RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: ARMY

CASE NUMBER: PD0900145 BOARD DATE: 20100126

SEPARATION DATE: 20071227

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SUMMARY OF CASE: This covered individual (CI) was a Specialist/E4 (Infantryman) medically separated from the Army in 2007 after 3 years of service. The medical basis for the separation was Post Traumatic Stress Disorder (PTSD) and Epilepsy due to Head Trauma. Following return from a near-1yr deployment to Iraq, the CI had symptoms of, and was diagnosed with PTSD. He also had new-onset epilepsy which was well controlled on medication. There were a number of stated potential AOR exposures for PTSD as well as a number of alleged different AOR exposures to blast. There were multiple Commander's statements and differing histories of absence or presence of AOR exposures to PTSD stressors and blasts. The CI had evidence of personality disorders (paranoid and antisocial) and head injuries prior to entering Service. The CI's PTSD and Post Traumatic Epilepsy were determined to be medically unacceptable IAW AR 40-501. The CI was referred to the PEB, found unfit for these conditions, determined unfit for continued military service and separated at 20% disability (PTSD 10%, Epilepsy due to Head Trauma 10%) using the Veterans Affairs Schedule for Ratings Disabilities (VASRD) and applicable Army and Department of Defense regulations.

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CI CONTENTION: “Dept. of Army evaluated me at 10% disabling for PTSD. VA rated me 50% disabling for PTSD.”

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RATING COMPARISON:

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| --- | --- |
| **Service** | **VA ( <1 Mo. after Separation)** |
| **Unfitting Conditions** | **Code** | **Rating** | **Date** | **Condition** | **Code** | **Rating** | **Exam** | **Effective** |
| PTSD (*see text*)(MEB Dx 1) | 9411 | 10% | 20071018 | PTSD w/Symptoms of Bipolar D/O, Depressive D/O, Personality D/O, Anxiety D/O, and Insomnia | 9411 | 50%then100% | **20080108****20090401** | **20071228****20090213** |
| Depressive D/O(MEB Dx 4) | Not Unfitting |
| Epilepsy due to Head Trauma (*see text*) (MEB Dx 3) | 8045-8910 | 10% | 20071018 | Post Traumatic Epilepsy | 8045- 8912 | 10% | **20080109** | **20071228** |
| Post-Concussive Syndrome (MEB Dx 2) | Not Independently Unfitting | Post Concussion Syndrome, Migraine Headaches & Memory Loss | 8045-9304 | 10% | **20080109** | **20071228** |
| Paranoid D/O (MEB Dx 5) | Determined to be Personality D/O, which, if determined to render you unable to perform military duty, can be the basis for an admin rather than medical separation | No VA Entry |  |  |  |  |
| Antisocial Personality D/O(MEB Dx 6) | No VA Entry |  |  |  |  |
| History of Alcohol Abuse/Dependence(MEB Dx 7) | Not Unfitting | No VA Entry |  |  |  |  |
| Bilateral Knee Pain (MEB Dx 10) | Not Unfitting | Patellofemoral Syndrome, Right Knee |  | 10% | 20080109 | 20071228 |
| Chronic Back Pain (MEB Dx 11) | Not Unfitting | Low Back Pain |  | 10% | 20080109 | 20071228 |
| No PEB Entry | Note in MEB Psychiatric Consult (Dr Toepp) 20070524, otherwise, Not in DES Package | Pre-Glaucoma Open Angle Both Eyes |  | 10% | 20080109 | 20071228 |
| Left Ear Tinnitus(MEB Dx 12) | Not Unfitting | Tinnitus |  | 10% | 20080109 | 20071228 |
| GERD(MEB Dx 8) | Not Unfitting | Hiatal Hernia (Claimed as GERD |  | 10% | 20080109 | 20071228 |
| No PEB Entry | 2808 Med Exam: Hearing Loss | Hearing Loss, Left Ear |  | 0% | 20080109 | 20071228 |
| Left Inguinal Lymphadenopathy(MEB Dx 13) | Not Unfitting | Lymphadenopathy w/Residual Scar |  | 0% | 20080109 | 20071228 |
| Chronic Intermittent Right Shoulder Pain(MEB Dx 9) | Not Unfitting | Right Shoulder Condition;  | NSC |  |  |  |
| No PEB Entry | Not in DES Package | Right Ankle Condition; Hearing Loss Right Ear | NSC |  |  |  |
| **TOTAL Combined: 20%** | **TOTAL Combined (*Includes Non-PEB Conditions*):** **80% from 20071228****100% from 20090213**   |

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**ANALYSIS SUMMARY:** Following a nearly 1yr infantryman deployment to Iraq, the CI had symptoms of PTSD clearly diagnosed with marked military impairment, but, "mild social and industrial impairment." The CI also had new epilepsy (general seizure x2) well controlled on medication. There were a number of claimed AOR exposures to stressors for PTSD as well as a number of different AOR exposures to blast which were not supported in all of the CI's Commander's statements. The Physical Evaluation Board (PEB) noted that the "In-Theater Commander’s statement does not corroborate exposure to IED blast or other head injury. According to Commander, there is no noticeable impairment of duty performance due to mental health issues." Important in this case are the CI's complicating diagnoses of severe personality disorders (both paranoid and antisocial) and head injuries from sports and an MVA prior to Service entry. The PEB found PTSD as unfitting. The military and initial VA exams for PTSD were essentially identical from the VASRD-criteria perspective. The PEB found Depressive Disorder, and history of alcohol abuse/dependence not unfitting and the Paranoid and Antisocial Personality Disorders were conditions not considered disabilities. There were no psychiatric exams which clearly apportioned the CI's mental health symptoms to differing diagnoses. The PEB's inclusion of Personality Disorder "caveats" in the disability description may indicate a subtraction from overall disability rating for mental health that did not include specifically showing any deductions or decrement due to non-PTSD mental health diagnoses. Reading of multiple Commanders’ memos supports the CI's exposure to dead bodies (friend/foe) and clean-up.

