RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXXXXXXXXXX BRANCH OF SERVICE: MARINE CORPS

CASE NUMBER: PD0900201 BOARD DATE: 20100414

SEPARATION DATE: 20020730

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SUMMARY OF CASE: This covered individual (CI) was SGT, Personnel Clerk medically separated from the Marine Corps in 2002 after more than eleven years of total service. The medical basis for the separation was Chronic Ankle Pain. The Chronic Ankle Pain was determined to be medically unacceptable. The CI was referred to the Physical Evaluation Board (PEB), determined unfit for continued military service, and separated at 10% disability using the Veterans Affairs Schedule for Ratings Disabilities (VASRD) and applicable Navy and Department of Defense regulations.

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CI CONTENTION: The CI states: “(1. Right Ankle 2. Reflex Sympathetic Dystrophy Right Foot Associated with Right Ankle 3. Mood Disorder with Depressive and Anxiety Symptoms Associated with Reflex Sympathetic Dystrophy Right Ankle//To Members of PDBR Board:

As mandated by Congress in 2007, I am requesting the PDBR Board to re-review my Medical Separation rating of 10% and find that I should have been Medically Retired by the DOD. After reviewing varied sources, I believe my case warrants another evaluation since it has been noted that varied disability ratings were given by different Branches in comparison to the Department of Veteran Affairs. My current rating at the Veterans Administration is 60% service connected, of which 50% is service connected to my Active duty Injury to my ankle. There are two reasons I believe I should be retired: I have a current rating of 50% service connected disability rating pertaining to my ankle injury and my future pending Veteran Claims pertaining to my ankle injury. The Veteran Affairs has my disability broken down into four categories of which three equaling 50% are directly connected to my Ankle Discharge and in my opinion each of these diseases would have made me unfit for service, but as a whole should make me unfit. These three injuries that are currently service connected to my Medical Severance Discharge are right ankle sprain/status post open lateral reconstruction and partial synovectomy, reflex sympathetic dystrophy right foot (RSD), and mood disorder with depressive and anxiety in relation to reflex sympathy disorder. My current rating for my right ankle sprain/status post open lateral reconstruction and partial synovectomy is currently rated at 20% disability with the Department of Veteran Affairs with and effective date of 8/1/02. The Military discharged me with a 10% rating for this disability which I believe should be changed to a minimum of 20% as the V.A. did a day after my discharge. This injury made me unfit for service for the simple fact that I could no longer maintain the standards of service which includes but not limited to running, marching, standing for any period of time, and constant sprains coupled with constant pain and swelling. This injury has affected me in ways that I cannot ever explain on paper, but it has limited by jobs prospects because of the physical limitations and therefore limited my fiscal earning power and standard of living, which in my opinion warrants a retirement for this simple fact alone. The ankle surgery led a diagnosis of RSD approximately a year after my discharge, but I was suffering from this condition while I was in the Service; it was never recognized or diagnosed by Military Physicians even though symptoms were ever present before Jul 2002. The second thing which makes me unfit for service is my RSD. The Veterans Affairs awarded this decision on 7/19/06. Per my Veteran Records concerning a C&P Exam dated 10/26/06, "He was evaluated by an orthopedic doctor and a podiatrist after he got out of the Military. He saw a Neurologist, in 2003 who diagnosed him chronic right ankle sprain, status post right ankle arthroscopy with partial synovectomy and lateral ankle reconstruction reflux Sympathetic Dystrophy." A claim was never initiated by me or my Veteran Representative at the time because there was a lack of knowledge of RSD and how it impacts a person’s life, both physically and mentally. It was finally recognized by a Veterans Representative as a Medical Disorder and a claim was filed for and received a rating of 0%, but the V.A. had the records prior to the appeal for compensation. This condition is