U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of GLORIA M. WALKER and THE DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTATION MEDICAL CENTER, Long Beach, CA

Docket No. 01-2177; Submitted on the Record;
Issued May 13, 2002

DECISION and ORDER

The issue is whether appellant has established that she sustained bilateral carpal tunnel syndrome and cubital tunnel syndrome in the performance of her duties as a federal employee.

The Board finds that appellant has not met her burden of proof to establish that she sustained bilateral carpal tunnel syndrome and cubital tunnel syndrome causally related to her federal employment.

On March 5, 1993 appellant, then a 61-year-old medical clerk, filed an occupational disease claim (Form CA-2), alleging that as a result of her work activities she sustained a medical condition in her left wrist, hand and thumb. On August 20, 1993 the Office of Workers' Compensation Programs accepted appellant's claim for tendinitis of the left wrist. On June 3, 1993 appellant underwent surgery on her left wrist and hand consisting of left thumb carpometacarpal (CMC) joint silastic interposition hemiarthoplasty, left wrist de Quervain's decompression and excision of abductor pulley and trigger release of the left middle and ring fingers. Prior to the procedure the Office denied authorization of the surgery. On May 10, 1995 the Office also denied authorization to perform thumb joint revision surgery.

On August 18, 1995 appellant filed a Form CA-2 for the right hand and arm condition that was denied by the Office on January 5, 1996 due to the insufficiency of the medical evidence in establishing a causal relationship between appellant's medical condition and her employment factors.

On August 23, 1996 appellant filed a request for reconsideration of the January 5, 1996. In support of her claim, appellant submitted a medical report from Dr. Joan Wright. In her April 26, 1996 report, Dr. Wright described appellant's work history and the results of her examination. She diagnosed silastic synovitis left thumb basilar joint following silastic interpositional arthroplasty; mild right carpal tunnel and cubital tunnel syndromes; and right thumb CMC joint osteoarthritis. Dr. Wright stated that the right carpal tunnel syndrome and right cubital tunnel syndrome were caused by appellant's employment factors and the osteoarthritis of both thumbs was materially worsened by appellant's work duties.

On October 17, 1996 appellant was examined by Dr. Lewis Newman, an orthopedic surgeon, as a second opinion referral. In addition to examining appellant, Dr. Newman referred her to Dr. David Slutsky, an orthopedic surgeon, specializing in hand surgery and to Dr. Parag Mehta, a Board-certified neurologist.

In his November 7, 1996 report, Dr. Slutsky stated that appellant's electromyogram and nerve conduction velocity (EMG)/NCV testing was within normal limits. He found there was a negative Tinel's over the carpal tunnel and Guyon's canal, a negative Phalen's test and no significant carpal tenderness. A nonanatomic elbow flexion test produced tingling in the index, middle and ring finger. There was a negative Tinel's over the ulnar and median nerves. There were no clinical signs of right carpal tunnel syndrome or right cubital tunnel syndrome. The osteoarthritis in the bilateral thumbs was aggravated and possibly accelerated by appellant's work conditions.

Dr. Mehta reported that he conducted an interview, examination and NCV and EMG study of the appellant and found "no obvious joint swelling or restriction of movement of the left wrist or thumb CMC joint. Tinel's and Phalen signs are bilaterally negative at the wrist…." The NCV and EMG of the upper extremities was "unremarkable in its entirety." Dr. Mehta concluded there was "no neurological basis for any of her current alleged pains or paresthesae in the upper limbs."

In a report dated November 25, 1996, Dr. Newman described the results of his physical examination including; slight tenderness at the anterior margin of the right cubital tunnel, no tenderness over the apex of the medial epicondyle; or the ulnar nerve and the cubital tunnel and no Tinel's sign; no Tinel's sign over the median nerve in either wrist; and a negative Finkelstein's bilaterally. He concluded that appellant did not have carpal tunnel or cubital tunnel syndromes in the right or left upper extremities and that her subjective complaints were "excessive compared to the clinical evidence…." Dr. Newman also found that appellant's bilateral thumb condition had been permanently aggravated by the claimant's work activities.

