ECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: ARMY

CASE NUMBER: PD0900141 BOARD DATE: 20100520

SEPARATION DATE: 20060121

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SUMMARY OF CASE: This covered individual (CI) was a Guard MAJ (21B, Engineer) medically separated from the Army in 2006 after 21 years of combined service. The medical basis for the separation was Acute Myelogenous Leukemia (AML). The CI developed progressive fatigue and night sweats in 2004 while mobilized to Kosovo. Laboratory investigation suggested a leukemic process and he was evacuated to Landstuhl where a diagnosis of AML was confirmed. Initial chemotherapy was commenced and he was evacuated to Walter-Reed Army Medical Center (WRAMC). In October 2004, he underwent a stem cell transplant from a sibling donor. The transplant effected a remission with an overall favorable course, but was complicated by Graft Versus Host Disease (GVHD), an abnormal immune reaction with multiple organ involvement. The CI required ongoing maintenance with an immunosuppressant and prophylactic antibiotics to sustain remission, as well as steroid suppression of the GVHD. He remained somewhat weakened from his overall condition, and was unable to meet the physical requirements of his military occupational specialty (MOS) or participate in the Army Physical Fitness Test (APFT). He was therefore placed on a permanent P-3 profile and underwent a Military Evaluation Board (MEB). Additionally the CI developed depression as a consequence of his medical issues. This was diagnosed as an adjustment disorder and forwarded by the MEB as medically acceptable IAW AR 40-501. AML was forwarded to the Physical Evaluation Board (PEB) as a medically unacceptable condition. GVHD and some later complications were submitted to the MEB in a rebuttal letter, but no other conditions were entered on the MEB’s DA Form 3947 or noted on the informal PEB’s DA Form 199. The informal PEB adjudicated the AML as unfitting, rated 10%, and the adjustment disorder as not unfitting. The CI appealed the GVHD and several other conditions as complications of AML and its treatment. These are detailed below and were heard by a formal PEB which rendered the same adjudication as the informal PEB. The CI further appealed to the formal PEB for a 30% rating and Temporary Disability Retired List (TDRL), and cited irregularities regarding the formal PEB proceedings. The findings of the formal PEB were reaffirmed, however, and the CI was medically separated with a combined disability rating of 10%.

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CI CONTENTION: The CI states: ‘I was not provided a fair, impartial PEB hearing. ... Sufficient evidence was submitted to the PEB to be rated at least 30%.‘ The omitted statements from this quote allege procedural breaches and other improprieties associated with the PEB proceedings. The core of his contention is that he ‘was not allowed to add any other disabilities to the MEB results’. The conditions he lists (along with their VA ratings) were depression, GVHD, filamentary keratitis and supraventricular arrhythmia.

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RATING COMPARISON:

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Service PEB – Dated 20050916** | | | **VA (~2 Mo. after Separation) –Effective 20060122** | | | | |
| **Condition** | **Code** | **Rating** | **Condition** | | **Code** | **Rating** | **Exam** |
| AML | 7703-7716 | 10% | AML | 7799-7700 | | 0% | 20060314 |
| GVHD a/w AML | 7399-7345 | | 40% | 20060314 |
| Adjustment Disorder | Not Unfitting | | Depression a/w AML | | 9434 | 50% | 20060303 |
| ↓No Additional DA Form 3947 Entries.↓ | | | Filamentary keratitis | | 6001 | 10% | 20060307 |
| Atrial Fibrillation a/w GVHD  (Deferred→Effective 20060311) | | 7010 | 10% | 20060314 |
| Non-PEB X 1 / Deferred X 3 | | | | 20060314 |
| **TOTAL Combined: 10%** | | | **TOTAL Combined (*Includes Non-PEB Conditions*): 80%** | | | | |

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ANALYSIS SUMMARY:

It is noted for the record that the Board has neither the jurisdiction nor authority to scrutinize or render opinions in reference to the CI’s statements in the application regarding suspected Disability Evaluation System (DES) improprieties in the processing of his case. The Board’s role is confined to the review of medical records and all evidence at hand to assess the fairness of PEB rating determinations compared to Veterans Administration Schedule for Rating Disabilities (VASRD) standards, as well as the fairness of PEB fitness adjudications.

