BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F303982

SHERRY G. MANKIN, EMPLOYEE CLAIMANT

FEDERAL MOGUL CORPORATION, EMPLOYER RESPONDENT

TRAVELERS INSURANCE COMPANY, CARRIER RESPONDENT

OPINION FILED DECEMBER 18, 2003

Hearing before ADMINISTRATIVE LAW JUDGE ELIZABETH W. HOGAN, on September 19, 2003, at Pine Bluff, Jefferson County, Arkansas.

Claimant represented by the HONORABLE KENNETH A. HARPER, Attorney at Law, Monticello, Arkansas.

Respondents represented by the HONORABLE PHILLIP CUFFMAN, Attorney at Law, Little Rock, Arkansas.

ISSUES

A hearing was conducted to determine the claimant's entitlement to payment of medical expenses, temporary total disability benefits and attorney's fees.

At issue is whether or not the claimant sustained a compensable occupational illness or as defined by Ark. Code Ann. §11-9-601.

After reviewing the evidence impartially without giving the benefit of the doubt to either party, Ark. Code Ann. §11-9-704, I find the evidence does not preponderate in favor of the claimant and benefits must be denied.

STATEMENT OF THE CASE

The parties have agreed to the following stipulations: An employer-employee-carrier relationship during October 2002, at which time the claimant was earning sufficient wages to be entitled to a compensation rate of $397.00/$297.00, in the event this claim is found to be

compensable. Some benefits and expenses have been paid by Blue Cross Blue Shield and Arkansas Carpenter's Health and Workers Fund.

The claimant contends she developed an occupational illness or disease, arsenic poisoning, as a result of her employment. She seeks payment of medical expenses, temporary total disability benefits from and attorney's fees.

The respondents contend there is no causal connection between the claimant's illness and her employment. Alternatively, they are not liable prior to receipt of notice of this claim.

The following were submitted without objection and comprise the evidence of record: the parties' prehearing questionnaires and exhibits contained in the hearing transcript along with the depositions of Dr. David Silas and Dr. Henry Simmons, incorporated by reference.

The following witnesses testified at the hearing: the claimant and human resource manager, Pearlie Hilson.

The claimant, age 40 (D.O.B. December 3, 1964) has an eleventh grade education and some on-the-job computer training. She has worked for the respondent-employer for eighteen years. For the last seven or eight years, she was stationed in the battery cable department organizing parts and equipment for the employees who operated the KUX machine. The claimant's desk was located directly behind the machine. Her job title, process person, is similar to an assistant supervisor.

The KUX machine holds liquid lead. Battery cables are covered in lead using a mold. The finished cables are sprayed with air to rid the cables of excess lead. This created lead dust which routinely settled on the claimant's desk. Although the machine was vented to the outside, dust and fumes were not eliminated.

In 1997, the claimant became ill. She saw numerous doctors who attributed her symptoms of nausea, weakness and anxiety to her nerves or to allergies. Her symptoms worsened and by 2000, she was being tested for kidney and heart disease. In September 2002, Dr. Go diagnosed arsenic poisoning.

Once she was diagnosed, the claimant returned to work and spoke with Dennis Rash, safety manager. He told her arsenic was not used at the plant, so she did not relate her symptoms to the job. In fact, she had the drinking water at her home tested.

In October, 2002, the plant was audited by OSHA and a MSDS sheet was generated showing that melted heavy metal (lead) creates arsenic dust and fumes. The MSDS listed symptoms similar to those the claimant had been experiencing, (loss of appetite, metallic taste in her mouth, anxiety, constipation, nausea, pallor, weakness, muscle and joint pain, dizziness, tremors).

The claimant took the MSDS sheet to her doctor before speaking to her boss, Kenneth Creighton. She was instructed to report to management but she went to the personnel department. The claimant spoke to Annette Clark and Mary Madden. Neither her boss or the personnel clerk offered her a workers' compensation claim form.

The claimant is requesting 36 weeks of temporary total disability benefits. She missed work from September 12 - September 25, October 1 - November 14, 2002 and January 28 - March 17, 2003, and March 21 - August 15, 2003. She returned to work for four days and had to be carried to the emergency room because of increased symptoms. She has not worked since March 20, 2003 and her health has improved. Her physician released her to return to work with some other employer in August, 2003 but he advised her not to return to the respondent-employer until or unless the lead

was removed. The claimant still uses an inhaler for her lungs and has anxiety attacks and nausea controlled with medication.

The claimant has paid $3,347.87 out-of-pocket expenses with the group carrier; incurred mileage expenses of $593.60 and received $500.00 in disability benefits from a private policy.

