RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: NAVY

CASE NUMBER: PD0900069 BOARD DATE: 20100203

SEPARATION DATE: 20050603

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SUMMARY OF CASE: This covered individual (CI) was a Second Class Petty Officer Mineman who was medically separated from the Navy in 2005 after 7.5 years of service. The medical basis for the separation was for the “overall effect“ of three different conditions: Unresolved Bereavement, Chronic Thoracic Back Pain and Right Upper Quadrant Pain. The overall effect of the conditions was determined to be medically unacceptable. The CI was referred to the Physical Evaluation Board (PEB), found unfit for continued military service and separated at 0% disability using the Veterans Affairs Schedule for Ratings Disabilities (VASRD) and applicable Naval and Department of Defense regulations.

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CI CONTENTION: The CI states: “I was in the navy for 7 1/2 years and when I faced the PEB board they told me to be separated unfit with a rating of 0% and after filing with the VA they rated me 100% and 50% of that rating was just my back injury and the whole reason for the PEB board where they said i had "unresolved bereavement ,chronic thoracic back pain, upper right quandrant pain", and the "unresolved bereavement" later would be called PTSD by the VA. I served my country with honor, and am a OFI/OEF veteran. I feel that my country should do my family right, but instead I have a wife and three kids without insurance. I filed my claim with the VA the day after leaving the US NAVY, it took our family three months to receive a 40% rating for my back injury and took the PEB board 9 months to give me 0% and it took the VA 9 months to diagnose my PTSD from serving for 2 1/2 years in the gulf during OEF and OIF and rate me at 100% permanently disabled and it took the PBR board 9 months to call it unresolved bereavement when it should have been PTSD. When i got out of the navy they told me my hearing was fine, well as you can see from the doctor I'm deaf in one ear and have limited in the other and wearing two hearing aids every day. thanks for your time.“

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RATING COMPARISON:

|  |  |
| --- | --- |
| Service PEB | VA (3 Mo. after Separation) |
| **Condition** | **Code** | **Rating** | **Date** | **Condition** | **Code** | **Rating** | **Exam** | **Effective** |
| Unresolved Bereavement | Cat I(Overall effect) | 0% Overall | 20050421 | Anxiety Disorder | 9413 | NSC | 20050825 |  |
| PTSD | 9411 | 50%70% | VA Records20090623 | 2006020220090323 |
| Chronic Thoracic Back Pain | Lumbar Degenerative Disc Disease and Thoracic Scoliosis | 5242 | 20% | 20050825 | 20050604 |
| Right Upper Quadrant Pain | Spastic Duodenal Bulb and Rectal Polyps | 7399-7346 | 10% | 20050825 | 20050604 |
| Left Sensorineural Hearing Loss, Mild | Cat III--Those conditions that are not separately unfitting, and do not contribute to the unfitting condition. |  | Bilateral Hearing Loss | 6100 | 10%30% | 2005082520070309 | 2005060420070104 |
| Obesity | Cat IV | n/a |  |  |  |  |  |  |
|  |  |  | Tinnitus | 6260 | 10% | 20050825 | 20050604 |
|  |  |  | Sinusitis of Maxillary, Ethmoid and Right FrontalSinuses | 6512 | 0% | 20050825 | 20050604 |
|  |  |  | Allergic Rhinitis | 6522 | 0% | 20050825 | 20050604 |
| . | Individual unemployability from 20060202 |
| TOTAL **(Overall effect): 0%** | TOTAL Combined (*Includes Non-PEB Conditions*): 40% from 2005060470% from 20060202 80% from 2007010490% from 20090323  |

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ANALYSIS SUMMARY:

Condition 1: Back Pain and Right Upper Quadrant Pain

This CI first reported pain in his lower back in 1998 after lifting heavy concrete blocks while on duty. The pain worsened over time and he was seen intermittently for treatment. By October 2004 he also developed a pain in the right upper lateral thoracic region anteriorly, just under the lower costal margin. Pain was present in the lumbosacral area, more right sided and under the right anterior costal margin.

