BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F507172

KAREN BOHANNON,
EMPLOYEE CLAIMANT

WAL-MART STORES, INC.,
EMPLOYER RESPONDENT

CLAIMS MANAGEMENT INC.,
INSURANCE CARRIER RESPONDENT

OPINION FILED JUNE 28, 2007

Upon review before the FULL COMMISSION in Little Rock, Pulaski County, Arkansas.

Claimant represented by the HONORABLE JASON M. HATFIELD, Attorney at Law, Fayetteville, Arkansas.

Respondents represented by the HONORABLE DALE BROWN, Attorney at Law, Fayetteville, Arkansas.

Decision of Administrative Law Judge: Reversed.

OPINION AND ORDER

The respondents appeal an administrative law judge's opinion filed September 14, 2006. The administrative law judge found, among other things, that the claimant proved she was entitled to additional medical treatment. After reviewing the entire record *de novo*, the Full Commission reverses the opinion of the administrative law judge. The Full Commission finds that the claimant did not prove she was entitled to additional medical treatment.

I. HISTORY

Karen Lorene Bohannon, age 43, testified that she began working at Wal-Mart in November 2002. Dr. A.D. Bicak, who the claimant testified was her personal physician, assessed the claimant as having "skin tags" and "fatigue" in May 2003. In December 2003, the claimant sought emergency treatment for headache, increased blood pressure, and light-headedness. The clinical impression appeared to be "hypertension." A CT of the head without contrast was taken in December 2003, with the impression, "Negative non-contrast CT of the head." The claimant was treated for headache and sinusitis in October 2004. The claimant was assessed with the following in February 2005: "1. Degenerative disc disease of the cervical spine. 2. Headache, most likely tension headache resulting from muscle spasm in her neck. 3. Sinusitis."

The claimant testified that she was working for the respondent-employer in "facilities monitoring" in June 2005. The parties stipulated that the claimant suffered a compensable injury on June 21, 2005. The respondents' attorney questioned the claimant (at deposition):

> Q. Tell me what you were doing and what happened. Start in the beginning.

> A. I was working and sitting at my desk and I smelled something, and I ignored it, and began to get light-headed, and I thought I would get some water; had to hold on to walls to get to the lounge. When I got there, I drank the water, and I wasn't feeling any better so I said I was going to step outside. I stepped outside, and there was my other two co-workers that were - Susan was like staggering. I was like what is going on and she came and sat beside me and said, Girl, you don't know what's going on, and I'm like what are you talking about. She said that they were cleaning the coils and didn't shut the units down. You're supposed to shut the unit down and you learn this, you know, through our jobs, before you clean the coils. And the chemical got in, and that's why we're feeling the way we were feeling. So I remember trying to get up and I couldn't stand up, so Susan and somebody else helped me up. They walked me into the break room and I sat there. Daniel, my other co-worker, was sitting beside me and the only thing I really remember from there is a bunch of people and ambulance, hospital....

The claimant received emergency treatment on June 21, 2005, at which time the chief complaint was "Chemical inhalation. Pt was working in her space & someone was cleaning ducts....Pt awake but drowsy pt. trying to speak but words are garbled."

A brain CT without contrast was taken on June 21, 2005:

> HISTORY: 41 year-old female with headache, dizziness, difficulty with

> balance and slurred speech with left arm weakness....
>
> FINDINGS: No mass effect is present. There is no midline shift. There is no extracerebral fluid collection. The ventricles and sulci are within normal limits for the patient's age. There is no intracerebral hemorrhage. There is no demonstration of acute ischemic infarction. There is no subarachnoid hemorrhage. There is no demonstration of calvarial fracture.
>
> IMPRESSION:
> 1. No mass effect, midline shift or extracerebral fluid collection.
> 2. No intracerebral hemorrhage or demonstration of acute ischemic infarction.
> 3. No subarachnoid hemorrhage.
> 4. There is subtotal opacification of the ethmoid air cells bilaterally.

The clinical impression on June 21, 2005 was "Inhalation." The claimant was released to go home.

Dr. Shari DeSilva provided a Neurology Consultant's Report on June 22, 2005:

> This 41-year-old woman was in generally good health until yesterday, when while at work, she developed lightheadedness, chest tightness, dizziness and weakness with difficulty speaking within one hour of exposure to a "chemical" in the air conditioning system at Wal-Mart, where she worked. Apparently the system was being cleaned with "Kleencoil," (A solution containing 2-Butoxyethanol, sodium metasilicate, and isopropyl alcohol). Following the exposure she and three coworkers apparently had

severe symptoms. In Mrs. Bohannon's case, these lasted about an hour. She was taken to Northwest Medical Center in Bentonville, where a head CT scan was performed and was negative. Tox screen and alcohol level were also negative. Sedimentation rate was 8, CBC and electrolytes were unremarkable save for a fasting blood glucose of 218. She seemed to improve spontaneously; however, her symptoms returned intermittently the rest of that day, and this morning they tended if anything, to worsen. The patient noticed that after each spell of weakness, with difficulty speaking, she would have headaches which were over the left side of the eye and forehead. These would be throbbing, associated with nausea and would be severe. The patient denied double vision, though she did admit to blurry vision of the left eye. She also noted tinnitus in both ears together with lightheadedness and a sensation of imbalance. She denied numbness, though she admitted to tingling over both sides of the face. These tended to precede the headaches. Due to continued symptoms, the patient came to St. Mary's Hospital. Workup at St. Mary's was notable for repeat CBC, which was unremarkable. CPK and troponin were normal. EKG was unremarkable. Glucose today was 131 with a potassium of 3.4, but was otherwise unremarkable....

IMPRESSION(S)
The patient's lightheadedness and diffuse "weakness" (which may reflect unsteadiness), and dysarthria and headache following exposure to inhaled 2-Butoxyethanol, among other compounds, waxes and wanes. Her examination suggests cerebellar involvement.

> The differential diagnosis includes:
> 1. Vertebrobasilar migraines provoked by inhalent (sic).
> 2. Vertebrobasilar transient ischemic attacks.
> 3. Partial-complex seizures (I think this less likely).

Dr. DeSilva's recommendations included additional diagnostic testing.

Dr. K. Lamar Howard examined the claimant on June 22, 2005 and diagnosed the following: "1. 'Aphasia' and associated neurologic symptoms. 2. Mild hypertension. 3. Impaired glucose tolerance. 4. Status post amputation of right foot at age 18 for malignancy. 5. Inhalation. Unsure at all if this is related. 6. Hypokalemia."

(Dorland's *Illustrated* Medical Dictionary, 28th Ed., defines "aphasia" as follows: "defect or loss of the power of expression by speech, writing, or signs, or of comprehending spoken or written language, due to injury or disease of the brain.")

An x-ray of the claimant's chest on June 22, 2005 showed the following findings: "Lungs are free of infiltrates or effusions. No pneumothorax. Heart size is upper limits of normal. Trachea is midline." The impression was, "No evidence of acute cardiopulmonary disease."

