U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of ELEANOR J. MATSEN, claiming as widow of EDWARD MATSEN and DEPARTMENT OF DEFENSE, SECRETARY OF DEFENSE, Washington, DC

Docket No. 98-665; Submitted on the Record;
Issued January 13, 2000

DECISION and ORDER

Before DAVID S. GERSON, WILLIE T.C. THOMAS,
A. PETER KANJORSKI

The issue is whether appellant met her burden of proof in establishing that the employee's death on February 10, 1996 was causally related to the July 1, 1945 employment injury.

The Board has duly reviewed the record and finds that appellant has not established that the employee's death was causally related to his federal employment.

The Office of Workers' Compensation Programs accepted the employee's claim for malaria, beri beri, malnutrition, arthritis, pellagra and scurvy resulting from his July 1, 1945 employment injury when, as an engineer serving with the armed forces on Bataan and Corrigidor, he was held by the Japanese as a prisoner of war from 1942 to 1945. The employee's death certificate stated that the employee's immediate cause of death on February 10, 1996 was "natural causes" but that he also died due to atherosclerotic cardiovascular disease (ASCVD) and Alzheimer's type dementia. The employee was 94 years old when he died. On March 4, 1996 appellant, the employee's widow, filed for death benefits, alleging that appellant's medical condition, particularly his beri beri, caused his ASCVD which caused his death.

A chest x-ray performed on November 14, 1980 stated that as compared to a previous study dated September 15, 1978, there was little change. The report stated that appellant had some prominence of the right hilum but it did not appear to have changed since 1978 and otherwise appellant's chest was normal. During appellant's hospitalization in 1980, the diagnoses of Dr. Howard M. Harris, a Board-certified internist, included hypertensive reactor.

In a report dated June 28, 1986, Dr. Howard M. Harris stated that during appellant's hospitalization in 1986, he performed an electrocardiogram (EKG), which showed "PVC"s [premature ventricular contraction] and "PAC"s [premature atrial contraction] and episodes of supraventricular tachycardia. He stated that appellant had a history of orthostatic hypotension.

In his report dated January 24, 1992, Dr. Douglas G. Henricks, a Board-certified internist, considered appellant's history of injury, performed a physical examination and diagnosed, *inter alia*, atrial fibrillation. He stated that "cardiac problems have been present, although [he] did not know the exact type." He noted that appellant had an episode of weakness in the right hand in September 1991 which was called a small stroke. In his May 21, 1992 report, Dr. Henricks stated that appellant complained of chest pain and took a nitroglycerin. In his October 27, 1992 report, Dr. Henricks stated that appellant's heart condition "seemed to be stable." He stated that appellant denied any shortness of breath or chest pain. Dr. Henricks diagnoses included aortic valve disease with aortic insufficiency, left ventricular dysfunction and systolic hypertension. He stated that appellant's chest pain was probably noncardiac. In his July 24, 1992 report, he stated that appellant did not seem to have any significant cardiorespiratory problems. He stated that appellant denied shortness of breath or any chest pain which sounded anginal. Dr. Henricks stated that the symptoms the employee described sounded very atypical for angina as it was short and sharp, and moved around to different parts of the chest. His diagnoses included peripheral neuropathy and aortic insufficiency with "LV" dysfunction.

In the attending physician's report dated March 4, 1996 which was attached to appellant's claim, Dr. Henricks stated that the employee's immediate cause of death was atherosclerotic heart disease and that "beri beri causes atherosclerotic heart disease."

In a report dated April 2, 1996, the district medical adviser, referring to the death certificate, stated that no work-related conditions contributed to appellant's death. He stated that appellant's cardiac changes such as fibrillation in 1992 and aortic valve disease with aortic insufficiency were not accepted conditions and are a degenerative condition. The district medical adviser stated that appellant had some "TIA" episodes in 1990 and 1991 "but this probably related to generalized and cerebral or carotid atherosclerosis." He stated that there was no specific evidence in the report relating them "to the final death certificate ASCVD." The district medical adviser recommended that the case be reviewed.

In a report dated August 2, 1996, the referral physician, Dr. Lawrence J. Kanter, a Board-certified internist with a specialty in cardiovascular disease, considered appellant's history of injury and medical history, and stated that appellant's injuries were "predominantly related to arthritis." He stated that there was no evidence to support atherosclerotic heart disease as stated on the death certificate. Dr. Kanter stated:

> "There is little documentation that [appellant] suffered significant cardiac problems. At no time is there any mention of ASCVD. The only time this is mentioned is on his death certificate. He had systolic hypertension and aortic regurgitation. Neither problem supports a diagnosis of ASCVD. There is no history of a myocardial infarction. There is no history of angina pectoris. He never had an evaluation of coronary blood flow or even documentation of left ventricular asynergy. According to the records, he lived to a ripe old age.
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> "... There was no documentation of any coronary obstruction, or even a problem with cardiac function. He had aortic insufficiency and systolic hypertension,

neither of which supports a diagnosis of atherosclerotic heart disease. It is unclear as to the cause of his death."

By decision dated July 9, 1997, the Office denied appellant's claim, stating that the evidence of record failed to establish that the employee's death was related to the accepted conditions.