The Board wishes to acknowledge the sentiment expressed by the CI in his PEB appeals, i.e., that the gravity of his condition and predictable lifetime consequences merited consideration for a higher separation rating. This is commonly expressed by our applicants. It is a fact, however, that the DES has neither the role nor the authority to compensate service members for anticipated future severity or potential complications of conditions resulting in medical separation. This role and authority is granted by Congress to the Veterans Administration.

The Board also discussed the existing prior to service (EPTS) issues associated with this case. The CI did not have the requisite active duty time for direct service connection of his conditions, and the development of an intrinsic medical condition like leukemia was almost certainly coincidental with, not a consequence of, his military service. In one of his appeals he invoked the delay in treatment occasioned by the circumstances of the deployment as evidence of service aggravation. Given the clinical course and early remission, that link is quite speculative. More likely than not, the natural history of the disease was not significantly altered by military service. As appropriately constrained by DoDI 6040.44 and by policy, the Board cannot remove a service-rated condition from consideration in its rating recommendations. It does not therefore make formal recommendations regarding EPTS designations in this case, but places this deliberation in the record.

AML. The initial Board consideration is directed to the PEB rating for the AML condition independently of the GVHD question. VASRD §4.117 directs that leukemia be rated 100% during the active treatment phase (not applicable here). It is otherwise rated under the general anemia code (7700) or the aplastic anemia code (7716), ‘whichever would result in the greater benefit’. The PEB chose the latter and the VA the former. Rating under 7700 is based on severity of hemoglobin deficiency and associated symptoms. Hemoglobin less than 10gm/100ml with symptoms is required for a compensable rating. The CI’s hemoglobin value was 14.2 and thus the VA 0% rating under that code was accurate. The 7716 aplastic anemia code is based on the need for ‘continuous medication for control’ (10%) or the frequency of transfusion requirement (CI required none). The PEB based its 10% rating on the requirement for daily medications. By the §4.117 stipulation for defaulting to the most favorable rating, the PEB’s choice of code and rating was the more appropriate one. It must be countered, however, that technically the medications required by the CI were immunosuppressive and were not directed at controlling anemia (which he never had). Given that anemia is a common complication of AML and that the medications were required to maintain remission, the link may be conceded. Although the CI stated in his appeal to the formal PEB, ‘there is sufficient evidence in my case to rate me with at least 30% under VA Code 7703-7716’, the evidence does not provide a VASRD pathway to a higher rating for the leukemia under either applicable code. All evidence considered, there is not reasonable doubt in the CI’s favor supporting recharacterization of the PEB adjudication for the Acute Myelogenous Leukemia condition.

GVHD. The Board next considered the contention that GVHD should be included in the separation rating. Although not elaborated in the NARSUM nor forwarded on the DA Form 3947, the GVHD complication was documented in the NARSUM. It was also appealed in writing along with a letter from a private oncologist providing medical details. The condition is therefore eligible for Board consideration as additionally unfitting for separation rating. In determining the association of GVHD with the overall fitness picture it is important to take note of what the unfitting limitations were. Although there is no Commander’s statement in evidence to provide details of what specific MOS requirements were impaired, the NARSUM and the physical profile provide the necessary information to determine the scope of the limitations. This is confined to generalized weakness, fatigue and overall debilitation. The GVHD was associated with a host of secondary impairments including the eye condition, extensive rash, dental disease, pulmonary symptoms and others. These are not encompassed in the impairments which are established as unfitting and the appropriate ones will be discussed separately. It is documented and clinically likely, however, that GVHD was at least one of the culprits in the generalized weakness and fatigue which were unfitting. This is true to the extent that the unfitting symptoms cannot be clinically parceled among GVHD, residuals of the AML disease process and after effects of the acute treatment phase. The Board believes, therefore, that these generalized manifestations of GVHD should be considered separately unfitting and a basis for additional separation rating. Reasonable doubt is resolved in favor of the CI for recommending GVHD as an additionally unfitting condition by the Board.

