United States Department of Labor
Employees' Compensation Appeals Board

R.C., Appellant **and** **DEPARTMENT OF DEFENSE, DEFENSE INTELLIGENCE AGENCY, Pearl Harbor, HI, Employer**	)	**Docket No. 13-181** **Issued: April 1, 2013**

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

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA HOWARD FITZGERALD, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On October 31, 2012 appellant filed a timely appeal from a July 12, 2012 merit decision of the Office of Workers' Compensation Programs (OWCP) which denied his occupational disease claim. Pursuant to the Federal Employees' Compensation Act[1] (FECA) 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 met his burden of proof to establish that he developed a pulmonary or skin condition causally related to factors of his employment.

FACTUAL HISTORY

On June 24, 2010 appellant, then a 46-year-old information technology specialist, filed an occupational disease claim alleging allergy and skin problems as a result of exposure to various

[1] 5 U.S.C. § 8101 *et seq.*

types of construction dust. He stated that he developed red scaly patches on his face, elbows, knees, arms and legs and experienced nasal congestion, runny nose, itchy eyes and eye infections whenever construction or renovations occurred at his workplace. Appellant first became aware of his illness on May 18, 2006 and realized that it was caused or aggravated by his employment on November 2, 2009. His supervisor noted that appellant's condition was first reported on October 15, 2007 and that his health problems included rashes, coughing and congestion.[2]

In an attached statement, appellant explained that he was reassigned to various cubicles between the mailroom 107A and RM-113 from 2001 to 2005, which mildly aggravated his allergies from exposure to dust. In September 2005, smoke from welding caused nasal congestion, runny nose and a sore throat. In October 2005, a four-year renovation project began and appellant was exposed to fine cement dust, fiberglass dust, black mold, fungus from the air conditioning systems, possible asbestos, smoke and fumes (Neugenic 4175). During that time period, he had normal allergy problems, including nasal congestion and runny nose, but also developed a skin rash on his face, elbows, knees, arms and legs, with itchy eyes, eye infections, gastrointestinal (GI) problems, and very loud snoring and sleep problems. When the renovations ended in March 2009, his health problems improved. He reported $2,272.27 in out of pocket medical expenses and 182 hours of sick leave used over a four-year period while he worked in a dusty and unhealthy work environment.

Appellant submitted various e-mails between himself and the employing establishment regarding the skin problems he experienced and his need to take various sick days after renovations in the building. He also submitted statements and e-mails from coworkers who observed rashes and open sores on his skin during a time of major construction throughout the building. Appellant submitted a Materials Safety Data Sheet and a map of the employing establishment.

In a July 1, 2010 statement, Grace Tanaka, appellant's supervisor, reported that appellant was a systems administrator who worked on a computer at his desk and also in the server computer room. She had seen appellant with congestion and red eyes. Ms. Tanaka noted that construction began in the room across the hall in the fall of 2007 and that in February 2008 renovations of the bathroom began which resulted in dust, smell and excessive noise. She explained that appellant's desk was next to the bathroom wall and that concrete dust accumulated in the office spaces. Ms. Tanaka believed that appellant's medical documentation, timecards and statements were accurate.

Appellant was treated for his skin condition from March 2008 to November 2009 by Dr. Paul Takiguchi, a dermatologist, who noted that appellant had a four-year history of rash on his scalp and extremities and a long history of upper respiratory allergies, recurrent sinus infections and a deviated nasal septum. In March 3 and November 3, 2008 reports, he related that the rash began when appellant took antibiotics for an upper respiratory infection (URI). Upon examination, Dr. Takiguchi observed multiple small to large erythematous, scaly, sharply

[2] Appellant also submitted a claim for disability compensation for the period October 27, 2005 to April 18, 2010 and a time analysis card indicating that he missed work a few hours a day for medical appointments. Because OWCP has not issued a final decision regarding his disability compensation claim, the Board will not address that issue here on appeal.

