U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of MARTHA WILSON, claiming as widow of JAMES D. WILSON and DEPARTMENT OF THE ARMY, ARMY MATERIEL COMMAND, JEFFERSON PROVING GROUND, Madison, IN

Docket No. 02-1812; Submitted on the Record;
Issued May 12, 2003

DECISION and ORDER

Before ALEC J. KOROMILAS, DAVID S. GERSON, WILLIE T.C. THOMAS

The issue is whether the death of appellant's husband was causally related to his federal employment.

On July 21, 1965 appellant's husband, then a 48-year-old maintenance lead foreman, filed a claim for compensation (Form CA-1), alleging that on June 10, 1965, while helping to take a Graphotype machine up stairs on a cart, he sustained a severe lower back strain. The claim was accepted for low back sprain superimposed on minimal hypertrophic arthritic changes on C5-6, minimal hypertrophic changes in the thoracic spine and lumbar degenerated disc. The employee had concurrent conditions in his lifetime, consisting of nephritis of the kidneys and lungs, pulmonary fibrosis, spinal arthritis, coronary artery disease and history of bypass surgeries.

Appellant's husband died on March 8, 1996. The death certificate lists the causes of death as volume overload/pulmonary edema, as a consequence of renal failure, chronic glomerular nephritis and coronary artery disease.

On April 11, 1996 appellant's widow filed a claim for compensation for death benefits (Form CA-5).

By letter dated May 8, 1996, Dr. Robert F. Baker, appellant's treating physician, noted that no condition that appellant was being treated for by him directly lead to his death. Dr. Baker did note that it was known that appellant for many years had significant heart and circulatory problems. He also noted that appellant had back problems for many years and that over the past several years, the pain had worsened. However, he noted that appellant's significant heart problems made conservative care the only possible alternative for care.

By decision dated June 12, 1996, the Office of Workers' Compensation Programs denied appellant's claim for compensation for the reason that the evidence failed to establish that his death was causally related to the work injury of June 12, 1996.

By letter dated June 30, 1996, appellant requested a hearing.

In a medical report dated June 23, 1997, Dr. Steven Riddle, a Board-certified internist, stated that he had reviewed appellant's medical records and that his treatment for a low back strain he sustained on June 10, 1965 "ultimately lead to an exacerbation of a chronic renal condition, which definitely contributed in some way to an acceleration of his renal disease and his cardiac disease, which eventually claimed his life." He explained:

> "[B]eginning in 1974, while continuing to undergo treatment for [his back injury of June 10, 1965], the patient began to receive a nonsteroidal anti-inflammatory medications and some steroidal anti-inflammatory medications on a very regular basis in order to treat his increasing amount of discomfort and disability. The patient almost certainly continued to have worsening damage to his kidneys secondary to the continuous nonsteroidal anti-inflammatory drugs, which are known aggravators of renal insufficiency. It is also known that these agents when delivered over a long period of time will cause renal injury and hepatic injury even in people who start with normal origins without any pathology. Due to the length of time that the patient was on these medications which spans approximately 20 years and his previous nephritic condition, there is no question once again that the treatment for back injury increased his disability from a renal standpoint. Also, with the worsening damage to his kidneys, this will have a significant effect on his cardiac condition as the renal pathology will certainly give rise to elevated blood pressures and the promotion of arterial sclerotic disease via mechanism which raises the patient's cholesterol.
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> "Due to the fact that the patient eventually succumbed to a combination of renal failure and coronary artery disease progressing to heart failure, it is without reservation, that I can state that the prolonged exposure to nonsteroidal anti-inflammatory drugs almost certainly helped lead to this patient's demise over a long period of time."

A hearing was held on June 24, 1997. Appellant, the injured workers' widow, testified that she was married to the employee, that he spent his entire federal employment working for the employing establishment until he left in 1971 and that he had a back injury for which he was disabled for several periods of time. She testified that appellant did not have surgery because he was a high risk for surgery due to his heart and kidney problems. She noted that the employee was bedridden for the last year of his life.

By decision dated August 13, 1997, the hearing representative remanded the case for further development of the record. The hearing representative noted that although Dr. Riddle's opinion was somewhat speculative in nature, it was sufficient to establish a *prima facie* case.

