IN THE COURT OF APPEALS OF NORTH CAROLINA

No. COA16-1210

Filed: 19 December 2017

North Carolina Industrial Commission, I.C. No. 029712

PAULA FISHER, Widow of HARRISON FISHER, JR., Deceased Employee, Plaintiff,

v.

UNITED CONTINENTAL HOLDINGS, INC. d/b/a UNITED AIRLINES, Employer, INSURANCE COMPANY OF THE STATE OF PENNSYLVANIA, Carrier (GALLAGHER BASSETT SERVICES, INC., Administrator), Defendants.

Appeal by defendants from opinion and award entered 1 August 2016 by the North Carolina Industrial Commission. Heard in the Court of Appeals 2 May 2017.

The Bollinger Law Firm, PC, by Bobby L. Bollinger, Jr., for plaintiff-appellee.

Brewer Defense Group, by Joy H. Brewer and Ginny P. Lanier, for defendants-appellants.

STROUD, Judge.

Defendants appeal from the North Carolina Industrial Commission's opinion and award concluding that the decedent's death was a direct and natural consequence of and causally related to his 22 February 2000 workplace injury to his abdomen and groin. On appeal, defendants argue that the Full Commission erred in reaching such conclusion and argue there is no competent medical evidence to support the Full

Commission's findings and conclusions. After review, we find that the findings are supported by the evidence and that the findings support the Commission's conclusion. We affirm the Commission's opinion and award.

I. Background

The Full Commission's opinion and award sets forth these facts. On 22 February 2000, decedent Harrison Fisher ("decedent") sustained a work-related injury to his abdomen and groin while lifting a tire. Defendants -- his employer and workers compensation insurance carrier -- admitted the compensability of his injury and filed a Form 60 Employer's Admission of Employee's Right to Compensation. Defendants began paying decedent temporary total disability compensation as of 29 February 2000 at a rate of $554.48 per week, and continued to pay this amount until the date of decedent's death, 15 August 2013.

Defendants also provided decedent with medical treatment for his injury. On 22 March 2000, decedent had surgery -- specifically, a bilateral laparoscopic inguinal herniorrhaphies procedure. After surgery, decedent experienced "chronic increased pain[,]" which caused him to see several other physicians who provided treatment with medications and various additional procedures. On 10 May 2001, decedent was evaluated by Dr. Mark Romanoff. Decedent complained of significant groin pain, and Dr. Romanoff diagnosed him with ilioinguinal genitofemoral neuralgia and possible sympathetically mediated pain syndrome. Between 16 October 2001 and 18 February

2013, decedent received 17 nerve block injections and Dr. Romanoff performed two neuroma neurolysis procedures. Dr. Romanoff prescribed various medications to treat decedent's condition. Originally, Dr. Romanoff prescribed Duragesic patches and an opiate pain medication. At first, decedent reported receiving a good level of symptom relief from his medications and the nerve block injections, and on 11 October 2002, Dr. Romanoff opined that decedent had reached maximum medical improvement in relation to his groin condition. After decedent denied any recent improvement with his groin pain on 18 October 2006, Dr. Romanoff stopped his use of the Duragesic patches and instead had decedent begin using Avinza, "an extended release morphine medication designed to provide around-the-clock pain relief to persons with chronic pain."

Plaintiff testified that after decedent began taking Avinza, he experienced frequent and severe constipation. When he complained to his doctor about the constipation, plaintiff testified that the doctor then prescribed Relistor, which provided decedent limited relief. On 26 April 2007, decedent reported to another doctor that while he previously had experienced nearly complete relief from his symptoms, they had come back " 'with a vengeance' " and were now much more severe. In the months that followed, decedent reported no side effects from his medications.

In December 2007, decedent was diagnosed with colon cancer. On 26 December 2007, decedent underwent a low anterior resection sigmoidectomy with primary reanastomosis. Afterwards, he began adjuvant chemotherapy treatments, which continued through August 2008. On 18 January 2008, decedent reported significant constipation to Dr. Romanoff. In May 2008, decedent was hospitalized for severe nausea, vomiting and constipation, and his chemotherapy dosage was decreased due to gastroparesis and severe constipation. In late 2008, decedent's constipation became so severe that he was prescribed injections of Relistor for treatment.