On December 20, 1996 the Office modified its January 5, 1996 decision and found that appellant sustained an aggravation of her left and right thumbs osteoarthritis due to her work, but denied the right carpal tunnel and cubital tunnel syndrome basing the weight of the evidence on Dr. Newman's report. On June 23, 1998 the Office upon request of appellant's attorney and direction of the hearing representative,[1] determined there was a conflict between Drs. Wright, Slutsky and Newman on the issue of carpal tunnel and cubital tunnel syndromes. Appellant was referred to Dr. James London, an orthopedic surgeon, for independent medical examination. In a report dated October 25, 1998, Dr. London concluded that there was no evidence of cubital tunnel syndrome. He found that appellant had right carpal tunnel syndrome but that it was not causally related to her work activities, "were not sufficiently traumatic to cause or aggravate, precipitate or worsen any entrapment of the median nerve at the right wrist."

In a decision dated August 24, 1999, the Office denied appellant's claim based on Dr. London's initial and supplemental reports.

[1] The hearing representative had hard evidence on appellant's request to change his physician.

In a September 8, 1999 letter from her representative, appellant requested a hearing. In a decision dated April 10, 2000, the case was remanded to the Office finding that Dr. London based his findings on an inaccurate medical history.

The Office subsequently referred appellant to Dr. Wilmer Irvine, a Board-certified orthopedic surgeon, along with a new statement of accepted facts for another independent medical examination.

In a report dated August 31, 2000, Dr. Irvine reviewed in detail appellant's extensive medical history and work duties. Regarding his physical examination Dr. Irvine reported: negative Phalen's bilateral, negative Tinel's bilateral with tenderness to pressure over the carpal tunnel. On the right hand there is normal finger and thumb motion with discomfort at the base of the thumb over the first metacarpal joint. Finkelstein's test is negative. On the left wrist he found normal finger motion.

On his neurological examination Dr. Irvine reported "decreased sensation to light touch over most of the right upper extremity including the palmar and dorsal aspect of all fingers and thumb, the entire forearm and arm to the level of the shoulder." Regarding muscle testing in the hands, he stated "there is evidence of weakness bilaterally, however, I definitely get the impression that [appellant] is not putting forth maximum effort with this test. There is slight thenar atrophy of the left as compared to the right."

Radiographs of the right wrist reveal "severe osteoarthritis with complete loss of cartilage space of the first metacarpocarpal joint…. There is a slight degree of arthritic change of the trapezionavicular joint." The remainder of the carpus appeared to be within normal limits. The left wrist had "severe narrowing of the first metacarpocarpal joint with large lytic areas in the proximal portion of the first metacarpal adjacent to the joint in the apposing portion of the trapezium, compatible with a loose or broken implant.

After an extensive review of the medical reports in the file including conflicting findings in NCV studies reports, Dr. Irvine commented that "I would tend to place more weight on the values of set, results and opinion of Dr. Mehta's electrodiagnostics studies and neurological exam[ination], than I would on Arnold Tripp's, RPT, EMG and [NCV] studies done one year prior to Dr. Mehta's studies and consultation. If a nerve entrapment syndrome persists for one year I would expect the electrodiagnostics studies to become more positive not less positive, especially since Dr. Wright felt that [appellant's] symptoms of carpal tunnel syndrome and cubital tunnel syndrome were becoming more severe…."

Dr. Irvine further wrote that "[o]n examining [appellant] I cannot find convincing clinical evidence of carpal tunnel syndrome or cubital tunnel syndrome in either upper extremity." There is "no evidence of peripheral neuropathy or nerve entrapment syndrome on [NCV] studies and no evidence of neuropathy or cervical radiculopathy on EMG exam[inations]."

> "If carpal tunnel syndrome or cubital tunnel syndrome have persisted, since 1995 and especially if the symptoms have progressed over that period from mild to severe described by Dr. Wright, I would expect clinical and electrodiagnostics exam[ination]s to be positive and yet at this time they are not.… [I]t is my

opinion that [appellant] does not have carpal tunnel syndrome or cubital tunnel syndrome at this time."

