

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F210278

DANNY W. DUNLAP, EMPLOYEE	CLAIMANT
EDWARDS BROTHERS, INC., EMPLOYER	RESPONDENT
TRAVELERS INSURANCE COMPANY, CARRIER	RESPONDENT

OPINION FILED FEBRUARY 11, 2008

Hearing before ADMINISTRATIVE LAW JUDGE CHANDRA HICKS, on November 21, 2007, in Mountain Home, Baxter County, Arkansas.

Claimant represented by THE HONORABLE FREDERICK S. "RICK" SPENCER, Attorney at Law, Mountain Home, Arkansas.

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

STATEMENT OF THE CASE

A hearing was held in the above-styled claim on November 21, 2007, in Mountain Home, Arkansas. A Prehearing Telephone Conference was conducted on August 13, 2007, and a Prehearing Order was filed on that same date.

By agreement of the parties, the stipulations applicable to this claim are as follows:

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

2. The employee-employer-carrier relationship existed at all relevant times including on or about June 14, 2002.

3. The claimant suffered a compensable injury to his low back in June of 2002, for which some medical benefits have been

paid.

4. The respondents have controverted any further benefits at this time.

By agreement of the parties, the issues to be presented at the hearing are as follows:

1. Constitutional issues.
2. The issue of permanency is reserved.
3. Whether the claimant suffered lung problems as a compensable consequence of his low back injury, as well as from breathing dust at work.
4. Claimant's entitlement to additional reasonable and necessary medical care (back and lungs).
5. Claimant's entitlement to additional temporary total disability from June 19, 2002, until a date yet to be determined.
6. Controverted attorney's fee.
7. At the time of the hearing, respondents clarified its position concerning the date of injury. Respondents requested a determination of this issue by the Commission.

The claimant contends that he sustained a compensable injury to his back and that his problems with his lungs are related to his injury at work on June 14, 2002. The claimant contends that he has not recovered from these injuries and continues to have ongoing medical problems. The claimant contends that he is entitled to all related workers' compensation benefits.

The respondents contend that the claimant's pulmonary problems are not related to his back strain. Respondents contend further that the claimant is not entitled to additional temporary total disability benefits.

The documentary evidence in this case consists of the Commission's Prehearing Order, the claimant's Response to the Prehearing Questionnaire, and the respondents' Response to the Prehearing Questionnaire, which were all marked as Commission's Exhibit No. 1. The claimant's medical packet has been marked as Claimant's Exhibit No. 1. The claimant's second medical packet was marked as Claimant's Exhibit No. 2. The claimant's Constitutional Issues have been blue-backed and marked Claimant's Exhibit No. 3, as these are hereby incorporated herein by reference. The deposition of Dr. Oldenberg was marked as Joint Exhibit No. 1. The deposition of Dr. Neaville was marked as Joint Exhibit No. 2.

The following witnesses testified at the hearing: the claimant and James Dunlap.

DISCUSSION

The claimant, age 37 (8/04/1970), sustained an admittedly compensable injury to his back while working for the respondent-employer in June of 2002. The claimant admitted he is barely able to read and write, as he would not be able to understand or read instructions for any type of work-related activity. The claimant admitted that he drove a dump truck for the respondent-employer,

and to having done this for almost three months prior to this injury. The claimant further admitted to working for the respondent-employer on or around June 14, 2002.

With respect to his job duties, the claimant essentially testified he would back the truck up onto a stock pile and dump the gravel, as the conveyor belt would dump the rock and gravel in the back of the truck, plus he would back the truck up onto the stock pile and stock pile the gravel. The claimant admitted that this was a rock crusher operation, as they crushed rock up to make it into gravel.

Specifically, the claimant gave the following testimony concerning his injury:

A. Yeah. And they got a, like crossroad tie. When I stepped on that it twisted, and that's when I went in the trailer with my lower back and my side, and my side hit the corner clockwise, hit me sideways hitting it.

Q. Hitting into the trailer of the dump truck?

A. No. It's like a diesel trailer, but the surveyor (conveyor) belt sit up on that. Hit that button to shut down the barrel.

Q. Did you, so you smashed into the, your side and your back smashed into that --

A. Yes, sir.

Q. Into what?

A. Into the trailer.

Q. What do you mean by trailer?

A. It's the trailer of the diesel truck.

The claimant testified that the trailer his back and side struck was made of cast iron. According to the claimant, his

injury took place around 2:00 p.m., on a Friday. The claimant testified he reported his injury to the mechanic. He essentially testified that he was in a lot pain when he got off work around 5:00 p.m.; therefore, he went to the emergency room. The claimant testified he went to White River Medical in Batesville. He further testified he was given antibiotics and muscle relaxers, and sent home. According to the claimant, over the weekend his symptoms continued to worsen to the point that he could not breathe.

At the time of his injury, the claimant testified he experienced pain in the lower part of his back and along his left side. The claimant testified that the next day, his pain continued to increase and his breathing continued to worsen.

