RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: ARMY

CASE NUMBER: PD0900118 BOARD DATE: 20100429

SEPARATION DATE: 20060524

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SUMMARY OF CASE: This covered individual (CI) was a Reserve SSG, Network Systems Operator, medically separated from the Army in 2006 after 27 years of combined service (4+ active duty years). The medical basis for the separation was bilateral shoulder impairment from surgical residuals complicating hydradenitis suppurativa (infection of the axillary lymph nodes). There are discrepancies in the history of events leading to the condition which will be subsequently discussed. The following account is consistent with the narrative summary (NARSUM) and the preponderance of the evidence. In 2002 the CI was mobilized in support of Operation Enduring Freedom (OEF). During pre-deployment training he received a facial laceration and bilateral corneal injuries from a simulator device thrown into his tent. The facial wound was complicated by recurrent infections and residual keratitis from the eye injuries. These conditions did not prevent his deployment to Afghanistan where he was assigned to Bagram Air Force Base from Nov 2002 to Jun 2003. During the OEF deployment he developed cutaneous furuncles (boils) and the bilateral hydradenitis suppurativa condition. He underwent surgical drainage of the left axilla in theater. There is nothing in evidence clarifying whether he was medically evacuated for the conditions, but the axillary infections required subsequent surgical interventions at Walter Reed Army Medical Center (WRAMC) on his return from Afghanistan. The surgeries consisted of wide excisions of each axilla with lymph node resection and grafting. He underwent additional scar revision of the left axilla. He was subsequently diagnosed with Methicillin-Resistant Staphylococcus Aureus (MRSA), which is suspicious for origin with the original training accident. This was eventually cleared with antibiotics and systemic measures. He suffered significant impairment of both shoulders as a result of limitations from the residual axillary surgical scars and was referred for a Medical Evaluation Board (MEB).

Additionally the CI suffered a neck injury in Afghanistan, reported in the NARSUM as secondary to striking his head negotiating a tent doorway. A Magnetic Resonance Imaging (MRI) at WRAMC revealed three-level disc disease (C4/5 - C6/7) and he underwent a foraminotomy and laminotomy procedure in 2004. He was returned to duty after the surgery, but developed recurrent pain and left upper extremity (LUE) radicular symptoms later in the MEB period. A repeat MRI in 2005 showed degenerative disc changes, but no new herniations. He was also evaluated for low back pain during the MEB period. The reported onset was shortly after the OEF neck injury, but he did not seek medical care until 2005. An MRI reported stenosis and foraminal narrowing at the L4/5 level, but no disc protrusion or surgical indications. He was treated conservatively and placed on an L2 profile. The CI also underwent a psychiatric evaluation, contended as post-traumatic stress disorder (PTSD). This will be detailed below.

The MEB’s DA Form 3947 noted six conditions: anxiety disorder, hydradenitis suppurativa, bilateral axillary scarring, recurrent furunculitis, neck pain, back pain and recurrent marginal keratitis. Only the hydradenitis and axillary scarring were forwarded as medically unacceptable IAW AR 40-501. An informal Physical Evaluation Board (PEB) found the two medically unacceptable conditions unfitting and combined them under scar coding, rated 20%. The remaining conditions were determined to be not unfitting. The informal PEB findings underwent a protracted period of appeals. This included further medical evaluations and a formal PEB. The formal PEB produced no change in the original adjudication, and this was further upheld on US Army Physical Disability Agency (USAPDA) appeal. The CI was thus medically separated with a combined disability rating of 20%. The case was subsequently considered on Army Board of Correction for Military Records (ABCMR) appeal and the final PEB adjudication was again upheld.

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CI CONTENTION: The CI states: ‘The Board that reviewed my disabilities did not rate all the disabilities that I acquired during my combat in Afghanistan.’ He goes on to state that he should have been rated for all of the conditions in ‘the list of VA ratings’. In that regard he added an attachment listing all of his VA ratings as of January 27, 2009. In addition to the conditions noted in the summary and others, this list included sleep apnea, PTSD/Anxiety, left radiculopathy and traumatic brain injury (TBI).

