RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: army

CASE NUMBER: PD0900268 BOARD DATE: 20090825

SEPARATION DATE: 20070131

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SUMMARY OF CASE: This covered individual (CI) was an O-3, critical care nurse, medically separated from the Army in 2007 after 6 years of service. The medical basis for the separation was acute intermittent and chronic right upper quadrant (RUQ) abdominal pain with onset in 2004 following complications of a liver biopsy to stage chronic active Hepatitis C. The CI was referred to the PEB which recessed until hepatitis C therapy was completed. Upon resumption of the PEB, the CI's hepatitis C viral load was cleared (in remission). However, the CI had continued RUQ pain requiring chronic narcotic use and the PEB found the CI unfit at 10%. The CI appealed to the Formal PEB (upheld) and the CI non-concurred. The case was reconsidered by the USAPDA who made administrative coding changes and the CI was found unfit and separated at 10% disability.

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CI CONTENTION: CI contends that the Army did not correctly apply the VASRD as her PEB rating was 10% and the VA rated her at 100% for the same diagnosis.

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RATING COMPARISON:

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Previous Determinations** | | | | | | | | |
| **Service** | | | | **VA** Exam **Pre-discharge** | | | | |
| **FPEB Condition** | **Code** | **Rating** | **Date** | **Condition** | **Code** | **Rating** | **Exam Date** | **Effective date** |
| Acute intermittent and chronic right upper quadrant abdominal pain with onset in 2004 from a liver hematoma following hepatic biopsy to stage chronic active hepatitis C. | 7311 7301  7399-7301 | 10% | **20060928**  FPEB admin change | Hepatitis C with residuals of liver biopsy arterioportovenus fistula, hemobilia and neuropathic right upper quadrant pain | 7354 | 100% | 20070115  20070118 | **20070201** |
| Chronic hepatitis C with stage I portal fibrosis: Meets retention standards. | Medically Acceptable |  |  |
| Migraines; Meets retention standards (MEB; EPTS, no Service aggravation) | Medically Acceptable |  |  | Migraine Headaches | 8100 | 0% | 20070115  20070118 | 20070201 |
| Mechanical low back pain: Meets retention standards | Medically Acceptable |  |  | Lumbar Spine DJD | 5242 | 10% | 20070115  20070118 | 20070201 |
| Cholelithiasis; Meets retention standards. | Medically Acceptable |  |  | Cholelithiasis | 7315 | NSC | 20070115  20070118 | 20070201 |
| Hypertension: Meets retention standards. | Medically Acceptable |  |  | Hypertension | 7101 | 0% | 20070115  20070118 | 20070201 |
|  |  |  |  | Mood Disorder with primary Insomnia due to residuals of Hepatitis C and Liver Biopsy | 9435 | 30% | 20070115  20070118 | 20070201 |
|  |  |  |  | Left Shoulder Impingement | 5024 | 10% | 20070115  20070118 | 20070201 |
|  |  |  |  | Hypothyroidism | 7903 | 10% | 20070115  20070118 | 20070201 |
|  |  |  |  | Chronic Fatigue Syndrome | 6354 | 0% | 20070115  20070118 | 20070201 |
|  |  |  |  | Multiple other 0% and NSC diagnoses | - | - | - |  |
| **TOTAL Combined: 10%** | | | | **TOTAL Combined (*incl non-PEB Dxs*): 100**% | | | | |

**ANALYSIS SUMMARY**: Only the CI's RUQ abdominal pain and liver conditions are contended and will be addressed by the Board. Other MEB diagnoses and VA rated conditions were not addressed, except as they related to adjudicating the contended conditions. The VA diagnosis of Mood Disorder with primary Insomnia due to residuals of Hepatitis C and Liver Biopsy were not substantively addressed in the PEB and are beyond the Board's scope.

