U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

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In the Matter of VIVIAN L. HENDERSON and U.S. POSTAL SERVICE,
POST OFFICE, Carol Stream, Ill.

*Docket No. 95-2961; Submitted on the Record;*
*Issued February 4, 1998*

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DECISION and ORDER

Before DAVID S. GERSON, WILLIE T.C. THOMAS,
BRADLEY T. KNOTT

The issue is whether appellant has established that her claimed condition of Raynaud's phenomenon is causally related to factors of her federal employment.

On May 11, 1993 appellant filed an occupational disease claim alleging that she sustained Raynaud's phenomenon in the performance of duty. Appellant related that she experienced the same symptoms as occurred prior to her 1985 surgery for right carpal tunnel syndrome and 1990 surgery for left carpal tunnel syndrome.[1] Appellant stated that she continued to perform "excessive repetitive motion, lifting, pushing and pulling" in the course of her employment.

In a statement accompanying her claim, appellant related that her symptoms began in September 1992 and consisted of numbness, sweating, tingling and coldness in both hands. Appellant further described her employment duties, which consisted of repetitive motion, and her previous problems with carpal tunnel syndrome.

In a statement dated September 15, 1993, appellant attributed her condition to her job requirements of heavy lifting, pushing, pulling, bending and stooping. Appellant stated:

My condition first stated as carpal tunnel and then developed as tendinitis and eventually Raynaud's disease. I cannot pinpoint when I first noticed any symptoms although I first reported my injury in 1984. My condition has worsened which you can tell if you know anything at all about the conditions described above. Excessive movement seems to make it worse, along with cold weather. The only thing that makes my condition slightly better is to not use my hands for a

[1] The Office accepted appellant's claim for right and left carpal tunnel syndrome.

couple of weeks at time, there has been no effective treatment thus far in curing and controlling my condition."[2]

By decision dated April 15, 1994, the Office denied appellant's claim on the grounds that the evidence did not establish a causal relationship between the claimed condition and factors of her federal employment.

By letter dated April 20, 1994, appellant request a hearing before an Office hearing representative.

At the hearing, held on September 21, 1994, appellant testified that she originally included Raynaud's phenomenon as part of her carpal tunnel claim , but that the Office denied the claim.

By decision dated November 8, 1994, the Office hearing representative affirmed the Office's April 15, 1994 decision.

An employee seeking benefits under the Federal Employees' Compensation Act[3] has the burden of establishing the essential elements of his or her claim including the fact that the individual is an "employee" of the United States within the meaning of the Act, that the claim was timely filed within the applicable time limitation period of the Act, that an injury was sustained in the performance of duty as alleged and that any disability and/or specific condition for which compensation is claimed are causally related to the employment injury.[4]

Under pathology and pathophysiology, the following is noted:

> "Attacks of vasopasm of the digit arteries and arterioles may last from minutes to hours, but are rarely severe enough to cause gross loss. With long-standing Raynaud's disease, the skin of the digits may become smooth, shiny and tight with loss of subcutaneous tissue (sclerodactyly). Small painful ulcers may appear on the tips of the digits…."

Under symptoms, signs and diagnosis, the following is noted:

> "Intermittent attacks of blanching or cyanosis of the digits are precipitated by exposure to cold or by emotional upsets. Color changes may be triphasic: pallor, cyanosis, redness (reactive hyperemia); or biphasic: cyanosis, then reactive hyperemia. Rewarming the hands restores normal color and sensation. Color changes do not occur above the metacarpophalangeal joints and rarely involve the thumb. Pain is uncommon, but paresthesia are frequent during the attacks.

[2] Appellant filed a notice of recurrence of disability on November 19, 1993 causally related to her August 1, 1992 employment injury.

[3] 5 U.S.C. §§ 8101-8193.

[4] *Elaine Pendleton*, 40 ECAB 1143 (1989).

"Raynaud's disease is differentiated from secondary Raynaud's phenomenon by bilateral involvement, a history of symptoms for at least two years without progression, and no evidence of an underlying cause."

