
In the Matter of the Compensation of
ROBERT J. VANDENBOGAARD, Claimant
WCB Case No. 13-00482
ORDER ON REVIEW
Ransom Gilbertson Martin et al, Claimant Attorneys
Radler Bohy et al, Defense Attorneys

Reviewing Panel: Members Lanning, Johnson, and Somers. Member Lanning dissents.

The self-insured employer requests review of Administrative Law Judge (ALJ) Naugle's order that set aside its denial of claimant's aggravation claim for a left ankle condition. On review, the issue is aggravation. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

In September 2011, claimant compensably injured his left ankle, which the employer accepted as a nondisabling left ankle sprain. (Exs. 4-6, 14, 42). Claimant's left ankle condition became medically stationary on February 1, 2012. (Exs. 24, 35).

On December 11, 2012, claimant filed an aggravation claim. On December 19, 2012, the employer denied that claim, asserting that medical evidence did not establish that the accepted condition had "pathologically worsened * * *." (Ex. 35).

Based on the opinion of Dr. Bowen, claimant's treating podiatrist and surgeon, the ALJ set aside the employer's denial. The ALJ determined that Dr. Bowen's opinion was most persuasive because he observed claimant's condition firsthand during surgery.

On review, the employer contends that claimant did not prove an actual worsening of his compensable condition. The employer relies on the opinions of Drs. Bynum, James, and Youngblood. For the following reasons, we agree.

To establish a compensable aggravation claim, claimant must establish an actual worsening of the compensable condition supported by objective medical findings. ORS 656.266(1); ORS 656.273(1). An “actual worsening” may be established either by direct proof of a pathological worsening or through inference of such a worsening based on increased symptoms. If an actual worsening is inferred from a symptomatic worsening, a physician must make the inference. *SAIF v. Walker*, 330 Or 102, 118-19 (2000).

Determining whether claimant’s compensable injury actually worsened is a complex medical question that must be resolved by expert medical opinion. *Uris v. State Comp. Dep’t*, 247 Or 420, 426 (1967); *Barnett v. SAIF*, 122 Or App 279, 283 (1993); *Willie D. Brown, Jr.*, 62 Van Natta 2808, 2809 (2010). When presented with disagreement among experts, we give more weight to those opinions that are well reasoned and based on complete information. *Somers v. SAIF*, 77 Or App 259, 263 (1986).

Dr. Bynum, claimant’s treating orthopedist, and Drs. James and Youngblood, examining orthopedic physicians, all agreed that an inflammatory arthritic condition, not a worsening of the accepted sprain, was the cause of claimant’s left ankle complaints after February 2012. Dr. Bowen, on the other hand, concluded that claimant’s accepted ankle condition had worsened. For the following reasons, we find the opinion of Dr. Bynum, as supported by Dr. James and Youngblood, most persuasive.

Dr. Bowen began treating claimant on December 3, 2012, for increased ankle pain and swelling. (Ex. 26). He reported normal ankle anterior drawer and talar tilt testing bilaterally. (Ex. 26-3). His assessment (among other things not related to this claim) was ankle and foot bursitis/peroneal tendonitis. (Ex. 26-4). After a December 7, 2012 MRI revealed “moderate strain of low lateral ankle ligaments,” Dr. Bowen added “instability of ankle joint” to his diagnoses. (Exs. 27, 29-4). Due to a history of failed conservative treatment and the state of the ligaments (as shown by the December 2012 MRI, clinical findings, and claimant’s specific pain), Dr. Bowen recommended ankle stabilization surgery, which he performed on December 17, 2012. (Exs. 33, 46-2).

