

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F400052

JAMES KUNZELMANN	CLAIMANT
FAYETTEVILLE SCHOOL DISTRICT	RESPONDENT
RISK MANAGEMENT RESOURCES INSURANCE CARRIER	RESPONDENT

OPINION FILED OCTOBER 6, 2004

Hearing before ADMINISTRATIVE LAW JUDGE ELIZABETH DANIELSON in Springdale, Washington County, Arkansas.

Claimant represented by JASON HATFIELD, Attorney, Fayetteville, Arkansas.

Respondents represented by BETTY DEMORY, Attorney, Little Rock, Arkansas.

STATEMENT OF THE CASE

A hearing was held on August 3, 2004, in Springdale, Arkansas.

A pre-hearing conference was held in this claim, and as a result a pre-hearing order was entered in the claim on March 26, 2004. This pre-hearing order set forth the stipulations offered by the parties, the issues to litigate and the contentions thereto.

The following stipulations were submitted by the parties and are hereby accepted:

1. The Arkansas Workers' Compensation Commission has jurisdiction of this claim.

2. On January 7, 2003, the relationship of employee-employer-carrier existed between the parties.

3. The claimant sustained a compensable injury to his eye on January 7, 2003.

4. Medical expenses have been paid to December 15, 2003.

5. The claimant earned an annual salary of \$24,500.

By agreement of the parties the issues to litigate are limited to the following:

1. Additional medical after December 5, 2003.
2. Permanent disfigurement pursuant to Ark. Code Ann. §11-9-524.
3. Attorney's fees.

The claimant specifically reserved the issue of permanent partial impairment along with all other issues.

In regard to the foregoing issues the claimant contends that he is employed by the respondent as a junior high teacher. While preparing for class on January 7, 2003, claimant sustained a compensable injury to his right eye when glaze came in contact with his eye. As a result claimant was required medical monitoring from an eye doctor almost every day for two months following the incident. Claimant's injuries included blurred vision, pain, redness, and eye pressure changes. Surgery was performed in June 2003, and claimant continues to see an eye doctor for monitoring at least once per month and usually more than once per month. Claimant continues to be on medication for this problem. Respondents on or about December 5, 2003, informed claimant by letter that respondent would no longer be paying for his medical expenses. Claimant's right eye is permanently dilated and continues to be red. Claimant continues to need and wear prescription sunglasses.

In regard to the foregoing issues the respondents contend that the claimant has been provided all appropriate benefits to which he is entitled. Respondents have accepted and paid medical expenses until October 20, 2003. It is the respondents' position that the additional treatment sought by the claimant is not reasonably necessary nor causally related to a work related injury. Additionally, the respondents reserve the right to assert additional contentions as may become known through discovery.

The documentary evidence submitted in this matter consists of the documentary evidence submitted in this matter consisting of the Commission's pre-hearing order marked Commission's Exhibit No. 1. The claimant submitted documentary evidence marked Claimant's Exhibit No. 1 and photographs marked Claimant's Exhibit No. 2. The respondents submitted medical exhibits marked Respondents' Exhibit No. 1, the deposition of Dr. Buell marked Respondents' Exhibit No. 2, the deposition of Dr. Henry marked Respondents' Exhibit No. 3 and the deposition of Dr. Walton which is marked as Respondents' Exhibit No. 4. All these exhibits were admitted without objection.

During the taking of Dr. Christopher Walton's deposition, which is marked Respondents' Exhibit No. 4, the claimant's attorney raised an objection to the doctor voicing his opinion on what he thought the MSDS Guideline said. The claimant's attorney stated that the doctor was not qualified to state an opinion as to what an MSDS sheet on a chemical would say, noting that Dr. Walton is an Ophthalmologist and can give opinions about that but not on how to write the MSDS. The objection is found on page 45 of Dr. Walton's

deposition. The claimant's objection to the doctor's answer is hereby overruled, noting the claimant's exception. It is further noted that the doctor's response will be viewed as a lay person's opinion and not that of an expert.

DISCUSSION

Mr. Donald Arthur Marr, Jr. was called to testify on behalf of the claimant. Mr. Marr testified that he works for HR Factor explaining that this was a human resource consulting company. Mr. Marr stated that he and the claimant have been acquaintance for the past fifteen to sixteen years and that they have lived together for probably fourteen or fifteen years. This witness testified in the fourteen to sixteen years he has known the claimant he has never complained of having any eye problems prior to January 7, 2003. Mr. Marr testified that he saw the claimant before he went to work on January 7, 2003, and he did not notice any redness or problems with the claimant's eyes. Mr. Marr was asked that if prior to January 7, 2003, had he known the claimant to have a permanently dilated right eye and Mr. Marr responded, "No." Mr. Marr responded no to a series of questions as to whether he has ever known the claimant to wear glasses, contacts or use any prescription eye drops or medications. Mr. Marr testified that the claimant has gone with him to get his eyes checked by Dr. Jody McCallister and Dr. Brian Buell and remembers that it probably was within the year. Mr. Marr testified that after the claimant had his eyes examined he did not purchase any prescription glasses, contacts and was not aware of any problems the claimant had with his eyes.