A very extensive gastrointestinal (GI) system work-up was completed to assess the pain under the right anterior costal margin. However all GI causes of right upper quadrant (RUQ) pain were ruled out and no GI diagnosis was found. A comprehensive psychiatric work-up ruled out conversion and somatoform disorders.

The CI also received a comprehensive evaluation upon referral to a pain clinic on 20050125. This evaluation revealed that the RUQ pain was due to costovertebral joint dysfunction, predominately right sided, in the lower thoracic area, with probable referral of pain to the anterior costal region. The CI also had significant thoracic facet dysfunction as well as a longstanding history of low back pain with sacroiliac joint and lumbar facet dysfunction with segmental instability and significant myofascial involvement with muscle guarding and spasms. The pain clinic provided a series of thoracic facet injections as well as epidural injections which brought only temporary relief. His condition was considered permanent and it was noted that he will require six sets of injections each year for the rest of his life. The CI also received physical therapy but this did not provide much relief of his pain.

The CI’s primary care manager completed his Medical Evaluation Board (MEB) History and Physical Examination and Narrative Summary (NARSUM). These evaluations concluded that the CI’s condition interfered with the performance of his military duties and he was referred to the PEB. No range of motion (ROM) measurements were documented in the service treatment record but the examination did note limited ROM in all directions secondary to pain. The CI had complained of his right leg giving out and going numb. However no motor or sensory abnormalities were documented and reflexes were 2+ and equal in both lower extremities. No EMG or nerve conduction studies were done. The CI had been moved to an administrative position as he was not able to perform his regular duties.

Using an evaluation completed approximately 3 months after the time of separation from the Navy, the Veterans Administration (VA) rated this disability as Lumbar Degenerative Disc Disease and Thoracic Scoliosis at 20%. Findings of the VA evaluation are in the chart below and include a complete ROM examination with flexion limited to fifty degrees by pain. No neurologic abnormality was noted.

While the VA examination is more complete, its findings are consistent with the Navy examination. The Navy examination does not quantify the amount of limitation of the ROM but does document limitation was present in all directions. Also motor, sensory, and reflex examinations are identical and neither examination documents any evidence of a radiculopathy. X-rays documented degenerative arthritis. An MRI documented multilevel mild thoracic spondylosis along with a T3 to T4 small central herniated disc that caused mild central stenosis and minimal impingement upon the ventral aspect of the thoracic cord.

|  |  |  |  |
| --- | --- | --- | --- |
| MovementThoracolumbar | NormalROM | ROM Mil20050322 | ROM VA20050825 (pain) |
| Flex | 0-**90** |  | 50 |
| Ext | 0-**30** |  | 20 |
| R Lat flex | 0-**30** |  | 20 |
| L lat flex | 0-**30** |  | 20 |
| R rotation | 0-**30** |  | 20 |
| L rotation | 0-**30** |  | 20 |
| COMBINED | 240 |  | 150 |
| Notes: |  | Normal motor and sensory. Pain over the thoracic spine; limitations of flexion secondary to the pain. No obvious deformity or obvious scoliosis; ROM in all directions is limited secondary to this thoracic pain.  | Normal posture and gait; additionally limited by pain and fatigue after repetitive motion; positive muscle spasm and tenderness to palpation; radiating pain, positive SLR bilateral; no signs of disc disease with chronic and permanent nerve root involvement; normal motor and sensory exam, reflexes 2+ and equal bilaterally. X-Ray: thoracic scoliosis, degenerative arthritis of lumbar spine |

Condition 2: Mental Health

The CI had previously been seen for mental health issues (anxiety) in 1998 after being in service only six months. No psychiatric diagnosis was made, he was found fit for duty, and no psychiatric follow-up was recommended.