A CT scan of the brain without contrast was taken on June 22, 2005, with the following findings:

> Exam is compared with a similar study dated 12/21/03. Brain parenchyma appears normal. Gray/white differentiation is well maintained. No mass lesions, midline shift, or mass effect. No evidence of acute intracranial hemorrhage or abnormal extraaxial fluid collections. Ventricles are normal in size, shape, and symmetry. Sulci and basal cisterns are intact.

The impression was, "Normal noncontrast CT scan of the brain."

The following impression resulted from a Bilateral Carotid Doppler Ultrasound on June 23, 2005: "No significant plaque identified in the carotid arteries bilaterally. No evidence of hemodynamically significant stenosis." An MRI of the brain with and without contrast and MRA of the "circle of Willis" was taken on June 23, 2005, with the following impression: "1. Normal MRI of the brain. 2. Normal MRA of the circle of Willis."

An electroencephalogram was administered on June 23, 2005, with the following impression: "1. This is a normal study. 2. There is no evidence of abnormal epileptiform activity, nor of any electrogenic seizures. 3. There are

no focal slow waves, and there are no significant slow waves of any kind that might suggest metabolic delirium."

An M-Mode and 2-Dimensional echocardiogram was done on June 23, 2005, with the following interpretation: "This is a good quality cardiac ultrasound study showing normal segmental contraction of the left ventricle with an ejection fraction of 60% to 65%. Left atrium, right atrium and right ventricle are normal. There is no evidence of pericardial effusion or intracardiac thrombus. The aortic, mitral, tricuspid and pulmonic valves are normal."

Dr. Howard authored a Discharge Summary Report on or about June 24, 2005:

> This 41-year-old patient was evaluated with aphasia and some peripheral and facial sensory disturbance associated with a left-sided retro-orbital headache. She had inhaled a cleaning chemical at work that is listed on her chart (Kleencoil). The ingredients seemed fairly innocuous and unlikely to have caused any neurologic symptoms on their own, particularly in the manner of her exposure. She had a very halting speech with an unusual cadence with word searching and some very impaired communication. This had been fluctuating for approximately 24 hours since the onset. She had been to Northwest emergency room initially where some other coworkers were also evaluated. She had a CT scan of her head done there and the following evening returned, but at this time to

> St. Mary's, and a repeat CT scan was also done. The emergency room physician asked me to see her for admission. She normally sees Dr. Bicak who was out of town. She was monitored on telemetry during her stay and had no significant arrhythmias.
>
> The patient was admitted and Dr. Shari DeSilva saw her also that evening for neurology consultation. She was given Solu-Medrol and subsequently Prednisone and started on Inderal LA. Overnight her speech improved considerably though she still has had some disruption in her speech cadence. Today, she is very near normal.

Dr. Howard noted that the claimant had been prescribed medication, and he released the claimant to follow up with Dr. Bicak in about two weeks.

The claimant was admitted to Northwest Health on July 5, 2005 after she was "found unresponsive at work today. Brought to ER, remains dysphasic. All utterances unintelligible. Will attempt to have her write."

A brain CT without contrast was taken on July 5, 2005, with the following impression: "1. No mass effect, midline shift or extracerebral fluid collection. 2. No intracerebral hemorrhage or demonstration of acute ischemic infarction. 3. No subarachnoid hemorrhage. 4. The imaged portion of the paranasal sinuses is well aerated."

A duplex carotid ultrasound on July 5, 2005 was negative for any abnormalities.

The impression of an MR of the brain without contrast on July 5, 2005 was "Normal intracranial examination."

Dr. David Ewart gave the following impression on July 5, 2005:

> ▪ Intermittent expressive aphasia of uncertain etiology. One could consider the possibility of repeated chemical exposure. I am unaware of a chemical exposure that causes intermittent expressive aphasia. This does not seem like a TIA, especially in view of the normal MRI. However, this is possible. Another possibility would be conversion reaction.
> ▪ Hyperglycemia.

Dr. Gary L. Moffitt examined the claimant and informed the respondents on July 9, 2005, "At this time, I do not know exactly what is going on with Ms. Bohannon. I do not know if she has had a complex migraine, if the solvent that she was exposed to has anything to do with this, and I feel that more work needs to be done. Due to the nature of her job answering phones and solving problems and with what is going on at this time, I do not think work is the best thing for her to do."

Dr. Reginald J. Rutherford provided a Consultation Report on July 26, 2005:

> Ms. Bohannon reports that she noted a strong smell at work on June 21, 2005. She felt unwell going to the restroom for a drink of water. She then went outside for fresh air. She reports that she felt unsteady as though she was drunk. This was followed by numbness of her whole body and inability to speak. She was seen in the emergency department but discharged after several hours. The next day she was hospitalized for two to three days. She has undergone extensive diagnostic testing. This has comprised extensive blood work which proved normal other than demonstration of diabetes, cardiac monitoring which proved normal, echocardiogram which proved normal, carotid doppler which proved normal, CT and MRI imaging of the brain which proved normal, MRA of the circle of Willis which proved normal and EEG which proved normal. Definitive diagnosis was not achieved. Complicated migraine was offered as a possibility but it is of note that there is no evidence for cerebral infarction via brain imaging. Ms. Bohannon reports continued problems with speech as well as headache and insomnia....
>
> The probability of complicated migraine in Ms. Bohannon's case is considered quite low. A more probable explanation is considered to reside within diagnosis of conversion reaction. Alternatively this may represent acute psychosis but this as well is considered of low probability in that there is no evidence in taking her history of a thought disorder or hallucinations. She requires a SPECT scan of the brain to evaluate brain function rather than brain structure. If this is normal psychological evaluation would then be appropriate. She will be seen in follow

> up upon completion of the SPECT scan of the brain.

Dr. Moffitt informed the respondents on July 29, 2005, "I would recommend the SPECT scan. I talked with Dr. Rutherford and if the SPECT scan is not approved, neuro-psych testing also could be helpful."

The following opinion resulted from an NM Brain Scan and SPECT taken August 12, 2005:

> The lateral ventricles appear asymmetric likely artifactual due to oblique positioning. However, this can be confirmed with CT or MRI both of which have greater spatial resolution. There may be a small defect in the left parieto-occipital junction possibly from a small infarct. Alternatively this could be due to artifact or simply a prominent sulcus. Recommend clinical correlation and comparison with head MRI with stroke sensitive sequences....

Dr. Rutherford noted the following on August 12, 2005:

> Ms. Bohannon is seen in follow up. Her SPECT scan of the brain raises the possibility of an abnormality or lesion left hemisphere. This was discussed with the radiologist. This may also represent artifact. To clarify whether or not there is evidence of a structural abnormality left hemisphere not disclosed on prior MRI imaging of the brain arrangements will be made for a current MRI study of the brain. This is to be correlated with the SPECT scan and will be performed at St. Vincent's Infirmary....