Mr. Marr testified that the claimant came by his office after school on January 7, 2003, and he was holding his eye saying that he had splashed chemical in it. Mr. Marr testified that the claimant told him that he had washed out his eye and seen the school nurse but his eye was still bothering him. Mr. Marr testified that he contacted Dr. Buell and that he and the claimant went to the doctor's office. Mr. Marr testified that the claimant's eye was blood shot red and it was light sensitive because the claimant was holding his hand over his eye or he would squint and look out one eye. Mr. Marr testified that he and the claimant were at Dr. Buell's office until after 9:00 or 10:00 that evening. When asked if the claimant was seeing other patients or just the claimant, Mr. Marr testified, "No, it was closed." Mr. Marr testified that for the week following this incident the claimant continued to go to have the pressure in his eye checked twice a day and that his eye continued to be bloodshot and very light sensitive. Mr. Marr testified that even after a year the claimant continues to be very light sensitive and he wears a visor or sunglasses all the time even on very cloudy days. Mr. Marr testified that even at their house the claimant keeps the lights dim and he feels like sometimes they are living in a cave.

Anita Lawson testified that she was the principal at the Woodlawn Junior High School where the claimant is head of the art department. Ms. Lawson testified that she has known the claimant for four and a half years and that he is one of seven department chairs. Ms. Lawson testified that the claimant has a strong work

ethic and that he has a leadership role in their administration. This witness also stated that the claimant was very cooperative with everybody and professional. Ms. Lawson testified that the claimant was an excellent employee and she relies on him for feedback as well as uses him as a sounding board for some of her ideas. Ms. Lawson testified that the claimant is very open and honest and she feels like he is an extremely honest person. Ms. Lawson testified that on January 7, 2003, the claimant came to her office for another matter and she noticed that his eye was very red. Ms. Lawson testified that she and other people in the office encouraged the claimant to go to the doctor and have his eye seen about but he did not take their advise at that time. Ms. Lawson testified that it was her understanding that he did in fact seek medical attention later in the day. Ms. Lawson testified that prior to this date she had never noticed the claimant having any problems with his eyes. Ms. Lawson testified that prior to January 7, 2003, you could not help but notice the claimant's eyes because they were very clear blue and very pretty. This witness testified that after this date, the pupil of his eye does not change but stays open all the time. Ms. Lawson testified that his eye appears dilated in just that one eye. Ms. Lawson testified that the claimant reported to her that he was mixing some glaze and it must have splashed in his eye. Ms. Lawson testified that since that date the claimant has continued to have problems with his eyes. Ms. Lawson testified that she thinks that the claimant wears sunglasses all the time now and that he has even worn them in the classroom. This witness responded "no" when

asked if she ever questioned the claimant's honesty or credibility about the fact that this glaze did get in his eyes and cause these problems.

On cross examination, Ms. Lawson testified that although she cannot remember exactly what time of day the claimant came into her office on January 7, 2003, she does remember that at this meeting he did report to her that he was mixing glaze. Ms. Lawson could not remember the exact words which the claimant used during this conversation. Ms. Lawson testified that the claimant's permanently dilated eye does not affect her opinion of him professionally nor has it affected their working relationship.

The claimant testified that he was head of the art department for the Woodland High Junior High. The claimant testified that before January 7, 2003, he had no problems with his right eye and he has never worn prescription glasses or prescription contacts. The claimant testified that throughout his lifetime he can remember having his eyes checked when he was in the sixth grade and at that time no glasses or prescriptions were given to him for his eyes. The claimant testified that he has also had his eyes checked at Wal-Mart around 1998 or 1999 and after this exam there was no need for him to have any type of prescription lenses. The claimant indicated that he was not having any complaints of pain or redness at the time he had his eye examination. The claimant testified that the only reason he went and had his eyes examined at this time was because his friend, Don Marr, was having his eyes examined and he felt left out. The claimant testified that no doctor has ever

told him that he had herpes and he had never been told by another doctor that since he had chicken pox as a baby he was a carrier of herpes.

The claimant testified that on January 7, 2003, he was preparing ceramic glaze for his art class and as he was stirring the glaze some of it splashed on his face and he wiped his face with his hand and continued working approximately another twenty minutes or so until his students arrived at class. The claimant testified that when his students started entering his class they immediately asked him what was wrong with his eye and he looked in the mirror and immediately ran to the nurse's station. The claimant testified that his right eye was very bloodshot but that his left eye appeared to be normal. The claimant testified that the school nurse had him flush out his eye and then he went back to his classroom because he had unattended students. The claimant testified that as the day progressed his eye became increasingly light sensitive and that at the end of the day when he went out into the parking lot, he had to keep his right eye completely closed. The claimant testified that he drove immediately to Don Marr's office and then he went directly to Dr. Buell's office. The claimant testified that his right eye was red, light sensitive and he was experiencing discomfort. The claimant testified that when he got to Dr. Buell's office the doctor checked the pressure in his eye and the doctor continued treating him and checking him up until approximately 9:30 that evening. The claimant testified that besides checking the pressure in his eye the doctor began applying