The PEB found Epilepsy due to head trauma as unfitting and presumed Service aggravated (pre-existing head traumas). The PEB description noted "In-Theater Commander's statement does not corroborate exposure to IED blast or other head injury": which is important in both this condition and post-concussive syndrome (TBI). Independent review of multiple Commanders’ memos and the record indicate that the CI was exposed to at least 1 event likely to cause TBI (projectile strike to the helmet with aid station noting resolved concussion). The PEB found Post-Concussive Syndrome as not unfitting. The CI's separation date of 20071227 is after the date of application of VA Training Letter TL 07-05, AUG 2007 for rating TBI under VASRD code 8045, §4.124a, and prior to the VASRD revision for TBI in 2008 and the 2008 NDAA. Therefore, the new VASRD TBI criteria are not applicable, but TL 07-05 should be applied in this case.

There was no unfitness contention for the CI's original MEB conditions of Right Shoulder Pain, Chronic Bilateral Knee Pain, Chronic Intermittent lower back pain (LBP) left inguinal adenopathy or left ear tinnitus. There were no Commander's comments or significant profiles regarding any duty restrictions from these conditions and they were found to meet retention standards.

CC Statement (CPT Burgess) 20070628: Under my command since May 2007; proven to be the standard performer throughout; CI’s prior chain of command concur that CI had no problem performing duties as an infantryman while deployed to OIF IV or prior deployment; during OIF patrol was grazed by an unknown projectile from enemy weapon system; was knocked off his feet, but was not rendered unconscious and completed patrol; medics diagnosed him with a possible mild concussion; prescribed Motrin and deemed him return to duty; CI completed deployment without any mention of further medical concerns. Once home from OIF, CI had martial and civil disturbance issues which led to multiple court appearances. CI continued to train as Grenadier and Platoon member without any additional medical issues. During Gunnery Training Exercise, Apr 02, CI complained of possible seizures. Medics cleared CI for continued training and CI completed the exercise to standard. CI followed up with series of appointments and diagnosed with TBI and PTSD. CI prescribed Percocet, Ambien, Seroquel, Tylenol 3, Wellbutrin, Lamictal, Kionpin, Depokote and Zomig, and issued temporary profile. Due to P3 permanent profile (Jun 07) limitations, he is not capable of performing 11B duties. CI has been assigned admin duties and attends appointments. He works 40hrs/week and performs satisfactorily. He works well enough independently and is able to maintain an appropriate relationship w/peers and superiors.

CC Statement (CPT B---) 20070807: SPC C--- was deployed to Iraq from December 2005 to November 2006. During that time, he was continually exposed to direct fire from the enemy. He was exposed to deceased enemy bodies. SPC C--- was present on several occasions when friendly and enemy bodies were being cleaned up. The soldier never witnessed any downed aircraft and did not ever directly injure or kill anyone. The soldier did not treat or care for any deceased or severely injured personnel. SPC C---'s behavior was significantly different after the deployment than it was prior to and during the deployment. He experienced marital issues and was cited for civil disturbances that resulted in court appearances.

Profile 20070904: P3, S3 for (1) Chronic Post-Traumatic Stress Disorder; (2) Post-Concussion Syndrome (Chronic Headaches); (3) Post-Traumatic Epilepsy

**Military**

**Condition 1 PTSD (CI Contention).**

IPEB 20071018: mild, due to exposure to combat trauma during duty as Infantryman in Iraq (10 A/C,CIB), complicated by longstanding formal Axis II personality disorders manifested by paranoia, impulsivity, irritability, violence, lack of remorse, and problems with authority causing recurrent encounters with the law. PTSD symptoms are mild and include physiological reactivity with exposure to cues, avoidance, and irritability, and exacerbate some symptoms of the personality disorders. In-Theater Commander's statement does not corroborate exposure to IED blast or other head injury. According to Commander, there is no noticeable impairment of duty performance due to mental health issues. Unfit due to potential for decompensation with further duty in a combat environment. Treated with psychotropic medications, rated 10% due to symptoms that require continuous medications. (MEBD Dx 1, NARSUM, Psychiatry MEB consult, In-Theater statement, Commander's performance statement)

NARSUM 20070904:

MEDICAL CONDITIONS (1) PTSD – From 20070524 Psychiatric Consultation (Dr Toepp): The· Soldier was given an Axis I diagnosis of *"Post-traumatic stress disorder,"* for which his impairment for further military duty was felt to be *"Marked."* He was issued a permanent S3 profile and subsequently referred for Medical Evaluation Board for this condition. He was also given Axis I diagnosis of *"Depressive disorder not otherwise specified,"* for which his impairment for further military duty was felt to be *"minimal."* Additional diagnoses included *"Nicotine dependence"* and *"Partner Relational Problem"* (a divorce has since been initiated). Axis II diagnoses included *"Paranoid personality disorder"* and *"Antisocial personality disorder."*

PAST MEDICAL HISTORY: A MEPS physical from June 2004 revealed no ongoing chronic health problems or significant abnormalities on exam. The Soldier did apparently require administrative waivers because of his prior history of marijuana use, as well as prior arrests. He was also ticketed at one point for a minor in possession of alcohol offense in 2003. During his childhood, in addition to the injuries/concussions described above, the Soldier states that he has also had abandonment issues, anger problems, mood swings, and paranoia his *"entire life."* He was diagnosed with hyperactivity at the age of 9, but does not recall any regular professional follow-up or medical treatment for it.

Since entering the military, in addition to the issues described above, the Soldier has also had chronic right shoulder pain (was on temporary profile in 2005, with no current significant deficits), chronic bilateral knee pain, intermittent low back pain (since one month after his redeployment from Iraq), gastroesophageal reflux disease (GERD), and recent left inguinal lymphadenopathy (pending surgical excision for recent recurrence). Also, despite a recent normal hearing screen, the Soldier also reports continued left ear tinnitus since his return from Iraq.

