

U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of KAREN D. LANE and DEPARTMENT OF VETERANS AFFAIRS,
VETERANS ADMINISTRATION MEDICAL CENTER, Denver, CO

*Docket No. 00-359; Submitted on the Record;
Issued August 23, 2001*

DECISION and ORDER

Before MICHAEL J. WALSH, WILLIE T.C. THOMAS,
MICHAEL E. GROOM

The issues are: (1) whether appellant's accepted myofascial pain syndrome should be changed to "chronic myofascial pain syndrome"; and (2) whether appellant's dysesthesias and lower extremity weakness are causally related to her employment injuries.

On May 28, 1991, May 29 and October 1, 1992 appellant, then a 49-year-old licensed practical nurse, sustained employment-related lumbar and thoracic sprains. She was placed on the periodic rolls on May 7, 1993 and has not worked since. The Office of Workers' Compensation Programs continued to develop the claim, and on November 20, 1997 referred appellant to Dr. Jeffrey J. Sabin, a Board-certified physiatrist, for a second opinion evaluation. By letter dated March 27, 1998, the Office informed appellant that it proposed to terminate her compensation, based on the opinion of Dr. Sabin. By decision dated April 27, 1998 and finalized April 28, 1998, the Office terminated appellant's compensation, effective May 23, 1998.

Appellant requested reconsideration and submitted additional medical evidence, including a report dated October 9, 1998 from Dr. Lawrence A. Lesnak, an osteopathic physician, and a July 29, 1998 report from her treating physician, Dr. Beverly F. Gilder, who is Board-certified in psychiatry and neurology. Finding that a conflict in the medical opinion existed between the opinions of Dr. Sabin and those of Drs. Lesnak and Gilder, by letter dated April 19, 1999, the Office referred appellant to Dr. Leonard P. Burke, a Board-certified neurosurgeon, for an impartial medical evaluation.¹ By decision dated July 9, 1999, the Office modified its previous decision, noting that, while appellant's back strains had resolved, she had developed the consequential condition of myofascial pain syndrome. Compensation was reinstated.

¹ Drs. Sabin and Burke were furnished with the medical record, a statement of accepted facts and a set of questions.

On appeal appellant contends that her accepted condition should be changed to read “chronic myofascial pain syndrome” and that dysesthesias and lower extremity weakness be added as consequential conditions to the accepted conditions.

The Board finds that the Office properly accepted that appellant sustained employment-related “myofascial pain syndrome” and did not accept that she sustained employment-related lower extremity weakness. The Board, however, finds that this case is not in posture for decision regarding whether appellant sustained employment-related dysesthesias are a consequence of her accepted conditions.²

It is an accepted principle of workers’ compensation law, and the Board has so recognized, that when the primary injury is shown to have arisen out of and in the course of employment, every natural consequence that flows from the injury is deemed to arise out of the employment, unless it is the result of an independent intervening cause.³ As is noted by Professor Larson in his treatise: “[O]nce the work-connected character of any injury has been established, the subsequent progression of the condition remains compensable so long as the worsening is not shown to have been produced by an independent nonindustrial cause.”⁴ Appellant has the burden of establishing by the weight of the reliable, probative and substantial evidence that his or her condition was caused or adversely affected by his or her employment. As part of this burden he or she must present rationalized medical opinion evidence, based on a complete factual and medical background, showing causal relationship. The mere fact that a disease manifests itself during a period of employment does not raise an inference that there is a causal relationship between the two. Neither the fact that the disease became apparent during a period of employment, nor the belief of appellant that the disease was caused or aggravated by employment conditions, is sufficient to establish causal relationship.⁵ Furthermore, 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.⁶

In this case, finding that a conflict of medical opinion existed, the Office referred appellant to Dr. Burke, a Board-certified neurosurgeon, to provide an impartial evaluation. In a report dated May 13, 1999, on physical examination Dr. Burke advised that he believed that muscle strength in appellant’s lower extremities was 5/5, noting that she tended to give way slightly on the right but did not note any specific muscle weakness. He palpated no muscles in spasm or evidence of atrophy. Dr. Burke reported that she was extremely sensitive to light touch

² Dysesthesia is defined as a distortion of any sense, especially of that of touch. *Dorland’s Illustrated Medical Dictionary*, 29th edition (2000).

