United States Department of Labor
Employees' Compensation Appeals Board

D.T., Appellant	)	
and	)	**Docket No. 06-2009**
	)	**Issued: March 15, 2007**
DEPARTMENT OF JUSTICE, BUREAU OF PRISONS, FEDERAL CORRECTIONAL INSTITUTE, Sandstone, MN, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On August 21, 2006 appellant filed an appeal from a June 1, 2006 decision of the Office of Workers' Compensation Programs which found that his cardiac condition was not caused by his employment injury. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant met his burden of proof to establish that his cardiac condition is a consequence of his accepted herniated disc at L5-S1 and April 9, 2002 surgical procedure.

FACTUAL HISTORY

This case has previously been before the Board. By decision dated January 27, 2003, the Board affirmed Office decisions dated January 22 and May 2, 2002 which denied appellant's

request for reimbursement of travel expenses.[1] The law and the facts of the previous Board decision are incorporated herein by reference.[2]

The record reflects that, on April 9, 2002, appellant underwent surgical fusion at L4-5 and L5-S1 posteriorly. In an April 11, 2002 report, Dr. David G. Benditt, a cardiologist, noted that after the surgery appellant was found to have atrial flutter and underwent cardioversion with no complications. A hospital progress note dated April 12, 2002 advised that he did well after cardioversion. He underwent a myocardial perfusion study on April 15, 2002. In a May 23, 2002 report, Dr. Benditt advised that appellant had no additional episodes of atrial flutter and would be treated with medication for three months.

By letter dated July 1, 2005, appellant informed the Office that his atrial flutter condition had returned and requested payment for medical treatment. He submitted a June 16, 2005 stress electrocardiogram (EKG) report that demonstrated supraventricular tachycardia with secondary dyspnea. By report dated June 27, 2005, Dr. Chuen Y. Tang, Board-certified in internal medicine and cardiovascular disease, noted appellant's history of atrial flutter in 2002 and that he was asymptomatic until April 2005 when he began to have shortness of breath with exertion. Dr. Tang reviewed the results of the June 16, 2005 stress test and advised that EKG testing the day of his examination revealed atrial flutter and advised that this atypical atrial flutter occurred during physical exertion. Appellant was started on medication and scheduled for external direct cardioversion. He was to start taking propafenone three times a day, starting two days prior to the scheduled procedure. In a treatment note dated August 3, 2005, Dr. Randall A. Bostrom, Board-certified in family medicine, noted that appellant was in for an annual checkup. He reported that appellant spent the year traveling in his motor home and had developed shortness of breath over the prior two months. Dr. Bostrom diagnosed hyperlipidemia, hypertension and dyspnea on exertion and recommended further testing.

On August 22, 2005 appellant was admitted to St. Luke's Hospital in Duluth, Minnesota through the emergency room. In an admission note, Dr. Stephen T. Bernard, a Board-certified cardiologist, noted the 2002 episode of atrial flutter, recent episodes of shortness of breath, treatment by Dr. Tang, and that appellant was scheduled for cardioversion. He reported a history that, after taking four doses of propafenone, appellant became profoundly lightheaded and developed bradycardia. Dr. Bernard was taken to an emergency room in Cloquet, Minnesota where he was defibrillated and transported to the facility in Duluth. His impression

[1] Docket No. 02-1628 (issued January 27, 2003).

[2] The Office accepted that appellant, a former cook foreman, sustained an employment-related herniated disc at L5-S1. Appellant retired from the employing establishment on December 3, 1998. On April 18, 2003 he filed a schedule award claim and the Office began development.[2] Appellant submitted an April 20, 2005 impairment rating from Dr. Fozia A. Abrar, Board-certified in occupational medicine, that was reviewed by an Office medical adviser on September 12, 2005. Dr. Bryan L. Lynn, Board-certified in orthopedic surgery, provided treatment notes dated June 27 and 28, December 12, 2005 and May 8, 2006 in which he advised that he evaluated appellant for radiating low back pain. Dr. Beth A. Baker, Board-certified in occupational medicine, provided an impairment rating dated March 7, 2006. Appellant had previously received schedule awards for a 3 percent impairment of the right lower extremity and an 11 percent impairment on the left.

was profound bradycardia, likely iatrogenic[3] associated with appellant's current medications and exacerbated by dopamine; recent therapy with propafenone; and atrial flutter with significant cardiac risk factors of obesity, hypertension, dyslipidemia and diabetes. A temporary pacemaker was placed. In a consultation note dated August 23, 2005, Dr. Gene G. Karwoski, Board-certified in internal medicine, diagnosed complete heart block, possibly related to Rythmol (propafenone), paroxysmal atrial flutter, ventricular fibrillation for tachycardia and chronic back pain controlled on Neurontin. While hospitalized appellant underwent cardiac catheterization, EKG, echocardiogram and Holter monitor testing. He was discharged on August 26, 2005 with diagnoses of profound bradycardia, likely iatrogenic, history of atrial flutter, history of hypertension, obesity, dyslipidemia, diabetes, status post ventricular tachycardia associated with current medications as well as possibly exacerbated by dopamine. Appellant was discharged stable on a medication regimen and was to return for additional testing.