The claimant continued to follow up with Dr. Moffitt, who noted that he agreed with Dr. Rutherford's diagnostic recommendations. Dr. Moffitt noted on September 13, 2005, "Ms. Bohannon is seen today for recheck. She is much, much better. She says she is still having problems with headaches, but she is dealing with them. Her speech if (sic) doing extremely well. She is quite articulate. She has not been having any halting qualities to her speech....Her condition is improved. She is released to work at full duties. She has no return appointment and no permanent impairment."

On October 11, 2005, the claimant returned to Northwest Health for complaints including slurred speech. It was noted that there had been a chemical exposure in June 2005. A head CT without contrast on October 11, 2005 showed "No acute intracranial abnormality."

The assessment of Dr. Mildred A. Ehrhart on October 12, 2005 included dysarthria, hypertension, and diabetes.

Dr. Michael M. Morse, a neurologist, consulted with the claimant on December 5, 2005:

> Karen Bohannon is a 41-year-old black female sent in consultation from Dr. Bicak. She gives a history of being in her office at Facilities Monitoring in

> Bentonville on 6/22/05. She felt a bad smell....She had inability to speak for a month....She was apparently hospitalized for four days and had a negative evaluation. She has also seen a Little Rock, neurologist, Dr. Rutherford, who found a "spot" on her brain and wanted to run additional testing. She states the worker's comp would not allow the testing. Unfortunately, I do not have access to any of those records.
>
> She states the air conditioning coils were being cleaned on the roof immediately above her office. Two other individuals were also affected and had headaches, blackouts, balance problems, and insomnia....
>
> She has some hesitancy in speech and some slowness in following commands such as finger tapping and arm roll. Certainly, the speech problem is intermittent and her slowness of movement when she does something to command is certainly different than what she does spontaneously.
>
> IMPRESSION: This patient has neurologic symptoms related to a possible exposure at work. I want to get all her old medical records and review them. I will have a recommendation at that time. I will see her back in a month in follow-up or sooner if we obtain her records before then.

The claimant again sought emergency treatment on December 12, 2005. Dr. Bicak examined the claimant on December 12, 2005 and gave the following diagnoses: "1.

Headache with dysarthria. 2. Hypertension with poor control earlier today. 3. Diabetes mellitus."

Dr. DeSilva examined the claimant on December 12, 2005 and gave the following impression:

> The patient's examination is somewhat marred by give-way weakness. I continue to believe that she most likely has vertebrobasilar migraine headaches, but there appears to be some degree of psychogenic overlay. The patient has already had an extensive workup and has failed a trial of Prednisone and inderal.
>
> RECOMMENDATIONS
> I would recommend performing an overnight pulse oximetry as a screen for sleep apnea and giving her a trial of 100% 02 by rebreathing mask for 20 minutes. This is often helpful in breaking migraine status. In addition, I would add Nitrazine at bedtime. Unfortunately, the patient is not a candidate for DHE, or triptans; as she has vertebrobasilar migraines, as there is an increase in symptoms of stroke.

The claimant was discharged from St. Mary's Hospital on December 14, 2005, with the following diagnoses: "Vertebrobasilar migraine headaches with associated dysarthria. Hypertension, improved control. Diabetes mellitus." Dr. Bicak noted, "She did see neurology in consultation. At the time of discharge, the patient denied any headache whatsoever."

A pre-hearing order was filed on March 16, 2006. The claimant contended that she sustained a compensable injury "when she was exposed to chemical inhalation and sustained loss of consciousness, speech problems, memory loss, balance problems, and continues to have severe migraine headaches. There have been multiple recommendations for further testing that have been controverted by the respondents. Additionally, the respondents have failed to pay medical bills. The claimant continues to be employed with respondent as a monitoring tech, wherein she has to work on the computer and incoming and outgoing calls all day. Claimant endures migraine headaches daily and needs additional treatment for these."

The respondents contended that they "initially accepted the claim as compensable before denying the claimant's request for additional benefits. The respondent further contends the claimant is not entitled to additional medical treatment as any additional treatment is both unreasonable and unnecessary. The claimant is beyond her healing period."

The parties agreed to litigate the following issue: "1. Claimant's entitlement to additional medical treatment;

including but not limited to Dr. Rutherford's recommendations."

The claimant was deposed on April 19, 2006. The respondents' attorney questioned the claimant:

> Q. As we sit here today, what are your current problems you relate to this exposure?
>
> A. My headaches still. I still have light-headedness. Mainly those two things....
>
> Q. Do you know what chemical and product was used on that date to clean those air conditioning units?
>
> A. I don't have that information, but I know Jan does.
>
> Q. To your knowledge, has anyone looked at the ingredients of the chemical they used and told you this would cause your problems?
>
> A. No. According to what Jan found out, they said that the chemicals were not harmful.
>
> Q. And Jan's last name was what?
>
> A. Snow, S-n-o-w....
>
> Q. Do you know where Jan got that information?
>
> A. Jan did some research and got that information.
>
> Q. When did she tell you this?

> A. I don't know. I don't know. I really can't tell you the exact time.

Howell R. Foster, a Doctor of Pharmacy and a toxicologist, wrote to the respondents' attorney on April 26, 2006:

> Thank you for asking me to review the case of Ms. Karen Bohannon's alleged inhalation exposure to "Kleen Coil" on June 21, 2005. On the date in question, after reviewing the patient's medical record, I believe based on the reasonable scientific, medical, and toxicologic data available it is within a reasonable degree of toxicologic certainty that it is unlikely the alleged exposure resulted in any toxicity to Ms. Bohannon. The following report is the basis of my conclusion.
>
> On June 21, 2005 Ms. Karen Bohannon was allegedly exposed to "Kleen Coil" vapor via the air conditioning duct system. The material in question was diluted five to one and was being used to clean air conditioning coils found on the industrial air conditioning units located on the building's roof. The units were turned on during the cleaning process. The units were shut off shortly after the initial alleged exposure. Ms. Bohannon noticed a smell and then exited the building within a short time.
>
> Two different formulations of "Kleen Coil" may have been available for use. A Material Safety Data Sheet (MSDS) was supplied and this is the formulation that was allegedly used. A product label was also supplied with a slightly

different formulation. Both products contain 2-butoxyethanol at like concentrations (3% according to the manufacturer), as well as surfactants and water. For the sake of this report Formulation One will refer to the MSDS formulation and Formulation Two will refer to the product label....

