RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: AIR FORCE

CASE NUMBER: PD0900383 BOARD DATE: 20100113

SEPARATION DATE: 20080317

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SUMMARY OF CASE: This covered individual (CI) was a Staff Sergeant/E5 (Communication-Computer System Operator Craftsman) medically separated from the Air Force in 2008 after 11 years of service. The medical basis for the separation was Chest Pain of Non-cardiac Etiology.

An MEB established the diagnoses of Chest Pain, Palpitations, and Obstructive Sleep Apnea (OSA) and the CI was referred to the Air Force Informal Physical Evaluation Board (IPEB). The IPEB determined the Chest Pain of non-cardiac etiology condition was unfitting for continued military service. A formal PEB concurred with the informal PEB and the CI was separated at 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: “The Formal Evaluation Board did not follow the VASDR for determination of ratable and compensable conditions and I would like the PDBR to make a recommendation based on my VA determination letter given within the same year for the same conditions.”

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RATING COMPARISON:

|  |  |
| --- | --- |
| **Service PEB** | **VA (1 Mo. after Separation)** |
| **Unfitting Conditions** | **Code** | **Rating** | **Date** | **Condition** | **Code** | **Rating** | **Exam** | **Effective** |
| Chest Pain of Non-Cardiac Etiology | 5099- 5022 | 10% | 20080129 | Angina (To include atypical Chest Pains, Heart Palpitations and Abnormal EKG Findings | 7099- 7005 | 10% | **20080221 & 20080222** | **20080318** |
| Palpations with History of Occasional Premature Atrial Contractions | Fit/CAT II | PEB |
| OSA requiring use of CPAP | Fit/ Cat II | PEB | Chronic OSA | 6847 | 50% | **20080221 & 20080222** | **20080318** |
|  | No |  | Ganglion Cyst of the Left Foot (To include Plantar Fibromatosis) | 5299- 5020 | 10% | **20080221 & 20080222** | **20080318** |
|  | No |  | Hypertension | 7101 | 10% | **20080221 & 20080222** | **20080318** |
|  |  | NARUSM | Gastritis (To include Esophagitis, and Gastroesophaegeal Reflux and Hiatal Hernia) | 7307 | 10% | **20080221 & 20080222** | **20080318** |
|  | No |  | Pseudofolliculitis Barbae | 7899- 7806 | 10% | **20080221 & 20080222** | **20080318** |
|  | No |  | Right Foot Bunion | 5280 | 0% | **20080221 & 20080222** | **20080318** |
|  | No |  | Left Foot Bunion | 5280 | 0% | **20080221 & 20080222** | **20080318** |
|  | **No** |  | 6 x Conditions (Benign Neoplasm Sub Lipoma; Mild Conjunctivitis of the Left Eye; G6PD Deficiency; Asbestos Exposure; Esophagogastro-duodenoscope and Biopsy; Renal Insufficiency) | NSC |  |  |  |
| **TOTAL Combined: 10%** | **TOTAL Combined (*Includes Non-PEB Conditions*):** **70% from 20080318**   |

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ANALYSIS SUMMARY:

Chest Pain and Palpitations

The CI first had chest pains and palpitations in January 2003 after receiving an anthrax immunization from a lot that was recalled by the US FDA for possible contamination. Initial cardiac workup by a civilian cardiologist in 2003 lead to a diagnosis of paroxysmal supraventricular tachycardia (PSVT). At that time EKG and ECHO showed left ventricular hypertrophy with strain. The cardiologist started patient on a long-acting beta-blocker to treat hypertension and arrhythmias. Doppler echocardiography showed septal and posterior wall thickness increased with mild concentric left ventricular hypertrophy but otherwise a normal study. Later in September 2003, a 96 hour Holter study showed palpitations/PSVT were still prevalent on a consistent basis but there were not any other signs of cardiac abnormalities. The CI then moved to the DC area and in January 2004 experienced chest pains and dizziness while at work and was taken to the Emergency room. Paramedics documented elevated blood pressure of 190/127 and a pulse of 129. Apparently no other significant episodes of chest pains or palpitations occurred until September 2006 when he was seen for elevated blood pressure and palpitations. He was referred to Cardiology at the National Naval Medical Center. A treadmill stress test showed normal exercise tolerance with some palpitations and his chest pain was considered non-cardiac. In April and May 2007 an extensive cardiac work-up was completed. All tests revealed normal findings and tests included treadmill stress test, echocardiogram, Holter monitor, and cardiac multidetector CT.

Despite normal tests, the CI continued to have symptoms and the Cardiologist opined his chest pain and palpitations were not cardiac conditions. He stated PSVT was not a current condition and the CI now described symptoms consistent with single extra systoles without syncope. No further evaluation was recommended and no cardiac condition was identified that required a MEB.

BCT, HEART ANGIO W/CONTRAST CT Cardiac Angio 20070419:

FINDINGS included Cardiac morphology and function: Normal LV size and wall motion. Left ventricular ED volume: 126 ml Left ventricular ES volume: 43 ml Left ventricular ejection fraction (EF): 65 %

Echocardiogram 20070419:

Technically adequate study, normal chamber sizes and function, LVEF 60%, normal valve morphology and function.