Phenomenon is defined in the Webster's New Collegiate Dictionary as follows:

1. An observable fact or event.

2. An object or aspect known through the senses rather than by thought or nonsensuous intuition.

3. A rare or significant fact or event.

It is with the foregoing description, etiology, symptoms, diagnosis and definition that the Board will evaluate the factual and medical evidence in this case to determine whether appellant has met her burden of establishing that she sustained Raynaud's phenomenon causally related to factors of her employment.

The earliest medical evidence of record is a medical report dated August 17, 1992 from Dr. Matthew Samuelson for Dr. Daniel P. Mass. Dr. Samuelson reported that appellant presented with an one month history of numbness and coolness in her finger tips of both hands. Nerve conduction velocity monofilament tests were reported as normal. Dr. Samuelson reported that as his evaluation of appellant progressed, appellant's finger tips in both hands became increasingly cool. He postulated that appellant had Raynaud's disease and that he would treat appellant with 10 mg. of Nifedipine once at night.

The record contains medical reports from Dr. James J. Curran of the Rheumatology Clinic at the University of Chicago Hospital. In his September 16, 1992 report Dr. Curran performed a thorough objective clinical examination and referred appellant for extensive lab testing. In his December 17, 1992 report Dr. Curran noted that this was a follow-up visit; that appellant had undergone carpal tunnel surgery and then tendinitis but experienced persistent numbness in the hands after surgery. He reported that there was a question of Raynaud's phenomenon symptoms in both hands. He noted that appellant was referred to Rheumatology for evaluation of connective tissue disease as a cause of her intermittent Raynaud's complaints. He reported a negative ANA, DNA, normal Cryoglobulins, TSH as 1.8, Rheumatoid factor and Smith were negative and immunoglobulins and C2 were within normal limits. Objective evaluation revealed vital signs were stable, lungs clear, cardiac examination was normal. Bone, muscle, and joint examination revealed no peripheral edema, no aclerodactyl, no periungual telangiectasias, no purpuraor peripheral arthritis or synovitis, no skin rash, petechia, purpura of fingertips, no evidence of ischemic changes and no evidence of connective tissue disease on examination. Under assessment, Dr. Curran stated, "Question Raynaud's phenomenon or coldness in the hands. No evidence of evolving connective tissue disease. At this point, there is no collagen vascular explanation for the patient's Raynaud's phenomenon.

Dr. Percy C. May submitted a report dated May 7, 1993. He reported appellant complained of numbness and tingling in the wrist and hands for several months. He stated that

the diagnosis was carpal tunnel syndrome with secondary Raynaud's phenomenon. Dr. May further states that the only preexisting condition was bilateral carpal tunnel syndrome; that the prognosis was guarded; and that there was no cure for this condition. Dr. May further stated:

> "The job description must be changed, such that the patient is exposed to a minimal vibrations in the hands. It is also critical that the hands stay warm at all times. It is clear that the job history of working on the LSM machine, flat sorter machine, and as tub pack clerk, and a letter sorter have led to these job-related condition."

Dr. May submitted a subsequent report on September 20, 1993. He again noted that appellant complained of cold hands with aching followed by burning of the hands. He reported that the diagnosis was Raynaud's phenomenon. Dr. May noted that "treatment has been Trental and Vasodilan with a partial resolution of the symptoms. The surgical treatment of the carpal tunnel (caused by prolonged keying) evolved into Raynaud's phenomena."

From a careful perusal of the total evidence of record with particular emphasis on the medical opinions enumerated herein, the Board is persuaded that appellant has established by the weight of the evidence of record that she developed Raynaud's phenomenon as a result of her carpal tunnel surgery as well as the duties required in performing her job.

First, it should be noted that appellant was initially diagnosed with this condition following her carpal tunnel surgery in 1990 by Dr. Mass and Dr. Curran of the University of Chicago hospital. Dr. Curran noted an absence of any underlying identifiable causes after administering numerous diagnostic tests to detect other potential diseases.