Ms. Bohannon, left the office area within minutes of smelling an odor on 6/21/2005. 2-butoxyethanol has an odor threshold of 0.1ppm according to OSHA. At exposures to 195ppm all subjects displayed immediate nose and throat irritation. (Carpenter 1956) Exposure of humans to 300ppm-600ppm, for several hours, would be expected to cause respiratory and eye irritation, narcosis, and damage to the kidney and liver (Clayton and Clayton, 1981.) Ms. Bohannon was exposed to the vapor for only a few minutes, levels required to produce narcosis with an exposure time of less than 30 minutes would obviously exceed the aforementioned ranges. Even if the patient could have been exposed to levels greater than 600ppm, she would have experienced marked respiratory, ocular, and nasal irritation. At no time were any of these signs or symptoms documented. Furthermore, the amount of 0.6% 2-butoxyethanol solution that would be required to produce 600 ppm in a cubic meter of air assuming equilibrium and a temperature of 25 degrees Celsius would be 491 milliliters; it would require a phenomenal amount of material to fill an office space.

Based on the known toxicologic properties of 2-butoxyethanol, Ms. Bohannon was exposed to less than 195ppm for only a few minutes, her symptoms are not consistent with levels exceeding

195ppm as nasal and occular irritation is not present per the medical record. And she was not exposed to a level less than this for a sufficient amount of time to develop a decreased level of consciousness or other central nervous system toxicity. Migraines have not been associated with 2-butoxyethanol according to the available literature nor has slurred speech, aphasia, or dysphasia....

Ms. Bohannon was seen in the St. Mary's Hospital Emergency Department nearly 24 hours after her brief exposure to Kleen Coil. Based on a toxicokinetic study (Johanson, Kornbord, Naslund, et. al) peak levels of 2-butoxyethanol occurred within 1 to 2 hours post exposure. Based on this finding and coupled with the clinical presentation seen in the aforementioned studies, signs and symptoms would not appear, and then disappear only to reappear or intensify hours later. All symptoms in these studies disappeared within 24 hours. The pathophysiology for headache already existed according to Ms. Bohannon's medical record on 2/2/05.

As previously discussed Ms. Bohannon's initial exposure signs and symptoms do not correlate with toxicity to 2-butoxyethanol under the described conditions. Delayed toxicity is not described in the literature. Individuals that develop serious central nervous system toxicity commonly develop renal or hepatic toxicity. The absence of the irritation of mucosal membranes, renal toxicity and/or hepatic toxicity is not consistent with an individual developing severe central nervous system toxicity.

Conclusion

> Ms. Bohannon already had a history of headaches that were severe enough to seek medical attention. Headaches can occur with exposures to inhaled 2-butoxyethanol at concentrations equal to 98ppm over hours of exposure; these headaches have been mild and transient and nasal, throat and/or ocular irritation have been present. Ms. Bohannon never complained of any irritation. The amount of inhaled 2-butoxyethanol required to induce weakness and a decreased level of consciousness that she describes in conjunction with the timeframe provided by the history would assuredly produce nasal, throat and ocular irritation with probable concomitant renal or hepatic toxicity. Her signs and symptoms are not consistent with the medical and toxicological literature on 2-butoxyethanol. The etiology of Ms. Bohannon's speech problems and headaches has not been delineated, but 2-butoxyethanol in my professional opinion and within a reasonable degree of toxicologic certainty is not the cause.

The parties deposed Dr. Foster on July 18, 2006. The claimant's attorney questioned Dr. Foster:

> Q. What symptoms did Ms. Bohannon have?
>
> A. Basically, she had a decreased level of consciousness, evidently had some form of aphasia or dysphasia, she was having some inability to speak....
>
> Q. Did she have headaches?
>
> A. She complains of a headache, yes....

Q. You don't know how much 2-butoxyethanol was put into the air conditioner unit?

A. No, sir.

Q. You don't know how long the 2-butoxyethanol was blown into the room where Ms. Bohannon was?

A. No, sir.

Q. And you don't know what proximity she was to the vent that was blowing in the 2-butoxyethanol?

A. No, sir....But given the fact that she didn't have any nasal, ocular, or oral irritation, it is most likely that she was exposed to less than five parts per million....

Q. And you're a physician, correct?

A. No.

Q. Oh, you've got a PhD?

A. No, I have my PHARM.D., and then I have boards in toxicology.

Q. Okay. When you say boards in toxicology, what do you mean?

A. Basically, I've been the director of the Poison Control Center for the last six years. During that time, if you have handled so many exposures, or consulted on so many poison situations, and meet other criteria, you can sit for the American Boards of Applied Toxicology....

Q. Okay, and what was your undergraduate degree in?

> A. I don't have an undergraduate degree. Well, I have a BS in pharmacy, and then I have my PHARM.D. at a later date....
>
> Q. What do you mean when you say a PHARM.D.?
>
> A. It's a Doctor of Pharmacy....
>
> Q. Is that the strongest part of your opinion, is that you didn't see any nasal, ocular or throat irritation and so you just don't believe that she was exposed to a high enough amount of 2-butoxyethanol to cause neurological -
>
> A. Neurological symptoms. Yes, that's correct.
>
> Q. I mean, that's the heart of your opinion?
>
> A. Absolutely.

The claimant's attorney wrote to the administrative law judge on July 19, 2006 and stated in part:

> [A]fter reviewing the Claimant's Response to the Pre-Hearing Questionnaire and the Pre-Hearing Order, the Claimant has not made it clear exactly what additional medical treatment she is requesting, and additionally we have not made it clear that we are asking that past medical be paid by the Respondents.
>
> Claimant has sustained medical expenses in the form of office visits and hospitalization since this inhalation exposure on June 21, 2005. Respondents have made some payments, including the emergency room visit on the day of the

> incident and some payments to Dr. Moffitt and Dr. Rutherford; however, it is Claimant's position that other treatment, including hospitalization and treatment from Dr. Michael Morse, should be paid by the Respondents. The Respondents have controverted these treatments.
>
> Additionally, Claimant is requesting a psychological evaluation, which was recommended by Dr. Rutherford on July 26, 2005 (Claimant's Medical Exhibit, page 38) and an MRI of the brain, as recommended by Dr. Rutherford on August 12, 2005 (Claimant's Medical Exhibit, page 41). Claimant is also requesting that she be able to return to Dr. Michael Morse. Dr. Morse on December 5, 2005 wrote that "The patient has neurologic symptoms related to a possible exposure at work. I want to get all her medical records and review them. I will have a recommendation at that time. I will see her back in a month in follow-up or sooner if we obtain her records before then." (Claimant's Medical Exhibit, page 52) Claimant is also requesting the overnight test of pulse oximetry as a screen for sleep apnea and a trial of 100% 0^2 by rebreathing mask for 20 minutes, which was requested by Dr. DeSilva on December 12, 2005 (Claimant's Medical Exhibit, page 58). Finally, Claimant is requesting continued medications for her headaches, as Dr. Bicak recommended in December of 2005 (Claimant's Medical Exhibit, page 59).

