RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: air force

CASE NUMBER: PD0900224 BOARD DATE: 20100127

SEPARATION DATE: 20051202

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SUMMARY OF CASE: This covered individual (CI) was an Airmen First Class serving as an aircraft structural maintenance apprentice medically separated from the Air Force in 2005 after 2 years and 11 months of service. The medical basis for the separation was generalized seizure disorder, epilepsy associated with possible cognitive and amnestic disorder. The CI was referred to the Air Force Informal Physical Evaluation Board (PEB), was found unfit for continued military service, and a disability rating of 10% was recommended. He appealed to both the Formal PEB and Air Force Personnel Council (AFPC) and was ultimately separated with a 10% disability using the Veterans Affairs Schedule for Ratings Disabilities (VASRD) and applicable Air Force and Department of Defense regulations.

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CI CONTENTION: “I was awarded 10% by the MEB board then 40% by the V.A. which would have retired me.”

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RATING COMPARISON:

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| --- | --- |
| **Service PEB** | **VA (7 Mo. After Separation)** |
| **Unfitting Conditions** | **Code** | **Rating** | **Date** | **Condition** | **Code** | **Rating** | **Exam** | **Effective** |
| General Seizure Disorder, Epilepsy ; Associated with Possible Cognitive and Amnestic Disorder, Social and Industrial Adaptability Impairment, Mild | 8914-8999(IPEB 8910) | 10%10% | 2005071220050524 | Epilepsy, Grand Mal Seizure Type with Memory Loss | 8910 | 40%80%60% | 20060729Appeal | 200512032005120320080501 |
| Tobacco Habituation | CAT III |  |  | Not Addressed |  |  |  |  |
| Alcohol Abuse | CAT III |  |  | Not Addressed |  |  |  |  |
| Borderline Personality Traits | CAT III |  |  | Major Depressive Disorder with Cognitive DisorderSecondary to Seizure Disorder | 9434 | 30% | 20080521 | 20070227 |
| History of Unknown Substance Abuse (Intoxication) | CAT III |  |  | Not Addressed  |  |  |  |  |
| No PEB Entry |  | Not in DES | Bilateral Hearing Loss |  | NSC |  |  |
| **TOTAL Combined:** 10% | **TOTAL Combined (*incl non-PEB Dxs):*** 80% from 20051203  90% from 20070227 70% from 20080501 |

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ANALYSIS SUMMARY:

General Seizure Disorder, Epilepsy ; Associated with Possible Cognitive and Amnestic Disorder, Social and Industrial Adaptability Impairment, Mild

At the time of his first seizure in October 2004, the CI was in the process of administrative separation from the Air Force secondary to multiple issues, one of which was substandard job performance with slow on-the-job training and a Career Development Course failure. He appeared to have great learning difficulties despite constant supervision and additional training. The administrative separation was held pending a complete medical evaluation and the Air Force Personnel Council (AFPC) ultimately determined that a medical disposition was appropriate. The case was adjudicated by the Air Force disability system.

The CI’s first documented seizure occurred while he was at work and co-workers noted he fell to the floor and had twitching activity. He cut his head when he fell and was confused afterwards. An ambulance was called and he was taken to the Emergency Room. Although progress notes are not available it appears he was followed by primary care until February 2005. During this time he had EEG testing and a Brain MRI with and without contrast and both were normal. He also had a normal brain MRA. In February he was noted to be convulsing on the side of the road by a passerby who called an ambulance. After this Emergency Room visit he was seen by neurology. An elevated prolactin was noted along with a history consistent with multiple tonic clonic seizures with urinary incontinence and postictal confusion. A diagnosis of generalized tonic clonic seizure was made and the CI was started on Lamictal. He developed a rash and his medication was changed to Topamax. No further seizures were documented until November 2005 when he had two within a three week period. He continued to have seizures after separation and did not have a driver’s license or job for approximately two years. He did later regain the ability to drive so he must have been seizure-free for a period of six months while on medication but the exact date is not certain.

In April 2005 the same Commander who had previously recommended an administrative separation then recommended a medical discharge. July 2005 he wrote a letter of recommendation for the CI stating he had done a good job working in an administrative environment for the past six months and that he had displayed a very positive attitude despite the medical condition that had displaced him from his primary career field. The CI’s First Sergeant wrote a similar letter of recommendation. He stated the CI was an extremely hard worker who was dedicated and just needed the opportunity to prove himself in the right job. Both agreed the CI could not perform in his AFSC because of his medical condition and lack of mechanical abilities.