In this connection, appellant's condition of Raynaud's phenomenon follows the recognized characteristic of what is generally known of this condition, that is, the condition affects both of appellant's hands and has been observed directly by physicians examining appellant. Despite numerous evaluations and extensive diagnostic testing, no autoimmune disease was identified since all know tests were negative. In fact, Dr. John R. Ruder, a hand surgeon, examined appellant on February 25, 1994. His impression was appellant had multiple complaints involving both hands and upper extremities consisting primarily of intermittent numbness and tingling, cold intolerance, and a pain over the dorsoradial aspect of the right wrist. He further stated that appellant's history was consistent with possible Raynaud's syndrome and recommended the wearing of gloves when she is working in a cool environment. He also stated that he did not see the need for additional diagnostic studies.

Dr. May related the Raynaud's phenomenon directly to appellant's carpal tunnel syndrome and her job duties such as prolonged keying on the LSM machine. The Office hearing representative rejected Dr. May's opinion citing "he provided no rationale explaining in medical terms how the surgery for carpal tunnel syndrome had caused or contributed to the claimant's Raynaud's phenomenon." This presumes for this diagnosed condition that there is medical consensus and recognized accepted medical explanation for this readily observed medical condition reported in medical books and journals. Based on the medical evidence and medical notes included in this record, there is no such rationalized explanation for the phenomenon.

Accordingly, the Board concludes that appellant had proven by the weight of the evidence that she has sustained the condition diagnosed as Raynaud's phenomenon causally related to her carpal tunnel surgery which has been accepted by the Office as directly related to her employment as well as subsequent job duties causally related to her employment.[5] There is no contrary evidence.

The decisions of the Office of Workers' Compensation Programs dated November 8 and April 15, 1994 are hereby reversed and the case is remanded for a determination of any period or periods of wage lost due to this condition and payment of appropriate medical benefits.

Dated, Washington, D.C.
January 28, 1998

Willie T.C. Thomas
Alternate Member

Bradley T. Knott
Alternate Member

Gerson, member, dissenting:

The majority "is persuaded that appellant has established by the weight of the evidence of record that she developed Raynaud's phenomenon as a result of her carpal tunnel surgery as well as the duties required in performing her job. They go on to acknowledge that Dr. Curran "noted an absence of any underlying identifiable causes … to detect other potential diseases." Dr. Ruder speculated that appellant's history was consistent with possible Raynaud's syndrome and her job duties but, as found by the hearing representative, "he provided no rationale explaining in medical terms how the surgery for carpal tunnel syndrome had caused or contributed to the claimant's Raynaud's phenomenon." The majority then faults the hearing representative's finding as it "presumes … a medical consensus and recognized accepted medical explanation for this readily observed medical condition" whereas the majority concludes, "[T]here is no such rationalized explanation for this phenomenon." With no further discussion or explanation, the majority simply concludes that appellant has proven by the weight of the evidence that she has

[5] It is not necessary that the medical opinion be so conclusive as to suggest a causal connection beyond all reasonable doubt. The evidence required is only that necessary to convince the adjudicator that the conclusion drawn is rational, sound and logical. *Kenneth J. Deerman*, 34 ECAB 641, 645 (1983) and cases cited therein at note 1.

sustained the Raynaud's phenomenon causally related to her carpal tunnel surgery and her job duties.

I cannot agree with the position of the majority as I cannot determine whether it is attempting to make a legal determination on causation or a medical determination which should be based on the evidence of record. As pointed out by the majority, appellant has the burden of establishing that any disability or specific condition for which compensation is claimed is causally related to the employment injury. Appellant clearly has not done that here. There is no rationalized medical evidence in the record connecting the claimed condition to the employment. The majority nevertheless appears to be somehow finding that appellant has met her burden of proof "by the weight of the evidence."

I would weigh the evidence as presented by the majority and restated above. I can conclude only that appellant has not met her burden of proof and I would affirm the November 8, 1994 decision of the Office.