On 14 January 2009, decedent underwent a "second resection in response to the presence of abnormal polyps[,]" which was related to his colon cancer. Afterwards, he reported to Dr. Romanoff he had experienced a decent amount of pain relief and relief from constipation through his use of prescribed medications, including Relistor. In November 2009, decedent reported abdominal and bilateral groin pain and some constipation and tiredness as side effects from medications. Throughout 2010, decedent did not report constipation-related symptoms and overall noted that his medications were helping his pain.

During medical visits in April and July 2011, it was noted that decedent was taking Relistor for "opiate induced constipation" as well as Avinza, a narcotic. In September 2011, decedent's medical records noted that decedent reported

experiencing severe constipation, nausea, and sedation "secondary" to his medications, and his physician explained that as all narcotics lead to chronic constipation, he may have to continue taking Relistor, although he could try different medications to see if the side effects may change. Decedent indicated that he did not want to change his medications at that time because any changes would have to be approved through workers' compensation, so his prescriptions for Avinza and Relistor were filled that day.

Decedent reported constant, low grade pain at his appointment on 21 November 2011, and he reported worsening pain later that same month following a colonoscopy. In 2012, decedent continued taking Avinza and Relistor but noted no side effects or issues from his medications at any medical appointments. In May 2013, a tumor was found growing into decedent's bladder and he was diagnosed with invasive, metastatic colonic adenocarcinoma. Dr. Powderly begged a surgeon to operate on him, but the surgeon was unwilling to do so because of decedent's other issues, including his chronic constipation and bowel issues.

Decedent went to the emergency room on 9 August 2013 complaining of difficulty urinating and tenderness in his lower abdomen. He returned to the hospital on 11 August 2013 complaining of abdominal pain, distention, and disorientation, and diagnostic tests revealed that he had a bowel obstruction. Decedent underwent emergency surgery that same date in an attempt to rescue his catastrophic necrotic

bowel, but he never regained consciousness following the surgery and eventually passed away on 15 August 2013. The primary cause of death was listed as bowel ischemia, which is "when the bowel is not getting enough blood flow, usually from the bowel being obstructed and the bowel becomes necrotic and dies."

On 25 March 2014, plaintiff, decedent's widow, filed a Form 33 request for hearing, seeking death benefits arising out of decedent's 22 February workplace abdomen and groin injury. Defendants responded by filing a Form 33R, contending that decedent's death was not causally related to his 22 February 2000 workplace injury. On 30 July 2015, Deputy Commissioner Bradley W. Houser issued an opinion and award concluding that decedent's death was causally related to his compensable 22 February 2000 workplace injury and awarding death benefits to plaintiff.

Defendants timely appealed to the Full Commission. On 1 August 2016, the Full Commission affirmed the decision of the Deputy Commissioner, concluding that decedent's "death due to bowel ischemia was a direct and natural consequence of and causally related to his February 22, 2000 injury by accident and resulting conditions and treatment." The Full Commission concluded that plaintiff was entitled to have defendants pay for all of decedent's related medical expenses and for the actual cost incurred for burial services. Defendants timely appealed to this Court.

II. Standard of Review

> The standard of review for an opinion and award of the North Carolina Industrial Commission is (1) whether

> any competent evidence in the record supports the Commission's findings of fact, and (2) whether such findings of fact support the Commission's conclusions of law. The Commission's findings of fact are conclusive on appeal if supported by competent evidence, notwithstanding evidence that might support a contrary finding. In determining the facts of a particular case, the Commission is the sole judge of the credibility of the witnesses and the weight accorded to their testimony. This Court reviews the Commission's conclusions of law *de novo*.

Booker-Douglas v. J & S Truck Serv., Inc., 178 N.C. App. 174, 176-77, 630 S.E.2d 726, 729 (2006) (citations and quotation marks omitted).

