APPEAL NO. 990728

Following a contested case hearing held on March 23, 1999, pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act), the hearing officer, resolved the disputed issues by determining that the respondent's (claimant) compensable injury of _____, extends to peripheral nerve damage and ulcers to the inside of his right foot and that he had disability from October 16, 1996, through January 2, 1997, from March 15 through May 5, 1997, and from August 27 through December 5, 1997. The appellant (carrier) urges in its request for review that these determinations are against the great weight of the evidence because claimant had preexisting venous circulation problems in the right leg, the compensable injury was limited to the right side of the right foot, and the nerve damage and ulcers involved other areas of the right foot and were unrelated to the compensable injury. The carrier also urges that the periods of disability were due to the noncompensable right foot problems. The file does not contain a response from claimant.

DECISION

Affirmed.

Claimant testified through a Spanish language translator that on _____, while employed by (employer) as an operator of a furnace used in the manufacturing of copper wire, a heating spout exploded and molten copper, heated to 2000 degrees Fahrenheit, fell onto his right foot with some of it getting into his boot and sock and burning both sides of his foot; that the injury was worse on the right side of the foot and caused the bursting of a vein in that area; that after first going home, he then went to a hospital where the ruptured vein was sutured; that he was taken off work and then released to return to work approximately12 days later; that after returning to work at his usual duties, his foot became infected and swollen and he developed ulcers on the foot; that he was reassigned to warehouse duties; and that his treating doctor, Dr. F, had him off work for treatment and therapy on his foot from October 16, 1996, to January 2, 1997, from March 15 to May 5, 1997, and from August 27, 1997, until early 1998. Claimant said that unlike Dr. F, three of the doctors he saw, Dr. E, the carrier's doctor, Dr. G, a designated doctor, and Dr. S, apparently a referral doctor, do not speak Spanish; that he has never been diagnosed with diabetes; that he never had any prior problem with his left leg or foot; and that he never missed any work on account of any prior problems with his right leg.

Dr. P report of December 27, 1995, stated that he saw claimant at the request of Dr. V, who had been treating claimant for a work-related injury of _____, involving molten metal striking claimant's right lateral foot, and that claimant also has a nonhealing ulcer, localized inferior and anterior to the right medial malleolus, "which has been present for two months" and which appears to be secondary to the venostasis. Claimant indicated that he did not recall telling doctors he had any ulceration of his right foot prior to the accident at work and that he never missed any work on account of such condition.

Dr. S wrote Dr. F on October 25, 1996, stating that he gathered from claimant that a healed leg ulceration "goes back at least two years" and may have been aggravated by a molten copper burn on that area about nine months ago. Dr. S further stated that claimant's swelling gets worse as the day goes on and leads to aching around the ankles; that "this is pretty classic for the postphelebitic syndrome"; and that he will keep claimant off work until he is able to use a specially manufactured support stocking and can be comfortable and do his job effectively.

Dr. E's December 8, 1997, report, which stated that claimant reached maximum medical improvement (MMI) on December 5, 1997, with an impairment rating (IR) of zero percent, noted that claimant developed stasis ulcers at the area of the burn, required debridement, was placed in a boot, and has had chronic wound care. Dr. E also stated that claimant was currently off work because of persistent ankle pain and ulcerative changes of the skin. He said that claimant's left leg demonstrated similar changes, comparable swelling, and some mild skin breakdown, but no ulcerative lesions; that claimant had swelling and venous stasis changes in both legs; that the injury to his skin predisposes claimant to having further breakdown; that claimant has underlying venous stasis changes in both legs and poor superficial venous flow which will continue to be aggravated by any type of frictional abrasion to the skin or increased hydrostatic pressure secondary to edema and swelling; and that the venous insufficiency itself was not caused by the injury but rather that "an injury became aggravated by the underlying condition." In a January 13, 1998, addendum report responding to questions raised by the carrier, Dr. E states at one point that it seemed apparent that the lesions on the right lateral foot were due to the work-related burn and at another point that the ulcers that later developed in the ankle area, particularly on the medial side, are not specifically work related and that the proximate cause appears to be underlying venous stasis and venous insufficiency.