circumscribed plaques to appellant's scalp, elbows, upper arms, knees, thighs, lower legs and distal right great toe, which covered four to five percent of his body surface area. He diagnosed chronic moderate plaque psoriasis and recommended appellant try a clobex spray. In November 2008, Dr. Takiguchi reported improvement to most of appellant's skin after medication. He still observed multiple psoriatic plaques on appellant's scalp and new tender red lesions to his legs. Dr. Takiguchi diagnosed resolved impetigo, flared psoriasis due to impetigo, and atopic dermatitis to face. In February 2009, he noted that appellant's psoriasis was much better and that small psoriatic plaques and lesions covered about one to two percent of his body surface area. In a May 23, 2009 note, Dr. Takiguchi related appellant's belief that the psoriasis might be due to air pollutants at his office from the air vents as construction was done. He reviewed the known factors which aggravated psoriasis but did not believe that appellant's psoriasis was related to any air pollutants from the workplace. In an August 22, 2009 note, Dr. Takiguchi reported that he was unable to determine whether or not appellant's allegations of dust exposure at his workplace had any role in his psoriasis or atopic dermatitis. In a November 18, 2009 report, he recommended appellant see an occupational medicine specialist or an allergist. Dr. Takiguchi opined that appellant's symptoms might be possibly related to workplace dust exposure.

In a May 25, 2006 report, Dr. William K. Wong, a dermatologist, noted that he examined appellant and observed erythematous dry scaly patches on his forehead, cheeks and chin. He also noted mild perioral erythema and flaking of appellant's upper lip and classical psoriasiform scaly patches and plaques in both elbows and knees. Dr. Wong diagnosed psoriasiform dermatitis and probable psoriasis of the elbows and knees and essential xerosis in underlying atopic diathesis.

In an October 26, 2007 report, Dr. Wayne Fujita, a Board-certified dermatologist, stated that he examined appellant. He diagnosed psoriasis and secondary impetigo with body surface area of three percent involving the face and extremities.

In an October 24, 2008 report, Dr. S. James Lee, an ear, nose and throat surgeon, examined appellant for rhinitis and hearing loss that had persisted for 10 years and gradually worsened over time. He obtained appellant's history and conducted an examination. Otoscopic examination demonstrated no abnormalities of external auditory canal sand tympanic membranes. Dr. Lee reported that the hearing examination showed normal hearing. A respiratory examination also revealed no rales, rhonchi, wheezing or rubs. Dr. Lee opined that appellant suffered from chronic sinusitis, deviated nasal septum and hyposmia.

In a March 28, 2009 polysomnography summary report, Dr. Gabriele M. Barthlen, a psychiatrist and neurologist, conducted a sleep study for indications of sleep apnea. He observed mild obstructive sleep apnea syndrome during the baseline diagnostic and good therapeutic response to continuous positive airway pressure (CPAP) during the treatment part.

In an April 22, 2009 report, Dr. Wilson T. Murakami, a Board-certified otolaryngologist, stated that appellant had a history of snoring and observed sleep apnea with gasping respirations. He reported that appellant appeared to have a narrow velopharyngeal area and class 1 oropharyngeal airway. Dr. Murakami recommended that appellant use nasal CPAP and surgical management.

In June 1 and September 26, 2009 progress notes, Dr. Craig Hamasaki, an internist, noted appellant's history of chronic allergic rhinitis, asthma and psoriasis beginning in 2005. He related that his condition was worse during construction at work and improved since construction was completed earlier that year. Upon examination, Dr. Hamasaki observed pulmonary dyspnea, a skin rash and nasal congestion. He diagnosed allergic rhinitis, asthma and psoriasis that were allegedly worsened by occupational exposure.

In a June 2, 2009 report, Dr. Philip I. Kuo, Jr., a Board-certified allergist and immunologist, noted appellant's history of congestion and rhinorrhea with itchiness for years with occasional ocular symptoms and cough. Appellant's previous allergy testing was positive to mold and dust mite. Dr. Kuo related that appellant developed a pruritic rash with generalized raised, erythematous and pruritic eruptions in 2001 while working at the employing establishment. He stated that the rash had resolved, but he wondered what triggered the rash. Upon examination, Dr. Kuo observed pale nasal mucosa that was moderately congested and moist and postnasal drip without erythema. He reported that skin allergy testing was positive to cat and dust mite. Dr. Kuo also found severe symptoms and findings of allergic rhinitis, mild, intermittent symptoms of asthma and contact dermatitis.

