RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXX BRANCH OF SERVICE: USMC

CASE NUMBER: PD0900068 BOARD DATE: 20100119

SEPARATION DATE: 20031213

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SUMMARY OF CASE: This covered individual (CI) was SGT Rifleman medically separated from the USMC in 2003 after 5 years and 7 months of service. The medical basis for the separation was Plaque Stage (skin) Psoriasis. The CI developed a transient abdominal rash after receiving Anthrax vaccinations in Feb 1999. Recurring rash was diagnosed and treated as a fungal problem until diagnosis of psoriasis by dermatology in Feb 2002 which was biopsy proven in Jan 2003. The CI had had complaints of bilateral knee, ankle, right wrist and back pain that he was concerned may be related to psoriasis, but there was no diagnosis of psoriatic arthritis, with each joint having a history of trauma, and no radiographic evidence for psoriatic arthritis. The CI had pain at the right calf biopsy site and a history of panic attacks. The CI's psoriasis was treated with multiple topical medications; however, his skin complaints with exertion interfered with his ability to do field duties and the Commander recommended discharge. The CI's Plaque Stage (skin) Psoriasis was determined to be medically unacceptable IAW AR 40-501. The additional musculoskeletal diagnoses (pain in bilateral knees, ankles, and spine; and cyst on right wrist) were determined to be medically acceptable. The CI was referred to the PEB, found unfit only for the Plaque Stage Psoriasis condition, determined unfit for continued military service and separated at 10% combined disability using the Veterans Affairs Schedule for Ratings Disabilities (VASRD) and applicable Navy and Department of Defense regulations.

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CI CONTENTION: The CI submitted a multi-page contention, essentially contending that: “At the very least just from the psoriasis based on what it looked like I should have been rated at 30% and put on permanent retirement."; Mental health issues related to his appearance; psoriasis and also effects vision; breathing; eyelids with dry eyes/itching; psoriatic arthritis; punch biopsy site painful area (scar) on right calf; additional joint(s) pain of fingers, feet and right hip; "They thought that I may have had rheumatoid arthritis. However after the test results came back it was very briefly mentioned that I might have Psoriatic Arthritis. This was never brought up again prior to me being medically discharged at only 10%, I should have been rated at minimum 30%. It turns out that I did have psoriatic arthritis, which I have been taking methotrexate and diclofenac 50 mg and folic acid on a daily basis in order to help my inflammation and skin and painful joints." The "cyst … in my right wrist was not included"; "chronic lower back pain has never subsided but has only gotten worse"; exam and process of MEB/PEB was fast, confusing, and without adequate assistance; "since then been prescribes citalopram"; "STS (hearing) has never gone away but has in fact gotten worse. I get a headache every time the ringing begins in my ears (Tinnitus). … even had dizziness related to it." Some of the symptoms that were not addressed as well that contributed to all of this was in January of 2002, at Quantico, VA. I was demonstrating to the officer candidates at OCS, the proper way to complete the "Combat Course". Well during this time it was very cold with snow on the ground. The water portion of the combat course was iced over. Once our fire team reached the beginning of the water we had to bust through it with the butt of our rifles to get into the very frigid waters. The other team members had wet suites on. I had no wet suit, because there were not enough of them. Since I was a sergeant the wet suite were given to the corporals and lance corporals. We ended up in the water for over ten minutes and by the time we reached the cargo nets, I could not move. I made it to the top of the cargo nets and from there the last thing I remember was the corpsman telling me to strip off my clothes, but I could not. The nest thing I knew I was naked and wrapped in blankets in the back of the medic wagon. My temperature had not yet been taken and was not taken until I was taken to the BAS. I still suffer from residuals of cold injuries. I ask that the board find in my favor add rate me at least 30% and grant me permanent medical retirement from the United States Marine Corps."

