RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: NAVY

CASE NUMBER: PD0900525 BOARD DATE: 20100811

SEPARATION DATE: 20011005

TDRL DATE: 19950131

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SUMMARY OF CASE: This covered individual (CI) was a Storekeeper Second Class medically separated from the Navy in 2001 after more than eight years of service. The medical basis for the separation was Failed Back Syndrome. The CI was referred to the Physical Evaluation Board (PEB), found unfit for the condition, determined unfit for continued military service and placed on TDRL in January 1995. The CI underwent periodic evaluations in July 1996 and February 2001. The informal PEB determined he was unfit for continued Naval service and rated his condition at 10%. A formal PEB confirmed the findings of the informal PEB and the CI was separated with a 10% disability using the Veterans Affairs Schedule for Ratings Disabilities (VASRD) and applicable Naval and Department of Defense regulations.

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CI CONTENTION: The CI states: ‘VA rated disability at 40% Service connection on May 28, 1997 and considered me unemployable on 4-22-04 for the back condition military discharged me with at 10%. I feel I should have been medically retired.’

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RATING COMPARISON:

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| **Service Formal PEB** | | | | **VA** | | | | |
| **Unfitting Conditions** | **Code** | **Rating** | **Date** | **Condition** | **Code** | **Rating** | **Exam** | **Effective** |
| Failed Back Syndrome | 5293 | 40%  then  10% | 19941205  then  20010809 | Herniated Disc, L4-L5, S/P Microdiscectomy, with  Residual Back Pain and Right Leg Pain | 5293 | 40%  60%  100%  60% | STR | 19950201  20030606  20040407  20040701 |
| Status Post Herniated Nucleus Excision, L4-5 Right Side, Healed With Residual Low Back Pain, Back Stiffness And Right Leg Pain | Related to: Failed Back Syndrome | | 19941205  and  20010809 | Radiculopathy, Right Lower Extremity | 8525 | 10% | 20031119 | 20030606 |
|  | Not in DES at Time Entered TDRL | | | Dysthymia Associated with Herniated Disc,  L4-5, Status Post Micro-discectomy with Residual Back and Right Leg Pain | 9433 | 10% | 19971224 | 19970212 |
|  |  |  |  | Hearing Loss | 6100 | NSC |  |  |
| **TOTAL Combined: 10%**  Entered TDRL 19950131 5293 40%  IPEB 20010403 5295 10%  FPEB 20010809 5293 10%  Separated 20011005 | | | | **TOTAL Combined (*Includes Non-PEB Conditions*):**  40% from 19950201  50% from 19970212  70% from 20030606  100% from 20040407 (Surgery)  70% from 20040701  Individual Unemployability Granted from June 6, 2003 | | | | |

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ANALYSIS SUMMARY:

Failed Back Syndrome

The CI first had back pain in January 1994 and it rapidly became severe. A magnetic resonance imaging (MRI) showed a herniated disc at L4-5 and myelogram showed a near complete block at L4-5. He underwent an L4-5 microdiscectomy in March 1994 but his symptoms persisted and he was not able to return to full duty. In August 1994 he was only able to work half days. After his surgery he continued to have back pain although he had good relief from his radicular pain. The CI was placed on the TDRL in 1995 with a 40% rating for 5293 Failed Back Syndrome. He underwent TDRL evaluations on 19960709 and 20010212. An informal PEB determined his condition had improved and recommended separation with a 10% rating for 5295. A formal PEB met 20010627 and determined his condition warranted a 10% rating under 5293 (the original VASRD code) because his condition had improved. The formal PEB rationale stated ‘There is some evidence of objective improvement at least since 1997. The most recent physical examinations demonstrate no weakness and negative straight leg raise test. There is no documentation of muscle wasting, of muscle asymmetry, or of muscle spasm. There is one incidental finding of absent ankle jerks that has no specific clinic significance.’ The rationale also stated there was a sparsity of visits for treatment but did not specify frequency of symptoms.

