RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXX BRANCH OF SERVICE: MARINE CORPS

CASE NUMBER: PD0900553 BOARD DATE: 20101103

SEPARATION DATE: 20030331

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SUMMARY OF CASE: This covered individual (CI) was a Corporal/E-4, (3043, Supply Administration Clerk), medically separated from the Marine Corps in 2003 after a total of eleven years of service. The medical basis for the separation was a Bulging Disk (L4-5) with Radiculitis. The CI was initially on eight months of limited duty (LIMDU) for bilateral tibial stress fractures starting in December 2000. However, four months later, in April 2002, a second LIMDU board for lower back pain with bilateral thigh pain was completed and eight months of LIMDU was recommended for this condition. In November 2002 a Medical Evaluation Board (MEB) Narrative Summary (NARSUM) was completed for lower back pain with left leg pain and numbness. The case was referred to the Physical Evaluation Board (PEB), he was determined unfit for continued Naval service, and separated at 20% disability using the Veterans Affairs Schedule for Ratings Disabilities (VASRD) and applicable Navy/Marine Corps and Department of Defense regulations in effect at that time.

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CI CONTENTION: No contention stated.

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RATING COMPARISON:

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| **Service PEB 20030123** | **VA (2 years and 5 months after Separation)****All Effective 20040930** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Disk Bulge L4-5 with Radiculitis, Paracentral Protrusion L5-S1 | 5293 | 20% | Degenerative Disk Disease, Lumbar Spine L4-5 and L5-S1 (Also diagnosed Disk Bulge with L4-5 with Radiculitis, Spinal Stenosis and Paracentral Protrusion L5-S-1) | 5243 | 40% | 2005090720070712 |
|  | NARSUM | Bilateral Stress Fractures, Lower Legs | 5022 | 0% | 20050907 |
|  | Not in DES | Tinnitus | 6260 | 10% | 2005090920070703 |
|  | Not in DES | Bilateral Hearing Loss | 6100 | 0% | 2005090920070703 |
| **TOTAL Combined: 20%** | **TOTAL Combined (*Includes Non-PEB Conditions*):** **50% from 20040930**  |

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ANALYSIS SUMMARY:

Degenerative Disc Disease with Radiculitis. The CI experienced left leg pain after physical training in Oct 2001. He had been seen on many occasions for lower back pain, and had a CT (computed tomography) scan of the Lumbar Spine on 24 January 2002 that revealed an enlarged, broad-based disk bulge at L4-L5, with mild central canal stenosis and mild left lateral recess stenosis, possibly affecting the L5 nerve root on that side. There was also an L5-S1 right paracentral disk protrusion that was small and contacted the right S1 root. In March 2002 CI was placed on an extended LIMDU for this condition. His limitations were: “No lifting greater than 10 pounds, no marching, no hiking, and no running. Patient can PT at his own pace. Patient is presently unable to perform a Physical Fitness Test (PFT), but is able to perform the duties required of his job except heavy lifting. Said Named Marine (SNM) is motivated to stay in the military.” His first LIMDU was secondary to bilateral lower extremity stress fractures and began in December 2000. He attended physical therapy with mild improvement over the next several months. However, he was seen in the Emergency Room on 31 August 2002 after arising from bed and losing control of his left leg and bladder. MRI (magnetic imaging) performed 20020906 documented a mild degenerative disk with a small right paracentral protrusion at L5-S1 and a broad-based bulge at L4-5. There was no canal or foraminal stenosis. The L5-S1 protrusion did not displace the traversing nerve roots or contact the traversing right S1 root. A consulting Neurosurgeon did not believe the CI was a good surgical candidate, and referred him to Physical Medicine and Rehabilitation for non-surgical therapy. At the time of the NARSUM the CI was on non-steroidal anti-inflammatory medications.