various eye drops to his eye. The claimant testified that he returned to Dr. Buell's office the next morning at 8:00 and he stayed at the doctor's office until 5:00 that evening and repeated this same procedure the following day. The claimant remembers that Dr. Buell checked the pressure in his eye each hour and continued putting drops in his eye. The claimant testified that he returned to work on the third day but he did see the doctor at some point during that day. The claimant testified that when he returned to work his right eye was very light sensitive and he could not see, it was blurry and this condition lasted for several weeks. The claimant testified that he continued to see Dr. Buell everyday until he was referred to Dr. Henry some two and a half to three weeks later. The claimant testified that then he began to see Dr. Henry several times a week but at present is seeing him once every six weeks. The claimant testified that initially his eye was totally bloodshot and this lasted for about a month to six or seven weeks and then there was redness in the left side of his right eye for almost a year, noting that there is still some redness and some scarring. The claimant testified that in order to work he would wear sunglasses in his classroom for two to two and a half weeks and that after that when he used the overhead projector he would have to put on his sunglasses. The claimant testified that it was recommended that he wear sunglasses because with his eye staying dilated and light entering into his eye it would cause cataract. The claimant testified that he had to purchase sunglasses that had UV protections and that he is requesting that workers' compensation

pay for these sunglasses. The claimant testified that he also has to purchase regular glasses as prescribed to him by Dr. Buell which he is requesting reimbursement. The claimant testified that his ability to read has been affected because his sight is blurry, noting that it is like he is looking through a milky film with his right eye. The claimant testified that his right eye is physically incapable of focusing, noting that the pupil in his right eye stays the same and does not change. The claimant testified that he was seen by Dr. Walton in Memphis one time for approximately fifteen minutes and he did not prescribe any treatment for him. The claimant testified that he considers Dr. Henry his treating physician. The claimant testified that his biggest problem with his right eye is that it is permanently dilated and since he is a visual artist it is difficult sometimes with his work or even helping students to judge distances because of a focusing problem. The claimant testified that having to wear sunglasses all the time alters the color of everything around him and he does not perceive color as he once did. The claimant testified that his hobby is painting and this problem has certainly affected his ability to pursue this hobby. The claimant testified that he currently is using a topical steroid in his right eye once every two days. The claimant stated that when he began using this steroid he was using it two or three times a day but he has been trying to wean himself off of it. The claimant testified that he had never used any topical steroid in his eye prior to January 7, 2003. The claimant

testified that he is already developing a cataract in his right eye and that Dr. Henry wants to do surgery.

On cross examination, the claimant testified that he understood that he had childhood chicken pox but he has no memory of it. The claimant agreed that he is still director of the fine arts department at the junior high and that his pay has not changed other than an annual increase. The claimant testified that it was his understanding that Dr. Henry wanted a second opinion, therefore, he was sent to Dr. Walton.

On redirect examination, the claimant stated that the SMDS sheet which pertains to the glaze he was using was not available to him at the time of his accident. The claimant agreed that after his accident he used an eye wash and that he did seek medical attention due to the persistent irritation in his right eye.

The medical records set forth that Dr. Buell saw the claimant on January 7, 2003, for an injury to his right eye which he sustained on the job. Dr. Buell writes on January 10, 2003, that the claimant's injury resulted in an eye infection which required extensive treatment. Dr. Henry writes on March 26, 2003, that he initially saw the claimant on January 20, 2003, with complaints of blurred vision and having a history of significant elevation of his intraocular pressures as well as increasing inflammation. Dr. Henry notes that the initial examination of January 20, 2003, revealed that the claimant had 20/200 best corrected visual acuity. The doctor notes that this was related to the claimant's corneal irregularity or epitheliopathy; he also had three plus mutton fat

keratitic precipitates in the right eye with intraocular pressure of 24 in the right and 14 in the left. The doctor notes that the claimant had a hazy view of the posterior pole with a point four cup-to-disc and no retinal abnormality. Dr. Henry notes that the claimant's right pupil was dilated but no afferent pupillary defect was present. Dr. Henry listed the claimant's current medications and noted that he was adjusting these medications. The doctor notes that the claimant's vision has improved at this point to 20/30 to 20/25 with a smooth corneal epithelium and no conjunctivitis at this point. Dr. Henry notes that the claimant's persistent iritis is concerning and he recommended an evaluation by a uveitis specialist.

Dr. Christopher Walton writes on April 17, 2003, that he has examined the claimant that day and found that he has a visual acuity of 20/20 in both eyes with the right pupil being slightly mydriatic and irregular. The doctor notes that there are numerous pigmented keratic precipitates inferiolly in the right eye and that the iris exhibited numerous transillumination defects. The doctor writes that there were only rare cells noted in the anterior chamber. The doctor opines that the claimant has chronic anterior uveitis affecting the right eye of uncertain etiology. The doctor discussed the possibility of the claimant having a herpes simplex virus associated with uveitis due to the iris transillumination noted as well as the elevated intraocular pressure. Dr. Walton then discusses the claimant's medications and make recommendations concerning these medications. Dr. Walton concludes by saying that

he would not recommend any additional forms of immunosuppressive therapy since the uveitis appears to finally be resolving and hopes that it will completely resolve over the next couple of weeks.