VASRD 5293 rating criteria was based on the severity and frequency of symptoms compatible with sciatic neuropathy. During his time on TDRL the CI’s intervertebral disc syndrome worsened as evidenced by X-ray and MRI results, as well as increasing severity and frequency of pain documented at multiple visits for back pain. X-ray examinations progressed from normal exams to documenting degenerative changes and disc space narrowing. MRI examinations progressed from possible disc herniation at L5-S1 to Marked degenerative disc and facet changes from L3/4 to L5/S1, including a right paracentral herniated disc at L5-S1 that effaced the anterior thecal sac and impinged on the right S1 nerve root. Electromyogram (EMG) studies done prior to the 1994 surgery and repeated in 2003 documented chronic, on-going nerve damage related to the degenerative disc disease. The CI had multiple visits for back pain in 2000, 2001, and later. Many were for increased frequency and/or severity of symptoms of back and leg pain and resulted in prescriptions for short term use of narcotic pain medications. The CI eventually was given methadone for his chronic pain. His muscle weakness did resolve and his straight leg raise test was intermittently positive. By December 2001, two months after he separated, his back pain was constant and his radicular pain was often. Surgery was considered as an option for his progressive symptoms in 1997, 2000, and 2002 and was eventually done in 2004.

Around the time of his second and final TDRL evaluation 20010212 the CI had been scheduled to undergo an Intradiscal electrothermic therapy (IDET) procedure to his L5-S1 disk. He had been undergoing evaluation at Brooke Army Medical Center for continued back pain that radiated down his right leg and had persisted after the 1994 discectomy at L4-5. In addition to his persistent symptoms he had abnormal X-rays and MRIs that showed progressively worsening degenerative disc disease at L5-S1 and L3-4. Myelograms also documented evidence of worsening degenerative disc disease. He also had EMG testing that showed nerve damage persisted after the 1994 surgery.

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| **Date** | **X-rays Lumbar Spine** | | **MRI (Myelogram, EMG)** | |
| 19940207 | Negative Lumbar spine | |  | |
| 1994 |  | | MRI before surgery: Herniated disc at L4-5 and possibly also at L5-S1. Very large central disc at L4 with dual sac impingement | |
|  |  | | Myelogram before surgery: Near complete block at L4-5 because of a large ruptured disc | |
| 19940313 |  | | EMG: L5 nerve root with distal sural latency | |
| **19940321 L4-5 Discectomy** | | | | |
| After 19940321 |  | | MRI after surgery: Severe scarring in the epidural space, possibly infection | |
| 19940409 | Negative Lumbar spine | |  | |
| **19941204 Informal PEB** | | | | |
| **19950131 Entered TDRL** | | | | |
| 19950406 | Moderate degenerative disc disease, L4-5. Mild degenerative disc disease, L3-4. | |  | |
| **19960709 First TDRL Evaluation** | | | | |
| 19970221 | Decreased disc space at 4th level with spondylotic fusion of L4 and L5. Some facet arthritis in the lower two segments | |  | |
| 19970916 |  | | Civilian ortho reported MRI showed: markedly degenerative disc, especially at L3-4 and L4-5 and decreased signal at L5-S1. At L3-4 there is a right paracentral bulge or herniation. At L5-S1 there is more of a central bulge. | |
| 19971212 | Disc degeneration L4/L5; Early spondylosis, lower lumbar spine | |  | |
| 20001012 |  | | Discogram: L3-4 showed some degeneration with flattening but no concordant pain. L4-5 was fused. L5-S1 showed degeneration with a flat disc and concordant pain. (IDET was scheduled for 20001117 but never done) | |
| **20010212 Second (final) TDRL evaluation** | | | | |
| ~20010309 | |  | | Marked degenerative disc and facet changes from L3/4 to L5/S1. L4/5 appears to be fused anteriorly. There is persistent spinal and lateral recess stenosis across these levels. (Results reported at BAMC Neurosurgery visit 20010309) |
| **20010403 Informal PEB** | | | | |
| **20010809 Formal PEB** | | | | |
| **20011005 Separation** | | | | |
| 20020315 |  | | Post-operative changes L3-5. Bulging of the posterior margin of the L3-L4 intervertebral disc, effacing the anterior thecal sac and mildly encroaching on the right neural foramen. Right paracentral herniated disc at L5-S1, effacing the anterior thecal sac and impinging on the right S1 nerve root. | |
| **20021004 12 Months after Separation** | | | | |
| 20021118 | Mild retrolisthesis of the L5 upon the S1 vertebra. No indication of instability. Normal lumbar lordosis. No significant compression of vertebral bodies. Bridging osteophytes are seen anteriorly at the L3-4 and L4-5 levels. Narrowing of the L4-5 disc space compatible with degenerative disc disease at this level. No spondylolysis is seen bilaterally. | |  | |
| 20031110 |  | | L1-2 annular disc bulge with mild central canal stenosis. L2-3 annular disc bulge with moderate central canal stenosis. L3-4 annular disc bulge with moderate to sever central canal stenosis. L4-5 fusion plus moderate central canal present. L5-S1 right paracentral disc bulge with mild central canal stenosis and bilateral neural foraminal narrowing. Multilevel degenerative lumbar spondylosis. Fusion of the L4 and 5 vertebral bodies in the anterior right portions. Contrast enhancing epidural tissue at L5-S1, either post-operative or inflammatory. Bilateral L5-S1 foraminal narrowing. | |
| 20031124 |  | | EMG: consistent with old or chronic right L5-S1 radiculopathy | |
| **20040407 L5-S1 Microdiscectomy** | | | | |