According to the claimant, while working for the employer-respondent, the dust was worse on the days that it did not rain. The claimant testified he last worked for the employer-respondent on the 19th. The claimant agreed that the next Monday and Tuesday when he went to work, he let his boss know he was trying to "tough it out."

The claimant admitted to going back to the emergency room about the middle of the week, on the 18th (June). The claimant testified that the second time he went to the emergency room, they put oxygen on him. The claimant maintains he was placed in intensive care. He admitted that eventually they had to remove his left lung.

The claimant admitted he went to see Dr. Allen at the request of his employer, which was when he went into the emergency room

the first time. He also admitted to seeing a Dr. Greg Neaville, who admitted him to the hospital when he went to the emergency room the second time. According to the claimant, all of his surgeries were all performed by Dr. John Lambert.

The claimant testified he has been unable to work since he had his lung removed. The claimant admitted that Dr. Oldenberg is his primary treating physician. The claimant admitted he is asking that it be found in his favor that he has a compensable lung injury as a consequence of his injury. He also admitted he is requesting reasonable and necessary medical care for his back and lungs, as a result of his fall against the trailer. The claimant again denied having worked anywhere since June 19, 2002. According to the claimant he has problems getting around and has also had problems breathing since this time.

The claimant testified he has had problems continually since his first surgery, as he has pain in his lungs and back due to his compensable back injury of June 2002. However, he denied any back operations. The claimant admitted to having an MRI work-up recently to determine what was going on with his back. He also admitted he is requesting that he gets whatever care is necessary for his back.

The claimant denied being provided a mask while working. The claimant admitted he was placed back in the hospital in 2006 or 2005 due to a staph infection. According to the claimant, he went to the hospital in the first place because he was unable to breathe.

On cross examination, the claimant admitted to being a smoker. The claimant testified he has smoked since he was 16 or 18. According to the claimant, he now smokes one cigarette a day. The claimant admits that he continues to smoke but not like he did prior to his injury. The claimant admitted that with respect to his injury on June 14, 2002, he was stepping on a board and the board twisted, and pitched him onto a solid object, causing him to hit his back and side. According to the claimant, the incident occurred June 14th, on a Friday. He agreed that he went to the hospital on that same day. The claimant admitted to seeking all of his emergency room treatment from White River Medical Center.

The claimant agreed that he next went to the emergency room on the 19th, at which time he saw Dr. Neaville. He denied first seeing Dr. Neaville on July 1st.

He next testified that he was seen for an ER visit on June 20th, but not on the 19th. The claimant testified he went to the ER the 14th and 20th of June, he maintains he specifically remembered this because the 20th is when he stayed in the hospital the longest. The claimant testified his injury occurred on the 14th and that he went to the ER on the 14th. According to the claimant, when he went into to the ER, he described to hospital personnel the slip and fall at work, and told them he had injured his side and back. He also admitted to having difficulty breathing when he went in to the ER on the 14th.

The claimant further testified that he either went into the ER on the 19th or the 20th. However, the claimant again testified he

was injured on a Friday. He maintains that he went back to work the following Monday, and that his last day of work was the 18th. The claimant essentially admitted he was nervous and puzzled as to which dates he went into the ER at White River Medical Center.

He testified his last surgery occurred in 2003 or 2004, due to a hernia surgery. The claimant testified he now draws Social Security Disability benefits, and has done so since 2002.

Upon being questioned by the Commission, the claimant denied any prior problems with his lungs or any other physical/health problems prior to the incident at work.

James Dunlap, the claimant's older brother, also testified during the hearing. He essentially testified the claimant was in special education type-classes while in school. He testified that he has always had to look out for the claimant most of his life. Mr. Dunlap admitted to working for the employer while the claimant worked there. He also gave extensive testimony concerning the dust and other working conditions. He admitted the claimant was injured around June 14, 2002. According to Mr. Dunlap, prior to the injury, the claimant did not appear to be hurt, but after the incident, he stated he needed to go lie down. He also testified the foreman and head mechanic was Tom Finley.

According to Mr. Dunlap, the claimant did not go to the emergency room on the day of the incident. Mr. Dunlap admitted the claimant went to the emergency room around June 19th, and that this is when all of the procedures and operations started. He admitted the claimant has not been able to work since June of 2002. Based

on his observations, Mr. Dunlap stated that the claimant has continued with back and lung problems. According to Mr. Dunlap, he shares a room with the claimant just in case he stops breathing.

On October 9, 2007, the deposition of Dr. Denise Oldenberg was taken. Dr. Oldenberg testified that her specialty is general practice with training in chronic pain. According to Dr. Oldenberg, she first saw the claimant on January 6, 2004, at the request of his parents because he was having some complications.