The Board now directs its attention to the coding and rating of GVHD. There is no specific VASRD code for this or any clinically equivalent condition. Furthermore, the Action Officer is opposed to the analogous code chosen by the VA (7399-7345) and unconvinced that the 40% rating criteria were met under that code. Rating the clinical manifestations of GVHD under the 7345 code for chronic liver disease is not congruent with the clinical evidence in this case. The CI’s hepatic involvement was minimal (modest enzyme elevations, no hyperammoniemia, no lactate production, etc.) and ‘multi-factorial’ quoting his oncologist. The unfitting symptoms were not from hepatic dysfunction and, understandably, none of the liver-specific symptoms covered in the code were present. The Action Officer opines that the best analogous fit for GVHD in this case, especially for the symptoms rendering it unfitting, is the rating schedule for chronic fatigue syndrome. The Board therefore will render its rating recommendation under 6399-6354. This rating is for debilitating fatigue, cognitive impairment or ‘combination of other signs and symptoms’. It is based on whether symptoms are constant, the degree to which they ‘restrict routine daily activities’ compared to the ‘pre-illness level’ and the frequency (if present) of incapacitating episodes. Nothing in the record notes any respite from the weakness and fatigue, so it may be assumed that the symptoms were constant. The rating provides a definition for incapacitating as ‘requires bed rest and treatment by a physician’. There are some physician recommendations for light activities, but none for bed rest. The rating in this case will be left then to an estimation of activity restriction compared to the previous baseline. The baseline is assumed to be that of a typical active adult male. Therefore the rating scale considered by the Board was restriction < 25% (rated 20%), 25 - 50% (rated 40%) or > 50% (rated 60%).

With this scale in mind, the Board extracted as much hard evidence regarding activity level as could be gleaned from the record. The NARSUM referenced the CI as indicating ‘that he is unable to [do] any APFT events due to his weakened condition’. The physical profile however allowed the 2 mile run at personal pace and all of the other events. The VA rating examiner noted impairment as ‘moderate’ for some activities and ‘severe’ for others, although he engaged in the impossible exercise of sorting this between the AML and GVHD related impairments. He did not elaborate and cited no examples. He noted ‘general health between remissions’ (there was one sustained remission) as ‘fair’. There were numerous other VA specialty rating examinations in evidence. Typical quotes were ‘some fatigue’ and ‘some generalized weakness’. No other examiner used the descriptors moderate or severe for severity of these symptoms or level of impairment. The psychiatric examiner documented active recreational activities. The most detailed description of activity level was from the osteoporosis rating examination which stated ‘Regarding function the patient is independent in activities of daily living. He is ambulatory without assistive device. He is working full time for Stearns County. He has a Masters in geography. He normally can stand for about 30 minutes before he has to sit down. He is able to walk one to two miles before he has to sit down.’ Regarding employment, it was documented by the psychiatric examiner that his job (management) was of long-standing duration and was resumed right after separation. Also helpful were periodic progress notes by the civilian oncologist. Six months prior to separation the report stated, ‘He remains active, doing light chores around the house and occasional walks.’ One month prior to separation the report stated, ‘Indeed, he recently completed a 100-mile bike ride for the Leukemia Society ... and did not have any unexpected problems with this ride.’ One month after separation the note read, ‘[CI’s name] feels markedly better, though not back to normal.’ In reference to the bike ride, it should be noted that the CI stated in his appeal to the formal PEB that ‘The cited bike ride implying a robust state of health was not an aerobic workout or demonstration of endurance.’ He elaborated further, but the Board noted that it conceded that the CI was not in ‘robust’ condition in recommending this rating. The evidence is used as one data point in establishing an estimate of activity limitations. The Board deliberated at length regarding a reasonable estimation in that regard. It was concluded that there was no evidence of considerable impairment in any area of daily activities. Family, recreational and occupational activities do not appear to have been more than modestly compromised. It was agreed that an estimation of overall restriction of routine daily activities was less than 25% from that enjoyed by healthy subjects. GVHD, coded 6399-6354, is therefore appropriately rated 20%.