The CI underwent neuropsychological testing in March 2005 and the results indicated the CI had focal neuropsychological deficits that are consistent with his diagnosis of a seizure disorder. Although he is of average intelligence and his scores were within normal limits on most tests, he displayed significant impairments on measures of visuomotor construction, processing speed on certain visuomotor tasks, visual memory, and the ability to discriminate between different patterns of nonverbal sounds. His dominant left-handed grip strengths and manual dexterity were also worse than expected compared to his right hand. Together, A1C Sharp's pattern of neuropsychological test scores consistently point toward right cerebral hemisphere dysfunction. His deficits are severe enough that they are likely to interfere with aspects of his occupational functioning, particularly tasks requiring mechanical skills and complex visuomotor coordination. The cognitive difficulties A1C Sharp is experiencing are probably of a long-standing nature, and are not expected to dramatically improve even if his seizures are successfully controlled. His condition met the criteria for Cognitive Disorder, Not Otherwise Specified (NOS) with focal, generally mild to moderate impairments. A GAF of 60 was noted, Military Impairment characterized as Moderate and Social/Industrial Impairment as Mild to Definite (job specific). The psychologist stated decisions regarding the CI's military career should be based primarily on the duty implications of his seizure disorder (e.g., safety issues, duty limitations, worldwide qualification). His cognitive disorder would undoubtedly interfere with his performance on mechanical tasks (including his current AFSC) although he might succeed at jobs that rely more on his relatively strong math, verbal comprehension, and abstract reasoning skills. If A1C Sharp was returned to duty, cross-training was strongly recommended.

The testing was felt to be valid and representative of a good effort by the CI. He appears to have read the test items carefully and responded consistently and truthfully. There is no evidence of a major mood or thought disorder. He reported a higher than average number of somatic complaints, consistent with his medical diagnosis. A somatoform disorder does not appear likely. He tended to present himself favorably, as a person with no major emotional orpsychological problems, although he did report some feelings of persecution including a sense that he is sometimes misunderstood or unappreciated. VA neuropsychological testing done in August 2006 showed similar findings and concluded that his verbal memory deficits are a residual of his epilepsy condition.

The Air Force Informal and Formal PEBs and AFPC appear to have applied DoDI 1332.39 and rated the CI’s seizure disorder based on his social and industrial impairment (which they considered to be mild) and not on the frequency of seizures as directed by the VASRD The rationales for the Formal PEB and AFPC decisions stated they found evidence that the member’s neuropsychological deficits were directly related to his seizure disorder but that rating both conditions would constitute pyramiding disability ratings, an action which was prohibited under current Department of Defense disability rating policies.

The VA initially rated the CI’s epilepsy at 40% but did not specify the frequency of his seizures. The CI later appealed the rating and presented statements that documented the frequency of his seizures. The statements were from family members he was living with at the time. According to these statements, the CI had been having at least one seizure every three months on average but not one every month. The VA then increased his rating to 80% from the day after separation until May 2008 when the frequency of his reported seizures had decreased to an average of one every four months. A 60% rating was then applied.

The findings from the neuropsychological testing clearly show cognitive deficits that impaired the CI’s performance of his duties as an Aircraft Structural Maintenance Apprentice and would preclude him from ever succeeding in a similar job. He was generally functioning normally but there were certain aspects of his job that he just could not do even with special training and help. The letters from his Commander and supervisors also support this. However, the CI’s cognitive limitations were not global in nature but rather were more focused in mechanical and visuomotor abilities. So even though his problems are not limited to periods of significant stress it appears the 10% rating most accurately describes his level of functional impairment. He has significant impairments in the areas most critical for his AFSC but these would not be as critical in many other AFSCs.

Depression

A psychiatric evaluation was completed as part of the CI’s Medical Evaluation board in Feb 2005. The CI did have a history of depression and had been hospitalized for depression and suicidal gestures. In April 2004 he broke up with his girlfriend of 1-2 months. On April 15th he reportedly took between 3 to 15 mg of Ativan and jumped out of a moving vehicle (5 mph). He denied the act as a suicidal gesture, but was hospitalized (Rivercrest) for 3-4 day for depression. After discharge he presented to Life Skills voluntarily for therapy approximately once per month for an unknown period of time. He also verified that he was hospitalized at Abilene Psychiatric Center in September for one week and in December for one week. He reported his admission in September was due to slight depression and cutting his face with a knife (i.e., blood was evident, but cuts were not deep). He had insight into behaviors as a cry for help. In December the CI reported that he was seeing several different doctors that prescribed him pain medication and were not communicating about the possible interaction or side effects of the medication. The use of the pills as described resulted in a DUI. He also reported losing time for 24 hours prior to a supervisor from work picking him up. Per his mother, he began acting strangely and the supervisor drove him to Abilene Hospital where he was admitted. Although the staff believed his behavior was related to alcohol use, the CI's blood alcohol level was zero according to his mother. The CI spoke with a chaplain at both Rivercrest and Abilene Hospital for support. Based on reports from Dyess AFB, the pt had attended three prescribed alcohol treatment groups in October 2004 and continued treatment based on his own initiative. Pt reported abstinence from alcohol since that time.