By letter dated August 24, 2005, the Office informed appellant that his cardiac condition was not accepted as related to his lumbar disc herniation. In a September 1, 2005 note, Bryan Austin, a certified nurse practitioner, reported appellant's recent medical history, findings on examination and medication update. On September 8, 2005 appellant underwent a myocardial infusion study and cardiac stress test. In a report dated September 16, 2005, Dr. Jake R. Powell, a Board-certified internist, noted appellant's medical history including lumbar fusion surgery in 2000 and 2002 and his recent hospitalization. EKG demonstrated normal sinus rhythm without ischemic changes. Dr. Powell diagnosed atrial flutter with recent hospitalization for bradycardia and ventricular tachycardia, likely iatrogenic, hypertension, hyperlipidemia and chronic back pain and recommended that appellant continue his current medications.

In a September 22, 2005 letter, appellant contended that his cardiac condition was a consequence of the April 2002 back surgery and the episode of atrial flutter that he had at that time. On October 5, 2005 the Office informed appellant of the medical evidence needed to establish his claim that his current cardiac condition was a consequence of the April 2002 orthopedic surgery. By decision dated December 5, 2005, the Office denied appellant's claim for compensation on the grounds that the medical evidence did not establish that his cardiac condition was caused or contributed to by his accepted back condition.

On December 27, 2005 appellant requested a hearing. In a September 20, 2005 report, Dr. Mark R. Dagostino, a Board-certified internist, noted appellant's medical history and examination findings. He diagnosed paroxysmal atrial flutter, at least three episodes, with severe bradycardia noted on Atenolol and propafenone combination, systemic hypertension, dyslipidemia, endogenous obesity, a recent favorable Myoview scan and possible sleep apnea. In a December 7, 2005 report, Dr. Benditt advised that he had treated appellant following an episode of atrial flutter which occurred in the perioperative period in 2002. He noted that this

[3] Iatrogenic is defined as "resulting from the activity of physicians." *Dorland's Illustrated Medical Dictionary*, 29th edition (2000).

was the first time appellant was known to have an arrhythmia and that cardioversion was successful. Dr. Benditt opined:

> "Atrial flutter and atrial fibrillation may occur as a consequence of surgical procedures. These occurrences may be due to electrolyte changes, catecholamine effects ('stress'), infection, or fluid volume changes. Inherent susceptibility may be a factor as well."

Dr. Benditt concluded that he had not played a role in appellant's subsequent health care and could not comment on what had happened since.

A telephone hearing was held on April 7, 2006. Appellant testified that he had no heart problems until April 2002 and then no further symptoms until he developed shortness of breath in April 2005 when he was in Mississippi. He returned to Minnesota for medical care and described the events of August 2005. The hearing representative informed appellant of the evidence needed to support his claim for a consequential injury. No medical evidence was submitted. By decision dated June 1, 2006, the Office hearing representative affirmed the December 5, 2005 decision.

LEGAL PRECEDENT

It is an accepted principle of workers' compensation law that, when the primary injury is shown to have arisen out of and in the course of employment, every natural consequence that flows from the injury is deemed to arise out of the employment, unless it is the result of an independent intervening cause.[4] Regarding the range of compensable consequences of an employment-related injury, Larson notes that, when the question is whether compensability should be extended to a subsequent injury or aggravation related in some way to the primary injury, the rules that come into play are essentially based upon the concepts of "direct and natural results" and of the claimant's own conduct as an independent intervening cause. The basic rule is that a subsequent injury, whether an aggravation of the original injury or a new and distinct injury, is compensable if it is the direct and natural result of a compensable primary injury. Thus, once the work-connected character of any condition is established, the subsequent progression of that condition remains compensable so long as the worsening is not shown to have been produced by an independent nonindustrial cause.[5]

Causal relationship is a medical issue, and the medical evidence required to establish a causal relationship is rationalized medical evidence.[6] Rationalized medical evidence is medical evidence which includes a physician's rationalized medical 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

[4] *Mary Poller*, 55 ECAB 483 (2004).

[5] A. Larson, *The Law of Workers' Compensation* § 13.11.

