United States Department of Labor
Employees' Compensation Appeals Board

W.W., Appellant	)	
and	)	**Docket No. 09-1619**
	)	**Issued: June 2, 2010**
DEPARTMENT OF THE INTERIOR, BUREAU OF RECLAMATION, Alcova, WY, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On June 10, 2009 appellant filed a timely appeal of the June 1, 2009 merit decision of the Office of Workers' Compensation Programs, which affirmed the denial of his occupational disease claim. Pursuant to 20 C.F.R. §§ 501.2 and 501.3(e), the Board has jurisdiction over the merits of the case.

ISSUE

The issue is whether appellant sustained pulmonary sarcoidosis or other condition causally related to his federal employment as a welder.

FACTUAL HISTORY

On January 15, 2008 appellant, then a 59-year-old plant mechanic, filed an occupational disease claim for sleep apnea, hyperventilation, sarcoidosis and congestive heart failure. He listed February 10, 2000 as the date of injury and April 23, 2005 as the date he first realized his condition was employment related. In a statement received on February 11, 2008, appellant described the physical demands of his job and identified employment factors that he believed

contributed to his claimed conditions. He noted prolonged exposure to noxious fumes caused by welding and grinding and using caustic chemicals to clean and prepare welding surfaces. Appellant stated that there was no uniform air circulation in the welding area or recirculation fans to keep dust down. He stated that the grinders lacked hoses to extinguish dust from the area. Appellant also advised that he was provided with an ill-fitting welding hood, with no respirator or outside air source.

On February 28, 2008 the employing establishment provided a copy of appellant's position description, which confirmed that his plant mechanic duties included welding and grinding. It noted that cavitation welding usually lasted three weeks a year and was one of the most physically demanding tasks which appellant "could be performing ... 8 [to] 9 hours per day, [4] days a week, up to 15 weeks per year," with occasional overtime work. As to his claim of ill-fitting equipment and inadequate ventilation, the employer advised that welding areas were equipped with exhaust fans and hoods supplied by fresh air. Since 1986, fresh air was supplied to the hoods from pumps with air filters located outside the welding/grinding area. The equipment was updated in 1999 and additional equipment installed in 2001 to cool the hood air supply. Ventilation systems were installed around 1990 and were used when performing welding and grinding on turbine runners. The system pulled air in from around the workers' legs and dispersed it above their heads. There were large ventilation fans to remove hot air located just below the roof. The employer stated that workers were required to wear their personal protective equipment when performing welding/grinding operations. When acid was used for air arcing and grinding, employees were supplied with air hoods and/or respirators. It was noted that air hoods were not designed to be airtight.

The Office received copies of appellant's employee health records and medical records from his treating physician, Dr. Eric E. Stevens, Board-certified internist in pulmonary disease. Appellant was hospitalized on April 23, 2005 for progressive respiratory distress. A mediastinal biopsy showed noncaseating granulomas consistent with sarcoidosis. Appellant was also diagnosed with pneumonia, diastolic congestive heart failure, type 2 diabetes, possible sleep apnea and obesity hypoventilation.[1] On August 19, 2005 Dr. Stevens advised that appellant had recently undergone a sleep study that established sleep apnea.[2] As to his pulmonary condition, he stated that a recent computerized tomography (CT) scan showed that lymphadenopathy had dramatically improved from an earlier study on April 23, 2005. Moreover, the previously seen patchy pulmonary infiltrates had resolved. A pulmonary function study administered earlier that day was reported as "near normal." Dr. Stevens diagnosed biopsy-proven sarcoidosis, diastolic cardiac dysfunction, right heart failure, obstructive sleep apnea, diabetes and history of kidney stones. He advised that the previously seen patchy infiltrate on CT scan may have been an infection or sarcoid. Appellant was using oxygen and a continuous positive airway pressure (CPAP) machine for his sleep apnea. Dr. Stevens advised that appellant could continue to work with some moderate work restrictions, such as avoiding work on high platforms at the end of cranes. Otherwise, appellant seemed to be doing well at work and had improved considerably since first seen in the spring 2005.

[1] The hospital discharge summary did not list appellant's weight, but contemporaneous medical records indicated that he weighed in excess of 350 pounds.

[2] Overnight polysomnography testing was performed on May 20, 2005.

On March 24, 2006 Dr. Stevens reported that appellant had been doing well, with no coughing, wheezing or chest pain, but with some dyspnea on exertion, especially if appellant climbed anything. Appellant used his CPAP regularly at night and reported having a good energy level during the day until about 5:00 p.m. when he grew tired. His weight was listed at 358 pounds and his various diagnoses remained unchanged. Dr. Stevens advised against climbing greater than 10 feet at work.