A hearing was held on August 7, 2006. The claimant testified that she suffered from daily headaches after the June 21, 2005 incident. Jackie D. Abbott testified that he

worked in facilities maintenance for the respondent-employer. Mr. Abbott agreed that, on June 21, 2005, he was cleaning air conditioning units in the facility where the claimant worked, i.e., the "1300 building." Mr. Abbott testified for the respondents:

> Q. And did you have some sort of solution to clean the coils with?
>
> A. Yeah. It was evaporator coil cleaner....
>
> Q. Can you identify what I just placed in front of you?
>
> A. Yes....It's just a sprayer....
>
> Q. What do you use the sprayer for?
>
> A. That's where we put the cleaning solution in, mix it up, and just spray it.
>
> Q. And are you referring to Kleen Coil?
>
> A. Yeah....
>
> Q. Did you use that sprayer or one like it on June 21st, 2005?
>
> A. Yeah. That's the exact bottle....It was either that one or one just like it.
>
> Q. Okay. And when I say the day in question, I'm talking about June 21st, 2005. Did you prepare the cleaning solution?
>
> A. Yeah. I believe that Jesse, he put the cleaner in, and then I had the water hose and filled it up....

Q. And what did you mix the Kleen Coil with?

A. With water.

Q. Just tap water?

A. Yes....

Q. Tell me on the date in question, June 21st, 2005, how much Kleen Coil solution - we'll get to the water in a minute - but the Kleen Coil solution you put in this container.

A. Uh-huh. Well, I was going by the - it said, I believe, six parts per one. So I was filling it up here (pointing on sprayer). You know, there's not a 1 mark but I was, you know, kind of guesstimating that right there is 1 (pointing on sprayer), so that's my one part. And then for my six other parts I'd go 1, 2, 3, 4, 5, 6 (pointing on sprayer), but we would fill it all the way up, I mean, as much as we could get in it, because we could get more done and it seemed to work the same - work fine.

Q. Okay.

A. But I was getting my at least, you know, six parts. Right there was the cleaning solution (pointing on sprayer). We would pour that in first and then fill it all the way up as full as I could get it, and a lot of times we would kind of overfill it and when we would put the lid on it would spill out.

Q. And based on what your testimony just was, what do you believe the unit -

how many liters of Kleen Coil solution did you place in this?

A. Well, I guess by that it would be one liter....

Q. And with that solution you prepared, that's the container and sprayer you or another one of your coworkers used on the 1300 building?

A. Yeah, because I think we only have two of them. That's the two we used. We used that one and one exactly like it....

Q. Did it matter to you one way or the other whether the unit was on or off when you applied the cleaning chemical?

A. No. I mean, we would spray it either way. I would prefer it was running, myself.

Q. And why would you prefer it running?

A. Just because I got it all over me. It would - because the return is right there, so when you would open up the doors, you know, it's sucking the air out.

The claimant's attorney cross-examined Mr. Abbott:

Q. Do you ever turn off the ventilating fans when you spray it into the unit?

A. No.

Q. No one from Wal-Mart has ever told you to do that?

A. No....

Q. So you spray it until you get all the dirt and dust off?

A. No. It would just - I just always give it the once-over. That's how I done it. Just one pass and that dirt just disappeared.

Q. And when you're using the product on a rooftop, you're outside?

A. Right....

Q. Were you told on that day to turn the units off?

A. No.

Q. You never got a call to turn off the units?

A. Oh, yes. Yes.

Q. Who called you to turn off the units?

A. Carl Cartwright....I don't know his exact title, but he is my supervisor's supervisor.

Q. Did he tell you why he needed to turn off the units?

A. He said that some people were - it was making them sick, is what he said, that they had a call that people were getting sick....

Maintenance workers Jesse Campbell and Kevin Burkett corroborated Mr. Abbott's testimony.

The administrative law judge found, in pertinent part:

> 2. Claimant has met her burden of proving by a preponderance of the evidence that she is entitled to additional medical treatment for her compensable injury.
> 3. Dr. Michael Morse is hereby recognized as claimant's authorized treating physician for future medical treatment. Because Dr. Morse is recognized as claimant's authorized treating physician, additional requested medical treatment from Dr. Rutherford and Dr. DeSilva is not reasonable and necessary.
> 4. Respondent is liable for unpaid medical benefits provided in connection with claimant's compensable injury; this includes prior hospitalizations and medical treatment from Dr. Morse.

The respondents appeal to the Full Commission.

II. ADJUDICATION

The 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 must prove by a preponderance of the evidence that she is entitled to additional medical treatment. *Wal-Mart Stores, Inc. v. Brown*, 82 Ark. App. 600, 120 S.W.3d 153 (2003). What constitutes reasonably necessary medical treatment is a question of fact for the Commission. *Dalton v. Allen Eng'g Co.*, 66 Ark. App. 201, 989 S.W.2d 543 (1999).

The administrative law judge found in the present matter, "Claimant has met her burden of proving by a preponderance of the evidence that she is entitled to additional medical treatment for her compensable injury." The Full Commission reverses this finding.

The parties stipulated that the claimant sustained a compensable injury on June 21, 2005. The claimant testified that she "smelled something" while sitting at her desk, and that she became light-headed and stepped outside. The record does not clearly demonstrate what quantity of Kleencoil, or 2-butoxyethanol, the claimant inhaled. The claimant received emergency treatment on June 21, 2005 for a complaint of "chemical inhalation." The initial medical report noted headache, dizziness, difficulty with balance, slurred speech, and left arm weakness. A brain CT without contrast on June 21, 2005 showed the following: "1. No mass effect, midline shift or extracerebral fluid collection. 2. No intracerebral hemorrhage or demonstration of acute ischemic infarction. 3. No subarachnoid hemorrhage. 4. There is subtotal opacification of the ethmoid cells bilaterally."

The only abnormality shown on the June 21, 2005 brain CT, and indeed the only physical abnormality shown in the

entire record post-injury, was "subtotal opacification of the ethmoid air cells bilaterally." Dr. DeSilva noted on June 22, 2005 noted that a head CT scan was negative, and that a toxilogical screen was negative. Other diagnostic testing was also normal, including a repeat CBC and an EKG. Dr. DeSilva's initial diagnosis included "vertebrobasilar migraines provoked by inhalant." Dr. Howard on June 22, 2005 diagnosed symptoms including aphasia and mild hypertension, and inhalation, but he noted, "Unsure at all if this is related." A chest x-ray on June 22, 2005 was normal, as was a CT scan of the brain, a doppler ultrasound, an MRI of the brain, an MRA of the circle of Willis, an electroencephelogram on June 23, 2005, and an echocardiogram on June 23, 2005. Dr. Howard reported on June 23, 2005 that the claimant was "very near normal." Dr. Howard stated on June 24, 2005, "The ingredients seemed fairly innocuous and unlikely to have caused any neurologic symptoms on their own, particularly in the manner of her exposure."

