U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of HARRY J. DILLON and DEPARTMENT OF THE NAVY, MARE ISLAND NAVAL SHIPYARD, Vallejo, CA

Docket No. 98-2008; Submitted on the Record;
Issued May 22, 2000

DECISION and ORDER

Before MICHAEL J. WALSH, WILLIE T.C. THOMAS, A. PETER KANJORSKI

The issue is whether appellant has established that he developed asbestosis in the performance of duty, causally related to his federal employment.

On February 27, 1995 appellant, then a 53-year-old pipefitter, filed a claim alleging that on February 8, 1995 he first became aware that he had developed asbestos-related interstitial fibrosis due to asbestosis exposure during his 21 years at the employing establishment. He retired from the employing establishment on February 28, 1995.[1]

In support of his claim appellant submitted a June 9, 1993 report from Dr. Carolyn S. Ray, a Board-certified internist specializing in pulmonary diseases, which noted that she had examined and tested him on March 5, 1993. Dr. Ray reviewed appellant's medical and employment history of exposure to asbestos, noted his current complaints of shortness of breath upon exertion and fatigue, conducted a complete review of his systems, and performed a physical examination, reviewed his chest x-rays and pulmonary function studies. She opined:

> "[Appellant] has a history of exposure to asbestos. He has chest x-ray findings consistent with asbestosis and asbestos pleural disease. His pulmonary function studies were normal. His symptoms are consistent with some impairment in terms of his exertional dyspnea.
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> "[Appellant] has an increased risk of developing lung cancer due to his history of cigarette smoking and asbestos exposure. His asbestos exposure increases his risk of developing mesothelioma, gastrointestinal, laryngeal, pharyngeal and renal carcinomas. [Appellant's] exposure to asbestos and the development of

[1] In response to the Office of Workers' Compensation Programs' questions, appellant indicated that he had smoked approximately one pack of cigarettes per day from 1974 until 1984 and that he had also been exposed to xylene, naptha, transite, trichlorethelene, polyvinyl chloride and carbon tetrachloride.

asbestosis and asbestos pleural disease have had an adverse impact on his immune system. … A CT [computerized tomography] scan of the chest is recommended to further evaluate the pleural and parenchymal abnormalities."

A CT scan was performed on October 20, 1994 consisting of both a conventional CT and a thin section CT. In a detailed report, Dr. William P. Meseroll, a Board-certified radiologist, indicated that the scans revealed localized, hyalinized plagues on the posterior lung base and pleural chest wall surfaces bilaterally, and on the hemidiaphragmatic and mediastinal surfaces, and that the pulmonary parenchyma was remarkable for increased arcades at the bases and ill-defined dependent density. Also noted were an abnormal profusion of abnormally peripherally prominent thickened interlobular septae and subpleural core structures. Dr. Meseroll diagnosed "Pleural abnormalities consistent with asbestos-related pleural disease, [and] interstitial abnormalities consistent with mild interstitial fibrosis. The distribution and appearance of the abnormalities seen are consistent with asbestos-related interstitial fibrosis."

On October 31, 1995 the Office referred appellant's record, together with a statement of accepted facts and questions to be answered, to an Office medical adviser, Dr. Charles C. McDonald, a Board-certified internist specializing in pulmonary diseases, for a record review and an opinion as to whether appellant had an occupational lung condition related to his asbestos exposure.

By report dated November 21, 1995, Dr. McDonald noted that he had previously examined appellant on August 9, 1994 for a "comprehensive independent medical examination" and provided a report dated May 5, 1995, and he referred the Office to those reports as well as the pulmonary function studies and x-rays obtained at that time. He noted that appellant did have minor, nonspecific abnormalities on CT scan of the chest which he did not feel were adequate to make the specific diagnosis of asbestos-related pleural plaques. Dr. McDonald opined that appellant did not have interstitial fibrosis. He answered the Office questions noting that appellant had no condition related to his employment; he diagnosed "history of asbestos exposure without asbestos-related abnormalities," but noted that appellant did have a history of dyspnea on exertion of uncertain etiology and opined that he was not disabled due to asbestos-related disease.

By decision dated January 23, 1996, the Office rejected appellant's claim finding that the Office medical adviser had found that appellant had no asbestos-related disease or disability.

Appellant appealed to the Board, and the case was docked as No. 96-1270. On February 25, 1998 the Board issued an order remanding case finding that there was no comprehensive report from Dr. McDonald in the case record, which prevented the Board from reviewing all of the medical evidence relied upon by Dr. McDonald in formulating his opinion.[2]

On March 20, 1998 the Office requested Dr. McDonald's comprehensive reports. The Office also referred appellant, together with a statement of accepted facts and questions to be

[2] The Board also found a *Couch* problem with the Office's decision; *see William A. Couch*, 41 ECAB 548 (1990).

answered, to Dr. James M. Steele, a Board-certified internist specializing in pulmonary diseases, for a second opinion as to whether appellant had asbestosis or asbestos-related disease.

Thereafter the Office received Dr. McDonald's August 9, 1994 report which reviewed appellant's history,[3] reviewed his pulmonary function test results and chest x-rays from August 9, 1994, reviewed the medical reports of record, and concluded: "[Appellant] does not have any asbestos-related abnormalities. While his chest x-rays did show pleural prominence, it appears that this is most likely due to a combination of extrapleural fat and possible serratus anterior muscle prominence…. [Appellant] does have complaints of dyspnea on exertion. It is clear from this evaluation that pulmonary factors do not impact upon his exercise tolerance."

