

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F210278

DANNY DUNLAP,
EMPLOYEE

CLAIMANT

EDWARDS BROTHERS, INC.,
EMPLOYER

RESPONDENT

TRAVELERS INSURANCE COMPANY,
INSURANCE CARRIER

RESPONDENT

OPINION FILED FEBRUARY 27, 2009

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

Claimant represented by the HONORABLE FREDERICK SPENCER,
Attorney at Law, Mountain Home, Arkansas.

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

Decision of Administrative Law Judge: Affirmed as modified.

OPINION AND ORDER

The respondents appeal an administrative law judge's opinion filed February 11, 2008. The administrative law judge found that the claimant proved his pulmonary problems were a compensable consequence of the claimant's compensable injury. The administrative law judge found that the claimant proved he was entitled to temporary total disability from June 19, 2002 until a date yet to be

determined. After reviewing the entire record *de novo*, the Full Commission affirms the administrative law judge's opinion as modified. The Full Commission finds that the claimant proved his pulmonary problems were a compensable consequence of the claimant's compensable injury. We find that the claimant proved he was entitled to temporary total disability benefits from June 19, 2002 through June 26, 2003.

I. HISTORY

The testimony of Danny Dunlap, age 38, indicated that he became employed as a dump truck driver for Edwards, Brothers, Inc. in about March 2002. The parties stipulated that Mr. Dunlap "suffered a compensable injury to his low back on June 14, 2002, for which medical benefits have been paid." The claimant testified at hearing:

Q. How did you injure yourself?

A. Well, the guy was on the surveyor belt -

Q. You mean conveyor?

A. - the veyor (phonetic) house. That's what they call it is the veyor house. And when they, they shut it off because they have a button up there to shut it off....

And the guy they had working for him, he drinks. I guess he didn't, I guess he fell asleep or something, and I had to jump down on the fender where you get down at.

Q. Get down from the truck?

A. Yeah. And they got a, like a 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.

The first medical treatment of record took place at White River Medical Center on or about June 19, 2002. The claimant complained of chest pain and shortness of breath. The emergency physician record indicated that the claimant could not recall the onset of his symptoms. The claimant did not complain of any pain or symptoms involving his low back. The clinical impression was "Chest Pain - acute." The claimant testified that he did not work after June 19, 2002. An x-ray of the claimant's chest was taken on June 20, 2002:

PA and lateral views of the chest demonstrate the inspiratory effort to be mildly limited. The heart is within normal limits in size. No acute infiltrates are seen. There is no pneumothorax or pleural effusion. No hilar enlargement is noted.

IMPRESSION:

No acute cardiopulmonary process identified.

Another Emergency Physician Record, apparently dated June 20, 2002, indicated that the claimant complained of pain in his lower back, "thought he hurt his back at work

... jumped on back on truck that gave out." The clinical impression was "Acute Myofascial Strain dorsal."

The claimant next sought medical treatment on June 28, 2002. According to the record, the claimant complained of "mid back pain since last week was seen here in ER. States pain is worse and has not been able to work." It was noted that the claimant "jumped out of truck landed on a board." It was noted that the claimant was a "Smoker 1 pk daily."

Dr. John S. Lambert consulted with the claimant on July 17, 2002:

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.

PAST HISTORY:

MEDICAL: Negative for MI, congestive heart failure, hypertension, diabetes, pulmonary, renal or hepatic disease....

He works for a local rock quarry....He has been a two-pack-a-day smoker since age 13....

LUNGS: Clear on the right. On the left there are decreased breath sound anteriorly, laterally, and

posteriorly with dullness to percussion throughout the left hemithorax.
There is a healing tube thoracostomy site with purulent drainage present....

Dr. Lambert assessed "Recurrent empyema with suspected lung abscess, left hemithorax....Would recommend a CT scan of the chest and pulmonary function testing with anticipated thoracotomy in the next few days."

Dr. Greg W. Neaville examined the claimant on July 17, 2002:

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 and is admitted now for surgical intervention and likely decortication. He is feeling badly with fever and chest pain.

PAST HISTORY:

MEDICAL: Unremarkable except for the aforementioned complicated pneumonia....

HABITS: Smoked two packs per day of cigarettes....

LUNGS: Reveal some diminished breath sounds on the left with almost absent breath sounds in the left base. There is dullness to percussion....

Dr. Neaville assessed "Empyema. Questionable abscess."