The claimant was again admitted to the hospital on July 5, 2005 for renewed symptoms of dysphasia. Yet, no abnormalities were shown in a brain CT taken July 5, 2005. In contrast to the opacification of ethmoid cells shown on June 21, 2005, the July 5, 2005 brain CT showed that "the

imaged portion of the paranasal sinuses is well aerated." A duplex carotid ultrasound on July 5, 2005 was also negative for any abnormalities. The Full Commission recognizes that the claimant does not have to establish objective medical findings to support a need for continuing medical treatment. *Castleberry v. Elite Lamp Co.*, 69 Ark. App. 359, 13 S.W.3d 211 (2000). In the present matter, however, the claimant did not prove that additional medical treatment was reasonably necessary in connection with her June 21, 2005 compensable inhalation injury. Dr. Ewart's impression on July 5, 2005 was "Intermittent expressive aphasia of uncertain etiology. One could consider the possibility of repeated chemical exposure. I am unaware of a chemical exposure that causes intermittent expressive aphasia." Dr. Ewart did not causally connect the claimant's aphasia on July 5, 2005 to the June 21, 2005 inhalation incident. Nor does the record show that the claimant suffered from any further exposure to "Kleen coil" after June 21, 2005. Dr. Moffitt was unsure on July 9, 2005 that any chemical inhalation was the cause of the claimant's continued symptoms.

Dr. Rutherford examined the claimant on July 26, 2005 and noted that all of the diagnostic testing had been

normal. Dr. Rutherford stated, "The probability of complicated migraine in Ms. Bohannon's case is considered quite low. A more probable explanation is considered to reside within diagnosis of conversion reaction." Dr. Rutherford recommended a SPECT scan. The report from an August 2005 SPECT scan concluded, "There may be a small defect in the left parieto-occipital junction possibly from a small infarct. Alternatively this could be due to artifact or simply a prominent sulcus. Recommend clinical correlation and comparison with head MRI with stroke sensitive sequences." Dr. Rutherford therefore recommended another MRI study. However, Dr. Moffitt reported in September 2005 that the claimant has "much, much better." Dr. Moffitt released the claimant with no return appointment. Further, although another MRI study was not administered at that time, a head CT on October 11, 2005 showed "No acute intracranial abnormality."

We recognize that Dr. Morse saw the claimant in December 2005 and recommended yet another series of diagnostic testing. However, treating physician Dr. DeSilva saw the claimant on December 12, 2005 and diagnosed migraine headaches with psychogenic overlay. Dr. DeSilva did not causally link these conditions to the June 21, 2005

inhalation injury. Dr. DeSilva did recommend an overnight pulse oximetry for sleep apnea in an effort to ease the claimant's migraines. Again, however, Dr. DeSilva did not causally link this treatment to the June 21, 2005 inhalation injury. Nor does the record otherwise demonstrate such a causal connection. Further, Dr. DeSilva did not recommend a follow-up MRI of the claimant's brain.

Finally, the Full Commission attaches significant weight to the findings of Dr. Foster, the pharmacist and toxicologist. Dr. Foster, a credible and knowledgeable expert witness, found it "unlikely the alleged exposure resulted in any toxicity to Ms. Bohannon....The etiology of Ms. Bohannon's speech problems and headaches has not been delineated, but 2-butoxyethanol in my professional opinion and within a reasonable degree of medical certainty." Dr. Foster credibly testified that the claimant's continued symptoms were not causally related to the June 21, 2005 inhalation incident. The Full Commission finds that Dr. Foster's reports and findings were based on a complete and accurate review of the medical record. Dr. Foster's opinions on causation were also squarely in line and comported with the findings of Dr. DeSilva, Dr. Moffitt, Dr. Howard, and Dr. Ewart.

Based on our *de novo* review of the entire record, the Full Commission finds that the claimant did not prove she was entitled to additional treatment from Dr. Rutherford or Dr. Morse, and that the claimant did not prove she was entitled to a psychological evaluation at the respondents' expense. The claimant did not prove that additional treatment and/or referrals from Dr. Rutherford or Dr. Morse were reasonably necessary in connection with the compensable inhalation injury. Nor did the claimant prove that the treatment for sleep apnea and migraines recommended by Dr. DeSilva was reasonably necessary in connection with the compensable injury. Finally, the claimant did not prove that continued medications for headaches were reasonably necessary in connection with the June 21, 2005 compensable injury. The Full Commission therefore reverses the administrative law judge's finding that the claimant proved she was entitled to additional medical treatment, and this claim is denied and dismissed.

IT IS SO ORDERED.

OLAN W. REEVES, Chairman

KAREN H. McKINNEY, Commissioner

Commissioner Hood dissents.

DISSENTING OPINION

I must respectfully dissent from the Majority opinion, which reverses the September 14, 2006, decision of an Administrative Law Judge finding that the claimant was entitled to additional medical benefits and that the respondent was liable for certain unpaid medical benefits which the claimant had previously received in connection with her admittedly compensable injury. The Judge also designated a new doctor to provide the claimant continuing care. For the reasons set out below, I find that the Majority has arbitrarily disregarded medical evidence and instead relied on the report of Dr. Foster, whose opinion was based on wrong information and therefore inherently flawed.

The injury occurred on June 21, 2005. The claimant's job duties required her to work in a cubicle at a computer screen, monitoring heating and air conditioning systems at various Wal-Mart locations around the country. Three other co-employees who had the same or similar job duties were also in cubicles adjoining or nearby her. Two of those employees, Jan

Snow and Susan Rodenburg, testified at the hearing. According to those two witnesses, they began noticing a "chemical" smelling odor emanating from an overhead air conditioner vent. Shortly after they noticed the odor, both women testified that they began feeling lightheaded, dizzy, and suffering from a headache. After about thirty (30) minutes had passed, they advised their supervisor that they were not feeling well and went outside to get some fresh air. Sometime after that, the claimant and one other co-worker joined them. Eventually, an ambulance was summoned and all four employees were transported to an area hospital. Two of the employees, the claimant and Ms. Rodenburg, were noted to be unconscious by the paramedics upon their arrival.

The claimant testified that she also noticed the odor from the air conditioning vent but that she ignored it and continued working. Eventually, she became dizzy and lightheaded and left her work area to get a drink of water and go to the break room. The claimant testified that she was having a hard time walking and to had to lean on the wall for support. She later went outside, where she joined Snow and Rodenburg.

All three witnesses testified that they developed severe headaches shortly after they noticed a chemical smell. Snow and Rodenburg also testified that when the claimant appeared outside, she was unable to speak coherently.

All three of the women received some medical treatment, at the respondent's expense following the injury. At the hearing, they also testified that they still suffered from chronic headaches and that the various medications they had taken were not successful in providing them any relief.

