RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXX BRANCH OF SERVICE: NAVY

CASE NUMBER: PD0900431 BOARD DATE: 20100210

SEPARATION DATE: 20090304 (TDRL 20041209)

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SUMMARY OF CASE: This covered individual (CI) was a Lieutenant Commander (DD Form 294 says O-5, everything else says O-4) Nurse who was medically separated from the Navy in 2009 after 16.5 years of service. The medical basis for the separation was Cognitive Deficits Secondary to Vitamin B-12 deficiency. The CI was referred to the Physical Evaluation Board (PEB), found unfit for the condition, 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. I, L--- B---, XXX\_XX\_-3575 (hereafter "Applicant"), hereby respectfully request that:

a. I be medically retired, permanent disability retired list (PDRL), with a disability percentage of forty percent (40%) as of the date of my separation; and b. I receive back retirement pay from the date of my retirement to the present. 2. The Navy - Marine Corps Formal Physical Evaluation Board (FPEB) erred when it awarded Applicant 10% with severance pay for "Cognitive Deficits Secondary to Vitamin 8-12 Deficiency." The FPEB further noted under Category II that Applicant's Ataxia and Chronic Vertigo contributed to the unfitting condition, but were not separately rated.”

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RATING COMPARISON:

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Service PEB** | | | | **VA (6 mo after entering TDRL)** | | | | |
| **Unfitting Conditions** | **Code** | **Rating** | **Date** | **Condition** | **Code** | **Rating** | **Exam** | **Effective** |
| Cognitive Deficits Secondary to Vitamin B-12 deficiency | 9399 9326 | 10% | 20090121 | Not addressed by VA |  |  |  |  |
| Chronic Vertigo  (TDRL Retirement date 20041115) | 6299 6205 | 60%  (TDRL)  then Cat II | 20040811  (TDRL)  then  20090121 | Chronic Vertigo With Ataxia | 6299 6204 | 10% | 20050629 | 20041210 |
| Ataxia | Cat II |  | |
| Not addressed by MEB or PEB |  | Mentioned in NARSUM | | Total Abdominal Hysterectomy, Right Salpingo Oophorectomy | 7618 | 30% | 20050629 | 20041210 |
| High Frequency Hearing Loss | Cat III |  | | Hearing Loss, Right Ear | 6100 | NSC |  |  |
| Hearing Loss, Left Ear | 6199 6100 | NSC |  |  |
| Right Ear Tinnitus | Cat III |  | | Tinnitus | 6260 | 10% | 20050629 | 20041210 |
| Right Shoulder Impingement | Cat III |  | | Right Shoulder Mild Impingement | 5201 | 0% | 20050629 | 20041210 |
| Right Shoulder Pain & Weakness Secondary to AC Joint Arthrosis | Cat III |  | |
| Hypertension | Cat III |  | | Hypertension | 7101 | 10% | 20050629 | 20041210 |
| Hypothyroidism | Cat III |  | | Hypothyroidism | 7903 | NSC |  |  |
| Right Lung Calcified Granuloma Va Hamartoma | Cat III |  | | Right Lung Granuloma | 6820 | 0% | 20050629 | 20041210 |
| Benign Colon Polyps | Cat III |  | | Colon Polyps | 7399-7344 | NSC |  |  |
| Mood Disorder | Cat III |  | | Bipolar Disorder And General Anxiety Disorders (Also Claimed As Depression) | 9432 | 10% | 20050629 | 20041210 |
| Anxiety Disorder | Cat III |  | |
| Left Great Toe Pain, Probably djd | Cat III |  | | Residuals, Osteomyelitis, Left Great Toe Secondary To Toe Nail Removal | 7804 | 0% | 20050629 | 20041210 |
| Obesity | Cat IV |  | | Not addressed by VA |  |  |  |  |
| Not addressed by MEB or PEB |  | Mentioned in 2nd TDRL eval | | Anemia | 7799-7716 | 10% | 20050629 | 20041210 |
| Not addressed by MEB or PEB | | | | Residuals, Head Injury, Post Concussive | 8045 | NSC |  |  |  | |  |
| Not addressed by MEB or PEB | | | | Headaches | 8199 8100 | NSC |  |  |
| **Category II:** Conditions that contribute to the unfitting condition(s): | | | |  |  |  |  |  |
| **Category III:** Conditions that are not separately unfitting and do not contribute to the unfitting condition(s): | | | |  |  |  |  |  |
| **Category IV:** Conditions that do not constitute a physical disability: | | | |  | | | | |  |
| **TOTAL Combined: 10%** | | | | **TOTAL Combined (*Includes Non-PEB Conditions*):**  **60% from 20041210** | | | | |