Dr. Oldenberg gave the following history of the claimant's injury, as reported it to her:

A. Okay. He said he was hurt on the job when he tripped while getting off the dump truck, a dump truck in 2001. And he, basically, twisted his back. He was trying to stop a conveyor belt that was dumping the stuff, and he was more concerned about trying to correct the problem than he was his health. And then, he ended up with what seemed to be a contusion of the chest wall, which later - evidently, he went to a doctor and was treated for minor problems due to the back pain. He was told to go back to work, but his pain became worse and worse. Went to the hospital, and they found fluid on his lungs, which was probably a bloody efu-, yeah, infiltrate. And evidently, that turned into an abscess or infection that required lung surgery or a thoracotomy with, I think it was - he had a thoracotomy in 2002, lungectomy secondary to chronic pneumonia. So, that's, in other words, this fluid that was in his lungs, due to the contusion, ended up causing infection that had to be evacuated with part of his lung being removed.

Dr. Oldenberg essentially admitted she believes that there is a connection, that all this is connected, his lung injury and the injury the following Monday when he went back to work. Dr. Oldenberg testified:

A. Oh. Well, here you see where he hit a board. This board is what caused the contusion and most likely caused the - okay. A contusion means there's a broken blood

vessel. And it probably got this what they call hematoma. Hematoma is probably between the pleura and the chest wall. I'm just going to assume that 'cause I don't have that record. And it subsequently could have got infected. I don't know if there was an open sore. We'd have to get the record.

Q. Let me interrupt you and ask this. When you say contusion, you mean as part of this injury process, he suffered a blow to his chest wall?

A. Yes, un-huh. That's what, 'cause it says he was hit by a board. Now, the board could have come around like this, like a slap injury (demonstrating), and hit him from behind. I'm going to assume that.

Q. And he told you this in the---

A. Yeah, I wouldn't have got it any other way.

Q. Okay.

A. He, he jumped off this truck, hit a board, twisting his back. I mean, you know, he's a poor historian because he's backward and uneducated, but - - -

Q. But that's clearly what you came away with?

A. Yes, that's what I came away with.

Q. This injury involved an episode on a truck where he jumped off, twisted his back, and contused his chest, all as part of the same thing?

A. That's right.

According to Dr. Oldenberg, the x-ray taken on June 20th does not show contusion of the chest, but it does indicate that the respiratory effort is mildly limited. She denied that it shows a smoking injury, such as emphyzematous type-changes.

Dr. Oldenberg testified she believes that the claimant's pneumonia, high fever or infection was initiated by the blow they've been discussing, with a possibly a hematoma having formed, which became infectious and then led to the removal of the lung in

about a month or so.

With respect to the claimant's back injury, Dr. Oldenberg essentially testified that since the claimant had a compression type injury, therefore, all the facet joints are going to be traumatized, and therefore, they will start the inflammatory process. However, she admitted that the type injury had not been established because it is unknown the type of mechanism which he fell.

She specifically testified:

Q.... And assume, Doctor, if you will, that this man, prior to November, prior to June of 2002, was having no problems with pain or with difficulties in either his back or lungs. Assume further that he is smoking approximately a pack of cigarettes a day. And assume further that he's only 32 years of age at the time. Actually, he was only 31 years of age at the time of the accident, if that makes any difference.

Given the history that Danny gave you when he came to you, do you believe that as a combination of the injury he sustained when he jumped off the truck, the dump truck, to turn off that conveyor belt which was dumping stuff into the truck, and he hit the board and twisted his back, do you believe that that and/or the number of particulates that he was inhaling in that job was at least the major cause, major cause defined as more than 50%, of the problems that he later evidenced with in terms of his lung problems? Do you believe that at least the major cause for the lung problems would have been the combination or either one, either one that you think is significant, either having to breathe the particulates in a rock crushing business, and then, add to that that he jumped off the truck, twisted his back, and had a hematoma? Do you believe that the major cause for his subsequent need for treatment to his lungs and to his back would have been that injury?

A. I, that's my belief, my medical opinion.

Q. All right. And is that medical opinion based upon a reasonable degree of medical certainty?

A. Yes.

Dr. Oldenberg testified that although the claimant may have smoked for 13 years, if he had no problems with his lungs, and had the injury on Friday and went back to work, the exposure on the following Monday, could have caused his breathing to be shallow. She also admitted that the triggering event, the domino effect that started all of this (the claimant's pain, inability to breath), at least the major reason for that, was the injury he sustained and/or particulates he was exposed to. She admitted she is not a pulmonary specialist.

Specifically, Dr. Oldenberg testified:

Q. All right. I understand that. And I understand that it's clearly your opinion that the left lung which was removed was directly related to the injury he suffered, predicated on the fact that he had a contusion to that lung.

A. Uh-huh. Yes.

Dr. Oldenberg also testified that the claimant is unable to work eight hours a day, five days a week due to pain, breathing problems and a lack of stamina.