currently under review and a scheduled board hearing in Washington D.C. has been setup for this condition. RSD involves "the complex interaction of the sensory, motor, and autonomic nervous systems; and the immune system." RSD cannot be cured and is a lifelong debilitating disease, "CRPS/RSDS pain is ranked a whopping 42 on the McGill Pain Index!... It means it is rated as the most painful chronic pain disease that exists." Some of the symptoms of RSD include burning pain, extreme sensitivity to touch, and pain that is usually disproportionate to the degree of injury and can be triggered by using the affected limb or by stress. Of all the items listed previously, I have been experiencing this on a daily basis since my ankle surgery. Other side effects of RSD are Anxiety, Depression, and Infections. Per the listed information given about RSD and my Physical RSD condition, I believe this warrants a retirement vice the Medical Separation as it is a lifelong disease that causes constant pain, is non-curable, and furthermore should have been diagnosed while I was in the Military vice quickly after my Medical Discharge by a Civilian Doctor. My last service connected disorder related to my RSD is anxiety and depression. The Veterans Affairs have a current rating of 30% for my case. As discussed above, one of the side effects of RSD is anxiety and depression. Information for the American RSD Hope, "Depression does not cause CRPS/RSD More than 70% of CRPS/RSD patients considered themselves depressed. The other major side effect is anxiety. "RSD/CRPS patients often become depressed and anxious because of chronic pain and loss of physical activity." My anxiety and depressive disorder would make me unfit for service because I have difficulty with concentration, memory, depression and anxiety; furthermore, I have difficulty facing complex or stressful situations including high pressure jobs because of this disorder, which would explain why I just took the discharge after serving the Country Honorably for 10 years. I currently have multiple appeals claims pending against the V.A. as mentioned briefly above. Current appeal cases include RSD, mood disorder, scars from MRSA, and MRSA itself. Currently my RSD and mood disorder are being reviewed in Washington D.C. on an Appeals Board. Since I have discussed some of the above items, I would like to discuss my current appeal of MRSA (Staphylococcus Aureus) as this disease would make me unfit for service. In time, the V.A. will recognize my MRSA as service connected to my ankle. I had my first MRSA attack occurred while I was in the Marine Corps, but I did not seek medical treatment in the service as I thought it was a boil and treated this at home. At the time I honestly did not know what MRSA was and it went away just to come back again. Approximately a year out of service, I got my first major MRSA attack on my right hand and almost died as it spread to my lymphoid. I spent three days in the hospital after receiving surgery on my right hand. Since my Military surgery (only surgery I had had), I have had over fifteen MRSA attacks including but not limited to surgery on both hands and on my face. Per my letter from a Veterans Doctor, "It is as likely as not that he contracted the MRSA infection while hospitalized, as this MRSA is most commonly found in a Hospital setting." Per the Neurological Associates Pain Management Center, RSD is linked to infections by "Controlling and up regulating and down regulating the immune system." "Surgery to the hand or foot causing inflammation and swelling at the wrist or ankle... Surgery at the wrist or ankle in such patients aggravates the condition tremendously and weakens the immune system." Furthermore, "65% of all hospital acquired staph are MRSA" and "2/3 of the 85% of MRSA infections that could be traced to hospital stays or other health care exposures occurred among people who were no longer hospitalized." I can attest that MRSA is a killer per my own condition and experiences and this disease is more prevalent in the military and Hospitals, and for this fact listed above I believe this should be considered as service related to my ankle. As discussed above, I am requesting a retirement vice a Medical Separation. I believe anyone of these factors would warrant a Retirement, but taken as a whole should require a Medical Retirement. I have included my sources for review. Thank you for reading this and taking the information provided into consideration.).”