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ANALYSIS SUMMARY:

CI was placed on the temporary disability retired list (TDRL) on 20041209 for Chronic Vertigo 6299-6205 at 60% with ataxia, high frequency hearing loss, and right ear tinnitus as related category II diagnoses. She was initially thought to have Meniere’s disease. However, an otoneurology consultation in September 2004 determined she did not have Meniere’s. At this exam she had a normal gait and a normal battery of vestibular studies. She could stand with narrow base on flat stable support surface with eyes open, but was somewhat unstable with eyes closed and a bit more on a compliant surface of 6-inch foam with eyes closes but could maintain static standing independently.

After entrance into the TDRL, CI was diagnosed with B-12 deficiency and began treatment. It was determined that B-12 deficiency was the most likely the cause of her ataxia and newly discovered cognitive disorder. In hindsight, her hearing loss was not of the type seen with Meniere’s and was felt to be noise related. After treatment with B-12 injections her symptoms of ataxia and vertigo were greatly improved by both her report and physical examination. Repeated neuropsychological testing also showed improvements in performance. After the second TDRL evaluation, the Informal Physical Evaluation Board (IPEB) determined she was fit for duty on 20080813.

CI appealed to the Formal Physical Evaluation Board (FPEB) to rate her at 30% for cognitive deficits secondary to Vitamin B-12 Deficiency 9399-9326 and 10% for left ankle instability with pain 5271. She did not request that ataxia or vertigo be added as unfitting conditions. The FPEB determined she was marginally unfit and rated her cognitive deficits at 10% under VASRD 9399-9326. Chronic Vertigo and ataxia were considered Category II and all other conditions were Category III or IV.

CI submitted a petition for relief (PFR) requesting a rating of 30% for cognitive deficits, 10% for ataxia, and 10% for chronic vertigo all secondary to chronically untreated Vitamin B-12 deficiency. The PFR request was denied stating that Ataxia and Chronic Vertigo are not unfitting as they did not prevent non-clinical nursing duties.

Cognitive Deficits Secondary to Vitamin B-12 Deficiency

Neuropsychological testing did show a level of functioning lower than the high average level that would be expected given the CI’s age, education, and gender. However on the latest testing most areas were still average and many were at the expected high average level. Few were below average. Six areas were high average and not impaired relative to expected performance. These included multiple functional domains: academic and language functions, learning and memory, and motor skills. Only one area repeatedly tested at the impaired level and this was hypothesis testing. Two areas, sustained attention and visuoconstruction, tested at the borderline level but both showed variability in performance ranging from borderline to average or normal. Performance in verbal fluency and immediate visual memory was at the low average level but both of these had improved when compared to previous testing.

On the latest neuropsychological testing, the CI did not report any problems with performing her job as a civilian educational registered nurse. The testing report stated the deficits noted could interfere with her job performance but that the CI had apparently successfully developed compensatory strategies for her problems and her employer was able to accommodate her with a flexible schedule and occasional working at home. At her Formal Board hearing she indicated that she was performing her duties in a satisfactory manner and had received positive feedback from her employer to that effect.

