RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: NAVY

CASE NUMBER: PD090111 BOARD DATE: 20091124

SEPARATION DATE: 20061031

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SUMMARY OF CASE: This covered individual (CI) was a Lieutenant Biochemist who was medically separated from the Navy in 2006 after 10 years of service. The medical basis for the separation was Anxiety Disorder and Undifferentiated Somatoform Disorder.

The CI was referred to the Navy Physical Evaluation Board (PEB) and determined unfit for continued Naval service. He asked for a reconsideration and requested that he be found fit for duty. He stated he was much improved and implied much of his problem had been due to the vocal/motor tic disorder which had resolved. At reconsideration the PEB determined he was unfit and he was separated at 10% disability using the Veterans Affairs Schedule for Ratings Disabilities (VASRD) and applicable Navy and Department of Defense regulations.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CI CONTENTION: The CI states: “The chronic anxiety disorder that I was found to be unfit for was actually multiple disorders, including PTSD, ADHD, and bipolar disorder in addition to chronic anxiety disorder per VA medical records and VA rating letters. Please refer to personal statement for details.”

RATING COMPARISON:

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Service PEB** | | | | **VA (6 Mo. after Separation)** | | | | |
| **Condition** | **Code** | **Rating** | **Date** | **Condition** | **Code** | **Rating** | **Exam** | **Effective** |
| Anxiety Disorder | 9400 | 10% | 20060705 | Chronic Anxiety Disorder | 9400 | 30%  50% | 20070430  Dec 2008 or Jan 2009 | 20061101  20081015 |
| Undifferentiated Somatoform Disorder | 9421 | 0% | 20060705 |
|  |  |  |  | Vocal Motor Tic Disorder | 8103 | 0%  10% | 20070503 | 20061101  20081015 |
|  |  |  |  | Temporomandibular Joint Syndrome | 9905 | 40% | 20070503 | 20061101 |
|  |  |  |  | Right Knee Instability, Status Post Right Knee Meniscal Tear With Arthroscopy | 5257 | 10% | 20070502 | 20061101 |
|  |  |  |  | Status Post Right Knee Meniscal Tear With Arthroscopy | 5262 | 10% | 20070502 | 20061101 |
|  |  |  |  | Residuals of Injury, Right Ankle | 5271 | 0%  10% | 20070502 | 19960501  AD d/c  20061101 |
| Chronic Sinusitis | Category III: Conditions that are not separately unfitting and do not contribute to the unfitting condition(s) | |  | Sinusitis | Not Service Connected, Not Incurred/Caused By Service | |  |  |
| Borderline Elevated Antistretolysin-0  Antibody Titer of No Apparent Clinical  Significance at This Time From a Rheumatic Disease Standpoint. |  |  |  |  |  |  |
| Allergic Rhinitis |  |  |  |  |  |  |
| Mildly Elevated Liver Function Tests |  |  |  |  |  |  |
| Diffuse Arthralgias |  |  |  |  |  |  |
|  | | | | NSC X 1 | | |  |  |
| **TOTAL Combined: 10%** | | | | **TOTAL Combined (*Includes Non-PEB Conditions*):**  **0% from 19960501**  **70% from 20061101**  **80% from 20081015** | | | | |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ANALYSIS SUMMARY:

The CI was in the Army from 19900531 to 19960430 and the Navy from 20021102 to 20061031. He was diagnosed with Generalized Anxiety Disorder at age 28 (20000212-20010211) during his break in service. During graduate school while working on his Masters in Biochemistry he worried a lot and had multiple somatic complaints. He was treated with Effexor XR for one to two years. He also was treated with relaxation therapy which was minimally to moderately helpful. On his commissioning H&P he reported test anxiety during grad school age 28-29 and this was documented as resolved. After he graduated, he went approximately two years without medication or any type of psychiatric or psychological treatment. At age 31 (20030212-20040211) medication was reinitiated following an increase in life stressors. He was active duty in the Navy at this time, pursuing a PhD in Toxicology while working in research. Multiple different medications were used to treat anxiety and mild depressive symptoms. He was also diagnosed with ADHD in 2005 for complaints of distractibility, impulsivity, hyperactivity, and inattention despite a prior history of superior academic achievement and was treated with Adderall XR and then Strattera. At an August 2005 evaluation the CI reported a five to seven year history of obsessive-compulsive symptoms including repeating questions or comments multiple times to ensure others heard him and having an increasing need to be neat and tidy. He felt a need to control any situation. He displayed multiple motor and verbal tics throughout his initial interview (i.e. grunting and excessive eye blinking). He felt his obsessive symptoms became worse when he married two years prior and had to deal with “the randomness of his wife and children” (one stepchild and one biological child). He also had multiple somatic complaints including night sweats and sleep disturbance and pursued an extensive medical work-up with his primary care provider. Tenex was added to address his tics and his Zoloft was increased. At a follow-up visit in September 2005 he reported he had stopped all of his medications because they weren’t really helping him and he wanted to rule out any possible medical or neurological causes of his multiple persistent somatic symptoms. An exhaustive medical workup revealed no abnormalities and the CI was very frustrated. He felt that if his “medical” problems were appropriately diagnosed and treated he would not have any psychological distress. Although he had abruptly stopped his psychotropic medications, he denied any overwhelming withdrawal syndrome or worsening of his anxiety, depression, and questionable ADHD symptoms. He noticed that his motor and verbal tics had resolved for the most part after he stopped taking the stimulant medication. He remained off all medication until November 2005 when he began to utilize Valium for breakthrough anxiety.

He was evaluated by neurology and received a tentative diagnosis of Pediatric Autoimmune Neuropsychiatric Disorder Associated with Group A Streptococci (PANDAS) after an elevated ASO titer. He was treated with five 6mg doses of intravenous immunoglobulin (IVIG). Although his symptoms began as an adult, the neurologist noted he had a positive ASO titer with an acquired motor-evoked tic and anxiety and thought the treatment might be helpful. However, it did not help. Notes from rheumatology question the diagnosis as the ASO level was not as elevated as that provider normally sees in patients with PANDAS. The neurologist also initiated Risperdal and then Klonopin to treat the tremors and thought it might also help the CI’s anxiety. It did not. The Risperdal was stopped because of side effects.

He was also evaluated by rheumatology in March 2006 and there was no evidence of a rheumatologic disease that would explain his multiple somatic complaints. The rheumatologist determined the elevated ASO titer had no clinical significance and there was no evidence of prior rheumatic fever. He did not think PANDAS syndrome was present because of non-typical history and lack of response to treatment. He thought diffuse arthralgias may be related to myofascial pain or a side effect from the use of Celebrex. The examination and labs do not support the diagnosis of an inflammatory arthropathy. He recommended ruling out sleep apnea as a cause and a sleep study done in April 2006 showed no apnea or sleep disorder. The rheumatologist thought the multiple somatic complaints could be medication related. He did not diagnose fibromyalgia.

The CI complained of extreme exhaustion and fatigue. He was reluctant to take medications for obsessive compulsive symptoms (failed multiple trials of antidepressants) or tics (had problems with Risperdal) and remained convinced that all of his psychiatric problems stemmed from neurologic and/or rheumatologic disease. In April 2006 he requested medication to help with his impaired concentration and fatigue and was given Provigil.

His Commander initially attributed many of the CI’s difficulties to the stress of working in the Navy while also working on his PhD but noticed no improvement when the CI dropped out of his doctoral program. He and other staff noted erratic behavior, agitation, euphoria, depression, inability to focus on any major task, inability to perform more than one task at a time, would often forget assigned tasks and duties, was constantly fatigued and often irritable, missed significant amount of work for medical reasons, and was therefore unable to perform his duties as a researcher. He also has to put extra effort to overcome joint pain and stiffness, swelling, and loss of dexterity apparently due to medical treatment and/or condition. And his inability to perform physical fitness requirements could make him unfit.

