

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

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WILLIAM DIETRICH,

97 CV 2962

Plaintiff,

MEMORANDUM
AND
ORDER

-against-

KENNETH S. APFEL, COMMISSIONER,
SOCIAL SECURITY ADMINISTRATION,

Defendant.

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BINDER & BINDER

(Charles E. Binder, of counsel)

1393 Veterans Memorial Highway
Brooklyn, New York 11788
for plaintiff.

ZACHARY W. CARTER, United States Attorney
Eastern District of New York
Christopher G. Lehmann, Assistant U.S. Attorney
(of Counsel)
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for defendant.

NICKERSON, District Judge:

Plaintiff William Dietrich brought this action pursuant to 42 U.S.C. § 405(g) to review a final decision of the defendant Commissioner of Social Security that he was not entitled to disability insurance benefits under the Social Security Act.

I

Plaintiff filed an application for disability insurance benefits on May 17, 1993. The Commissioner denied the application. Plaintiff requested a hearing, which was held on May 9, 1994. On September 21, 1994 the Administrative Law Judge found plaintiff not disabled. On February 8, 1995 the Appeals Council vacated the Administrative Law Judge's decision and remanded for further proceedings.

A further hearing was held on September 13, 1995. On December 22, 1995 the Administrative Law Judge again found plaintiff not disabled. The Appeals Council denied a request for review on March 28, 1997, and this action followed.

II

The plaintiff was 49 years of age on the date of the September 13, 1995 hearing. He is a high school graduate with past work experience as a carpet installer and as president of a carpet installing business, which employed approximately 80 people. For some twelve years before the first hearing in 1994 he had not been doing any actual installing but, before he became totally disabled, supervised the work.

He testified he became disabled on May 30, 1992 and had to stop working because of extreme fatigue, pain and numbness in his arms and legs, and lack of coordination due to multiple sclerosis and hypertension. Plaintiff has not engaged in any substantial gainful activity since that date. Indeed, by 1994 he did not even drive a car because, as he testified, by that year his legs were so uncoordinated and fatigue came upon him so rapidly that he was required to make frequent stops.

The Administrative Law Judge determined both in 1994 and 1995 that plaintiff was not disabled and could not perform work as a carpet installer but had the ability to perform other jobs. After the 1994 hearing he found that plaintiff had the residual functional capacity to do only sedentary work. But in 1995 he found that plaintiff, who had the progressively debilitating disease of multiple sclerosis, could do light work, and was not disabled.

III

Plaintiff says he became disabled on May 30, 1992. The record contains medical evidence concerning plaintiff's condition prior to and after that date.

A. Evidence before May 30, 1992

The medical evidence shows that plaintiff had a water-skiing accident in July 1987. Soon thereafter he began to complain of leg numbness, blurred and double vision, and a drooping left eyelid. He subsequently underwent a series of tests and neurological evaluations.

A September 1987 CT scan and a magnetic resonance imaging of plaintiff's brain showed normal results, as did a September 22, 1987 MRI of the brain. These tests were ordered by Dr. John DeLuca, plaintiff's long term primary treating physician, board certified in family medicine.

In October of 1987 Dr. DeLuca referred plaintiff to Dr. Roger W. Davenport, a neurologist at Lutheran Medical Center. Dr. Davenport noted that the plaintiff suffered from left ptosis (drooping of the upper eyelid), a condition he believed to be suggestive of ocular myasthenia. He noted a history of numbness in the plaintiff's right leg, decreased ankle jerk in the plaintiff's lower right extremity, and numbness in the left upper extremity. He concluded that if the plaintiff was not suffering from ocular myasthenia, his other two diagnoses would be (1) the possibility of an

occult diabetes, or (2) a cervical cord lesion involving the sympathetic chain in the cervical cord.

Dr. Davenport referred plaintiff for laboratory studies, including acetylcholine receptor antibodies, sedimentation rate, serum aldolase levels, CPK levels, and a fasting blood sugar test. The test results were normal. He also referred plaintiff for an electromyography, and for nerve conduction studies of his upper and lower extremities with repetitive stimulation. The studies disclosed no evidence of neuropathy or neuromuscular transmission defect. Dr. Davenport noted at that time that plaintiff denied any end of the day weakness.

Dr. Davenport examined plaintiff again on February 11, 1989. Plaintiff reported a reoccurrence of his previous symptoms following an episode of flu-like symptoms several weeks earlier. Dr. Davenport found diplopia on right and left lateral and upward gaze, and weakness of the medial and superior rectus muscle. Plaintiff's pupils were equal and reactive to light and accommodation. There was some general pallor of both optic discs, and ptosis of the left eyelid. Dr. Davenport noted right facial asymmetry on grimace, but there was no forehead flattening or eyelid weakness. He found questionable fasciculation of the tongue, and

noted the appearance of a deviation to the right, which he stated was probably due to right facial weakness. Facial sensation was intact.