By letter dated July 30, 1997, appellant requested reconsideration of the decision. In her request, she stated that "over the years" the employee complained of pain in his chest, that he took nitroglycerin tablets to ease the pain, that she found two bottles of nitroglycerin tablets "among his things," and he always carried a small bottle of nitroglycerin with him. Appellant also submitted news articles stating that "wet beri beri" or beri beri heart disease, involved the cardiovascular system and medical reports and correspondence which had previously been submitted. Additionally, appellant submitted a bulletin addressing federal regulations which compensate former prisoners of war who become afflicted with beri beri heart disease.

By decision dated October 7, 1997, the Office denied appellant's request for modification.

Appellant has the burden of proving by the weight of the reliable, probative and substantial evidence that the employee's death was causally related to his employment. This burden includes the necessity of furnishing medical opinion evidence of a cause and effect relationship based on a proper factual and medical background.[1] The medical evidence required to establish causal relationship is rationalized medical opinion evidence explaining how the accepted employment-related condition caused or contributed to the employee's death.[2] The mere showing that an employee was receiving compensation at the time of death does not establish that the employee's death was causally related to his employment.[3]

In the present case, the medical opinion of the referral physician, Dr. Kanter, dated August 2, 1996, which is corroborated by the district medical adviser's opinion dated April 2, 1996, constitutes the weight of the evidence and establishes that the employee's death on February 10, 1996 was not work related. The employee's death certificate stated that his immediate cause of death was "natural causes" but the employee also died due to ASCVD and Alzheimer's type dementia. In his August 2, 1996 report, Dr. Kanter found that appellant's medical history predominantly related to arthritis. He stated that there was little documentation that the employee suffered significant cardiac problems. Dr. Kanter stated that the only time ASCVD was mentioned was on the death certificate. He stated that the employee had systolic hypertension and aortic regurgitation but these conditions did not support a diagnosis of ASCVD. Dr. Kanter found there was no history of a myocardial infarction and of angina pectoris, no documentation of left ventricular asynergy, coronary obstruction or a problem of

[1] *Gertrude T. Zakrajsek*, 47 ECAB 770, 773 (1996); *Carolyn P. Spiewak (Paul Spiewak)*, 40 ECAB 552 (1989); *Mary M. DeFalco (Gordon S. DeFalco)*, 30 ECAB 514 (1979).

[2] *Gertrude J. Zakrajsek , supra* note 1; *Edna M. Davis (Kenneth L. Davis)*, 42 ECAB 728, 733 (1991).

[3] *Elinor Bacorn (David Bacorn)*, 46 ECAB 857, 860-61 (1995).

cardiac function and there was no evaluation of coronary blood flow. He concluded that the employee's cause of death was unclear.

In his April 2, 1996 report, the district medical adviser stated that no work-related conditions contributed to the employee's death. He stated that the employee's cardiac changes such as fibrillation in 1992 and aortic valve disease with aortic insufficiency were not accepted conditions and are a degenerative condition. The district medical adviser stated that the employee had some transient ischemic attacks in 1990 and 1991 but they were probably related to generalized and cerebral or carotid atherosclerosis.

Appellant has not presented any medical evidence containing the requisite rationale which establishes that the employee's death was due to ASCVD. Dr. Harris diagnosed hypertensive reactor during the employee's hospitalization in 1980. The November 14, 1980 x-ray report stated that the employee had some prominence of the right hilum but his report had not changed since 1978. In his reports dated from January 24 through July 24, 1992, Dr. Heinricks noted the employee had a small stroke in September 1991, that he took nitroglycerin in May 1992, and diagnosed that the employee had atrial fibrillation, aortic insufficiency with left ventricular dysfunction and systolic hypertension and peripheral neuropathy. On May 21, 1992 he stated that the employee's chest pain was probably noncardiac. On October 27, 1992 Dr. Henricks stated that the employee's heart condition "appeared to be stable" and that the employee denied any shortness of breath or chest pain. On July 24, 1992 he found that the employee's symptoms of chest pain were atypical for angina.

In his March 4, 1996 report, Dr. Henricks stated that the employee's immediate cause of death was ASCVD and stated that beri beri "causes" ASCVD. No doctor of record directly attributed the employee's death to beri beri. While Dr. Henricks stated that beri beri causes ASCVD, he did not state that it caused the employee's death in this instance and therefore his opinion is not probative.[4] Nor did he provide a rationale for his statement.[5] The articles appellant submitted as to beri beri causing ASCVD are general and do not specifically address the employee's situation and therefore are not probative.[6] Inasmuch as appellant has not presented sufficient evidence to establish that the employee's death was work related, appellant has failed to establish her claim. Dr. Kanter's opinion which is well rationalized and establishes that appellant's death was not due to ASCVD constitutes the weight of the evidence.

[4] *See Durwood H. Nolin*, 46 ECAB 818, 821-22 (1995).

[5] *See Carolyn F. Allen*, 47 ECAB 240, 246 (1995).

[6] *See Kathy Marshall*, 45 ECAB 827, 834 (1994).

The decisions of the Office of Workers' Compensation Programs dated October 7 and July 9, 1997 are hereby affirmed.

Dated, Washington, D.C.
January 13, 2000

David S. Gerson
Member

Willie T.C. Thomas
Alternate Member

A. Peter Kanjorski
Alternate Member