After ambulance personnel removed the claimant from her place of employment, she was taken to the emergency room at Northwest Health Center in Bentonville, Arkansas. At the hospital, the claimant was diagnosed as suffering from chemical inhalation. Her blood pressure was 162/103, and she was administered IV fluids, and observed by the hospital staff. She also underwent a brain CT scan, which did not find any abnormalities. The claimant was also noted to be aphasic (that is, she suffered from a speech impediment, in this case, stuttering, and an inability to speak clearly). Later that day, the claimant was discharged

from the hospital emergency room. The following day, the claimant's symptoms persisted and she was directed to seek treatment from the Lowell Medical Clinic where she saw Max Beasley, a nurse practitioner. Mr. Beasley noted that she was aphasic, and had erythema (reddening) in her nasal passages. After consulting with Dr. Ajdahan Bicak, the claimant's personal physician, and Dr. Konstantine Berestnev, Mr. Beasley summoned an ambulance to transport the claimant to a local hospital.

On arriving at the St. Mary's Regional Hospital in Rogers, Arkansas, the claimant was found to have a speaking problem and was complaining of a headache, and pain behind her left eye. She was also noted as having a blurring of her left eye and, based upon a partially legible handwritten notation, swelling of her lips and mouth.

The claimant was discharged from the hospital two days later. At that time, her speech problems had improved significantly but had not disappeared. She was released and given some medication and was advised to return to work on the following Monday and to follow up with her personal physician in about two weeks.

As a result of this hospital stay and, at the direction of her other physicians, the claimant underwent multiple CT scans and MRI scans of her brain and other parts of her body. Unfortunately, none of these scans were able to detect any organic reason for her continuing headaches, speech difficulties, and other symptoms. The claimant did return to work and was able to function in her job. While her speech impediment did substantially improve with time, I note from reviewing the hearing transcript that, during her testimony, she continually broke down and at one point the hearing was adjourned for her to compose herself. Obviously, she was still having some problems expressing herself even at that late date.

The apparent source of the odor detected by the claimant and the other witnesses was a cleaning solution being used on the air conditioning of the building in which the claimant was working. Jack Abbott, Jessie Campbell, and Kevin Burkett provided testimony on the cleaning solution. These gentlemen identified themselves as maintenance employees at the Wal-Mart headquarters complex. They testified that, on the date in question, they were using a cleaning product

to clean the air conditioning coils at the building where the claimant and the other witnesses were located. The product they were using was identified by the brand name Kleen-Coil. The active ingredient in this agent is 2-butoxyethanol, which was is one of several similar compounds often times referred to generically as ethyleneglycol. This substance is commonly used in both commercial and household cleaning agents. Various documents made a part of the record indicate that exposure to 2-butoxyethanol can cause a variety of symptoms, beginning with headaches at exposures of 98 parts per million. Higher exposures can cause impairment in taste sensations, eye, nose, and throat irritations, and progressively worse symptoms including death, if exposure is sufficiently high.

The label from the Kleen-Coil product being used by the cleaning crew was made a part of the record. According to the label, various safety precautions are recommended before use of the product. One of the steps is to dilute the Kleen-Coil in a solution of one part of the product to five parts of water. All of the three of the maintenance men testified that the cleaning solution they prepared had a greater amount of water than was

recommended. However, they admitted that they disregarded the other precautions such as using protective gloves, goggles, and similar gear. They also stated that they did not brush hair and dust from the coil prior to spraying it or turn off the units or the ventilation system prior to spraying it on the coils as specifically directed by the label. However, all three men also testified that they frequently used this compound and were heavily exposed to it themselves. They stated that they had already sprayed a number of air conditioning units in the Wal-Mart headquarters complex prior to cleaning the one at the building containing the claimant and her coworkers. All of the repairmen testified that, in spite of their frequent and heavy exposure to Kleen-Coil, they have never suffered from any of the symptoms related by the claimant and her coworkers.

In denying benefits, the Majority relies primarily upon the opinion of Dr. Howell Foster (in applying the title "doctor" to this witness, it should be noted that Dr. Foster stated in his deposition that he does not have a medical degree or an academic PhD and does not provide care or treat patients. Rather, he has

an undergraduate degree in pharmacy and has another degree which he refers to as a PHARM.D. which he states equates to a doctor of pharmacy). Dr. Foster is the Director of the Arkansas Poison Control Center and is affiliated with UAMS. In a report dated April 26, 2006, he reviewed certain information about the claimant's case and various literature regarding exposure to 2-butoxyethanol. Dr. Foster's conclusion was that, in his professional opinion, 2-butoxyethanol was not the cause of the claimant's headaches and speech problems. He also indicated that this opinion was stated within a reasonable degree of medical certainty.

The Administrative Law Judge decided to give little weight to Dr. Foster's opinion. He explained his reasons for doing so as set out below:

> Based upon my review of the totality of the evidence presented in this case, I find that Dr. Foster's opinion is entitled to little weight. Dr. Foster's opinion that claimant's current symptoms are not causally related to her chemical inhalation is based upon his belief that claimant was not exposed to a significant enough level of 2-butoxyethanol, the active ingredient in Kleen Coil, to lead to her current symptoms. However, a review of Dr. Foster's deposition indicates that his belief is based upon

numerous assumptions. I find it significant that Dr. Foster formed his opinion without reviewing any statements made by the claimant. Although he had reviewed claimant's medical records, Dr. Foster was unaware of the exact circumstances of claimant's exposure. Significantly, Dr. Foster admitted that he did not know how big the room was where claimant was exposed, he did not know the number of vents in the room, he did not know how much 2-butoxyethanol was put in the air conditioner unit, and did not know how much of the chemical was blown into the room where the claimant was. Nor did Dr. Foster know how close the claimant was to the vent nor the length of her exposure. Dr. Foster admitted at his deposition that he had read a report indicating that after claimant noticed the smell she existed the building within a short time. He assumed that this time period was less than 15 minutes. However, he admitted that he had not read any statements to indicate that this was factual. In contrast to the less than 15-minute time period, I note that Janice Snow testified at the hearing that they did not contact their supervisor until approximately 30 minutes after they noticed the chemical smell. Furthermore, it was Snow and Rodenburg who left the work area after 30 minutes, not the claimant. Testimony from both Snow and the claimant was to the effect that claimant remained at her work desk after Snow and Rodenburg left. Thus, the claimant would have been exposed to this chemical for more than 30

> minutes, not less than 15 as assumed by Dr. Foster.
> I note that exhibits to Dr. Foster's deposition include a material safety data sheet from National Chemicals, the maker of Kleen Coil. That exhibit indicates that inhalation of vapors in high concentrations may cause headache, nausea, and vomiting. Furthermore, a hazardous substance fact sheet from the New Jersey Department of Health and Senior Services indicates that exposure may cause headaches, dizziness, light headedness, confusion, and passing out. The evidence indicates that the inhalation by the claimant and other individuals was significant enough that some of these symptoms occurred including light headedness, confusion, and passing out. Susan Rodenburg, one of the individuals present on June 21, did in fact lose consciousness and did not wake up until she was in the emergency room. Likewise, the claimant also experienced some loss of consciousness which was reflected on the EMT report of June 21, 2005.

