RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXX. BRANCH OF SERVICE: USMC

CASE NUMBER: PD0900429 BOARD DATE: 20100120

SEPARATION DATE: 20061015

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SUMMARY OF CASE: This covered individual (CI) was a Sergeant Motor Transport Operator who was medically separated from the Marine Corps in 2006 after 3 years of service. The medical basis for the separation was nerve damage to right leg due to shrapnel wound received in Iraq. The CI was referred to the PEB, found unfit for the leg condition, and separated at 20% 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: “In my Physical Evaluation Board on Aug 23 2006 I was given a 20% disability rating and separated from active duty with unfitting conditions of probable right sural traumatic neuropathy, from a enemy grenade injury which I received during combat operations in Fallujah Iraq. I believe that I should have been given a higher percentage from the Marine Corps. It has been over four years from when the injury occurred and I still have pain, and weakness in my right leg. This was a combat related disability incurred in the line of duty as a direct result of armed conflict. I was also diagnosed with PTSD and Major depression however, in my PEB they were not considered unfitting conditions. After being separated from the Marine Corps I went to the VA for a disability claim and received a 60% rating. I have enclosed in this packet my VA decisions for service connect disabilities, a copy of my PEB findings, and progress note from the VA which shows my PTSD medical evaluation.”

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RATING COMPARISON:

|  |  |
| --- | --- |
| **Service PEB** | **VA (22 Mo. after Separation)** |
| **Condition** | **Code** | **Rating** | **Date** | **Condition** | **Code** | **Rating** | **Exam** | **Effective** |
| Probable Right Sural Traumatic Neuropathy | 8724 | 20% | **20060815** | Peroneal Neuropathy of Right Lower Extremity,Secondary to Shrapnel Fragment Wound | 8521 | 30% | **20080820** | **20080808** |
| Major Depression | CATEGORY III: Conditions that are not separately unfitting and do not contribute to the unfitting condition(s) | Post Traumatic Stress Disorder with Depression | 9411 | 30% | **20080827** | **20080808** |
| Post Traumatic Stress Disorder |
|   |  |  |  | Scar Right Leg Associated With Peroneal Neuropathy of Right Lower Extremity, Secondary to Shrapnel Fragment Wound | 7804 | 10% | **20080820** | **20080808** |
|  | NSC X 4 |  |  |
| **TOTAL Combined: 20%** | **TOTAL Combined (*Includes Non-PEB Conditions*): 60%**   |

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ANALYSIS SUMMARY:

Condition 1: Right Leg Neuropathy

Navy:

NARSUM (Date 20060125):

HISTORY OF PRESENT ILLNESS: This is a 23-year-old Marine who was injured in December 2004 by a hand grenade. He has an injury from this where shrapnel entered his right calf and was removed within a day or so at the battalion aid station where he was. Around this time, he developed pain and achiness in his right lower extremity that radiated down his right foot in the distribution of the right sural nerve. He has been to a civilian neurologist and had an electromyelogram of the right and left legs. On reviewing this electromyelogram, which was on 18 May 2005, there were some asymmetries of amplitude of the right peroneal nerve being shorter than the left peroneal nerve but within the realm of normal. The sural nerve was normal by their testing, at least by their report. The patient has had some success with physical therapy but still has significant pain in the right foot, worse with driving, running, and when he accidentally bangs his foot. It also bothers him somewhat to wear shoes. He is currently being treated for pain with Neurontin 2,700 milligrams a day, Topamax 200 milligrams a day, and baclofen 10 milligrams as needed.

PHYSICAL EXAMINATION: On physical examination, he is alert and oriented times three. Speech is slow. Cranial nerves are intact. Motor examination shows normal tone, no bulk, no atrophy, no discoloration of his right leg. Strength was 5 out of 5 throughout his right leg. He did have give-way weakness on the right side with dorsiflexion, plantar flexion, and inversion eversion testing of the right extensor hallucis longus. Sensory examination shows a mild decrease in sensation with significant allodynia on the right foot in a distribution of the right sural nerve. Reflexes were 3 out of 4 and symmetric throughout the bilateral lower extremities. Two to three-beat to clonus on each foot. Plantar response was down-going bilaterally.

IPEB 20060321 and Reconsideration 20060502:

Both rated sensory neuropathy at 10%.

