United States Department of Labor
Employees' Compensation Appeals Board

V.D., Appellant	)	
and	)	**Docket No. 15-0807**
	)	**Issued: August 13, 2015**
U.S. ARMY, U.S. ARMY MEDICAL RESEARCH INSTITUTE OF INFECTIOUS DISEASES, Fort Detrick, MD, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On February 26, 2015 appellant filed a timely appeal from the September 3, 2014 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to review the merits of this case.

ISSUE

The issue is whether appellant has established expansion of her claim to include a right shoulder condition or any other condition causally related the July 23, 2012 accepted work injury.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On July 23, 2012 appellant, a 47-year-old biologist, sustained a traumatic injury in the performance of duty when she received a routine smallpox vaccination. She developed a large blister at the site, which required drainage on two occasions. On August 9, 2012 appellant presented with localized redness, pain, warmth, and firmness at the site. She was found to have a localized allergic reaction to the vaccination.

On August 29, 2012 Dr. Renata J.M. Engler, a Board-certified allergist and immunologist, related appellant's history and symptoms and findings on physical examination. In addition to fatigue, shoulder myalgia and myositis, and hypertension (systemic), she assessed generalized myalgias with features of arthralgias and joint stiffness. "Onset linked with cytokine peaks triggered by potent THl cytokine responses to vaccinia immunization.… Symptoms may have been confounded by overlapping drug reaction…." Dr. Engler also assessed dermatitis due to drugs and medicines, generalized. She noted a generalized rash with onset temporally associated to peak vaccinia reactions following immunization "but etiology confounded by addition of antibiotic." Dr. Engler added that appellant's response to corticosteroids suggested immune mediated rash rather than other infection as the source.

OWCP accepted appellant's claim for contact dermatitis due to drugs or medicines in contact with skin.

Given the chronicity of her right shoulder pain, OWCP referred appellant, together with her medical record and a statement of accepted facts, to Dr. Jonathan R. Van Meter, a Board-certified dermatologist. Dr. Van Meter examined her on November 15, 2013. It was his opinion that, as he observed no current rash on examination, there was no need for continuing active treatment and as the skin reaction had resolved, continuing physical therapy was not required.

OWCP also referred appellant to Dr. Ulgan I. Sila, a Board-certified allergist and immunologist, for the purpose of determining whether the smallpox vaccine could cause a shoulder condition. Dr. Sila related appellant's history. He noted that on April 30, 2013 she received a routine tuberculosis skin test on her left forearm, to which she had a severe reaction with warmth and erythema. The left arm was painful and moderately swollen and during this time, there was a significant flare up of appellant's right arm and shoulder pain. Dr. Sila described his findings on physical examination. The right shoulder had no gross limitation of motion, but the neck and right upper shoulder were sensitive to touch.

Dr. Sila diagnosed an adverse reaction to a smallpox vaccination characterized by an exaggerated local reaction, generalized pruritic dermatitis, and chronic pain syndrome involving the shoulder area. Asked if a smallpox vaccination would cause a severe allergic reaction, he explained that it could cause an immediate allergic or hypersensitivity reaction, most likely due to the vaccine or its various components, such as antibiotics that are present in the vaccine. Such immediate reactions were usually IgE mediated, occurred within several hours after the administration of the vaccine, and were characterized by generalized dermatitis, pruritus, and symptoms of anaphylaxis, such as hypertension, breathing difficulties, cardiac abnormalities, and abdominal pain. Dr. Sila explained that a hypersensitivity reaction could also be delayed

Type III reaction, such as serum sickness or Arthus reaction.[2] Arthus reaction could occur within a few hours and was a local reaction involving pain, redness, swelling, and sometime tissue damage. Serum sickness was a generalized reaction occurring 7 to 21 days after an injection of the antigen and was characterized by generalized rash, fever, lymph node enlargement, and sometimes urinary problems. Dr. Sila reiterated that a hypersensitivity reaction could involve the local vaccination site or become systemic, or both.