Psychiatric Condition (Appealed to PEB). It is conceded that the CI’s psychiatric condition was, to a great extent, a result of his unfitting medical conditions. In order to support a recommendation for additional rating, however, the Board must be satisfied that it was separately unfitting. The condition was directly addressed by the MEB, although a full psychiatric examination was not provided in the addendum. The MEB psychiatrist provided an Axis I diagnosis of ‘Adjustment Disorder with Mixed Anxiety and Depressed Mood’ and opined that it met AR 40-501 retention standards. The physical profile was S-2 without weapon restriction. The psychiatric condition was therefore understandably adjudicated as not unfitting by the informal and formal PEB’s. The CI wrote in his appeal, ‘Depression and Anxiety. This condition hampers my ability to perform required tasks and decreases my work efficiency, which are key requirements of a leader and officer. This independently makes me unfit to complete my requirements of a Combat Engineer Officer.’ There is no third-party evidence supporting the CI’s opinion in this regard, although no Commander’s statement or Officer Evaluation Reports are in evidence. Other than the VA psychiatric rating examination, the only other behavioral health information is from some outpatient counseling notes by the VA a few months prior to separation. Although psychiatric impairment is evidenced, psychiatric impairment to the extent of occupational compromise is not evidenced. The VA psychiatrist documented full time employment in a reasonably high-functioning capacity, and noted that the only work loss was from medical appointments. In response to the VA template question ‘symptoms cause significant impairment in social, occupational, or other areas of function’, the examiner entered ‘no’. As the rationale for a 50% psychiatric rating, the VA rating decision (VARD) invoked daily panic attacks and memory impairment. The exam noted that the CI reported daily panic attacks of 2-3 hours duration. Incapacitation for several hours out of every day is not congruent with his overall level of functioning, however. The exam noted a subjective complaint of memory impairment, but did not identify cognitive impairment on the mental status exam. The global level of functioning (GAF) score was 48 (41-50 considered severe), although this must be considered multi-factorial given its inconsistency with the overall psychiatric findings and functional status. The Board deliberated if the factors documented in the VA records outweighed the bases for the PEB’s determination (psychiatric opinion supporting AR 40-501 compatibility and physical profile denoting no unfitting psychiatric impairment). Especially considering the facts that the employment status and lack of evidence for impaired mental performance in the military approached *de facto* proof of fitness, the Board did not find sufficient reasonable doubt in the CI’s favor to support a recommendation for recharacterization of the PEB’s fitness adjudication for the psychiatric condition.

Keratitis Condition (Appealed to PEB). Although not formally adjudicated on the DA Form 199, this issue was heard by the formal PEB. In his appeal regarding the eye condition the CI wrote, ‘This condition renders my ability to have clear vision which is necessary with various engineering tasks from electrically wiring houses to dismantling improvised explosive devices. It independently makes me unfit for the specialty of Combat Engineer as a physical requirement is normal color vision.’ The CI’s opinions are undermined by the ophthalmologic examinations in evidence, however. Visual acuity was minimally impaired. The VARD for the 10% rating provided compensation for ‘active keratitis with ocular discomfort‘, not visual impairment. Color vision was not documented on the examinations in evidence, although color perception is not involved with keratitis. The profile was E-1. All evidence considered, there is not reasonable doubt in the CI’s favor supporting addition of filamentary keratitis as an unfitting condition for separation rating.

