extremities. He performed an amputation of the right leg, below the knee, an endovascular aortoiliac repair procedure. Appellant had a known history of hypertension and noninsulin-dependent diabetes mellitus and had been diagnosed with a large infrarenal abdominal aortic aneurysm, an iliac aneurysm with a large amount of thrombus in February 2007. Dr. Crossland noted that six to eight weeks prior appellant developed symptoms of chronic embolic phenomena of the left lower extremity manifested by increasing episodes of calf pain, claudication, inability to ambulate and ischemic rest pain. He advised that appellant had progressive ischemic emboli changes in his feet, particularly on the right; he noted that appellant had undergone anticoagulant therapy. Dr. Crossland noted that appellant was recently hospitalized for ischemic, gangrenous changes of both feet and related that he initially deferred surgical intervention and had been placed on antiplatelet therapy.

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[1] Although the Office stated in its April 17, 2008 statement of accepted facts that appellant did not return to work after his injury, he submitted leave analysis sheets which indicated that he returned to work on January 3, 2007 and continued to work periodically until May 21, 2007. A Form CA-17 dated December 30, 2006 indicates that he was released to return to work on January 1, 2007.

[2] The Office noted that appellant did not file a claim for wage-loss compensation and was only receiving medical benefits for the December 20, 2006 work injury.

In a report dated August 22, 2007, Dr. Crossland performed surgery to amputate the left great toe and left fourth and fifth toes. He stated that appellant had developed gangrene in each of these toes, in addition to the lateral side of the foot, which necessitated the amputation procedure.

The Office received a January 11, 2007 computerized axial tomography (CAT) scan of his abdomen and pelvis on April 7, 2008. The test was scheduled by Dr. Falsone, who had diagnosed an abdominal aortic aneurysm six days before. A comparison was made to an abdominal CT scan performed on May 21, 2006. The test results demonstrated marked atherosclerotic disease of the aorta with eccentric plaque formation and a 3.9 centimeter abdominal aortic aneurysm which extended into the common iliac arteries.

In an April 17, 2008 addendum to the statement of accepted facts, the Office noted that appellant's aneurysms in the abdominal aorta and iliac were nonwork-related conditions.

In order to determine whether appellant's aneurysm, emboli and subsequent amputations were causally related to the December 20, 2006 work injury, and whether he still had residuals from his accepted conditions, the Office referred appellant to Dr. Joshua A. Eisenberg, a specialist in general surgery, for a second opinion examination. In a May 28, 2008 report, Dr. Eisenberg reviewed the medical history and the statement of accepted facts, stated findings on examination and opined that the accepted, work-related December 20, 2006 back contusion and left leg abrasion did not aggravate or contribute to the embolism that resulted in his June 12 and August 22, 2007 limb amputations. He advised that appellant's abdominal aortic aneurysm with thrombus was a very common finding which was unrelated to the December 20, 2006 trauma; he stated that it was very unlikely that the free floating thrombus was caused by this trauma. Dr. Eisenberg advised that a floating thrombus can be visualized even when trauma is not present, and since no previous studies were done to document whether it was present or not, it is impossible to say whether it contributed to the embolic nature of his disease. He noted that appellant had initially complained of calf pain for several months; he stated, however, that this type of microemboli had usually occurred in more distal vessels such as the toes, especially since he had no signs of occlusive disease of the vessels. Dr. Eisenberg opined that emboli to small vessels in his toes should not cause claudication symptoms or calf pain.

Dr. Eisenberg noted that appellant had an abdominal aortic aneurysm at the time of his traumatic injury; he opined, however, that this was unrelated to the traumatic injury. He stated that appellant had hypertension and diabetes, which are associated with progression of aneurysm disease, and were contributing risk factors to his aneurysm. Dr. Eisenberg indicated that it was common knowledge that thrombus forms in an aneurysm and that distal emboli can occur with aneurismal disease. He opined that all of these conditions contributed to appellant's aneurysm formation and limb loss. Dr. Eisenberg concluded that appellant's embolic phenomenon was most likely not related to the thrombus in his aneurysm.