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RATING COMPARISON:

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Service PEB – Dated 20060321** | | | **VA (~4 Mo. after Separation) – All Effective 20060525** | | | | | |
| **Condition** | **Code** | **Rating** | **Condition** | | **Code** | | **Rating** | **Exam** |
| Hydradenitis Suppurativa … Limited ROM Bilat. Shoulders | 7801 | 20% | Hydradenitis Suppurativa, L Axilla | | 7801 | | 10% | 20050531 |
| Hydradenitis Suppurativa, R Axilla | | 7801 | | 10% | 20050531 |
| Anxiety Disorder, NOS | Not Unfitting | | PTSD/Anxiety | | 9411 | | 50% | 20061003 |
| Bacterial Furunculitis | Not Unfitting | | Abscess on Face | 7899-7800 | | | 10% | 20061003 |
| Neck Pain | Not Unfitting | | Residuals of Cervical Surgery | | 5242 | | 10% | 20061003 |
| Low Back Pain/Flank Pain | Not Unfitting | | No VA Code | | | | | 20061003 |
| Recurrent Marginal Keratitis | Not Unfitting | | Residuals of Eye Injuries | | | 6009 | 10% | 20050527 |
| Left shoulder not separately coded. | | | L Radiculopathy w/ [Shoulder] DJD | | | 8513 | 40% | 20061003 |
| No DA Form 3947 Entry. | | | Tinnitus | | | 6260 | 10% | 20050531 |
| **TOTAL Combined: 20%** | | | **TOTAL Combined (*Includes BLF*): 90%** | | | | | |

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ANALYSIS SUMMARY:

The Board makes note that several VA and Army records are referenced but not in evidence. These could not be located after requests to both agencies. Additional attempts at obtaining the records would likely be futile and introduce further undue delay in processing the case. The missing evidence will be mentioned where it is relevant. It is not suspected that any of the missing evidence would significantly alter our recommendations.

Hydradenitis Suppurativa Condition. The post-surgical scarring in both axillae was relatively severe as evidenced in the service and VA examinations. It was associated with pain on motion of both shoulders, especially the left (dominant). It imposed mechanical limitation of motion, albeit not to a compensable degree, of the left shoulder. It was also associated with impairment of heat tolerance from the loss of the axillary sweating mechanism. This prohibited Mission-Oriented Protective Posture (MOPP) wear and other requirements of basic soldiering, rendering the condition unequivocally unfitting. The PEB decision to employ scar code rating was rational. The DA Form 199 and subsequent USAPDA documentation make it clear that the joint code rating was considered, but it was concluded that scar rating was more favorable to the member. The rating was done on the basis of total surface area of the scars IAW Veterans Administration Schedule for Rating Disabilities (VASRD) §4.118. This was accurately documented on the DA Form 199 as 18.4 square inches. The PEB’s combined rating for both axillae was compliant with Note (2) under the 7801 rating description. The VA’s separate 10% scar ratings were in fact not IAW §4.118 and resulted in inappropriate application of that bilateral factor to their combined rating (which would have been 80%, not 90%). All evidence considered, there is not reasonable doubt in the CI’s favor supporting recharacterization of the PEB adjudication for the hydradenitis suppurativa condition.