On examination of plaintiff's upper and lower extremities, Dr. Davenport found full muscle strength and equal grasps. He thought that the eye signs were strongly suggestive of ocular myasthenia, but that the parathesia and tongue findings favored a diagnosis of diabetes mellitus or another metabolic problem. He further stated that "multiple sclerosis seems less likely, but a possibility.

Dr. Davenport referred plaintiff for cerebrospinal fluid testing on February 15, 1989. The test results were normal.

Next plaintiff was referred to Dr. Sergio Schwartzmann at the Hospital for Special Surgery in Manhattan. The doctor examined plaintiff on August 1, 1989. Plaintiff stated that in the summer of 1988 he again developed drooping of the left eyelid and numbness in the feet and periorbital area but that after hospitalization he had complete resolution of his symptoms until several days before Dr. Schwartzmann saw him. Plaintiff said that he again had periorbital tingling, tongue parathesia, and a drooping left eyelid. He also described a "pins and needles"

sensation over his right lower extremity, predominately over the foot. He denied any vision changes, fatigue, focal weakness or fever.

The doctor noted that plaintiff had lost 47 pounds on a liquid diet over a seven month period. Plaintiff's blood pressure was 120/90. A cardiac examination revealed no abnormalities. A neurological examination revealed left ptosis and some questionable decrease to pin sensation in the left dorsal aspect of the foot. Cranial nerves were otherwise grossly intact. Motor strength was grossly intact. Reflexes were two-plus and symmetrical, with downgoing Babinski reflexes.

Dr. Schwartzmann concluded that plaintiff had a "neurological syndrome characterized by ptosis and multiple sensory changes," and that "clearly, multiple sclerosis could account for the [plaintiff's] current symptoms." He suggested that while Lyme disease could account for plaintiff's symptoms, the one Lyme test was negative. The doctor also speculated that a vasculitic syndrome or "perhaps" a antiphospholipid syndrome could account for the neurological findings, "except that no evidence of thrombosis was noted on the MRI."

Dr. Schwartzmann referred plaintiff for clinical immunology tests, including rheumatoid factor, ANA, and

a Lyme titer. All test results were negative. Blood tests and an erythrocyte sedimentation rate were normal.

Dr. Schwartzmann then referred plaintiff to Dr. John J. Caronna, Professor and Vice Chairman of the Department of Neurology at The New York Hospital - Cornell Medical Center. Plaintiff reported to Doctor Caronna on August 22, 1989 that for two years he had had ptosis of the left lid, which increased with fatigue, and that he had some numbness and pain in both legs, especially in the soles of his feet and intermittent numbness in the hands so that when he extended his wrists they fell asleep. He also described intermittent double vision, which he corrected by covering his left eye, and severe intermittent headaches, described as "ice pick-like pains" on both sides of the head but not in the eyes.

On examination cranial nerve testing revealed some pallor of the optic disc on the left, but plaintiff's uncorrected visual acuity was 20/20 on the left and 20/25 on the right. Visual fields were full to confrontation. Pupils were equal and reactive. Dr. Caronna found ptosis of the left lid and some weakness of the medial rectus muscle on the left. There was diminished hearing on cranial nerve VIII on the left,

but otherwise the cranial nerves were intact. Motor, sensory, and cerebellar testing was normal. Reflexes were full with toes downgoing.

Dr. Caronna concluded, "I don't have unifying diagnosis in this case and I agree with the patient's previous physicians that the symptoms are suspicious for multiple sclerosis."

Plaintiff underwent motor and sensory nerve conduction studies and an EMG on October 2, 1989. The study disclosed no evidence of peripheral neuropathy.

A lumbar MRI on March 1, 1990 revealed minimal disc bulging at L4-5, with minimal deformity upon the thecal sac, and minimal disc bulging at L5-S1, with no evidence of compression or deformity upon the thecal sac or bilateral nerve roots. Additionally, there were degenerative arthritic changes at L4-L5 and L5-S1, without evidence of neural foraminal encroachment.

In May 1990 plaintiff sought treatment at the Lahey Clinic in Burlington, Massachusetts. He was evaluated by Dr. Irma Lesswell, a neurologist on May 2, 1990. Plaintiff was complaining of numbness in his leg. He explained that after he saw the neurologist in 1987 the droopy lid and the numbness intermittently came and went. By February of 1989 he developed double vision, like a "ghost image," and both legs and feet

were numb and his tongue had a tingling numbness. In the summer of 1989 his legs would "give way" and his knees buckled. There had been no improvement since that summer.