In a September 19, 2000 decision, the Office denied appellant's claim finding Dr. Irvine's report as the independent medical examiner constituted the weight of the medical evidence.

The Board finds that appellant has not met her burden of proof to establish that she sustained carpal tunnel or cubital tunnel syndromes in the performance of employment duties.

An employee seeking benefits under the Federal Employees' Compensation Act has the burden of establishing the essential elements of his or her claim, including the fact that an injury was sustained in the performance of duty as alleged and that any disability for which compensation is claimed is causally related to the employment injury.[2] The evidence required to establish causal relationship is rationalized medical evidence, based on complete factual and medical background, showing a causal relationship between the claimed medical condition and the identified factors.[3]

In support of her claim, appellant submitted several reports from her treating physician, Dr. Wright who opined that appellant sustained carpal tunnel syndrome or cubital tunnel syndrome in the performance of employment duties. Second opinion referrals, Drs. Newman and Slutsky opined that no such condition existed. Each of these reports is from Board-certified orthopedic surgeons. They are well rationalized, based on accurate medical history and expressed in terms of medical certainty.

In situations where there exist 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 upon a proper factual background, must be given special weight.[4]

The report by Dr. Irvine, the impartial medical specialist, has these qualities. He reviewed appellant's extensive medical history including the results of several diagnostic tests. Dr. Irvine also conducted a physical examination. In his examination he found a negative Phalen's bilaterally, negative Tinel's bilaterally, with tenderness to pressure over the carpal tunnel. On the right hand he found normal finger and thumb motion with discomfort at the base of the thumb over the first metacarpal joint. Finkelstein's test was negative. On the left wrist he found normal finger motion.

On his neurological examination Dr. Irvine reported decreased sensation to light touch over most of the right upper extremity including the palmar and dorsal aspect of all fingers and thumb, the entire forearm and arm to the level of the shoulder. Regarding muscle testing in the hands he found evidence of weakness bilaterally, however, Dr. Irvine qualified this finding by

[2] *Duane B. Harris,* 49 ECAB 170 (1997).

[3] *Id.; Dennis Mascarenas,* 49 ECAB 215 (1997).

[4] *Jack R. Smith,* 41 ECAB 691, 701 (1990); *James P. Roberts,* 31 ECAB 1010, 1021 (1980).

the comment that appellant was not putting forth maximum effort with this test. He also found slight thenar atrophy of the left as compared to the right.

Radiographs of the right wrist revealed severe osteoarthritis with complete loss of cartilage space of the first metacarpocarpal joint. There was a slight degree of arthritic change of the trapezionavicular joint. The remainder of the carpus appeared to be within normal limits. The left wrist had severe narrowing of the first metacarpocarpal joint with large lytic areas at the proximal portion of the first metacarpal adjacent to the joint I the apposing portion of the trapezium, compatible with a loose or broke implant.

Dr. Irvine explained that he found that Dr. Mehta's NCV studies reports more convincing than Mr. Tripp's, as stated previously herein.

Dr. Irvine further concluded that he could not find convincing clinical evidence of carpal tunnel syndrome or cubital tunnel syndrome in either upper extremity. He found no evidence of peripheral neuropathy or nerve entrapment syndrome on nerve conduction studies and no evidence of neuropathy or cervical radiculopathy on EMG examination. Dr. Irvine further explained that, if carpal tunnel syndrome or cubital tunnel syndrome have persisted since 1995 and especially if the symptoms have persisted over that period from mild to severe, as Dr. Wright opine, he would expect clinical and electrodiagnostic examinations to be positive and yet at this point they are not.

Dr. Irvine's report is well rationalized, based on accurate medical history and expressed in terms of reasonable medical certainty. The Board finds the Office properly accorded Dr. Irvine's reports special weight in resolving the conflict in the medical evidence. Therefore, the Board finds the Office properly denied appellant's claim.

The September 19, 2000 decision of the Office of Workers' Compensation Programs is hereby affirmed.

Dated, Washington, DC
May 13, 2002

Alec J. Koromilas
Member

Colleen Duffy Kiko
Member

Willie T.C. Thomas
Alternate Member