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RATING COMPARISON:

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| --- | --- |
| **Service PEB** | **VA (6 Mo. after Separation)** |
| **Unfitting Conditions** | **Code** | **Rating** | **Date** | **Condition** | **Code** | **Rating** | **Exam** | **Effective** |
| PLAQUE STAGE PSORIASIS | 7816 | 10% | 20031118 | Psoriasis | 7816 | 0%10% | 20040413STR & 20040915  | 20040101 |
| ADDITIONAL MUSCULOSKELETAL DIAGNOSES DEFERRED TO PRIMARY CARE PROVIDER OR ORTHOPEDIST  | Category III: Conditions that are not separately unfitting and do not contribute to the unfitting condition(s) | Chronic Right Knee Strain | 5299-5010 | 0%10% | 20040413STR & 20040915  | 20040101 |
| Chronic Right (major) Wrist Strain | 5215 | 0%10% | 20040413STR & 20040915 | 20040101 |
| Chronic Left Knee Strain | 5260-5024 | 0%10% | 20040413\*20070212 | 2004010120070212 |
| Chronic Cervical Strain | 5237 | 0%10% | 20040413STR & 20040915 | 20040101 |
| Chronic Lumbar Strain | 5237 | 10%20% | 20040413\*20070212 | 2004010120070212 |
| Chronic Right Ankle Strain | 5271 | 0%10% | 20040413STR & 20040915 | 20040101 |
| Chronic Left Ankle Strain | 5271 | 0%10% | 20040413\*20070212 | 2004010120070212 |
| Right calf punch biopsy scar | 78057804 | 0%10% | 20040413\*20070212 | 2004010120070212 |
| Right Shoulder Scar | 7805 | 0% | 20040413 | 20040101 |
|  |  | None | Tinnitus | 6260 | 10% | 20040420 | 20040101 |
|  |  | NARSUM (STS) | Bilateral hearing loss | NSC |  |  |  |
| **TOTAL Combined: 10%** | **TOTAL Combined (*Includes Non-PEB Conditions*):** **50% from 20040101****70% from 20070212****Increased 20070601 to include Dx of "psoriatic arthritis"****\* VA treatment and evidence from 200609-200702** |

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**Analysis summary:**

Commanding Officer's Comments 20030918:

What is the average number of work hours per week that the member's condition has required the member to be away from current duties for treatment? Twenty hours. While Sergeant B--- has continued to discharge his duties faithfully with a positive attitude, the presence of the ring like skin lesions covering his body have severely impacted his ability to perform physical tasks, particularly in a warm environment - a critical aspect of his occupational specialty. His medical records indicate that in February 1999, after receiving his first Anthrax vaccination, he experienced a rash on his lower abdomen. The rash resolved and then returned after the 2nd dosage of the Anthrax vaccination in Feb 1999. Since the first appearance of the rash, it has transformed into skin lesions resembling small blister rings that cover his entire body, to include his genitalia. Sergeant B--- also suffers from severe knee, ankle and back pain, possibly stemming from psoriatic arthritis. During physical exercise, hot weather and cold weather, the lesions seem to inflame and cause extreme discomfort. While taking showers Sergeant B--- complains the water burns the rashy areas and he cannot stay in the shower for more than 5 minutes at a time. His physical appearance draws attention to him when he's wearing shorts. To alleviate people starring at him he avoids wearing clothing that reveals parts of his body. Based on the assessment of Sergeant B---'s immediate chain of command, I recommend he be discharged from the United States Marine Corps.

**Condition 1: PLAQUE STAGE PSORIASIS**

**IPEB (20031118):** **Plaque Stage Psoriasis, 7816 at 10%**

**NARSUM (**20030825**):** MILITARY HISTORY: The patient is an active duty, Caucasian male, E-5, who entered in active duty on 03 February 1998 at Camp Pendleton, with multiple assignments overseas to include Hawaii and Okinawa. He is now stationed at Quantico.

CHIEF COMPLAINT: Recurrent and chronic skin condition.