Social history-The Soldier has been a smoker since the age of 14, and he states that he has smoked up to one half pack per day. He says the only time he has had alcohol to excess was after his high school graduation, but the Soldier was referred to the ASAP program by his command because of reported alcohol dependence since his return from Iraq. He denies any illegal drug use since 2 years prior to enlisting in the U.S. Army. Family history-TBI with seizure disorder (father), history of unknown drug abuse (mother and father), cancer, and glaucoma.

CURRENT MEDICATIONS: Depakote, Seroquel.

PHYSICAL EXAMINATION: A general physical exam was completed on 21 June 2007 and it was generally unremarkable. See DD 2807 and DD 2808 for details.

FUNCTIONAL STATUS: This Soldier has not worked in his primary MOS since April 2007, and his duties since that time have primarily included various details, as well as attending his numerous medical appointments. When asked how his medical conditions affect his performance of MOS-related tasks, he states that he feels that he might black out if his *"Adrenalin pumps.*" He also feels that he would *"Freak out"* in a combat setting. In addition, he is concerned about having headaches or passing out with any exertional activity. He cites his poor memory, possibility of seizures, and general paranoia as other limiting factors. Other military functional activities, including training for the Army Physical Fitness Test (APFT); are affected in that he is unable to run or do push-ups or sit-ups because of his exertional headaches. His last APFT was in March 2007, at which time he scored 268.

COMMANDER'S PERFORMANCE STATEMENT: A commander's performance statement dated 28 June 2007 from CPT R--- H. B---, Jr., Rear Detachment Commander, indicates *"Currently, SPC Crumbley is still unable to meet the requirements of his previous duty position due to his recent permanent profile and pending Medical Evaluation Board."* COMPLIANCE STATEMENT: There is no indication of non-compliance with medical treatment or recommendations. PROGNOSIS: This Soldier's conditions are unlikely to improve with continued military service, and it appears doubtful that he will ever be able to fully perform the duties required of a U.S. Army Soldier, especially in a combat setting. PROFILE AND DUTY RESTRICTIONS: For the MOS of 11B, the physical demands rating "very heavy," and the accession profile is-listed as 111221. The Soldier is now on a permanent 311113 profile dated 4 September 2007 with assignment limitations of no functional activities other than wearing a wearing a protective mask and all chemical defense equipment; no events on the Army Physical Fitness Test other than the alternate walk and bike events; no unlimited running, walking, biking, or swimming; walking; biking and swimming at own pace and distance only; no upper or lower body weight training; no access to firearms; no assignments remote from definitive psychiatric care; avoid assignments where sudden loss of consciousness would put Soldier or others at risk, such as driving military vehicles, using heavy machinery, or working at heights.

DIAGNOSES:

1. PTSD. Related to this condition, Soldier fails to meet retention standards IAW AR 40-501, Ch 3-33 b and c.

2. Post Concussion Syndrome, w/chronic headache (also memory problems, which do not fall below retention standards) (EPTS). Related to this condition, the Soldier fails to meet retention standards IAW AR 40-501, Ch 3-30 j.

3. Post Traumatic Epilepsy. Related to this condition, the Soldier fails to meet retention standards in accordance with AR 40-501, Chapter 3-30 i. (1).

Additional diagnoses that do not cause Soldier to fall below retention standards.

4. Depressive disorder, not otherwise specified (not unfitting for military duty).

5. Paranoid personality disorder.

6. Antisocial personality disorder.

7. History of alcohol abuse/dependence.

8. Gastroesophageal reflux disease.

9. History of chronic intermittent right shoulder pain.

10. History of chronic intermittent bilateral knee pain.

11. Chronic intermittent low back pain.

12. Left ear tinnitus.

13. Recurrent left inguinal lymphadenopathy.

When asked if he would like to remain in the U.S. Army, the Soldier stated *"No."*

MEB Psychiatric Consult (Dr Toepp) 20070524: DIAGNOSIS: AXIS I - Post-traumatic stress disorder, chronic, mild, manifested by physiological reactivity on exposure to cures that resemble combat duty, efforts to avoid thoughts feelings or conversations associated, decreased interest in significant activities, a feeling of detachment from others, restricted range of affect, a sense of foreshortened future, difficulty falling and staying asleep, irritability, difficulty concentrating, hypervigilance, and exaggerated startle response; Stress: extreme, combat duty, and marital problems; Predisposition: severe personality disorder; Impairment for military duty: marked; Impairment for social and industrial adaptability: mild; Line of duty: yes;

EPTS: no.

Depressive disorder not otherwise specified, manifested by dsyphoric mood, lowered motivation, lowered energy, and feelings of worthlessness and hopelessness; Stress: extreme, combat duty, legal problems, and marital problems; Predisposition: severe personality disorder; Impairment for military duty: minimal; Impairment for social and industrial adaptability: none

Line of duty: yes; EPTS: no

AXIS II: Paranoid personality disorder, manifested by suspecting that others are harming him, preoccupied with doubles about the loyalty of others, reluctance to confide in others because of fear that the information will be used against him, reading hidden demeaning or threatening meanings into benign remarks, persistently, bearing grudges, perceiving attacks on his character that are not apparent to others, and is quick to react angrily.

- Antisocial personality disorder, manifested by failure to conform for social norms, impulsivity, irritability and aggressiveness, reckless disregard for safely of others, and lack of remorse.