The medical records set forth that the claimant continued to be seen at Dr. Henry's Eye Clinic in May, June, July and August. Dr. Henry writes on August 22, 2003, that, "The time course of the ceramic glaze and the subsequent events would lead me to believe that it is all related to the ceramic glaze." The doctor notes that the claimant has been treated for a retinal tear in his right eye and that he has been seen most recently for a recurrence of his iritis and elevated intraocular pressure. Dr. Henry writes that he feels the claimant is over the acute insult but the claimant is having recurrent problems relating to the original injury and that future treatment will require multiple medications to reduce his intraocular pressure and possible surgery to reduce this pressure. The doctor notes that latent complications of medications include cataract and retinal detachment, noting that the claimant is developing a cataract which will develop over time. The doctor recommended glasses to help with the glare related to the claimant's cataract. Dr. Henry writes that the claimant has a dysfunctional pupil on the right eye which may require reading glasses or occlusive lenses over the right eye when reading or doing near tasks. The doctor writes that this will affect his binocular vision function at near also. The records set forth that the claimant continued to be seen by Dr. Henry through the end of 2003.

Dr. Christopher Walton writes on October 20, 2003, that after reviewing Dr. Henry's medical records as well as his own examination of the claimant, he finds no correlation between the claimant's eye problems and the possibility of the claimant getting a ceramic glaze in his eye. Dr. Walton opines that the claimant's likely iris atrophy is herpes simplex or varicells virus uveitis. Dr. Walton notes that another diagnostic possibility is acute primary ischemic iris atrophy, noting that this, however, is a very rare disorder, noting further that it could just have an unknown etiology. The claimant continued to be seen by Dr. Henry for problems with his right eye throughout January 2004. Dr. Brian Buell writes in response to the claimant's attorney's letter proposing questions to him concerning the claimant's eye problems. Dr. Buell responded that based on a reasonable degree of medical certainty, he believes the claimant's eye was injured as a result of the glaze that entered his eye on January 7, 2003, that the claimant's treatment since January 7, 2003, has been reasonable and necessary and that he believes that the major cause of the claimant's need for treatment is a direct result of the glaze which entered his eye on January 7, 2003. Dr. Buell further states that based on a reasonable degree of medical certainty he believes that the major cause of the treatment that the claimant continues to receive is a direct result of the glaze that entered his eye on January 7, 2003. Dr. Paul Henry responded the same to the same questions proposed to him by the claimant's attorney in a letter dated March 30, 2004.

Dr. Brian Buell, in his deposition, stated that he was an optometrist and had been practicing in the Fayetteville area for the past twenty eight years. Dr. Buell stated that on January 7, 2003, the claimant came to his office shortly before 5:00 presenting himself with a very angry eye, poor vision and the pressure in his right eye was very high. Dr. Buell testified that it was his understanding that that morning the claimant had splashed a glazing compound into his eye. The doctor stated that the claimant was not a patient of his prior to January 7, 2003, and that he did not have any reports or records on the claimant prior to January 7, 2003. Dr. Buell stated that in the course of trying to regulate the pressure in the claimant's eye as well as treat the inflammation they used at least six different kinds of eye drops before they could regulate the pressure in the claimant's eye that day. Dr. Buell testified that on January 7, 2003, the claimant presented himself with a lot of inflammation inside the eye itself not just on the outside. The doctor stated that whatever the chemical was that got into the claimant's eye not only caused the inflammation of the eye but it penetrated the eye as well which is unique. Dr. Buell stated that the main concern was to get the pressure in the claimant's eye lowed in order to prevent damaging the nerve. The doctor testified that he used an instrument to check the pressure in the eyeball itself, agreeing that it is a puff of air. Dr. Buell testified that what is normal pressure for a person's eye varies greatly but that the pressure in the claimant's other eye was much lower than that of his right eye.

Dr. Buell was asked if he could determine how long the inflammation had been going on in the claimant's eye and the doctor responded, "Well, it had to be pretty immediate because it was highly inflamed and the level of inflammation---it was very recent, so I'm sure it happened that day." The doctor stated that his opinion was based on the inflammation inside the eye itself. Dr. Buell stated that he also did a biomicroscopy which is used to look at the optic nerve and he also did a direct ophthalmoscope. The doctor testified that the claimant's optic nerve looked ok because the pressure had not been up very long. Dr. Buell testified that the claimant's cornea was burned, noting that it had a surface burn from the chemical itself but most of it had penetrated into the claimant's eye. Dr. Buell agreed that the claimant was at his office for several hours while they continued to try to lower the pressure in his eye. The doctor testified that the claimant returned to his office on January 8 where they continued to treat his eye for the elevated pressure. Dr. Buell stated that normally when you have an inflammation like the claimant had, you can get the pressure treated and get the eye quieted down but it will not stay that way because the body responds very quickly to medication. Dr. Buell stated that the next day usually you would have to start the medication process over again and that is exactly what they did in the claimant's case. The doctor testified that when the claimant came in at 9:00 the pressure in his right eye was thirty-nine and that by 11:30 after treatment it was down to twenty-three. Dr. Buell testified that he treated the claimant with an anti-steroid for the

