United States Department of Labor
Employees' Compensation Appeals Board

EDWIN J. PAPESH, Appellant	)	
and	)	**Docket No. 04-758**
	)	**Issued: July 27, 2004**
U.S. POSTAL SERVICE, POST OFFICE, Belle Plaine, IA, Employer	)	

Appearances:
Edwin J. Papesh, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chairman
DAVID S. GERSON, Alternate Member
WILLIE T.C. THOMAS, Alternate Member

JURISDICTION

On January 28, 2004 appellant filed a timely appeal from the Office of Workers' Compensation Programs' decision dated December 19, 2003 finding appellant did not meet his burden of proof to establish a consequential injury. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant has established that his peroneal neuropathy with axonal degeneration is a consequential condition of his accepted work injury.

FACTUAL HISTORY

On September 3, 1997 appellant, then a 46-year-old maintenance specialist, filed a traumatic injury claim alleging he injured his back when he lifted a 75-pound box and then drove

240 miles causing his back muscles to tighten and weakness in his left foot.[1] Appellant's relevant medical history includes laminectomies in 1976 and 1988 that were not work related and another in 1992 that was work related. A fourth laminectomy was performed on September 9, 1997. In an October 10, 1997 decision, the Office accepted appellant's claim for lumbar strain, subsequently the Office accepted herniated disc at L5-S1, and a left drop foot.

On April 22, 2002 appellant filed an occupational disease claim alleging that his leg brace worn for his light-duty work caused him discomfort including numbness, pain and loss of muscle mass.

In an October 14, 1998 report, Dr. David Durand, an osteopath, stated that appellant presented with pain over the interphalangeal joint on the plantar surface of the big toe. He noted that subsequent to appellant's 1997 surgery, which did not improve his left drop foot, he wore an ankle foot orthrosis (AFO) on his left foot. On examination Dr. Durand found strong dorsiflexion of the foot with anterior tibia tendon, but very weak evertors of the foot and minimal, if any, dorsiflexion of the big toe or lesser toes. He noted that most of appellant's symptoms seemed to be in the big toe area and seemed to be related to his shoe wear and AFO; he recommended modifications to the foot plate. In a March 1999 progress report, Dr. Durand noted that the toe plate modification had relieved his symptoms, but he also noted that, after appellant began wearing his brace, he developed pain and swelling over the dorsal lateral aspect of the posterior os calsis. In a February 16, 1999 decision, the Office found appellant entitled to a schedule award for a 16 percent permanent impairment to his left lower extremity.

In a June 6, 2001 report, Dr. Craig Dove, Board-certified in electrodiagnostic medicine and physical medicine and rehabilitation, stated that appellant presented with cramping and aching in his left calf and foot for approximately 6 to 12 months. He added that needle electromyography was done of the left lower extremity which revealed multiple abnormalities consistent with chronic denervation seen in multiple L5 and S1 muscles. Dr. Dove diagnosed chronic left L5 and S1 radiculopathy and probable superimposed left common peroneal neuropathy with axonal degeneration. He added that appellant had multiple abnormalities consistent with chronic left L5-S1 radiculopathy and more severe changes were noted in common peroneal innervated muscles and absent nerve conductions in the peroneal nerve. Dr. Dove opined that this is most consistent with severe left common peroneal neuropathy with axonal degeneration; and he added that this type of situation was caused by some type of compression of the common peroneal nerve near the fibular head. Dr. Dove noted that appellant did not have any history of trauma in this area, but that he does wear an AFO that seemed to fit well and does not cause compression.

On September 21, 2001 appellant requested an increase in his schedule award related to his lower back that was denied in a March 29, 2002 decision. In an April 7, 2002 letter, appellant wrote that he wears a left leg brace for work, approximately five days a week from 6:15 a.m. to 4:55 p.m. He noted that he always had some discomfort with the brace but it had recently worsened. In July 2001, he was fitted with a new brace that cut into his leg.

[1] The Office has also accepted that appellant sustained a work-related back injury on May 27, 1992.

In a December 18, 2002 report, Dr. Dove stated that appellant presented with pain and numbness in his left calf. He noted that results of a magnetic resonance imaging scan revealed chronic plantar fascitis in his left foot. Dr. Dove added that appellant had a new AFO fabricated and his left foot symptoms had improved. In an April 10, 2003 form report, Dr. Joan Berow, an osteopath, indicated that appellant had a work-related diagnosis of left peroneal neuropathy and residual foot drop secondary to a 1997 surgery. She stated that appellant had permanent work restrictions.