In an October 6, 2008 report, Dr. Eisenberg advised that diagnostic tests taken shortly after the December 20, 2006 employment injury showed that appellant had an abdominal aortic aneurysm and thrombus. Although it was impossible to determine whether thrombus was related to the December 20, 2006 traumatic event, he believed that it was probably not related in light of the fact that appellant did not have significant symptoms until several months later.

Dr. Eisenberg found nothing in the medical literature indicating that traumatic events caused dislodgement of aortic thrombus, resulting in the development of embolic disease over a period of months. He opined that if appellant's subsequent symptoms were related to the December 20, 2006 traumatic work incident then this embolic event would have occurred shortly thereafter. Dr. Eisenberg reiterated that appellant's embolic disease was not related to the December 2006 traumatic event.

In a report dated October 9, 2008, received by the Office on October 16, 2008, Dr. Crossland disagreed with Dr. Eisenberg's opinion. While he agreed that appellant's abdominal aneurysm did not develop from the December 20, 2006 traumatic injury, he noted that appellant already had an abdominal aneurysm with thrombus at the time of his injury, which was at high risk for embolization. He stated that medical records dating from the time of that injury until appellant underwent revascularization and amputation indicated multiple complaints consistent with embolic phenomena and elevated muscle enzymes. The biopsy of the muscles taken at the time of appellant's June 12, 2007 amputation clearly showed a tissue infarct at an age consistent with a pattern of continued embolic phenomena from his aneurysm from the time of his original injury to the time of repair. He stated:

> "The aneurysm seen at the time of his injury should have been repaired prior to all of the embolic phenomena that occurred. The emboli that [appellant] experienced are not related to his prior underlining medical conditions. It is my opinion however that the aneurysm and his thrombus were traumatized by the injury to his back and resulted in embolic phenomena despite the use of coumadin and anticoagulation. I also disagree with Dr. Eisenberg that this lesion was appropriately surgically managed. Given the aneurysm that is documented on computerized axial tomography scan with iliac involvement and large amounts of thrombus [appellant] was at significant risk of embolization and rupture. I believe that earlier repair of this aneurysm shortly after his injury may well have precluded the loss of his limb and the resulted amputations on the contralateral side."

The Office found a conflict in medical opinion between Dr. Crossland, who opined that appellant had residuals due to an aneurysm precipitated by the December 20, 2006 work injury, and Dr. Eisenberg, who opined that appellant's accepted and left leg abrasion conditions had resolved and that appellant's embolic disease was not related to the December 20, 2006 traumatic injury. On February 24, 2009 the Office referred the case to Dr. Maurice R. Roulhac, a Board-certified general surgeon, selected as the impartial medical specialist. In a June 14, 2009 report, Dr. Roulhac reviewed the medical history and statement of accepted facts and made findings on examination. He opined that appellant's December 20, 2006 work injury did not aggravate or contribute to the embolism that resulted in limb amputation. Dr. Roulhac stated that the aneurysm of the aortoiliac segment was present prior to the injury and did not lead to immediate emboli. He advised that no medical literature supported that a blunt trauma could cause emboli immediately or, as Dr. Crossland asserted, five months later. Dr. Roulhac stated:

> "Most emboli are secondary atherosclerotic plaque and possible ulceration thereof, that leads to micro and microembolization to the proximal muscular regions of the thigh. However there is literature that supports the fact that

coumadin anticoagulation can produce hemorrhagic plaque rupture with distal embolization.... The standard treatment to minimize embolization from an [aneurysm] is antiplatelet therapy with aspirin and plavix. The patient was indeed placed on coumadin in January of 2007 with muscle pain noted in March and subsequent skin changes and lower extremity embolization noted in May. These sequence of events were completely unrelated to the initial trauma.