In a September 26, 2009 x-ray report, Dr. Stephen Ko, a Board-certified diagnostic radiologist, noted a history of cough and asbestos exposure but his examination did not reveal any interstitial markings, calcified pleural plaques or pulmonary masses. He diagnosed nonspecific interstitial markings. In an October 5, 2009 computerized tomography (CT) scan, Dr. Ko found no calcified pleural plaques, no pleural effusions, no pulmonary masses or consolidations and no enlarged mediastinal or hilar lymph nodes. He diagnosed bilateral apical scar.

In an October 5, 2009 report, Dr. Kevin S. Hara, a pulmonary disease specialist, related that appellant was exposed to asbestos from October 2005 through March 2009 when construction renovations were going on at his work building at the employing establishment. Although precautions were taken, he was exposed to dust and believed that he developed a rash, nasal congestion and a cough with sputum production. Dr. Hara noted appellant's history of nasal allergies to dusts and mold that seemed to worsen during the renovations. He reported that appellant no longer had problems and had improved drastically since the construction stopped. Upon examination, Dr. Hara observed no sinus tenderness in his nose and clear to auscultation lungs. He diagnosed allergic rhinitis with no definite lung disease at this time. In an October 17, 2009 pulmonary function analysis report, Dr. Hara noted mild reduction in mid-flows which improved significantly after inhaled bronchodilator suggesting the presence of reversible small airways obstruction.

On September 16, 2010 OWCP advised appellant that the evidence submitted was insufficient to establish his claim. It requested that he submit a comprehensive medical report from a treating physician which included a description of his symptoms, examination findings, a firm diagnosis and an opinion based on medical rationale explaining how his alleged condition was causally related to his federal employment.

Appellant submitted a June 26, 2006 Industrial Hygiene Survey report which indicated that escort personnel wore filtering face piece respirators due to the dust generated from the

ongoing building renovations. Hygiene air sampling needed to be done to assess the need for respiratory protection.

In September 23 and October 4 and 13, 2010 reports, Dr. D. Scott McCaffrey, a preventive medicine specialist, noted appellant's complaints of a continuing rash in his bilateral arms and legs. Appellant had a four-year history of work-related allergies including stuffy nose, sinusitis, mouth lesions, skin rashes, and skin lesion and that he worked as a computer engineer for the employing establishment. Appellant related that his symptoms worsened with increased exposure and improved when he removed himself from the office environment. Examination revealed that the skin was remarkable for diffused erythematous lesions with some nodularity Dr. McCaffrey also observed multiple nodular lesions in the lower extremities. He diagnosed chronic/persistent erythema nodosum with probable work environment triggers (dust and fumes).

In an October 23, 2010 report, Dr. McCaffrey reviewed appellant's medical records and clinically evaluated him. After interviewing appellant, it had been well established that appellant's work environment caused significant allergic rhinitis, conjunctivitis and upper respiratory inflammatory objective response. Dr. McCaffrey reported that an industrial hygiene assessment showed Aspergillus and other fungal entities at his workplace and noted that appellant had significant problems during the renovation phase of his workplace. Although it was unclear to what allergen appellant had a reaction, Dr. McCaffrey opined that a causal relationship appeared to be well established.

In December 1, 2010 and March 29, 2011 reports, Dr. McCaffrey related appellant's complaints of light rashes, pink and red, with no pain and itching in the bilateral arms, left knee and bilateral legs from dust and mold exposure from October 2005 to November 2010. Upon examination, he observed left eye with sclera and psoriasis orbital edema. Dr. McCaffrey diagnosed chronic/persistent work-related erythema nodosum.

In an October 14, 2010 report, Dr. Daniel J. Hohman, a preventative medicine specialist, stated that after a thorough review of appellant's medical record it was certainly possible that there was a causative relationship between his ongoing skin and respiratory condition and the irritants present in the worksite, especially during the building's renovations. He noted that the description of the work done, including removal of reportedly nonfriable asbestos and old ceiling tiles, could have significant impact on an employee's health especially if he was prone to chronic sinus or respiratory problems. Dr. Hohman explained that there was no way to determine a "clear-cut cause and effect relationship" since there was no way to measure the quality of the air to which appellant was exposed to now that the renovation work was completed.

In an October 21, 2010 report, Dr. Hamasaki noted appellant's complaints of allergic rhinitis and related that his system worsened when construction was done at his work building. Examination revealed an improving skin rash, sleep apnea, nasal congestion and a heart murmur. Dr. Hamasaki diagnosed allergic rhinitis, asthma, psoriasis, aortic valve insufficiency and obstructive sleep apnea.