During this evaluation, the CI denied any psychological symptoms, including mood disturbance, substance abuse, and social impairment. He complained of a decline in short term memory that was initially noticed by his mother. She reported memory problems starting in the summer of 2004 when the CI was studying for his CDCs and recalled a specific incident when the CI failed to recall bringing his father tickets for a local event. A diagnosis of Amnestic Disorder due to General Medical Condition was the only current Axis I diagnosis. The provider opined the memory problem may be secondary to the patient’s seizure disorder and/or his abuse of alcohol and use of prescription drugs. The memory problem is not isolated to the seizure and/or substance abuse events and has impaired the patient’s occupational functioning. These findings separate the disorder from a “blackout” type event that is temporally related to substance abuse and from the memory losses that accompany seizures. Borderline Personality Traits were noted on Axis II and GAF was 70. Military Impairment was moderate and social/industrial impairment was definite. His profile was S-1.

Neither the psychiatric evaluation nor the neuropsychological testing are consistent with a diagnosis of depression although it does appear the CI had previously been depressed. Neither evaluation was consistent with a chronic alcohol or substance abuse problem either. The VA initially did not rate depression but a rating was added fourteen months after separation and it appears the CI was depressed at that time. There is no evidence that the CI was depressed or that depression added to his unfitness for military service at the time of separation from service.

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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 PEB relied on DoDI 1332.39 for rating the CI’s seizure disorder and the Board adjudicated this condition independently of that instruction. After careful consideration of all available information, the Board unanimously recommends that the CI’s condition be rated at a combined 60% with 60% for 8910 Generalized Tonic-Clonic Seizure Disorder and 10% for Cognitive Disorder NOS/Amnestic Disorder due to a General Medical Condition.

The CI had three documented generalized tonic-clonic seizures in the twelve months prior to separation, one in February and two in October or November. This averages to one major seizure every four months and warrants a 60% rating under the VASRD General Rating Formula for Major and Minor Epileptic Seizures.

The CI also had Cognitive Disorder, Not Otherwise Specified (NOS),that was directly associated with his epilepsy and significantly contributed to the determination that he was not fit for continued military service. The VASRD states that diagnosed mental disorders that are shown to be secondary to or directly associated with epilepsy will be rated separately. Therefore the CI’s Cognitive Disorder NOS is rated separately. The CI had also been diagnosed with Amnestic Disorder due to General Medical Condition but only one mental disorder rating is applied. Mental disorders are rated based on functional impairments rather than on specific diagnoses. Therefore both conditions are considered together and one rating is applied. The Board determined that a rating of 10% was most appropriate under the General Rating Formula for Mental Disorders. Although the CI’s deficits were significant and interfered with his occupational functioning on a regular basis and not only during periods of significant stress, they were narrow in scope. He had moderate to severe difficulties in areas related to mechanical skills and complex visuomotor coordination but tested at average or above average levels in all other areas. Also, while the CI had a history of depression, he did not appear to have any psychological symptoms at the time of separation and this condition did not cause him to be unfit for military service.

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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 |
| Generalized Tonic-Clonic Seizure Disorder | 8910 | 60 |
| Cognitive Disorder NOS/Amnestic Disorder due to General Medical Condition  | 9326 | 10 |
| COMBINED | 60% |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20090306, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

PDBR PD-2009-00224

MEMORANDUM FOR THE CHIEF OF STAFF

 Having received and considered the recommendation of the Physical Disability Board of Review and under the authority of Section 1554, Title 10, United States Code (122 Stat. 466) and Section 1552, Title 10, United States Code (70A Stat. 116) it is directed that:

 The pertinent military records of the Department of the Air Force relating to XXXXXXX be corrected to show that:

 a.  The diagnoses in his finding of unfitness was generalized tonic-clonic seizure disorder, VASRD code 8910, rated at 60% and cognitive disorder NOS/amnestic disorder due to general medical condition, VASRD code 9326, rated at 10%, with a combined rating of 60%.

 b.  On 2 December 2005, he elected not to participate in the Survivor Benefit Plan.

 c.  He was not discharged on 2 December 2005 with entitlement to disability severance pay; rather, on that date he was relieved from active duty and on 3 December 2005 his name was placed on the Permanent Disability Retired List.

 JOE G. LINEBERGER

 Director

 Air Force Review Boards Agency