U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of GLORIA D'ELETTO, claiming as widow of VINCENT D'ELETTO and U.S. POSTAL SERVICE, POST OFFICE, East Northport, N.Y.

Docket No. 97-1349; Submitted on the Record;
Issued April 5, 1999

DECISION and ORDER

Before MICHAEL J. WALSH, GEORGE E. RIVERS,
WILLIE T.C. THOMAS

The issue is whether the employee's death on December 29, 1993 was causally related to his accepted myocardial infarction on February 3, 1977.

The Office of Workers' Compensation Programs accepted that the employee's February 3, 1977 myocardial infarction occurred in the performance of duty, and paid him compensation for total disability from February 3, 1977 until his death on December 29, 1993. On February 10, 1994 appellant, the employee's widow, filed a claim for death benefits.

The Office determined that there was a conflict of medical opinion between the employee's attending physician, Dr. Gerald L. Eastman, a Board-certified internist, and an Office medical adviser, Dr. Lawrence Geeslin, a Board-certified internist, on the question of whether the employee's death on December 29, 1993 was causally related to his accepted February 3, 1977 myocardial infarction. To resolve this conflict of medical opinion, the Office referred the case record and a statement of accepted facts to Dr. Paul W. Farrell, a Board-certified cardiologist. In a report dated October 4, 1994, Dr. Farrell, after reviewing the prior medical evidence, concluded:

> "It certainly would not be surprising that a gentleman with his known risk factors and coronary anatomy would have progression of disease over 16 years. I think this would be the expected sequence of events that there would be worsening of the arteriosclerosis over that period of time. With that in mind and my opinion that something must have provoked this rather abrupt change in his symptoms for the few days preceding his terminal event, I think that the underlying damage to his heart from 1977 was not what provoked his demise. I think it is likely that his underlying condition of arteriosclerosis progressed, leading to increasing ischemia and further decompensation of his left ventricle. I think the underlying problems from 1977 certainly do present a substrate for which further compromise in his cardiac status would have grave consequences. *** I do not

think the damage caused in February 1977 was a direct relation to his demise in December 1993. I think that the compromise from the MI [myocardial infarction] in 1977 certainly was a problem, but it appeared to have been stable over that interval and then something acutely happened for the two to three days preceding his demise, leading to his demise. I think he must have had progressive arteriosclerosis leading to increasing ischemia and further left ventricular dysfunction and perhaps an acute myocardial infarction."

By decision dated January 6, 1995, the Office found that the employee's death on December 29, 1993 was not caused or materially hastened by his accepted injury. Appellant requested a hearing, which was held before an Office hearing representative on September 5, 1995. At this hearing she submitted a report dated July 11, 1995 from Dr. Richard S. Joseph, a Board-certified cardiologist, who stated:

"While it is certainly true that the terminal episode was accompanied by arrhythmia as a final link in the chain of circumstances, this would be totally expected. However, it is most important to realize that this patient suffered from a severe cardiac insult in 1977, lost a great deal of muscle tissue and, from what we now understand to be associated with congestive heart failure, experienced an expanding heart muscle and evidence of calcification on x-ray which may have been pericardial or represented a rim of calcium around a ventricular aneurysm. These are now known to cause a progressive sequence of events lasting many years and culminating in congestive heart failure which may terminate with cardiac arrhythmia or progressive heart failure.…

"While the initial event in 1977 was separate by a considerable interval of years, it is quite apparent to this reviewer that the greater part of the iceberg was the initial insult and the tip of the iceberg was the subsequent underlying coronary artery disease and progressive myocardial pump dysfunction. It is therefore quite evident to me that the patient's initial myocardial infarction was the precipitation and direct causality for his subsequent demise in 1993."

By decision dated November 13, 1995, an Office hearing representative found that the opinion of Dr. Farrell represented the weight of the medical evidence, and that Dr. Joseph's report was not sufficient to overcome Dr. Farrell's report or to create a new conflict of medical opinion, as Dr. Joseph's statements on causal relation were "actually unclear and unsupported by any description of the pathophysiological mechanism by which this occurred."

Appellant requested reconsideration and submitted a report from Dr. Joseph dated January 24, 1996. Dr. Joseph provided a detailed description of the pathophysiological mechanism of congestive heart failure following myocardial infarction. Dr. Joseph summarized:

"In summary, [the employee] suffered an extensive myocardial infarction as objectively demonstrated by widespread electrocardiographic Q-waves, myocardial calcification and cardiac enlargement by x-ray. Congestive heart failure ensued as a result of expansion, myocardial thinning, myocardial calcification, maladaptive remodeling mechanisms and inevitably progressive

> myocardial dysfunction and reduced output. Death ensued as a result of the natural course of these sequential events, as noted by the 50 percent mortality rate in five years, with most patients succumbing over ten years to either progressive heart failure or sudden ventricular arrhythmia."

