United States Department of Labor
Employees' Compensation Appeals Board

M.A., Appellant	)	
and	)	
DEPARTMENT OF AGRICULTURE, AGRICULTURE MARKETING SERVICE, COTTON PROGRAMS, CLASSING OFFICE, Corpus Christi, TX, Employer	)	**Docket No. 09-1581** **Issued: July 16, 2010**

Appearances:
Appellant, pro se
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 June 3, 2009 appellant filed a timely appeal from a March 19, 2009 decision of the Office of Workers' Compensation Programs that denied her claim. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant met her burden of proof to establish that she sustained bronchiectasis or other pulmonary conditions caused or aggravated by factors of her federal employment.

On appeal, she asserts that her physician's opinion establishes her claim.

FACTUAL HISTORY

On May 10, 2003 appellant, then a 55-year-old seasonal commodity aide, filed an occupational disease claim alleging that her exposure to cotton samples daily caused

bronchiectasis. In January 2002, she began to experience a cough and chest problems. Appellant was hospitalized in May and November 2002 and January 2003 for persistent cough, fever, nausea and vomiting. She described her job duties, stating that commencing in 1988 she tested and classified cotton samples and cleaned machines. Appellant noted that her attending internist, Dr. Vicente Rodriguez, told her that she could no longer work in an environment with airborne dust and lint.

The employing establishment controverted the claim, stating that appellant worked approximately three months each year. Appellant had accepted claims for carpal tunnel syndrome.

By letter dated June 10, 2003, the Office informed appellant of the type of evidence needed to support her claim. Appellant submitted a March 25, 2002 pulmonary function study that was interpreted as normal. In a December 30, 2002 report, Dr. W. John Arringdale, a thoracic and cardiovascular surgeon, noted a history of nonHodgkin's lymphoma in remission. He diagnosed right lower lobe bronchiectasis and advised that appellant needed to quit her job and stay away "from something that obviously gives her rhinorrhea and aggravates the present problem." In chart notes dated January 8 and 31, 2003, Dr. Albert J. Wood, Board-certified in internal medicine and oncology, noted her complaints of cough and congestion. He advised that a computerized tomography (CT) scan and bone marrow biopsy revealed no evidence of lymphoma. In a July 2, 2003 duty status report, Dr. Rodriguez described clinical findings of dyspnea with exertion, cough and hemoptysis. He diagnosed pneumoconiosis and provided restrictions to appellant's physical activity.

By letter dated July 9, 2003, the employing establishment submitted a position description, noted that appellant worked light duty following her previous claims and described her specific light duties and the work environment. It also provided dust level measurements, stating that they were below Occupational Safety & Health Administration (OSHA) standards when tested in 2001. The employing establishment provided a table of days appellant worked for the period July 31, 1988 through October 20, 2002, when she last worked.

In a July 10, 2003 decision, the Office denied the claim. It accepted that the exposure to cotton dust occurred but that she did not submit sufficient medical evidence to establish a diagnosis caused by the exposure.

On September 28, 2003 appellant requested reconsideration and submitted additional medical evidence, including a January 29, 2002 chest x-ray that was interpreted as normal. A November 11, 2002 chest x-ray demonstrated a small, right mid-lung opacity. A bronchoscopy was performed on November 11, 2002; brushings and washings were benign and the culture was normal. A November 14, 2002 x-ray demonstrated no active infiltrate and a tiny calcified granuloma in the left apex.

In a July 23, 2003 report, Dr. Rodriguez advised that he first treated appellant in October 2002 but her symptoms of wheezing, coughing, shortness of breath and high grade fever persisted. He concluded that she had pneumoconiosis secondary to cotton exposure at work. Dr. Rodriguez recommended that she not return to work in the cotton industry since it would be detrimental to her health.