MEDICAL EVIDENCE

Some of the medical records beginning in 1997, are handwritten and difficult to read. It appears the claimant was hospitalized on April 10, 2000 with chest pain, difficulty breathing, exhaustion, epigastric pain and pressure. She was evaluated for heart problems and gallbladder disease. Testing was negative.

The claimant developed nausea, vomiting and began passing blood. Testing of her bladder and kidneys in August, 2000 was negative. Testing (upper endoscopy) of the esophagus, stomach and duodenum was performed in September 2000. A colonoscopy was conducted in October, 2000 for abdominal pain, diarrhea and rectal bleeding. Testing was negative.

The claimant was evaluated for chest pain and breast cancer again in January 2002. Testing was negative.

In February 2002 the claimant developed dizziness, ringing in her ears, blurred vision, fainting spells, weakness and shaking of her limbs. She was diagnosed with anxiety and placed on Wellbutrin. An MRI scan of the brain, EKG, EEG, auditory brain stem response in February 2002 for vertigo and left arm weakness proved normal. Testing in April 2002 included carotid and vertebral ultrasound and another echocardiogram. Cardiac catheterization was performed in May 2002.

The claimant was treated for asthma and allergies from August to October, 2002 based on her dizziness and respiratory problems.

The claimant was evaluated for back and neck pain in July and August 2002. In August, 2002, Dr. P. B. Simpson examined the claimant but found no neurological deficits.

A urine test in August 2002 detected arsenic, and was repeated several more times.

The claimant was hospitalized in October 2002 with nausea, vomiting and an inability to eat, and shortness of breath. Dr. Go diagnosed acute gastroenteritis, anxiety, urinary tract infection and arsenic poisoning.

On August 6, 2003, Dr. Henry Simmons authored a report, summarizing the claimant's history and opining that she did not suffer from arsenic poisoning.

Dr. Henry Simmons practices at UAMS. He is board certified in emergency medicine, family practice and medical toxicology. He is an associate professor of toxicology, emergency medicine and biopharmaceutical science. He is also the medical director of the state poison center.

Dr. Simmons explained that arsenic is found in numerous sources – air, water, food and pesticides. In industrial settings, it is used in the treatment of wood and transistors. Because it is so common, doctors have a great deal of experience with the symptoms of arsenic poisoning.

ACUTE EXPOSURE:

1) mental changes
2) nerve damage (both sensory and motor) and pain in the extremities
3) heart damage (abnormal rhythms, inflammation, difficulty with pumping
4) nausea and vomiting
5) respiratory failure and excess fluid in the lungs
6) kidney damage

7) breakdown of red blood cells
8) irritation of the mucous membranes
9) fever
10) breakdown of muscle tissue

Symptoms could recede or become chronic depending on the length of exposure and absorption of arsenic.

CHRONIC EXPOSURE

1) change in mental status
2) sensory-motor peripheral neuropathy
3) weakness
4) tender extremities
5) milder gastrointestinal effects
6) cough
7) anemia
8) changes in the skin (pigmentation, callus-like lesions, cancers)
9) lines in the fingernails

Arsenic is primarily absorbed by ingestion although there is some exposure from skin absorption and inhalation. The best method of testing is a urine specimen although arsenic can be detected in blood, hair, and fingernails. Once it is ingested, meaningful amounts remain in the body only two or three days although trace amounts remain for several months. A urine test will confirm short term exposure while hair and nail analysis can reveal long-term exposure. A blood test is the least effective since the arsenic dissipates quickly in the bloodstream.

There are several types of arsenic. Organic arsenic is found in food, especially seafood, however, it is rarely toxic. Inorganic forms of arsenic are toxic. Urine levels of 50 micrograms per 24 hours would be considered normal or organic arsenic. Levels in the 100 range would be cause for concern to exposure to inorganic arsenic.

Dr. Simmons reviewed the claimant's medical records (including Dr. Silas' deposition) and a recorded statement from the claimant describing her work place. He compared that information with the material safety and data sheets for lead used at the plant, the industrial hygiene report and the occupational disease investigation guide. The arsenic content in the lead used at the plant was 0-2%. Air monitoring of the plant was found to be free of excessive contamination of either lead or arsenic. Employees were also monitored and the airborne exposure did not exceed OSHA guidelines. The studies were conducted in 1997 and 2003.

The claimant's urine tests showed arsenic within the normal range, however, the test was not specific enough to distinguish between organic and inorganic arsenic. The claimant's urine test was negative for lead which Dr. Simmons found unusual if the source of arsenic at the plant came from lead. The MSDS sheets show the concentration of lead to be much higher than that of arsenic.

DR. SIMMONS:

> ...the fact that this lady is apparently not even absorbing enough lead to be detectable is again added reassurance that she's not having a problem with inhalation or oral absorption or dermal absorption of significant amounts of this hard lead, at work...