The NARSUM examination on 20021118 did not include a back exam. Neurologic exam was normal with 5/5 strength in extremities, normal sensation to light touch throughout, equal patellar reflexes, and normal Babinski bilaterally. The diagnosis of Disk bulge L4-5 with Radiculitis, Paracentral Protrusion L5-S1 was noted. At the time of the NARSUM the CI was unable to complete a Physical Fitness Test, bike, march, or lift greater than 10 pounds. A Physical Medicine evaluation on 20021009 noted the history of low back pain for one year that was intermittent, with sudden onset, intense, worse with running, cutting grass, riding bike, 10/10, sharp, radiated down the left lateral thigh to the knee with associated paresthesias in the foot. The CI denied any leg weakness. There were two questionable episodes of partial urinary incontinence and no bowel incontinence. His medications at the time included Motrin and Roxicet (combination Oxycodone with Acetaminophen) for pain. The neurologic exam was normal with 5/5 strength in extremities, normal sensation to light touch throughout, patellar and ankle tendon reflexes equal, Babinski normal bilaterally. The back exam noted tenderness to palpation over the left sacroiliac region and full flexion and extension with negative straight leg raise. Left S1 radiculitis was diagnosed along with left piriformis syndrome and Neurontin was added. There were multiple visits for low back pain from January 2001 through October 2002. He had an emergency room visit 20020831 for leg numbness and incontinence after running. He was treated with a steroid injection intramuscularly. Bedrest was recommended and urgent neurosurgeon consult was obtained. An undated list of appointments shows the latest Neurosurgery appointment on 20020924 and the last physical medicine appointment on 20021112. However, the progress note from the 20021112 visit was not in the service treatment record (STR). The latest note in the chart related to back pain is the Physical Medicine consult 20021009 mentioned above. The PEB evaluated the lower back condition IAW 2002 VASRD standards which were in effect at the time of separation from service. A 20% rating was based on intervertebral disc syndrome with moderate persistent symptoms compatible with sciatic neuropathy with characteristic pain and demonstrable muscle spasm, absent ankle jerk, or other neurological findings appropriate to site of diseased disc with recurring attacks. A 40% rating would require severe symptoms with recurring attacks and little intermittent relief. The most complete examination available for review is the Physical Medicine Consult from 20021009 which clearly stated the pain was intermittent. When present the CI’s symptoms were severe but he did have intermittent relief.

The CI did not file a VA claim until September 2004, one year and six months after he separated. A VA Compensation and Pension (C&P) examination completed 20050907 documented pain described as constant and traveling to buttock and left leg rated 10/10. Pain was elicited by physical activity and sudden movement. The pain also came on by itself. It was relieved by pain medication and at times requires bed rest. CI reported incapacitating episodes occurred four times per year, lasting 6 days, with a total of 12 days incapacitation in the year prior to the VA examination. Functional impairment was described as inability to sit or stand for prolonged periods, inability to lift heavy objects or exercise. On examination, there was evidence of radiating pain on movement or bending. There were muscle spasms present and tenderness to palpation. There was positive straight leg raising on both sides. There was no evidence of ankylosis of the spine. Range of motion (ROM) measurements of the thoracolumbar spine revealed forward flexion limited to 30 degrees with pain (normal 90 degrees). Extension was limited to 10 degrees with pain (normal 30 degrees). Lateral flexion in both directions was limited to 10 degrees with pain (normal 30 degrees). Rotation in both directions was limited to 10 degrees with pain (normal 30 degrees). With repetitive motion, the lumbar spine was additionally limited by pain and fatigue. Spine was not additionally limited by weakness, lack of endurance, and incoordination. Neurological examination was normal. X-ray of the lumbar spine revealed degenerative arthritis and degenerative disc disease at L4-L5 and L5-S1 levels. The VA rated the condition using the current VASRD General Rating Formula for diseases and injuries of the Spine as it was effect at the time of the rating. A 40% rating was based on thoracolumbar flexion limited to 30 degrees or less.