A CT scan of the claimant's chest was taken on July 17, 2002:

The right lung is expanded and clear of infiltrative change. No pleural effusion on

the right side is noted. The left main bronchus is patent and is seen extending into a consolidated left upper lobe. There is some minimal reexpanded lung in the left upper chest. I am not sure if this is a portion of the left upper lobe or part of the superior segment of the left lower lobe extending superiorly. This is the only aerated lung that is seen on the left side. A large amount of fluid in the left pleural space is noted. There is air noted within this fluid collection. At about the mid chest level, a small air fluid level on the left side is noted anteriorly. In addition, there is suggestion of slight enhancement of the pleura posteriorly raising the possibility of developing empyema. The visualized portion of the liver appears normal. The adrenal glands are not enlarged.

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.

Dr. Lambert performed an operation and noted on July 19, 2002: "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....It was then amputated and the left lung was submitted for histologic examination."

Dr. Lambert performed an "Evacuation of infected hematoma and construction of Eloesser flap" on August 2, 2002. The pre-operative diagnosis was "Recurrent empyema, left hemithorax." The surgical findings were "Subfascial seroma, left chest wall. Organized infected hematoma, left hemithorax." The post-operative diagnosis was "Infected hematoma, left hemithorax."

Dr. Neaville gave the following impression on October 29, 2002: "1. Severe pneumonia/bronchiectasis, status post pneumonectomy, now with bronchitis. 2. COPD. 3. Depression R/T above."

A CT scan of the claimant's chest was taken on October 31, 2002, with the following impression:

1. Postoperative changes present in the left chest consistent with pneumonectomy.
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. Lambert reported on November 5, 2002:

This is a 31-year-old morbidly-obese white male who underwent drainage of an empyema, decortication and left pneumonectomy with rotation muscle flap on July 19, 2002. He required evacuation of an infected hematoma and construction of an Eloesser flap on August 2, 2002. He has been followed as an outpatient and had two dilations of Eloesser flap since that time; his last operative procedure on October 13, 2002. He presented to inpatient status on October 31, 2002 with shortness of breath. By CT scan as well as echocardiography he was found to have a moderate-size pericardial effusion without tamponade. He is also in need of closure of his Eloesser flap, his last pleural space culture being positive for a very small growth of Staphylococcus aureus. Both procedures have been recommended....

Dr. Lambert performed an operation on November 5, 2002:

"1. Subxiphoid construction of pericardial window with biopsy. 2. Closure of Eloesser flap." The post-operative diagnosis was "1. Moderate-size pericardial effusion, etiology unclear. 2. Status post construction of Eloesser flap, left hemithorax."

Dr. Lambert wrote a Discharge Summary on or about December 23, 2002 and stated in part:

This is a 32-year-old male who is postop left pneumonectomy for bronchiectasis and empyema. He presented with a several day history of progressive shortness of breath. He was admitted on October 31, 2002 with acute shortness of breath in association with a large pericardial effusion undergoing a pericardial window as well as closure of an Eloesser flap....He continues to smoke

despite numerous counseling sessions in regards to recurring bronchitis and his increase risk of respiratory failure and/or pneumonia because of a solitary pulmonary unit. He was admitted with a diagnosis of respiratory distress.

The claimant was admitted to the medical center on June 19, 2003, at which time Dr. Neaville noted, "The patient is a gentleman with a multitude of medical problems who presented to the emergency room with the onset of chest pain and fever. He had had some chest congestion but denies any significant cough. He has no other complaints at present." Dr. Neaville's assessment was "Pneumonia."

The record indicates that Dr. Neaville discharged the claimant on June 26, 2003. The principal diagnosis was "Bronchiectasias (sic) with purulent bronchitis." The secondary diagnoses were "1. Chest pain. 2. Fever. 3. Chronic obstructive pulmonary disease. 4. Depression. 5. Back pain." The claimant was discharged home with the disposition of diet and activity as tolerated, medications, and follow-up with Dr. Neaville."

The record indicates that the claimant began treating at Rural Medical Clinic with Dr. Denise Oldenberg, a general practitioner, on August 10, 2004. Dr. Oldenberg prescribed home oxygen and diagnosed "Abnormal Pulmonary Function

Hypoxemia COPD s/p Pneumonectomy Left." Dr. Oldenberg arranged an MRI of the claimant's lumbar spine, taken August 12, 2004:

The lumbar area is evaluated with coronal and sagittal T1 and sagittal T2 sequence with axial T1 and T2 images from L2-L3 to L5-S1. On the sagittal sequence, no abnormal posterior disk protrusion is seen. Conus medullaris appears normal. The axial sequences show no focal disk protrusion or extrusion.

The impression was "No disk herniation noted."

Dr. Oldenberg began examining the claimant at approximately two to three-month intervals on January 6, 2005. Dr. Oldenberg treated the claimant for symptoms including chronic lower back pain.