**Chronic Hepatitis C with Stage I Portal Fibrosis**. The PEB determined that this met retention standards and absent any residual of hepatitis C (RUQ pain), hepatitis C in remission should not be found unfitting. However, given that CI's principle unfitting condition (RUQ pain) requiring chronic narcotics is a residual of diagnoses and treatment of hepatitis C (liver biopsy), the code for hepatitis C is predominant for rating the principle RUQ pain.

**Cholelithiasis**. Meets retention standards and following extensive documentation was determined not to be a contributor to the CI's RUQ pain. This diagnosis should not be added as unfitting.

**Acute Intermittent and Chronic RUQ Abdominal Pain with Onset in 2004 From a Liver Hematoma Following Hepatic Biopsy to Stage Chronic Active Hepatitis C**. The CI was in good health until 29 Dec 2004. The CI had a liver biopsy because of hepatitis C with elevated liver function tests and a high hepatitis C viral load. Liver biopsy was complicated by a liver hematoma and left gastric artery dissection occluding flow to the abdominal vessels in the left lobe of the liver (20050103 Celiac arteriogram w/ complication), an arterial portal venous fistula, and hemobilia. The complications of the liver biopsy caused RUQ pain. The hospital discharge of 20050319 noted: 1) CHRONIC PAIN - located in mid epigastrum, baseline is 2-3/10 non-radiating. Pain source is possibly from mesenteric angina near area of dissection and thrombosis, 2) Mesenteric Angina - questionable diagnosis; however, pain worsens with activity, 3) Stable iatrogenic arterio-venous fistula s/p liver biopsy on 29 Dec 04, 4) Celiac artery thrombosis now s/p hepatic artery embolization, 5) Chronic Hepatitis C - diagnosed during routine pregnancy screening last year. Pt has Grade II chronic Hep C a/w portal fibrosis, 6) Cholelithiasis.

The CI was started on narcotics for pain control and referred to the pain clinic. The pain clinic tried numerous medications and 2 celiac plexus nerve blocks, which did not produce even temporary relief. The CI had 2 gallbladder scans, which showed improving gallbladder function and 2 endoscopic retrograde pancreatic cholangiograms, which showed normal pancreatic and Common bile duct flow. Continued pain and use of substantial amounts of daily narcotics and breakthrough pain requiring episodic ER IV narcotic therapy lead to referral for a PEB at 1 year. The initial PEB placed the CI on a hold (continued on duty) until her hepatitis C therapy was completed based on the CI's stated desire to complete therapy and to reduce or be withdrawn from narcotic use. The **final MEB/PEB re-eval of 20060911** indicated that the CI's hepatitis C was successfully treated with Interferon and ribavirin therapy (viral load cleared—"remission"). The summary indicated a hepatitis C viral load of < 50 in contrast to a pre-treatment load of 439,000 IU/mL and indicated that the CI had resumed working in the ICU doing only administrative work because of unchanged chronic abdominal pain and use of chronic narcotics for "…the same pain for which she underwent the MEB/PEB, i.e., located in the mid-epigastric area, chronic in nature and made worse by running and doing sit-ups. At the time that I saw her today, the pain was rated as bearable at a grade of 3 out of 10. She has also been functioning as the charge nurse in the intensive care unit and works 40 hours/week. She did inform me that she had taken her APFT consisting of the pushups and 2.5 mile walk (no sit ups because of the abdominal pain) and had passed. Her weight has been stable and her appetite has been improving. She denied any shortness of breath or DOE due to the abdominal pain; no diarrhea, constipation, nor petechiael rash. General overall feeling: "No illness since last visit. Symptoms controlled on current medication, No fever No chills" No recent weight change pain controlled by medication."