On January 19, 2007 Dr. Stevens noted that a recent CT scan showed improvement in appellant's mediastinal and hilar lymphadenopathy, with a decrease in size and number of the lymph nodes. The diagnostic study also showed improvement in the lung parenchymal interstitial reticulonodular pattern. Dr. Stevens reported that appellant was doing well and he continued to work, but recently had what sounded like a cold. Appellant also reported a little more shortness of breath with activity, particularly when climbing stairs. Dr. Stevens advised that appellant had gained significant weight at 418 pounds. He diagnosed biopsy-proven sarcoidosis and noted that appellant's CT scan showed improvement. Additional diagnoses included a history of patchy infiltrate on CT scan with minimal residual reticulonodular pattern; diastolic cardiac dysfunction with right heart failure -- clinically better, though prone to edema; obstructive sleep apnea; hypoxia; diabetes; renal insufficiency; and self-reported increased shortness of breath. Dr. Stevens continued appellant's work restriction with respect to going up and down in a crane, but found that he was able to climb short distances, for example to change a light bulb with a ladder.

On June 7, 2007 Dr. Kate Flanigan Sawyer, an physician with the U.S. Department of Health and Human Services, Federal Occupational Health (FOH), conducted a medical surveillance examination.[3] In a September 13, 2007 report, she did not list any employment-related diagnoses. Dr. Sawyer placed an "x" on the form indicating that there were "No medical findings ... noted that indicate a work-related injury/illness." The report identified several health problems not caused by work, which included sarcoidosis, diabetes mellitus, obstructive sleep apnea, obesity, vision loss, knee pain, back pain, abnormal cholesterol and hypertension. Dr. Sawyer also noted that appellant had a moderate bilateral mid/high frequency hearing loss, but she did not address causation. Appellant's work limitations included no crane operation, no climbing, no arduous exertion and no prolonged kneeling. He was encouraged to utilize protective equipment when exposed to loud noise.

On August 3, 2007 Dr. Stevens noted that appellant reported doing well since his last visit. Appellant's sleep quality had improved after acquiring a new bed and use of his CPAP every night, which resulted in fairly good daytime energy. Dr. Stevens reported no shortness of breath, no coughing, no wheezing, no fevers or chills and no chest pain. There were no visual complaints, skin complaints or musculoskeletal complaints. Appellant's weight was listed at 431 pounds. Dr. Stevens repeated his prior list of diagnoses and reiterated that appellant was "doing well." As to appellant's work restrictions, he was to avoid going up in the crane but allowed to use a 10- to 12-foot ladder to change light bulbs. Dr. Stevens explained that because of appellant's stable subjective status, no specific diagnostic tests or studies were presently required.

[3] Dr. Sawyer is Board-certified in occupational medicine.

In a December 11, 2007 letter, Dr. Stevens noted that appellant had been a patient since April 2005 and had biopsy-proven sarcoidosis, with a history of pulmonary involvement. He stated that other issues included diastolic and cardiac dysfunction, right heart failure, diabetes, chronic hypoxia, renal insufficiency and sleep apnea. Dr. Stevens advised that appellant had an apnea-hypopnea index of 45, which was indicative of severe sleep apnea, but that he was compliant on CPAP.

In a January 7, 2008 letter, Dr. Sawyer noted that appellant requested that she submit a description of his current status at the workplace. As a medical reviewing officer for FOH, she reviewed his periodic surveillance examinations for the employing establishment from 2004 to 2007 and provided medical clearances for his job as power plant mechanic. Dr. Sawyer explained that appellant's current exposures at work included noise, dust, occasional heat stress, coatings (coal tar, epoxies), solvents, welding fumes and heavy metals (arsenic, cadmium, chromium, lead, manganese, nickel and zinc). Appellant was also involved in occasional confined space welding operations. According to his workplace exposure assessment form, he currently used protective equipment 100 percent of the time (such as earplugs, respirator and welding leathers). Additionally, appellant had not reported any current symptoms from his exposures. Dr. Sawyer stated that appellant informed her that, during his almost 32 years of work at the employing establishment, his exposures had been much greater in the past and that protective equipment had not been used on the job, particularly with welding. She advised that he was currently medically cleared for his job with a restriction and his respirator clearance was limited. Due to a nonwork-related medical problem, appellant was restricted from climbing anything taller than eight feet. His respirator clearance was limited to supplied-air respirators or powered-air purifying respirators and he was cleared for using a respirator at mild exertion only. During appellant's June 7, 2007 physical examination, there was no shortness of breath, wheezing or coughing. Dr. Sawyer also indicated that appellant's physical examination revealed distant decreased lung sounds. She noted that his pulmonary function had declined each year from 2004 to 2007 and his latest pulmonary function study followed a moderately restricted pattern, with reported values at approximately 60 percent of predicted. Because appellant's respiratory status had declined over the years and he already had limitations at work, Dr. Sawyer predicted that his job limitations would become greater in the future.