An eye examination revealed that plaintiff's visual acuity was 20/20 bilaterally. Visual fields were grossly normal. Pupils were reactive to light, though less so on the left. There was ptosis of the left eyelid and left facial weakness when plaintiff grimaced. There was no weakness of plaintiff's eyelids or neck muscles. Dr. Lesswell noted a left afferent pupil defect and left optic disc pallor. Fundi were normal on the right.

Examination of plaintiff's extremities revealed that muscle strength was five out of five and muscle tone was normal. Plaintiff's gait, station and coordination were normal. Heel-toe walking was hesitant but normal. Sensation to pin and touch was normal. Knee and ankle reflexes were zero. Dr. Lesswell noted, "he's lost his reflexes!" Deep tendon reflexes in the upper extremities were one-plus and symmetrical. Testing revealed no evidence of myathesia.

Dr. Lesswell concluded that despite the negative MRI and LP, "I think he has to have multiple sclerosis."

B. Evidence after May 30, 1992

Plaintiff testified that, although he had been accustomed to work fifteen hours a day, as of May 30, 1992 his fatigue became so severe and his legs so painful and unstable as to make it impossible for him to work. He was constantly exhausted, had trouble staying awake, and had to take frequent naps during the day. He did no work around the house and no shopping. He fell many times when his knees gave out. He repeated the symptoms he had described to the numerous doctors from whom he had sought help.

On July 18, 1993, plaintiff underwent a consultative examination on behalf of the government by Dr. Minkailv Sankoh, whose specialty, if any, is not revealed in the record. The doctor's diagnosis was "multiple sclerosis by history", "degenerative joint disease involving the knees" with good range of motion, and "marked obesity." He concluded that "based on the history" and examination plaintiff can sit, but did not say for how long. The doctor also said that plaintiff's ability to lift heavy weights, walk long

distances, climb, push, pull and carry is mildly to moderately limited. Dr. Sankoh did not give any estimate as to how long plaintiff could stand or walk, nor did he address the matter of extreme fatigue or the pain and buckling in the legs.

Dr. John DeLuca, plaintiff's treating physician, since February 1986 who for many years saw plaintiff on a monthly basis, submitted a report dated May 8, 1994.

Dr. DeLuca's report states, in substance, the following. On August 25, 1987 plaintiff complained of headache, pain in his jaw and ear, paresthesia of his right thigh, and ptosis of his left upper eyelid. He was advised to lose weight and he did so while his blood pressure remained under control and his symptoms subsided.

On February 10, 1989 plaintiff developed third nerve palsy and was admitted to Lutheran Medical Center for further testing. The conclusion of the studies was multiple cranial neuropathies. Thereafter plaintiff went to the Lahey Clinic, then to the Neurological Institute at Columbia Presbyterian Medical Center where he was diagnosed by Dr. Miller as having multiple sclerosis and prescribed Tegretol 200 mg three times a day.

Dr. DeLuca stated that plaintiff returned to Lutheran Medical Center in April 1991 for "hemorrhagic cystitis" and a neurogenic bladder. The pain in plaintiff's legs required anti-inflammatory and analgesic medications through to the date of Dr. DeLuca's report.

The doctor concluded that plaintiff's condition had worsened in the past few years with increased fatigue and decreased motor strength so that he had not been able to perform his employment duties. In the doctor's medical opinion plaintiff could not be gainfully employed at any time in the future.

This opinion was confirmed by the reports of Dr. Leonard A. Langman, a neurologist, who examined plaintiff on December 6, 1994 and August 15, 1995. The doctor found nystagmus on left and right lateral gaze, compromised and non-correctable visual acuity, 3/5 weakness in both lower extremities, reflexes hyperactive bilaterally, and equivocal Romberg and Babinski reflexes. Dr. Langman diagnosed multiple sclerosis and found plaintiff totally and permanently disabled.

IV

The Administrative Law Judge was "not persuaded" by Dr. DeLuca's opinion, reciting that the doctor had

"not provided laboratory and clinical findings to support his conclusion." Dr. DeLuca did not purport to duplicate the tests performed at the various institutions to which plaintiff went for help with his disease. Dr. DeLuca naturally relied on the tests and findings made by the experts at five separate distinguished hospitals.

The only medical authorities on whom the Administrative Law Judge relied were Dr. Minkailv Sankoh and Dr. Charles Plotz, an internal medicine "medical expert", but plainly no expert as to multiple sclerosis. Neither of these doctors treated plaintiff. Dr. Plotz did not even examine him.

Dr. Sankoh's report of 1993 (two and half pages) gives no attention to the probable effects of multiple sclerosis.

Dr. Plotz's testimony showed a limited knowledge of the symptoms and effects of multiple sclerosis. For example, he testified that plaintiff's weakness, fatigue, and droopy eyelid were not symptoms commonly associated with multiple sclerosis. This was contrary to the opinion of the institutions where plaintiff was examined. The Regulations themselves state that one of the criteria for evaluating impairment caused by multiple sclerosis is "fatigue." According to the

regulation, someone without muscle weakness or other significant disorganization of motor function at rest may show weakness on activity "as a result of fatigue", 20 C.F.R. Ch. 111, Pt. 404, Subpt. P, App. 1, § 11.00 E & 11.09 C.