FPEB 20060928 Disability Description: "**Acute intermittent and chronic right upper quadrant abdominal pain with onset in 2004 from a liver hematoma following hepatic biopsy to stage chronic active hepatitis C**. The formal board was recessed so that the Soldier could complete a year long course of viral suppressive therapy with the hope of reducing narcotic pain medication and allowing return to duty. Current tests 24 weeks post-treatment show sustained remission reflecting a probable cure. The Soldier, however, has been unwilling or unable to reduce her dependency on narcotics. The Soldier now requires significantly higher daily doses of oral narcotics for pain control than at the time of the recessed board. Issues of patient safety and liability prevent her from working in direct patient care. Her last recorded APFT was in 2003. Rated for residual pain under peritoneal adhesions as moderate with pulling pain on attempting work or aggravated by movements of the body with occasional episodes of colic pain, nausea or abdominal distension." Excerpt of 20061020 FPEB reply to non-concur: "Unfortunately, you did not accomplish the most important, reducing your dependence on narcotic medication so that you could return to patient care. The Board will make an administrative correction to your DA Form 199 to change your VA code to 7399-7301 as you correctly noted that an analogous code is appropriate in your case."

Emergency Room (ER) exams preceding and following the MEB/PEB re-eval summary describe a much more symptomatic picture of severe recurrent and debilitating RUQ pain. The AHLTA note of **20061016 (1 month following PEB re-eval summary)** is excerpted for comparison: Systemic symptoms. This has been a summary of how (CI) has been feeling in the past few months. She has been compliant with her appointments with me. She calls for refills and is not early for her refills. Subjective since the beginning of her illness. Her current **weight fluctuates between 85-91 pounds**. She has been unable to regain this weight. 5) Abdominal and shoulder muscle pain: she has had increased muscule pain in addition to her chronic neuropathic pain due to vomiting. She treats this with daily naprosyn 500 mg bid and cyclobenzaprine as needed. She will also use heat. 6) **increase in opioid analgesia medications**: (CI) has developed some **tolerance** to her pain medication. It has been less effective than it used to be. She has decreased her use of hydromorphone because of the side effects (increased stupor, dizziness). She would rather experience minor withdrawal symptoms, rebound pain, and pain exacerbations as the hydromorophone wears off. 7) sweating and weakness: (CI) usual develops this prior to a pain exacerbation. She has had increased sweating and shaking with increases in her pain. Review of systems (CI) is a 31 yo AD nurse here for follow-up about several chronic medical conditions: **chronic neuropathic pain, nausea/vomiting, insomnia/fatigue, weight loss, musculoskeletal pain, increase in opioid analgesics and their side effects** (sweating and shaking). 1) Currently her chronic neuropathic pain is usually 4·5/10; the pain is constant, dull, heavy, and often throbbing. When she has an exacerbation, the intensity increases to 8-9/10 and is sharp and burning; the pain then is constant with stabbing sensations to the epigastrium, This is often accompanied by severe nausea and occasional vomiting. 2) Nausea/vomiting: (CI) has **daily nausea, especially in the morning. She usually takes either oral pehenergan or cornpazine or rectal phenergan** in addition to all of her morning medications, Her nausea increases in severity with her pain exacerbations; her bouts of emesis also increase during this time. 'The physical <Jet of vomiting causes her to pain abdominal pain due to strain placed upon her abdominal muscles. 3) Insomnia/fatigue: (CI) has 5/10 pain nearly **every morning**; she takes opioid pain meds to counter this. Her pain is worse **at night**; because her pain is worse at night, she uses ambien and trazadone to help her sleep. She occasionally uses Benadryl as well as a sleep aid, Finally, she uses nortryptiline normally for chronic pain, but takes alt in conjunction with her nightly meds. Finally, after work (regular 8 hour shifts/5 days per week) she is physically tired and exhausted. Her increased fatigue in the afternoon progresses to the evening and usually increases her pain level to 6-7/10 4) weight loss/dietary changes: (CI) has experienced decreased appetite and decreased intake due to her nausea. She has instituted her own dietilry changes and have avoid foods that increase her nausea, She stops eating at the onset of nausea; she takes ensure with supplements now. She has **lost approximately 12-20 lbs**.

The updated MEB summary/re-eval of 20060911 did not appear to reflect the CI's condition as reflected in numerous treatment record entries before and after that single evaluation. The summary did not address frequent ER visits for pain breakthrough (14 in prior 12 months), CI's compliance with a pain clinic pain contract, use of sleeping pills and anti-emetics, or overall loss of weight from the start of Hepatitis C therapy/liver biopsy (20060106 H&P wt 102 lbs; Jan 07 wt 85 lbs).