"More importantly atheroemboli following open and endovascular aortic aneurysm is a well known occurrence and with two episodes of intra-aortic instrumentations of angiographic evaluation and endograft placement. This directly led to rhabdomyolysis and a nonviable extremity resulting in [amputation of the right leg below the knee] and subsequent toe amputations of the left foot. These sequences of events are perioperative complications and completely unrelated to the work injury.

"It is therefore my impression that [an aneurysm] can lead to emboli regardless of trauma and in fact the literature documents that anticoagulation with coumadin as well as [aneurysm] repair can and did lead to emboli to the extremity resulting in amputation. This is therefore most consistent with a management problem rather than a sequelae from blunt trauma in a patient with an [abdominal aortic aneurysm] and mural thrombus."

On July 13, 2009 the Office issued a notice of proposed termination of compensation to appellant. It stated that the weight of the medical evidence, as represented by Dr. Roulhac's referee opinion, established that his accepted low back and left leg conditions had ceased or were no longer injury related. The Office found that appellant's aneurysm and subsequent amputations were not causally related to his December 20, 2006 work injury. It noted that the record indicated that appellant had a preexisting condition, abdominal aortic aneurysm, at the time of the December 20, 2006 work injury which did not become symptomatic until the May 2007 events in which appellant developed gangrene, discoloration and inflammation in his right calf and right toe. Based on these findings, the Office concluded that the weight of medical evidence showed that he no longer had any disability or residuals from his accepted, work-related condition.

By decision dated August 17, 2009, the Office terminated appellant's compensation, finding that Dr. Roulhac's opinion represented the weight of the medical evidence.

On August 11, 2009 appellant's attorney requested reconsideration. Counsel contended that Drs. Eisenberg and Roulhac erroneously stated that there was no medical literature supporting the theory that a traumatic blow can mobilize aortic thrombosis. He attached two articles from the Journal of Vascular Surgery purporting to describe the occurrence of such an event. Counsel noted that Dr. Crossland was the physician who actually performed the amputations and on examination of the amputated tissue was able to locate emboli that would be approximately the expected age of such tissue given the date of the accident and the onset of the acute symptoms. He therefore argued that Dr. Crossland's opinion outweighs those of Dr. Eisenberg and Dr. Roulhac.

Counsel further argued that, although appellant continued to experience pain immediately following his December 20, 2006 work injury, his physicians told him his condition was normal. He contended that this assertion is supported by several attached statements from coworkers which demonstrate that following the accident of December 2006 he remained in constant pain and was unable to work on his feet the way he did prior to the December 20, 2006 employment injury. Based on the arguments advanced above, counsel requested that the Office set aside the August 17, 2009 termination decision and accept a condition for aggravation and/or acceleration by trauma of abdominal aortic aneurysm resulting in embolic gangrene of the extremities, right worse than left, and amputation of right lower extremity and partial amputation of left foot.

Appellant submitted time analysis sheets from December 2006 through May 2007 which showed that he took increasing amounts of sick leave and time off after December 20, 2006. He also submitted a July 29, 2009 statement from Heather Bell, a coworker, a July 31, 2009 statement from Yvonne S. Young, a coworker, and an undated statement from J.D. Hooker, a coworker. These statements indicated that appellant, formerly a robust and productive employee with a good attendance record, experienced a significant deterioration in his physical condition and ability to walk following the December 20, 2006 employment injury.

By decision dated November 5, 2009, the Office denied modification of the August 17, 2009 decision.

LEGAL PRECEDENT -- ISSUE 1

Once the Office accepts a claim, it has the burden of proving that the disability has ceased or lessened in order to justify termination or modification of compensation benefits.[3] After it has determined that an employee has disability causally related to his or her federal employment, the Office may not terminate compensation without establishing that the disability has ceased or that it is no longer related to the employment.[4]

ANALYSIS -- ISSUE 1

The Board finds that the Office has failed to meet its burden to terminate compensation.