HISTORY OF PRESENT ILLNESS: Sergeant B--- had a history of a scaling rash on his trunk, which was first noted as per the chart in November of 1999. This was initially diagnosed as tinea corporis. According to notes at that time, the patient stated that it was a red, scaling, itchy eruption of his trunk, treated as tinea corporis. Subsequently, the patient states that it had erupted after his anthrax vaccination series. According to his chart, he had received the anthrax shots on 10 February 1999, 22 February 1999 and 19 March 1999, with the noted scaling eruption in November of 1999. Subsequent review of his medical chart documented multiple visits to either primary care or dermatology. The next note was documented on 17 December 2001, approximately two years after the first note documenting the rash. Supposedly at that time according to the history of present illness section, the patient had noted a four month history of a red scaling rash, which was again diagnosed as tine corporis. The patient was treated with ketoconazo1e for ten days oral course; however, according to subsequent visits documented on 16 November 2001, he had not respond as before and he was switched to griseofulvin orally to treat the suspected tinea infection. Further notes documented that the rash did not resolve after treatment with griseofulvin on 16 November 2001 and he was seen again by dermatology on 11 February 2002, approximately two months after the last doctor's visit, where he was diagnosed by a staff dermatologist, Dr. C---, with having psoriasis. At the present time, he was treated with Temovate, a strong topical steroid, as well Aquaphor moisturizer. Subsequent visits documented multiple dermatologic consultations, including 12 July 2002, where Dovonex ointment was added to the treatment, and 28 January 2003, where a biopsy was performed to solidify the diagnosis and results were consistent with psoriasis. At a subsequent visit on 16 April 2003, clobetasol and triamcinolone steroid creams were used together to treat the rash. Finally, on 30 July 2003, the patient was again prescribed Dovonex for his plaque psoriasis. Most recently, the patient was evaluated on 25 August 2003, where the patient came in with the complaint that he was not adequately educated about his condition and he thought that the Anthrax vaccine had precipitated the psoriasis and he had begun a Congressional inquiry about his whole medical condition. At the present time, he had a chief complaint of soreness and irritation in the affected skin areas of the psoriasis; specifically after physical training, he said that he had exacerbated lesions where they would become red, swollen and painful. He also noted that they were irritated with activities such as combat simulation, low crawls, whereas they would get irritated against his uniform. The patient also had a myriad of other complaints including musculoskeletal concerns and he had stated that he was concerned about the possibility of having psoriatic arthritis. Upon further questioning, the patient expressed an interest in initiating a Medical Board secondary to his chronic skin condition and symptomatology.

ALLERGIES: THE PATIENT HAS A SELF-REPORTED ALLERGY TO ANTHRAX VACCINE.

CURRENT MEDICATIONS: Triamcinolone ointment; clobetasol ointment; Dovonex ointment; Naprosyn intermittently for musculoskeletal complaints.

PAST MEDICAL HISTORY: Is significant for multiple musculoskeletal complaints including chronic knee pain and wrist pain, secondary to a cyst. According to his chart, the cyst was evaluated by MRI and was consistent with degenerated subchondral cyst. The patient has a history of panic attacks during a difficult emotional period for him, which was documented in the chart. He also has a history of minor musculoskeletal complaints, back pain and ankle pain. No other medical conditions were documented.

PAST SURGICAL HISTORY: The patient stated that he had no history of prior surgeries.

SOCIAL HISTORY: The patient states that he does not smoke and he drinks alcohol approximately one time per month.

REVIEW OF SYSTEMS: Musculoskeletal - the patient complains of chronic knee pain. He states that this knee pain is worse in the morning and improves throughout the day, although it is chronic in nature and prevents him from engaging in full PT or combat training activities. The patient had complaints of pain at the biopsy sites with additional complaints of pain, irritation and neurologic symptoms in the areas of the previous two 4 mm punch biopsies of the lower extremities, which were performed on 28 January 2003. Pertinent positives include the skin examination, with patient noting severe irritation of his psoriasis plaques, especially upon physical exertion as well as during activities such as low crawl where he will traumatize the areas by crawling on the ground using his knees. The patient states that after physical training the areas get red, inflamed, painful and irritated. The patient does not have any other specific complaints.