The Office determined that this report created a new conflict of medical opinion, and referred the case record and a statement of accepted facts to Dr. C. Richard Conti, a Board-certified cardiologist, to resolve this conflict. In a report dated April 10, 1996, Dr. Conti stated:

> "I do believe that the acute myocardial infarction was related to his eventual death because the patient obviously had coronary artery disease. Coronary artery disease is a progressive process which often results in recurrent myocardial infarction, arrhythmias resulting in sudden cardiac death, recurrent angina pectoris, or eventual heart failure and its complications such as arrhythmias, etc. However, let it be noted that patients with severe heart failure as a result of a myocardial infarction rarely live more than five years. Even under the best of circumstances the heart failure mortality in someone who is a Class III or IV heart failure is 50 percent in three years. Thus I doubt that he was in serious heart failure after his myocardial infarction in 1977. Thus I would reason that the heart attack in 1977 although not trivial was not one associated with cardiogenic shock and severe heart failure in the immediate post infarction state or even 6 months later."
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> "In summary I do not believe that the patient's initial injury had anything to do with his death."

By letter dated May 9, 1996, the Office requested that Dr. Conti clarify his opinion, particularly to reconcile his statement that he believed the acute myocardial infarction was related to the employee's death with his other statements that indicated there was no causal relationship. Dr. Conti declined to respond, and the Office then referred the case record and a statement of accepted facts to Dr. Lawrence J. Kanter, a Board-certified cardiologist, to resolve the conflict of medical opinion. In a report dated September 24, 1996, Dr. Kanter, after reviewing the prior medical evidence, concluded:

> "This man suffered a myocardial infarction in February 1977. One can only speculate about the extent of permanent heart damage caused by this 1977 myocardial infarction. No quantitative data is given. Specifically, the amount of enzymatic rise, an echocardiogram, cardiac catheterization or nuclear study could have given quantitative information but were not performed. Presumably anterior wall myocardial infarctions produce at least a moderate amount of damage. It is stated though that this man was able to tolerate 160 mg [milligrams] of Inderal a day, suggesting that his heart was quite well compensated. Given the fact that he had well-compensated heart disease from his 1977 myocardial infarction, one cannot claim that his well-compensated heart and moderate-sized infarction caused his death in 1993. It is the claimant's other noncompensable heart

problems, specifically the arteriosclerotic heart disease that caused recurrent myocardial ischemia and either further loss of power function or a significant arrhythmia, which produced his death. The claimant was amazingly stable for almost 17 years. He did suffer from angina pectoris which is an ischemic condition, due predominantly to arteriosclerotic heart disease, specifically obstructive coronary artery disease. One would be hard pressed to claim that the degree of his myocardial damage from the 1977 myocardial infarction was the cause of his angina pectoris. He had compensated heart disease, was clinically quite stable and had chronic myocardial ischemia due to his arteriosclerotic heart disease. It was the arteriosclerotic heart disease that caused his demise on December 29, 1993."

By decision dated October 23, 1996, the Office refused to modify its prior decisions denying appellant's claim, finding that Dr. Kanter's report represented the weight of the medical evidence.

The Board finds that the weight of the medical evidence establishes that the employee's death on December 29, 1993 was not causally related to his accepted myocardial infarction on February 3, 1977.

In situations where there are opposing medical reports of virtually equal weight and rationale, and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual background, must be given special weight.[1]

In the present case, after the Office resolved the initial conflict of medical opinion with the opinion of Dr. Farrell that damage from the employee's 1977 myocardial infarction did not cause his death, appellant created a second conflict of medical opinion with the submission of reports from Dr. Joseph, who, like Dr. Farrell, is a Board-certified cardiologist. To resolve this conflict of medical opinion, the Office referred the case record to Dr. Conti, a Board-certified cardiologist, but Dr. Conti declined to reconcile seemingly contradictory statements in his report. The Office therefore properly referred the case record to a second impartial medical specialist to resolve the conflict of medical opinion.[2] The report of this specialist, Dr. Kanter, a Board-certified cardiologist, was based on an accurate history and contained rationale for the doctor's conclusion that the employee's accepted myocardial infarction on February 3, 1977 was not causally related to his death on December 29, 1993. This report constitutes the weight of the medical evidence. The fact that the employee was receiving compensation at the time of his

[1] *James P. Roberts*, 31 ECAB 1010 (1980).

[2] The Board has held that when the opinion of an impartial specialist requires clarification or elaboration, the Office has the responsibility to secure a supplemental report from the specialist for the purpose of correcting the defect in the original report. The Board has further held that when the impartial specialist's statement of clarification or elaboration is not forthcoming to the Office, the Office must submit the case record and a statement of accepted facts to a second impartial specialist for a rationalized medical opinion on the issue in question. *Harold Travis*, 30 ECAB 1071 (1979).

death does not establish that his death was causally related to conditions resulting from the employment.[3]

The decision of the Office of Workers' Compensation Programs dated October 23, 1996 is affirmed.

Dated, Washington, D.C.
April 5, 1999

Michael J. Walsh
Chairman

George E. Rivers
Member

Willie T.C. Thomas
Alternate Member

[3] *Leonora A. Buco (Guido Buco),* 36 ECAB 588 (1985).