The diagnosis of a cognitive disorder due to chronic B-12 deficiency is appropriately rated under VASRD 9326. The criteria for the 30% rating are not met and a 10% rating is recommended. The CI appears to be able to function in her current job most of the time. She does seem to have some problems with attention but appears to have developed strategies to cope with this. There is difficulty with multitasking and distraction but has developed strategies and work-arounds. There are no reports of substandard job performance.

Of note, the VA did not provide any rating for a cognitive disorder. However the VA did rate the mental conditions of Bipolar Disorder and General Anxiety Disorders and determined that her functional limitations warranted a 10% rating IAW the VASRD General Schedule for Rating Mental Disorders. All mental conditions are rated together based on the overall level of functional limitation, not based on the diagnoses. The Navy PEB had previously determined that the CI’s mood and anxiety disorders were not unfitting. While the VA and the Navy rated two different mental conditions, both assessed the level of functional impairment at 10%.

Ataxia and vertigo

CI had impaired proprioception secondary to chronic B-12 deficiency and this interfered with her ability to walk normally when visual cues were not present, such as in the dark or when her eyes were closed. An extensive work-up ruled out the presence of a vestibular disorder. Positive Romberg and absence of a vestibular problem means CI’s problem is with proprioception.

The original narrative summary (NARSUM) dated 20040527 stated the CI had symptoms of vertigo and ataxia intermittently over the previous three years but the symptoms have become more severe and more incapacitation over the past year. The working diagnosis was Meniere’s although it appeared that no one thought this was the definitive diagnosis. The plan was to obtain further specialty consultations. Her vertigo and ataxia were felt to be unfitting and the IPEB placed her on the TDRL.

At the time of the original NARSUM, physical exam revealed a positive Romberg and inability to perform tandem gait with significant ataxia. Rapid alternating movements were intact as was sensory and motor examinations. She was diffusely hyper-reflexive with 3+ in bilateral upper extremity and 2+ in bilateral lower extremity. Finger to nose and heel to shin were mildly abnormal on the left. The VA compensation and pension (C&P) examination completed 20050630 reported normal 2+ reflexes, normal finger to nose, and no nystagmus. However, the Romberg was positive and the CI staggered with the tandem gait.

The first TDRL evaluation was done after the CI had been diagnosed with B-12 deficiency at the VA and was receiving B-12 replacement. She reported her ataxia had improved but she had ongoing difficulty with ambulation when visual cues were not entirely evident or were misleading. Exam by ear, nose and throat (ENT) revealed an overall normal neurologic exam and a normal gait. She was able to do tandem gait (heel-toe walk). Vestibular testing was negative including Fukuda step test, Halmagyi head thrust, and absence of positional testing post head-shake nystagmus. Extensive vestibular testing had been done and was normal. CI did not have Meniere’s or any other vestibular problem.

At the second TDRL evaluation conducted by a neurologist on 20080721 the CI complained that balance remained problematic. She reported she often staggers if visual cues are not present, although as reported at the first TDRL evaluation, she stated her symptoms had improved with the injections. The physical exam was normal and the neurologist appeared to imply the CI might be embellishing or had symptoms out of proportion to actual medical condition/psychosomatic. He stated there was no evidence of upper motor neuron dysfunction, sensory dysfunction, or neurologically based ataxia but there was ‘some astasia-abasia on gait and balance testing today as well as augmentation during reflex testing’. He opined the CI had had an excellent recovery from prolonged vitamin B-12 deficiency and had no current evidence of any on-going neurological dysfunction. He referenced the VA neuropsychological testing of 20080402 and stated the ‘astasia-abasia and augmentation of reflexes is reflective of the anxiety and re-acclimation to her good health, as suggested in the recent neuropsychological testing.’