inflammation and they used glaucoma drops to lower the pressure. Dr. Buell stated that on January 9, 2003, the pressure in the claimant's eye was a bit more stable, noting that it was at twenty-three. The doctor testified that the claimant's visual acuity began to deteriorate each day as the inflammation process caused swelling and more inflammation inside the eye. Dr. Buell remembers that on January 9 the claimant's eye was improving but by the 10th it had taken a turn for the worse and the pressure was much elevated, being as high as forty-one. The doctor recalled that at this point they called in Dr. Henry to examine the claimant's eye. Dr. Buell stated that because he was going to be out of town he turned the claimant's care over to Dr. Henry so that he could follow the claimant's treatment plan and that on January 20, 2003, when the claimant's care was turned over to Dr. Henry the pressure in the claimant's eye was twenty-one but the inflammation process was still there and his vision was not the best. Dr. Buell testified that besides treating and taking the claimant's pressure in his eye and doing a visual acuity test, they also worked with trying to reactivate the claimant's right pupil since it had become unreactive due to having been dilated for so many weeks. Dr. Buell stated that he agreed with Dr. Henry's referral of the claimant to Dr. Walton since Dr. Walton is a specialist in treating inflammation of the eye. Dr. Buell was asked about the chemical properties of the glaze which the claimant reported he had gotten into his eye and the doctor responded that he was not an expert in chemicals but there are not a lot of things that cause an inflammation like the

claimant had in his eye and if the chemical had splashed in the claimant's eye that day and was the only thing that had happened to him that day, it had to be the cause of the claimant's problem. Dr. Buell stated, "It would take a pretty massive chemical or injury to cause an inflammation in the eye like that."

On cross examination, the doctor stated that the physical evidence and injury to the claimant's eye was like a chemical burn. Dr. Buell was asked by the claimant's attorney, "Do you feel like that chemical caused these problems that he's had for the last year?" Dr. Buell responded, "Absolutely." Dr. Buell was asked by the claimant's attorney that when he first saw the claimant did he see a chemical burn to the cornea that had any link to a herpes infection and Dr. Buell responded, "No."

Dr. Christopher Walton testified, in his deposition, that he was an ophthalmologist. The doctor testified that he has a fellowship in ocular immunology and uveitis and is practicing medicine in Memphis, Tennessee. Dr. Walton agreed that he was a classified regional specialist in uveitis. Dr. Walton testified that he saw the claimant on April 17, 2003, and that at the time of his visit with the claimant, he had access to Dr. Henry's progress notes. Dr. Walton stated that the claimant gave him a history of having splashed a ceramic glaze into his right eye in January 2003 and had been treated for right eye inflammation since that time. The doctor testified that he examined the claimant and found that he had a visual acuity in his right eye of 20/20 and in his left eye 20/20+3. Dr. Walton stated that the external examination of

the claimant including his skin and eye lids was entirely within normal limits and he had normal conjunctiva and sclera. Dr. Walton testified that the claimant's cornea exhibited keratic precipitates but the superficial area of the cornea appeared normal and clear. The doctor testified that he examined the anterior chamber and there were a few anterior chamber cells present noting that on this examination when he examined the claimant's iris there were some areas that he referred to as transillumination defects which in essence allowed light to pass through so they appeared to be reddish in character. The doctor stated that this was only because the iris in this location was atrophic and that additionally the claimant had a posterior subcapsular cataract. Dr. Walton was asked to explain what atrophic means and he responded, "Normally when one examines the iris of the eye, which is the colored part of the eye, it has a consistency such that the coloration prevents you from seeing anything behind it except in the opening which is the pupil. In Mr. Kunzelmann's case when you examine portions of his iris you can actually see through that as if you are looking through sheer drapery." The doctor stated that based on this one single examination and the history provided to him, his findings were consistent with a chronic anterior uveitis. Dr. Walton now was asked to explain what uveitis is and what some of the causes may be. Dr. Walton stated, "Uveitis refers to inflammation of the inner portion of the eye....but uveitis we cannot see without specialized equipment." The doctor went on to explain that this is inflammation that is inside the watery part of the eye or actually