On March 4, 2004 the Office determined that further development of the medical evidence was warranted. On March 8, 2004 it referred appellant to Dr. Douglas W. Jenkins, Board-certified in internal medicine and pulmonary disease, for a second opinion evaluation. In an April 16, 2004 report, Dr. Jenkins reviewed her work and medical history and provided findings on physical examination. He listed appellant's symptoms of frequent coughing, nasal erythema and edema. On examination, appellant's throat was normal. There was no adenopathy and the lungs were free of rales and rhonchi. Dr. Jenkins advised that a chest x-ray that day was normal. He reviewed the previous diagnostic studies, noting that there was a questionable infiltrate present in August 2002 that had cleared by the time of subsequent studies. CT scans in January and February 2003 were considered normal except for one right middle lobe area, which was inconsistent and not repeated. Pulmonary function studies done under his supervision showed a trivial restriction with no obstruction and were adequate for usual activities of daily life. In response to Office questions, Dr. Jenkins advised that there was insufficient evidence to support the diagnosis of bronchiectasis. He noted that appellant could have had a residual of previous pneumonia which was questionable but did not represent bronchiectasis. Dr. Jenkins found that she did not have permanent severe lung disease and diagnosed adult onset asthma, advising that there was insufficient evidence of record to establish any condition as employment related. He attached the results of pulmonary function testing. An April 10, 2004 chest x-ray demonstrated a calcified granuloma in the left lung apex and was otherwise negative. In a work capacity evaluation dated April 22, 2004, Dr. Jenkins advised that appellant was capable of performing her usual job but that it was reasonable that she should wear a dust mask during exposure to dust such as cotton fibers.

In a June 17, 2005 decision, the Office found that appellant failed to establish that she sustained an injury causally related to her federal employment.

Appellant subsequently requested reconsideration on four occasions. In merit decisions dated June 6, 2006, February 28, 2007, January 31 and April 9, 2008,[1] the Office denied modification of the prior decisions.

Appellant asserted that she worked under adverse conditions that resulted in chronic illness because the employing establishment did not follow policies recommended by the National Institute for Occupational Safety and Health or the Centers for Disease Control. She contended that the ventilation was inadequate, she was not provided protective work clothing or proper health and safety training and that medical testing was not performed. Appellant described her employment and dust exposure beginning in 1988, noting that she worked at three facilities.

In an April 17, 2006 letter, the employing establishment advised that the policies cited by appellant were not relevant to the facility, noting that it passed OSHA testing, protective clothing and medical testing were not required but that safety training was provided. The employer noted

[1] On April 9, 2008 the Office reissued the January 31, 2008 decision and mailed it to appellant's new address.

that respirators and masks were provided and that the facility and machinery were properly ventilated.[2]

Appellant submitted treatment notes from Dr. Raymond Acebo, an internist, dated March 30, 2001 and January 30, 2002. Dr. Acebo diagnosed an upper respiratory infection, sinusitis and conjunctivitis. A March 20, 2002 CT scan of the right maxillary sinus demonstrated mild acute chronic sinusitis. In reports dated June 25 and August 20, 2002, Dr. Wood noted complaints of cough and congestion and diagnosed possible recurrent lymphoma. An August 26, 2002 CT scan of the abdomen and pelvis demonstrated a large patchy area at the right lung base with the appearance of pneumonia and no evidence of lymphadenopathy in the abdomen or pelvis. A September 16, 2002 chest x-ray demonstrated persistent focal consolidation of the right middle lobe. On October 2, 2002 Dr. Acebo diagnosed viral syndrome and an October 9, 2002 chest x-ray was unchanged. On October 22, 2002 he advised that appellant's x-rays showed bronchiectasis and, on November 20 and December 20, 2002, noted continued complaints of coughing, fatigue, fever and body aches. Pulmonary function tests on November 8, 2002 demonstrated minimal obstruction.

On December 30, 2002 Dr. Arringdale advised that appellant might benefit from a right lower lobe resection or intravenous antibiotic therapy to clear up her bronchiectasis. A December 31, 2002 CT scan of the chest demonstrated a patchy opacification in the right middle lobe suggestive of bronchiectasis and an area of opacity in the medial right lower lobe suggestive of pneumonia. On January 21, 2003 Dr. Rodriguez diagnosed stable bronchiectasis. In notes dated January 21 to June 12, 2003, Dr. Acebo noted appellant's continued complaint of cough and fatigue. On April 8, 2003 Dr. Rodriguez diagnosed acute bronchitis and sinusitis.

On March 17, 2004 Dr. Wood provided findings on physical examination and diagnosed nonHodgkin's lymphoma in complete remission, bronchiectasis with history of recurrent pneumonias and degenerative arthritis. On June 15, 2004 appellant was admitted to the hospital. She was discharged on June 1, 2004 with a primary diagnosis of pneumonia and a secondary diagnosis of bronchiectasis. A January 18, 2005 CT scan of the thorax, abdomen and pelvis showed no evidence of adenopathy and infiltrates in the right and left lung base suggestive of alveolitis or bronchiolitis but a malignancy could not be excluded.