I believe the Administrative Law Judge has accurately and completely outlined the problems with Dr. Foster's report. Like the ALJ, I do not question Dr. Foster's competence or ability. However, it appears that, to a great degree, his report is based upon information provided to him by the respondent's counsel. Consequently, in reaching his opinion, he was relying

upon several erroneous facts. Also, while he states that he obtained information from the claimant's medical records, it certainly appears that he did not peruse these reports carefully. I make that statement because Dr. Foster made it clear during his deposition that the key factor in his opinion that the claimant's continuing headaches and speech problems were not caused by 2-butoxyethanol was because she did not also have eye, nose, and skin irritations in conjunction with her headaches. In fact, Dr. Foster agreed that those findings were at the heart of his opinion. However, as noted above, the claimant reported both at the hospital emergency room, when seen by Dr. Beasley, and at the St. Mary's Medical Center that she was suffering from pain and blurred vision in her left eye, had redness in her nasal chambers, and appeared to have swelling in her lips and mouth. Those findings would contradict Dr. Foster's assertion that no such symptoms were present after her chemical exposure.

In short, it appears to me that Dr. Foster prepared his report based upon information provided him by the respondent, which was not entirely correct. He then compounded that error by making a number of

assumptions based upon those facts which led to his opinion that the claimant's symptoms were not caused by any chemical exposure at work. While Dr. Foster is justifiably recognized as an expert in his field, that does not mean that this Commission must accept his opinions without question. I believe that his report was flawed and in preparing it, he had a preconceived result which he wanted to reach. For that reason, I believe that his opinion in regard to the cause of the claimant's symptoms should be given little, if any, weight. As such, the Majority errs in relying on his opinion.

The other medical opinion relied upon by the Majority is that of Dr. Lamar Howard, an emergency room physician who saw the claimant during her admission at St. Mary's Hospital. Dr. Howard stated in a report of June 24, 2005, that he believes the contents of the Kleen Coil were innocuous and exposure to them would not have caused any neurological symptoms. However, Dr. Howard is an emergency room physician who does not have any particular expertise in the area of toxicology, pharmacology, or any other area in relation to chemical exposure. Further, as Dr. Foster outlined in his

deposition and accompanying report, 2-butoxyethanol has been documented as having numerous effects from exposure, including the neurological symptoms displayed by the claimant. Once again, I believe that his opinion is not entitled to any weight or credit.

I do, however, believe that the opinions of other physicians who have seen the claimant are of considerable probative value. Another physician who saw the claimant during her hospitalization in June 2005, was Dr. Shari DeSilva, a neurologist. In her report of June 22, 2005, she correlated the claimant's neurological symptoms with her chemical exposure the previous day.

Another physician who examined the claimant was Dr. Reginald Rutherford, a Little Rock neurologist, who saw the claimant at the direction of the respondent. Dr. Rutherford saw the claimant on July 26, 2005, and in a report of that date reviewed the claimant's symptoms and stated that it was his opinion that her problems were probably unrelated to migraine headaches or an acute psychosis. In order to more precisely diagnose her condition, he recommend that she undergo a SPECT (single proton emission tomography) scan of her brain.

The scan was performed on August 12, 2005. The radiologist report of that date stated that there appeared to be a small linear defect in the left parieto-occipital junction. However, the radiologist also noted that the defect could be due to an artifact or a prominent sulcus. When Dr. Rutherford reviewed the SPECT scan, he stated in his report of August 12, 2005, that an MRI image of the brain should be conducted to correlate and confirm the SPECT scan finding. Unfortunately, the respondent controverted this treatment and this recommended MRI was never performed.

The last neurological specialist to see the claimant was Dr. Michael Morris who saw her in December 2005. In his report of December 5,2005, he stated his opinion that claimant's neurological symptoms were related to her exposure at work.

In my opinion, the evidence supports the Administrative Law Judge's conclusion that the claimant sustained a compensable injury at work and that she is entitled to additional medical benefits for treatment of this condition. Further, while there was considerable evidence given suggesting that 2-butoxyethanol was the cause of the claimant's symptoms, in my opinion, the key

determination in this case is that the claimant did sustain a compensable injury and since the date of that injury, she has suffered from severe and debilitating headaches and a neurological speech impediment. The claimant is certainly entitled to medical treatment for those conditions. Whether the claimant's symptoms are the result of an exposure of 2-butoxyethanol or some other chemical, or some combination of both, is not as important as a clear diagnosis of what her problem is. As indicated above, the respondent has refused to provide the claimant the MRI scan recommended by physicians to confirm the findings of the SPECT scan, or any other medical treatment of her condition.

In denying the claimant the requested medical treatment, the Majority notes that, in the past, the claimant sought treatment for a sinus headache and a migraine problem. However, those conditions were related to a sinus infection and high blood pressure. Both of those conditions were treated with appropriate medication and resolved. The Majority also notes that after the SPECT scan, the claimant underwent a second CT scan which did not denote any abnormalities. However, a CT scan was not the diagnostic test recommended. The

SPECT scan is intended to measure brain function and not its structural integrity. As explained by Dr. Rutherford, an MRI scan is a more appropriate follow-up test than a CT scan.

The claimant continues to suffer from ongoing symptoms that began on the date of her admittedly compensable injury. Every specialist who has seen and treated the claimant was of the opinion that these symptoms were neurologically related and that they correlated to the chemical exposure that occurred on June 21, 2005. Even Dr. Foster admitted that the symptoms the claimant was complaining of were identified by prior studies as symptoms related to 2-butoxyethanol exposure.

In sum, I find that to deny the claimant benefits is in error as the overwhelming weight of the evidence shows the claimant has ongoing symptoms which are related to her admittedly compensable injury. Furthermore, the Majority fails to consider the testimony of specialists who treated the claimant in favor of Dr. Foster, whose opinion was wrought with factual mistakes. Additionally, while the emergency room doctor was unsure of the claimant’s symptoms being

related to her exposure, he was a general practitioner and his opinion was directly opposed by that of Dr. DeSilva, who was a specialist and treated the claimant contemporaneously. I find that it is incredibly disturbing that the Majority would prefer the opinion of a general practitioner rather than that of the specialist, especially when Dr. Howard referred the claimant to the specialist. Finally, I find that it is simply in error to rely on such an opinion when the claimant had objective findings on the same day and the claimant's injury was accepted as compensable. While I recognize that the Commission has the ability to weigh varying medical evidence and doctor's opinions, that should not and does not equate to favoring factually erroneous opinions or ignoring all evidence that shows a causal relationship. Furthermore, it does not give the Commission to ignore the recommendations of every treating physician with regard to treatment.

Therefore, I must respectfully dissent.

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PHILIP A. HOOD, Commissioner