United States Department of Labor
Employees' Compensation Appeals Board

R.M., Appellant	)	
and	)	**Docket No. 11-169**
	)	**Issued: September 7, 2011**
U.S. POSTAL SERVICE, PROCESSING & DISTRIBUTION CENTER, Seattle, WA, Employer	)	

Appearances:
Howard L. Graham, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On October 26, 2010 appellant filed a timely appeal from a May 5, 2010 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act (FECA)[1] and 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 sustained a urinary incontinence condition as a consequence of his August 14, 2006 employment injury.

FACTUAL HISTORY

On August 14, 2006 appellant, then a 61-year-old motor vehicle operator, filed a traumatic injury claim (Form CA-1) alleging that he sustained an injury on that date in the

[1] 5 U.S.C. § 8101 *et seq.*

performance of duty. He fell backwards while in the restroom. OWCP accepted the claim for a lumbar strain and for a torn medial meniscus of the left knee. Appellant underwent left knee arthroscopic surgery on November 21, 2006.

In a report dated February 9, 2007, Dr. Kyle Smoot, a neurologist, advised that appellant was seen with complaints of urinary incontinence. He noted a prior history of a transurethral resection of the prostate (TURP) and it was unclear what was causing appellant's urinary symptoms. By report dated March 14, 2007, Dr. William Johnson, a urologist, provided a history of a TURP operation five years earlier, followed by several weeks of urinary incontinence that resolved. He noted that appellant had left knee surgery in November 2006 with a spinal or epidural anesthesia, followed by an acute onset of incontinence that had not resolved.

In a report dated May 30, 2007, Dr. Timothy Gilmore, an occupational medicine specialist, diagnosed lumbar sprain/strain and urinary incontinence. He stated that the incontinence was possibly related to the lumbar strain, although a magnetic resonance imaging (MRI) scan did not show an anatomical lesion explaining the connection. By report dated November 6, 2007, Dr. Gilmore stated that appellant believed his urinary incontinence was directly related to the anesthesia from knee surgery and subsequent treatment of his knee, possibly a consequence of the low back injury on August 14, 2006. He noted the onset of symptoms following the knee surgery and stated that the exact cause of the urinary incontinence was uncertain.

Appellant submitted a February 26, 2008 report from Dr. Smoot, who stated, "The exact etiology for his incontinence is unclear. I suspect it is due to multiple reasons. In the past, he has had a TURP. It is also interesting [that] the symptoms did start after his spinal anesthesia; however, it is unclear if this is playing any role and how this would have occurred. The patient's occupation can also be contributing and he has had episodes of trauma to the back in the past which also could be playing some role." Dr. Smoot stated that it was unlikely that a lesion seen in the spine was contributing to appellant's symptoms without having any other neurological symptoms or signs on examination.

In a report dated March 3, 2008, Dr. Gilmore stated that appellant continued to suffer from low back pain, muscle spasms and problems with bladder spasms which appeared related to his low back condition (spondylolisthesis and lumbar disc disease, aggravated by work activities). On April 14, 2008 he reported that, "while no direct evidence supporting the link between spinal anesthesia and [appellant's] problems has been established, there are reports of incontinence following spinal anesthesia."

By decision dated February 13, 2009, OWCP determined that appellant's urinary incontinence condition was not a consequential condition of the August 14, 2006 injury or left knee surgery. It found the medical evidence was insufficient to establish causal relationship.

On February 4, 2010 appellant requested reconsideration of his claim. He submitted a February 1, 2010 report from Dr. Gilmore, who stated that there was evidence in the medical literature "that supports the relationship between spinal anesthesia and the development of urinary incontinence in some individuals. This certainly seems to be the case for [appellant], with a very strong historical support of the development of incontinence following the surgery."

Dr. Gilmore reviewed the surgical records from the November 2006 knee surgery, where appellant was given a spinal anesthesia using bupivacaine. He quoted from a drug information service that a rare side effect of this medication included urinary incontinence, usually associated with unintentional subarachnoid injection during high spinal anesthesia. Although Dr. Gilmore did not see evidence that a subarachnoid injection occurred, appellant did experience incontinence after the procedure which was not documented prior to that time. He also noted preexisting problems with appellant's prostate and spinal stenosis, which would make appellant more likely than a patient with no underlying medical problems to develop urinary tract problems with any adverse effect from anesthesia on the nervous system. Dr. Gilmore concluded, "On a more-probable-than-not basis, I feel that [appellant's] urinary incontinence problem resulted from events related to the arthroscopic knee surgery of [November 21, 2006]."