**Anxiety**

**Navy:**

NARSUM (date 20060406):

MENTAL STATUS EXAMINATION: At the time of evaluation, the patient was alert and oriented to all spheres. He was pleasant and cooperative and showed positive and consistent eye contact. He was appropriately dressed, but appeared quite anxious and fidgety throughout, expressing intermittent mild vocal and motor tics. His speech was shown to be normal in rate, rhythm, tone and volume. His mood was reported as “frustrated.” His affect ranged from euthymic to mildly dysphoric and was appropriate to content of speech and non-labile. His thought processes were found to be logical, coherent, although quite circumstantial. His thought content revealed no hallucinations, delusions or illusions. He denied any suicidal or homicidal ideation. Both his judgment and insight were found to be fair. The patient’s cognition was relatively intact at the time of evaluation.

DIAGNOSES: (DSM-IV)

AXIS I:

300.00 Anxiety Disorder NOS as evidenced by a history worrying which is associated with multiple somatic complaints including headaches, generalized muscle aches/pains, increased fatigue, sleep disturbances, perfuse nighttime sweats, headaches, self-reported bilateral hearing loss, bilateral breast enlargement, bilateral lower extremity paresthesias, tics, and a history of obsessive-compulsive symptoms including repeating questions or comments multiple times to ensure others heard him and having an increasing need to be orderly and tidy.

EXTERNAL PRECIPITATING STRESS: Minimal

PREMORBID PREDISPOSITION: Mild

IMPAIRMENT FOR MILITARY SERVICE: Marked

SOCIAL AND INDUSTRIAL IMPAIRMENT: Definite

LINE OF DUTY: No -Existing Prior To Service

300.82 Undifferentiated Somatoform Disorder as evidenced by multiple somatic complaints including headaches, generalized muscle aches/pains, increased fatigue, sleep disturbances, perfuse nighttime sweats, headaches, self-reported bilateral hearing loss, bilateral breast enlargement and bilateral lower extremity paresthesias, and after appropriate investigation, the symptoms cannot be fully explained by a known general medical condition or by the direct effects of a substance. In addition, these symptoms cause clinically significant distress or impairment in both social and occupational functioning and are not thought to be intentionally produced or feigned.

EXTERNAL PRECIPITATING STRESS: Minimal

PREMORBID PREDISPOSITION: Mild

IMPAIRMENT FOR MILITARY SERVICE: Marked

SOCIAL AND INDUSTRIAL IMPAIRMENT: Definite

LINE OF DUTY: No - Existing Prior to Service

AXIS II: No Diagnosis on Axis II

AXIS III: Chronic Sinusitis, Allergic Rhinitis

AXIS IV: Family Stress, Limited Social Support

AXIS V: Currently =65 Highest Past Year =65-70

CURRENT PROFILE: S4-T

WORLDWIDE QUALIFICATION: No

DISPOSITION AND RECOMMENDATIONS: Lt Naylor is being presented for medical evaluation board to determine eligibility for continued worldwide active duty. He presently displays a potentially disqualifying defect under the conditions of AF136-3212 and AFI48-123, Attachment 2, Paragraph A2, 12. He has had a marked decrease in duty performance. It is recommended that Lt Naylor continue with his mental health professional(s) for Individual/Group Therapy and Medication Management Otherwise, this patient appears mildly to moderately impaired from a mental health perspective, but capable of cooperating with any administrative actions in association with this MEB process. It is recommended that the patient be returned to duty while receiving treatment and forwarded to a Physical Evaluation Board or the Navy equivalent Lt Naylor remains competent to handle his pay and records. He does not present as an imminent risk of harm to himself or others at this time.

**VA:**

Using an evaluation completed on 20070430, 6 months after the time of separation from the Navy,the Veterans Administration (VA) rated this disability as CHRONIC ANXIETY DISORDER at 30%.