III. Discussion

Defendants' sole issue on appeal is whether the Full Commission erred in finding and concluding that decedent's death was a direct and natural consequence of and causally related to his 22 February 2000 workplace injury.

Under N.C. Gen. Stat. § 97-38 (2015):

> If death results proximately from a compensable injury or occupational disease and within six years thereafter, or within two years of the final determination of disability, whichever is later, the employer shall pay or cause to be paid, subject to the provisions of other sections of this Article, weekly payments of compensation equal to sixty-six and two-thirds percent (66 2/3 %) of the average weekly wages of the deceased employee at the time of the accident, but not more than the amount established annually to be effective October 1 as provided in G.S. 97-29, nor less than thirty dollars ($30.00), per week, and burial expenses not exceeding ten thousand dollars ($10,000), to the person or persons entitled thereto[.]"

In order to receive death benefits under N.C. Gen. Stat. § 97-38, "a compensable injury must be the proximate cause of the employee's death." *Booker-Douglas*, 178 N.C. App. at 177, 630 S.E.2d at 729.

Defendants argue there was no competent medical evidence that decedent's narcotic-induced constipation caused or significantly contributed to his bowel obstruction and death. We disagree.

Dr. John D. Powderly, one of decedent's oncologists, testified that decedent had a "unique history" because he was on high doses of narcotic pain medications for severe chronic pain, and due to those medications he developed constipation and started taking Relistor to help deal with the constipation. Dr. Powderly recalled that taking Relistor seemed to help with decedent's constipation but did not resolve the issue. In August 2013, decedent ended up in the hospital with abdominal pain and distension, and a CT scan revealed a small bowel obstruction. When asked whether abdominal distension is something Dr. Powderly sees associated with colon cancer, Dr. Powderly explained that it depends on where the colon cancer is located. In decedent's case, "[h]e had a small solitary recurrence in the right posterior abdominal wall that was outside of the bowel. And it was behind the ureter. . . . So based on [Dr. Powderly's] recollection and based on the -- the imaging, it [did not] look like his colon cancer had recurred in the -- the bowel itself or the mesentery. It was extracolonic . . . in the posterior abdominal wall."

Dr. Powderly was also asked about decedent's bowel ischemia, specifically whether chemotherapy can cause inflammation issues. Dr. Powderly responded that "[i]t can. But maybe not to this degree." And when asked whether there is "any way to know with certainty what caused the bowel ischemia[,]" Dr. Powderly testified: "I'd be pretty confident that it was related to his chronic constipation. There's not too many patients walking on the earth that need Relistor every other day for years and years." Dr. Powderly noted that on "most" of decedent's scans, "he had major constipation and fecalization. You know, stool was all the way up into his small bowel. So his bowels were always distended, which is why he needed the Relistor[.]" When asked what impact chemotherapy, radiation, kidney disease, and other things might have or if they would "play a factor" in decedent's development of constipation, Dr. Powderly testified:

> I think that, you know, once you have such bad chronic constipation, that your bowels become distended and the radiologist at every single CAT scan is saying, you know fecalization of the -- of the bowels and distension and obvious constipation, he had -- that's a chronic disease. And yes, it was being well managed with Relistor, but it doesn't -- it doesn't cancel out the fact that that's an underlying chronic disease. It was a major quality of life issue for him as well.
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> So I think what you're trying to ask is what all contributed to his -- his toxic bowel necrosis. And, you know, bowel necrosis and ischemia like that don't just fall out of the sky. They are typically in patients that have chronic bowel issues. And he obviously had very bad chronic bowel issues.

Dr. Powderly also explained that the most common side effect of chemotherapy is diarrhea, not constipation. When asked about the impact having his colon resectioned twice would have on how his bowels work, Dr. Powderly pointed out that usually patients with a colon resection suffer from chronic diarrhea. Dr. Powderly testified in more detail that the chemotherapy pill Xeloda causes "diarrhea on top of chronic diarrhea." So, most of Dr. Powderly's patients have the opposite problem of decedent -- chronic diarrhea -- rather than chronic constipation. But Dr. Powderly noted further that "when patients are on such high doses of narcotics, the number one complication of chronic narcotics . . . is constipation. And so I think that was a major contributing cause to his -- his bowl [sic] catastrophe, unfortunately."