Left Shoulder Impairment Unrelated to Surgical Scars. There is documentation by the CI and the examiner in the MEB physical examination of a left shoulder complaint independent of the hydradenitis suppurativa complications. There are various examinations in the MEB records of left shoulder tenderness not confined to the scar area, although the NARSUM examination stated there was no tenderness. The VA rating examination four months after separation noted significant peri-articular tenderness of the left shoulder along with other significant signs of impairment and ordered an MRI. This showed diffuse tendinopathy, a supraspinatus tear and acromioclavicular degenerative changes. There is documentation of an emergency room (ER) visit for left shoulder pain at the VA shortly after discharge, but there is no history for a discrete traumatic event involving the left shoulder either before or after separation. Especially considering the presence of degenerative changes on imaging, it must be conceded that the separate shoulder pathology was incurred (albeit not specifically diagnosed) while on active duty. There was documentation available to the PEB in the Disability Evaluation System (DES) packet that a separate condition existed. It is judged to be sufficient to support its eligibility for Board consideration as an additionally unfitting condition for separation rating. The VA physician opined (reasonably so) that the left shoulder impairment was a combined result of the intrinsic pathology, the scar tissue impairment and the residual cervical radiculopathy impairment. The VA rating combined all of this into a single 40% rating under the peripheral nerve code. The cervical radiculopathy component, yet to be discussed, will not be considered by the Board for its contribution to the separate impairment of the left shoulder. Although the VA examiner documented painful motion for the shoulder at 60° abduction (compensable to 30% on its own), this limitation would have included contributions from all three factors just elaborated. The Board therefore does not find it reasonable to base a separate rating divorced from two of those factors on this finding. In its rationale for the hydradenitis suppurativa rating the DA Form 199 referenced the NARSUM range-of-motion (ROM) findings as ‘slightly greater that 90 degrees abduction in both shoulders, measurements not limited by pain’. No such statement regarding limitation by pain is found in the NARSUM, however. The NARSUM references a physical therapy (PT) goniometric exam for shoulder ROM and the PT exam itself specifically states, ‘ROM limited due to pain’. Documentation of painful motion of the shoulder was abundant in other MEB entries, including the WRAMC Specialized Care Program narrative which was presumably part of the DES packet. Moreover painful motion would be expected on the basis of the arthritis demonstrated on imaging.

All evidence considered, reasonable doubt is resolved in favor of the CI for recommending left shoulder pain as an additionally unfitting condition by the Board. It is appropriately coded 5299-5201 and meets §4.59 (painful motion) criteria for the minimum compensable rating which is 20%.

Cervical/LUE Radiculopathy Condition. In his appeals, the CI contended that his cervical condition and its associated radiculopathy were unfitting. The NARSUM description of the condition, which opined that the condition met AR 40-501 standards, does not lend strong support for this assertion. It is excerpted below.

PRESENT CONDITON OF NECK - [CI’s name] reports that he has a ‘sticking sensation’ in his C6 - C7 spinous process that is usually present when he gets up in the morning. His neck will also feel stiff at times. If he isn't careful about how he gets up, he will definitely have it. It usually goes away when he starts moving around. He also notices it intermittently when flexing or extending his neck. It is not consistent. It does not radiate. He states ‘it is not consistent where it is a real pain.’ He notices some numbness in the left thumb and LIF, although the numbness in his LMF that was present before his surgery has resolved. Overall, it is better than described before the surgery.

The NARSUM description, preceding the appeals process, is dated eight months prior to actual separation. In the USAPDA opinion and in the subsequent ABMCR decision, reference is made to a repeat neurosurgical evaluation that was performed after the appeal. This is one of the missing documents referenced above. Both of the agency documents state that the reviewing neurosurgeon concluded ‘his cervical disease met medical retention standards and that he did not have any evidence of active radiculopathy or myelopathy’. Although a first-hand review of the examination would have carried more probative value, the Board can only conclude that the Army agencies provided an accurate characterization of the findings. The VA rating examiner four months after separation did not provide a detailed account of functional limitations from the neck condition, but did state ‘The patient also has persistent neck pain but mainly his endurance and his ability to write has been impaired by pain in his left shoulder and also fatigability in using his left hand.’ The physical profile for U-3 included neck pain, but the limitations imposed are impossible to separate from the bilateral shoulder impairments. A Commander’s statement was also unfortunately part of the missing evidence, although typically those from Medical Hold commanders do not provide directed statements regarding specific impairments related to specific conditions.