In reports dated January 26 and March 21, 2005, Dr. Sivakumar Padmanabhan, Board-certified in internal medicine and pulmonary disease, noted appellant's past work history in cotton and her complaint of chronic cough and clear sputum. He reviewed the diagnostic studies, noted her past medical history, and diagnosed bronchitis, unspecified; right and left bronchiectasis; right middle lobe infiltrate and a history of lymphoma. A June 20, 2005 CT scan of the thorax demonstrated interstitial lung disease with bronchiectasis with improvement of inflammatory changes. Appellant was again hospitalized on October 3, 2005 for fever and diffuse rhonchi throughout all lung fields. She was discharged on October 6, 2005 with diagnoses of pneumonia with bronchiectasis.

[2] The employing establishment stated that appellant's job consisted of scanning bale identity cards and taking moisture readings of samples that were already trayed before reaching her station, noting that handling of cotton and dust exposure was minimal to none.

On February 16, 2006 Dr. Rodriguez reviewed the report of Dr. Jenkins. He diagnosed organic pneumoconiosis due to cotton exposure with symptoms of fever, malaise, cough, hemoptysis and bronchospasm, noting that appellant had significant improvement in pulmonary function after she stopped work. In a December 6, 2006 report, Dr. Rodriguez reiterated that appellant's lung condition was caused by her work exposure to cotton.

In reports dated June 5 to 28, 2007, Dr. Padmanabhan noted appellant's history of nonHodgkin's lymphoma in remission and her complaint of cough and nasal congestion. He advised that bone marrow examination demonstrated no evidence of lymphoma but that panhypogammaglobulinemia, possibly related to her history of lymphoma, could account for her recurrent infections. In an October 26, 2007 report, Dr. Rodriguez diagnosed organic pneumoconiosis and advised that appellant's medical condition was a direct result of exposure and inhalation of cotton dust at work for 15 seasons.

A March 31, 2008 sputum study was positive for haemophilus influenzae. In reports dated October 27 and November 20, 2008, Dr. Aftab Mahmood, Board-certified in hematology, internal medicine and oncology, advised that appellant had developed panhypogammaglobulinemia with resultant upper respiratory tract infections. He noted that she had rarely received breakthrough infections since the institution of intravenous immunoglobulin treatment every four weeks and diagnosed polyglandular dysfunction and chronic lymphocytic leukemia in remission.

In a March 19, 2009 decision, the Office denied modification of the prior decisions, finding that the medical evidence did not establish a causal relationship between her claimed condition and employment factors.

LEGAL PRECEDENT

An employee seeking benefits under the Federal Employees' Compensation Act[3] has the burden of establishing the essential elements of his or her claim including the fact that the individual is an employee of the United States within the meaning of the Act, that the claim was timely filed within the applicable time limitation period of the Act, that an injury was sustained in the performance of duty as alleged and that any disability and/or specific condition for which compensation is claimed are causally related to the employment injury. These are the essential elements of each and every compensation claim, regardless of whether the asserted claim involves traumatic injury or occupational disease, an employee must satisfy this burden of proof.[4]

Office regulations define the term "occupational disease or illness" as a condition produced by the work environment over a period longer than a single workday or shift."[5] To establish that an injury was sustained in the performance of duty in an occupational disease

[3] 5 U.S.C. §§ 8101-8193.

[4] *Roy L. Humphrey*, 57 ECAB 238 (2005).

[5] 20 C.F.R. § 10.5(ee).

claim, a claimant must submit the following: (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 employment factors identified by the claimant. The medical opinion must be 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 claimant.[6]

Causal relationship is a medical issue and the medical evidence required to establish a causal relationship is rationalized medical evidence.[7] Rationalized medical evidence is medical evidence which includes a physician's rationalized medical opinion on the issue of whether there is a causal relationship between the claimant's diagnosed condition and the implicated employment factors. The opinion of the physician must be based on a complete factual and medical background of the claimant, must be 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 claimant.[8] Neither the mere fact that a disease or condition manifests itself during a period of employment nor the belief that the disease or condition was caused or aggravated by employment factors or incidents is sufficient to establish causal relationship.[9]

ANALYSIS

The Office accepted appellant's occupational exposure to cotton dust. Appellant, however, did not meet her burden of proof to establish that her lung condition was caused by factors of employment. The medical evidence of record lacks sufficient opinion from a physician that provides a complete history of appellant's occupational exposure and an explanation as to how it caused or contributed to her lung condition.