Dr. McDonald's May 5, 1995 report was also provided which reviewed appellant's factual and medical history, repeated Dr. Ray's and Dr. Meseroll's findings, and then stated:

> "A CT scan of the chest has been provided for review. This was obtained … on October 20, 1994. The routine scan of the chest shows minimal nonspecific pleural prominence in the right posterior base which is seen only on scan number 20. The remainder of the pleura is entirely normal. The parenchyma is normal with the usual findings of dependent density at the posterior bases.
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> "The additional medical records provided for review confirm the lack of an asbestos-related abnormality. While a physical examination of the lungs was not detailed by Dr. Ray, it was normal at the time of my examination on August 9, 1994. Pulmonary function tests are entirely within the normal limits.[4] The CT scan shows only nonspecific unilateral pleural prominence which is not diagnostic of asbestos related pleural thickening. The conclusions reached in my previous report remain unchanged."

By second opinion report dated April 22, 1998, Dr. Steele reviewed appellant's history, the statement of accepted facts and the available medical records,[5] he examined appellant and reviewed recent chest x-rays and pulmonary function studies and he opined:

> "[Appellant] has complaints of dyspnea at the current time. I have evaluated his pulmonary function, and this overall shows pulmonary function that is remarkable for a mild to moderate degree of air trapping and a slight reduction in expiratory flow via spirometric measurements with a little bit of reversibility…. This would be consistent with mild chronic obstructive pulmonary disease and is most likely related to [appellant's] smoking. [Appellant's] diffusion capacity falls in a

[3] Appellant's wife had died of lung cancer, which he attributed to her asbestos exposure as a child, and his children had asthma, which he attributed to his agent orange exposure in Vietnam.

[4] Pulmonary function study results were included, as was an August 9, 1994 x-ray report.

[5] Dr. McDonald's August 9, 1994 and May 5, 1995 reports were not provided to Dr. Steele for his examination as they were not submitted to the record until after Dr. Steele's examination.

normal range, and I do not see any definite interstitial infiltrates on [appellant's] chest x-ray. Therefore, I believe that [appellant] is not suffering from asbestosis.

"[Appellant] does have a pleural-based density in the left chest, which is of concern; however, it has been described on prior chest x-rays that were available, dating back to prior evaluations of his pulmonary function.

"[Appellant] therefore appears to have mild chronic obstructive disease related to his smoking, and I can find no definite evidence of asbestosis…."

By decision dated May 13, 1998, the Office rejected appellant's claim finding that the weight of the medical evidence demonstrated that he had no asbestos-related pulmonary condition. The Office found that Dr. McDonald, the Office pulmonary specialist, and Dr. Steele, a second opinion specialist, found no evidence of asbestos-related pulmonary disease and that Dr. Steele found mild chronic obstructive pulmonary disease related to his smoking history. The Office also found that Dr. McDonald's interpretation of Dr. Meseroll's CT scan differed from Dr. Meseroll's interpretation, and that Dr. McDonald provided medical reasoning.

The Board finds that this case is not in posture for decision.

In this case, appellant has submitted a report from a Board-certified specialist in pulmonary medicine which supported the diagnosis of asbestosis and asbestos-related pleural disease with pleural and parenchymal abnormalities, and a CT scan interpreted by a Board-certified radiologist which was noted as revealing pleural abnormalities consistent with asbestos-related pleural disease and interstitial abnormalities consistent with asbestos-related interstitial fibrosis.

In contrast, the Office obtained reports from an Office consultant pulmonary specialist who found no asbestos-related disease, based upon normal pulmonary function test results, chest x-rays and his interpretation of the radiologist's CT scan results and from a second opinion pulmonary specialist, who found no evidence of asbestos but did find evidence of pulmonary function studies abnormalities which he characterized as mild chronic obstructive pulmonary disease due to prior cigarette smoking. The Office did not seek the opinion of a Board-certified radiologist as to what appellant's October 20, 1994 CT scan results represented.

The Federal Employees' Compensation Act, at 5 U.S.C. § 8123(a), in pertinent part, provides: "If there is a disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination."

In this case, the findings of appellant's pulmonary specialist and radiologist, Drs. Ray and Meseroll, disagree with the findings of the Office pulmonary specialist and its second opinion examiner, Drs. McDonald and Steele, such that a conflict in medical opinion evidence arises.

Consequently, the case must be remanded so that the Office may refer appellant, together with the complete case record and a statement of accepted facts, to appropriate Board-certified

specialists in pulmonary medicine and radiology, for examinations and rationalized medical opinions to resolve the medical conflict regarding whether appellant has any asbestos-related pulmonary condition or disease.

Consequently, the decision of the Office of Workers' Compensation Programs dated May 13, 1998 is hereby set aside and the case is remanded for further development in accordance with this decision and order of the Board.

Dated, Washington, D.C.
May 22, 2000

Michael J. Walsh
Chairman

Willie T.C. Thomas
Alternate Member

A. Peter Kanjorski
Alternate Member