A CT of the claimant's chest was taken on April 3, 2006:

There has been a prior left pneumonectomy. There has either been a thoracoplasty procedure or prior trauma with several old rib fractures seen in the left mid chest. The trachea and heart and mediastinal structures are shifted to the left. There is compensatory hyperinflation in the right lung. The right lung is clear of infiltrates or masses. No pneumothorax or pleural effusion is seen on the right. There is no pericardial effusion. Surgical clips are seen around the left bronchial stump. No hilar mass is seen on the right or left. Benign appearing mediastinal lymph nodes are present....

IMPRESSION:

1. Prior left pneumoectomy.
2. Old posttraumatic deformity in the left rib cage is also seen.
3. The right lung is clear of infiltrates or masses.
4. No recurrent mass seen around the left bronchus stump region.

The claimant continued to treat with Dr. Oldenberg.

The parties deposed Dr. Neaville, an internal medicine specialist, on July 10, 2006. The respondents' attorney questioned Dr. Neaville:

Q. And to restate it for you, if you accept as given the fact that this gentleman presented to the White River Medical Center Emergency Room on June 20, 2002, with a complaint of low back pain, would you see any connection between that problem and the problems he developed in his left lung?

A. If there is an injury to the back or to the ribcage or to the chest wall that results in decreased ventilation of the lungs, it's well established that that type of injury can result in pneumonia....

Q. And in looking at the report of his visit to the emergency room on June 20, 2002, there is a diagram, front and back of a human torso. And it has marked on it the location of the pain. And in this instance, and I know you're not looking at it, but I can tell you that the diagram that I'm looking at right now shows pain localized in the low back area right above the buttocks with X's put on the torso here. Would you then, consistent with what you just said, expect there to be some concurrent lung injury, a bruising, rib problem, something like that if he was to develop the pneumonia as you've described it?

A. If there is an indication that, using a common term, that there was pain in what you might call the small of the back there above the buttock area, I don't feel like that trauma to that area or pain in that area would necessarily fit the description that I had given prior. Generally persons with terrific low back pain are not a great risk for the development of pneumonia as I have just described....

Q. Is the last time you've seen him at all on June 19th, 2003?

A. My records suggest that I saw him through the end of that hospitalization, but I don't have record of any significant contact since then....

The claimant's attorney questioned Dr. Neaville:

Q. So, Doctor, assume if you will that there was no prior problems or difficulties that this man was experiencing before he had this; he jumped off of the truck, the board hit him, he twisted and began having severe pain. Assume that that is true, and assume further, Doctor, that his condition was of such pain that it did restrict him significantly from being able to move about. Is it not reasonable, and based upon a reasonable degree of medical certainty, can you not say more probable than not that the major cause, more than 50 percent, of the beginnings of this pneumonia would've been the injury he sustained?

A. I can say that if an injury occurred that required bedrest or resulted in significant pain, that is a prelude to the establishment of pneumonia.

Q. And so your answer would be yes, is that correct?

A. I'm sorry, yes....I think it is a reasonable thought that the injury that he sustained set off

a course of events that resulted in his hospitalization for pneumonia.

Q. And his need for treatment?

A. Yes.

Q. And would you 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....

Q. And do you believe this man, given the prognosis of poor, is not going to be able to work now?

A. I would say at the time I saw him three years ago he was one hundred percent disabled. And though I have not seen his recovery over the past three years, my expectation at that time was that he would be at least some degree disabled lifelong.

Dr. Oldenberg signed the following statement on January 15, 2007:

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."

A pre-hearing order was filed on August 13, 2007. The claimant contended 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 is 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 contended that the claimant's pulmonary problems were "not related to his back strain. Respondents contend further that the claimant is not entitled to additional temporary total disability benefits."

The parties agreed to litigate the following issues: "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."

The parties deposed Dr. Oldenberg on October 9, 2007. Dr. Oldenberg opined that the claimant was hit by a board during his compensable injury, and that the accident caused a contusion to the claimant's chest wall. Dr. Oldenberg testified, "You'd have to assume that this injury caused the pneumonia. I mean, I have no reason to doubt in my mind that we could find a pulmonologist or one of those guys that taught me in medical school that this would be a direct, pretty much a direct result of the injury." Dr. Oldenberg opined at deposition that the claimant was entitled to a permanent impairment rating for his back condition.

A hearing was held on November 21, 2007. The claimant testified that he suffered from continual pain in his left lung area and in his back. The claimant testified that his physical condition was worsening.

