U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of JOHN W. CRESSWELL and GENERAL SERVICES ADMINISTRATION, PERSONNEL DIVISION, Fort Worth, TX

Docket No. 98-282; Submitted on the Record;
Issued September 17, 1999

DECISION and ORDER

Before DAVID S. GERSON, WILLIE T.C. THOMAS,
MICHAEL E. GROOM

The issue is whether the medical conditions for which appellant sought treatment on or after November 24, 1995 are causally related to his accepted employment injury of April 19, 1995.

On April 19, 1995 appellant, a maintenance mechanic, sustained an emotional condition while in the performance of his duty when the Alfred P. Murrah Federal Building in Oklahoma City, Oklahoma, was bombed. His attending psychologist diagnosed post-traumatic stress disorder and depression and related these conditions to the bombing. The Office of Workers' Compensation Programs accepted his claim for an unspecified emotional reaction.

Appellant was hospitalized on November 25, 1995 and discharged on November 30, 1995 with a diagnosis of Buerger's disease, possible tuberculosis and fever of unknown origin most likely secondary to possible tuberculosis.

On February 12, 1996 Dr. Thomas L. Whitsett, Professor of Medicine and Pharmacology and Director of the Vascular Medicine Program at The University of Oklahoma Health Sciences Center, reported that appellant had an occlusive arterial disease involving his hands and to some degree his feet that was consistent with Buerger's disease. Dr. Whitsett continued as follows:

> "This a form of inflammatory vasculitis that is related to smoking. [Appellant] was a nonsmoker at the time of the bombing incident, but with the stress and mental problems that followed, he resumed a heavy smoking habit. His symptoms of vasculitis and Buerger's disease clearly had its onset during this time of resumed smoking. I feel confident that if he had remained a nonsmoker this would have never occurred.
>
> "There is also a suspicion that the respiratory and febrile aspects of his illness that are associated with a positive tuberculin skin test could represent an underlying

> form of tuberculosis. While we were not able to culture a tuberculosis organism, the clinical findings and the skin test strongly suggested this disease. It was for that reason our infectious disease experts felt he should receive treatment for tuberculosis. While it is difficult to precisely say that the mental stress he experienced as a result of the bombing caused the tuberculous problem, we do know that under times of great distress people have lowered immune mechanisms, and an underlying dormant tuberculosis organism would have an opportunity to emerge as a clinical infection."[1]

On February 26, 1996 Dr. Morris Reichlin, Professor of Medicine and Chief of the Immunology Section of The University of Oklahoma Health Sciences Center, reported that appellant had occlusive arterial disease at the wrists, believed to be due to thromboangiitis obliterans or Buerger's disease. Dr. Reichlin stated that this occlusive arterial disease was of unknown etiology but was known to be greatly exacerbated by smoking. "[Appellant] is a heavy smoker who has quit smoking," he reported. "Because of the severity of his disease and what we know about the natural history of any kind of occlusive arterial disease of this type, it is very likely that he [ha]s had this for many years. However, we cannot be sure of that."

Dr. Reichlin also reported that appellant had a skin disease on the wrists that proved to be granuloma annulare, an erythematous macular eruption of unknown etiology. "Whether it is caused by the blast or not is unknown," Dr. Reichlin stated.

On the nature of appellant's tuberculous condition, Dr. Reichlin reported as follows:

> "[Appellant] also has a positive skin test for tuberculosis and although his chest x-ray has been stable for the past five years and we did not find organisms in his bone marrow, he is nonetheless being treated for tuberculosis because that could be causing his fever. He has never been treated for this disease. The etiology of tuberculosis which is an infectious disease is the organism mycobacterium tuberculosis. Thus, while the bombing may have compromised his emotional and psychological status, it could not have caused his positive skin test, which is due to an infection."