At surgery, Dr. Bowen observed attenuated and fatty anterior talofibular and calcaneofibular ligaments. (Ex. 33-2, -4). Based on such observations, he opined that claimant’s left ankle condition had worsened and that the worsening was directly related to the September 2011 injury. (Ex. 46-2). He indicated that objective findings supporting a worsened ankle sprain included the December 2012

MRI finding of a moderate strain of the lateral ankle ligaments and his surgical observations of attenuated and fatty anterior talofibular and calcaneal fibular ligaments. (*Id.*; see also Exs. 27-2, 33-2). He concluded that the accepted ankle sprain was the major cause of the need for surgery. (*Id.*)

In contrast, Dr. Bynum concluded that claimant's accepted ankle sprain had resolved, and that the condition at the time of the alleged aggravation was not work-related. (Exs. 44A, 49). As noted, his opinion was supported by Drs. Youngblood and James. For the following reasons, we find Dr. Bynum's opinion more persuasive than Dr. Bowen's.

First, Dr. Bynum evaluated claimant's condition both before and after the alleged aggravation. See *Kienow's Food Stores v. Lyster*, 79 Or App 416, 421 (1986) (greater weight accorded to the opinion of physician who observed the claimant's condition before and after the relevant event). In January 2010 and January 2011 (before claimant's September 2011 work injury), respectively, Dr. Bynum diagnosed "possible acute gouty arthropathy" of the left knee, and "acute arthritis right knee, probably gout." (Exs. E, F).¹

In October 2011, Dr. Bynum began treating claimant for his September 11 ankle injury. (Ex. 1). In December 2011, he concluded that claimant had "monoarticular arthritis" of the left ankle that was "recurrent" and suggestive of an "underlying inflammatory arthropathy," and not related to the September 2011 work injury. (Ex. 21). He felt that the work-related ankle sprain had been improving before the acute onset of the monoarticular arthritis. (*Id.*) On February 1, 2012, Dr. Bynum concluded that claimant's work-related ankle condition had resolved without impairment. (Ex. 24).

In relation to claimant's aggravation claim, Dr. Bynum reviewed Dr. James's February 12, 2013 report and Dr. Bowen's chart notes. (Exs. 44A, 45-1). He agreed with Dr. James's opinion and assessment in its entirety.²

¹ Ultimately, a test for gout was negative. (Ex. G).

² Claimant told Dr. James that between February and December 2012, he did not have any significant injury, "just the recurrent episodes of some swelling and pain in the ankle if he made a misstep with a poorly-supportive shoe." (Ex. 43-2). He told Dr. James that he did some work at home on a ladder with loafers, which increased his pain, prompting him to seek care with Dr. Bowen. (*Id.*) Dr. James diagnosed left ankle sprain resolved and recurrent inflammatory arthropathy of undetermined etiology. (Ex. 43-10). He explained that claimant's symptoms for diagnosing polyarticular inflammatory arthritis included joint swelling, joint warmth, joint pain, and similar symptoms in multiple joints. (Ex. 48-2).

(Exs. 44A, 45-2). Dr. Bynum explained that, of all of the multiple abnormalities noted on the December 2012 MRI, the only finding that could be related to the work accident was the strain of the lateral ankle ligaments. (Exs. 27-2, 44A, 45-2). However, he noted that claimant did not report instability and there was no documented instability by exam or stress x-rays. Therefore, he did not believe lateral ligament reconstruction was indicated. (Exs. 44, 45-2, 49-26). According to Dr. Bynum, all the other findings were age-related or degenerative or secondary to claimant's recurrent inflammatory arthropathy. He explained that the MRI finding of moderate talocrural effusion with distention of the anterior capsule was consistent with an arthritic condition of the ankle joint. (Ex. 44A). He agreed with Dr. James that the fact the calcaneofibular ligament was fatty and attenuated was not necessarily indicative of ankle instability or the need for surgical stabilization. (Ex. 49-5).