The service treatment record (STR) documents multiple visits for back and leg symptoms as well as requests for medication refills and pain medication from 1997 through the time of separation from TDRL in 2001 and continuing to April 2004. The CI was seen in multiple VA Medical Centers in Oklahoma, Phoenix, and Omaha as well as Reynolds Army Community Hospital at Fort Sill, OK and Brooke Army Medical Center in San Antonio TX. He also was seen a few times in 1997 by a civilian orthopedic surgeon in Tulsa, OK. This surgeon provided epidural steroid injections which provided some relief. This surgeon also recommended surgery but CI was reluctant because of difficulties after his first surgery. He did not permanently rule out the possibility. He was taking nonsteroidal anti-inflammatory medication most of this time with intermittent periods of treatment with narcotic pain medications such as Tylenol #3, Lortab, and Percodan.

* 20000331 Tulsa VA. On Motrin asking for pain medication.
* 20000516 Muskogee VA. Trouble sleeping due to back pain. Uses heated water bed and heating pad when not in bed. Constant radiation of pain down right lower extremity to foot. Pain and radicular symptoms worse if walks two to four blocks. He also had trouble sitting or standing in one position due to pain. Exam showed obvious back discomfort and frequently shifted positions. He had difficulty mobilizing to and from the exam table. Back flexion limited to 40 degrees and extension to 10 degrees. He was given gabapentin and Lortab for his back pain.
* 2000 June and July Reynolds ACH orthopedics. Seen for increasing symptoms of back pain and radicular pain in right lower extremity. Was referred to spine surgeon for possible surgery.
* 20000807 Muskogee VA. Symptoms had not improved and were worse with driving. Gabapentin wasn’t helping and it made him nauseated and he stopped taking it. He was taking the Lortab and Vioxx was added. Had appointment scheduled with spine surgeon in Sept 2000.
* 20000906 and 07 Brooke AMC Orthopedic, spine. Evaluation for possible surgery. Can sit one hour but then must walk and stand. Can walk or stand only 15 minutes and then he has increased pain. If he drives more than 2 hours he has increased leg pain and his right foot goes numb. Ordered MRI, CT, and then diskogram after abnormal MRI results obtained.
* 20001012 and 13 BAMC. Diskogram done to determine if CI was a candidate for IDET or if he required a fusion. L4-5 showed fusion. L3-4 showed degeneration but no concordant pain. L5-S1 showed disc degeneration and concordant pain. At follow-up on the 13th, orthopedic surgeon recommended IDET and it was tentatively scheduled for 20001117.
* 20010103 Muskogee VA. Seen for back pain. CI had fallen on ice and his back pain was rated 6-10 out of 10. Note stated he was scheduled for back surgery at BAMC within weeks. Vioxx had not relieved his pain and he was given Lortab for back pain.
* 20010212 2nd TDRL evaluation.
* 20010309 BAMC Neurosurgery. Absent ankle reflexes noted and decreased sensation to pinprick in right L5 distribution. Noted MRI showed marked degenerative disc and facet changes from L3/4 to L5/S1 and L4/5 appeared to be fused anteriorly. There was persistent spinal and lateral recess stenosis across these levels. He diagnosed degenerative disc disease with spinal stenosis and recommended a three level decompression and fusion with a 50% chance of some improvement. He thought IDET and simple decompression were less likely to provide and significant benefit. He recommended surgery as last resort. The CI was to decide if he wanted to pursue surgery and return if he wanted to proceed.