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| ThoracolumbarROM | Separation Date: 20030331 |
| Physical Medicine20021009 | MEB20021118 | VA C&P20050907 | VA C&P20070712 | VA C&P 20090827 |
| Flexion (0-90⁰ normal) | Full | Not examined | 30⁰ | 60⁰; Pain at 40⁰ | 80⁰ |
| Combined (240⁰ normal) |  | Not examined | 80⁰ | 200⁰; Pain at 180⁰ | 220⁰ |
| §4.71a Rating |  |  | 40% | 40% continued | Unknown |
| Comments | Full flexion and extension; negative straight leg raise; normal motor, sensory, and reflexes | No back exam; normal motor, sensory, reflexes | Normal motor, sensory, and reflex exams; positive muscle spasm; tender to palpation; straight leg raise positive on the right | Improvement not sustained.No radiating pain, SLR negative, no spasm, not tender to palpation; normal motor, sensory, and reflexes | Guarding on right; abnormal gait; normal motor, sensory and reflexes except left knee flexion 4/5 and pinprick 1/2 on left posterior calf |

The VA examination demonstrates more severe symptoms than were documented prior to separation from service and significant limitation of range of motion of the thoracolumbar spine. However, this examination was completed two and a half years after the CI separated. The worsening symptoms could be a result of an intervening injury or the natural progression of the disease. The presence of continuing and worsening symptoms over time shows that the condition at the time of separation was a permanent condition. However, the Board must rate the condition as it was on the date of separation using the VASRD that was in effect at the time. There is no evidence in the STR that the CI’s symptoms were constant or that he had little intermittent relief. Therefore 20% is the most appropriate rating. If the current VASRD were applied retroactively, the condition would not have been rated at greater than 20%.

Other Conditions: Bilateral Stress Fractures, Lower Extremities

The CI had previously been on LIMDU for tibial stress fractures, but this condition had resolved prior to his MEB. The history of bilateral stress fractures was noted in the NARSUM but it was not a current condition and was not forwarded to the PEB for fitness determination. After six months on LIMDU the condition of Bilateral Shin Splints (Tibial Stress Syndrome) was considered resolved. A Limited Duty Board for Disk Bulge L4-L5 and Paracentral Protrusion was completed 20020429 and this board considered the bilateral shin splints to be resolved. There is no evidence in the STR that this condition was present and interfered with performance of any required duties at the time of separation from service. Therefore it is not considered unfitting and no disability rating is recommended.

Other Conditions Not in the Disability Evaluation System (DES): Tinnitus and Bilateral Hearing Loss

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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 determined that the CI’s condition is most appropriately rated at 20% for 5293 Disk Bulge L4-5 with Radiculitis, Paracentral Protrusion L5-S1. While the CI’s condition clearly worsened over time, the Board must determine the appropriate rating for the condition at the time of separation from service using the VASRD that was in effect at the time. Using the contemporary VASRD a 20% rating is warranted based on intervertebral disc syndrome with moderate persistent symptoms compatible with sciatic neuropathy with characteristic pain and demonstrable muscle spasm, absent ankle jerk, or other neurological findings appropriate to site of diseased disc with recurring attacks.

The Board also considered the condition of Bilateral Stress Fractures, Lower Extremities and unanimously determined that this condition was not unfitting at the time of separation from service and therefore no disability rating is applied. This condition was considered resolved at the time of the second Limited Duty Board completed in April 2002. The other diagnoses rated by the VA, tinnitus and hearing loss, 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 Board of Correction for Naval Records (BCNR) 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 20090825, 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 XXXX, EX-USMC, XXX XX XXXX

Ref: (a) DoDI 6040.44

 (b) PDBR ltr dtd 18 Nov10

 I have reviewed the subject case pursuant to reference (a) and approve the recommendation of the Physical Disability Board of Review (reference (b)) that Mr. XXXXX’s records not be corrected to reflect a change in either his 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)