RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: ARMY

CASE NUMBER: PD0900070 SEPARATION DATE: 20070313

BOARD DATE: 20090716

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SUMMARY OF CASE: This covered individual (CI) was an NCO medically separated from the Army in 2007 after 12 years of service. The medical basis for the separation was a lung infection (actinomycosis) requiring a lobectomy, complicated by post-thoracotomy pain.  It is assumed that the original infection was acquired during a tour in Bosnia in 1999. There were intermittent pulmonary and chest pain symptoms dating to that time, without a definitive diagnosis until 2004. At this point a right lower lobe lobectomy was performed. The CI suffered persistent chest wall pain after the surgery, which was presumed to be neuropathic from the affected intercostal (rib) nerves. This interfered with use of flak and other gear, and did not respond adequately to various interventions. The CI also suffered some pulmonary symptoms which were not specifically addressed by the MEB, but a pre-separation VA evaluation included pulmonary function testing (PFT’s) with reasonably good results. He was referred to the PEB, found unfit for the chest wall pain and separated at 20% disability. The underlying pulmonary condition was adjudicated as not independently unfitting.

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CI CONTENTION:

The CI contends that ‘VA awarded 30% for the same condition.’

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RATING COMPARISON:

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Service (PEB)** | | | | **VA ~ pre-separation to 9 Mos.** | | | | |
| **PEB Condition** | **Code** | **Rating** | **Date** | **Condition** | **Code** | **Rating** | **Exam Date** | **Effective date** |
| Right chest pain which may be neuropathic | 5009-5003 | 20% | 20061024 | Chronic post-surgical neuralgia | 8410-8210 | 10% | 20071211 | 20070314 |
| R lower lobe pulmonary sequestration | Fit |  |  | S/P thoracotomy… pulmonary actinomycosis\* | 6844-6822 | 0% | 20070126 | 20070314 |
|  |  |  |  | Scar, s/p thoracotomy | 7804 | 10% | 20070126 | 20070314 |
|  |  |  |  | Restrictive lung disease associated with (as above\*) | 6844 | 30% | 20071114 | 20071114 |
|  |  |  |  | Non-PEB X 2 |  |  |  |  |
| **TOTAL Combined: 20 %** | | | | **TOTAL Combined (incl non-PEB Dxs): 30% from 20070314**  **50% from 20071114** | | | | |

ANALYSIS SUMMARY:

Chest Pain Rating. The disparity between PEB and VA ratings may have been affected by difficulty in fitting the CI’s pathology with VASRD coding options. The PEB coded directly as arthritis, although that is loosely analogous. Their rating, under that code, was generous and fair. The VA chose peripheral nerve coding, but the VASRD does not code truncal peripheral nerves. The cranial nerve chosen (probably because it has the vagal branch to the chest) makes no anatomic sense, and should have at least been designated analogous. This code essentially forced the lower 10% rating by the VA and was not strictly IAW §4.7 (higher of two evaluations). The board AO (Action Officer) recommended the analogous code for general chest wall pathology, i.e., 5399-5321.

Fitness for Lung Condition. The MEB recommendation and PEB adjudication for lung infection requiring lobectomy seems to have been based on the fact that the underlying actinomycosis was clinically resolved. Neither focused well on the pulmonary compromise inherent with the surgery. The reassuring PFT prior to separation was apparently instituted on the VA side and was not referenced in the PEB adjudication. The CI appealed to the Army DES and specified the respiratory compromise, but the PEB and USAPDA reply did not specifically address it (although it focused very well on the pain issue). The pre-separation VA examiner described shortness of breath with exertion and even prolonged talking, but such significant symptoms are not apparent in the military health record. The C.O. performance statement included specific mention of breathing difficulties, but the activity restrictions noted in the profile and the MEB narrative summary do not convincingly implicate pulmonary limitations. In general, healthy patients (CI does not smoke) have good pulmonary reserves following single lobe resection, and the PFT’s performed prior to separation would yield only a 10% rating under the VASRD. Most of the CI’s pulmonary deterioration was noted 1½ years after separation.

Scar. In general, surgical scars (invariably coded and rated by the VA) cannot be construed as affecting fitness at the PEB adjudication level. In this case, an argument to the contrary strongly warranted consideration. There are several detailed descriptions of the thoracotomy scar, located along the right rib margin, which suggest that it was not a trivial contribution to unfitness (especially in the wearing of flak, which was repeatedly noted in fitness entries). The most detailed one is found in the pre-separation VA exam, which states ‘16 cm thoracotomy scar, right posterior chest wall, hypersensitive to light rubbing; 4 cm drainage scar immediately below the thoracotomy scar, hypersensitive to light rubbing’. There is no question from this documentation that the scar might have independently impeded the wearing of flak, although the underlying neuropathic pain prevents clinical separation of which was which. It is clear that the scar, as a minimum, contributes to unfitness in regards to the wearing of LBE, although questionable that it brings another 10% to the table.

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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 PDBR 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. Regarding the rating of the unfitting chest wall pain, the board was in unanimous agreement that the PEB rating of 20% was fair. The Board did adopt the AO-recommended code of 5399-5321 as most reflective of the unfitting pathology, but concluded that a higher rating under this, or any other VASRD code, could not be supported.

The Board considered whether to re-adjudicate the underlying chest pathology as separately unfitting, especially considering the possibility of pulmonary compromise ratable at 10% from the pre-separation PFT’s. It was unanimously concluded, however, that the preponderance of evidence, as elaborated above, would not support over-turning the PEB’s expertise (and DES review) in its original fitness decision.

The Board struggled with the decision of whether to conclude the scar itself was additionally unfitting. It was accepted that a convincing threshold should be reached to justify the addition of a VASRD-mandated 10% to the separation rating of any soldier on this commonly-occurring basis. The AO was likewise conflicted but concluded that it could not be stated, more likely than not, that the scar would *not* independently impede the use of flak or other obligatory gear. IAW §4.3 of the VASRD (reasonable doubt), therefore, the Board decided by a 2:1 vote that the scar code was indicated as an addition to the separation rating. The single voter for dissent (who recommended no addition of the scar rating) elected not to submit a minority opinion.

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RECOMMENDATION:  The Board recommends that the CI’s prior determination be modified as follows and that the discharge with severance pay be recharacterized to reflect permanent disability retirement, effective as of the date of his prior medical separation.

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| **Unfitting Condition** | **VASRD Code** | **Rating** |
| Right chest pain which may be neuropathic | 5399-5321 | 20% |
| Scar, s/p thoracotomy, interfering with the use of flak and load-bearing equipment | 7804 | 10% |
| **Combined** | **30%** |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20090126, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