In a November 5, 2010 report, Dr. Aparna Shah, an allergist and immunologist, reevaluated appellant for allergic rhinitis, asthma and problems at work due to construction dust aggregating his allergic symptoms. He related that appellant had a history of asthma since

childhood and of allergic rhinitis. Dr. Shah noted that construction and renovation work started in appellant's building approximately four to five years ago and that he was exposed to a lot of construction dust, including cement dust and fumes. Upon examination, he observed clear lungs without any wheezes, rales, or rhonchi and edematous macular rash over the front of his thighs, lower legs and back of the forearms. Dr. Shah stated that appellant had a rash, allergic rhinitis, and asthma aggregated by environmental pollutants including construction dust and paint fumes at work. He reported that appellant was exposed to construction dust, including cement dust and fumes, since October 2005 and noted significant worsening of his allergic symptoms, asthma and recurrent respiratory infections.

In a November 18, 2010 report, Dr. Ira D. Zunin, Board-certified in occupational medicine, stated that appellant sustained a series of work-related incidents that began on or about May 18, 2006. Appellant's chief complaints was of skin rash, respiratory issues, fatigue and allergic symptoms and his exposure to dust, fiberglass, welding fumes, smoke, asbestos and cement when he worked at the employing establishment. Dr. Zunin opined that, after conducting a medical investigation and diagnostics, on a more probable than not basis, appellant's complaints were causally related to his work exposures. Upon examination, he observed erythematous nodular rash in various stages of resolution in the upper and lower extremities. Appellant's lungs were clear to auscultation. Dr. Zunin diagnosed allergic rhinitis, asthma, psoriasis, allergic conjunctivitis and bilateral apical pleural thickening.

In a decision dated April 15, 2011, OWCP denied appellant's claim finding insufficient medical evidence to establish that he sustained a pulmonary or skin condition as a result of factors of his employment. It accepted that construction was performed at his workplace, but found that no specific chemical was identified to which he was exposed and the medical evidence did not establish how any specific chemicals caused or contributed to his accepted conditions.

In an April 10, 2012 statement, appellant expressed his disagreement with the OWCP decision and requested reimbursement for all his medical costs and lost leave due to illness caused by being exposed to various types of construction dust and fumes while working in Building 352 in Pearl Harbor from May 2006 through June 2010. He requested a fair opportunity to prove that he suffered numerous illnesses from being exposed to construction dust at work from 2005 to 2009.

In an April 12, 2011 report, Dr. McCaffrey noted appellant's continued complaints of a rash in the bilateral arms and legs and noted that he had a four-year history of work-related allergies. Appellant stated that his condition worsened when exposed to a dusty environment. Dr. McCaffrey diagnosed work-related chronic/persistent erythema nodosum and environmental psoriasis.

In a June 27, 2011 report, Dr. McCaffrey related appellant's complaints of right and left eyelid infections on June 2011 and a rash on the bilateral arms, posterior thighs and lower bilateral legs. Appellant stated that his symptoms worsened since 2010 and he believed that his symptoms were connected to construction on the fourth floor of his work building. Examination revealed scattered large erythematous skin lesions on the upper and lower extremities that were closed and dry. Dr. McCaffrey diagnosed work-related, chronic/persistent erythema nodosum

and environmental psoriasis. He stated that appellant had severe reaction probably to his work environment and recommended that he be transferred to an office away from the construction site.

In progress notes dated from September 14 to November 16, 2011, Dr. John R. Hannon, Board-certified in occupational medicine, noted appellant's history of a rash and upper respiratory reaction symptoms from exposure at work during construction in his building over the last few years. Appellant stated that when there was construction activity in his building he developed a rash on his arms and legs and itchy eyes and nasal congestion but when he worked in a building with no construction, his symptoms improve. Dr. Hannon reported that patch testing confirmed a positive reaction to air duct dust from a workroom, specifically from neomycin sulfate and dust from the ceiling air duct vent from room 314. He stated that appellant's rash had much improved over the past few weeks since he relocated to an alternative building. Dr. Hannon diagnosed superficial perivascular mixed spongiotic dermatitis and noted previous diagnoses of allergic contact dermatitis, atopic dermatitis, nummular dermatitis and other spongiotic dermatitis. He concluded that, based on the history, mechanism of injury and examination appellant's injury was more than likely caused by the above alleged work injury and was an industrial-related injury.