PHYSICAL EXAMINATION: The full physical examination was deferred to the primary care provider. The patient was a well-appearing, young, active duty, Caucasian male, in no apparent distress. Musculoskeletal examination did not reveal any swelling or reduction in range of motion of all affected extremities. There was no pain or tenderness in the hands or swelling of the metacarpophalangeal joints. There was no axial rigidity and there was full range of motion. Skin examination included multiple erythematous patches and plaques distributed on the anterior shins as well as at the knees, with scattered patches and plaques, predominantly on the lower extremities as well as the proximally extremities. There were no active lesions of the scalp, no involvement in the gluteal clefts and there was no noticeable nail involvement.

LABORATORY & X-RAY DATA: Extensive laboratories were performed on 19 September 2002 including CBC, rheumatoid factor, urinalysis, liver function tests, RPR and erythrocyte sedimentation rate, all of which were within normal limits On 28 January 2003, the patient had two biopsies (A. Punch biopsy, right calf; B. Punch biopsy, right posterior arm), which showed on Specimen A, a diagnosis of psoriasiform dermatitis, consistent with psoriasis and special stains negative for fungal elements, and on Specimen B psoriasiform dermatitis, consistent with psoriasis and again special stains negative for fungal elements. The patient had no electrocardiogram performed. Recent radiologic studies included MRI of the knee performed on 01 October 2002 demonstrated fraying of the medial edge of the body of the lateral meniscus with accompanying moderate to several focal lateral tibial plateau bruising and no ligamentous or cartilaginous abnormalities as queried. On 31 January 2003, right wrist x-ray demonstrated very mild tendinopathy of the extensor carpi ulnaris tendon, without subluxation, thickening or tear, with degenerative subchondral cyst in the pisiform.

DIAGNOSES: 1. Plaque stage psoriasis. 2. Additional musculoskeletal diagnoses deferred to primary care provider or orthopedist.

PHYSICAL PROFILE: There is no current profile concerning the patient's skin condition. CURRENT CONDITION: Sergeant B--- is currently unable to perform his military duties as reflected by the member. Direct supervisors have not contacted us. The patient is very concerned with his physical condition and he has initiated a Congressional inquiry about his skin condition. The soldier states that his current medical condition has significantly impacted his personal life, both cosmetically as well as physically. He states that he believes that his skin condition is unsightly and attempts at all opportunities to wear or reclusive or obstructive clothing. Physically, he believes that when he engages in physical activity that it worsens his rash. PROGNOSIS: Sergeant B--- is likely to require life-long ongoing therapy for his skin condition, which at this point in time is limited to plaque stage psoriasis, and he will need to be followed by a dermatologist or primary care provider with knowledge of this condition. RECOMMENDATIONS: Sergeant B---'s current medical condition of chronic psoriasis precludes him from continuation on active duty; and he is, therefore, going to be referred to the Physical Evaluation Board for further evaluation and disposition. At the current state of psoriasis, the patient will most likely continue to be treated topically with the use of both Dovonex ointment as well as a topical steroid preparation of various strengths, depending upon the severity of his condition. The patient has been educated about the other organ systems which can be involved with psoriasis, including the musculoskeletal system. The patient's condition is most likely to remain stable, based upon its limited body surface involvement, currently at less than 10%. We do not believe at this point that the patient will need systemic therapy to treat his skin condition, although this is impossible to predict with 100% certainty. He will need to be followed up at least yearly for this condition by a dermatologist or by a primary care physician educated in psoriasis. We believe that his condition is not compatible with active duty, combat status or field status due to the fact that these conditions worsen in field environments for a variety of reasons to include lack of continuous medical treatment, self-treatment, access to medications and physical conditions such as friction trauma, which has been known to worsen psoriasis. The patient could serve the military within a non-combat environment. We do not believe that the patient has any evidence of psoriatic arthritis, which usually affects the hands almost universally or the central axial skeleton in sacroiliac disease as per patient's complaints and current evaluation; however, we would defer to rheumatology for that diagnosis. The patient should be assigned near a medical facility capable of management of his condition. Other limitations are deferred to the Medical Board summary.

**MEB exam signed 20030918** noted "skin clear today (h/o psoriasis)". Prior clinical notes from Jan-Jul 2003 had various diagrams of psoriatic lesion location including bilateral anterior lower extremities distal to the knees, bilateral upper extremity flexor creases at elbow, and anterior thorax and abdomen.