The administrative law judge filed an opinion on February 11, 2008. The administrative law judge found, among other things, that the claimant suffered a compensable injury to his low back on June 14, 2002. That administrative law judge found that the claimant proved "his pulmonary problems are a compensable consequence of his work-incident of June 14, 2002." The administrative law

judge found that the claimant proved he was entitled to temporary total disability benefits from June 19, 2002 until a date yet to be determined. The respondents appeal to the Full Commission.

II. ADJUDICATION

A. Compensability

If an injury is compensable, then every natural consequence of that injury is also compensable. *Air Compressor Equip. v. Sword*, 69 Ark. App. 162, 11 S.W.3d 1 (2000), citing *Hublely v. Best Western Governor's Inn*, 52 Ark. App. 226, 916 S.W.2d 143 (1996). The basic test is whether there is a causal connection between the two episodes. *Bearden Lumber Co. v. Bond*, 7 Ark. App. 65, 644 S.W.2d 321 (1983).

In the present matter, the parties stipulated that the claimant sustained a compensable injury to his low back on June 14, 2002. The claimant testified that he jumped from a truck, landed on a railroad tie, twisted, and hit his back and side into a cast-iron trailer. The claimant began receiving medical treatment for chest pain and shortness of breath on or about June 19, 2002. The record does not show a history of these symptoms prior to the claimant's compensable back injury. A physician's impression on June

20, 2002 was acute myofascial strain. An emergency room note on June 28, 2002 indicated that the claimant had "jumped out of truck landed on board." Dr. Lambert began treating the claimant for pneumonia and an acute left lung condition on July 17, 2002. The record does not show a history of pneumonia or an acute lung condition prior to the June 14, 2002 compensable injury. A CT of the claimant's chest on July 17, 2002 showed a large amount of fluid in the pleural space. Dr. Lambert performed surgery removing the claimant's left lung on July 19, 2002.

The claimant proved that the diagnosis of pneumonia and treatment for his left lung condition were a natural and compensable consequence of the stipulated June 14, 2002 back injury. We have pointed out that there is no proof the claimant suffered from these conditions prior to the compensable injury. Dr. Neaville, a treating physician and internal medicine specialist, testified with regard to the claimant's injury, "it's well established that that type of injury can result in pneumonia....I think it is a reasonable thought that the injury that he sustained set off a course of events that resulted in his hospitalization for pneumonia." Dr. Oldenberg signed a statement on January 15,

2007 stating her belief "based upon a reasonable degree of medical certainty" that the compensable injury was the cause of the claimant's lung problems. Dr. Oldenberg opined at deposition that the claimant's pulmonary condition was "a direct result of the injury" to the claimant's back.

The Commission has the authority to accept or reject a medical opinion and the authority to determine its probative value. *Poulan Weed Eater v. Marshall*, 79 Ark. App. 129, 84 S.W.3d 878 (2002). We find in the present matter that the opinions of Dr. Neaville and Dr. Oldenberg are entitled to significant probative weight. There are no medical opinions of record which contradict the opinions of these treating physicians. The Full Commission affirms the administrative law judge's finding, "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." We find that the treatment and associated referrals of Dr. Lambert and Dr. Neaville were reasonably necessary in accordance with Ark. Code Ann. §11-9-508(a) (Repl. 2002).

B. Temporary Disability

Temporary total disability is that period within the healing period in which the employee suffers a total incapacity to earn wages. *Ark. State Hwy. Dept. v. Breshears*, 272 Ark. 244, 613 S.W.2d 392 (1981). The healing period ends when the employee is as far restored as the permanent nature of the injury will permit, and if the underlying condition causing the disability has become stable and if nothing in the way of treatment will improve that condition, the healing period has ended. *High Capacity Prods. v. Moore*, 61 Ark. App. 1, 962 S.W.2d 831 (1998). The determination of the end of the healing period is a question of fact for the Commission. *Id.*

In the present matter, the parties stipulated that the claimant sustained a compensable injury to his back on June 14, 2002. The claimant was diagnosed with acute myofascial strain. The claimant subsequently began receiving treatment for pneumonia and an acute lung condition. We have determined that the claimant's pulmonary problems were a natural and compensable consequence of the compensable injury. The claimant did not work after June 19, 2002. The claimant underwent treatment and surgery from medical specialists including Dr. Lambert and Dr. Neaville. The

last hospitalization of record from Dr. Neaville was on June 19, 2003. Dr. Neaville discharged the claimant from the hospital on June 26, 2003. The principal diagnosis was "Bronchiectasias with purulent bronchitis." Dr. Neaville testified on July 10, 2006 that he had not treated the claimant since June 2003. Dr. Neaville testified, "I would say at the time I saw him three years ago he was one hundred percent disabled. And though I have not seen his recovery over the past three years, my expectation at that time was that he would be at least some degree disabled lifelong."