To seek clarification of the complex medical issue, the Office referred a copy of the medical record and a statement of accepted facts to Dr. Darrell E. Thigpen, a specialist in internal and rehabilitation medicine, for a second opinion. In a report dated April 3, 1996, Dr. Thigpen noted the following pertinent facts: Appellant initially had no subjective complaints and lost no time from gainful employment. He was followed by a psychologist for an emotional reaction. In early September 1995 he sustained a fall that resulted in a chest contusion/hematoma that subsequently developed into pneumonia. According to records, Dr. Thigpen stated, "[appellant] was treated with antibiotics and a steroid dose pa[c]k without resolution of [his] symptomatology." In late November 1995 he was admitted to the hospital and was extensively evaluated because of night sweats, fever, the development of splinter

[1] The Office subsequently found that appellant was entitled to payment for medical expenses for the therapy prescribed following the positive tuberculin skin test, although the diagnosis of tuberculosis was not established.

hemorrhages and coldness of the fingers. Appellant was discharged with a diagnosis of possible tuberculosis and Buerger's disease.

Before addressing specific questions posed by the Office, Dr. Thigpen explained that thromboangiitis obliterans or Buerger's disease is a distinct clinical and pathologic entity that is a progressive, often relentless and devastating vasculitis, characterized by segmental inflammatory and proliferative lesions of the tunica media of small arteries and veins. It is a relatively uncommon cause of occlusive peripheral vascular disease frequently seen in men who have a history of heavy cigarette smoking.

Turning to the Office's questions, Dr. Thigpen reported that the diagnosis of Buerger's disease was not established, that a presumptive clinical diagnosis only had been established. He stated that to confirm the diagnosis one would have to have characteristic clinical, angiographic and histopathologic features that would allow a specific diagnosis and that would differentiate it from premature atherosclerosis, vasculitis or other mechanism of distal and microcirculatory deficits. Dr. Thigpen opined that there was no causal relationship between the diagnosis and the bombing, that the alleged association between appellant's increased tobacco usage and post-traumatic stress syndrome had no clinical basis for his presumptive Buerger's disease. First, he explained, appellant had never been diagnosed with Buerger's disease or any other occlusive vasculitis. Second, appellant had a well-documented four- to five-pack-a-day cigarette usage for 25 years with no documented smoking cessation in his medical records or history.

Dr. Thigpen noted that appellant had no confirmatory biopsy for granuloma annulae, a usually benign self-limiting skin rash of unknown etiology. There was no causal relationship to the bombing, he stated, because the causes and pathogens of granular annular are unknown but are suspected to be autoimmune related.

Finally, Dr. Thigpen reported that the diagnosis of tuberculosis was not established.[2] The clinical history, diagnostic studies and physical examination did not confirm the disease. Appellant, he explained, was treated because of his atypical clinical findings; in view of his positive skin test and fibrotic changes on chest x-ray, empiric treatment was warranted, which Dr. Thigpen described as "standard accepted medical care."

In a decision dated May 7, 1996, the Office denied appellant's claim for tuberculosis and Buerger's disease.

Appellant requested an oral hearing before an Office hearing representative. He submitted a February 15, 1996 report from Dr. Ronald A. Greenfield, Professor of Medicine and Chief of the Infectious Diseases Section of The University of Oklahoma Health Services Center. He reported that it was his professional opinion that the post-traumatic stress related to the events of April 19, 1995 might well have contributed to appellant's current illness. "To my knowledge," he stated, "there is no way to definitively confirm or refute this possibility, but the possibility certainly exists."

[2] Dr. Thigpen noted, however, that the presence of an employee with active tuberculosis during rescue efforts was already accepted, the issue being whether the diagnosis was present in appellant's case.

In a March 8, 1996 report, Dr. James D. Dixson noted that appellant was in excellent health until he was involved in the bombing of the federal building in Oklahoma City on April 19, 1995. Since that time, he stated, appellant had multiple medical problems with the development of Raynaud's phenomenon, diffuse arthralgias, possible tuberculosis, hypertension and general malaise, for which conditions appellant had seen a multitude of physicians. "It is my opinion," Dr. Dixson reported, "that these problems are related to this traumatic incident."