Dr. Greg Neaville's deposition was taken on July 10, 2006. He testified that his specialty is internal medicine. He admitted to having access to the claimant's smoking history, as a two-pack a day smoker, for approximately 19 years. He testified that x-rays did not show any acute problems with the claimant's lungs. Dr. Neaville testified that the CT scan showed that the claimant had severe pneumonia that was complicated by a pleural effusion, or collection of infectious liquid outside the lung tissue, that required a placement of a chest tube to drain that

area, which was done. He admitted that Dr. Lambert removed the claimant's lung on July 19th.

According to Dr. Neaville, there are two reasons why the claimant's lung was in such condition as that described by Dr. Lambert, an acute infection and chronic damage that comes from cigarette smoking. He also stated that the claimant's changes were infectious in nature.

Dr. Neaville testified:

A. Okay. Okay. Actually I think that that issue is one of the most significant when you try to make the determination based on opinion and reasonable certainty and so forth. It's difficult to try to say that this gentleman's problem was due to severe cigarette smoking when he was not being treated for lung disease at the time of his presentation. In other words, this is not a gentleman who had been treated for five years for asthma or emphysema prior to this presentation for his pneumonia. He had no clinical symptoms that were brought for treatment, to my knowledge.

If an injury occurred that resulted in pain that stopped him from being able to take part in his daily activities, it is not unreasonable to suggest that that same pain could fall into the category that I had described further as being pain that prevented him from breathing appropriately and allow a pneumonia to form. Now, I wish that we had more details of his presentation for acute treatment available where I could give additional comment.

I think one of the questions asked before was, is it unusual that you would see this degree of damage from the infection. Certainly it's not impossible for that time course to occur. It would be easier for that type of damage to occur if there was true damage to the lung if there was a pulmonary contusion that occurred. However, I don't have evidence that that occurred based on the previous x-rays. And I have no description of trauma specifically to the chest wall that can give further comment.

Q. Doctor, would it even be possible to see all contusions to a lung or to the chest wall from just an x-ray?

A. It is possible for a chest x-ray to miss a true pulmonary contusion when taken shortly after the injury. And it is actually not possible to make the diagnosis of a chest wall contusion, or in other words, a badly bruised chest wall, on chest x-ray because it doesn't show up at all.

Q. Because it's soft tissue?

A. Correct.

Dr. Neaville testified within a reasonable degree of medical certainty that the major cause, more than 50 percent, of the beginnings of the claimant's pneumonia would have been due to the injury he sustained. However, he admitted he would not expect the claimant to present with fever and chills immediately after the injury.

He specifically testified:

Q. Now, again, Doctor, if you're hurt on, accepting June 20, 2002, as the date of injury, and you present with complaints of back pain and you have concurrent complaints of fever and chills, would you think that fever and chills would normally accompany a back injury?

A. No.

Q. Would you think that that would be a coincidental finding that just happened to be present at the same time he appeared to have his back looked at?

A. Yes.

Q. All right. Could these findings be a prelude having occurred on June 20, 2002, to the more serious problem that you would have seen about ten days later?

A. Yes.

Q. Is there any way to say, then, from what I've described to you, assuming that he did have fever and chills at the time of this presentation, any way to say that the back injury would have led to the fever and chills?

A. As you described, no. One thing I would think is important that if you can document objectively an elevated temperature, that's better evidence of true fever than someone's description of, quote, fever and chills. In other words, that's often something - - many times persons feel feverish, and they don't have a temperature.

There should be a vital sign sheet associated with that ER visit. If there was a temperature recorded, I think that your scenario is supported. If it's not documented there, it doesn't mean he didn't have any fever, it means he didn't have fever at that moment. But I was just going to add to the fact that, you know, if you have that record there, the actual measured temperature that's abnormal would be important.

Dr. Neaville specifically testified that it is a reasonable thought that the injury that the claimant sustained set off a course of events that resulted in his hospitalization for pneumonia and his need for treatment. He further testified:

Q. And you would believe based upon a reasonable degree of medical certainty that the major cause of his need for treatment would've been the injury he would've sustained as has been described to you through his mother and also by hypothetical questions that I've asked today, as well as the medical records; is that correct?

A. Yes.

However, Dr. Neaville admitted that if on the very day the claimant injured himself, he had fever, chills, and a cough that had some objective documentation available, it would lessen the possibility that the injury itself caused a cascade of events to result in the need for treatment. According to Dr. Neaville, had these been present, this could suggest that this was a preexisting condition that happened to be brewing at the time he was injured.

Dr. Neaville testified concerning a potential contusion of the chest wall:

Q. Right. And while you have different types of that condition - adhesive atelectasis and non-obstructive atelectasis, you have passive atelectasis - all these things are different types of conditions which basically go to the same thing, where there's a decreasing in the amount of air in the entire or a part of the lung with resulting loss of lung volume, is that correct?