Notes: Unfit secondary to inability to drive truck or run; moderate difficulties with balance/proprioceptive activities of RLE; can’t stand for long periods of time, severe pain; hypersensitivity of ankle, foot; 5/5 strength except give-way, cogwheel; can no longer work in construction as did for civilian job; pain with driving, running, or if bangs; R sural allodynia with mild decreased sensation.

FPEB 20060815:

A Formal PEB hearing was conducted on 15 August 2006, at Washington Navy Yard, Washington, DC. LT D. M. M---, JAGC, USNR represented the member. The member did not appear at the hearing, but petitioned in absentia via counsel because the Formal PEB felt the member's petition could be granted based on the additional evidence submitted prior to the hearing. The member petitioned via counsel requesting to be found unfit for continued naval service due to a physical disability based on diagnosis 1 that he considered ratable at 20% under VA code 8724, with separation from active duty without benefits.

To support his request the member presented testimony and the following new information that was not included in the PEB case file. Exhibit Alpha: 24 pages of medical evidence, which included a Progress Update Note from Centers for Rehab Services; copies of recent prescriptions 27 May 2006 for vicodin, neurontin, topomax, and baclofen; copies of clinical status summary letters covering selected periods inclusive of May 2005 to May 2006 from Dr Mark E. H---, M.D. who is the member's civilian neurologist at Southwestern PA Neurology, and an EMG/NCS report performed by Neurology Associates LTD Southwestern Pennsylvania on 18 May 2005.

The member's medical treatment record and service record were available for review.

After careful review of all the available evidence and based on a unanimous opinion, the Formal PEB finds that the member is unfit for continued naval service because of a physical disability based on diagnosis 1. The record and evidence presented document that the medical disease or condition underlying the diagnosis actually interferes significantly with the member's ability to carry out the duties of his office, grade, rank or rating. The basis for the rating of this diagnosis is the continued presence of severe pain and allodynia in the right foot in a pattern best corresponding to the right sural nerve. The most recent EMG performed on 2 March 2006 documents no motor abnormality, but there was a borderline abnormality of the right Sural SNAP amplitude. While the member continues to note relative weakness of the right foot, the physical exam notes give-way weakness with dorsiflexion, plantar flexion, and inversion/eversion testing of the extensor hallicus longus. There is significant allodynia of the right foot in a sural nerve distribution. The member's current medications to address neuropathic pain as well as muscular cramping include neurontin 2700 mg per day, topamax 200 mg per day, baclofen 10 mg as needed and vicodin for breakthrough pain. The member's significant pain prevents his return to active duty and is attributable to a shrapnel injury to his right calf while in Iraq December 2004. Without motor deficiency, at present, the member is most appropriately rated at the moderate level (highest level permitted with a sensory only deficit as per VASRD) corresponding to 20% under VA code 8724. Diagnoses 2 and 3 are considered Category III and do not preclude the continued performance of duties and are not separately unfitting or contributing to the unfitting conditions.

VA:

Using an evaluation completed 22 months after the time of separation from the Marine Corps, the Veterans Administration (VA) rated this disability as Peroneal Neuropathy of Right Lower Extremity, Secondary to Shrapnel Fragment Wound at 30%.

Rating Decision 20090926:

Service connection for Peroneal Neuropathy of Right Lower Extremity, secondary to Shrapnel Fragment Wound.

Service connection for Peroneal Neuropathy of Right Lower Extremity, secondary to Shrapnel Fragment Wound has been established as directly related to military service. You were seen and examined at VAMC Pittsburgh Highland Drive on August 20, 2008. You had a grenade injury on December 12, 2004, which resulted in Peroneal and sural nerve damage. You have been followed by an outside Neurologist. Your injury to the right calf below the popliteal area, was treated in the field with shrapnel removal and followed in country after removal. You continue to experience difficulty with ambulation. You state that your condition has worsened since the original injury mostly with right dorsiflexion. You have foot drop on ambulation. You have pain lateral on the right leg from below the knee following the dermatome to the 5th digit of the right foot. You have difficulty ambulating on your toes or heels and you have a poor tandem gait. You cannot hop on your right foot and you have hyperesthesia in your right lower extremity from the below the knee down. You do have functional loss due to your inability to walk on your heels and toes and decreased balance with tandem gait. You are unable to stand any longer than ten minutes without support otherwise you will develop right lower extremity weakness. You have decreased monofilament along the dermatome to the 5th lateral aspect of the right 5th toe and sensitivity to the dorsal surface to the right foot. Your foot is warm to touch. You have a diagnosis of Peroneal neuropathy, right lower extremity, secondary to shrapnel fragment wound.