By decision dated July 12, 2012, OWCP denied modification of the April 15, 2011 decision finding insufficient medical evidence to establish that a pulmonary or skin condition causally related to exposure to chemicals and dust at work.

LEGAL PRECEDENT

An employee seeking benefits under FECA has the burden of proof to establish the essential elements of his or her claim by the weight of the reliable, probative and substantial evidence[3] including that he or she sustained an injury in the performance of duty and that any specific condition or disability for work for which he or she claims compensation is causally related to that employment injury.[4] In an occupational disease claim, appellant's burden requires submission of the following: (1) a factual statement identifying employment factors alleged to have caused or contributed to the presence or occurrence of the disease or condition; (2) medical evidence establishing the presence or existence of the disease or condition for which compensation is claimed; and (3) medical evidence establishing that the diagnosed condition is causally related to the employment factors identified by the employee.[5]

Causal relationship is a medical issue and the medical evidence generally required to establish causal relationship is rationalized medical opinion evidence.[6] The opinion of the physician must be based on a complete factual and medical background of the employee, must be

[3] *J.P.,* 59 ECAB 178 (2007); *Joseph M. Whelan,* 20 ECAB 55, 58 (1968).

[4] *M.M.,* Docket No. 08-1510 (issued November 25, 2010); *G.T.,* 59 ECAB 447 (2008); *Elaine Pendleton,* 40 ECAB 1143, 1145 (1989).

[5] *R.H.,* 59 ECAB 382 (2008); *Ernest St. Pierre,* 51 ECAB 623 (2000).

[6] *I.R.,* Docket No. 09-1229 (issued February 24, 2010); *D.I.,* 59 ECAB 158 (2007).

one of reasonable medical certainty and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the employee.[7] The weight of the medical evidence is determined by its reliability, its probative value, its convincing quality, the care of analysis manifested, and the medical rationale expressed in support of the physician's opinion.[8]

An award of compensation may not be based on surmise, conjecture or speculation. Neither the fact that appellant's condition became apparent during a period of employment nor is the belief that his condition was caused, precipitated or aggravated by his employment sufficient to establish causal relationship.[9]

ANALYSIS

Appellant alleged that he developed allergy and skin problems as a result of exposure to fine cement dust, fiberglass dust, black mold, fungus, possible asbestos, smoke and fumes due to renovation at his workplace from October 2005 to March 2009 and November 2009 to June 2010. He noted that he suffered from chronic allergy and sinus problems and had rashes on his skin during the renovation period. Appellant's conditions improved when the renovations stopped or he worked in a different building. OWCP denied appellant's claim finding insufficient medical evidence to establish that his pulmonary and skin conditions were causally related to exposure to chemicals and dust at work. The Board finds that appellant has not submitted sufficient medical evidence to establish a causal relationship between his diagnosed conditions and exposure to construction dust and fumes at work.

From March 2008 to February 2009 appellant was treated for his skin condition by Dr. Takiguchi who noted a history of a four-year history of rash on his scalp and extremities and a long history of upper respiratory allergies, recurrent sinus infections, deviated nasal septums, and sinus infections resulting in flares of the rash. He related that appellant's skin condition began when he took antibiotics for the upper respiratory infection. Upon examination, Dr. Takiguchi observed multiple small to large erythematous and scaly plaques covering four to five percent of appellant's body surface area. He diagnosed moderate chronic plaque psoriasis. In a May 23, 2009 progress note, Dr. Takiguchi related appellant's belief that his psoriasis might be due to air pollutants at his office from the air vents as construction was done. He stated that he reviewed the known factors which aggravate psoriasis and he did not believe that appellant's psoriasis was related to any air pollutants from the workplace. In a November 18, 2009 report, Dr. Takiguchi recommended that appellant see an occupational medicine specialist or an allergist who might be of more help to him as regards on his belief that workplace dust exposure caused him to have multiple medical problems. He opined that appellant's symptoms might be possibly related to workplace dust exposure.

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[7] *I.J.,* 59 ECAB 408 (2008); *Victor J. Woodhams,* 41 ECAB 465 (2005).

[8] *James Mack,* 43 ECAB 321 (1991).