OWCP prepared a statement of accepted facts and referred appellant for a second opinion evaluation. Appellant was initially seen by Dr. George Delyanis, a neurologist. In a report dated March 12, 2010, Dr. Delyanis reported that he "could not state either way on a more[-]probable[-]than[-]not basis" whether the urinary incontinence was related to the spinal anesthesia." OWCP subsequently referred appellant to Dr. Francis Schumann, a urologist, for a second opinion examination. In a report dated April 26, 2010, Dr. Schumann reviewed a history of injury and medical treatment and results on examination. He stated that appellant had been thoroughly worked up from a urologic standpoint and nothing indicated any obvious cause for appellant's condition. Dr. Schumann saw no reason for the condition to be related to the August 14, 2006 injury or to the spinal anesthesia from the knee surgery. He concluded that appellant did not have a work-related incontinence condition.

In a decision dated May 5, 2010, OWCP denied modification of its prior decision. It found the weight of the evidence was represented by Dr. Schumann.

LEGAL PRECEDENT

The general rule respecting consequential injuries is 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, which is attributable to the employees own intentional conduct.[2]

The fact that the etiology of a disease or condition is obscure does not shift the burden of proof to OWCP to disprove an employment relationship. Neither does the absence of a known etiology for a condition relieve a claimant of the burden of establishing a causal relationship by the weight of the evidence, which includes affirmative medical opinion evidence based on the material facts with supporting rationale.[3]

[2] *S.S.*, 59 ECAB 315 (2008).

[3] *Beverly A. Spencer*, 55 ECAB 501 (2004).

ANALYSIS

The Board finds that appellant has not established that his urinary incontinence condition is a consequence of his accepted August 14, 2006 employment injury.

The record reflects that appellant was initially seen for his complaints of urinary incontinence in 2007 by Dr. Smoot, a neurologist and Dr. Johnson, an urologist. Both of these physicians appropriately noted appellant's medical history including his prostate resection five years prior, as well as his November 2006 left knee surgery. In his February 9, 2007 report, Dr. Smoot stated that the cause of appellant's urinary symptoms was unclear. In a February 26, 2008 report, he listed several suspected causes of appellant's condition, including his past prostrate surgery, his spinal anesthesia during his knee surgery and episodes of prior back trauma. Dr. Smoot did not explain, however, how any specific event was competent to cause the urinary incontinence condition. In a March 14, 2007 report, Dr. Johnson stated his impression that appellant had overflow incontinence with hypocontractive bladder, but otherwise offered no opinion regarding the cause of the urinary condition. Lacking a rationalized medical opinion, explaining how the condition was caused by the accepted employment injury, or by the anesthesia administered during the November 21, 2006 knee surgery, these reports are of limited probative value.

Appellant thereafter submitted reports from his treating physician, Dr. Gilmore. On May 30, 2007 Dr. Gilmore opined that appellant's incontinence was possibly related to his accepted lumbar strain but he added that an MRI scan did not show any anatomical lesion explaining the connection. His opinion is mere speculation. Dr. Gilmore offered no affirmative medical explanation as to the cause of appellant's incontinence. Medical opinion that is speculative or equivocal in character has little probative value.[4] In reports dated November 6, 2007 and April 14, 2008, Dr. Gilmore noted that there was a possible relationship between appellant's incontinence and the spinal anesthesia he received during his left knee surgery. On February 1, 2010 he referenced medical literature which noted that a rare side effect of bupivacaine spinal anesthesia was urinary incontinence. Dr. Gilmore noted that the incontinence was usually associated with unintentional subarachnoid injection, but found no evidence that a subarchnoid injection had occurred. He concluded that appellant's urinary incontinence resulted from events related to his knee surgery of November 21, 2006. The Board finds that Dr. Gilmore offered insufficient rationalized medical opinion explaining how the urinary condition was a consequence of the surgical procedure. His opinion that a causal relationship existed is speculation.

Dr. Schumann, a specialist in urology, conducted a thorough physical examination of appellant and reviewed the medical records. He noted the lack of certainty regarding the cause of urinary incontinence. Based upon appellant's findings on examination and the medical records, Dr. Schumann found no basis for a causal relationship between the 2006 left knee surgery and the urinary incontinence commencing in 2007. He offered an unequivocal opinion that the diagnosed condition was not a consequence of the August 14, 2006 employment injury

[4] *Michael R. Shaffer*, 55 ECAB 386 (2004).

or subsequent surgery. As a specialist in the relevant field, the Board finds that the opinion of Dr. Schumann constitutes the weight of medical evidence.[5]

As the record contains insufficient medical opinion explaining how appellant's urinary incontinence, diagnosed in February 2007, was a consequence of the accepted injury, appellant did not meet his burden of proof.

CONCLUSION

The Board finds that appellant has not established that his urinary incontinence is a consequence of the accepted injury or the November 21, 2006 left knee arthroscopic surgery.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated May 5, 2010 is affirmed.

Issued: September 7, 2011
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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

[5] *See Lee. R. Newberry*, 34 ECAB 1294 (1983). *See also Michael S. Mina*, 57 ECAB 379 (2006).