in the vitreous gel of the eye or in the various posterior portions of the eye, the retina. Dr. Walton stated that there are hundreds of ways that a person can develop uveitis. Dr. Walton was asked if a person could develop uveitis from something splashed in his eye such as the glaze the claimant had described and Dr. Walton responded that based on the medical records, the MSDS sheets and the existing literature, most patients who develop uveitis following exposure to a chemical do so only with certain chemicals which are extremely corrosive, noting that most of those are the alkalis. Dr. Walton stated that none of the chemicals known to cause uveitis were present in the ceramic glaze used by the claimant in January 2003. Dr. Walton stated that based on his single examination of the claimant and review of the claimant's medical records from Dr. Henry, he felt that the claimant had a chronic anterior uveitis which affected his right eye only. Dr. Walton stated that based on his examination and the claimant's history, it was his impression that this was not related to a chemical injury since there were no signs of a severe chemical burn to the cornea or conjunctiva. Dr. Walton noted that many of the claimant's findings could actually be part of an infectious process such as herpes simplex or herpes zoster. Dr. Walton explained that herpes simplex is like the familiar simple cold sore on a person's lips yet it often times can cause chronic eye problems specifically chronic keratitis or inflammation of the cornea and that in some cases it can also cause a secondary uveitis. Dr. Walton further explained that herpes zoster is a virus that many people are

exposed to when they develop chicken pox as children, noting that the chicken pox virus never dies but it becomes inactive in one of the nerve roots in our spine and that over time this virus can reactivate at any location in the body including the eye. Dr. Walton stated that there are many things that can reactivate this virus, noting that even a healthy individual can experience a reactivation. Dr. Walton stated that persons undergoing chemotherapy or taking drugs that would suppress their immune system or persons with HIV or Aids can be some causes. The doctor stated that at the time he examined the claimant his condition seemed to be very controlled and that his recommendation was that he continue under the treatment plan being administered by Dr. Henry. Dr. Walton testified that the type of cataract the claimant has is unique and that it is referred to as a posterior subcapsular cataract which means that the cataract itself, the opacity of the lense is located on the posterior portion only. The doctor explained that the cause of that kind of cataract is fairly limited, stating that it is known that corticosteroids are one of the leading causes of this, having chronic uveitis is another cause, having radiation therapy is a cause and diabetics will frequently get cataracts of this type. Dr. Walton stated that it appeared to him that the claimant had developed is cataract at some point between January 2003 and April 2003. Dr. Walton remembered that he and Dr. Henry had discussed treating the claimant with Valtrex thinking that this might represent a herpes uveitis to see if this medication would improve the claimant's condition. Dr.

Walton stated that the recommended period of time for treatment with Valtrex is approximately twelve weeks. Dr. Walton stated that overall, his impression was that uveitis and all the other findings that were noted concerning the claimant were not related to a chemical exposure that occurred in January 2003 and that he would state that opinion within a reasonable degree of medical certainty.

On cross examination, Dr. Walton stated that on the claimant's review of system sheet which the claimant filled out, he indicated that he had had chicken pox. Dr. Walton testified that he did not find anything in the literature search indicating that the specific glaze which the claimant used would cause a severe chemical burn. The doctor also stated that he did not find any literature that said that this chemical does not cause any type of injury to the eye. Dr. Walton stated that based on the MSDS sheets concerning this glaze, it basically states that if a person gets it in his eye it can be an irritant and you should irrigate the eye and if irritation persists, one should seek the advise of a physician. Dr. Walton stated that when he first saw the claimant, he did not note any chemical burn to the claimant's eye but does remember reading Dr. Buell's initial report where he states that the claimant's cornea was burnt. Dr. Walton stated that he did not see the claimant until some four to six weeks after the claimant's incident. Dr. Walton agreed that in a four to six-week period the cornea could have been healed after the initial insult. Dr. Walton was asked to explain keratic precipitates on the cornea. Dr. Walton stated that patients with uveitis often form deposits on the

back surface of the cornea, noting that in a simplistic view point this is akin to looking through a clear glass window and imagining that someone had splattered mud on the window. The doctor explained that these deposits are actually big clumps of inflammatory cells on the back surface of the cornea. Dr. Walton testified that there are a variety of chemicals that can cause irritation to the external eye but that not all chemicals will penetrate into the inner eye and cause irritation. Dr. Walton then stated that the MSDS sheets that were provided do not set forth that the components in the glaze contain severe corrosive materials that would cause uveitis from chemical exposure. Dr. Walton was asked if he thought it was just a coincidence that the claimant splashed this chemical in his eye and then had to have all of this treatment and the doctor responded, "Correct." Dr. Walton testified that patients with herpes simplex and herpes zoster often will develop an iris that does not function as it did before and often times it will become dilated. Dr. Walton explained that this was due to the damage to a person's eye from the virus. Dr. Walton was asked if it were possible that this chemical which the claimant had splashed in his eye had activated a latent herpes virus which resulted in all of his problems and Dr. Walton answered, "No." Dr. Walton explained that it would take days for a reaction to develop to the point as described by Dr. Buell when he first saw the claimant in January 2003. Dr. Walton did agree that the medications prescribed by Dr. Henry, corticosteroids, can cause cataracts and that it is possible that all of these corticosteroids

which the claimant has been receiving as treatment have caused him to develop a cataract. Dr. Walton stated that he did not think that the chemical caused a severe burn in the claimant's eye. Dr. Walton was asked if chemicals can cause permanent damage the same way the herpes virus does and the doctor responded, "Not in the same fashion as herpes."