As a component of the cervical condition and in consideration of its potential as a stand-alone unfitting condition, the Board considered the LUE radiculopathy. The pain associated with the radiculopathy is tied to the overall fitness implications of the underlying cervical condition itself as just discussed, but sensory or motor impairments may directly impact fitness with disregard to pain. The NARSUM documented no positive findings for motor or sensory deficits and the second-hand account from the reviewing neurosurgeon lends support to those findings. The VA general rating examination documented 3/5 motor strength in the LUE proximal motor groups, although no tendon reflex or sensory deficits. The VA neurologic rating examination performed the same day did not find deficits, although noted that the exam was compromised by guarding from shoulder pain. Other MEB examinations were also taken into account. An ER physician, medical consultant and general surgical consultant all documented normal exams. The WRAMC Specialized Care Program narrative noted 4/5 motor strength in three LUE motor groups, not commenting on tendon reflex or sensory findings. The preponderance of the evidence would indicate that any neurologic deficits associated with the radiculopathy were intermittent, sub-clinical or mild at most. All evidence considered there is not reasonable doubt in the CI’s favor supporting addition of the cervical condition or its associated radiculopathy as unfitting for separation rating.

Mental Disorder. In regard to this condition the Board first wishes to address the discrepancies in the medical history as mentioned in the summary and define its position regarding the implications that has for its recommendations. The history as stated in the NARSUM and the summary above was contradicted in numerous other accounts as related by the CI to various providers. This was most apparent and relevant in VA evaluations for PTSD and a subsequent claim for TBI. It was noted in VA rating examinations for several other conditions and throughout VA behavioral health notes. It also surfaced in a few MEB outpatient notes. The original training simulator incident was often assessed as grenade shrapnel injuries, usually (but not always) in the context of combat trauma. The neck injury was reported to occur from a land mine explosion, killing a soldier next to the CI. An incident of shock from exsanguination (‘nearly bled to death’) complicating surgery at WRAMC was documented in behavioral health notes and by a VA TBI examiner. The NARSUM account was duplicated in an earlier 2005 VA rating examination well prior to separation, in the early line-of-duty statements, in the WRAMC operative notes and in most routine outpatient notes in the service record. The WRAMC operative notes do not document any operative or peri-operative complications. OEF records and the post-deployment health assessment are unavailable and were not obtainable upon Board request. Additional OEF events described in VA records include retrieving body parts, witnessing horrific civilian casualties and various other severe stressors. The Board has no evidence at hand contradicting or corroborating these accounts. They were not noted in the earlier VA evaluations or directly documented in the scant MEB behavioral health notes. The CI was not the recipient of a Purple Heart or any combat-related awards.

The Board finds far more support for the NARSUM account of events than for those subsequently proffered by the CI and defaults to the former as a basis for its recommendations. The probative value relative to the accuracy of the accounts of the collateral events as Criterion A stressors for PTSD is diminished. It is not negated, however, since OEF service in an area of active hostilities is established. The Board cannot therefore weigh heavily any medical opinions premised on the conflicting history. It likewise cannot give full weight to the subjective elements of evaluations relative to the severity of conditions supported by contradictory history. Since this position is far more constraining to the VA evaluations than to the service evaluations, the Board’s recommendations are proportionately more influenced by the service records.