Following the December 30, 2006 work injury, the Office accepted the conditions of back contusion and abrasion or friction burn of the left leg. In its July 13, 2009 pretermination notice, it found that appellant was no longer entitled to compensation because the weight of the medical evidence, as represented by Dr. Roulhac's referee opinion, established that his accepted low back and left leg conditions had ceased or were no longer injury related. The Office further found that appellant's emboli, aneurysm and subsequent amputations were not causally related to his December 20, 2006 work injury. Based on these findings, it determined in its August 17, 2009 decision that the weight of medical evidence showed that he no longer had any disability or residuals from his accepted, work-related conditions. This finding was erroneous, however, as the Office did not present any medical evidence regarding whether appellant's accepted back and

[3] *Mohamed Yunis*, 42 ECAB 325, 334 (1991).

[4] *Id.*

left leg conditions had resolved. It had found that there was a conflict in the medical evidence regarding whether the accepted back contusion aggravated or contributed to the preexisting embolism resulting in the limb amputation. The Office never considered medical evidence pertaining to whether appellant's low back and left leg conditions, the only conditions accepted by the Office, had ceased. While Dr. Roulhac, the impartial medical specialist selected to resolve the conflict in the medical evidence, found that the gangrene, discoloration and inflammation which developed in appellant's right calf and right toe, and the emboli, abdominal aortic aneurysm, and subsequent amputations were not causally related to the accepted December 30, 2006 work injury, these conditions were never accepted by the Office. He made no mention of whether appellant's accepted low back or left leg conditions had resolved. Therefore Dr. Roulhac's referee opinion was not a sufficient basis to support the Office's finding that appellant no longer had any disability or residuals from his accepted, work-related conditions. Accordingly, the Office has failed to meet its burden to terminate compensation.

LEGAL PRECEDENT -- ISSUE 2

An employee seeking benefits under the Federal Employees' Compensation Act[5] has the burden of establishing that any specific condition for which compensation is claimed is causally related to the employment injury.[6]

The medical evidence required to establish causal relationship is usually rationalized medical evidence. Rationalized medical opinion evidence is medical evidence which includes a physician's rationalized opinion on the issue of whether there is a causal relationship between the claimant's diagnosed condition and the implicated employment factors. The opinion of the physician must be based on a complete factual and medical background of the claimant, must be one of reasonable medical certainty, and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the claimant.[7]

An award of compensation may not be based on surmise, conjecture or speculation. Neither the fact that appellant's condition became apparent during a period of employment nor the belief that her condition was caused, precipitated or aggravated by his employment is sufficient to establish causal relationship.[8] Causal relationship must be established by rationalized medical opinion evidence and appellant failed to submit such evidence.

Section 8123(a) provides that, if there is 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.[9]

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[5] 5 U.S.C. §§ 8101-8193.

[6] *Joe D. Cameron*, 41 ECAB 153 (1989); *Elaine Pendleton*, 40 ECAB 1143 (1989).

[7] *Id.*

[8] *Id.*

[9] *Regina T. Pellecchia*, 53 ECAB 155 (2001).