An evaluation of 30 percent is assigned from August 8, 2008.

Analysis:

The Navy PEB did not rate a muscle injury but did rate a sensory neuropathy. The formal PEB rationale from August 2006 stated that EMG did not document any motor abnormality and therefore they were limited to rating the neuropathy at the moderate level IAW §4.124a-10. There was in fact no motor nerve abnormality; however a muscle injury as evidenced by pain, weakness, and lack of endurance and coordination in the right lower extremity on multiple physical examinations was present. Notes from the initial and reconsideration PEBs document the following issues that led to the determination of unfit: severe pain, can’t stand for long periods of time, continued moderate difficulty with balance and proprioceptive activities of the RLE, hypersensitivity, 5/5 motor except give-way and cogwheel with eversion, pain especially with driving, running, or if foot hangs. These problems which led to the determination of unfitness are only partially explained by the sensory neuropathy. The CI’s calf muscle injury with resultant decreased endurance and coordination as well as decreased strength is also needed to fully explain the functional loss that lead to the determination of unfitness. While there is no motor neuron damage documented on EMG to explain motor weakness, the CI has a muscle injury that limits his strength as evidenced by the give-way weakness. He also has lack of endurance and impaired gait and balance.

Examinations from May 2005 by a civilian neurologist show difficulty with right foot dorsiflexion, a lot of pain laterally on the leg from the knee down, especially on the foot with any tactile stimuli or with movement. This did impact his ability to walk. He could not walk on his toes on the right and his tandem was poor. He could not hop on his right foot. Sensory exam was normal except for hyperesthesia in the right lower extremity, laterally, form the knee down. Other examinations performed prior to separation reveal the same findings. The VA C&P exam from Aug 2008 (22 months after separation) showed similar findings and additionally showed a foot drop which was not present in 2005. This foot drop is more likely than not a worsening of the condition and therefore should not be considered when rating the CI’s disability at the time of separation.

VASRD §4.40 Functional loss describes disability of the musculoskeletal system as the inability, due to damage or infection in parts of the system, to perform the normal working movements of the body with normal excursion, strength, speed, coordination and endurance. The functional loss may be due to absence of part, or all, of the necessary bones, joints and muscles, or associated structures, or to deformity, adhesions, defective innervation, or other pathology, or it may be due to pain, supported by adequate pathology and evidenced by the visible behavior of the claimant undertaking the motion. Weakness is as important as limitation of motion, and a part which becomes painful on use must be regarded as seriously disabled. In this case, the CI’s functional loss of endurance and strength are due to pain, not defective innervation.

Adding a rating for muscle injury is not equivalent to adding an additional unfitting condition. The CI was found unfit because of a right lower extremity functional loss that led to his inability to perform the duties of a truck driver or a Marine. This functional loss is caused by both a muscle injury and a sensory neuropathy.

The muscle injury could be considered either moderate or moderately severe as defined in §4.56 Evaluation of muscle disabilities and IAW §4.40 Functional loss. This would result in a rating of either 10% or 20%.

The muscle injury appears to be responsible for a significant proportion of the functional loss and VASRD 5311 Shrapnel Injury to Group XI (calf) muscles should be applied. Lack of endurance, impaired balance, and decreased strength due to pain can be attributed to the muscle injury. The muscle injury can be considered moderate because of consistent complaints of the cardinal signs and symptoms of muscle disability as defined in paragraph (c) of §4.56 Evaluation of muscle disabilities along with loss of power or lowered threshold of fatigue after average use when compared to the sound side attributed to the muscle injury. The decreased sensation, foot pain, and allodynia can be attributed to the sural nerve sensory neuropathy.

No apportionment of functional limitations that would warrant a 20% for both 8724 and 5311 while avoiding pyramiding could be found. Also the right lower extremity muscle injury does not meet the criteria for a severe muscle injury.

The VA rated the CI’s disability under a peripheral neuropathy code but included the functional motor loss and therefore was not limited to rating the disability at the moderate level. The 30% rating clearly included consideration of functional motor loss, even though the EMG showed no motor neuron abnormality. It is not clear why the VA rated the condition in this manner and did not apply a muscle injury rating, however, they did consider the motor problems in their rating. The VA used a different code 8521 Peroneal Nerve than the Navy 8724 Tibial Nerve but the ratings for these two codes is equivalent, 10% for Mild, 20% for moderate, 30% for severe, and 40% for Severe Incomplete Paralysis. The VA liaison to the Board stated that while this was a not a clear error, it would be considered more appropriate for the VA to rate the motor functional loss under a muscle injury code. No advantage or disadvantage is afforded to the CI by either method of rating.