A. Correct.

Q. And so, again, if a person is having severe pain, in your experience and based upon a reasonable degree of medical certainty, when people have severe pain in the mid back, are they not going to have a decreased amount of air arising solely out of the fact they've got severe pain in that area of the body, and that they are in a resting state?

A. I would be most comfortable saying that injury to the back or chest will always result in pain and difficulty breathing. It's an individualized case-by-case basis to determine whether or not that pain results in decreased aeration of the lungs. It is possible, if you fight through the discomfort, to aerate your lungs perfectly after injury; while in other cases, even with great effort it's impossible to get all of your lungs expanded. It's just varied from person to person, injury to injury.

Q. And that's the reason that after any operation, really, the person is in the hospital, physical therapists come by and make the person cough or push and take deep breaths; is that correct?

A. Exactly correct.

Q. Because of that very risk of having pneumonia. Because of the sensation the pain causes, causes one not to fully aerate the lungs, right?

A. Correct.

According to Dr. Neaville, if the claimant was injured on the 20th and had fever, it would be difficult to link the injury to the processes that would cause fever because in most cases it (atelectasis) would not have had an opportunity to occur by that time. He further explained specifically that the processes that

can cause atelectasis and such would not have been present long enough to cause a fever in most cases.

A review of the medical evidence of record demonstrates that the claimant was seen at the emergency room of White River Medical Center under the care of Dr. Greg Neaville, on June 19, 2002, due to complaints of chest pain, fever, chills, shortness of breath, and a cough. It is noted that the claimant has a past history of high blood pressure. The claimant is also noted to have pneumonia, but no onset date is recorded, and the claimant could not recall the onset date for his symptoms. Dr. Neaville's clinical impression was chest pain-acute, and the claimant is noted to have a fever. The claimant was discharged on this same day and instructed to follow-up with his family doctor.

It appears the claimant was seen back at the emergency room on June 20, 2002, at which point X-rays and blood and urinalysis studies were performed. X-rays identified "no acute cardio-pulmonary process." The claimant was discharged home with instructions to follow-up with his family physician.

The claimant returned to the emergency room on June 28, 2002 due to worsening complaints of back pain since last week after jumping out his truck and landing on a board. It appears that the claimant's temperature is noted to be, "no temp-99(?)."

On July 17, 2007, the claimant returned to White River Medical Center for consultation with Dr. J.S. Lambert due to complaints of chest pain. Dr. Lambert reported, in pertinent part:

PRESENT ILLNESS:

This patient is a 31-year-old white male who was recently admitted for treatment of pneumonia and an associated empyema. He underwent closed tube thoracostomy drainage during his previous hospitalization. Cultures from the pleural effusion were negative for growth. He responded to antibiotic therapy and was discharged. He presented to the clinic today with increasing chest pain, shortness of breath, and radiographic evidence of a recurrent large left pleural effusion consistent with recurrent pain and suspected lung abscess. He is admitted now for IV antibiotics and anticipated thoracotomy.

The claimant gave a prior history of being two-pack-a-day smoker since age 13. Dr. Lambert noted that the claimant had shortness of breath, chest pain and a nonproductive cough. On presentation, the claimant had a temperature of 99 degrees. His right lung was clear, but on the left there were decreased breath anteriorly, laterally, and posteriorly with dullness to percussion throughout the left hemithorax. There was healing tube thoracostomy site with purulent with drainage present. Dr. Lambert's assessment was "recurrent empyema with suspected lung abscess, left hemithorax." He admitted the claimant to the hospital for admission of intravenous antibiotics and noted he would recommend a CT scan of chest and pulmonary function testing with anticipated thoracotomy in the next few days.

Also on July 17, 2002, Dr. Neaville reported a History and Physical, in pertinent part, he wrote:

PRESENT ILLNESS

This is a young gentleman who was recently hospitalized for complicated pneumonia that required chest tube placement for likely empyema. He progressed well and was discharged home in stable condition. He presented for routine follow up with Dr. Lambert with pus draining from his previous chest tube site and is admitted now for surgical intervention and likely decortication. He is feeling badly with fever and chest pain.

Dr. Neaville reported the claimant's past medical history was unremarkable except for the aforementioned complicated pneumonia. His assessment was "Empyema. Questionable abscess," for which he recommended supportive care followed by surgical intervention.

A CT scan of the chest was performed on July 17, 2002, with the following impression:

IMPRESSION:

A large amount of fluid is present in the left pleural space. Areas of small air collections within this fluid are noted medially and a small air fluid level anteriorly is present. The slight enhancement of the pleura raises the possibility of developing empyema. There is consolidation of most of the left lung. The right lung is well expanded and clear.