Treadmill stress test 20070419:

Screening exam for cardiovascular disorder: 33 yr AD BM with palpitations. Exercise on full Bruce for 10.07 minutes stopping for fatigue. Had one episode of palpitations during exercise that lasted approximately 2 seconds. EKG was in ST at peak exercise during palpitation. No EKG changes, no ST changes, no ischemia noted on EKG. BP and HR responded appropriately. No chest pain, no dyspnea and no symptoms during exercise; Normal exercise stress test. 11.90 METs. Duke Treadmill Score: 11 Low risk category.

Holter monitor 20070509:

No diary or symptom log submitted.

Predominant rhythm: NSR

Max HR: 133, sinus rhythm

Min HR: 49, sinus bradycardia

Atrial arrhythmias/ectopy: Occ. PAC's. No atrial fibrillation.

Ventricular arrhythmias/ectopy: No PVC's recorded. No ventricular tachycardia.

Symptoms: No log submitted

ST Segment Analysis: No abnormalities noted

AV Block: No evidence of AV block; no pathological pauses noted Overall Impression: Predominantly sinus rhythm. Occasional PAC's; no other arrhythmia noted. No ST segment changes noted.

The cardiology consultant specifically stated that no cardiac condition was identified that required an MEB that would explain either the chest pain or the palpitations the CI experienced. However, the symptoms experienced by the CI were incapacitating and prevented him from performing the duties required of his rank and AFSC and therefore the PEB determined his condition was unfitting.

This disability is not specifically listed in the rating schedule; therefore, it is rated analogous to a disability in which not only the functions affected, but anatomical localization and symptoms, are closely related. The symptoms experienced by the CI could be accurately coded analogous to a musculoskeletal code or a cardiac code. The Air Force chose the former and rated the CI’s condition at 10% under 5099-5022. The VA chose the latter and rated the CI’s condition at 10% under 7099-7055. A 10% rating is accurate no matter which code is applied and neither offers any rating advantage.

Evidence of cardiac hypertrophy or dilatation on electrocardiogram, echocardiogram, or X-ray warrants a 30% rating under most cardiac VASRD codes including 7055. Mild left ventricular hypertrophy was documented on echocardiogram in March 2003. However later studies in 2007 (echocardiogram and CT) documented an absence of any hypertrophy. Therefore the 30% rating is not warranted.

Exercise stress testing was performed 20070419. CI achieved 11.90 METs and the test was stopped due to fatigue. During the test CI had one episode of palpitations which lasted 2 seconds and was accompanied by a rhythm of sinus tachycardia. These results do not meet the 10% rating criteria based on workload-related symptoms. The 10% criteria requires workload of greater than 7 METs but not greater than 10 METs results in symptoms of dyspnea, fatigue, angina, dizziness, or syncope. However, CI was on continuous medication and therefore a 10% rating is warranted under 7099-7055.

Obstructive Sleep Apnea (OSA) requiring use of CPAP

The CI was diagnosed with obstructive sleep apnea and was prescribed a CPAP machine prior to separation. The NARSUM and VA evaluations stated his daytime sleepiness was relieved with the use of CPAP.

There is no evidence this condition interfered with performance of duty. The Air Force PEB did not determine this condition was unfitting. At the time of CI’s separation, none of service PEBs considered this condition to be unfitting except in rare cases such as when symptoms could not be relieved with treatment. Also servicemembers have deployed with CPAP machines.

Gastritis (To include Esophagitis, and Gastroesophageal Reflux and Hiatal Hernia), Allergic Rhinitis, Hypertension

These conditions were identified in the NARSUM but were not addressed by PEB. However, there is no evidence any are unfitting conditions.

Other VA Conditions

Ganglion Cyst of the Left Foot, Right Foot Bunion, and Left Foot Bunion are not mentioned in the DES package and are therefore outside scope of Board.

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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 concluded that the CI’s condition is appropriately rated at 10% for Chest Pain of Non-Cardiac Etiology.

The CI’s symptoms of chest pain and palpitations did not result from a cardiac condition. However, the symptoms did exist, were incapacitating, and resulted in separation from service. No underlying cardiac arrhythmia caused the palpitations and it cannot be considered a separate ratable condition. No VASRD code for non-cardiac chest pain and palpitations exists and the CI’s disability must be rated analogously. The Air Force PEB and the VA used different codes to rate the CI’s condition but both resulted in a rating of 10%. A higher rating cannot be justified under either code and therefore neither code offers any advantage over the other.

The Board considered the conditions of obstructive sleep apnea, gastritis, allergic rhinitis, hypertension, and pseudofolliculitis barbae and unanimously agreed that there is insufficient evidence to recommend characterizing any of these conditions as unfitting at the time of separation. Therefore none of these conditions are rated.

The other diagnoses rated by the VA were not mentioned in the Disability Evaluation System (DES) package and are 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 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 20090518, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

 President

 Physical Disability Board of Review

SAF/MRB

1535 Command Drive, Suite E-302

Andrews AFB, MD 20762-7002

 Reference your application submitted under the provisions of DoDI 6040.44 (Section 1554, 10 USC), PDBR Case Number PD-2009-00383.

 After careful consideration of your application and treatment records, the Physical Disability Board of Review determined that the rating assigned at the time of final disposition of your disability evaluation system processing was appropriate. Accordingly, the Board recommended no re-characterization or modification of your separation with severance pay.

 I have carefully reviewed the evidence of record and the recommendation of the Board. I concur with that finding and their conclusion that re-characterization of your separation is not warranted. Accordingly, I accept their recommendation that your application be denied.

 Sincerely

Director

Air Force Review Boards Agency

Attachment:

Record of Proceedings

cc:

SAF/MRBR