Condition 2: PTSD

Navy:

NARSUM date 20060125:

No mention of any mental illness

MEB H&P DD FORM 2808, block 76 and 77 listed PTSD as a defect or diagnosis.

FPEB (date 20060815):

The PEB determined that the PTSD was not separately unfitting and did not contribute to the unfitting condition.

VA:

Using an evaluation completed 22 months after the time of separation from the Marine Corps, the VA rated this disability as Post Traumatic Stress Disorder with Depression and rated at 30%.

Rating Decision 20090226:

1. Service connection for Post Traumatic Stress Disorder with Depression.

Service connection for Post Traumatic Stress Disorder with Depression has been established as directly related to military service. You were seen and examined at VAMC Pittsburgh Highland Drive on August 27, 2008 and your Service Treatment Records were reviewed. You received a Purple Heart and a Combat Action Ribbon. Your stressors have been verified by your examiners. When you returned home you didn't want to go outside and when you did you had to have your back safe. You had a short temper and would explode at small things. You are now married and there are times when you are in bed and you get this tingling feeling going through your body like when you were in Iraq. You were waiting to see if someone was there with a gun and this put you on high alert. You over react to things and it stresses you out. You cannot be in crowds. You stated that you drank all the time when you first came home and now you might have a can of beer once a month. You state that you are not sociable and you will only go to one of your friends home. You stated that your parents have a farm and it is isolated and that you can go there. You said that you are always assessing and looking for snipers. You say that you have a child on the way and that you want to be a good dad. You say that your mood is irritable and that you want to be left alone. Your appetite is low and you have lost 25 pounds in the last year. Your sleep is poor and it takes about 45 minutes to fall asleep and you sleep for about 5 hours a night. You have nightmares twice a week and have basically the same dreams over again about firefights and friends dying. You wake up sweating and don't know where you are. About a year ago you had suicidal thoughts but you didn't think you could do it. You have a lot of feelings of deja vu. You report obsessive behaviors at bedtime and everything has to be in the right place and that you must secure your house. On your Impact of Event Scale your score was 66/80 suggesting a rather severe impact of traumatic stressors. On the Beck Depression Inventory II, you obtained a score of 17 which suggests mild to moderate depressive symptoms. Your Global Assessment of Function (GAF) is 60 which is moderate symptoms. You have a diagnosis of Post Traumatic Stress Disorder, moderate, chronic.

VA treatment records:

Treatment notes from December 2005 document diagnosis of PTSD and major depression with GAF of 65.

Analysis:

PTSD and Major depression were diagnosed at Pittsburgh VA in December 2005. GAF was 65 and he was taking citalopram (Celexa, antidepressant). It appears he was on active duty at this time.

C&P exam from August 2008 not available but rating decision has detailed information.

However, nothing in STR supports finding of unfit. No mention in either Commander’s letter (initial and reconsideration PEB).

Other Conditions.

Scar, Right Leg Associated with Peroneal Neuropathy of Right Lower Extremity, Secondary to Shrapnel Fragment Wound

TBI (VA rating deferred)

Not in DES package and therefore outside the scope of the 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 recommends by simple majority that the CI’s condition be rated at a combined 30% with 20% for VASRD 8724 Probable Right Sural Nerve Traumatic Neuropathy and 10% for VASRD 5311 Shrapnel Injury with Moderate Group XI (Right Calf) Muscle Injury IAW VASRD §4.124a-215 Diseases of the Peripheral Nerves, §4.73 Schedule for Ratings-Muscle Injuries, §4.40 Functional Loss, and §4.56 Evaluation of Muscle Disabilities. The single voter for dissent (who recommended no recharacterization) did not elect to submit a minority opinion.