³ Larson, *The Law of Workers’ Compensation* § 13.00; see also Stuart K. Stanton, 40 ECAB 859 (1989); Charles J. Jenkins, 40 ECAB 362 (1988).

⁴ *Id.* at § 13.11(a).

⁵ Robert G. Morris, 48 ECAB 238 (1996).

⁶ See Kathryn Haggerty, 45 ECAB 383 (1994); Edward E. Wright, 43 ECAB 702 (1992).

over the lower and mid-back area, the sacral region, sacroiliac joint on the right, sciatic notch bilaterally and, to a lesser extent, over the midposterior thigh on the right. Motor tone showed no evidence of rigidity and deep tendon reflexes were 2+ in the upper and lower extremities with no evidence of pathologic reflexes. He further advised that sensory examination was unusual in that she had diminished sensation in the right lower extremity, more so over the outer aspect of the leg, calf and foot but also over the inner aspect of the right lower extremity as compared to the left but that the left lower extremity also demonstrated diminished sensation throughout to pinprick and light touch with decreased perception to light touch in the right upper extremity over the deltoid, biceps and triceps area which continued in a nondermatomal pattern down the right arm to the hand, being most noted over the last two fingers of the hand. This was in contrast to pin sensation that seemed to be decreased in the left upper extremity over the “snuffbox” area of the hand and over the last two fingers of the hand. Dr. Burke also noted decreased sensation to touch and pinprick throughout the abdominal area up to approximately the T8 level with no sensory abnormalities in the face or head. He diagnosed myofascial involvement of the cervical, thoracic and lumbar spine, advised that she could not return to her former employment as a licensed practical nurse due to her painful state which restricted her ability to perform normal duties.

As detailed above, in a comprehensive report dated May 13, 1999, Dr. Burke provided a diagnosis of myofascial pain syndrome and found no evidence of lower extremity weakness on physical examination. The Board, therefore, finds that the Office properly found that appellant failed to establish that she sustained employment-related lower extremity weakness or that her myofascial pain syndrome should be characterized as “chronic.”

The Board, however, finds that Dr. Burke’s report that appellant was extremely sensitive to light touch and demonstrated diminished sensation to pinprick and light touch in all extremities, together with the reports of appellant’s treating physician, Dr. Gilder, who noted that appellant could not feel pinprick in the arms or legs and Dr. Lesnak who noted findings of numbness constitutes evidence generally supportive of appellant’s claim that her dysesthesias are employment related. While these reports lack detailed medical rationale sufficient to discharge appellant’s burden of proof to establish by the weight of reliable, substantial and probative evidence that this condition is employment related, this does not mean that the findings may be completely disregarded by the Office. It merely means that their probative value is diminished.⁷ In the absence of medical evidence to the contrary, the reports are sufficient to require further development of the record.⁸ The case will, therefore, be remanded for the Office to obtain a supplementary report from Dr. Burke.⁹ After such development as it deems necessary, the Office shall issue a *de novo* decision.

⁷ See *Delores C. Ellyett*, 41 ECAB 992 (1990).

⁸ *John J. Carlone*, 41 ECAB 354 (1989).

⁹ The Board notes that, when the impartial medical specialist’s statement of clarification or elaboration is not forthcoming to the Office, or if the physician is unable to clarify or elaborate on the original report, or if the physician’s report is vague, speculative or lacks rationale, the Office must refer the employee to another impartial specialist for a rationalized medical opinion on the issue in question. *Terrance R. Stath*, 45 ECAB 412 (1994).

The decision of the Office of Workers' Compensation Programs dated July 8, 1999 is affirmed in part and vacated in part, and the case is remanded to the Office for proceedings consistent with this opinion.

Dated, Washington, DC
August 23, 2001

Michael J. Walsh
Chairman

Willie T.C. Thomas
Member

Michael E. Groom
Alternate Member