Analysis of the claimant's hair was also within the normal range. The hair reveals long-term exposure to arsenic.

DR. SIMMONS:

> I think (the hair levels) complement(s) the four urine tests that we have very nicely. You would expect that if you had multiple urine tests spread over time, and that all of them were within normal limits, you would ordinarily expect the hair arsenic or the nail arsenic to be normal. And that's what we find here.

In reviewing the claimant's medical records, Dr. Simmons noted that some of the claimant's symptoms (anxiety, dizziness, constipation, weight loss, genitourinary problems) predated her work

in the battery cable department and did not significantly change after she began work there. Testing by neurologist Dr. Sue Frigon and neurosurgeon, Dr. P. B. Simpson showed no neurological disease that Dr. Simmons could correlate with arsenic poisoning. And finally, the claimant's doctors never found evidence of some of the classic signs of arsenic poisoning with sensory - motor peripheral neuropathy or skin changes and sensitivity of the legs and arms. Bone marrow tests showed no arsenic intoxication and no major organ damage (liver, lungs, kidneys or heart) was detected. Dr. Simmons opined that although the claimant had a number of symptoms, they simply did not fit the pattern of arsenic poisoning.

Dr. Silas opined that the claimant was suffering from arsenic exposure. However, Dr. Simmons felt the claimant's symptoms were subjective, non-specific complaints and Dr. Silas had no objective medical data to support his conclusion. Dr. Simmons felt that Dr. Silas misunderstood the significance of the values assigned in the urine testing and the need to differentiate between organic and inorganic arsenic if the level was significant enough to warrant further testing.

> DR. SIMMONS:
>
> > When I take the multiple lab tests together over the period of time that they were collected, along with the hair and those medical records, I can tell you within reasonable medical and scientific certainty that in my opinion, she's not – as a medical toxicologist, she's not suffering from arsenic poisoning.

Dr. Silas practiced family medicine for thirty years before returning to school in 1999 for a three year study of neurology. Dr. Silas saw the claimant on referral from her family practitioner, Dr. Go, who requested that she be evaluated for arsenic poisoning.

Dr. Silas conceded that most of the claimant's symptoms were subjective. He also agreed that she had been through a battery of diagnostic testing with normal results.

Dr. Silas interpreted the lab results as showing elevated levels of arsenic in the claimant's urine. He thought anything greater than 3 was beyond the acceptable range and the likely method of delivery was ingestion or physical contact but not inhalation. Dr. Silas did not think it was odd that her arsenic levels dropped during a period of time when she continued to work in the battery cable department. He assumed her exposure happened in a specific event and then her levels dissipated. He never realized the claimant reported she was continuously exposed on a daily basis.

Dr. Silas did not attribute all of the claimant's symptoms to arsenic exposure. He felt that her anxiety was caused by her fear of returning to work and being exposed to arsenic a second time.

MR. CUFFMAN:

> Is there any specific symptoms that you could say, within a reasonable degree of medical certainty, was clearly attributable to the level of arsenic in her system of which you're aware?

DR. SILAS:

> I think I saw her too late to relate a level with her symptoms. I didn't see her during any acute phase.

Dr. Silas noted improvement when the claimant was off work. He opined she could return to work in August, 2003.

FINDINGS AND CONCLUSIONS

The resolution of this case depends on the evidentiary weight to be given to the conflicting opinions offered by Dr. Silas and Dr. Simmons. Jordan v. Tyson Foods, Inc., 51 Ark. App. 100, 911 S.W.2d 593 (1995), Beeson v. Landcoast, 43 Ark. App. 132, 862 S.W.2d 846 (1993). As a toxicologist, Dr. Simmons is clearly an expert in the field of arsenic poisoning. Although he did not physically examine the claimant, he had the benefit of reviewing her medical records, job description, Dr. Silas' deposition and the OSHA studies. Therefore, Dr. Simmons had sufficient

information on which to base his opinion. His deposition, in contrast to that of Dr. Silas, is very detailed about the symptoms and testing necessary to analyze arsenic poisoning. I find Dr. Simmons' opinion is entitled to greater evidentiary weight an accordingly, I find the claimant has not met her burden of proof by a preponderance of the evidence of record.

1. The Workers' Compensation Commission has jurisdiction of this case in which an employer-employee-carrier relationship existed during October, 2002, at which time the claimant was earning sufficient wages to be entitled to a compensation rate of $397.00/$297.00, in the event this claim is found to be compensable.

2. The claimant has failed to prove by a preponderance of the evidence of record that she developed arsenic poisoning as a result of exposure to lead dust based on the opinion of Dr. Simmons.

This claim is respectfully denied and dismissed.

IT IS SO ORDERED.

ELIZABETH W. HOGAN
Administrative Law Judge