OWCP referred appellant to Dr. Robert Allen Smith, a Board-certified orthopedic surgeon. He noted that appellant's condition appeared to resolve gradually over time, but at one point there was concern that because of the rather severe reaction to the vaccination there might be an underlying abscess or encroachment into the deep structures around the shoulder joint. An imaging study proved to be benign, however. Appellant nonetheless continued to complain of severe pain about her shoulder, which she stated involved both of her arms, causing weakness and muscle pain. "Apparently, [appellant] has some concern that she has other types of conditions such as thoracic outlet syndrome or chronic regional pain syndrome related to this incident."

Dr. Smith described his findings on physical examination. It was obvious to him that appellant was sensitive to these types of vaccination procedures, but it did not appear that she had any identifiable chronic destruction of her right shoulder joint. He confirmed that contact dermatitis was the correct and appropriate diagnosis for her case. Dr. Smith could find no evidence of any musculoskeletal involvement with regard to the right shoulder joint that would require an additional diagnosis being added to the accepted medical conditions. He observed: "In my opinion, [appellant's] symptoms are difficult to explain at this point from an objective [perspective] given her relatively benign examination and essentially normal structural studies."

In a decision dated March 14, 2014, OWCP denied an expansion of the accepted conditions in appellant's case.

Appellant requested a review of the written record by an OWCP hearing representative. She noted that in May 2013 she received a tuberculin skin test on her left arm that exacerbated her hyperimmune inflammatory response.

Dr. Jay R. Montgomery, a Board-certified family physician specializing in allergy and immunology, advised on March 31, 2014 that it was his opinion that appellant's right upper extremity findings were suggestive of brachial plexus neuritis. Brachial plexus neuritis following immunization against smallpox had been reported. Dr. Montgomery explained that the exact etiology of postvaccination brachial plexus neuritis was unknown, but an aberrant autoimmune possibility existed, rather than direct injury to the nerve. "Given the continued weakness documented most recently by the US Hansen's Center, [brachial plexus neuritis] seems all the more a possibility." In the absence of other causes, using the World Health Organization's most current Protocol of Assessing Vaccine Adverse Event Causally, the evidence presented in appellant's case would be adjudged "consistent with a causal association to immunization."

[2] Dr. Sila noted that appellant had previously received a smallpox vaccination as a child.

Appellant submitted reference materials relating brachial plexus neuropathy and its clinical presentation, smallpox vaccinations and adverse reactions, acute brachial neuropathy, and brachial plexus neuritis following genital human papillomavirus vaccination.

Dr. Patricia I. Dillon, Chief of the Medical Biosurety Program at the Barquist Army Health Clinic, related appellant's history on May 20, 2013. After receiving the smallpox vaccination, appellant demonstrated hypersensitivity to medications. The immune-triggered inflammatory process tended to occur in the right shoulder area involving the joint and overlying muscles. X-ray studies confirmed that there was an inflammatory reaction in the bursa region of the shoulder joint. Appellant continued to experience chronic pain. Dr. Dillon advised that it was their working diagnosis that the smallpox vaccination triggered a hypersensitivity immune cascade. On April 1, 2014 she noted that appellant would be following up with the immunologists at the Walter Reed National Military Medical Center with the goal of identifying what did and what did not cause her hyperimmune response in order to better identify the component of her immune system that had become hyperresponsive. Dr. Dillon indicated that, although testing for an underlying medical condition had thus far been negative, appellant's symptoms were consistent with brachial neuritis secondary to the smallpox vaccination.

In a decision dated September 3, 2014, an OWCP hearing representative affirmed the March 14, 2014 decision denying an expansion of the accepted medical conditions in appellant's case due to the lack of any substantial medical findings.

On appeal appellant argues that contact dermatitis was only one of the numerous symptoms she exhibited after the smallpox vaccination. Because of the complex nature of her reaction, she was evaluated by a number of medical specialists, and their consensus was that her condition was due to an injury triggered by the smallpox vaccination, which resulted in an inflammatory joint and nerve condition. Appellant points to Dr. Engler's August 29, 2012 report as to how the injury resulted in her diagnosed conditions. She points to comments made by an advanced practice registered nurse on September 23, 2012. Appellant also points to a December 20, 2013 letter written by Dr. Dillon in which she takes issue with a nonphysician evaluating the probative value of medical opinions and she takes issue with the hearing representative's discussion of the evidence.