On August 7, 1996 Dr. Greenfield indicated that he had reviewed the Office's decision and observed that an important point not considered, as regards to the diagnosis of tuberculosis, was appellant's response to therapy. Although he stated that it was technically correct that the clinical history, diagnostic studies and physical examination did not confirm active tuberculosis, this ignored the fact that appellant had a positive tuberculin skin test, which was felt to be an indication for anti-tuberculous treatment and that appellant promptly and convincingly responded to the anti-tuberculous therapy. Dr. Greenfield stated: "I believe that observation substantively increases the likelihood that [appellant] had active tuberculosis that we were unable to noninvasively convincingly demonstrate."

Appellant also submitted a statement from Kathy Brady, who acknowledged that she was aware that appellant had quit smoking in October 1994 and was aware that he started to smoke again on April 19, 1995.

After the oral hearing, which was held on June 17, 1997, the Office issued a decision on September 2, 1997 affirming the denial of appellant's claim for the medical conditions for which he sought treatment on and after November 24, 1995.

The Board finds that the evidence of record fails to establish that the medical conditions for which appellant sought treatment on or after November 24, 1995 are causally related to his accepted employment injury of April 19, 1995.

A claimant seeking benefits under the Federal Employees' Compensation Act[3] has the burden of proof to establish the essential elements of his claim by the weight of the evidence,[4] including that he sustained an injury in the performance of duty and that any specific condition or disability for work for which he claims compensation is causally related to that employment injury.[5]

The Office accepted that appellant sustained an unspecified emotional reaction while in the performance of his duties on April 19, 1995. He must therefore establish that the medical conditions for which he sought treatment on or after November 24, 1995 are causally related to that employment injury.

[3] 5 U.S.C. §§ 8101-8193.

[4] *Nathaniel Milton*, 37 ECAB 712 (1986); *Joseph M. Whelan*, 20 ECAB 55 (1968) and cases cited therein.

[5] *Elaine Pendleton*, 40 ECAB 1143, 1145 (1989).

The evidence generally required to establish causal relationship is rationalized medical opinion evidence. The claimant must submit a rationalized medical opinion that supports a causal connection between his current condition and the employment injury. The medical opinion must be based on a complete factual and medical background with an accurate history of the claimant's employment injury and must explain from a medical perspective how the current condition is related to the injury.[6]

To support his claim, appellant submitted medical opinion evidence from Dr. Whitsett, Dr. Reichlin, Dr. Greenfield and Dr. Dixson. Although this evidence to various degrees tends to support that appellant's Buerger's disease and possible tuberculosis were causally related to his resumption of heavy smoking following the bombing incident of April 19, 1995, the Board finds that the evidence is speculative in nature and is of diminished probative value in establishing a causal relationship between the bombing incident and appellant's diagnosed conditions. Although the medical opinion of a physician supporting causal relationship does not have to reduce the cause or etiology of a disease or condition to an absolute medical certainty, neither can such an opinion be speculative or equivocal.[7] The Board finds that the weight of the medical opinion evidence rests with the Office referral physician, Dr. Thigpen, who explained that the diagnoses of Buerger's disease and tuberculosis were not established in the present case and who noted that the alleged association between appellant's increased tobacco usage and post-traumatic stress syndrome had no clinical basis for his presumptive Buerger's disease.

As the weight of the medical evidence fails to establish that the medical conditions for which appellant sought treatment on or after November 24, 1995 are causally related to his accepted employment injury of April 19, 1995, the Board finds that appellant failed to discharge his burden of proof.

[6] *John A. Ceresoli, Sr.*, 40 ECAB 305 (1988).

[7] *Philip J. Deroo*, 39 ECAB 1294 (1988).

The September 2, 1997 decision of the Office of Workers' Compensation Programs is affirmed.

Dated, Washington, D.C.
September 17, 1999

David S. Gerson
Member

Willie T.C. Thomas
Alternate Member

Michael E. Groom
Alternate Member