RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: AIR FORCE

CASE NUMBER: PD0900552 BOARD DATE: 20100721

SEPARATION DATE: 20031110

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SUMMARY OF CASE: This covered individual (CI) was a Senior Airman/E4, Aircraft Loadmaster, medically separated from the Air Force in 2003 after three years of service. The medical basis for the separation was Central Nervous System Hypersomnolence. The CI was referred to the PEB, determined unfit for continued military service, and 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: ‘Hypersomnia/Narcolepsy’

‘I encourage the panel to review all of my VA file. I have included a statement to the panel as well as a few documents which I believe will be especially helpful in determining my case. However, as stated, I would like my entire VA file reviewed.’

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RATING COMPARISON:

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Service** | | | | **VA (5 Months After Separation)** | | | | |
| **Unfitting Conditions** | **Code** | **Rating** | **Date** | **Condition** | **Code** | **Rating** | **Exam** | **Effective** |
| Central Nervous System Hypersomnolence | 8108-8911 | 10% | 20030911 | Sleep Disturbance  Narcolepsy/  Idiopathic Hypersomnia | NA  8199-8108 | 10%  then  80%\* | 20040426  DRO and 20070621 | 20031111  20031111 |
|  | Not in DES Package | | | Temporomandibular Joint Dysfunction | 9905 | NSC  0%\* | 20040426  20070621 | 20031111  20031111 |
|  | Not in DES Package | | | NSC X 3 |  |  |  |  |
| **TOTAL Combined: 10%** | | | | **TOTAL Combined (*Includes Non-PEB Conditions*):**  **10% from 20031111**  **80% from 20031111\* (DRO after appeal)** | | | | |

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ANALYSIS SUMMARY:

Central Nervous System (CNS) Hypersomnolence

The CI was initially evaluated in December 2002 for excessive daytime sleepiness. He would sleep 12 hours continuously with uninterrupted sleep and despite this long sleep duration, he would wake up un-refreshed and still sleepy. The patient had been on this sleep cycle for approximately 12 months. Prior to that, the patient generally had an eight-hour sleep cycle with a four hour nap in the afternoon. The patient denied any history of initiation insomnia or maintenance insomnia. The patient noted that he got fatigued, but he would never fall asleep unwillingly. At the Narrative Summary (NARSUM) completed in June 2003 he reported he had never fallen asleep while driving nor had a motor vehicle accident related to sleepiness. He denied morning headache or snoring. He denied apnea. The patient had no history of leg kicking. The patient denies any symptoms consistent with hypnopompic or hypnagogic hallucinations, cataplexy or sleep paralysis.

A multiple sleep latency test was performed in February 2003 and demonstrated an average sleep onset latency of 6 minutes. No sleep onset Rapid Eye Movement (REM) periods were noted. These findings were most consistent with idiopathic CNS hypersomnolence. This condition differs from narcolepsy on the sleep latency test only by the absence of REM sleep. The CI also had polysomnographic testing in February 2003 and the results were normal. He had snoring but no apnea.

He was treated initially with modafinil (Provigil) but his symptoms of excessive daytime sleepiness worsened and in April 2003 he was changed to methylphenidate (Ritalin). In May 2003 his symptoms had improved somewhat but he continued to have excessive daytime sleepiness and his dose was increased. He periodically had symptoms of sleep paralysis but denied symptoms consistent with cataplexy or hypnagogic hallucinations.

The pulmonologist stated his diagnosis was most consistent with idiopathic or CNS hypersomnolence. However, the patient could develop other signs consistent with narcolepsy in the future. Thus, his differential diagnosis was CNS hypersomnolence versus narcolepsy. He remained on a profile that limited his work hours to day shift only and no shift rotation. He would likely require lifelong therapy with stimulant medications. His prognosis was fair to good provided he continued his medications. The CI was highly motivated to stay in the Air Force. If the patient stayed in a work environment that did not expose him to undue risks or other people to undue risks, the pulmonologist thought it was possible for the CI to maintain or to continue in active duty status with certain precautions: He should not be in an environment where his work shifts are changing frequently, he should not be on flying status or work in other occupations which would be hazardous secondary to the increased risk of falling asleep. He would probably do best on a swing-shift schedule such that he does not have to get up excessively early.

The CI was also evaluated by Behavioral Health in December 2002 which determined he did not have depression or any other mental health condition.

The CI was referred to the Informal Physical Evaluation Board (PEB) and it determined his condition had existed prior to service as it was definitively correlated to his Attention Deficit Hyperactivity Disorder (ADHD). However, the CI was evaluated by a psychiatrist who stated there was no evidence in the medical literature of a connection between ADHD and any sleep disorders. Also, the CI had reported he was treated for ADHD in high school but it had resolved. While in tech school he had a psychological evaluation that concluded he had no impairment from ADHD. He returned to training and completed it on time. There was no mention of any sleep disorder in the evaluation. The pulmonologist also submitted a letter stating she was unable to find evidence of any connection between ADHD and Idiopathic Hypersomnolence. A formal PEB determined the CI’s condition was not related to his pre-existing ADHD. The Formal PEB determined he was unfit for this condition and recommended Discharge with Severance Pay with a disability rating of 10% for 8108-8911 Central Nervous System Hypersomnolence.