After the complete GI work-up had failed to find a cause for the CI’s RUQ pain, along with an additional month of continued symptoms without explanation or resolution accompanied by ongoing requests for Lortab his primary care manager referred him to psychiatry. A comprehensive psychiatric evaluation was completed on 20050105. This evaluation determined the CI did not have a psychiatric diagnosis and specifically documented that he did not meet the diagnostic criteria for either conversion disorder or somatoform disorder. The CI denied every symptom he was questioned about stating he was happy and had no stress whatsoever either at home or at work. He specifically denied any sleep disturbance even though he had repeatedly complained about difficulty falling and staying asleep to his primary care manager.

The psychiatrist did note that the CI had unresolved issues related to the death of his step-father with whom he had been very close and that his RUQ pain was related to this unresolved bereavement. However, the subsequent pain clinic consult concluded the RUQ pain was due to costovertebral joint dysfunction, predominately right sided, in the lower thoracic area, with probable referral of pain to the anterior costal region.

The psychiatric evaluation revealed that his step-father, who he saw as his only father figure, had died from metastatic throat cancer on 9/17/04. The CI had not grieved this loss and reported his only coping mechanism for his grief had been to return to work. His right flank pain began shortly after the death of his step-father. He reported that his step-father's metastatic disease was first evident on his right flank and then spread outward. His step-father apparently refused to seek medical care, requested to be placed in a nursing home just shortly before his death, and requested that the patient not return to see him or attend any funeral services after his step-father died. The CI was initially conflicted about not attending the funeral as he did wish to do this, but ultimately decided to comply with his step-father's wishes. He did report that his wife had told him on several occasions that she believed his physical complaints and intermittent irritability were due to his "worrying over my father too much". The CI stated he had often thought of him since his death. No psychiatric diagnosis was made and the symptom of unresolved bereavement was the only abnormality noted.

At the initial VA C&P exam, two months after separation, the CI admitted to multiple mental symptoms that had begun five years previously and he was diagnosed with anxiety disorder with an associated depressed mood. However, this condition was not service connected as it was never diagnosed while the CI was on active duty. The CI reported trouble sleeping for the past three years as well as constantly feeling nervous and having a short temper. The symptoms described occur constantly. He reported that his being nervous all the time affected his ability to perform daily functions. He had not sought any care for these symptoms and was not receiving any treatment. This VA examination revealed abnormal affect and mood with impaired impulse control and some unprovoked irritability and periods of violence and that affects motivation by having a short temper and irritability problem.

After separation, the CI was receiving the majority of his medical care at the VA. During the course of his regular care, a VA healthcare provider suspected the CI might have post-traumatic stress disorder (PTSD) and he was subsequently diagnosed with PTSD and depression (4 months after separation). A June 2005 PTSD screen had been negative. However, his wife had noticed several symptoms and she accompanied CI to later visits. The CI admitted more symptoms during visits to the VA in September and October 2005. He reported stressors of seeing multiple dead bodies when working on recovery efforts of the USS Cole bombing, an intercepted oil tanker, and an F-18 crash. He was diagnosed with PTSD and started on medication and therapy soon afterwards. He received an initial rating of 50%. His condition worsened over time and after a re-evaluation in 2009, his rating was increased to 70%.

It appears that the CI may have been denying mental symptoms while on active duty and at his initial VA evaluation. This initial denial commonly occurs with PTSD. While on active duty and during his initial VA evaluation he also had denied any significant use of alcohol but later admitted he was using alcohol to deal with his mental symptoms.

It is possible that the CI had undiagnosed PTSD while he was on active duty and this may have contributed to his inability to perform his required duties. The PEB did consider the mental symptom of unresolved bereavement as contributing to the determination of unfitness. The problems related to this issue may have actually been secondary to undiagnosed PTSD. Therefore the Board decided to consider determining whether PTSD contributed to the CI’s inability to perform his required duties.

Careful review of all available records revealed no specific evidence of mental symptoms affecting the CI’s ability to perform his required duties. He did have a decline in performance evaluations that could have been secondary to a mental condition such as PTSD. However, no evidence shows that the condition of PTSD, more likely than not, did exist while the CI was on active duty or that if PTSD did exist it, more likely than not, contributed to his unfitness.