The claimant underwent surgery on July 19, 2007, Dr. Lambert reported, in pertinent part:

OPERATION CONTINUED:

... After the pleural space had been completely drained, the lung was identified. It was completely collapsed with the left lower lobe being very thickened and rubbery. At this point, anesthesia was asked to reinflate the left lung and only the apical posterior segment was able to be reinflated. The remainder of the lung was stiff and very diseased. It was not felt that the lung was salvageable and it was elected to proceed with a total pneumonectomy. The pulmonary artery was ligated proximally with the vascular stapling device and distally with double ligatures of 2-0 silk. The inferior and superior pulmonary veins were ligated and divided in similar fashion. The main stem bronchus was closed with the TX-30 stapling device with 4.8 mm staples. It was then amputated and the left lung was submitted for histologic examination.

On July 25, 2002, the claimant underwent left lower extremity venous Doppler, with an impression of "No evidence of deep venous thrombosis at this time."

The claimant underwent surgery with Dr. Lambert on August 2,

2002 due to recurrent empyema, left hemithorax. The claimant's post operative diagnosis was "infected hematoma, left hemithroax," with operative findings of "subfascial seroma, left chest wall. Organized infected hematoma, left hemithroax."

A CT scan of the of the chest with contrast was performed on October 31, 2002 with the following impression:

IMPRESSION:

1. Postoperative changes present in the left chest consistent with penumonectomy.
2. Interval development of large pericardial effusion.
3. Mild haziness at the right lung base may represent minimal pulmonary edema or mild pneumonitis. Would recommend following with serial chest x-rays.

Dr. Neaville saw the claimant on October 29, 2002, he reported, in pertinent part:

SUBJECTIVE: Complains of continued purulent drainage from chest wall wound. Also notes congestion and occasional cough. Thinks his wound "stinks." Concerned about need for antibiotic for bronchitis and wound. Having problems with depression.

IMPRESSION

1. Severe pneumonia/bronchiectasis, status post pneumonectomy, now with bronchitis.
2. COPD.
3. Depression R/T above.

On November 5, 2002, the claimant underwent surgery with Dr. Lambert. He reported:

PREOP DIAGNOSIS (ES):

1. Moderate-size pericardial effusion, etiology unclear.
2. Status post construction of Eloesser flap, left hemithorax.

POSTOP DIAGNOSIS (ES):

1. Moderate-size pericardial effusion, etiology unclear.

2. Status post construction of Eloesser flap, left hemithorax.

OPERATION:

1. Subxiphoid construction of pericardial window with biopsy.
2. Closure of Eloesser flap.

The claimant was discharged from the hospital on November 10, 2002. Dr. Lambert reported, in pertinent part:

PROVISIONAL DIAGNOSIS:

Acute onset of shortness of breath in association with large pericardial effusion.

FINAL DIAGNOSIS (ES):

1. Acute onset of shortness of breath in association with large pericardial effusion.
2. Pericarditis.
3. Status post left total pneumonectomy for treatment of chronic empyema and bronchiectasis.
4. Status post construction of a Eloesser flap.

OPERATION:

1. Subxiphoid construction of pericardial window with biopsy, November 5, 2002.
 - A. Pericardial biopsy demonstrating pericardial tissue with focal mild chronic inflammation.
 - B. No granulomas or evidence of malignancy.
2. Closure of Eloesser flap November 5, 2002.

PROCEDURES:

1. Echocardiogram, October 31, 2002.
 - A. Technically suboptimal study due to very poor acoustic windows.
 - B. Estimated left ventricular ejection fraction greater than 40% although unable to quantitate left ventricular ejection fraction.
 - C. Mild to moderate pericardial effusion without evidence of hemodynamic compromise.
 - D. Placement of left subclavian 7-French triple lumen catheter for venous access, November 5, 2002.

His assessment and plan included the following:

ASSESSMENT:

1. Acute onset of shortness of breath in association of large pericardial effusion. Elevated white

count may be secondary to chronic bronchitis with acute exacerbation.

2. Status post left total pneumonectomy for treatment of chronic empyema and bronchiectasis.
3. Status post construction of Eloesser flap.

PLAN:

1. Will evaluate for possible closure of his Eloesser flap, since his recent cultures have demonstrated just a small growth of bacteria.
2. Additionally will need further evaluation of his pericardial effusion which could be contributing to his shortness of breath.

The claimant was admitted to White River Medical Center on December 16, 2002 due to progressive shortness of breath with history of left total pneumonectomy and continued tobacco use. Dr. Lambert discharged the claimant on December 23, 2002, with final diagnoses of the following:

FINAL DIAGNOSIS(ES):

1. Progressive shortness of breath with history of left total pneumonectomy and continued tobacco abuse with acute bronchitis, improved.
2. Recent construction of subxiphoid pericardial window demonstrating excessive pericardial fluid related to fibrinous pericarditis with echo demonstrating small to moderate pericardial effusion.
3. Status post left total pneumonectomy with rotation of intercostal flap (July 19, 2002).
4. Evacuation of infected hematoma with construction of Eloesser flap (August 2, 2002).
5. Dilatation of the Eloesser flap on September 13, 2002 and October 13, 2002.
6. Subxiphoid construction of pericardial window with closure of Eloesser flap (November 5, 2002).
7. Anemia most likely secondary to chronic disease.
8. Dyspnea on exertion, improved.
9. Incomplete wound closure, possible wound infection of the left chest.
10. Abnormal echocardiogram....