[9] *Joe T. Williams,* 44 ECAB 518, 521 (1993).

The Board finds that the reports from Dr. Takiguchi are not sufficient to establish that appellant's skin condition was causally related to factors of his employment. Dr. Takiguchi indicated that appellant's skin condition began when he took antibiotics for a URI infection. In a May 23, 2009 report, he reviewed the factors that caused psoriasis and did not believe that appellant's psoriasis was related to any air pollutants at work. In a November 18, 2009 report, Dr. Takiguchi recommended that appellant see an allergist for his symptoms and opined generally that appellant's symptoms might be possibly related to workplace dust exposure. The Board notes that Dr. Takiguchi contradicted his opinion that appellant's psoriasis was not related to any air pollutants at work. Inconsistent or contradictory reports from a physician lack probative value.[10] Dr. Takiguchi's opinion regarding causal relationship is insufficient to establish appellant's claim.

In an October 25, 2009 report, Dr. Hara related that appellant was exposed to asbestos from October 2005 through March 2009 when construction renovations were going on at his work building. He noted that appellant's history of nasal allergies to dusts and mold seemed to worsen during this same time period as the renovations. Dr. Hara reported that appellant no longer had problems and had improved drastically since the construction stopped. He diagnosed allergic rhinitis with no definite lung disease at this time. Although Dr. Hara attributed the worsening of appellant's conditions to exposure to dusts and mold at work, he did not provide sufficient opinion or explanation regarding how this exposure caused or contributed to appellant's pulmonary condition. The Board has held that the fact that appellant's conditions improved when he was no longer exposed to the work environments alleged to have caused his condition, without further medical rationale, is insufficient to establish a causal relationship between his condition and factors of his employment.[11] In a November 5, 2010 report, Dr. Shah also noted appellant's complaints of allergic rhinitis, asthma and problems at work due to construction dust aggregating his allergic symptoms. He reported that appellant's symptoms significantly worsened when exposed to construction dust and fumes at his workplace. The mere fact that work activities may produce symptoms revelatory of an underlying condition does not raise an inference of an employment relation. Such a relationship must be shown by rationalized medical evidence of a causal relation based upon a specific and accurate history of employment conditions which are alleged to have caused or exacerbated a disabling condition.[12] The Board finds that these reports fail to establish a causal relationship between appellant's condition and factors of his employment.

From September to October 2010, appellant was seen by Dr. McCaffrey for his allergies, including stuffy nose and sinusitis, mouth lesions and skin rashes. Dr. McCaffrey related that appellant worked as a computer engineer and noted that his symptoms worsened with increased exposure at work and improved when he improved himself from the office building. He diagnosed chronic/persistent erythema nodosum with probable work environment triggers (dust and fumes). In an October 23, 2010 report, Dr. McCaffrey stated that it had been well

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[10] *K.S.,* Docket No. 11-2071 (issued April 17, 2012); *Cleona M. Simmons,* 38 ECAB 814 (1987).

[11] *T.M.,* Docket No. 08-0975 (issued February 6, 2009); *John F. Glynn,* 53 ECAB 562 (2002); *Cleopatra McDougal-Saddler,* 47 ECAB 480 (1996).

[12] *Patricia J. Bolleter,* 40 ECAB 373 (1988).

established that appellant's work environment caused significant allergic rhinitis, conjunctivitis, and URI objective response. He reported that an industrial hygiene assessment showed Aspergillus and other fungal entities at his workplace. Although it was unclear what appellant had an allergic reaction to, Dr. McCaffrey opined that a causal relationship appeared to be well established. The Board finds that Dr. McCaffrey's opinion regarding causal relationship is speculative. While he concluded that a causal relationship was established, Dr. McCaffrey also stated that it was "unclear what appellant had an allergic reaction to." The Board finds that this opinion is vague and equivocal and failed to adequately explain the causal relationship between appellant's condition and any specific work-related exposures.[13] Similarly, Dr. Hohman's opinion in his October 14, 2010 report that it was "certainly possible that there was a causative relationship between his ongoing skin and respiratory condition and the irritants present in the worksite" is also speculative and does not constitute a well-rationalized medical opinion establishing causal relationship. He explained that there was no way to determine a "clear-cut cause and effect relationship" because he could not measure the quality of the air that appellant was exposed to. Because these opinions are speculative and equivocal, the Board finds that they do not establish appellant's claim.