Neither Dr. Wood nor Dr. Acebo discussed a cause of appellant's pulmonary condition. It is well established 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.[10] Dr. Arringdale merely advised that appellant should avoid work because it aggravated her symptoms. These opinions are insufficient to meet appellant's burden of proof.

In an April 16, 2004 report, Dr. Jenkins, an Office referral physician and Board-certified pulmonologist, reviewed appellant's work and medical history and provided findings on physical examination. Chest x-ray the day of his examination was normal, and pulmonary function

[6] *Roy L. Humphrey, supra* note 4.

[7] *D.G.*, 59 ECAB ____ (Docket No. 08-1139, issued September 24, 2008).

[8] *Id.*

[9] *Roy L. Humphrey, supra* note 4.

[10] *Willie M. Miller*, 53 ECAB 697 (2002).

studies done under his supervision showed a trivial restriction with no obstruction and were adequate for usual activities of daily life. Dr. Jenkins reviewed the previous diagnostic studies, noting that there was a questionable infiltrate present in August 2002 that had cleared on further studies, including CT scans in January and February 2003. He considered these normal except for one right middle lobe area, noting that this was inconsistent and was not repeated. Dr. Jenkins advised that there was no evidence to support the diagnosis of bronchiectasis, advising that appellant's symptoms could be a residual of previous pneumonia which was questionable but did not represent bronchiectasis. The area in question was so small that it did not account for her symptoms. Dr. Jenkins diagnosed adult onset asthma, not related to her employment exposure to cotton, advising that if work related, one would expect resolution during her prolonged periods away from seasonal work, which did not happen. He concluded that appellant was capable of performing her usual job but that it was reasonable that she should wear a dust mask during exposure to dust such as cotton fibers.

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 rational expressed in support of the physician's opinion.[11] The Board finds that Dr. Jenkins provided a comprehensive report in which he outlined examination findings and provided a rationalized explanation for his determination that appellant did not have bronchiectasis and that her adult onset asthma or any lung condition was not caused by factors of her federal employment.

Dr. Padmanabhan, also a Board-certified pulmonologist, reviewed CT scan and x-ray reports and diagnosed unspecified bronchitis, right and left bronchiectasis, right middle lobe infiltrate and history of lymphoma and a June 20, 2005 CT scan demonstrated interstitial lung disease with bronchiectasis. In reports dated June 5 to 28, 2007, Dr. Padmanabhan revised the diagnosis to organic panhypogammoglobulinemia,[12] possibly related to appellant's history of lymphoma and advised that it could account for her recurrent infections. Dr. Mahmood also noted that appellant had developed panhypogammaglobulinemia with respiratory infections and advised that she rarely had breakthrough infections since beginning intravenous immunoglobulin treatment. He diagnosed polyglandular dysfunction and chronic lymphocytic leukemia in remission.

Dr. Rodriguez, an attending pulmonologist, found that appellant had pneumoconiosis caused by exposure and inhalation of cotton dust at work for 15 seasons. The record, however, contains no objective finding of pneumoconiosis by x-ray or CT study. Dr. Rodriguez did not discuss appellant's diagnosis of panhypogammoglobulinemia or the opinions of Dr. Padmanabhan and Dr. Mahmood that this condition could account for her recurrent infections. Dr. Mahmood noted the fact that she had few infections once she began treatment for her immunodeficiency condition. A mere conclusion without the necessary medical rationale explaining how and why a physician believes that a claimant's accepted exposure could result in a diagnosed condition is not sufficient to meet the claimant's burden of proof. The medical

[11] *C.B.*, 60 ECAB ____ (Docket No. 08-1583, issued December 9, 2008).

[12] Panhypogammaglobulinemia is defined as hypogammaglobulinemia; deficiency of all immunoglobulin classes; it is also called common variable immunodeficiency or agammaglobulinemia. *Dorland's Illustrated Medical Dictionary*, 29th edition (2000).

evidence must also include rationale explaining how the physician reached the conclusion he or she is supporting.[13] Dr. Rodriguez provided insufficient rationale to establish causal relation.

CONCLUSION

The Board finds that appellant has not met her burden of proof to establish that she has sustained bronchiectasis causally related to factors of her federal employment.

ORDER

IT IS HEREBY ORDERED THAT the March 19, 2009 decision of the Office of Workers' Compensation Programs be affirmed.

Issued: July 16, 2010
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

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