The Full Commission finds that the claimant reached the end of his healing period for the compensable back injury and compensable pulmonary condition no later than June 26, 2003. Temporary total disability benefits cannot be awarded after a claimant's healing period has ended. *Elk Roofing Co. v. Pinson*, 22 Ark. App. 191, 737 S.W.2d 661 (1987). The instant claimant's condition became stable no later than June 26, 2003 and nothing further in the way of treatment would improve that condition. The claimant's subsequent treatment from Dr. Oldenberg did not extend the claimant's healing period for the compensable back injury or compensable pulmonary condition. By the time of his

hospital discharge on June 26, 2003, the claimant was as far restored as the permanent character of his injury would permit.

Based on our *de novo* review of the entire record, the Full Commission affirms the administrative law judge's opinion as modified. The Full Commission finds that the claimant proved his pneumonia and left lung condition were a natural and compensable consequence of the claimant's compensable back injury. Treatment and associated referrals by Dr. Lambert and Dr. Neaville were reasonably necessary pursuant to Ark. Code Ann. §11-9-508(a) (Repl. 2002). We find that the claimant proved he was entitled to temporary total disability benefits from June 19, 2002 through June 26, 2003. The claimant did not prove that his healing period continued beyond June 26, 2003. The Full Commission affirms the administrative law judge's denial of the motion to recuse, and we affirm the administrative law judge's finding that the claimant's constitutional challenge to the relevant law is without merit. The claimant's attorney is entitled to fees for legal services pursuant to Ark. Code Ann. §11-9-715(Repl. 2002). For prevailing in part on appeal, the claimant's attorney is entitled to an additional

fee of five hundred dollars (\$500), pursuant to Ark. Code Ann. §11-9-715(b) (2) (Repl. 2002).

IT IS SO ORDERED.

A. WATSON BELL, Chairman

PHILIP A. HOOD, Commissioner

Commissioner McKinney dissents.

DISSENTING OPINION

I must respectfully dissent from the majority opinion. Based upon my de novo review of the record, I find that the claimant has failed to meet his burden of proof. In my opinion the claimant has failed to prove by a preponderance of the evidence that his pulmonary problems were a compensable consequence of his back injury.

The claimant testified he has been unable to work since he had his lung removed. Dr. Oldenberg is his primary treating physician now. 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. The claimant has recently had an MRI work-up to determine what, if any, problems were associated with 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. The claimant admitted to being a smoker and he has smoked since he was 13 years old. According to the claimant, he now smokes one cigarette a day but he does not smoke the two packs a day like he did prior to his injury. He testified that his last surgery occurred in 2003 or 2004, due to a hernia. The claimant draws Social Security Disability benefits, and has done so since 2002.

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 has always had to look out for the claimant most of his life. Mr. Dunlap worked for

the employer while the claimant worked there. He testified that 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. According to Mr. Dunlap, the claimant did not go to the emergency room on the day of the incident but went around June 19th, and that this was when all of the procedures and operations started.

According to Dr. Oldenberg, the x-ray taken on June 20th does not show a 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 believed that the claimant's pneumonia, high fever or infection was initiated by the blow with the possibility a hematoma 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 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.

Dr. Greg Neaville, an internal medicine special, testified via deposition. He testified that x-rays did not show any acute problems with the claimant's lungs. The claimant's 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 stated that Dr. Lambert removed the claimant's lung on July 19th. According to Dr. Neaville, there were 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 xray?

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 that the major cause 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.

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. 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.

With respect to the claimant's pulmonary problems, I find that the claimant cannot prove by a preponderance of the evidence that his pulmonary problems are related to his work related incident. The claimant was seen in the emergency room on June 19th and June 28th with complaints of shortness of breath, pain under his left breast and cough associated with fever and chills. The claimant's chest x-ray from those visits were normal. By the time the claimant presented to the

emergency room on July 1, 2002, he had pneumonia in his left lung and was suffering from respiratory failure. The claimant never reported a chest wall contusion. Even Dr. Neaville admitted that if the claimant had fever, chills and a cough on the day he was injured it would not be the injury that caused the claimant's pulmonary problems. The claimant at the time of his injury smoked one to two packs of cigarettes a day. In fact, the claimant continues to smoke in spite of his pulmonary problems and completely against doctors orders. Simply put, there is not enough evidence in the record linking the claimant's pulmonary problems to the work-related injury. Therefore, for all the reasons set forth herein, I must respectfully dissent from the majority opinion.

KAREN H. MCKINNEY, Commissioner