AXIS III: Headaches; Rule out Gastroesophageal reflux disease

AXIS IV Stressors: combat duty, marital problems, and legal problems

AXIS V GAF current 55

PROFILE Psychiatric S3 profile

PRESENT CONDITION: This is a 23-year old male with a long history of aggressiveness, impulsivity, and irritability, which were manifestations of a severe personality disorder. He has a history of several head injuries prior to service. He sought help for his symptoms in Behavioral Health prior to deployment. His symptoms have been exacerbated by combat duty in Iraq, and possibly by head trauma. He developed symptoms of post-traumatic stress disorder, most significantly, an increase in irritability. He is fully aware of the possible consequences of the behavior. He is capable of managing his emotions and his behavior. His reports of blackouts sound like intense anger and impulsiveness. He can’t recall everything that happens in good detail. Neuropsychological testing shows normal performance in all areas. His report of "hearing voices" does not appear to-be psychotic in nature, and his description of this symptom is not consistent with a major psychiatric problem. He is currently receiving psychiatric treatment for his post-traumatic stress disorder symptoms. His prognosis is adversely affected by his significant underlying personality disorder, and because of this he is at risk for future violence. His marital situation is volatile and should be assessed as soon as possible.

VARD 20080516 rated at 50% from exam dated 20080108: At the time of your examination you were alert and oriented in time, place, person, and the purpose of the visit. Appearance and hygiene were casual, but appropriate. You were chewing on some metallic object throughout the interview. Behavior was formal and guarded. Mood was depressed. Your depression is near continuous, but does not affect your ability to function independently. Communication, speech, and concentration are normal. You have panic attacks when in a large crowd during, which you feel anxious and has palpitations lasting for a few minutes. You are suspicious by nature. You report "everybody is up to something." There are no delusions. You denied hallucinations except ringing in the ears. You have obsessional rituals like checking on doors and locks and periphery of the environment you are in. Thought processes indicate paucity of thought, but no delusions. You did not have any impaired judgment or impaired abstract thinking. You have moderate memory problems such as retention of highly learned material and forgetting to complete tasks. You denied any suicidal or homicidal ideation. The examiner has assigned a Global Assessment of Functioning (GAF) {*55 per C&P exam*}. An evaluation of 50 percent is assigned for occupational and social impairment with reduced reliability and productivity due to such symptoms as: flattened affect; circumstantial, circumlocutory, or stereotyped speech; panic attacks more than once a week; difficulty in understanding complex commands; impairment of short- and long-term memory (e.g., retention of only highly learned material, forgetting to complete tasks); impaired judgment; impaired abstract thinking; disturbances of motivation and mood; difficulty in establishing and maintaining effective work and social relationships.

C&P 20080108: MENTAL STATUS EXAMINATION: The claimant is a 23-year-old white male who is a fairly reliable historian, but was quite guarded and tense. He was alert and oriented in time, place, person, and the purpose of the visit. His appearance and hygiene were casual, but appropriate. He was chewing on some metallic object throughout the interview. His behavior was formal and guarded. His mood was depressed. His depression is near continuous, but does not affect his ability to function independently. His communication, speech, and concentration are normal. He has panic attacks when he is in a large crowd during, which he feels anxious and has palpitations lasting for a few minutes. He is suspicious by nature. He reports he feels "everybody is up to something." He has no delusions. He denied hallucinations except ringing in his ears. He does have obsessional rituals like checking on doors and locks and periphery of the environment he is in. His thought processes indicate paucity of thought, but no delusions. He did not have any impaired judgment or impaired abstract thinking. He does have moderate memory problems such as retention of highly learned material and forgetting to complete tasks. He denied any suicidal or homicidal ideation.

MEDICAL RECORD REVIEW: Medical record review consisted of reviewing his C-file, which had his service medical records. He has been diagnosed as having several syndromes, but I think most of those are symptoms related to posttraumatic stress disorder.

DIAGNOSES: For the claimant's claimed condition of posttraumatic stress disorder: bipolar disorder: personality disorder, anxiety disorder, depressive disorder, memory loss and insomnia.

Axis I: Posttraumatic stress disorder. Axis V: Current GAF score is 55.

QUESTIONS: Clarifications from the examiner. The traumatic event is persistently experienced as: Recurrent recollection of the event; Persistent avoidance of stimuli associated with trauma: 1. Sense of a foreshortened future. 2. Feeling of detachment from others. 3. Restricted range of affect; Persistent symptoms of increased arousal: 1. Difficulty falling or staying asleep. 2. Hypervigilance; The disturbance causes impairment in social, occupational, and other areas of functioning. The disease is chronic. Symptoms have lasted for three months or more.

REMARKS: The claimant is able to manage his benefit payment in his own best interest. The claimant has occasional interference in performing activities of daily living. The claimant's psychiatric symptoms cause occupational and social impairment with occasional decrease in work efficiency and intermittent inability to perform occupational tasks' although generally the person is functioning satisfactorily with routine behavior, self-care, and normal conversation. The claimant has depressed mood, anxiety, suspiciousness, panic attacks, and chronic sleep impairment and moderate memory loss. The claimant has no difficulty understanding simple or complex commands. The claimant does not pose any threat of persistent danger or injury to self or to others.