ANALYSIS -- ISSUE 2

The Board finds that appellant has failed to meet his burden of proof in establishing that his abdominal aortic aneurysm and emboli conditions and subsequent amputations were causally related to his accepted employment injury. The record indicates that appellant had a preexisting condition, abdominal aortic aneurysm, at the time of the December 20, 2006 work injury. Appellant subsequently developed an emboli and required amputation of the right leg below the knee and the subsequent toe amputations of the left foot. In order to resolve the conflict in the medical evidence between appellant's treating physician, Dr. Crossland, and Dr. Eisenstein, the second opinion physician, regarding whether appellant's claimed conditions were causally related to employment factors, the Office referred the case to a referee medical specialist, Dr. Roulhac, who found in his June 14, 2009 report that appellant's December 20, 2006 work injury did not aggravate or contribute to the embolism which resulted in limb amputation. Dr. Roulhac noted that appellant's aneurysm of the aortoiliac segment was present prior to the injury and did not lead to immediate emboli. He asserted that there was no medical literature supporting that a blunt trauma can cause emboli immediately or even five months later. Dr. Roulhac stated that there was literature supporting the fact that coumadin anticoagulation, which was prescribed to appellant in January 2007, can produce hemorrhagic plaque rupture with distal embolization. He advised that the atheroemboli following open and endovascular aortic aneurysm that appellant experienced is a well known occurrence; appellant had two episodes of intra-aortic instrumentations of angiographic evaluation and endograft placement. Dr. Roulhac stated that this directly led to rhabdomyolysis and a nonviable extremity resulting in the amputation of the right leg below the knee and the subsequent toe amputations of the left foot. He concluded that this sequence of events involved perioperative complications from an abdominal aortic aneurysm and mural thrombus and was completely unrelated to the trauma appellant experienced from the December 20, 2006 work injury.

The Board finds that Dr. Roulhac's referee opinion constituted medical evidence sufficient to negate a causal relationship between appellant's claimed condition and disability and employment factors. The Board has held that the mere fact that appellant's symptoms arise during a period of employment or produce symptoms revelatory of an underlying condition does not establish a causal relationship between appellant's condition and his employment factors.[10] Causal relationship is a medical question that can generally be resolved only by rationalized medical opinion evidence.[11] Dr. Roulhac thoroughly discussed the medical history documenting that appellant sustained abdominal aortic aneurysm and emboli conditions which subsequently required amputation of the right leg below the knee and toe amputations of the left foot. He found, however, that the development of these conditions occurred in a manner which was completely unrelated to the December 20, 2006 work injury. Dr. Roulhac's opinion is sufficiently probative, rationalized, and based upon a proper factual background. Therefore, the Office properly accorded Dr. Roulhac's opinion the special weight of an impartial medical

[10] *See Richard B. Cissel*, 32 ECAB 1910, 1917 (1981); *William Nimitz, Jr.*, 30 ECAB 567, 570 (1979).

[11] *See Steven S. Saleh*, 55 ECAB 169 (2003); *Robert G. Morris*, 48 ECAB 238 (1996).

examiner in finding that appellant's abdominal aortic aneurysm and emboli conditions and subsequent amputations were not related to employment factors.[12]

Following the Office's August 17, 2009 decision, appellant requested reconsideration. However, he did not submit any additional medical evidence. His attorney submitted medical literature which, he argued, supported the theory that a traumatic blow can trigger aortic thrombosis, contrary to the opinions of Drs. Eisenberg and Roulhac. Counsel contended that Dr. Crossland's opinion was entitled to greater weight because he was the physician who actually performed appellant's amputations. The Office properly rejected these arguments. Appellant's attorney is not a physician and his opinion and the medical literature he presented with his request for reconsideration contains no probative value; neither do the time analysis sheets and witness statements from coworkers. The question of whether appellant has an occupational condition causally related to employment factors is a medical one and appellant has submitted no medical evidence in support of his request for reconsideration. Counsel is merely restating one side of the conflict in medical evidence which was resolved by Dr. Roulhac's opinion; he did not provide well-reasoned and sufficiently supported opinions that would vitiate the Office's August 17, 2009 determination that appellant did not have any employment-related disability or residuals stemming from the December 2006 work injury.

CONCLUSION

The Board finds that the Office did not meet its burden of proof to terminate appellant's compensation benefits in its August 17, 2009 decision. The Board finds that appellant has not met his burden of proof to establish that he developed an abdominal aortic aneurysm and an embolic condition in the performance of duty.

[12] *Gary R. Seiber*, 46 ECAB 215 (1994).

ORDER

IT IS HEREBY ORDERED THAT the November 5 and August 17, 2009 decision of the Office of Workers' Compensation Programs is reversed in part and affirmed in part.

Issued: December 17, 2010
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board