**Service Treatment records:** Numerous treatment notes for skin condition and changes of topical medication.

**VA:** Using evaluations completed (20040413 and 20040915) 4 and 9 months post-separation from the USMC, the Veterans Administration (VA) rated this disability as 7816 at 10% (initially 0% changed to 10% by DRO including intervening VA exams).

**Rating Decision (date 20040806 with DRO of 20050208):** Service medical records indicated that you developed a body rash in 2001, that was initially diagnosed as tinea corporis and later revised to psoriasis. Treatment was by application of topical cream. At your VA examination you indicated that the skin disorder causes irritation, itching, and sensitivity to hot and humid weather. Physical examination showed a few psoriatic patches almost entirely on the lower extremities; The rest were a few small linear patches along the hair line. No ulceration, exfoliation, crusting, tissue loss, induration, inflexibility, abnormal texture, limitation of motion or significant pigment changes are present. The psoriatic rash covered less than 1 percent of the exposed area and less than 1 percent of the whole body. On DRO Review of 20050208 this was changed to a 10% rating: We have granted an increased evaluation of 10 percent for your psoriasis based on the evidence discussed below. An evaluation of 10 percent is assigned with evidence of at least 5 percent, but less than 20 percent, of the entire body, or at least 5 percent, but less than 20 percent, of exposed areas affected; or intermittent systemic therapy such as corticosteroids or other immunosuppressive drugs are required for a total duration of less than six weeks during the past 12-month period. A higher evaluation of 30 percent is not assigned unless the record shows 20 to 40 percent of the entire body or 20 to 40 percent of exposed areas affected; or systemic therapy such as corticosteroids or other immunosuppressive drugs are required for a total duration of six weeks or more, but not constantly, during the past l2-month period. The separation examination dated September 18, 2003 noted a history of psoriasis with skin clear on physical examination. The QTC Medical Services examination on April 13, 2004 revealed a few psoriatic patches almost entirely on the lower extremities with a few small linear patches along the hair line. Your VA treatment records revealed psoriatic patches over the flexor surfaces of the lower extremities and on the chest at the time of a physical examination on September 15, 2004.

**Discussion:** Although the MEB exam noted no psoriatic lesions, the NARSUM and PEB rating were for "limited body surface involvement, currently at less than 10%." Proximate to separation, VA exam of 20040413 "revealed a few psoriatic patches almost entirely on the lower extremities with a few small linear patches along the hair line." The VA did not rate the CI for scar or disfigurement of the head (7800 through 7805), and there was not sufficient exam detail to meet the rating characteristics of 7800 or pain, instability, or surface area of 7801 to 7805. Prior STR clinical notes from Jan-Jul 2003 had various diagrams of the CI's psoriatic lesion locations including bilateral anterior lower extremities distal to the knees, bilateral upper extremity flexor creases at elbow and mid upper arm, and anterior thorax and abdomen. Using the interpretation of "exposed areas affected" as short sleeves with long pants and shoes/socks, the CI did not have equal to or greater than 20% of his affected area involved. The diagram of 20030128 could be interpreted as covering 20%, but less than 40% of the body surface area. This was when the CI's psoriasis was first biopsy-proven and precedes medication changes for improved treatment. The Commander's statement of 20030918 "His physical appearance draws attention to him when he's wearing shorts."; could be interpreted as extensive bilateral lower extremity skin involvement, but would not be considered as "exposed skin", nor raise the total body surface area covered, as the STR indicated the lower extremities were the predominately affected areas. The VA records and exams indicated worsening of the CI's skin condition, eventually requiring systemic therapy years after discharge which may have been for the later skin or joint involvement. This does not indicate an error of either diagnosis or rating at the time of the CI's discharge, but rather a worsening of the CI's condition. The CI was correctly rated as 7816, Plaque Stage Psoriasis at 10%.