Condition 3: Hearing

Using an evaluation completed approximately 3 months after the time of separation from the Navy, the Veterans Administration (VA) rated this disability as Bilateral Hearing Loss at 10%.

The CI did have a significant hearing loss but there is no evidence that this condition limited his ability to perform the primary duties of his rank, rate, or rating.

Other Conditions.

The other conditions rated by the VA; Tinnitus, Sinusitis of Maxillary, Ethmoid and Right Frontal Sinuses, and Allergic Rhinitis; are not mentioned in the DES package and are therefore outside the scope of the Board.

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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. After careful consideration of all available information, the Board unanimously recommends that the CI’s condition be rated at 20% for 5242 Chronic Thoracolumbar Back Pain IAW the VASRD General Rating Formula for Diseases and Injuries of the Spine.

The Navy PEB determined the CI was unfit for continued Naval Service based on the combined effect of unresolved bereavement, chronic thoracic back pain, and RUQ pain. Unresolved bereavement and RUQ pain are symptoms, not conditions that can be considered disabilities. However, as documented in the pain clinic consult and in the NARSUM, the CI’s RUQ pain was determined to be part of his thoracolumbar back pain and it is therefore included in the rating of his back pain. Flexion of the CI’s thoracolumbar spine was limited to fifty degrees and this warrants a 20% rating. There was no evidence of a radiculopathy or any other functional limitation that would warrant the application of any additional rating to the back condition.

The PEB also determined that Unresolved Bereavement contributed to the finding of unfitness. However, no psychiatric diagnosis was made prior to the CI’s separation from service and the CI repeatedly denied mental health symptoms. There is insufficient evidence to determine that PTSD or any other mental condition existed prior to separation. If a mental condition did exist prior to separation, there is insufficient evidence to determine the condition contributed to the CI’s inability to perform his required duties. The Board unanimously determined that there is insufficient evidence to determine PTSD was an unfitting condition.

The Board considered the condition of Hearing Loss and unanimously determined that this condition was not unfitting at the time of separation from service. The CI did have a significant hearing loss but there is no evidence that this condition limited his ability to perform his required duties.

The other conditions rated by the VA (Tinnitus; Sinusitis of Maxillary, Ethmoid and Right Frontal Sinuses; and Allergic Rhinitis) were not mentioned in the Disability Evaluation System (DES) package and are therefore outside the scope of the Board. The CI retains the right to request the Board of Correction for Naval Records (BCNR) to consider adding these conditions as unfitting.

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RECOMMENDATION: The Board recommends that the CI’s prior determination be modified as follows, effective as of the date of his prior medical separation.

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| UNFITTING CONDITION | VASRD CODE | RATING |
| Chronic Thoracolumbar Back Pain  | 5242 | 20% |
| COMBINED | 20% |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20090122, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

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**DEPARTMENT OF THE NAVY**

SECRETARY OF THE NAVY COUNCIL OF REVIEW BOARDS
 720 KENNON STREET SE STE 309
 WASHINGTON NAVY YARD DC 20374-5023

**IN REPLY** REFERTO

1850 CORB:003 24 Mar 2010

From: Director, Secretary of the Navy Council of Review Boards

To:

Subj: PHYSICAL DISABILITY BOARD OF REVIEW (PDBR)

Ref: (a) 0001 6040.44

(b) PDBR ltr of 18 Feb 10

1. Pursuant to reference (a), the PDBR reviewed your case and forwarded its recommendation (reference (b)) to the Department of the Navy for appropriate action.

2. On 23 March 2010, the Assistant Secretary of the Navy (Manpower & Reserve Affairs) took action in your case by accepting. the recommendation of the PDBR that your disability rating from the Department of the Navy be increased from zero (0) to twenty

(20) percent. The Secretary's decision represents final action on your case by the Department of the Navy.

3. The Secretary's determination has been forwarded to the Commander, Navy Personnel Command, who will make the appropriate changes to your military records.

 Copy to: PDBR