LEGAL PRECEDENT

A claimant seeking benefits under FECA has the burden of proof to establish the essential elements of his or her claim by the weight of the 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]

Causal relationship is a medical issue,[5] and the medical evidence generally required to establish causal relationship is rationalized medical opinion evidence. The opinion of the

[3] *Nathaniel Milton*, 37 ECAB 712 (1986); *Joseph M. Whelan*, 20 ECAB 55 (1968) and cases cited therein.

[4] *Elaine Pendleton*, 40 ECAB 1143, 1145 (1989).

[5] *Mary J. Briggs*, 37 ECAB 578 (1986).

physician must be based on a complete factual and medical background of the claimant,[6] must be one of reasonable medical certainty,[7] and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the established incident or factor of employment.[8]

OWCP is not a disinterested arbiter but rather performs the role of adjudicator on the one hand and gatherer of the relevant facts and protector of the compensation fund on the other, a role that imposes an obligation on OWCP to see that its administrative processes are impartially and fairly conducted.[9] Although the claimant has the burden of establishing entitlement to compensation, OWCP shares responsibility in the development of the evidence.[10] Once OWCP starts to procure medical opinion evidence, it must do a complete job.[11] It has the responsibility to obtain from its referral physician an evaluation that will resolve the issue involved in the case.[12]

ANALYSIS

OWCP accepted that appellant sustained a traumatic injury in the performance of duty on July 23, 2012 when she received a routine smallpox vaccination. The early medical evidence made clear that appellant had developed a large blister at the site with localized redness, pain, warmth, and firmness. Appellant was found to have a localized allergic reaction to the vaccination. Dr. Engler, the attending allergist and immunologist, diagnosed dermatitis due to drugs and medicines. She noted a generalized rash with onset temporally associated to peak vaccinia reactions following immunization. Thus, OWCP accepted appellant's claim for contact dermatitis due to drugs or medicines in contact with skin.

Appellant claims, however, that the vaccination caused more than dermatitis. She argues that it also caused an inflammatory joint and nerve condition or hyperimmune inflammatory response. Appellant bears the burden of proof to establish the essential elements of causal relationships. Causal relationship requires a rationalized medical opinion explaining, to a reasonable degree of medical certainty and based on objective clinical findings, how her smallpox vaccination caused a firmly diagnosed inflammatory joint and nerve condition or hypersensitivity reaction.

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[6] *William Nimitz, Jr.*, 30 ECAB 567, 570 (1979).

[7] *See Morris Scanlon*, 11 ECAB 384, 385 (1960).

[8] *See William E. Enright*, 31 ECAB 426, 430 (1980).

[9] *Thomas M. Lee*, 10 ECAB 175 (1958).

[10] *William J. Cantrell*, 34 ECAB 1233 (1983); *Gertrude E. Evans*, 26 ECAB 195 (1974); *see John J. Carlone*, 41 ECAB 345, 358 (1989) (finding that the medical evidence was not sufficient to discharge claimant's burden of proof but remanding the case for further development of the medical evidence given the uncontroverted inference of causal relationship).

[11] *William N. Saathoff*, 8 ECAB 769 (1956).

[12] *Mae Z. Hackett*, 34 ECAB 1421, 1426 (1983); *Richard W. Kinder*, 32 ECAB 863, 866 (1981) (noting that the report of OWCP referral physician did not resolve the issue).

The record contains several medical opinions that are supportive of appellant's claim. Dr. Engler noted that the onset of appellant's diagnosed generalized myalgias, with features of arthralgias and myositis, was linked with cytokine peaks triggered by potent Th1 cytokine responses to the vaccinia immunization. OWCP referred appellant to Dr. Sila, another allergist and immunologist, for the purpose of determining whether the smallpox vaccine could cause a shoulder condition. He answered in the affirmative. Dr. Sila diagnosed an adverse reaction to a smallpox vaccination characterized by an exaggerated local reaction, generalized pruritic dermatitis, and chronic pain syndrome involving the shoulder area. He confirmed that the vaccination appellant received could cause an allergic or hypersensitivity reaction, which could involve the local vaccination site or become systemic, or both. The characteristic symptoms he described appeared to reflect appellant's reaction. Although this tended to support the linkage Dr. Engler observed between appellant's chronic pain condition and the vaccination, OWCP did not ask Dr. Sila to comment on Dr. Engler's opinion or to address whether the July 23, 2012 smallpox vaccination had indeed caused a medical condition other than contact dermatitis.