Rating Decision (date 20070801):

2. Service connection for chronic anxiety disorder.

We have granted service connection for chronic anxiety disorder, as the service medical records diagnosed this disability, and continued residuals were shown at the VA examination of4/30/07, which was conducted soon after active duty discharge. Your condition is assigned a 30 percent evaluation effective the first day following your discharge from service.

A 30 percent evaluation is assigned because the VA examination confirms the Axis 1 diagnosis of chronic anxiety disorder with a GAF score of 65 and multiple symptoms of reduced memory, abnormal mood and affect, nervousness, anxiety, restless, difficulty with retention of learned materials, avoidance behavior, and reduced ability to function socially; all of which has been treated with multiple medications to include Adderall, Zoloft, Lexapro, and Gabapentin medications. The VA examiner reports that you are competent and fully capable of managing your own financial affairs.

**C&P Exam (date 20070503):**

**SOCIAL HISTORY**

The veteran's activities of daily living are less. He has had major changes in social functioning in that he avoids people because of his anxiety and nervousness. Again, regarding work, he just started a new job on April 2, 2007 working as a chemist. He said that most of the time he works by himself because he gets nervous easily. Regarding alcohol and drugs, he denies abuse.

**MENTAL STATUS EXAMINATION (OBJECTIVE FINDINGS)**

Orientation is normal. His appearance and hygiene are normal. Behavior is appropriate. Mood and affect are abnormal. He is nervous, anxious and fidgety and was restless and fidgety during the exam. This is part of his anxiety and nervous disorder. Communication is normal. There are no panic attacks. Speech is normal. Delusions are absent. Hallucinations are absent. Ritualistic obsession is absent. Thought processes are normal. Judgment is intact. Abstract thinking is absent. Memory is mildly to moderately abnormal. He has difficulty with retention of highly learned materials. He also forgets to complete tasks. He has no suicidal/homicidal ideations.

**DIAGNOSIS BY DSM-IV**

AXIS I: ANXIETY DISORDER, NOT OTHERWISE SPECIFIED. This is equivalent to the claimed condition of Anxiety and Nervousness. I would defer the Tic Disorder to the neurologist.

AXIS II: NO DIAGNOSIS.

AXIS III: DEFERRED TO THE APPROPRITE SPECIALIST.

AXIS IV: PSYCHOSOCIAL STRESSORS: Unspecified.

AXIS V: GAF: 60-65.

**DISCUSSION**

The veteran denies current drug or alcohol abuse. Based on my examination, the veteran is mentally capable of managing his benefit payments in his own best interest. He has occasional difficulty performing activities of daily living. He has problems establishing and maintaining work relationships. He has problems with co-workers and supervisors. His social relationships are also diminished. He has no difficulty understanding simple commands, but has some difficulty with complex (two to three-step) commands. He is not a danger to himself or other people.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 concluded that the CI’s condition is appropriately rated at 30% for 9400 Anxiety Disorder NOS and Undifferentiated Somatoform Disorder.

The psychiatrist who completed the NARSUM stated both Anxiety Disorder and Undifferentiated Somatoform Disorder existed prior to service. CI was diagnosed with Generalized Anxiety Disorder during his break in service. However, he was treated for 1-2 years and then treatment was discontinued prior to his commissioning. He completed his Masters in Biochemistry and this indicates he was functioning well. He revealed his anxiety disorder on his commissioning physical but denied any symptoms at the time and the condition was considered resolved. He continued to do well for two years. He had been commissioned and was attending graduate school, working on his PhD in Biochemistry. Approximately one year after entering the Navy, psychiatric treatment including medication was required after an increase in life stressors. His job performance began to decrease and continued to deteriorate. His Commander initially thought the CI’s problems were related to the stress of working on his PhD while working in a PhD researcher position. However, he noticed a continued decline and no improvement after the CI dropped out of graduate school and was receiving therapy and medication. The CI was not able to handle multiple assigned tasks; was constantly fatigued; missed approximately one full day per week for medical appointments; was not mentally prepared to perform his research when he was present; and was at times agitated, euphoric, depressed—sometimes all three in one day. He could only focus on one task at a time.