The Navy PEB provided a single rating for a right sural nerve traumatic neuropathy at 20%. This rating is appropriately applied and was appropriately limited to the 20% rating for moderate incomplete paralysis because the neurologic involvement is wholly sensory. However, this rating does not include all of the functional loss experienced by the CI as the result of the injury to his right calf. The PEB considered functional losses beyond what can be attributed to the sensory neuropathy as significant contributions to its finding of unfitness. The PEB considered the CI’s inability to stand for prolonged periods, moderate difficulties with balance/proprioceptive activities of the right lower extremity, pain with driving or running, and pain with banging of the right lower extremity as factors contributing to the finding of unfit. Evaluations both prior to and subsequent to separation from service demonstrated these functional losses as well as decreased strength and endurance and increased fatigue of the right lower extremity as compared to the left. Both sensory and motor functional losses attributable to the injury should be rated. The motor functional losses are not due to a neuropathy but to the injury to the muscle itself. The motor functional losses are appropriately rated under VASRD code 5311 Group XI from §4.73 Schedule for Ratings-Muscle Injuries. The muscle group includes the muscles of the calf. VASRD §4.56 Evaluation of Muscle Disabilities describes the criteria for findings of slight, moderate, moderately severe, and severe muscle injuries and the CI’s evaluations clearly demonstrate a level of moderate injury. The type of injury suffered by the CI was a deep penetrating wound of short track from shrapnel that did not have an explosive effect, residuals of debridement, or prolonged infection. There are records of consistent complaints of multiple cardinal signs and symptoms of muscle disability as defined in paragraph (c) of §4.56. These include loss of power, weakness, lowered threshold of fatigue, and impairment of coordination. The loss of power, weakness, and fatigue are most likely secondary to pain, not to any neurologic damage to motor nerves or significant damage to the bulk of the muscle. However, §4.40 Functional Loss specifically states that functional loss may be due to absence of part, or all, of the necessary bones, joints and muscles, or associated structures, or to deformity, adhesions, defective innervation, or other pathology, or it may be due to pain, supported by adequate pathology and evidenced by the visible behavior of the claimant undertaking the motion. The CI had motor weakness most likely due to pain documented on multiple examinations as give-way weakness of the right lower extremity. Physical examinations also demonstrated loss of power and lowered threshold of fatigue when compared to the sound (left) side. The CI also had documented balance and gait abnormalities that can be attributed to the differences in power and fatigability between the two lower extremities. The CI’s right lower extremity clearly meets the criteria for moderate disability of muscles. These motor functional losses are not secondary to the sensory neuropathy and therefore the muscle injury code must be added to adequately rate the CI’s disability. This is not considered adding an additional unfitting condition but is the most appropriate way to rate the functional loss that is attributed to the CI’s unfitting right lower extremity injury. Pyramiding is avoided as none of the motor functional losses are used to support the sensory neuropathy rating and the decreased sensation, foot pain, and allodynia are not used to support the muscle injury rating.

The Board also considered the conditions of Major Depression and Post-Traumatic Stress Disorder (PTSD) and found insufficient evidence to characterize either condition alone or in combination to be unfitting. These conditions were diagnosed while the CI was on active duty but did not demonstrate any interference with any duties required of the CI’s rank, rate, or station.

The other diagnosis rated by the VA, Scar, Right Leg Associated with Peroneal Neuropathy of Right Lower Extremity, Secondary to Shrapnel Fragment Wound was not mentioned in the Disability Evaluation System (DES) package and is therefore outside the scope of the Board. The VA had deferred a rating decision on Traumatic Brain Injury (TBI) and their final rating was unavailable to the Board. However, this diagnosis is 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 Naval Records (BCNR) to consider adding these conditions as unfitting.

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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** |
| Probable Right Sural Traumatic Neuropathy | 8724 | 20%  |
| Shrapnel Injury with Moderate Group XI (Right Calf) Muscle Injury  | 5311 | 10%  |
| **COMBINED** | **30%** |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20090703, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

 President

 Physical Disability Board of Review

MEMORANDUM FOR DEPUTY COMMANDANT, MANPOWER & RESERVE

 AFFAIRS

Subj: PHYSICAL DISABILITY BOARD OF REVIEW (PDBR) RECOMMENDATION

 ICO XXXXX, XXX XX XXXX

Ref: (a) DoDI 6040.44

Encl: (1) PDBR ltr dtd 27 Jan 10

1. I have reviewed subject case pursuant to reference (a) and accept the recommendation of the Physical Disability Board of Review (enclosure (1)).

2. Subject member’s official records are to be corrected to reflect the following disposition:

 a. Separation from the naval service due to a physical disability rated at 30% with placement on the Permanent Disability Retired List effective October 15, 2006, the date of his discharge from naval service.

3. Please ensure all necessary actions are taken to implement this decision, including the recoupment of previously paid funds if appropriate, and notification to the member once those actions are completed.

 Principal Deputy

 Assistant Secretary of the Navy

 (Manpower & Reserve Affairs)