**VA Exam (20070118 pre-discharge)**:

SPECIFIC HISTORY FOR: CHRONIC NEUROPATHIC ABDOMINAL PAIN

The claimant has been suffering from same. The condition has existed since 2004. The condition affects general body health by chronic pain since liver biopsy. Chronic nausea, vomiting. The condition affects body weight going from 115 pounds to 83 pounds within a 8 month period. She did not receive any treatment to correct her weight change. For her intestinal condition, she has nausea and vomiting, chronic constipation and sweats, decreased appetite. She suffers from abdominal pain located wherever biopsies were done. It occurs more than 2/3 of the year. The abdominal pain is constant sharp, stabbing, burning pain. The symptoms described occur intermittently, as often as 5 times a day, with each occurrence lasting 1 hour. The number of attacks within the past year was 100+. The ability to perform daily functions during flare-ups is depends on pain level during flare-up. The current treatment is MS Contin 60 mg, Nortryptyline 75mg, Tramadol 150 mg, MS Immediate release 30mg, Dilaudid 4 mg, surgical nerve blocks, 2 times. From the above condition the functional impairment is decreased physical activity. The usual occupation is critical care nurse, which she has performed for 4 year(s). She is currently employed in a different job from the one she used to have, and the job is administration. Height of the claimant is 59" and the **weight is 83 pounds.** Examination of the abdomen reveals the following findings: tenderness to palpation. The findings are right upper quadrant, liver edge tenderness. Abdominal Ultrasound: Mild intrahepatic ductal dilatation of uncertain etiology. CT scan could be helpful. Abdominal ultrasound results showed mild interhepatic ductal dilation of uncertain etiology.

**20070118 VA Exam Diagnosis was CRPS (Complex Regoinal Pain Syndrom-CRPS**) which is a new name for RSD - Reflex sympathetic dystrophy.

**VA Rating Narrative**: from **pre-discharge exam**:

Service connection for hepatitis C with residuals of liver biopsy including arterioportovenusfistula, hemobilia and neuropathic right upper quadrant pain has been established as directly related to military service. Your service medical records show that you were diagnosed for hepatitis C. This led to a liver biopsy which resulted in abnormal residuals. You had a arterio-portovenus fistula which causes chronic upper quadrant pain. You have had hemobilia, chronic fatigue, weight loss due to anorexia, constipation, nausea, vomiting and dizziness. You have gone from 120 pounds to 83 pounds. You wake up with nausea and vomiting and will feel nauseous after just a few bites of food. This occurs about twice per day. You also have problems with intercourse due to chronic pain. You have taken several medications for pain and nausea. You reported at your QTC exam that you were on interferon for a year with good response and you stated that your chronic fatigue is not incapacitating. You continue to require ongoing treatment. You received disability severance pay for this condition. An evaluation of 100 percent is assigned from February 1, 2007, the day following release from active duty. All grants of service connection are effective the day following release from active duty. An evaluation of 100 percent is assigned when there is serologic evidence of hepatitis C infection \with the following signs and symptoms: near constant debilitating symptoms (such as fatigue, malaise, nausea, vomiting, anorexia, arthralgia, and right upper quadrant pain). Your **evaluation is based on near-constant symptoms causing chronic fatigue, weight loss due to anorexia, nausea and vomiting and constant right upper quadrant pain**.

**AO Summary Pre-Board**: The PEB disability description linked the intermittent and chronic right upper quadrant abdominal pain to complications from a liver biopsy to stage chronic active hepatitis C. The PEB found chronic hepatitis C with stage I portal fibrosis as not unfitting, and absent the unfitting residual of RUQ pain, it would not be unfitting. However, given that CI's principle unfitting condition (RUQ pain) is a residual of complications of diagnoses and treatment of hepatitis C, the code for hepatitis C is predominant for rating the RUQ pain. Code 7311 Residuals of injury of the liver cannot be used since diagnosing and treating hepatitis C was the reason that a liver biopsy was performed and the RUQ pain is therefore considered a residual of hepatitis C (7354) for VASRD coding.