By letter dated November 25, 1997, the Office referred the case record to Dr. Paul W. Farrell, a Board-certified internist, for a second opinion. In a medical opinion dated December 12, 1997, he concluded:

> "Although it is possible that the scenario presented by Dr. Riddle could occur, I think it is unlikely and that it is far more likely in this case that the underlying renal disease and underlying cardiovascular disease, which had been documented for many years, were the primary problems leading to this patient's progressive downhill course and demise.
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> "It is certainly not known that the use of nonsteroidal anti-inflammatories over a long period of time will cause renal injury and hepatic injury in people without any evidence of pathology. It is known that chronic glomerular nephritis will progress even without nonsteroidal drugs and, therefore, I do not think one could implicate that the nonsteroidal drugs definitely worsened his condition."

On August 13, 1998 another hearing took place. At the hearing, appellant stated that she went back to see Dr. Riddle with a copy of Dr. Farrell's report. She then submitted into evidence a report wherein Dr. Riddle commented on Dr. Farrell's report. Dr. Riddle disagreed with the assessment of his previous report as speculative. He noted:

> "[Appellant] was diagnosed with a chronic glomerulonephritis prior to any injury to his back. Treatment for his back injury included the prescriptions for nonsteroidal and steroidal anti-inflammatory drugs. These types of medications are contraindicated for use in patients who suffer from glomerulonephritis due to their well known and well documented history of worsening renal disease. Despite this, these medications were continually prescribed in one form or another for decades. Any nephrologist will certainly render the opinion that NSAID's should not be used in patients who have such an illness, as they will promote the advancement of glomercular disease and hasten the patient's chronic renal insufficiency.
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> "Dr. Farrell's assertion that 'there is no known evidence that ... progressive renal dysfunction raises cholesterol promoting atherosclerotic cardiovascular disease' is just simply wrong. This knowledge is, in point, classic text book medical knowledge, as evidence by enclosed reference material. This same atherosclerotic process is that which leads to this patients worsening heart condition and ultimately to his death.
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> "There is no doubt in my mind that the persistent use of nonsteroidal anti-inflammatory drugs in a patient with known renal disease, will accelerate the decline in the overall kidney function. The association of chronic renal failure and ateriosclerosis is not speculative, but is in fact classical medical knowledge. [the employee's] demise from advancing cardiac failure is well documented to be due to worsening coronary arteriosclerotic disease. The conclusion that chronic use of NSAID's, in this patient with previous renal disease, hastened his death is inescapable."

At the request of appellant, Dr. R. Kara, a nephrologist, also reviewed the medical records of the deceased. He opined:

> "In summary this patient who had underlying renal disease received nonsteroidal anti-inflammatory medications over a prolonged period of time which finally caused chronic renal failure, hypertension, accelerated artheroscolerosis, coronary artery disease and congestive heart failure, which finally caused the demise of this patient."

In an October 13, 1998 decision, the hearing representative found that as the medical reports of Drs. Riddle and Kara conflict with the second opinion physician, Dr. Farrell, referral to an impartial medical physician was necessary. Accordingly, the case was remanded for referral of the file to an appropriate specialist to resolve the conflict in the evidence.

By letter dated January 4, 1999, the medical records of the deceased were referred to Dr. Lawrence Kanter, a Board-certified internist. In an April 16, 1999 medical report, he found that there was no rational evidence that the minimal amount of anti-inflammatory medications over a period of 19 years significantly contributed by aggravation, acceleration or materially hastening to the death of the employee. He specifically noted:

> "On three accounts, it is inconceivable that the use of ant-inflammatory medications over a period of 20 years significantly contributed by aggravation, acceleration or materially hastening to [the employee's] death. Specifically, the amount of medication that he was given was minimal to have significant effect on his kidneys. [The employee's] renal disease was chronic and had extremely slow progression. His coronary artery disease was also chronic and also had extremely slow progression. On all three accounts, it is not at all rational to consider the two or three pills that he was taking a day, some of which definitely had no effect on the kidneys could have contributed to his death."
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> "[The employee's] had three chronic problems. The first was congenital spinal stenosis which happened to be aggravated at work. He also apparently had rheumatoid arthritis. The spinal stenosis and the rheumatoid arthritis had nothing to do with his work-related injury. [The employee] also had renal disease for 26 years and coronary artery disease documented for 31 years. I find it quite impressive that he was alive as long as he was."
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> "In summary, clearly there is no rational evidence that the minimal amount of anti-inflammatory medications over a period of 19 years significantly contributed by aggravation, acceleration or materially hastening to [the employee's] death."

By decision dated April 30, 1999, the Office found that the weight of the medical evidence did not support a finding that the employee's death was caused or accelerated by his

back condition from the work-related injury he sustained on June 10, 1965. Accordingly, the claim for death benefits was denied.