VARD 20090730 (exams of 20090217 and 20090411 and treatment records of 20080508 to 20090707) rated CI at 100%. The evaluation of PTSD with symptoms of bipolar disorder, depressive disorder, personality disorder, anxiety disorder, and insomnia is increased to 100 percent disabling effective February 13, 2009. The cited evidence from Dr. A--- shows that you are unable to maintain gainful employment due to this service-connected disability. Examination showed orientation is within normal limits. Appearance and hygiene were appropriate. Behavior was appropriate. You maintained good eye contact during the exam. Affect and mood exam indicate impaired impulse control, some unprovoked irritability and periods of violence which have resulted in social isolation in an attempt to avoid confrontation. Communication was within normal limits. Speech was within normal limits. The concentration was poor. Panic attacks are absent. There is no suspiciousness present. There is no report of a history of delusions. At the time of examination, there was no delusion observed. Hallucination history is present occasionally. At the time of examination, there was no hallucination observed. Obsessional rituals are absent. Thought processes were appropriate. You are able to read and understand directions. You do not have slowness of thought nor appear confused. Judgment is not impaired. Abstract thinking is normal. Memory is within normal limits. Suicidal ideation is absent. Homicidal ideation is absent. There are behavioral, cognitive, social, affective or somatic symptoms attributed to PTSD and are described as nightmares, combat memories, flashbacks, isolation, avoidance, insomnia, agitation, loss of interest, feelings of detachment, hypervigilance, exaggerated startle. At this examination you were assigned a Global Assessment of Functioning (GAF) score of 50 (out of 100). GAF is a guideline to determine the overall level of social and occupational functioning. According to the VA examiner, the prognosis is good provided that you receive proper treatment and comply with it. VA outpatient treatment records show continued treatment; An earlier effective date was considered based on the cited VA outpatient treatment records, however, these records did not justify an earlier effective date based on the current VA requirements for a next higher evaluation.

**Discussion:** The CI was diagnosed with PTSD and was found unfit for PTSD at 10%. There was no TDRL period and per the DOD policy and IAW VASRD §4.129 the CI should be rated at 50% for PTSD for 6-months and then a permanent rating determined. The CI separated 20071227 and the period for reassessment should be prior to 20080627. The available VA rating exams are from 20080108 (50% by criteria versus §4.129 minimum) and 20090401 (100%). There were no psychiatric examinations which apportioned the CI's mental health symptoms sufficiently to make a deduction for any "not unfitting", or "non-medical disability related" mental health diagnoses. There were no medical waivers for CI's entry to Service, despite the retrospective note that personality disorders pre-existed Service. The record indicates that pre-deployment the CI demonstrated higher functioning behavior compared to post-deployment. The VA examiner (20080108) related PTSD as being the CI's primary difficulty "has been diagnosed with bipolar disorder, depressive disorder, personality disorder, anxiety disorder, and insomnia in the past, but I feel all these are probably symptoms secondary to PTSD, which I think is his primary difficulty." The military and initial VA exams for PTSD were essentially similar from the VASRD-criteria perspective. The PEB 10% rating aligns with the DODI 1332.39, encl 2, para E2.A1.5.1.4.5.in effect at the time for "Mild" social and industrial impairment. The PEB found Depressive Disorder, and history of alcohol abuse/dependence not unfitting and the Paranoid and Antisocial Personality Disorders were conditions not considered disabilities. There were no psychiatric exams which clearly apportioned the CI's mental health symptoms to differing diagnoses. The PEB's inclusion of Personality Disorder "caveats" in the disability description may indicate a subtraction from overall disability rating for mental health that did not include specifically showing any deductions or decrement due to non-PTSD mental health diagnoses. There is therefore no reasonable basis for any formal deduction for personality disorders. The VA PTSD evaluation of 20080108 most closely approximates that 6-month post separation final PTSD rating time period when viewed in conjunction with additional VA treatment records. The CI had monthly, or more frequent, VA treatment visits for PTSD with records of May, June, and July 2008 indicating significant and changing psychotropic medications, a stable GAF of ~55, and work and social difficulties that demonstrated findings consistent with a 50% PTSD rating. The VA PTSD exam of 20090401 (outside the 6-month post-separation period), although rated at 100% by the VA, did not independently rate at 100%. All evidence considered, the Board recommends an initial PTSD rating under TDRL at 50% IAW §4.129 for 6 months and rating at 50% as the fair permanent separation rating for PTSD.

**Condition 2 Depressive D/O.** See Condition 1 (MEB Dx 4) PEB not unfitting.

**Condition 3 Epilepsy due to Head Trauma.** IPEB 20071018: Epilepsy due to head trauma, suspected due to significant head injury prior to service, presumed service aggravated. Had two observed seizures in Mar 07 witnessed by his wife; none since initiating anti-seizure medications. EEG showed focal left temporal slowing; brain MRI normal. Rated for confirmed diagnosis of epilepsy with a history of seizures. (MEBD Dx 3 and NARSUM); MEB Dx. 3: Post traumatic epilepsy.

NARSUM 20070904: MEDICAL CONDITIONS (2) Post Concussion Syndrome w/Chronic Headaches & Post Traumatic Epilepsy.The Soldier reported a history of multiple concussions prior to his military service. These included several during early childhood, falling off the back of a moving truck a the age of 19, being a passenger in a car that hit a tree going 60 miles an hour, and a couple of concussions while playing football in high school. However, though the accidents involving vehicles were mentioned in his MEPS physical, no mention was made of the actual concussions themselves. The Soldier did not require any waivers to enlist, and he apparently had no known deficits at that time. While in Iraq, the Soldier reported several incidents of exposure to blast trauma. One was an IED that exploded in front of the Bradley vehicle he was driving in December 2005. In June 2006, a bullet hit his Kevlar causing a brief loss of consciousness. And then, in October 2006, another IED hit the rear of his Bradley vehicle, but at that time he did not lose consciousness. He also had a 60mm grenade explode approximately 10 feet away from him on the other side of a concrete wall. Though he had no symptoms in theatre, he has had daily headaches since his return from Iraq. The headaches are described as *"throbbing"* and are often associated with nausea and photophobia. The Soldier has also been noted by his wife to have had at least two convulsive episodes, one, in March 2007, lasting two to three minutes with bilateral upper and lower extremity stiffness and contraction. He had a second similar episode approximately two weeks later. The Soldier was seen by Neurology in May 2007 after an MRI of the brain, which was negative, was done in April 2007. He had been started on Lamictal and Depakote, and he had no further seizures after that time. However, because of his headaches, the Depakote dose was increased while the Lamictal was discontinued. An EEG was performed in June 2007, and it was read as *Abnormal EEG (awake, asleep) one focal slowing, left temporal.* But, a second EEG performed two days later was read as *"Normal EEG."* When he followed up with Neurology in August 2007, he reported no further seizure activity. He said that his headaches have decreased, but they continued to affect his ability to function in his MOS. His Depakote dose was 1000 mg q.h.s. with 125 mg q.a.m. His most recent Depakote level was in July 2007 and was 114.0 (normal range 50-125). He was told to continue Depakote. He was also given Zomig as an abortive agent, but has found it to be ineffective. The a.m. Depakote dose was increased to 250 mg in September 2007 because of an emotional outburst that occurred. He states that he currently has headaches approximately three times per week. He has missed work twice since the onset of his headaches, stating that the headaches do become incapacitating at times.