Code 7311 would indicate rating the specific residuals of liver injury separately as adhesions of peritoneum (diagnostic code 7301), cirrhosis of liver (diagnostic code 7312), and/or chronic liver disease without cirrhosis (diagnostic code 7345). However, code 7345 cannot be used in this case as the CI has hepatitis C and residuals of diagnosis and treatment are predominately coded under 7354 Hepatitis C. The PEB characterization of residual pain as moderate with pulling pain on attempting work or aggravated by movements of the body with occasional episodes of colic pain, nausea or abdominal distension appears to minimize the CI's requirements for chronic narcotics, sleep medication and anti-emetics.

The complexity of this case focuses on how marked the CI's symptoms were and the level of fatigue, malaise, and anorexia along with factors of weight loss, dietary restriction, continuous medication, or incapacitating episodes. I find the MEB/PEB re-evaluation to have less probative value than the preponderance of the CI's ER evaluations. While the PEB re-eval may indicate minimization of the CI's symptoms in order to try to remain in the Army, the remainder of the record indicates greater symptomatology and medication use than that evaluation portrays. I placed the highest probative value on the AHLTA note of 20061016 (1 month following PEB re-eval summary as it substantively agrees with the remainder of the treatment record entries. There may well be a degree of recall bias given the evaluation was following the PEB unfit determination; however the medication use history and pre PEB ER notes substantially agree with the CI's stated symptoms. The VA rated the Jan 07 exam as meeting the criteria for "**near constant debilitating symptoms** causing chronic fatigue, weight loss due to anorexia, nausea and vomiting and constant right upper quadrant pain," which rates at 100%. Independently rating the VA examination or the AHLTA note provided evidence of daily fatigue, malaise and anorexia with minor weight loss and RUQ pain intermittently not controlled with medications. I do not opine that there was substantial weight loss or other indication of malnutrition. There was no documented hepatomegaly, and incapacitating episodes would be at most 16 days in the last 12 months if each ER admission is counted as a day of incapacitation. I would therefore rate this evaluation at 40%. This rating level is also more supportable than a 100% rating using "near constant debilitating symptoms" given that the CI's total disability picture, ability to work an administrative 40-hr week and the lack of other indicators of a 60% 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 PDBR to the extent they were inconsistent with the VASRD in effect at the time of the adjudication. As discussed above, the correct VASRD code for this case was vital to correctly rating this case. The VA representative as well as an additional PDBR physician were present during discussion of this case. The Board was unanimous in selecting code 7311-7354 Residuals of injury of the liver rated under the criteria for Hepatitis C as the predominate coding schema despite Hepatitis C itself not being found unfitting. The disability level under this coding focused on the preponderance of evidence in the treatment records and the pre-discharge VA examination and treated the single re-eval summary as having lesser probative value. The Board discussed the possible impact the prior Army pain policy may have had on rating the CI's predominate symptom of pain without clear anatomical correlation, as well as the Army's reply to multiple prior appeals. The CI's incapacitation from pain was adjudged to have had a total duration of at least 2 weeks, but less than 4 weeks, during the 12-month pre-PEB period. It was adjudged that the CI did not meet the criteria for significant weight loss or other indication of malnutrition, nor near-constant debilitating symptoms. The Board unanimously rated the CI's condition as meeting the 40% disability level due to daily fatigue, malaise, and anorexia, with minor weight loss and incapacitating episodes (with symptoms such as fatigue, malaise, nausea, vomiting, anorexia, and right upper quadrant pain).

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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 the CI’s prior medical separation.

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| Unfitting Condition | VASRD Code | Rating |
| neuropathic right upper quadrant pain, as RESIDUAL OF LIVER BIOPSY FOR Hepatitis C | 7311-7354 | 40% |
| Combined | 40% |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20090326, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