* 20010430 Muskogee VA. Follow-up for back pain. Had seen neurosurgeon. His symptoms were continuing and the Vioxx was no longer helping his back and radicular pain. He requested more Lortab. Was given Lortab and Vioxx was continued.
* Separated 20011005
* 20011123 Tulsa VA. Pain getting worse. Lortab was prescribed.
* 20011217 Tulsa VA. Follow-up back pain. Chronic back pain now constant and often radiates to right foot and is worse with driving. Pain was in his low back and is associated with generalized numbness of the right lower extremity. Straight leg raise was positive at 70 degrees on the right. Methadone was prescribed.
* 20020308 Tulsa VA. Severe exacerbation of back pain started about 3 weeks prior to visit. On exam CI was in severe distress with pain and was diaphoretic. An MRI was ordered and neurosurgery was consulted.
* 20021004 12 months after separation. The CI had multiple visits after this time and eventually underwent a right L5-S1 microdiscectomy in April 2004.

(Separation Date 20011005, L4-5 surgery 19940321, L5-S1 surgery 20040407)

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| Movement  **Thoraco-**  **lumbar** | Normal ROM | Navy  19940817 | ROM VA  19950406 | Navy 19960709  1st TDRL | ROM VA  19970425 | ROM VA 19971212 | Navy  20010212  2nd TDRL | ROM VA 20031119 (Pain) |
| Flex | 0-**90** |  | 0-95 (90) | Loss of approxi-  mately one third of motion in all planes. More pain with extension and left lateral bending (estimate Flexion 60, total 160) | 70 | 30 | Loss of approxi-  mately one third of motion in all planes. More pain with extension and left lateral bending (estimate Flexion 60, total 160) | 85 (45)  Deluca 75 (40) |
| Ext | 0-**30** |  | 0-35 (30) | Full hyper- extension | 10 | 5  Deluca increased pain |
| R Lat flex | 0-**30** |  | 0-32 (30) | 30 | 20 | 25 |
| L lat flex | 0-**30** |  | 0-32 (30) | full | 20 | 25 |
| R rotation | 0-**30** |  | 0-30 | 30 | 20 | 25 |
| L rotation | 0-**30** |  | 0-30 | full | 20 | 25 |
| COMBINED | **240** |  | 240 |  | 220 | 120 |  | 150 |
| Gait |  | Moderate to severe antalgic | Without limp | Normal |  |  |  |  |
| Muscle spasm |  | Moderate to severe | None |  | None | Some, slightly worse on right side than left |  |  |
| Lordosis |  |  | Moderate loss |  | Some straight-  ening |  |  |  |
| Motor |  | All 5/5 | Adequate | Some difficulty with heel raises on right | Normal bilateral | Decreased strength in right quadriceps | 5/5 bilateral |  |
| Deep Tendon Reflexes |  | All 1+ | Symmetric bilaterally | Knees 2+, left achilles 1+, right achilles absent | 2+ bilateral knees and ankles | Symmetrical | Knees and ankles 2+ | Knees and achilles 1/  4 bilaterally |
| Sensory |  |  |  |  | Right decreased pinprick over great toe and dorsum of foot |  | Right decreased in light touch of great and second toes | Right decreased over great toe and dorsum of foot |
| Straight leg Raise |  | Back pain only | Positive on right at 90, negative on left | Negative for radicular symptoms | Positive on right, negative on left |  | Negative for radicular symptoms |  |
| Notes |  | EMG 19940313 L5 nerve root, right sural latency | Tender to palpation |  | Not tender | Uses a cane. Flares once a month, last 1-3 days where he is nearly totally bedridden | Uses a cane | EMG consistent with L5-S1 radiculo-pathy |