In a report dated January 29, 2008, Dr. James W. Washburn, an internist with the Department of Veterans Affairs (VA), noted that appellant had been a patient of his since July 2006. On March 28, 2005 appellant was admitted to the Sheridan medical center due to a three-week history of shortness of breath and was diagnosed and treated for pneumonia. He improved with treatment and was discharged on March 31, 2005. On April 19, 2005, however, appellant presented to the Casper outpatient clinic with a persistent cough and was treated with another course of antibiotics. Dr. Washburn noted that appellant was subsequently admitted to the medical center in Loveland on April 23, 2005 due to shortness of breath and a persistent cough and was seen in consultation by two pulmonologists. Pulmonary function studies administered at the time revealed a moderate obstructive lung defect. Additionally, a CT scan of the chest showed right infiltrate with a reticulonodular pattern and a mediastinal biopsy confirmed the diagnosis of sarcoidosis. Appellant was discharged on April 28, 2005 in improved condition. Since April 2005, he had been treated by Dr. Stevens for sarcoidosis at regular intervals. Regarding the cause of appellant's pulmonary condition, Dr. Washburn stated that the etiology of sarcoidosis was unknown but that current medical literature supported environmental

factors as a possible cause. He stated that "[f]rom [appellant's] detailed description of his working environment at the hydroelectric plant, it is plausible that his [s]arcoidosis is work related."

On May 23, 2008 Dr. Stevens submitted a one-paragraph letter noting that appellant had been his patient since April 2005 and had biopsy-proven sarcoidosis with a history of pulmonary involvement. Appellant underwent additional diagnostic testing on May 23, 2008 and the CT scan showed persistent mediastinal and hilar adenopathy, consistent with sarcoidosis. In addition, recent pulmonary function studies confirmed restrictive pulmonary physiology, which had worsened slightly since 2005. Dr. Stevens stated that appellant's condition remained the same as before and he was maximally compliant with therapy.

The Office referred appellant to Dr. Lawrence H. Repsher, a Board-certified pulmonary disease specialist, who examined him on February 18, 2009. Dr. Repsher reviewed appellant's employment and medical histories, diagnostic records, performed a physical examination and administered a pulmonary function and arterial blood gas studies. He found no evidence of any occupational lung disease and no evidence of welders' siderosis or other welding-related disorder. Dr. Repsher diagnosed morbid obesity (self-reported weight of 407 pounds), sarcoidosis, insulin-dependent diabetes mellitus, mild chronic renal failure -- probably secondary to diabetes, dyslipidemia, history of ureterolithiasis, recurrent gouty arthritis, obstructive sleep apnea -- very severe and pulmonary hypertension with decompensated biventricular congestive heart failure.

Based on the findings on examination and review of the medical records, Dr. Repsher advised that appellant did not currently or previously sustain any occupational lung disease related to his work as a welder. He explained that pulmonary sarcoidosis was a disease of unknown cause, which had never been statistically related to work as a stainless steel welder. Dr. Repsher found that appellant's pulmonary function abnormalities were more than adequately explained by his morbid obesity, sleep apnea and pulmonary sarcoidosis. He added that it was probably unsafe for appellant to work off the ground on ladders or scaffolding, but given appropriate respiratory protection, he could continue to work as a welder, albeit with some discomfort in view of his morbid obesity and decompensated right ventricular heart failure.

In a February 27, 2009 decision, the Office denied appellant's claim. It found that, while the record supported that the claimed occupational exposures occurred, the medical evidence did not establish that his diagnosed conditions were related to his work activities as a welder.