While the CI did have the diagnosis of Anxiety Disorder after he left the Army and before he entered the Navy, he appeared to be symptom free when he entered the Navy and his condition was considered resolved. Therefore his level of disability at the time of entry into the Navy was minimal and no EPTS deduction should be made. The Navy PEB does not appear to have made any deduction for EPTS and their notes reveal they were aware mental health conditions were deemed EPTS by the psychiatrist.

Similar symptoms were described in the NARSUM and the C&P exam and warrant a 30% rating under the General Rating Formula for Mental Disorders, VASRD §4.130. In accordance with VASRD §4.126, ratings for mental health conditions shall consider the frequency, severity, and duration of psychiatric symptoms, the length of remissions, and the veteran’s capacity for adjustment during periods of remission. The assigned rating will be based on all the evidence of record that bears on occupational and social impairment rather than solely on the examiner’s assessment of the level of disability at the moment of the examination. All symptoms related to mental health conditions are considered together in the rating determination and the rating is determined by the CI’s overall level of disability. Separate ratings for multiple psychiatric diagnoses are not allowed. The diagnostic code for the predominant condition is used in the rating.

The CI contended that his unfitting condition of chronic anxiety disorder actually encompassed multiple disorders including post traumatic stress disorder (PTSD), attention deficit hyperactivity disorder (ADHD), and bipolar disorder. There is no evidence in the service treatment record of a diagnosis of or treatment for either PTSD or bipolar disorder. As there was no diagnosis of PTSD or any mental disorder that resulted from a highly stressful event, VASRD §4.129 does not apply. There is evidence of treatment for ADHD, however the comprehensive psychiatric evaluation completed for his MEB did not list this condition as a diagnosis. It appears this condition was not present at the time of separation. Even if the condition had been present it would not affect the rating as this condition is not ratable or compensable.

The CI had occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks (although generally functioning satisfactorily, with routine behavior, self-care, and conversation normal) due to symptoms of: reduced memory, abnormal mood and affect, nervousness, anxiety, restless, difficulty with retention of learned materials, avoidance behavior, and reduced ability to function socially, history of worrying associated with multiple somatic complaints (including headaches, generalized muscle aches/pains, increased fatigue, sleep disturbances, perfuse nighttime sweats, headaches, self-reported bilateral hearing loss, bilateral breast enlargement, bilateral lower extremity paresthesias, tics, and a history of obsessive-compulsive symptoms including repeating questions or comments multiple times to ensure others heard him and having an increasing need to be orderly and tidy). The multiple somatic complaints cannot be fully explained by a known general medical condition or by the direct effects of a substance. In addition, these symptoms cause distress or impairment in both social and occupational functioning and are not thought to be intentionally produced or feigned. GAF was 60-65.

The CI’s condition worsened over time and the VA increased his rating to 50% effective two years after he separated from the Navy. This rating increase occurred because of a worsening condition, not an initial error in rating, and therefore does not affect the CI’s rating at the time of separation from the Navy.

The Board evaluated the following conditions and unanimously opined none had sufficient evidence to be considered unfitting: chronic sinusitis, allergic rhinitis, diffuse arthralgias, right knee injury, and right ankle injury.

Vocal motor tic disorder, post traumatic stress disorder, and bipolar disorder were not present at the time of separation and cannot be considered unfitting or rated.

Abnormal lab tests such as mildly elevated liver function tests and borderline elevated Antistreptolysin-O antibody titer are not disabilities or ratable conditions.

Temporomandibular joint syndrome was not mentioned in the DES paperwork and is outside the scope of the Board. The CI retains the right to request his service Board of Correction for Naval Records (BCNR) to consider adding this condition as unfitting.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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.

|  |  |  |  |
| --- | --- | --- | --- |
| **UNFITTING CONDITION** | | **VASRD CODE** | **RATING** |
| ANXIETY DISORDER NOS AND UNDIFFERENTIATED SOMATOFORM DISORDER | | 9400 | 30 |
| **COMBINED** | | **30%** |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20090202, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