Ultimately, Dr. Bynum concluded that the work injury was not a material contributing cause of claimant's foot/ankle condition, disability, or need for surgery, and that the accepted left ankle sprain did not worsen either symptomatically or pathologically after February 2012. (Exs. 44A, 45-2, -3, 49-26). Rather, Dr. Bynum considered claimant's symptoms in December 2012 to be due to a flare up of his nonwork-related inflammatory arthritis. (*Id.*)

In response to Dr. Bynum's opinion, Dr. Bowen asserted that claimant did not have inflammatory arthritis because it was ruled out by tests, including aspiration and a negative culture. (Ex. 46-3). He also found no "significant ankle arthritis" on observation or x-ray. (*Id.*) According to Dr. Bowen, claimant had inflammation in the ankle joint because the injured ligaments were not doing what they were intended to do, placing the ankle under more stress and creating irritation. Finally, in response to Dr. Bynum's conclusion that claimant did not

Dr. James explained that the strain on the December 2012 MRI was consistent with the original work related injury, but did not necessarily indicate a need for surgery, especially when there was no functional instability. (Ex. 43-10, -18). Dr. James's record review and examination revealed no clinical signs of instability and no complaints of functional instability. (Exs. 43-13, 48-2). He noted that the attenuated and fatty ligaments seen at surgery were a probable residual from the ankle sprain, but not necessarily indicative of ankle instability or the need for surgical stabilization with lack of clinical or functional instability. (Ex. 43-18).

Dr. James could not state with any degree of medical probability that claimant had a worsening of his left ankle sprain since February 2012. (Ex. 43-15). He did not see any direct relationship between the September 2011 injury, which was declared medically stationary in February 2012 with normal examination, and the condition subsequently diagnosed and treated. (Ex. 43-15).

report instability, Dr. Bowen asserted that a patient may not relate instability, he may relate weakness or pain, or that he just cannot use the ankle normally. (Ex. 46-3).

However, Dr. Bynum clearly explained that claimant's medical history did, in fact, indicate an inflammatory arthritis condition.³ Dr. Bynum's diagnosis of inflammatory arthritis was based on claimant's symptoms, evaluation of the medical history and response to various treatments, a thorough examination, and supported by imaging and laboratory testing.⁴ (Ex. 49-40). He explained that while a few types of inflammatory arthritis, such as rheumatoid arthritis or gouty arthritis, have specific tests, many types of inflammatory arthritis do not have a name and do not have a specific test. In the latter case, the diagnosis is based on the patient's history of recurring episodes of joint pain and swelling, results of joint fluid analysis and response to treatment such as cortisone injections into the joint. (Ex. 49-22). He concluded that claimant's history was consistent with one of these "unnamed" inflammatory arthritises.⁵ (*Id.*)

Dr. Bynum also explained that there is a difference between weakness and pain, and instability. (Ex. 49-17, -27). He reiterated that claimant had no findings of instability in any of his examinations or in his review of the record.⁶

³ The rheumatologist also felt that claimant's history was consistent with an inflammatory arthritic condition. (Exs. 22B-12, 24). Claimant reported to the rheumatologist a history of ankle, knee, wrist, and finger joint swelling. (Ex. 22A-4).

⁴ In response to Dr. Bowen's conclusions concerning claimant's arthritis, Dr. James also explained that while rheumatoid arthritis was ruled out, claimant had a polyarticular inflammatory arthritis. (Ex. 48-1-2). He explained that claimant's blood tests were not diagnostic for a non-rheumatoid type of polyarticular inflammatory arthritis. Likewise, he noted that claimant's ankle x-rays did not rule out a polyarticular inflammatory arthritis. Claimant, in his opinion, had all of the symptoms for diagnosing inflammatory arthritis (*e.g.*, joint swelling, joint warmth, joint pain, and similar symptoms in multiple joints) and a well documented history consistent with a polyarticular inflammatory arthritis. Furthermore, Dr. James explained that claimant's positive response to Dr. Bynum's corticosteroid injection in December 2011 was also diagnostic of polyarticular inflammatory arthritis. (Ex. 48-2). He also believed that at the time of Dr. Bynum's February 1, 2012 examination, he would have identified instability. He felt it was important that claimant did not have any significant ankle pain or guarding at that time. (Ex. 48-2-3). As with Dr. Bynum, Dr. James felt that the post-surgery casting and physical therapy had as much to do with claimant's improvement as the surgery itself. (*Id.*)