The CI filed a claim at the VA and had a Compensation and Pension (C&P) examination in April 2004, five months after separation from service and was initially rated at 10% for sleep disturbance. The CI appealed the rating and a Decision Review Officer determined he was appropriately rated at 80% for Narcolepsy/Idiopathic Hypersomnolence. The initial 10% rating was based on lack of evidence of either at least two minor seizures in the last six months or a diagnosis of sleep apnea with persistent day-time hypersomnolence.

The 80% rating was based on the original C&P exam, a later C&P exam 20070621, service treatment records, VA treatment records, treatment records and/or statements from Dr. W., Dr. E., and Dr. R., and statements from friends, coworkers and his roommate. The same symptoms were reported from the time prior to leaving service through 2009. The condition does not appear to have worsened over time but persistent at the same level of symptoms and impairment throughout the time from separation from service to 2009.

He was diagnosed with narcolepsy after he separated from service. He still did not have REM sleep on the multiple sleep latency test but he had developed cataplectic-like events as well as hypnagogic hallucinations at sleep onset. The development of these symptoms is consistent with the predictions of the military pulmonologist.

While the CI did develop some new symptoms that did not start until after he separated from service (cataplectic-like events as well as hypnagogic hallucinations at sleep onset) these symptoms are not necessary to support an 80% disability rating. The CI continued to have excessive daytime sleepiness, difficulty waking up on time and chronic lateness, missing social events secondary to falling asleep. He had multiple micro sleep episodes every day. He continued to nod off even on good days and on bad days it increased to such a level of severity that he could hardly get anything done. The micro sleep or nodding off was not the only manifestation of his disability. He sometimes felt weak or slurred his words which he found most troubling and would really avoid any interaction or he would desperately try to jar himself to a higher state of consciousness. This continued to occur on a daily basis and CI submitted several lay statements from friends, co-workers and room mate that have confirmed his statements of his ongoing, daily problems with his disability.

Idiopathic CNS Hypersomnolence is rated as analogous to 8108 Narcolepsy which is rated as for epilepsy, petit mal (8911). The rating is based on the frequency of episodes of micro sleep as these are analogous to minor seizures. Multiple episodes per day were documented from his time in service to 2009. This warrants an 80% rating as this is more than 10 minor seizures weekly.

Other Conditions Not in Disability Evaluation System (DES) Package

Temporomandibular Joint Dysfunction

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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 Veterans Administration Schedule for Rating Disabilities (VASRD) in effect at the time of the adjudication. After careful consideration of all available information the Board unanimously determined that the CI’s condition is most appropriately characterized at an 80% disability rating under 8199-8108 Central Nervous System Sleep Disturbance.

The CI had idiopathic central nervous system hypersomnolence which differs from narcolepsy only in the fact that REM sleep is not present on multiple sleep latency testing and cataplexy (sudden loss of muscle tone) is not present. Both conditions have symptoms of excessive daytime sleepiness and are treated the same. The CI’s condition is appropriately rated analogous to narcolepsy which is rated as petit mal epilepsy. The CI had multiple episodes of micro sleep every day. This is more than 10 episodes per week and an 80% rating is warranted.

The other diagnosis rated by the VA (Temporomandibular Joint Dysfunction) was not mentioned in the DES package and is 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 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** |
| Central Nervous System Hypersomnolence | 8199-8108 | 80% |
| **COMBINED** | **80%** |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20090908, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

Deputy Director

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-2009-00552.

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 not appropriate under the guidelines of the Veterans Administration Schedule for Rating Disabilities. Accordingly, the Board recommended your separation be re-characterized to reflect disability retirement, rather than separation with severance pay.

I have carefully reviewed the evidence of record and the recommendation of the Board. I concur with that finding, accept their recommendation and determined that your records should be corrected accordingly. The office responsible for making the correction will inform you when your records have been changed.

As a result of the aforementioned correction, you are entitled by law to elect coverage under the Survivor Benefit Plan (SBP). Upon receipt of this letter, you must contact the Air Force Personnel Center at 1-800-531-7502 to make arrangements to obtain an SBP briefing prior to rendering an election. If a valid election is not received within 30 days from the date of this letter, you will not be enrolled in the SBP program unless at the time of your separation, you were married or had an eligible dependent child, in such a case, failure to render an election will result in automatic enrollment.

Sincerely

Director

Air Force Review Boards Agency

Attachment:

Record of Proceedings

cc:

SAF/MRBR

DFAS-IN

PDBR PD-2009-00552

MEMORANDUM FOR THE CHIEF OF STAFF

Having received and considered the recommendation of the Physical Disability Board of Review and under the authority of Section 1554, Title 10, United States Code (122 Stat. 466) and Section 1552, Title 10, United States Code (70A Stat. 116) it is directed that:

The pertinent military records of the Department of the Air Force relating to xxxxxxxx, are corrected to show that:

a.  The diagnosis in his finding of unfitness was Central Nervous System Hypersomnolence, VASRD Code 8199-8108, rated at 80%; rather than Central Nervous System Hypersomonolence, VASRD Code 8108-8911, rated at 10%.

b.  On 9 November 2003 he elected not to participate in the Survivor Benefit Plan (SBP) because he had no eligible dependents.

c.  He was not discharged on 10 November 2003 with entitlement to disability severance pay; rather, on that date he was relieved from active duty and on 11 November 2003 his name was placed on the Permanent Disability Retired List.

Director

Air Force Review Boards Agency