Dr. Paul Henry testified that he was an ophthalmologist and had completed his residency in 1997. The doctor testified that he began seeing the claimant on January 20, 2003, for inflammation inside of his eye which they term uveitis. Dr. Henry explained that uveitis is in reality arthritis inside the eye so that a person's body is responding to some insult. Dr. Henry stated that often times the etiology of the inflammation is unknown but left untreated can cause long term damage at either the cornea or the retina. The doctor stated that because the claimant had high eye pressure associated with the acute inflammation, they began treating him to lower his intraocular pressure and decrease the chance of long term damage from glaucoma which is a combination of elevated eye pressure and progressive pressure to the optic nerve. Dr. Henry testified that on the initial evaluation it was thought that the claimant's elevated intraocular pressure was related to the acute inflammation caused by a chemical glaze getting inside of his eye. Dr. Henry was asked if there were any lesions on the claimant's eye and Dr. Henry responded that, "The claimant's eye looked like someone had taken sandpaper to his cornea but he had inflammation inside of his eye what they call granulomatous uveitis

or keratitic precipitates as well as associated intraocular pressure elevation." The doctor stated that he had never seen or treated the claimant prior to January 2003. Dr. Henry testified that the claimant presented himself at his office with a history of having gotten ceramic glaze in his right eye some two weeks earlier. Dr. Henry stated that the claimant's uncorrected visual acuity in his right eye was 20/200 and he had a lot of epithelial irregularities as well as a large collection of inflammatory cells sitting on the backside of his cornea. The doctor noted that the claimant's intraocular pressure was 24 noting that less than 20 is considered to be normal and that the claimant had been on considerable medications in order to lower his eye pressure prior to coming to his office. Dr. Henry stated that the claimant's pupil was non reactive, noting that it was not functioning to light like it normally should. Dr. Henry testified that he continued the claimant on his medications and in fact increased some of his dosages. Dr. Henry was asked if he was able to determine what caused the sandpaper affect on the claimant's cornea. Dr. Henry responded that the corneal epithelium turns over about every twenty-four hours and the claimant's initial insult to his right eye was not allowing his limbal stem cells to repopulate a smooth epithelium. Dr. Henry stated that the eye drops that they were using could possibly be contributing to his problem but he had used these same drops on other people without any problems. Dr. Henry testified that he continued to treat the claimant for several days and that his condition varied slightly. Dr. Henry was asked what

diagnostic tests he used to determine whether or not the claimant's condition was related to his exposure to the glaze and Dr. Henry responded that with the history the claimant presented, there really was no reason to work it up further. Dr. Henry stated the claimant came in and said that he got this stuff in his eye and now they have been dealing with the problem ever since and had not been before. Dr. Henry stated that the claimant showed some bit of improvement toward the end of January but his symptoms escalated in early February and they had to restart some of his medications. Over time, the claimant would have periods of improvement and then the inflammation in his eye would flair back up. Dr. Henry stated that in late March he referred the claimant to Dr. Walton for a second opinion. Dr. Henry testified that he was looking for treatment recommendations as well as assistance with other medications that might be beneficial and less toxic to the claimant. Dr. Henry testified that in March the claimant finally obtained a visual acuity of 20/30 and by the end of March he was at 20/20. The doctor stated that the claimant maintained that vision until June at which time he had another flair up of inflammation and elevated pressure in his right eye. Dr. Henry was asked if the recurrence of the claimant's elevated symptoms in June would suggest that his condition was being caused by something other than the exposure to the glaze in January, Dr. Henry responded that the claimant had no other evidence of anything else that would be causing the claimant's problems. Dr. Henry testified that chronic inflammation, taking oral steroids and using topical eye drops are

known causes for cataracts along with the natural aging changes. The doctor agreed that in June 2003 the claimant underwent laser surgery to repair a retinal tear. The doctor stated that when there is a change in the intraocular pressure you can get some changes in the vitreous, which is a clear jelly inside the eye, noting that the thinking is that contraction related to the chronic inflammation possibly caused the claimant to develop this retinal tear. Dr. Henry agreed that by August 22, 2003, he determined that the claimant had reached maximum medical improvement. The doctor stated that although the claimant had improved, he still was on several medications although some had been tapered back. Dr. Henry testified that he continued to treat the claimant after August 2003. Dr. Henry testified that in September 2003 the claimant began to experience additional symptoms and it was suspected that he had a recurrence of a retinal problem. Dr. Henry stated that on October 15, 2003, the claimant had an increase in the pressure in his eye which they treated with medications. Dr. Henry stated that he discussed the claimant's case with another uveitis specialist in St. Louis. The doctor stated that this association brought forth that an insult, possibly the chemical injury, will trigger a chronic recurrence of herpes virus which is present in about 80 to 90 percent of the people who had previously had chicken pox. The doctor agreed that stress can possibly be a factor in triggering the herpes virus as well. Dr. Henry testified that it is really not known exactly what triggers the virus but that every person has his or her own little triggers. After much discussion about Dr.

Walton's report, Dr. Henry stated that based on what he has followed over time he felt like the claimant's initial insult contributed to the reason he's gotten to evaluate the claimant so many times over the last year.