The Soldier had also reported memory problems since his return from Iraq. A neuropsychiatric evaluation was done in May 2007, along with the other work-up described above. In addition to having multiple concussions prior to his military service, he also admitted to using marijuana, hallucinogens, and various other *''pills.''* But, he insisted that his memory problems were new since his return from Iraq. The neuropsychiatric evaluation resulted in a final Axis I diagnosis of *"Post concussion Syndrome, chronic,*" in addition to the PTSD noted above. However, the post concussive syndrome, in general, was felt to be EPTS, and the possibly associated cognitive decline was not felt to be unfitting for military duty.

Reference additional NARSUM comments in Condition 1.

VARD (diagnosed as Post Traumatic Epilepsy) 20080516 was rated at 10% based on exam of 20080109: We have assigned a 10 percent evaluation for examination findings that note the condition has existed for 9 month(s). You a minor seizure disorder, hands and feet will lock with convulsions. It is evoked by TV and it is alleviated by the medication Depakote. Over the last 2 years, you have had 2 attacks in total, averaging 2 each month. You kept no attack diary. The condition does not cause pain. Currently you are receiving the following treatment for this condition: Depakote for 1 year and the response has been good. There have been no side effects.

C&P 20080109: We have assigned a 10 percent evaluation for examination findings that note the condition has existed for 9 month(s). You a minor seizure disorder, hands and feet will lock with convulsions. It is evoked by TV and it is alleviated by the medication Depakote. Over the last 2 years, you have had 2 attacks in total, averaging 2 each month. You kept no attack diary. The condition does not cause pain. Currently you are receiving the following treatment for this condition: Depakote for 1 year and the response has been good. There have been no side effects.

**Discussion.** The PEB stated, and records supported, that the CI had two observed seizures in Mar 07. These were described as "lasting two to three minutes with bilateral upper and lower extremity stiffness and contraction" without comment on any postictal period or loss of bowel or bladder function. The PEB coded this condition under 8045-8910 (Residuals of traumatic brain injury (TBI))-(Epilepsy, grand mal), while the VA rated it as 8045-8912 (Residuals of traumatic brain injury (TBI))-(Epilepsy, Jacksonian and focal motor or sensory). The CI's seizure appeared to be myoclonic and therefore should be considered "Minor" for VASRD rating IAW the notes under General Rating Formula for Major and Minor Epileptic Seizures: " Note (1): A major seizure is characterized by the generalized tonic-clonic convulsion with unconsciousness." and "Note (2): A minor seizure consists of a brief interruption in consciousness or conscious control associated with staring or rhythmic blinking of the eyes or nodding of the head (“pure” petit mal), or sudden jerking movements of the arms, trunk, or head (myoclonic type) or sudden loss of postural control (akinetic type)." As the CI was separated in 20071227, two minor seizures in Mar 07 fall beyond the six months required for a 20% rating. A recommendation of no recharacterization of the PEB’s adjudication for the Epilepsy due to head trauma condition is therefore indicated.

**Condition 4 Post-Concussive Syndrome. (Also see Condition #3)**

IPEB 20070108: MEBD Dx #2, Post-Concussive Syndrome. The PEB did not find the condition independently unfitting. The condition is suspected due to head injuries prior to service, currently with only mild symptoms that do not significantly interfere with military duty. - Not rated. NARSUM 20070904: Reference Conditions 3 & 1

VARD (diagnosed as Post Concussion Syndrome, Migraine Headaches & Memory Loss) 20080516: This condition, which existed prior to military service, permanently worsened as a result of service. The preservice percentage is normally deducted before assigning any service connected evaluation less than 100 percent. Since the preservice percentage is zero, no deduction is necessary. We have reached this decision based upon review of the service treatment records that reveal you encountered an improvised explosive device (lED) in December 2005 and May 2006. The records further reveal that you sustained two concussion prior to entrance on active duty falling off the back of a moving truck at the age of 19 and being a passenger in a car that hit a tree going 60 miles an hour and a couple of concussion while playing football. However, the medical board in its final determination concluded that the post concussion syndrome was exacerbated by military service.

We have assigned a 10 percent evaluation for purely subjective complaints such as headache, dizziness, insomnia, etc., recognized as symptomatic of brain trauma. We have assigned an effective date of December 28, 2007 the date following your release from active service as your claim was received within one year of your discharge.

C&P 20080109: Service connection for post concussion syndrome, migraine headaches and memory loss has been granted because this condition, which existed prior to military service, permanently worsened as a result of service. The preservice percentage is normally deducted before assigning any service connected evaluation less than 100 percent. Since the preservice percentage is zero, no deduction is necessary. We have reached this decision based upon review of the service treatment records that reveal you encountered an improvised explosive device (lED) in December 2005 and May 2006. The records further reveal that you sustained two concussion prior to entrance on active duty falling off the back of a moving truck at the age of 19 and being a passenger in a car that hit a tree going 60 miles an hour and a couple of concussion while playing football. However, the medical board in its final determination concluded that the post concussion syndrome was exacerbated by military service.

We have assigned a 10 percent evaluation for purely subjective complaints such as headache, dizziness, insomnia, etc., recognized as symptomatic of brain trauma.