Initially the ataxia and vertigo were significant and each episode of increased symptoms required bed rest for two days. The condition interfered with her activities of daily living and her military duties. Multiple medications were tried and all failed to improve her condition. Further testing ruled out a vestibular cause of her symptoms and a vitamin B12 deficiency was discovered. It appears the CI’s ataxia did improve after treatment with B12 replacement and she appeared to be fit for duty regarding ataxia after her second TDRL evaluation. There is insufficient evidence to support finding this condition unfitting. It would not interfere with clinical or non-clinical duties unless the CI was required to work in the dark or with her eyes closed.

Anemia:

While it appears the CI did have intermittent periods of low hemoglobin due to both iron deficiency and B12 deficiency, once she underwent treatment her hemoglobin appeared to remain in the normal level. Complications of pernicious anemia, such as dementia or peripheral neuropathy, should be rated separately. The anemia itself does not appear to have been an unfitting condition. However, the residual effect of cognitive dysfunction due to B12 deficiency was unfitting and that condition is rated. The VA appears to have used an incorrect VASRD code; the CI never had aplastic anemia. The proper code would be 7700 Anemia, hypochromic-microcytic and megaloblastic, such as iron-deficiency and pernicious anemia. VA testing does not show hemoglobin of less than 10 and therefore, even if this condition were considered unfitting, it would be rated at 0%.

Other Conditions

None of the other conditions rated by the VA (Total Abdominal Hysterectomy, Right Salpingo-Oophorectomy; Tinnitus; Right Shoulder Mild Impingement; Hypertension; Right Lung Granuloma; Bipolar Disorder and General Anxiety Disorders; or Residuals, Osteomyelitis, Left Great Toe Secondary to Toe Nail Removal) prohibited the CI from performing the duties of her rank and rate. There is not sufficient evidence for the Board to consider any of these conditions as unfitting.

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BOARD FINDINGS: IAW DoDI 6040.44, the Board used the Veteran’s Affairs Schedule of Rating Disabilities (VASRD) as the most favorable basis for rating. After careful review of all available information the Board unanimously recommends that the CI’s condition be rated at 10% for 9326 Cognitive Deficits Secondary to Vitamin B-12 Deficiency.

While chronic vertigo with associated ataxia was the condition for which the CI was initially placed on TDRL, further diagnostic work-up revealed that her symptoms were due to chronic B12 deficiency and not a vestibular problem. Her gait and balance problems were much improved after B12 replacement therapy was started and the Informal PEB found her fit for duty in August 2008. The CI appealed this finding stating she was unfit as a result of her cognitive deficits which had resulted from her B12 deficiency and left ankle instability which occurred after injury related to her gait and balance problems. She did not refute the finding of fitness for vertigo or ataxia. The Formal PEB determined her cognitive deficits were unfitting but did not consider any other condition to be unfitting. The CI then submitted a petition for relief requesting a 30% rating for cognitive deficits, a 10% rating for ataxia, and a 10% rating for vertigo. There was no mention of the ankle instability. The petition for relief was denied. At her initial VA evaluation after separation from active duty and entrance into TDRL, a rating of 10% for vertigo and ataxia together was applied by the VA. No subsequent VA evaluations addressed this condition.

The CI had a comprehensive evaluation that essentially ruled out any vestibular abnormality and after the B12 deficiency was diagnosed, her gait and balance problems were attributed to this problem. The neurologic evaluation in 2008 did not reveal any neurologic abnormality. The CI still complained of some problems with balance. She reported she often staggered if visual cues were not present, but that her symptoms had improved with the injections. The physical exam was normal and the neurologist stated there was no evidence of upper motor neuron dysfunction, sensory dysfunction, or neurologically based ataxia. He noted ‘some astasia-abasia on gait and balance testing today as well as augmentation during reflex testing’. He opined the CI had had an excellent recovery from prolonged vitamin B-12 deficiency and had no current evidence of any on-going neurological dysfunction. He referenced the VA neuropsychological testing of 20080402 and stated the ‘astasia-abasia and augmentation of reflexes is reflective of the anxiety and re-acclimation to her good health, as suggested in the recent neuropsychological testing.’ The Board acknowledges that the CI continued to have some ataxia but opined it would not have interfered with the performance of her duties as appropriate visual cues would likely be present. Therefore the Board unanimously recommends no recharacterization of ataxia or vertigo as unfitting.