2001 VASRD

* 5293 Intervertebral disc syndrome:

Pronounced; with persistent symptoms compatible with sciatic neuropathy

with characteristic pain and demonstrable muscle spasm, absent ankle jerk,

or other neurological findingsappropriate to site of diseased disc, little

intermittent relief...................................................................................... 60

Severe; recurring attacks, with intermittent relief.................................... 40

Moderate; recurring attacks................................................................ 20

Mild................................................................................................ 10

Postoperative, cured........................................................................ 0

Radiculopathy

The Right Lower Extremity Radiculopathy is an integral part of the 2001 rating criteria for intervertebral disc syndrome and therefore is not rated separately.

Other Conditions Not in the DES

Dysthymia

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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. As this CI separated from the TDRL in October 2001, the 2001 VASRD is used to rate his condition. After careful consideration of all available information the Board determined by simple majority tha the CI’s condition is most appropriately rated as 5293 Failed Back Syndrome at 40%.

The frequency and severity of the CI’s back pain and radicular pain increased significantly during his time on TDRL and this was consistent with the increasing severity of degenerative disc disease and herniated discs with impingement on the right S1 nerve root documented on serial x-rays and MRIs. Serial EMGs documented chronic nerve damage and decreased sensation and altered reflexes in the right lower extremity persisted. While the CI’s muscle spasms and motor weakness did resolve, these symptoms are not required to be present under VASRD 5293. The CI’s back pain, decreased sensation, and altered ankle reflexes were constant but radicular pain was intermittent. Although the frequency of attacks or exacerbations of intervertebral disc syndrome symptoms was not specifically identified in the STR, the Board inferred by the frequency of outpatient visits and requests for stronger pain medications that the attacks occurred monthly. Also, the STR did not address the severity of symptoms with any regularity. However, the repeated need for narcotic pain medication and recommendation for further surgery by three different providers at varying times throughout the TDRL period is highly suggestive of severe symptoms. Severe symptoms are also consistent with the objective findings on serial MRIs. Therefore a 40% rating is warranted for severe intervertebral disc syndrome with recurring attacks and intermittent relief.

The Right Lower Extremity Radiculopathy is an integral part of the 2001 VASRD rating criteria for intervertebral disc syndrome and therefore is not rated separately.

The single voter for dissent felt that there was not enough evidence to justify a 40% disability rating (severe pain with intermittent relief per VASRD code 5293) as a representation of the condition at time of separation from TDRL. Rather, the dissenting voter agreed with the Formal PEB’s rationale (dtd 20010809), feeling that it more accurately described the CI’s condition at that time. The dissenting voter recommends a rating of 5293 at 20% for “moderate; recurring attacks” as a more appropriate description of the CI’s total disability picture.

The other diagnosis rated by the VA (Dysthymia) was 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 this condition 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** |
| Failed Back Syndrome | 5293 | 40% |
| **COMBINED** | **40%** |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20090827, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

Deputy Director

Physical Disability Board of Review

MEMORANDUM FOR COMMAND, NAVY PERSONNEL COMMAND

SUBJECT: Physical Disability Board of Review (PDBR) Recommendation

Ref: (a) DoDI 6040.44

Encl: (1) PDBR ltr dtd 31 Aug 10

1. I have reviewed the subject case pursuant to reference (a). The subject member’s official records are to be corrected to reflect the following disposition:

a. Separation from the naval service due to physical disability with placement on the Permanent Disability Retired List with a disability rating of 40 percent effective 5 October 2001.

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

Principal Deputy

Assistant Secretary of the Navy

(Manpower & Reserve Affairs)