**Discussion.** The PEB found Post-Concussive Syndrome as not unfitting. However, the PEB found Epilepsy due to head trauma as unfitting with presumed Service aggravated (pre-existing head traumas) and coded it as 8045-8910. Therefore, it appears that the PEB granted that the CI had head-trauma despite the caveat in their disability description that “**In-Theater Commander’s statement does not corroborate exposure to IED blast or other head injury."** The CI had documented pre-Service head trauma events.Independent review of multiple Commanders’ memos and the record indicate that the CI was exposed to at least 1 event likely to cause TBI (projectile strike to the helmet with aid station noting resolved concussion).

Since the CI's separation date (20071227) is after the date of application of VA Training Letter TL 07-05, AUG 2007 for rating TBI under VASRD code 8045, §4.124a, prior to the VASRD revision for TBI in 2008. Therefore, TL 07-05 should be applied in this case. The CI's TBI residuals should be rated with separate coding regardless of their independently fit/unfitting determination so long as the CI was unfit for any TBI attributed symptoms. Memory loss is included under the CI's PTSD overall rating as predominate to rating under this code. The CI should be rated for Post Concussive Syndrome (separate from Epilepsy due to head trauma) as 8045 with inclusion of his subjective symptoms (headache and dizziness) at 10%.

**Condition 5 Paranoid Personality Disorder &**

**Condition 6. Antisocial Personality Disorder.** IAW DODI 1332.38 encl 4, para E4.13.1.4 these conditions are not considered physical disabilities.

Military: See Condition 1 (MEB Dx 5 & 6). VA: Included under PTSD exam and rating.

**Condition 7: History of Alcohol Abuse/Dependence.** IPEB 20070108: Not Unfitting (MEB Dx 7). VA: No entry

**Condition 8: Bilateral Knee Pain.** IPEB 20070108: Not Unfitting (MEB Dx 10)

NARSUM 20070904: Past Med Hx: Chronic bilateral knee pain (since one month after his redeployment from Iraq); Physical Exam in DD 2808 (Med Exam) list Lower Extremities normal, but diagnosed bilateral knee pain w/ no ROM specified.

VARD (diagnosed as Patellofemoral Syndrome, Right Knee) 20080516: The VA rated the right knee at 10% for painful motion based on an exam of 20080109 that demonstrated flexion limit at 135 degrees due to pain. The left knee was not ratable (normal ROM).

This condition did not rise to the level of being unfitting and is therefore not ratable.

**Condition 9: Chronic Back Pain.** IPEB 20070108: Not Unfitting (MEB Dx 11) NARSUM 20070904:

NARSUM 20070904: Past Med Hx: Intermittent Low Back Pain (since one month after his redeployment from Iraq); Physical Exam in DD 2808 (Med Exam) list Spine normal with no diagnosis or ROM

VARD (diagnosed as Low Back Pain) 20080516: The VA rated the LBP based on exam of 20080109 that demonstrated painful motion with thoracolumbar spine flexion limited to 85 degrees and combined ROM to 215 degrees.

This condition did not rise to the level of being unfitting and is therefore not ratable.

**Condition 10: Left Ear Tinnitus.** IPEB 20070108: Not Unfitting (MEB Dx 12)

NARSUM: "Also, despite a recent normal hearing screen, the Soldier also reports continued left ear tinnitus since his return from Iraq."

VARD (diagnosed as Tinnitus) 20080516 and rated it at 10% based on exam of 20080107: The condition is noted in your service treatment records as of May 3, 2007; We have assigned a 10 percent evaluation based on examination findings that has determined, your tinnitus is persistent in nature; the diagnosis that has been given is ringing in the left ear. The condition has existed for 6 months and began after exposure to IED's, a grenade, bullet off a kevlar and a palidon that fires a 1.55 round went off near the veteran in Iraq. The current symptoms are ringing in the left ear and having to ask people to repeat themselves; having to play music loud. The claimant is not receiving any treatment for his condition. Although the veteran had access to hearing protection, he could not use it during, combat because he needed to hear commands. He reports tinnitus for 6 months. It began after noise exposure in Iraq. The tinnitus occurs in the left ear and it is persistent. His duties during military service consisted of infantry. He fired weapons with his right hand. He used hearing protection. He required a hearing conservation program. He participated in hunting or recreational shooting without using any hearing protection. He has used power tools with hearing protection being used. He rode motorcycles or personal watercraft, or used other loud recreational equipment without using any hearing protection. He had been exposed to loud music without using any hearing protection. He has history of head trauma: IED's, car wrecks and grenades. There is no hearing loss present on the right and there is hearing loss present on the left: sensorineural hearing loss in the left ear and persistent tinnitus in the left ear; In reference to the question "IS IT AT LEAST AS LIKELY AS NOT THAT THE CURRENT HEARING LOSS IS DUE TO MILITARY NOISE EXPOSURE AS AN INFANTRYMAN? PLEASE PROVIDE RATIONALE", the following is the answer: It is at least as likely as not that the current hearing loss is due to military noise exposure as an infantryman. The rationale for this etiology is that the veteran reports being exposed to very loud explosions during active duty and could not wear hearing protection during combat. The veteran reports that the tinnitus and hearing loss began during active duty.

**Discussion:** See Condition #3 Epilepsy due to Head Trauma and #4 Post-Concussive Syndrome discussions for the adjudication determination that CI was unfit for TBI (Epilepsy) and that TL 07-05 should be applied in this case to rate CI's TBI residuals regardless of their independently fit/unfitting determination. The CI did not have pre-existing tinnitus noted in the STR and it is at least as likely as not that his tinnitus was due to Service related TBI. Therefore, the CI's tinnitus should be part of the CI's TBI unfitness determination and rated as Tinnitus due to Head Trauma 8045-6260 at 10%.