In his appeals up to the ABMCR, the CI adamantly and repeatedly contended that he suffered from an unfitting PTSD condition at separation. His VA behavioral health notes reflect that this remains an emotional issue with him. Most of the supporting material is from VA sources after separation and references the contradictory history just discussed. Although there is a diagnosis of PTSD referenced in various entries in the service record, there is nowhere a directed psychiatric examination quoting Criterion A stressors and DSM-IV requirements for establishing PTSD as an Axis I condition. The original psychiatric addendum to the NARSUM was in letter form and listed Anxiety Disorder, Not-Otherwise Stated (NOS) as the only Axis I diagnosis. It concluded ‘The service member does not have a psychiatric condition that warrants disposition through medical or administrative channels and does not warrant a Psychiatric addendum to the Medical Evaluation Board.’ The only supporting opinion by a service provider for PTSD was written by the same clinical psychologist who authored the original addendum. It was dated six months later and stated ‘I have treated him in ongoing psychotherapy for significant PTSD symptoms since Apri 4, 2005.’ His original letter and diagnostic opinion was dated after therapy commenced and it is noted that the follow-up letter still did not confirm PTSD as an Axis I diagnosis. The letter references ‘chronic re-experiencing horrific events during his service in Afghanistan’ and ‘psychological trauma secondary to life threatening events occurring during hospitalization after his return from Afghanistan’. The USAPDA opinion and the ABMCR decision reference a psychiatric re-evaluation after appeal. As with the cervical condition, this document is not available for direct review by the Board. The two agency documents state that the reviewing psychiatrist opined that the Axis I diagnosis was Adjustment Disorder, that criteria for PTSD were not met and that the condition met retention standards.

Even if a diagnosis of PTSD is conceded, the Board does not have a basis for recommending any psychiatric condition as unfitting. There is no Commander’s statement or enlisted evaluation reports available on which to gauge the CI’s level of mental functioning, but the physical profile was S1 and there was no prohibition to weapon access. None of the service behavioral health notes in evidence or the numerous clinical encounters for his other conditions document any altered mental status or other indications of psychiatric impairment. The Board, therefore, cannot find reasonable doubt in the CI’s favor to recommend PTSD or any other mental disorder as an additionally unfitting condition for separation rating.

Other DA Form 3947 Conditions (Back, Furunculitis, Keratitis). These three conditions were all discussed in the NARSUM and opined to be within AR 40-501 standards. The back condition was profiled L-2, a classification not generally associated with unfitting orthopedic conditions. It also did not surface as a ratable condition on the VA evaluation. There is nothing in the service record indicating that it was an acute issue or carried fitness implications. The skin condition, although obviously unpleasant, had no manifestations that could be considered unfitting. The evidence at hand suggests that the MRSA was eradicated prior to separation. The eye condition was covered by an ophthalmology addendum which documented near normal visual acuity and concordance with retention standards.

Other Conditions. The Board does not have the authority under DoDI 6040.44 to render fitness or rating recommendations for any conditions not considered by the DES. The only additional condition presented to the DES not already discussed was a left elbow complaint which surfaced on the MEB physical. The examiner noted it to be intermittent and aggravated by movement. No abnormal examination findings were present. It was not profiled and it was not rated by the VA. Additional conditions in the CI’s application include tinnitus, sleep apnea and TBI. Only the tinnitus was identified on the VA evaluation proximal to separation and cannot be linked to fitness. All three of the latter conditions, however, remain eligible for ABMCR consideration.

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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 hydradenitis suppurativa condition and IAW VASRD §4.118, the Board unanimously recommends no change in the PEB adjudication. In the matter of the separate left shoulder condition, the Board unanimously recommends that it be added as an additionally unfitting condition for separation rating; coded 5299-5201 and rated 20% IAW VASRD §4.71a. In the matter of the cervical condition and associated radiculopathy, the Board unanimously recommends no recharacterization of the PEB adjudication as not unfitting. In the matter of the psychiatric condition contended as post traumatic stress disorder, the Board unanimously recommends no recharacterization of the PEB diagnosis or fitness adjudication. In the matter of the back condition, skin furunculitis and eye keratitis conditions, the Board unanimously recommends no recharacterization of the PEB adjudications as not unfitting. In the matter of the left elbow condition or any other medical conditions eligible for Board consideration; the Board unanimously agrees that it cannot recommend any findings of unfit for additional rating at separation.

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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/her prior medical separation.

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| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Chronic Hydradenitis Suppurativa with Bilateral Shoulder Impairment Due to Post-Surgical Scar Residuals | 7801 | 20% |
| Chronic Left Shoulder Pain From Intrinsic Joint Disease | 5299-5201 | 20% |
| **COMBINED** | **40%** |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20090127, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