**Condition 2: Additional musculoskeletal diagnoses (pain in bilateral knees, ankles, and spine; and cyst on right wrist)**

**IPEB (20031118):** ADDITIONAL MUSCULOSKELETAL DIAGNOSES DEFERRED TO PRIMARY CARE PROVIDER OR ORTHOPEDIST. Category III: Conditions that are not separately unfitting and do not contribute to the unfitting condition(s)

**NARSUM (**20030825**):** The patient also had a myriad of other complaints including musculoskeletal concerns and he had stated that he was concerned about the possibility of having psoriatic arthritis; PAST MEDICAL HISTORY: Is significant for multiple musculoskeletal complaints including chronic knee pain and wrist pain, secondary to a cyst. According to his chart, the cyst was evaluated by MRI and was consistent with degenerated subchondral cyst. The patient has a history of panic attacks during a difficult emotional period for him, which was documented in the chart. He also has a history of minor musculoskeletal complaints, back pain and ankle pain. No other medical conditions were documented; REVIEW OF SYSTEMS: Musculoskeletal - the patient complains of chronic knee pain. He states that this knee pain is worse in the morning and improves throughout the day, although it is chronic in nature and prevents him from engaging in full PT or combat training activities; PHYSICAL EXAMINATION: The full physical examination was deferred to the primary care provider. The patient was a well-appearing, young, active duty, Caucasian male, in no apparent distress. Musculoskeletal examination did not reveal any swelling or reduction in range of motion of all affected extremities. There was no pain or tenderness in the hands or swelling of the metacarpophalangeal joints. There was no axial rigidity and there was full range of motion; Recent radiologic studies included MRI of the knee performed on 01 October 2002 demonstrated fraying of the medial edge of the body of the lateral meniscus with accompanying moderate to several focal lateral tibial plateau bruising and no ligamentous or cartilaginous abnormalities as queried. On 31 January 2003, right wrist x-ray demonstrated very mild tendinopathy of the extensor carpi ulnaris tendon, without subluxation, thickening or tear, with degenerative subchondral cyst in the pisiform. DIAGNOSES; 2. Additional musculoskeletal diagnoses deferred to primary care provider or orthopedist. PROGNOSIS: Sergeant B--- is likely to require life-long ongoing therapy for his skin condition, which at this point in time is limited to plaque stage psoriasis, and he will need to be followed by a dermatologist or primary care provider with knowledge of this condition. RECOMMENDATIONS: …We do not believe that the patient has any evidence of psoriatic arthritis, which usually affects the hands almost universally or the central axial skeleton in sacroiliac disease as per patient's complaints and current evaluation; however, we would defer to rheumatology for that diagnosis.

MEB exam (20030918): Noted normal musculoskeletal examination without formal measured ROMs.

**Service Treatment records:** There was no diagnosis of psoriatic arthritis in the record.

**VA:** Using evaluation completed 13 and 20 Apr 2004 (4 months following separation from the USMC) and Exams and VA treatment records and exam of 20040915 (9 months after separation), the Veterans Administration (VA) rated these conditions predominately under the musculoskeletal system codes for painful motion at 10%. The numerous non-compensable initial RD's for musculoskeletal complaints were changed following reconsideration and added exams and information by VARD 20050208. The VARD of 20070522 (exams in Nov 06 to Jun 07) added psoriatic arthritis involvement to lumbar, cervical, bilateral ankles, bilateral wrists, right hand and left hip. Right knee and left ankle did not have psoriatic involvement. All joints were at 10% with the lumbar and cervical spine segments each rated at 20% by Jun 07. Later VA exams of 2009 continued to show medication use and painful musculoskeletal joints and spine segments.

**Chronic lumbar strain:** Service medical records indicated that you experienced recurrent low back problems since November of 1999. The condition was assessed as paraspinal muscle spasm/mechanical low back pain and treated by pain medication. At your VA examination, you reported experiencing a recurrent dull lower back ache that does not radiate. Physical examination indicated that you had full painless lumbar motion. The impression was chronic lumbar strain.

**Chronic left knee strain:** Complained of experiencing left knee pain at your separation examination and were diagnosed with patellofemoral pain syndrome. At your VA examination, you reported experiencing left knee pain with increased activity. Physical examination indicated that the left knee had extension to 0 degrees (normal) and flexion to 120 degrees (140 being normal). The joint was stable, and without crepitus, effusion, subluxation or locking pain. The impression was chronic left knee strain.