In a July 24, 2003 report, Dr. Kevin Eck, an orthopedic surgeon, diagnosed left lower extremity foot drop related to chronic lumbosacral radiculopathy and left peroneal nerve neuropathy. Regarding causality of the neuropathy, he stated that there is no way to know with a high degree of certainty whether or not the initial AFO contributed to the development of his condition. Dr. Eck opined that it was certainly a possibility that the brace, had it been wearing out and pressing on his leg, could have contributed to the development of his peroneal neuropathy. He also noted that appellant had been wearing the brace for three years without incident and that he had been involved with spontaneous peroneal neuropathy cases where no external orthosis were involved. Dr. Eck stated that he could not say with a high degree of certainty that the brace was the sole cause of the development of the peroneal neuropathy, but that it was possible.

In a November 3, 2003 report, Dr. Daniel Zimmerman, the district medical adviser, wrote that neither the reports of Drs. Eck or Dove support a consequential injury. He noted that appellant's medical history indicates that he had tingling in lower left extremity before his 1997 surgery and that appellant was compensated for his weakness and sensory changes in the 1997 schedule award for his lower left extremity.

In a December 19, 2003 decision, the Office denied appellant's claim for a consequential injury finding that the medical evidence did not establish that his peroneal neuropathy resulted from the AFO brace.

LEGAL PRECEDENT

The claimant has the burden of establishing by the weight of the reliable, probative and substantial evidence that the condition for which compensation is sought is causally related to a specific employment incident or factors of employment. As part of this burden the claimant must present rationalized medical opinion evidence, based upon a complete and accurate factual and medical background establishing a causal relationship.[2]

The basic rule respecting consequential injuries, as expressed by Larson is, "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 likewise arises out of the employment."[3] The subsequent injury "is compensable if it is the direct and natural result of a compensable primary injury."[4]

[2] *Brian E. Flescher*, 40 ECAB 532 (1989).

[3] Larson, *The Law of Workers' Compensation* § 13.00.

[4] *Id.* at § 13.11.

With regard to consequential injuries, the Board has stated that where an injury is sustained as a consequence of an impairment residual to an employment injury, the new or second injury is deemed, because of the chain of causation, to arise out of and be in the course of employment.[5]

ANALYSIS

In the present case, appellant has not met his burden of proof to establish that his peroneal neuropathy was a direct consequence of his accepted back or foot injuries. The medical evidence of record is speculative and lacks sufficient rationale to meet appellant's burden of proof.

In his June 6, 2001 report, Dr. Dove diagnosed severe left common peroneal neuropathy with axonal degeneration, and added that this type of situation is caused by some type of compression of the common peroneal nerve near the fibular head. Dr. Dove noted that appellant did not have any history of trauma in this area, but he did wear an AFO. Dr. Dove also noted however that appellant's orthosis seemed to fit well and did not cause compression. While Dr. Dove suggests that the AFO could have caused such a condition, he does not directly attribute appellant's condition to the AFO or explain why and how the AFO caused the condition.

In her April 10, 2003 form report, Dr. Berow diagnosed a work-related left peroneal neuropathy and residual foot drop secondary to a 1997 surgery. However, she failed to explain her reasons for this conclusion. The Board has long held that a medical opinion which lacks medical rationale is of diminished probative value.[6]

Dr. Eck's July 24, 2003 report is also insufficient to meet appellant's burden of proof as it is speculative. He diagnosed left lower extremity left foot drop relating to chronic lumbosacral radiculopathy and left peroneal nerve neuropathy. But Dr. Eck also stated that there is no way to know with a high degree of certainty whether or not the initial AFO contributed to the condition. Dr. Eck opined that it was certainly a possibility that the brace, had it been wearing out and pressing on his leg, could have contributed to the development of his peroneal neuropathy. But he also noted that appellant had been wearing the brace for three years without incident and did not explain how the injury suddenly flared up. He also noted that peroneal neuropathy can be spontaneous and that he had seen cases where no external orthosis was involved. As Dr. Eck offered no real medical explanation as to how appellant's orthosis would have caused the condition, his opinion is also unrationalized and only speculative at best. The fact that a condition manifests itself or worsens during a period of employment or that work activities produce symptoms revelatory of an underlying condition does not raise an inference of causal relationship between a claimed condition and employment factors.[7]

[5] *Margarette B. Rogler*, 43 ECAB 1034, 1038 (1992).

[6] *Albert C. Brown*, 52 ECAB 152 (2000).

[7] *Ruby I. Fish*, 46 ECAB 276 (1994).

Finally, Dr. Zimmerman, the Office medical adviser, reviewed the record and noted that there was no medical evidence of record substantiating a consequential injury due to the orthosis. He noted that in fact appellant's symptoms of tingling in the lower extremity had begun before his 1997 surgery, not after the surgery when he began use of his orthosis.

CONCLUSION

Appellant has not met his burden of proof to establish that the peroneal neuropathy with axonal degeneration is a consequential of his accepted work injury.

ORDER

IT IS HEREBY ORDERED THAT the December 19, 2003 decision by the Office of Workers' Compensation Programs is affirmed.

Issued: July 27, 2004
Washington, DC

Alec J. Koromilas
Chairman

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member