Cushing's Syndrome, Osteoporosis and Degenerative Joint Complications of Steroids (Appealed to PEB). The musculoskeletal and systemic complications of prolonged steroid use are not inconsequential and the CI was diagnosed with Cushing’s syndrome and osteoporosis resulting from the steroid requirement. The Cushing’s syndrome was confined to moon fascies and did not involve renal impairment or adrenal insufficiency. Osteoporosis was suggested by a bone density study prior to separation, although one performed three months after separation was equivocal. Bone marrow density was normal for age, although ratios which influence interpretation raised the possibility of occult fractures or mild degenerative arthritis of the spine. These findings were not demonstrated by imaging studies. The CI’s appeal regarding osteoporosis invoked unfitting ‘weakened and brittle bones’; for ‘degenerative joint disease or occult fractures’ it invoked unfitting back pain; and, for Cushing’s syndrome it invoked muscle weakness. All of these connections are unduly speculative in light of the scant clinical evidence in support of them. The bone density loss demonstrated on the studies could not be fairly characterized as causing ‘brittle’ bones. Back pain was noted on the MEB physical and attributed by the CI to a ‘non-ergonomic’ chair and pain from the marrow biopsies. The examiner noted ‘pain in lower back after sitting for a long time’. There was no directed therapy for back problems in the service or temporary profiles for it. Regarding muscle weakness, motor testing on various exams documented 5/5 strength. The permanent profile at separation was U-1/L-1. The CI received no compensable ratings from the VA for any of these conditions. All evidence considered, there is not reasonable doubt in the CI’s favor supporting addition of Cushing’s syndrome, osteoporosis, degenerative joint disease or suspicion of occult vertebral fractures as unfitting conditions (any or all) for separation rating.

Orthopedic and Oral/Dental Complications of GVHD (Appealed to PEB). The CI appealed ‘muscle and joint stiffness and pain - caused by chronic GVHD’ on the same basis as appealed for the musculoskeletal complications discussed above. There is thus an inadequate link to fitness as discussed above. In his appeal he noted ‘extremely dry mouth and difficulty swallowing - caused by chronic GVHD’ which ‘would limit my ability to intake food and fluids, increasing the likelihood of my becoming a heat casualty during combat engineering operations in hot climates.’ There is no medical opinion supporting this conclusion. It is too speculative to support a Board recommendation premised on that basis. The CI’s appeal stated that ‘eight teeth are missing enamel’ as a consequence of dry mouth which ‘would likely render me non-deployable’. No timely service or VA dental examinations are in evidence, although the general VA rating examination stated ‘teeth in good repair’. Dental complications of GVHD and chemotherapy should nevertheless be conceded, but the link to fitness is too tenuous to support a favorable Board recommendation. There is furthermore no basis for a compensable rating if it were added. The VA did not service connect the dry mouth or dental disorders and all of these conditions were considered by the formal PEB. All evidence considered, there is not reasonable doubt in the CI’s favor supporting addition of musculoskeletal complications of GVHD, dry mouth or dental disease as unfitting conditions (any or all) for separation rating.

Contended Arrhythmia and Other Conditions. The CI was treated for a transient episode of atrial fibrillation (rapid heartbeat) two months after separation, and placed on medication for it. It was judged to be secondary to GVHD and was rated 10% by the VA. The CI contends for it in his application. Although a complaint of palpitations was documented in the NARSUM and on the MEB physical, the condition itself surfaced after separation. A ‘crystal ball’ requirement is not imposed on the service PEB’s by the Board; and, the 12 month window specified in DoDI 6040.44 is appropriate for rating comparisons but not for new developments after separation. The arrhythmia condition is therefore not eligible for Board consideration for rating at separation, although it remains eligible for Army Board of Correction for Military Records (ABCMR) consideration. A complaint of dyspnea and pulmonary residuals of chemotherapy were noted on the MEB physical and documented in the record. Pulmonary hypertension was also diagnosed at the same time as the atrial fibrillation. Pulmonary function testing was normal, and no active treatment for pulmonary disease was in place at the time of separation. It was not profiled and not the basis for any compensable ratings by the VA. Some gastrointestinal complaints were noted on the MEB physical and the CI had undergone a civilian GI work-up for potential radiation damage or AML complications of the gut. No significant pathology was identified, although he was maintained on an acid-blocker at separation. There was no evidence of severe or constant pain, protracted vomiting and/or diarrhea or any other potentially unfitting symptoms for GI disease. No GI conditions were coded or rated by the VA. A history of right knee pain (‘not hindering activity’) was noted in the NARSUM. It was not profiled or under active treatment at separation. Several other relatively minor medical conditions were identified in the NARSUM and MEB physical. They had no connection with fitness and are not relevant for Board consideration as additionally unfitting and ratable.