Appellant requested a hearing, which was held on December 14, 1999. She testified that during the "last period" her husband took two to three tablets of Tylenol-III a day. She also noted that he took over the counter Tylenol.

In a December 8, 1999 medical report, Dr. Nachman Brautbar, a Board-certified internist and nephrologist, reviewed appellant's medical record and opined:

> "The analysis of the creatinine chart, urinalysis, medication intake, medical records and reports, indicate that the [employee] had mild chronic renal failure which was very stable and started to deteriorate sometime prior to the end of 1990 and does not represent the natural progression of disease process (because his renal failure was stable over many years, there is no indication that it would have run the course of deterioration since his underlying disease/condition did not show any aggressive kidney aggravating immunological activity) and has deteriorated as a result of administration for some 20 years of nonsteroidal anti-inflammatory medications which are known to be risk factors for developing renal failure in patients with underlying kidney disease, aging and other conditions which cause changes in volume and hormonal status.
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> "Based on these factors and my experience in the field of internal medicine, toxicology, pharmacology and nephrology, it is my opinion with reasonable medical probability that the [employee's] ingestion of nonsteroidal anti-inflammatory medication for a long period of time superimposed on an aging kidney with chronic stable renal failure and shift in body fluids has caused this renal failure which resulted in end-stage renal failure in 1994 and was a significant cause in his demise."

In a February 10, 2000 decision, the hearing representative found that a conflict of medical opinion had appropriately been determined, however, the case records should be reviewed by a nephrologist to resolve the conflict of opinion of causal relationship.

In accordance with the remand decision, the Office scheduled the case for review by Dr. Clarence W. Applegate, a Board-certified nephrologist. Instead, however, the case was reviewed by Dr. Gary P. Hansen, a Board certified internist and nephrologist. In an April 17, 2000 report, he stated:

> "I think it is fair to say that in the absence of a kidney biopsy or other more detailed renal diagnostic studies, no one is able to categorically state that analgesics did or did not, contribute to [the employee's] kidney disease. However, [his] chronic nephritis and long history of severe hypertension offer very adequate explanations for his advance renal disease. In the absence of more definite evidence demonstrating analgesic nephropathy, I conclude that treatment of [the employee's] back pain did not contribute to either his renal failure or his death."

In a decision dated April 24, 2000, the Office denied appellant's claim for death benefits. The Office noted that the weight of the medical evidence rested with the opinion of the impartial medical specialist, Dr. Hansen.

On May 1, 2000 appellant through her attorney, requested a hearing.

In a decision dated October 18, 2000, the hearing representative found that the case was not in posture for decision. She noted that because Dr. Hansen was not the impartial medical specialist selected by the Office in accordance with its rotating selection procedures, his opinion was improperly obtained. Accordingly, the case was remanded for referral of the case record to a Board-certified nephrologist in accordance with the Office's procedures.

By letter dated December 20, 2000, the case was referred to Dr. Stephen L. Gluck, a Board-certified internist and nephrologist, for review. In a December 14, 2001, report, Dr. Gluck, after reviewing the medical record, noted:

> "The principal evidence that Dr. Bruatbar invoked is that the [employee's] renal function showed a marked acceleration during the period from 1990 through 1996, during which time, he was using acetaminophen. Dr. Braubar lists a table of creatinine values to support this interpretation of records. As most nephrologists would agree, serum creatiniene values alone can be misleading in assessing the rate of loss of renal function because of the inverse relationship between serum creatinine and residual renal function. Therefore, it is standard and accepted practice in nephrology to look at a plot of one over the creatinine versus time as index of loss of renal function. I have done this using creatinine values obtained from [the employee's] records and these clearly show that [his] renal function began to deteriorate well before the period in the late 1980's and 1990's that Dr. Brautbar implicated in causing his renal failure.... Because of his persistent proteinuria associated with elevated liver enzymes and an apparent positive test for rheumatoid arthritis, which is commonly a manifestation of chronic cryoglobulinemia associated with hepatitis C, the clinical evidence available in his medical records supports the interpretation that he had preexisting chronic glomerulonephritis such as IGA nephropathy, worsened by uncontrolled hypertension and had superimposed hepatitis-C associated chronic glomerulonephritis. It is my opinion that it is very unlikely that the cause of the progressive renal insufficiency was related to his use of acetaminophen."