**Chronic right knee strain:** Recurrent right knee problems since July of 2000. The condition was assessed as iliotibial band syndrome/patellofemoral pain syndrome and treated with rest and pain medication. At your VA examination, you reported experiencing right knee pain with increased activity. Physical examination indicated that the right knee had normal painless range or motion. The joint was stable, and without crepitus, effusion, subluxation or locking pain. The impression was chronic right knee strain.

**Chronic left ankle strain:** Recurrent left ankle problems since January of 2002. The condition was assessed as a sprain and treated with rest and pain medication. At your VA examination, you repotted experiencing left ankle pain with increased activity. Physical examination indicated that the left ankle full painless range of motion without deformity being present. The impression was chronic left ankle strain.

**Chronic right ankle strain:** Recurrent right ankle problems since January of 2002. The condition was assessed as a sprain and treated with rest and pain medication. At your VA examination, you reported experiencing right ankle pain with increased activity. Physical examination indicated that the right ankle full painless range of motion without deformity being present. The impression was chronic right ankle strain.

**Chronic right wrist strain:** You were seen with complaints of right wrist pain since January of 2002. MRI study demonstrated very mild tendinopathy, and the condition was assessed as tendonitis. At your VA examination, you reported experiencing right wrist pain after holding onto an object for a few minutes or after writing for 5 minutes. Physical examination indicated that the right wrist was without tenderness and had full painless range of motion. The impression was chronic right wrist strain.

**Neck pain:** You were seen on July 11, 2003 with complaints of neck pain. There was no specific disorder diagnosed, and you were instructed to follow-up if symptoms persisted. There were no additional treatment consults for this condition and your separation examination was also negative for any complaints or findings. In addition, your VA examination of April 13, 2004, was also negative for any complaints or findings relative to a neck disorder.

Discussion: The CI had multiple musculoskeletal complains of joint and spine pain without any instability. The only joints with imaging abnormalities were the knee with traumatic-type changes and the right wrist with mild tendinopathy. All ROMs were normal on both the MEB physical and in the NARSUM. There did not appear to be significant duty restrictions attributable to the joints or spine. The CI did not have a diagnosis of psoriatic arthritis until 3 years following separation and the records demonstrated worsening of the CI's psoriasis and musculoskeletal conditions post-separation. All evidence considered there is not reasonable doubt in the CI’s favor supporting recharacterization of the PEB fitness adjudication for the multiple musculoskeletal conditions. The Board can make no recommendation for any additionally unfitting conditions.

**Condition 3: Hearing Loss and Tinnitus.** The CI contends: "STS (hearing loss) has never gone away but has in fact gotten worse. I get a headache every time the ringing begins in my ears (Tinnitus). … even had dizziness (vertigo?) related to it."

Audiogram (20030313) demonstrated mild bilateral high frequency hearing loss and established as a re-established baseline. The CI was returned to duty without restrictions (20030912) by hearing conservation.

VARD 20040806: Results of your VA examination were reviewed and considered, but failed to show findings of hearing loss for VA purposes.

Discussion: The MEB H&P noted the CI's STS (hearing threshold shift), but there was no impact in speech discrimination noted in either the STR or VA documents. Hearing loss was not to the level of interfering with duty and did not rise to the level of being unfitting. Tinnitus was not noted in the STR, but any unfitting tinnitus would have had to interfere with duty or speech recognition, which was not noted in the record. The Board, therefore, has no reasonable basis for recommending either as unfitting conditions for separation rating.

**Condition 4: Painful punch biopsy scar, right calf.** The right calf punch biopsy scar was mentioned in the NARSUM. There was no limitation of motion from the punch biopsy. Tenderness was noted in STR notes and the scar was noted on the MEB physical.

VARD 20040806: "…underwent a punch biopsy of the right calf on January 28, 2003. Separation examination noted scar over the right calf area. Your VA examination was negative for any complaints relative to this issue."

Discussion: This condition did not rise to the level of being unfitting. The Board, therefore, has no reasonable basis for recommending this condition as unfitting conditions for separation rating.