On cross examination, Dr. Henry was asked if it was fair to say that the insult with the glaze precipitated everything that has happened to the claimant thus far. Dr. Henry responded, "When I review all my history and what I've seen that's what I felt was the cause." Dr. Henry further stated that based on his interpretation and experience as well as his discussion with a doctor in St. Louis, his opinion is based on a reasonable degree of medical certainty. Dr. Henry identified photographs taken of the claimant's eyes. These photographs are attached to the doctor's deposition. Dr. Henry agreed that the claimant's right eye has a permanent condition which has not changed over the last year in that it stays permanently dilated. Dr. Henry testified that the claimant cannot control the size of the pupil of his eye. Dr. Henry was asked about the letter which the claimant's attorney had sent him back in March. Dr. Henry stated that after reviewing his chart, generating his flow chart, he felt that based on the claimant's history, the claimant's right eye was injured as a result of the chemical glaze. Dr. Henry was asked what was the reasonable cause for the claimant to develop cataracts in his right eye and Dr. Henry responded;

"The only reasonable cause in his situation is that he had elevated pressure and he's been treated with those eye drops, and the only reason he was on those eye drops is because of

the elevated pressure. The only reason he had the elevated pressure, based on my history, is because of the initial insult."

Dr. Henry stated that when he last saw the claimant on April 26, 2004, the visual acuity in his right eye was 20/40 and the vision in his left eye was 20/20. The doctor also stated that a lot of people will develop elevated eye pressures, but usually they will be symmetric if there is no cause for it and certainly direct trauma to the eye can cause elevated eye pressure. Dr. Henry stated that there are no objective findings to indicate that some other disease process might be contributing to the claimant's inflammation and elevated intraocular pressure. The doctor stated that based on the claimant's history, he had an insult to his right eye and as a result of that developed the inflammatory response. The doctor continued by stating that the claimant's chronic inflammation was because he just would not respond to the normal topical eye drops which resolve most iritises or uveitises.

On redirect examination, Dr. Henry stated that based on the claimant's clinical findings of his posterior subcapsular cataract, it would be a reasonable finding that the claimant's level of vision would be diminished.

After a complete review of all the documentary evidence as well as the testimony, I find that the claimant has proven by a preponderance of the evidence that he is entitled to additional medical treatment after December 5, 2003. Dr. Henry and Dr. Buell have continually treated this claimant since his initial injury on January 7, 2003, when he splashed a ceramic glaze into his right

eye. Although none of the claimant's treating physicians are 100 percent certain that his ongoing need for medical treatment is a direct result of this January 7, 2003, event, it is certain that he has no record of treatment of his right eye prior to this date and subsequent to that date it has been continual. Dr. Henry, in his deposition, very clearly sets forth that the event of getting chemical in the claimant's eye started the need for a treatment process, some of the treatment itself has triggered other problems which must be addressed such as his cataracts. Therefore, the respondents should pay for additional medical treatment subsequent to December 5, 2003, to include sunglasses required to address the claimant's light sensitivity resulting from his right eye injury.

The claimant has requested benefits pursuant to Ark. Code Ann. §11-9-524. Although the claimant's right eye injury, which has resulted in his eye being watery looking, red and with a permanently dilated pupil, is not grotesque, it is quite noticeable and does detract from the claimant's appearance. Stating it quite bluntly, it looks weird. I find that the claimant is entitled to \$3,000.00 for his facial disfigurement.

FINDINGS & CONCLUSIONS

1. The Arkansas Workers' Compensation Commission has jurisdiction of this claim.
2. On January 7, 2003, the relationship of employee-employer-carrier existed between the parties.
3. The claimant sustained a compensable injury to his eye on January 7, 2003.

4. Medical expenses have been paid to December 15, 2003.

5. The claimant earned an annual salary of \$24,500.

6. The claimant has proven by a preponderance of the evidence that he is entitled to additional medical treatment for his right eye subsequent to December 5, 2003, as well as reimbursement for his sunglasses. See discussion above.

7. The claimant is entitled to \$3,000.00 for his permanent facial disfigurement pursuant to Ark. Code Ann. §11-9-524. See discussion above.

8. The respondents have controverted this claimant's entitlement to additional benefits.

9. The claimant's attorney is entitled to the maximum statutory attorney's fee based on the benefits awarded herein.

ORDER

The claimant has proven by a preponderance of the evidence that he is entitled to additional medical treatment for his right eye subsequent to December 5, 2003, to be paid at the respondent's expense and to include the cost of his sunglasses.

The claimant is entitled to \$3,000.00 for his permanent disfigurement pursuant to Ark. Code Ann. §11-9-524.

The respondents shall pay to the claimant's attorney the maximum statutory attorney's fee on the additional benefits awarded herein, with one half of said attorney's fee to be paid by the respondents in addition to such benefits and one half of said attorney's fee to be withheld by the respondents from such benefits.

All benefits herein awarded which have heretofore accrued are payable in a lump sum without discount.

This award shall bear the maximum legal rate of interest until paid.

IT IS SO ORDERED.

ELIZABETH DANIELSON
ADMINISTRATIVE LAW JUDGE