The CI did have evidence of low hemoglobin in her service treatment record but it returned to normal levels after B12 replacement therapy was initiated. While the CI had residual effects due to chronic pernicious anemia, she was not anemic at the time of separation and therefore this condition cannot be considered unfitting. Therefore the Board unanimously recommends no recharacterization of anemia as unfitting.

Although the VA performed neuropsychological testing that documented cognitive deficits, this was not rated as a service connected condition. While the VA did not rate her cognitive deficits, they did rate Bipolar and Generalized Anxiety Disorders. All mental disorders are rated together using the General Rating Formula for Mental Disorders in VASRD §4.130. The rating is based on the assessment of overall occupational and social functional impairments and only one rating is applied even if multiple mental conditions are present. The Navy PEB had previously determined that the CI’s mood and anxiety disorders were not unfitting. While the VA and the Navy rated two different mental conditions, both assessed the level of overall functional impairment at 10%.

The CI had three episodes of comprehensive neuropsychological testing that did show some cognitive deficits with improvement after B12 replacement was initiated. As explained in the testing reports, the CI would be expected to show a high average level of testing based on her age, education, and gender and therefore testing below this level would be considered impaired. The CI did score below the expected high average level in multiple areas but most were at the average level. Only one area remained at the impaired level on all three tests. On the latest testing, six areas were at the high average level and considered not impaired. Most areas measured at the average level. So while cognitive deficits are present, the CI’s level of testing is still considered average or above in most areas. Her ability to perform adequately in her job in nursing education correlates with this level of testing.

The diagnosis of a cognitive disorder due to chronic B-12 deficiency is appropriately rated under VASRD 9326. The criteria for the 30% rating are not met and a 10% rating is recommended. The CI appears to be able to function in her current job most of the time. She does seem to have some problems with attention but appears to have developed strategies to cope with this. She also has difficulty with multitasking and distraction but has developed strategies and work-arounds. There are no reports of substandard job performance.

None of the other conditions rated by the VA (Total Abdominal Hysterectomy, Right Salpingo-Oophorectomy; Tinnitus; Right Shoulder Mild Impingement; Hypertension; Right Lung Granuloma; Bipolar Disorder and General Anxiety Disorders; or Residuals, Osteomyelitis, Left Great Toe Secondary to Toe Nail Removal) prohibited the CI from performing the duties of her rank and rate. There is not sufficient evidence for the Board to consider any of these conditions as unfitting. The Board unanimously agrees that it cannot recommend a finding of unfit for any of these conditions.

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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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| --- | --- | --- |
| UNFITTING CONDITION | VASRD CODE | RATING |
| Cognitive Deficits Secondary to Vitamin B-12 Deficiency | 9326 | 10% |
| COMBINED | 10% |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20090527, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

Deputy Director

Physical Disability Board of Review

MEMORANDUM FOR DIRECTOR, SECRETARY OF THE NAVY COUNCIL

OF REVIEW BOARDS

Subj: PHYSICAL DISABILITY BOARD OF REVIEW (PDBR) RECOMMENDATION

ICO XXXXX

Ref: (a) DoDI 6040.44

(b) PDBR ltr dtd 1 Mar 10

I have reviewed subject case pursuant to reference (a) and approve the recommendation of the Physical Disability Board of Review (reference (b)) that XXXX’s records not be corrected to reflect a change in either her characterization of separation or in the disability rating previously assigned by the Department of the Navy’s Physical Evaluation Board.

Principal Deputy

Assistant Secretary of the Navy

(Manpower & Reserve Affairs)