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 Acute Myelogenous Leukemia condition, the Board by a 2:1 vote recommends no recharacterization of the PEB adjudication as not unfitting. The single voter for dissent (who recommended adopting the VA code and 0% rating) submitted the addended minority opinion. In the matter of the Graft Versus Host Disease complication of Acute Myelogenous Leukemia, the Board unanimously recommends that it be added as an additionally unfitting condition for separation rating; coded 6399-6354 and rated 20% IAW VASRD §4.88b. In the matter of the Adjustment Disorder/Depression and Anxiety condition, the Board unanimously recommends no recharacterization of the PEB adjudication as not unfitting. In the matter of the filamentary keratitis, Cushing’s syndrome, osteoporosis, degenerative joint disease, suspicion of occult vertebral fractures, musculoskeletal complications of GVHD, dry mouth, dental disease, pulmonary disease, gastrointestinal disorders, right knee 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 prior medical separation.

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| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Acute Myelogenous Leukemia | 7703-7716 | 10% |
| Graft Versus Host Disease Associated with Acute Myelogenous Leukemia | 6399-6354 | 20% |
| **COMBINED** | **30%** |

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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.

MINORITY OPINION:

As Action Officer my initial recommendation to the Board was to default to the VA code and rating (0%) for the AML condition, in light of the fact that the added rating for the closely intertwined GVHD condition basically absorbed the AML rating. DoDI 6040.44 permits the lowering of individual ratings granted by the PEB as long as the combined separation rating is unaltered or raised. The Board has exercised this option in the past and typically (as in this case) the resulting combined rating is more favorable to the applicant. For balance I am excerpting my draft of that approach, since it explains my rationale and unchanged opinion. It should be noted that the drafts are written as a predictive record of proceedings and the style was left unaltered for this opinion.

The Board believes, therefore, that these generalized manifestations of GVHD should be considered separately unfitting and a basis for additional separation rating. In so doing, however, the Board recognizes that the AML rating itself is rendered even more tenuous. Not only is it now being rated for treatment of a complication (anemia) never experienced, but its truly unfitting sequelae (weakness, fatigue, etc.) are being rated separately. The Board considered combining AML and GVHD as a single condition rated for the latter, but did not believe that the VASRD permits the latitude of rating leukemia outside its specified code. After deliberation the Board agreed that the AML rating should default to the more clinically palatable VA coding and consequent 0% rating in order to justify an overall more favorable rating under an analogous code for the GVHD. This remains compliant with DoDI 6040.44 and offers the more logical approach of rating the disability that constituted the basis for the unfitting determination.

Even though the inclusion of both ratings in this case tips the scale to medical retirement, I believe the rationale for a compensable AML rating was forfeited to justify a rating for GVHD. The principle of ‘robbing Peter to pay Paul’ was invoked to qualify GVHD as unfitting, yet in the rating process Peter was left whole. It is acknowledged that the VASRD does not provide a good rating model for leukemia which has been rescued by stem cell transplant and uncomplicated by anemia. Yet the VASRD is what it is and the clinical facts elaborated in the excerpt are what they are. The PEB conceded permanent service aggravation in this case when it was not medically obligated to do so and conceded that a compensable rating for AML should be ‘tweaked’ from the VASRD even though the VA did not do so. Had the PEB conceded the GVHD complication as an unfitting condition, it could have logically concluded that AML itself was not unfitting. The Board was unanimous in its conclusion that the 20% rating under 6399-6354 fairly reflected the disability associated with the unfitting symptom complex. Anything rated after that would logically not be unfitting.

I respectfully submit that the appropriate recommendation in this case is the draft recommendation submitted to the Board, to wit:

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| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Acute Myelogenous Leukemia | 7799-7700 | 0% |
| Graft Versus Host Disease Associated with Acute Myelogenous Leukemia | 6399-6354 | 20% |
| **COMBINED** | **20%** |