Appellant requested reconsideration on April 6, 2009 and submitted additional treatment records. In a May 9, 2005 report, Dr. Stevens stated that he initially evaluated appellant during the April 2005 hospitalization. He underwent a mediastinal lymph node biopsy that confirmed sarcoidosis as the cause of his mediastinal and hilar adenopathy. Dr. Stevens also found a patchy right lower lobe density on a CT scan, which may have been pneumonia, but could also have been focal sarcoidosis. There was also evidence of sleep apnea, diastolic heart failure and right heart dysfunction. Dr. Stevens stated that with diuresis and oxygen therapy appellant had done much better. He noted that appellant was employed as a journeyman, which was basically an all-around job "where he does just about everything, welding, repair work, etc." Under the heading "Social History," Dr. Stevens reported that appellant had a variety of exposures including

asbestos and welding. Appellant also had a pet cat and was a nonsmoker. After reviewing a recent pulmonary function study, Dr. Stevens stated that most of appellant's impairment was "probably" attributable to his "body habitus," so it was "not clear whether the sarcoidosis [was] actually causing any problems." He reiterated that the patch of infiltrate on the CT scan "may certainly have been an infectious pneumonia."

A February 15, 2008 treatment note stated that appellant sounded a little worse. Appellant told Dr. Stevens that this typically happened starting with a work-related activity that occurred in the fall when he would go into Freemont Canyon. Dr. Stevens advised that appellant was having more shortness of breath and more fluid retention. Appellant used his CPAP every night for eight or more hours without any complications and had good energy during the day until the late afternoon. Dr. Stevens found no current coughing or wheezing, just dyspnea on exertion. He noted that appellant probably had another year of working and had been exposed to welding and metal grinding dust in the past. Dr. Stevens diagnosed biopsy-proven sarcoidosis, sleep apnea, hypoxia, diabetes, history of renal insufficiency and diastolic heart failure. He also noted that appellant's peripheral edema might be worse, which could reflect worse oxygenation or worse right heart failure. The increase in shortness of breath could be due to weight gain or represent a flare of sarcoidosis, "though his lungs are clear." When seen on May 23, 2008, Dr. Stevens noted that subjectively appellant was about the same with dyspnea on exertion, no coughing and no wheezing.

The Office also received a May 20, 2008 FOH medical surveillance examination report from Dr. Christopher M. Snyder, an internist, who diagnosed pulmonary sarcoidosis with interstitial pulmonary fibrosis, type 2 diabetes and sensorineural hearing loss. The report did not address the etiology of any diagnosed condition.

In a June 1, 2009 decision, the Office denied appellant's occupational disease claim, finding that the medical evidence failed to establish a causal relationship between his diagnosed conditions and his employment.

LEGAL PRECEDENT

A claimant seeking benefits under the Federal Employees' Compensation Act[4] has the burden of establishing the essential elements of his claim by the weight of the reliable, probative and substantial evidence, including that an injury was sustained in the performance of duty as alleged and that any specific condition or disability claimed is causally related to the employment injury.[5]

[4] 5 U.S.C. §§ 8101-8193 (2006).

[5] 20 C.F.R. § 10.115(e), (f) (2009); *see Jacquelyn L. Oliver*, 48 ECAB 232, 235-36 (1996). Causal relationship is a medical question, which generally requires rationalized medical opinion evidence to resolve the issue. *See Robert G. Morris*, 48 ECAB 238 (1996). A physician's opinion on whether there is a causal relationship between the diagnosed condition and the implicated employment factors must be based on a complete factual and medical background. *Victor J. Woodhams*, 41 ECAB 345, 352 (1989). Additionally, the physician's opinion must be expressed in terms of a reasonable degree of medical certainty and must be supported by medical rationale, explaining the nature of the relationship between the diagnosed condition and appellant's specific employment factors. *Id.*

To establish that an injury was sustained in the performance of duty, a claimant must submit: (1) medical evidence establishing the presence or existence of the disease or condition for which compensation is claimed; (2) a factual statement identifying employment factors alleged to have caused or contributed to the presence or occurrence of the disease or condition; and (3) medical evidence establishing that the diagnosed condition is causally related to the identified employment factors.[6]

The issue of whether a claimant's disability is related to accepted conditions of his employment is a medical question that must be established by probative medical opinion from a physician. Medical opinions must be of reasonable medical certainty and supported with rationale explaining the nature of the relationship between the diagnosed condition and specific employment factors.[7] While the opinion supporting causal relationship does not have to reduce the cause or etiology of a disease or condition to an absolute certainty, the opinion must be one of reasonable medical certainty and not speculative or equivocal in character.[8] A medical opinion not fortified by medical rationale is of diminished probative value.[9]

ANALYSIS

Appellant contends that his employment as a welder and mechanic at the employing establishment caused his pulmonary and other medical conditions. The Office accepted that he was exposed to various chemicals, fumes and dusts in his federal employment. The Board finds that appellant has not submitted sufficient medical evidence to establish that any of his diagnosed medical conditions was caused or contributed to by his exposures in his federal employment.