**Condition 11: GERD.** IPEB 20070108: Not Unfitting (MEB Dx 8)

Possible (r/o) GERD was mentioned in the NARSUM.

VARD (diagnosed as Hiatal Hernia (Claimed as GERD) 20080516, rated at 10%: The condition has been found shortly after your release from active duty by the recent QTC examination and confirmed by Upper GI series.

This condition did not rise to the level of being unfitting and is therefore not ratable.

**Condition 12: Left Inguinal Lymphadenopathy.** IPEB 20070108: Not Unfitting (MEB Dx 13)

VARD (diagnosed as Lymphadenopathy w/Residual Scar) 20080516, rated at 0%: A review of the service treatment records reveal complaints of painful swelling in your left groin that required incisional drainage in October 2007.

This condition did not rise to the level of being unfitting and is therefore not ratable.

**Condition 13: Chronic Intermittent Right Shoulder Pain.** IPEB 20070108: Not Unfitting (MEB Dx 9)

NARSUM 20070904: Soldier has also had chronic right shoulder pain (was on temporary profile in 2005, with no current significant deficits)

VARD (diagnosed as Right Shoulder Condition) 20080516: NSC

This condition did not rise to the level of being unfitting and is therefore not ratable.

**VA Other Conditions:**

Hearing Loss, Left Ear – Addressed in DD 2808 (Med Exam). VA rated at 0%. Not unfitting.

Right Ankle Condition – Not in DES Package. VA NSC. Outside the scope of the Board.

Pre-Glaucoma – Not in DES Package. VA 10%. Outside the scope of the Board.

**Discussion.** The left ear hearing loss and Right Ankle Condition are not relevant for consideration as additionally unfitting. The Pre-Glaucoma was not mentioned in the DES file and is outside the scope of the Board. The Paranoid personality disorder and Antisocial personality disorder are not considered physical disabilities for DOD, and were discussed under condition #1. All evidence considered, there is not reasonable doubt in the CI’s favor supporting recharacterization of the PEB fitness adjudication for the Hx alcohol abuse / dependence, GERD, Hx chronic intermittent R shoulder pain, Hx chronic intermittent Bilateral knee pain, chronic intermittent LBP, Recurrent L inguinal adenopathy conditions.

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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. As discussed above, PEB reliance on DoDI 1332.39 for rating PTSD appeared operant in this case and the PTSD condition was adjudicated independently of that instruction by the Board. As discussed above, some Board recommendations in this case are IAW application of TL 07-05, AUG 2007 to rating TBI under VASRD code 8045,§4.124a, prior to the 2008 NDAA and VASRD revision for TBI in 2008.

In the matter of the PTSD condition, the Board unanimously recommends an initial TDRL rating of 50% in retroactive compliance with VASRD §4.129 as DOD directed; and a 50% permanent rating at 6 months IAW VASRD §4.130.

In the matter of the Epilepsy Due to Head Trauma condition and IAW VASRD §4.124a , the Board unanimously recommends no recharacterization of the PEB rating of 10%, but a recharacterization in coding to 8045-8912 to delineate minor seizures IAW VASRD definitions. The Board had extensive deliberation on the proper retrospective coding of the CI's TBI IAW the VASRD and absent Army and DOD rules that were in effect at the time of the CI's separation. As the PEB had found the CI unfit for Epilepsy due to Head Trauma, regardless of its etiology of either an AOR incident or permanent service aggravation of pre-Service head injuries, the Board adjudged that the provisions of TL 07-05 on rating TBI, should be applied to all residuals related to the CI's TBI. The CI had new subjective symptoms of TBI and new-onset of tinnitus documented in the records. In the matter of the Post-Concussive Syndrome, the Board unanimously recommends that it be added as an additionally unfitting condition for separation rating; coded 8045 and rated 10% IAW VASRD §4124a and applicable VA guidance on rating TBI in effect at the time of the CI's separation. In the matter of the CI's Left ear Tinnitus, it should be considered part of the CI's TBI unfitness determination and rated as 8045-6260 at 10% IAW VASRD §4.87 and applicable VA guidance on rating residuals from TBI in effect at the time of the CI's separation. In the matter of the Depressive Disorder, not otherwise specified; Paranoid personality disorder; Antisocial personality disorder; History of alcohol abuse/dependence; Gastroesophageal reflux disease; History of chronic intermittent right shoulder pain; History of chronic intermittent bilateral knee pain; Chronic intermittent low back pain; Recurrent left inguinal lymphadenopathy 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.

The diagnosis of Pre-Glaucoma, rated by the VA was not mentioned in the Disability Evaluation System (DES) package and is therefore outside the scope of the Board. The CI retains the right to request his service Board of Correction for Military Records (BCMR) to consider adding this condition as unfitting.

The Board voted unanimously to rate the CI as PTSD 9411 at 50%, Epilepsy due to Head Trauma 8045-8912 at 10%, Post-Concussive Syndrome (TBI) 8045 at 10%, and Tinnitus due to Head Trauma 8045-6260 at 10% for both the initial TDRL and permanent ratings.

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**RECOMMENDATION:** The Board recommends that the CI’s prior determination be modified as follows; TDRL at 70% for 6 months following CI’s prior medical separation (PTSD at minimum of 50% IAW §4.129 and DoD direction) and then a permanent combined 70% disability retirement as below.

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| --- | --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **TDRL RATING** | **PERMANENT****RATING** |
| Post-Traumatic Stress Disorder  | 9411 | 50% | 50% |
| Epilepsy due to Head Trauma  | 8045-8912 | 10% | 10% |
| Post-Concussive Syndrome (TBI)  | 8045 | 10% | 10% |
| Tinnitus due to Head Trauma | 8045-6260 | 10% | 10% |
| **COMBINED** | **70%** | **70%** |

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The following documentary evidence was considered:

Exhibit A. DD Form 294 dated 20090218, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