As the Court of Appeals for the Second Circuit stated in Shapiro v. Cadman Towers, Inc., 51 F.3d 328, 330 (1995), multiple sclerosis "generally manifest[s] itself by difficulty in walking, urinary problems, sensory problems, visual problems, and fatigue." This decision affirmed the holding of Judge (now Chief Judge) Sifton in Shapiro v. Cadman Towers, Inc., 844 F. Supp. 116, 118 (E.D.N.Y. 1994) (symptoms of multiple sclerosis "include physical weakness, difficulty in walking, loss of balance and coordination, visual disturbance, fatigue, loss of stamina and severe headaches"). See also Brunner Suddarth's Textbook of Medical - Surgical Nursing (Smeltzer & Bare eds., 8th ed.) ("Principal symptoms [of multiple sclerosis] most often reported are fatigue, weakness, numbness, difficulty in coordination, and loss of balance").

Dr. Plotz testified at the May 9, 1994 hearing and the September 13, 1995. The testimony at the second hearing was inconsistent with that given at the first hearing.

In 1994 Dr. Plotz stated that while the possibility of multiple sclerosis was raised, such a diagnosis was never confirmed by objective tests and "some of the tests for multiple sclerosis which (sic) should have been positive had he had it were not." He said that plaintiff had no motor weakness and that "fatigue is not weakness."

Dr. Plotz testified that plaintiff had "no abnormal reflexes, as is common in multiple sclerosis." The doctor apparently never read the report of Dr. Lesswell that a test of plaintiff's knee and ankle flexes were "zero", prompting her to note "he's lost his reflexes!" Dr. Plotz claimed plaintiff could drive a car, in the face of plaintiff's sworn testimony he had given up driving. Dr. Plotz would not even admit that plaintiff had multiple sclerosis, stating that plaintiff has "some neurological disease, which is not fully diagnosed and which may be multiple sclerosis."

Moreover, Dr. Plotz at that 1994 hearing testified that plaintiff could frequently lift and carry no more than ten pounds and could stand and walk no more than two hours. In the 1995 hearing Dr. Plotz testified plaintiff could frequently lift and carry twice as much --twenty pounds-- and stand and walk two or three times as long, four or six hours.

Thus Dr. Plotz, who was not sure in 1994 that plaintiff had multiple sclerosis, found plaintiff could then do only "sedentary" work. But in 1995 Dr. Plotz, after finally agreeing that plaintiff "probably" had multiple sclerosis, admittedly a progressively debilitating disease, found that plaintiff somehow got better and could do "light" work.

The Administrative Law Judge in his 1994 and 1995 findings agreed each time with Dr. Plotz. Neither Dr. Plotz nor the Administrative Law Judge explained how plaintiff's condition could have made such an astonishing improvement.

The medical signs and findings by the string of experts in multiple sclerosis show that it could reasonably be expected that plaintiff would suffer the pain and other consequences he described. See 20 C.F.R. § 1529. The complaints he voiced at the hearings were all internally consistent with the medical record with the exception of the opinions of Doctors Sankoh and Plotz. The opinions of those two were not substantial evidence such as to outweigh the opinion of the treating physician who had a long term relationship with plaintiff which give the doctor a "longitudinal picture" of plaintiff's disability. 20 C.F.R. § 404.1529.

The Administrative Law Judge, while acknowledging that plaintiff testified he was extremely fatigued, responded that plaintiff was ambulatory and able to care for himself. That was hardly an answer. The fatigue that plaintiff described was so great and came on so suddenly during the day that it prevented him from working.

The record does not show plaintiff as someone who was a malingerer. He started a business with a partner. He worked fifteen hours a day for twenty years. He employed some eighty people. Even after he first had the signs and symptoms of multiple sclerosis he continued to work, while desperately going to the various distinguished institutions seeking a cure for, or at least answers to, his advancing debilitation. He did not go to those institutions in order to make a case for disability benefits. He went there for help. Only when he realized he could not function did he stop work.

The opinion of Dr. DeLuca as the long term treating doctor was entitled to great weight, was supported by substantial evidence, and was not refuted by substantial evidence. The decision of the Administrative Law Judge was not based on substantial evidence. Plaintiff was disabled from May 30, 1992

through December 30, 1996, the last date on which he met the disability insurance status requirements.

The case is remanded for the calculation of benefits.

So ordered.

Dated: Brooklyn, New York
May 22, 1998

Eugene H. Nickerson
Eugene H. Nickerson, U.S.D.J.