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RATING COMPARISON:

|  |  |
| --- | --- |
| **Service PEB** | **VA (6 Mo. after Separation)** |
| **Unfitting Conditions** | **Code** | **Rating** | **Date** | **Condition** | **Code** | **Rating** | **Exam** | **Effective** |
| Chronic Right Ankle Pain Status Post Instability Repair | 5299-5003 | 10% | 20020503 | Residual, Right Ankle Sprain | 5299-52715271 | 0%20%20% | 2006102620080701 | 19940510AD discontinue20020801 |
|  |  | Not in DES | Reflex Sympathetic Dystrophy, Right Foot Associated w/Residual, Right Ankle Sprain | 8522 | 0% | 20061026 | 20060719 |
|  |  | Not in DES | Mood Disorder with depressive and anxiety symptoms TO Major Depressive Disorder w/Reflex Sympathetic Dystrophy Right Foot | 9435To9434 | 30%To50% | 20071113To20090513 | 20060719To20090513 |
|  |  | Not in DES | Hemorrhoids | 7336 | 20% | 20061026 | 20020801 |
|  |  |  | 7 X NSC |  |  |  |  |
| **TOTAL Combined: 10%** | **TOTAL Combined (*Includes Non-PEB Conditions*):** **0% from 19940510****40% from 20020801****60% from 20060719****70% from 20090513**   |

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ANALYSIS SUMMARY:

Right ankle

The CI had a history of multiple right ankle sprains. These usually occurred with sports or with his cross country hiking or military activities. He had been treated in the past with rehabilitation and chronic bracing and strengthening exercises but failed and ultimately required further evaluation. A Magnetic Resonance Imaging (MRI) was performed on Jan 2001 when his pain persisted after the most recent ankle sprain. The MRI revealed disruption of the anterior talofibular ligament (ATFL) and increased signal in the deltoid ligament deep structures. Reconstructive surgery was performed in Mar 2001.

The CI continued to have pain and difficulty with strenuous weight-bearing activities despite surgery that appears to have successfully repaired the damaged right ankle anterior talofibular ligament (ATFL) and deltoid ligament deep structures. The narrative summary (NARSUM) exam range of motion (ROM) exam revealed left ankle dorsiflexion of 18 degrees and plantar flexion of 40 degrees. When compared to the normal range of motion of 20 degrees of dorsiflexion and 45 degrees of plantar flexion, the CI’s limited ROM is accurately characterized as mild under VASRD 5271 and this is appropriately rated at 10%. The PEB used a different VASRD code, 5299-5003 but applied the same rating of 10%.

The CI had served in the Army prior to serving in the Marine Corps and he filed a VA claim during the break in service. The initial VA Compensation and Pension (C&P) examination done at that time resulted in a noncompensable rating of 0%. The first C&P exam done after the CI separation from the Marine Corps was in 2006, four years after he separated. At this C&P exam the CI’s ROM was much more limited than it was at the time of the NARSUM in 2001 and he had slightly decreased strength and hypersensitivity. His dorsiflexion was 5 degrees and plantar flexion was 21 degrees. The VA considered this to be moderately limited motion of the ankle and rated the condition under VASRD 5271 at 20%. At the 2006 VA C&P examination, the CI reported that his current occupation as a Coca-Cola delivery person had actually worsened his ankle condition because he had to walk quite a bit during his eight hour shift. There is no evidence that this level of limitation of ROM was present at the time of separation from service and it appears his condition worsened after he left active duty.

With a mild limitation of ROM at the time of separation, applying the 5271 code instead of 5003 provides no advantage to the CI. A minimum rating of 10% is required for painful motion IAW VASRD §4.59 and the appropriate rating with either 5217 or 5299-5003 is 10%.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| AnkleMovement | Normal ROM | ROM Mil19931001(PT) | ROM Mil20010906NARSUM | ROM VA20061026 |
| Right Dorsiflexion | 0 – 20 | 5 | 18 | 5 |
| Right Plantar flexion | 0 - 45 | 35 | 40 | 21 |
| Notes: |  |  | No instability; neurovascularly intact | Strength 4.5/5 right dorsiflexion; hypersensitivity around right lateral malleolus |
| Left Dorsiflexion | 0 – 20 | 10 |  | 20 |
| Left Plantar flexion | 0 - 45 | 45 |  | 45 |

Other conditions (not in Disability Evaluation System (DES) Package

Reflex Sympathetic Dystrophy, Mood Disorder/Major Depressive Disorder and Hemorrhoids.