[6] *Jacqueline M. Nixon-Steward*, 52 ECAB 140 (2000).

supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the claimant.[7] Neither the mere fact that a disease or condition manifests itself during a period of employment nor the belief that the disease or condition was caused or aggravated by employment factors or incidents is sufficient to establish causal relationship.[8]

ANALYSIS

The medical evidence in this case establishes that in April 2002 appellant developed atrial flutter following authorized lumbar surgery. In April 2005, he developed dyspnea with exertion, and in August 2005 he had an episode of profound bradycardia requiring hospitalization. The Board, however, finds that the medical evidence does not establish that his cardiac condition was a consequence of his accepted herniated disc at L5-S1 or the April 2002 surgery. The medical evidence of record does not relate appellant's cardiac condition to his back condition, the April 2002 surgery, or any factor of his federal employment.

Appellant, who retired in 1998, reported a history that while traveling in Mississippi in April 2005 he developed shortness of breath and returned to Minnesota for medical treatment. He was seen by Dr. Tang on June 27, 2005 who reported that EKG that day revealed atypical atrial flutter that occurred during physical exertion and scheduled cardioversion. Dr. Tang advised that appellant was to begin taking propafenone two days prior to the scheduled procedure. On August 22, 2005 appellant had an episode of severe bradycardia that required defibrillation and hospitalization. In the admission note, Dr. Bernard reported a history of an episode of atrial flutter following surgery in 2002, appellant's recent episodes of shortness of breath, and that Dr. Tang had scheduled cardioversion. He advised that, after taking four doses of propafenone, appellant became profoundly lightheaded and developed bradycardia which required an emergency admission to a local hospital where he was defibrillated and then transported to the Duluth facility. Dr. Bernard diagnosed profound bradycardia, likely iatrogenic, associated with his current medications and exacerbated by dopamine, recent therapy with propafenone and atrial flutter with significant cardiac risk factors of obesity, hypertension, dyslipidemia and diabetes. By report dated August 20, 2005, Dr. Dagostino diagnosed paroxysmal atrial flutter with severe bradycardia noted on Atenolol and propafenone combination. In a September 16, 2005 treatment note, Dr. Powell diagnosed atrial flutter with recent hospitalization for bradycardia and ventricular tachycardia which, he opined, was likely iatrogenic. Dr. Benditt, who had treated appellant for his episode of atrial flutter in 2002, advised on December 7, 2005 that atrial flutter could occur as a consequence of surgical procedures due to electrolyte changes, catecholamine effects, infection, fluid volume changes or inherent susceptibility. He advised that he had not played a role in appellant's subsequent health care and could not comment on what had happened since.

None of these reports relate appellant's cardiac condition with his accepted herniated disc, the April 2002 surgery, or his federal employment. Dr. Bostrom diagnosed dyspnea on exertion but provided no opinion regarding its cause and medical evidence that does not offer

[7] *Leslie C. Moore*, 52 ECAB 132 (2000); *Gary L. Fowler*, 45 ECAB 365 (1994).

[8] *Dennis M. Mascarenas*, 49 ECAB 215 (1997).

any opinion regarding the cause of an employee's condition is of diminished probative value on the issue of causal relationship.[9] Dr. Tang advised that appellant's atypical atrial flutter was caused by exertion. Drs. Bernard, Powell and Dagostino were in agreement that appellant's bradycardic episode that required hospitalization in August 2005 was iatrogenic, probably caused by the medication he was taking. In his December 7, 2005 report, while Dr. Benditt opined that atrial flutter and atrial fibrillation could occur as a consequence of several factors including an inherent susceptibility, medical opinions that are speculative or equivocal in character have little probative value.[10]

The record does not contain an opinion by a physician,[11] supporting causal relationship that is of reasonable medical certainty and supported with rationale explaining how appellant's current cardiac condition was caused or contributed to by the accepted herniated disc at L5-S1, the April 2002 surgery, or to any other factor of his federal employment.[12]

CONCLUSION

The Board finds that appellant has not met his burden of proof to establish that his current cardiac condition is a consequence of his accepted herniated disc at L5-S1 or caused by employment factors.

[9] *Ellen Noble*, 55 ECAB 530 (2004).

[10] *Michael R. Shaffer*, 55 ECAB 386 (2004).

[11] Mr. Austin's September 1, 2005 report is not probative medical evidence as nurse practitioners are not considered physicians under the Act. 5 U.S.C. § 8101(2); *Sean O'Connell*, 56 ECAB ___ (Docket No. 04-1746, issued December 20, 2004).

[12] *See Conard Hightower*, 54 ECAB 796 (2003).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated June 1, 2006 be affirmed.

Issued: March 15, 2007
Washington, DC

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

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

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