From June to November 2011, appellant was treated for his skin condition by Dr. Hannon, who noted his history of a rash and upper respiratory reaction symptoms from exposure at work during construction in his building over the last few years. He stated that appellant was exposed to allergens and diagnosed contact dermatitis due to chemicals. Dr. Hannon reported that patch testing confirmed a positive reaction to air duct dust from work room, specifically from neomycin sulfate and dust from the ceiling air duct vent from room 314. He diagnosed superficial perivascular mixed spongiotic dermatitis and noted previous diagnoses of allergic contact dermatitis, atopic dermatitis, nummular dermatitis, and other spongiotic dermatitis. Dr. Hannon concluded that, based on the history, mechanism of injury, and examination appellant's injury was more than likely caused by the above alleged work injury and was an industrial related injury. The Board notes that, while Dr. Hannon provides an opinion on causal relationship, his reports are not sufficient to meet appellant's burden of proof. He did not provide adequate medical reasoning to explain how appellant's exposure to concrete dust and fumes from renovation work caused or contributed to his skin condition. The Board has found that medical evidence that states a conclusion but does not offer any rationalized medical explanation regarding the cause of an employee's condition is of limited probative value on the issue of causal relationship.[14] Likewise, in the November 18, 2010 report, Dr. Zunin noted appellant's complaints of a skin rash and respiratory issues and his exposure to dust, welding fumes, smoke and asbestos at the employing establishment. He opined that appellant's complaints were causally related to his work exposures, but he did not provide any medical rationale to support his conclusion. Neither Dr. Hannon nor Dr. Zunin provided a rationalized, probative medical opinion explaining how appellant's condition was causally related to factors of his employment. Their reports are insufficient to establish causal relationship.

The additional reports of Drs. Wong, Fujita, Kuo, Lee, Hamasaki, Barthlem, Murakami and Ko are also insufficient to establish appellant's claim. While the physicians examined

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[13] *Roy L. Humphrey,* 57 ECAB 238, 242 (2005); *Michael E. Smith,* 50 ECAB 313 (1999).

[14] *J.F.,* Docket No. 09-1061 (issued November 17, 2009); *A.D.,* 58 ECAB 149 (2006).

appellant and provided diagnoses of chronic sinusitis, sleep apnea, dermatitis and psoriasis, none of the physicians provide any opinion on the cause of appellant's pulmonary and skin conditions. The Board has found that medical evidence that does not offer any opinion regarding the cause of an employee's condition is of limited probative value on the issue of causal relationship.[15] Furthermore, none of the physicians even mention appellant's work at the employing establishment or exposure to construction dust and fumes. To establish causal relationship, rationalized medical opinion evidence must relate specific employment factors identified by the claimant to the claimant's condition, with stated reasons by a physician.[16] Accordingly, the Board finds that these physicians fail to provide any rationalized medical opinion evidence in this case.

On appeal, appellant contends that Dr. McCaffrey's medical reports are not speculative in nature as Drs. Zunin, Hannon and Lau believed that his condition were caused by his work environment. As noted, these medical reports failed to provide a well-rationalized medical opinion explaining how appellant's diagnosed condition resulted from exposure to construction dust and fumes at his workplace. Causal relationship is a medical question that must be established by reasoned medical opinion evidence.[17] Because appellant has not provided such rationalized medical opinion establishing that his skin and pulmonary conditions were causally related to factors of his employment, the Board finds that he did not meet his burden of proof to establish his claim.

Appellant may submit new evidence or argument with a written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.605 through 10.607.

CONCLUSION

The Board finds that appellant has not met his burden of proof to establish that his skin and pulmonary conditions were causally related to factors of his employment.

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[15] *R.E.,* Docket No. 10-679 (issued November 16, 2010); *K.W.,* 59 ECAB 271 (2007).

[16] *L.F.,* Docket No. 10-2287 (issued July 6, 2011); *Solomon Polen,* 51 ECAB 341 (2000).

[17] *W.W.,* Docket No. 09-1619 (issued June 2, 2010); *David Apgar,* 57 ECAB 137 (2005).

ORDER

IT IS HEREBY ORDERED THAT the July 12, 2012 merit decision of the Office of Workers' Compensation Programs is affirmed.

Issued: April 1, 2013
Washington, DC

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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

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