⁵ Dr. Bynum explained that claimant's fluid analysis/joint aspiration and positive response to a cortisone injection were consistent with an inflammatory arthritis. (Ex. 49-23, -30; *see* Exs. 20, 21). He also considered claimant's 10-year history of recurrent pain and inflammation in other joints and the response to treatment for those episodes in diagnosing a recurring inflammatory arthritis. (Ex. 49-24).

⁶ Drs. Bynum, James, and Youngblood all agreed that if claimant's left ankle sprain resulted in a worsening, his ankle would have had findings of instability.

(*Id.*) His opinion was supported by Drs. James and Youngblood.⁷ According to Dr. Bynum, an abnormal appearing ligament on MRI and an abnormal appearing ligament at surgery were not indicative of instability or a need for a repair of the ligament, especially when there were no complaints or findings of instability. (Ex. 49-34). He further noted that even Dr. Bowen's initial examination revealed normal ankle anterior drawer test and talar tilt bilaterally (Ex. 26-3), and that he did not diagnose instability until after the December 2012 MRI. (Ex. 49-36-37). Finally, Dr. Bynum explained that he would have noted any guarding in his report if it had occurred. (Ex. 49-10, -20).

Regarding the fact that claimant improved after surgery, Dr. Bynum explained that following surgery, claimant had a long period of cast immobilization, which can be an effective treatment for a flare-up of an intermittently recurring arthritis. (Ex. 49-31). He also noted that claimant not only had surgery, but extensive physical therapy for strengthening. (Ex. 49-32).

In sum, considering Dr. Bynum's status as claimant's longtime treating physician and his well-reasoned rebuttal of Dr. Bowen's "instability" diagnosis, we find Dr. Bynum's opinion more persuasive.⁸ See *Weiland v. SAIF*, 64 Or App 810 (1983) (in some situations, a treating physician's opinion is entitled to greater weight because of a better opportunity to observe and evaluate a claimant's condition over an extended period of time). Dr. Bynum's conclusion that claimant's inflammatory arthritis was the cause of his left ankle symptoms requiring surgery is well-reasoned and convincing in light of the medical record, including the pre-December 2012 left ankle condition. Accordingly, based on

⁷ Dr. Youngblood reviewed claimant's medical records and examined claimant on April 11, 2013. (Ex. 45A). At that time, claimant denied having any recurrent ankle sprains or symptoms of instability before his surgery. (Ex. 45A-9). Dr. Youngblood's diagnoses included resolved left ankle sprain with no recurrent instability or permanent impairment and polyarticular inflammatory arthropathy of unknown etiology, well documented in the record, and not related to the September 2011 injury. (Ex. 45A-15, -16). He found no medical evidence that the accepted ankle sprain had worsened or persisted in any way after February 2012. (Ex. 45A-19, -20). As with Drs. James and Bynum, he found no evidence of ankle instability. (Ex. 45A-21). He believed that the December 2012 MRI sprain finding was mild and could have resulted from any ankle sprain in claimant's entire life. (Ex. 45A-20). Dr. Youngblood also noted that claimant's preexisting arthritis was well documented in the record. (Ex. 45A-16).

⁸ Thus, although Dr. Bowen observed the surgical findings first hand, this did not assist him in making a causation opinion given that the basis for his opinion (that claimant had instability) was not supported by a preponderance of the medical evidence. Cf. *Argonaut Ins. Co. v. Mageske*, 93 Or App 698, 702 (1988) (special deference given to treating surgeon's opinion relying on surgical observations).

Dr. Bynum's opinion (as supported by Drs. Youngblood and James), we find that claimant has not established a compensable aggravation claim. Therefore, we reverse.