Dr. G's February 11, 1998, report, which states that claimant reached MMI on December 5, 1997, with an IR of zero percent, indicates that subsequent to the _____, burn injury to claimant's right foot, he developed a venous stasis ulceration around the right ankle and that treatment included debridement of the ulceration, application of a boot, and chronic wound care. Dr. G also noted discoloration around the left ankle but no signs of skin breakdown and stated that claimant exhibits changes consistent with venous stasis bilaterally.

An undated record of Dr. F reflects that claimant was under Dr. F's care and off work for "right ankle treatment-venous stasis ulceration-burn injury-open wound" from August 1997 to October 14, 1997, and was released to return to work effective October 19, 1998. Dr. F's March 16, 1998, record states that he feels that the problem claimant had with the opening of his wounds "was due to the on-the-job injury from weakening and sloughing of the skin due to burning from the injury." Dr. F's May 30, 1997, report states that claimant was off work for the injury from October 16, 1996, through January 2, 1997; that he was taken off work again from March 15 to May 5, 1997; that he continues to have an open wound on his right foot that is exacerbated with working around heat; that he has to come in three times a week for therapy; and that he believes claimant's wound will heal with

continued therapy and working in the cooler warehouse environment. The carrier introduced claimant's requests for leave under the Family Medical Leave Act dated October 10, 1996, March 18, 1997, August 15, 1997 and August 22, 1997, as well as documents purporting to show temporary disability payments by the employer from approximately October 27, 1996, to approximately January 5, 1997, and from approximately August 24, 1997, to approximately February 1, 1998. Dr. F also wrote a report responding to the MMI date and IR assigned by Dr. E and Dr. G. However, neither the date of MMI nor the IR were disputed issues in this case.

The hearing officer stated in his discussion that claimant had a short period of disability immediately following the accident at work which is not in dispute; that several years later, claimant developed peripheral nerve damage and ulcers to the inside of the right foot which the carrier contends is an ordinary disease of life for which it is not liable and that the ensuing periods of missed work resulted from the noncompensable ordinary disease of life; that the medical evidence is confusing and conflicting concerning preexisting venous and phlebitis problems; that due to a miscommunication related to claimant's minimal English language skills, an incorrect history was taken; that no preexisting conditions or ordinary diseases of life contributed to the right foot problems; and that the peripheral nerve damage and ulcers to the inside of the right foot resulted from the compensable injury. The hearing officer further stated that claimant asserted he had periods of disability from October 16, 1996, through January 2, 1997, from March 15 through May 5, 1997, and from August 27 through December 5, 1997; and that the medical evidence and off-work slips support these periods.

Claimant had the burden to prove by a preponderance of the evidence that his compensable injury of _____, extended to peripheral nerve damage and ulcers to the inside of his right foot and that he had disability as that term is defined in Section 401.011(16). The hearing officer is the sole judge of the weight and credibility of the evidence (Section 410.165(a)), resolves the conflicts and inconsistencies in the evidence including the medical evidence (Texas Employers Insurance Association v. Campos, 666 S.W.2d 286 (Tex. App.-Houston [14th Dist.] 1984, no writ)), and determines what facts have been established from the conflicting evidence. St. Paul Fire & Marine Insurance Company v. Escalera, 385 S.W.2d 477 (Tex. Civ. App.-San Antonio 1964, writ ref'd n.r.e.). As an appellate reviewing tribunal, the Appeals Panel will not disturb the challenged factual findings of a hearing officer unless they are so against the great weight and preponderance of the evidence as to be clearly wrong or manifestly unjust and we do not find them so in this case. Cain v. Bain, 709 S.W.2d 175, 176 (Tex. 1986); In re King's Estate, 150 Tex. 662, 244 S.W.2d 660 (1951).

The decision and order of the hearing officer are affirmed.

_____
Philip F. O'Neill
Appeals Judge

CONCUR:

_____
Joe Sebesta
Appeals Judge

_____
Gary L. Kilgore
Appeals Judge