In addition, Dr. Powderly testified regarding his treatment of decedent's colon cancer recurrence: "I think we begged the surgeon to try to operate on him, but they were not willing because of his other comorbidities, you know, his chronic constipation, bowel issues, borderline kidney status." When Dr. Powderly was again asked whether decedent's bowel condition was "multifactorial[,]" he replied:

> So most -- when he came to me and landed at our clinic, he came with the very clear history of chronic constipation from narcotic-induced constipation. So that really was the underlying root cause. So it's hard to say, oh, well, you know, this patient has multifactorial bowel issues when it was -- he came to us with that history that was very clear he was on high dose narcotics, chronic narcotic constipation. And he got lucky the Relistor helped him manage it for a while. But ultimately that was his most

major comorbidity, if you will.

Dr. Powderly also noted that decedent's chemotherapy dose had to be reduced on multiple occasions because of decedent's gastroparesis, "meaning his bowels slowed down and stopped working." He reiterated: "I know his chronic constipation was his major comorbidity. Like I said, I don't think the chemo or radiation helped. But it didn't cause him to have rock solid stools and all the chronic fecalization of his small bowel, you know, for all those years." Dr. Powderly testified that a patient can get constipation from cancer when it is a "colonic recurrence" -- or where the tumor is occupying space of the bowel or the colon itself. But in decedent's case, "it was an extracolonic recurrence. It was in the lymph nodes, in the posterior abdominal wall. Not in the mesentery, not in the bowel. So that's why I don't think his colon cancer caused his constipation." He explained that for many years, radiologists would comment on decedent's CAT scans and notice "fecal matter distending his entire colon and all the way up into the small bowel[,]" which Dr. Powderly testified was "abnormal" but "consistent with his chronic, severe constipation."

Dr. Rohit Bhasin, a general surgeon, saw decedent in the hospital on 11 August 2013. Dr. Bhasin performed the emergency abdominal surgery on decedent and described it as "probably the worst bowel obstruction abdominal case I've had to do." Dr. Bhasin explained that decedent had an "extremely dilated bowel" that "appeared to be chronically fibrotic, scarred." Decedent's small bowel was "incredibly enlarged,

dilated," which Dr. Bhasin said indicated to him "longstanding obstruction to where the bowel is essentially not functional for some time."

When asked whether he saw evidence that decedent's colon cancer had recurred in the intestinal tract, Dr. Bhasin explained that it was not in the majority of the abdomen, but rather in the "same general area" as where the cancer recurred. When one attorney relayed to Dr. Bhasin that Dr. Powederly had testified that the cancer had recurred in an "isolated solitary location on the ureter or . . . surrounded the ureter[,]" Dr. Bhasin replied this description did not particularly help him recall what he saw during surgery, because one could describe it was a "small area" based on radiology or CAT scan procedures, but "when you get in there, it's usually a different story[.]"

Dr. Bhasin described seeing rock-like stool in the right colon, which was unusual. He said that it either "signifies . . . that stool has been present there for some time that the body has been able to reabsorb most of the fluid from that. So either there's been obstruction further down or basically the bowel has not been propelling that stool downstream." He concluded: "So it's a form of constipation really."

Dr. Bhasin was asked to explain what role he thought decedent's history of chronic constipation from narcotic pain medication played in developing the situation that Dr. Bhasin found when he performed surgery on him. Dr. Bhasin explained that

it is "hard to quantify what kind of role it had[,]" but that in his opinion, he thought "it had some, some role here." When asked whether he thought the underlying chronic constipation was a significant contributing factor to his obstructed bowel, Dr. Bhasin opined: "I believe the primary problem really was the cancer where the obstruction was because that's where I found in -- but I do think that underlying bowel functional obstruction in the sense that it wasn't propelling or working probably had some significant role." Dr. Bhasin was not comfortable quantifying the significance into a specific percentage amount, but he noted that decedent had a lot of underlying issues and multiple prior surgeries, so there were a lot of potential reasons for his bowel not being able to properly propel, including chronic constipation from long-term narcotic usage. Dr. Bhasin opined that decedent's chronic constipation was not, by itself, the primary cause of decedent's death, but he did "think it contributed[.]"