The VA considered both RSD and Mood Disorder to be associated with the service-connected condition of Residual, Right Ankle Sprain and therefore applied disability ratings to both conditions. The VA rating decision of 20070130 noted that neither service treatment record (STR) nor VA treatment records documented any treatment for RSD secondary to his right ankle condition. However, the VA examiner diagnosed right foot RSD based on the symptoms of burning and throbbing pain in the right foot and hypersensitivity around the right lateral malleolus. The examiner opined that it is at least as likely as not that this condition is secondary to the service-connected right ankle condition.

CI asked to be rated for RSD and anxiety and Depression (Mood Disorder). Neither was diagnosed while he was in service. CI claims he had RSD while in service that was undiagnosed. He did annotate burning right foot pain at night on the Medical Board History and Physical Form 2807 dated 20030313. No complaints of anxiety or depression were present. He also noted frequent trouble sleeping with the note ’Burning right foot at night’.

However there is not sufficient evidence to show the CI had undiagnosed RSD while on active duty. In order to make the diagnosis of RSD as defined by The International Research Foundation for Reflex Sympathetic Dystrophy/Complex Regional Pain Syndrome there must be a history of trauma to the affected area associated with pain that is disproportionate to the inciting event plus evidence at some time for one or more of the following: abnormal function of the sympathetic nervous system, e.g., abnormal changes in skin blood flow, sweating, or gooseflesh; swelling; movement disorder; and changes in tissue growth (dystrophy and atrophy). He did have pain and swelling but the edema was not pitting or hard (brawny). There is no evidence that any of the following were ever present while the CI was on active duty: any neurologic abnormality or sensory changes, allodynia, hypersensitivity, skin changes, movement disorder, joint stiffness, muscle cramps or spasms, dystonia, spreading symptoms, or bone changes such as patchy osteoporosis.

No mood disorder complaints or diagnoses are noted anywhere in the DES or STR.

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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. After careful consideration of all available information the Board unanimously determined that the CI’s condition is most appropriately rated at 10% for 5299-5003 Chronic Right Ankle Pain Status Post Instability Repair.

At the time of separation from service, the CI had mildly decreased range of motion of the right ankle due to pain. He had constant pain and was not able to perform any sustained weight-bearing activity. There was no joint instability or neurological problem. VASRD §4.59 mandates a minimum rating of 10% for painful motion and this could be accomplished using either 5217 or 5299-5003. The CI’s condition does not warrant a higher rating under any code.

The other diagnoses rated by the VA (Reflex Sympathetic Dystrophy, Mood Disorder/Major Depressive Disorder and Hemorrhoids) were not mentioned in the Disability Evaluation System package and are therefore outside the scope of the Board. The CI retains the right to request his service Board of Correction for Naval Records (BCNR) to consider adding these conditions as unfitting.

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RECOMMENDATION: The Board therefore recommends that there be no recharacterization of the CI’s disability and separation determination.

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20090225, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

 President

 Physical Disability Board of Review

 **DEPARTMENT OF THE NAVY**

SECRETARY OF THE NAVY COUNCIL OF REVIEW BOARDS 720 KENNON STREET SE STE 309

WASHINGTON NAVY YARD DC 20374-5023

IN REPLY REFER TO

1850

CORB:003

1 June 2010

From: Director, Secretary of the Navy Council of Review Boards

To:

Subj: PHYSICAL DISABILITY BOARD OF REVIEW (PDBR)

Ref: (a) 0001 6040.44

(b) PDBR ltr of 23 Apr 10

1. Pursuant to reference (a), the PDBR reviewed your case and forwarded its recommendation (reference (b)) to the Department of the Navy for appropriate action.
2. On 28 May 2010, the Assistant Secretary of the Navy (Manpower & Reserve Affairs) took action on your case by accepting the recommendation of the PDBR that no change be made to the characterization of separation or disability rating assigned by the Department of the Navy's Physical Evaluation Board.
3. The Secretary's decision represents final action in your case by the Department of the Navy and is not subject to appeal or further review by the Board for Correction of Naval Records.

By direction Copy to: PDBR