On June 19, 2003, the claimant presented again to the

emergency room with an onset of chest pain and fever, and a prior complaint of chest congestion, but denied any significant cough. Dr. Neaville assessed the claimant with "pneumonia" pursuant to reading of chest x-rays.

The claimant's hospital course and disposition entailed the following:

HOSPITAL COURSE:

This 32-year-old presented to the emergency room with complaints of chest pain and shortness of breath. He had temperature elevation of 101.5. He was placed in observation with IV fluids, IV Rocephin and p.o. Zithromax. On June 20, 2003 he continued to have a low grade temperature, productive cough and was converted to an inpatient status. He was given Toradol IV x 4 for complaints of continued chest pain with relief. His respiratory status improved with diminished cough and was discharged home in stable condition.

He was discharged home on June 26, 2003 with a principle diagnosis of "bronchiectasias with purulent bronchitis," and secondary diagnoses of chest pain, fever, chronic obstructive pulmonary disease depression, and back pain.

The claimant underwent an MRI to the spine on August 12, 2004, with an impression of "no herniation."

The medical evidence of record demonstrates that on August 10, 2004, Dr. Denise Oldenberg prescribed Oxygen for the claimant. The claimant continued to treat with Dr. Oldenberg primarily due to symptoms of chronic low back pain, CODP, fibromyalgia, chronic bronchitis and other related symptoms.

On January 15, 2007, Dr. Oldenberg rendered the following opinion:

IT IS MY BELIEF BASED UPON A REASONABLE DEGREE OF MEDICAL

CERTAINTY THAT THE INJURY suffered by Danny Dunlap when he jumped out of dump truck to turn off the conveyor belt that was dumping stuff into truck and hit a board twisting his back and then the injury to his lung which was injured after he went back to work on the following Monday and kept getting worse until he went to the ER where he was admitted to pump out his lung is the triggering event that caused his need for treatment to his back and lung problems and the major cause (more than 50%) of his back problems and lung problems is that injury.

ADJUDICATION

A. Motion to Recuse and Constitutional Challenges of the Act

The claimant filed a Motion to Recuse and a Brief in support of said Motion with the Commission on October 31, 2007.

Therein, the claimant sought my recusal from hearing this case, and challenged, *inter alia*, the constitutionality of the Workers' Compensation Act as it provides for the administrative adjudication of workers' compensation claims. At the time of the hearing, the claimant renewed his Motion to Recuse and challenged the constitutionality of the Act. With respect to the claimant's Motion for Recusal and the balance of the Motion pertaining to the constitutional challenges, I find that the Arkansas Court of Appeals has soundly rejected the same arguments in Long v. Wal-Mart Stores, Inc., ___ Ark. App. ___, ___ S.W.3d ___ (Ark. Ct. App. Feb. 21, 2007). Therefore, the claimant's Motion for Recusal is denied, and I find his constitutional challenges to be without merit.

B. Date of Injury

Although the claimant admitted to being puzzled and confused

about the occurrence of certain events, the claimant maintained throughout the hearing that his injury occurred on June 14, 2002. The claimant's brother also testified that the claimant's injury occurred on or about June 14, 2002. Based on the testimony elicited at the hearing, and in light of the absence of testimony from the respondents controverting same, I find that the preponderance of the evidence demonstrates that the claimant's injury occurred on or about June 14, 2002.

C. Lung Injury

Where a primary injury is shown to have arisen out of and in the course of employment, the employer is responsible for any natural consequence that flows from the injury, and the basic test is whether there is a causal connection between the two episodes. Wackenhut Corp. v. Jones, 73 Ark. App. 158, 40 S.W. 3d 333 (2001). The determination of whether a causal connection exists between the two episodes is a question of fact for the Commission to determine. Jeter v. B.R. McGinty Mech., 62 Ark. App. 53, 968 S. W. 2d 645 (1998).

In the present matter, the claimant proved that he suffered pulmonary problems as a result of his compensable injury. Although the claimant had been an avid smoker since the age of 13, he credibly testified that he had no history of problems with his lungs prior to his injury, but began to experience problems after his work-related incident. The testimony elicited from the

claimant's brother also demonstrates that the claimant had no prior pulmonary problems. Both Drs. Oldenberg and Neaville, were made aware of the claimant's history of tobacco abuse. Despite this fact, they both essentially opined that the claimant's left lung problem was a result of his compensable incident of June 2002, and there are no medical opinions to the contrary. Both these treating physicians provided medically sound explanations for same (see above discussions). Specifically, Dr. Neaville opined that the findings of the claimant's left lung were of the nature of an acute infection rather than the chronic damage that comes from smoking. The CT scan of July 17, 2002, taken of the claimant's left lung demonstrated severe pneumonia, which was complicated by a pleural effusion, or collection of infectious liquid outside the lung tissues. The evidence also demonstrates that the claimant did not seek treatment for his injury until a few days after the compensable incident. By having done so, such action adds credence to the opinions described above by Drs. Neaville and Oldenberg of the triggering event, the domino effect of the injury that started claimant's pulmonary problems, which led to his fever, inability to breathe, pneumonia, and infection, which ultimately led to the removal of his left lung.