ORDER

The ALJ's order dated December 26, 2013 is reversed. The employer's denial is reinstated and upheld. The ALJ's \$7,000 attorney fee and cost awards are reversed.

Entered at Salem, Oregon on July 25, 2014

Member Lanning dissenting.

In finding that claimant's accepted left ankle condition worsened, the majority relies on Dr. Bynum's opinion. Because I find Dr. Bowen's opinion more persuasive, I respectfully dissent.

Dr. Bowen first treated claimant on December 3, 2012, for increased ankle pain and swelling. (Ex. 26). After reviewing the December 7, 2012 MRI, which revealed a "moderate strain of low lateral ankle ligaments," Dr. Bowen diagnosed ankle joint instability. (Exs. 27, 29-4). Due to a failed history of conservative treatment and the state of the ligaments, as shown by the December 2012 MRI, clinical findings, and claimant's specific pain, Dr. Bowen recommended ankle stabilization surgery, which he performed on December 17, 2012. (Exs. 33, 46-2).

At surgery, Dr. Bowen observed attenuated and fatty anterior talofibular and calcaneofibular ligaments. (Ex. 33-2, -4). Based on such observations, he opined that claimant's left ankle condition had worsened and that the worsening was directly related to the September 2011 injury. (Ex. 46-2). He indicated that the objective findings supporting a worsened ankle sprain included the December 2012 MRI finding of a moderate strain of the lateral ankle ligaments and his surgical observations of attenuated and fatty anterior talofibular and calcaneal fibular ligaments. (*Id.*; *see also* Exs. 27-2, 33-2). He concluded that the accepted ankle sprain was the major cause of the need for surgery. (*Id.*)

Dr. Bowen persuasively rebutted Dr. Bynum's opinion. Dr. Bowen noted that inflammatory arthritis was ruled out by tests, including aspiration and negative culture. (Ex. 46-3). He also found no "significant ankle arthritis"

on observation or x-ray. (*Id.*) Dr. Bowen explained that claimant's ankle joint inflammation was due to the injured ligaments not doing what they were intended to do, placing the ankle under more stress and creating irritation. Finally, in response to Dr. Bynum's conclusion that claimant did not report instability, Dr. Bowen asserted that a patient may not relate instability, but that he may relate weakness or pain, or that he just cannot use the ankle normally. (*Id.*)

As noted by the ALJ, although Dr. James could not state with any degree of medical probability that claimant had a worsening of his left ankle sprain since February 2012, he acknowledged that the MRI finding of a moderate strain of the lateral ankle ligaments was "consistent" with the original work-related injury, although not necessarily indicative of ankle instability or the need for surgery. (Ex. 43-10, -18). Similarly, he explained that the surgery findings of attenuated and fatty ligaments "were a probable residual from the ankle sprain," but also not necessarily indicative of ankle instability or the need for surgery. (Ex. 43-18). Dr. Bynum agreed with Dr. James that there was a probable residual from the ankle sprain. He felt that the attenuated and fatty ligaments were consistent with a previous injury, but not indicative of instability or the need for surgery. (Ex. 49).

Thus, Dr. Bowen, relying on his observations of the ligaments in surgery, opined that the ankle sprain had worsened and that the injury was the major cause of claimant's disability and need for treatment. Given that Dr. Bowen had the unique opportunity to observe claimant's condition at surgery, I would defer to his opinion. *See Argonaut Ins. Co. v. Mageske*, 93 Or App 698, 702 (1988) (treating surgeon's opinion given great weight because he was able to observe the claimant's shoulder during surgery and had first-hand exposure to and knowledge of the claimant's condition). Therefore, based on Dr. Bowen's well-reasoned and persuasive opinion, I would conclude that claimant has established a compensable aggravation claim related to his accepted left ankle condition. Because the majority concludes otherwise, I respectfully dissent.