**Other Conditions.** The CI's cold injury is not a ratable disability and there was no disability condition linked to the cold exposure. The CI's right shoulder scar was not noted in the DES file and is therefore outside the scope of the Board. The CI's contention for mental health difficulty was not supported in the DES file or NARSUM. The NARSUM did note: "The patient has a history of panic attacks during a difficult emotional period for him, which was documented in the chart." There was no mental health Axis I diagnosis proximate to the CI's separation. The Board, therefore, has no reasonable basis for recommending any additional unfitting conditions for separation rating.

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BOARD FINDINGS: IAW DoDI 6040.44, provisions of DoD or Military Department regulations or guidelines relied upon by the PEB will not be considered by the Board to the extent they were inconsistent with the VASRD in effect at the time of the adjudication. The Board did not surmise from the record or PEB ruling in this case that any prerogatives outside the VASRD were exercised.

In the matter of the Plaque Stage Psoriasis condition and IAW VASRD §4.118, the Board unanimously recommends no recharacterization of the PEB coding or rating. Given the CI's limited body surface involvement of less than 10% and no diagnosis of psoriatic arthritis, the CI was appropriately rated under 7816 at 10%. The CI's psoriasis at discharge was confined to the skin and he did not have a diagnosis of psoriatic arthritis of any joint or spine segment. All skin exams proximate to discharge indicated an involvement of less than 10% of the entire body, or of exposed areas affected and the CI had not been on intermittent systemic therapy such as corticosteroids or other immunosuppressive drugs. In the matter of the CI's musculoskeletal complaints for bilateral knees, ankles, and spine; and a cyst on the right wrist, there was no diagnosis of psoriatic arthritis proximate to the date of CI's discharge. The VA treatment records and exams demonstrated worsening of the CI's psoriasis condition over the years following separation, with the first diagnosis of psoriatic arthritis three years following separation. This is not adjudged to indicate a missed diagnosis at the time of the CI's separation, but significant worsening of the CI's psoriasis mirroring his worsening of skin symptoms and requirements for systemic therapies. None of the musculoskeletal limitations noted in the records proximate to the date of CI's separation would have been unfitting. The Board, therefore, has no reasonable basis for recommending any additional unfitting musculoskeletal conditions for separation rating. In the matter of the multiple musculoskeletal conditions the Board unanimously recommends no recharacterization of the PEB adjudication as not unfitting. In the matter of a history of cold injury, hearing loss, and painful right calf punch biopsy scar, none of these conditions rose to an unfitting level and all evidence considered, the Board, has no reasonable basis for recommending any of these conditions for separation rating. The other diagnoses, right shoulder scar and tinnitus rated by the VA were not mentioned in the Disability Evaluation System (DES) package. Additionally, there was no compensable mental health diagnosis proximate to the CI's separation and these conditions are therefore outside the scope of the Board. The CI retains the right to request his Navy Board of Correction for Naval Records (BCNR) to consider adding these conditions as unfitting.

The Board unanimously voted for no recharacterization of the PEB coding 7816 or rating at 10%, with no additional unfitting conditions.

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RECOMMENDATION: The Board therefore recommends that there be no recharacterization of the CI’s disability and separation determination.

|  |  |  |
| --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| PLAQUE STAGE PSORIASIS | 7816 |  10% |
| **COMBINED** | **10%** |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20090125, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

 President

 Physical Disability Board of Review

MEMORANDUM FOR DIRECTOR, SECRETARY OF THE NAVY COUNCIL OF REVIEW

 BOARDS

Subj: PHYSICAL DISABILITY BOARD OF REVIEW (PDBR) RECOMMENDATION

 ICO XXXX

Ref: (a) DoDI 6040.44

 (b) PDBR ltr dtd 25 Jan 10

 I have reviewed the subject case pursuant to reference (a) and approve the Physical Disability Board of Review recommendation as contained in reference (b). The PDBR has recommended that no change in either the characterization of separation or in the disability rating previously assigned by the Department of the Navy’s Physical Evaluation Board be initiated.

 Principal Deputy

 Assistant Secretary of the Navy

 (Manpower & Reserve Affairs)