Further support for appellant's claim came from Dr. Montgomery, another allergist and immunologist. He believed that her right upper extremity findings were suggestive of brachial plexus neuritis. Brachial plexus neuritis following immunization against smallpox had been reported and although the exact etiology of postvaccination brachial plexus neuritis was unknown, an aberrant autoimmune possibility existed, as opposed to a direct injury to the nerve. Given appellant's continued documented weakness, Dr. Montgomery believed brachial plexus neuritis was all the more a possibility. It was his opinion that in the absence of other causes, using the World Health Organization's most current Protocol of Assessing Vaccine Adverse Event Causally, the evidence presented in appellant's case would be adjudged consistent with a causal association to immunization.

Appellant submitted reference materials relating brachial plexus neuropathy and its clinical presentation, smallpox vaccinations and adverse reactions, acute brachial neuropathy, and brachial plexus neuritis following genital human papillomavirus vaccination.[13]

It was also Dr. Dillon's opinion that appellant's symptoms were consistent with brachial neuritis secondary to the smallpox vaccination. Chief of the Medical Biosurety Program at the Barquist Army Health Clinic, Dr. Dillon noted that appellant demonstrated hypersensitivity to medications. The immune-triggered inflammatory process tended to occur in the right shoulder area involving the joint and overlying muscles. X-ray studies confirmed that there was an inflammatory reaction occurring in the bursa region of the shoulder joint. Appellant continued to experience chronic pain. It was Dr. Dillon's working diagnosis that the smallpox vaccination triggered a hypersensitivity immune cascade.

There is no medical opinion to the contrary. That is, no physician has taken issue with any of the opinions offered by Drs. Engler, Sila, Montgomery, and Dillon. Dr. Van Meter, the referral dermatologist, merely confirmed that appellant had no current rash on examination and

[13] Medical texts and excerpts from publications are of no evidentiary value in establishing the necessary causal relationship as they are of general application and are not determinative of whether the specific condition claimed was causally related to the particular employment injury involved. *Gaetan F. Valenza*, 35 ECAB 763 (1984); *Kenneth S. Vansick*, 31 ECAB 1132 (1980).

that her skin reaction had resolved and Dr. Smith, the referral orthopedic surgeon, noted that while it was obvious to him that appellant was sensitive to these types of vaccination procedures, it did not appear that she had any identifiable chronic destruction of her right shoulder joint. From an orthopedic perspective, he could find no evidence of any musculoskeletal involvement. Neither of these reports contradicted the opinions given by the specialists in allergy and immunology.

The Board will set aside OWCP's September 3, 2014 decision and will remand the case for a supplemental opinion from Dr. Silas. OWCP should ask Dr. Silas to comment on the opinions given by Drs. Engler, Montgomery, and Dillon and to offer his own opinion on whether appellant's smallpox vaccination caused an identifiable medical condition other than right shoulder contact dermatitis. Following such further development as may become necessary, OWCP shall issue a *de novo* decision on appellant's claim. On appeal appellant points to comments made by an advanced practice registered nurse on September 23, 2012. However, a nurse is not a "physician" within the meaning of FECA and is therefore not competent to give a medical opinion on the matter.[14] Appellant also references on appeal a letter from Dr. Dillon. However, that letter is not found in the case record.

CONCLUSION

The Board finds that this case is not in posture for decision on whether the July 23, 2012 work injury caused a right should condition or any other condition. Further development of the medical opinion evidence is warranted.

[14] *Vicky L. Hannis*, 48 ECAB 538 (1997); *see* 5 U.S.C. § 8101(2) (the term "physician" includes surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors and osteopathic practitioners within the scope of their practice as defined by state law).

ORDER

IT IS HEREBY ORDERED THAT the September 3, 2014 decision of the Office of Workers' Compensation Programs is set aside and the case remanded for further action.

Issued: August 13, 2015
Washington, DC

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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