The medical evidence of record reflects that appellant was hospitalized on April 23, 2005 for progressive respiratory distress. A biopsy was obtained that showed evidence leading to the diagnosis of sarcoidosis. Appellant was also diagnosed with pneumonia, congestive heart failure, diabetes mellitus and sleep apnea. Following his hospitalization, he was treated on a regular basis by Dr. Stevens, a specialist in pulmonary disease, who obtained diagnostic testing that showed improvement from earlier studies. Dr. Stevens confirmed the diagnosis of biopsy proven sarcoidosis and noted that earlier seen infiltrates observed on the CT scans may have been an infection or sarcoid. While he noted that appellant could continue to work within certain specified restrictions, Dr. Stevens did not provide any opinion relating appellant's diagnosed conditions to his federal employment. Dr. Stevens' treatment notes from 2005 to 2008 do not adequately explain how appellant's pulmonary condition or other medical problem related to his duties and exposures as a welder or mechanic. He addressed appellant's obesity and treatment for obstructive sleep apnea, for which appellant obtained some relief with compliance on CPAP. In a May 5, 2005 report, Dr. Stevens addressed appellant's job as a journeyman welder and mechanic and noted that there had been certain occupational exposures arising in his job. However, he obtained a pulmonary function study and stated that appellant's sarcoidosis was

[6] *Victor J. Woodhams*, *supra* note 5.

[7] *See Roy L. Humphrey*, 57 ECAB 238 (2005); *Steven S. Saleh*, 55 ECAB 169 (2003).

[8] *See Kathy A. Kelley*, 55 ECAB 206 (2004).

[9] *See David L. Scott*, 55 ECAB 330 (2004).

probably attributable to his body habitus and that the patchy infiltrate seen on CT scan may have been an infectious pneumonia. This is not sufficient medical opinion to relate appellant's diagnosed conditions to any exposure in his federal employment, as alleged. None of the treatment records from Dr. Stevens contain an adequate explanation of how the various diagnoses relate to appellant's federal employment.

In a January 29, 2008 report, Dr. Washburn stated that "[f]rom [appellant's] detailed description of his working environment at the hydroelectric plant, it is plausible that his [s]arcoidosis is work related." This opinion on causal relationship, however, is speculative and equivocal. Dr. Washburn acknowledged that the etiology of sarcoidosis was unknown but that medical literature indicated that environmental factors were a possible cause. He did not provide a detailed description of appellant's work environment or the accepted exposures arising in his work as a welder or mechanic. Moreover, Dr. Washburn did not provide any extensive discussion of the medical literature to which he referred as supporting a possible cause for appellant's pulmonary condition. This report is not sufficient to establish appellant's claim as causation is couched in speculative terms.

The medical evidence from Dr. Sawyer and Dr. Repsher does not support causal relationship. Based on a June 7, 2007 examination, Dr. Sawyer reported that there were no medical findings to support a work-related injury or illness. She identified several health problems not caused by work, including sarcoidosis, diabetes, obstructive sleep apnea and obesity. Dr. Sawyer subsequently reviewed appellant's surveillance physical examinations from 2004 to 2007 and addressed his exposures at work to dust, coatings, solvents, welding fumes, noise and heavy metals. However, she did not attribute any of his diagnosed conditions to these accepted exposures. Rather Dr. Sawyer noted that appellant was cleared to work but had restrictions due to nonwork-related medical problems. She noted a decrease in pulmonary functioning each year from 2004 but did not attribute this to any exposures in appellant's work as a welder or mechanic.

In a February 18, 2009 report, Dr. Repsher stated that appellant did not currently have or previously sustain any occupational lung disease related to his work as a welder. He was provided with appellant's medical records, reports from diagnostic studies and obtained a pulmonary function and arterial blood gas studies. Based on his examination, Dr. Repsher found that appellant did not have any evidence of a pulmonary condition related to his job as a welder. He explained pulmonary sarcoidosis was a disease of unknown cause which had never been statistically shown as related to the work appellant performed. Dr. Repsher attributed appellant's medical conditions to his morbid obesity, sleep apnea and decompensated right ventricular function.

Based on the evidence of record, appellant failed to establish that any of his diagnosed conditions are causally related to his employment as a plant mechanic or welder. The Board finds that the Office properly denied his occupational disease claim.

CONCLUSION

Appellant has not met his burden of proof to establish any medical condition, including pulmonary sarcoidosis, as causally related to his federal employment work exposure.

ORDER

IT IS HEREBY ORDERED THAT the June 1, 2009 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: June 2, 2010
Washington, DC

Alec J. Koromilas, Chief Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board