Defendants argue that "Dr. Powderly's testimony does not constitute competent medical evidence on the cause of decedent's bowel obstruction and death." To support this argument, defendants contend that Dr. Powderly's testimony "was rooted on the erroneous assumption that decedent's recurrent colon cancer was not located within the bowel." But defendants' contention that Dr. Powderly's testimony was based on an erroneous belief about where the cancer was located is not an accurate representation of the doctors' testimonies. Dr. Bhasin also testified that

decedent's recurrent colon cancer was only located down in the pelvis, not in the remainder of his abdomen. While the precise spot where the cancer was located may have been described in slightly different terms, it appears from the doctors' testimonies they were ultimately describing the same spot. And regardless, both doctors also ultimately concluded that decedent's chronic constipation was likely at least a contributing factor to his death, even if not the only factor.

While there was also expert opinion testimony to the contrary -- such as deposition testimony from defendants' retained expert Dr. Brian J. Shimkus, who never treated decedent but simply opined that the colon cancer was probably proximately related to decedent's death -- as long as there is any evidence that supports the Commission's findings, those findings are conclusive. *See, e.g., Clawson v. Phil Cline Trucking, Inc.*, 168 N.C. App. 108, 113, 606 S.E.2d 715, 718 (2005) ("Our standard of review is limited to reviewing whether any competent evidence supports the Commission's findings of fact and whether the findings of fact support the Commission's conclusions of law. The findings of fact of the Industrial Commission are conclusive on appeal when supported by competent evidence, even though there be evidence that would support findings to the contrary." (Citations, quotation marks, and brackets omitted)). As noted above, Dr. Powderly and Dr. Bhasin both were of the opinion that decedent's chronic constipation from long term narcotics usage played some significant role in his bowel obstruction that ultimately led to his

death. There was sufficient evidence that decedent's work-related compensable injury to his abdomen and groin was proximately related to his death, as his injury led to decedent being on the long-term narcotic pain medications which caused chronic constipation.

Although decedent also had recurrent colon cancer and it may have contributed to his death, that does not prevent plaintiff from recovery, so long as there is any evidence to support the finding that the work-related compensable injury and issues stemming directly from that was also a proximate cause and contributing factor to his death. *See, e.g., Vandiford v. Stewart Equip. Co.*, 98 N.C. App 458, 462, 391 S.E.2d 193, 195 (1990) ("While there must be some causal connection between the employment and the injury, it is not necessary that the original injury be the sole cause of the second injury."). There is no reason to conclude that decedent's death was solely caused by a non-work related disease. *See, e.g., Shaw v. U.S. Airways, Inc.*, 217 N.C. App. 539, 547, 720 S.E.2d 688, 693 (2011) ("To assert that Curry Shaw's death was *solely* the result of a non-work related liver disease is an untenable argument. The toxic build-up of methadone prescribed to manage Curry Shaw's pain resulting from a compensable injury to a reasonable degree contributed to his death. Therefore, defendants' argument that Curry Shaw's death was solely attributable to his liver disease and was in no way the natural consequence of his compensable injury is overruled."). Here, as in *Shaw*, the evidence supports the Commission's findings

that decedent's long-term use of narcotic medication to manage the pain from his compensable injury led to chronic constipation, which ultimately contributed to his death. The Commission's findings support the conclusion that decedent's death was a direct and natural consequence of and causally related to his 22 February work-related injury. We therefore affirm the Full Commission's opinion and award.

IV. Conclusion

We affirm the Full Commission's opinion and award.

AFFIRMED.

Judges BRYANT and DAVIS concur.

Report per Rule 30(e).