He then concluded:

> "In summary, the review of [the employee's] records reveals that he had chronic renal disease antedating his heavy use of acetaminophen, that the clinical features of his renal disease were not typical of analgesic nephropathy, that he had several other clinical conditions that could adequately provide an explanation for progressive renal disease without invoking the use of analgesics and that the linkage between chronic acetaminophen use and progressive renal injury is still in question internationally by a panel of experts. Therefore, in answer to the question posed, it is my opinion that the [employee's] death on April 11, 1996

was not directly caused, precipitated or aggravated by his work-related lumbar strain."

By decision dated May 8, 2002, the Office denied appellant's claim for death benefits. The Office found that the weight of the evidence was represented by the opinion of Dr. Gluck. Therefore, the Office found that the weight of the medical evidence does not support a finding that the employee's death was caused, precipitated or accelerated by his back condition, which was related to the work-related injury of June 10, 1965.

The Board finds that appellant has failed to meet her burden of proof in establishing that her husband's death was causally related to the accepted injury of June 10, 1965.

The Federal Employees' Compensation Act provides that the United States shall pay compensation for disability or death of an employee resulting from personal injury sustained while in the performance of duty.[1] However, an award of compensation in a survivor's claim may not be based on surmise, conjecture or speculation or on appellant's belief that the employee's death was caused, precipitated or aggravated by his employment.[2] The mere showing that the employee was receiving compensation for total disability at the time of his death does not establish that his death was causally related to conditions resulting from the employment injury.[3]

Appellant has the burden of establishing by the weight of the reliable, probative and substantial evidence that the employee's death was causally related to factors of his employment.[4] This burden includes the necessity of furnishing a rationalized medical opinion based on an accurate factual and medical background and supported by medical rationale explaining the nature of the cause and effect relationship between the employee's death and specific employment factors.[5]

In the instant case, appellant submitted the reports of Dr. Riddle, which indicated that the employee's treatment for a low back strain he sustained on June 10, 1965 and specifically, the use of anti-inflammatory medications helped lead to appellant's demise. In addition, appellant sent the medical record to Dr. Kara, a nephrologist, who stated that the anti-inflammatory medications over a period of time finally caused chronic renal failure, hypertension, accelerated artherosclerosis, coronary artery disease and which finally, caused the demise of the employee. The second opinion physician, Dr. Farrell, disagreed. Accordingly, his medical record was referred to Dr. Kanter for an impartial medical opinion and Dr. Kanter found that it was not rational to conclude that the minimal amount of anti-inflammatory medication appellant took over a period of 19 years significantly contributed by aggravation, acceleration or materially

[1] 5 U.S.C. § 8102(a).

[2] *Juanita Terry (Rex Terry)*, 31 ECAB 433, 34 (1980).

[3] *Id.*

[4] *Judith L. Albert (Charles P. Albert)*, 47 ECAB 810 (1996).

[5] *Kathy Marshall (Dennis Marshall)*, 45 ECAB 827, 832 (1994).

hastening appellant's husband's death. Appellant then had her husband's records reviewed by Dr. Brautbar, a nephrologist. He concluded that it was his opinion with reasonable medical probability that the employee's ingestion of nonsteroidal anti-inflammatory medication for a long period of time was a significant cause in his demise. Accordingly, the Office referred the medical record to Dr. Gluck, a nephrologist, for an impartial medical evaluation. He concluded that because the employee's renal disease antedated his heavy use of acetaminophen, his clinical features of his renal disease were not typical of analgesic nephropathy and that he had several other clinical conditions that could adequately provide an explanation for his progressive renal disease without invoking the use of analgesics, in his opinion, the employee's death on April 11, 1996 was not directly caused, precipitated or aggravated by his work-related lumbar strain.

In cases where there exist opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[6]

As there was a conflict in the medical evidence between the opinions of the physician retained by appellant, Drs. Riddle, Kara and Brautbaur and the second opinion physician, Dr. Farrell, the Office properly referred the case to an impartial medical specialist, Dr. Gluck, a nephrologists, who opined that the employee's use of anti-inflammatory medications to treat his back condition that resulted from the work-related injury did not contribute to the employee's death. Accordingly, the Office properly denied appellant's claim for death benefits.

The decision of the Office of Workers' Compensation Programs dated May 8, 2002 is affirmed.

Dated, Washington, DC
May 12, 2003

Alec J. Koromilas
Chairman

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member

[6] *Jack R.. Smith*, 41 ECAB 691, 701 (1990); *James P. Roberts*, 31 ECAB 1010, 1021 (1980).