Therefore, based on the expert opinions of the Drs. Neaville and Oldenberg, I find that the claimant proved a causal connection between his compensable injury and ensuing pulmonary problems.

D. Medical treatment for claimant's lung and back injuries

An employer shall promptly provide for an injured employee such medical treatment as may be reasonably necessary in connection with the injury received by the employee. Ark. Code Ann. § 11-9-508(a). The claimant bears the burden of proving that he is entitled to additional medical treatment. Dalton v. Allen Eng'g Co., 66 Ark. App. 201, 989 S.W.2d 543 (1999). What constitutes reasonably necessary medical treatment is a question of fact for the Commission. Wright Contracting Co. v. Randall, 12 Ark. App. 358, 676 S.W.2d 750 (1984).

The claimant is asserting his entitlement to additional treatment for his back. The claimant testified that he continues with back pain and related symptoms. Considering the persistent nature of the claimant's symptoms since his injury, the fact that he had no prior history of back pain or problems prior to the work-incident, the evidence demonstrates that the treatment of record for the claimant's back injury is reasonable and necessary treatment in connection with his compensable injury of June 14, 2002. The evidence also establishes that the treatment of record for the claimant's lung injury was reasonable and necessary treatment for his compensable injury pursuant to Ark. Code Ann. § 11-9-508(a).

As a result, the respondents are liable for the reasonable and necessary treatment the claimant has pursued in connection with his compensable back and lung injuries.

E. Temporary total disability

The claimant contends that he is entitled to temporary total disability from June 19, 2002, to a date yet to be determined.

An injured employee is entitled to temporary total disability compensation during the time that he is within his healing period and totally incapacitated to earn wages. Arkansas State Highway and Transportation Department v. Breshears, 272 Ark. 244, 613 S.W. 2d 392 (1981).

The claimant's testimony demonstrates that he has not been able to work at least since June 19, 2002. According to the claimant, he continues with back and lung pain and related symptoms. The claimant's treating physician, Dr. Oldenberg testified during her deposition that he is unable to work due to breathing problems and a lack of stamina. The evidence also demonstrates that since the claimant's first admission to the hospital, which ultimately resulted in the removal of his left lung, he has been totally incapacitated to earn wages and remained within his healing period for his compensable injury. Neither Dr. Oldenberg or Dr. Neaville has indicated that the claimant has been able to return to work since June 19, 2002. In sum, the evidence demonstrates that the claimant has remained and continues within his healing period and totally incapacitated to earn wages for his compensable injury since on or about June 19, 2002. Therefore, based on the record, the claimant proved by a preponderance of the evidence his entitlement to temporary total disability from June

19, 2002, until a date yet to be determined.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. The Arkansas Workers' Compensation Commission has jurisdiction of the within claim.
2. The employee-employer-carrier relationship existed at all relevant times, including on or about June 14, 2002.
3. The claimant suffered a compensable injury to his low back on June 14, 2002, for which some medical benefits have been paid.
4. Additional indemnity benefits have been controverted.
5. The claimant's Motion to Recuse is denied and his constitutional challenges of the Act are found to be without merit pursuant to *Long v. Wal-Mart Stores, Inc.*, ___ Ark. App. ___, ___ S.W.3d ___ (Ark. Ct. App. Feb. 21, 2007).
6. The evidence demonstrates that the claimant's injury occurred on or about June 14, 2002.
7. The claimant proved by a preponderance of the evidence that his pulmonary problems are a compensable consequence of his work-incident of June 14, 2002.
8. The claimant proved his entitled to additional medical treatment for his compensable back injury of June 2002.
9. The claimant proved that the medical treatment of record was reasonable and necessary treatment for his compensable consequence lung injury.
10. The claimant proved his entitlement to temporary total disability from June 19, 2002, until a date yet to be determined.
11. The claimant's attorney is entitled to the maximum statutory attorney's fee based on the benefits awarded herein.

AWARD

The respondents are directed to pay benefits in accordance with the Findings of Fact and Conclusions of Law set forth

herein.

Maximum attorney's fees are herein awarded to the claimant's attorney on the controverted indemnity benefits, pursuant to Arkansas Code Ann. § 11-9-715.

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

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

All other issues are expressly reserved.

IT IS SO ORDERED.

CHANDRA HICKS
Administrative Law Judge