RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: MARINE CORPS

CASE NUMBER: PD0900557 BOARD DATE: 20101103

SEPARATION DATE: 20041015

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SUMMARY OF CASE: This covered individual (CI) was a Lance Corporal, (5811 Military Policeman), medically separated from the Marine Corps in 2004 after approximately two years of service. The medical basis for the separation was complex regional pain syndrome, left upper extremity. Despite multiple treatment modalities, her symptoms did not resolve and she remained unable to perform the required duties of her MOS (occupational specialty). The CI was referred to the Physical Evaluation Board (PEB), determined unfit for continued Naval service, 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: “My knees were hurt during my tour in the Marines. I did not get a fair rating from the Marines. The VA has my records regarding the problem.” Supporting documents: “PTSD”

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RATING COMPARISON:

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| --- | --- |
| **Service PEB 20040805** | **VA (2 Months Prior to Separation)** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** | **Effective** |
| Complex Regional Pain Syndrome, Left Upper Extremity | 8799-8713 | 20% | Reflex Sympathetic Dystrophy of the Left Forearm | 8599-8515 | 20% | 20040812 | 20040817 |
| Left Knee Pain | MEB H&P |  |  |  |  |  |
| Right Knee Pain | NOT IN DES |  |  |  |  |  |
|  | NOT IN DES | Tinnitus | 6260 | 10% | 20040812 | 20040817 |
|  | NOT IN DES | Post Traumatic Stress Disorder | 9411 | 50% | 20090817 | 20090714 |
|  | 2 X NSC |  |
| **TOTAL Combined: 20%** | **TOTAL Combined (*Includes Non-PEB Conditions*):** **30% from 20040817****60% from 20090714**  |

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ANALYSIS SUMMARY:

The CI injured her left shoulder 20030615 when she was tackled during a football game while on deployment in Iraq. Very quickly she experienced swelling and exquisite pain, worse in the thumb but involving her entire hand and ascending to the level of the wrist. She sought care and was noted to have a dislocated fourth digit that was subsequently reduced. She then had markedly increased swelling and difficulty grasping objects. Her hand appeared more bruised and the pain persisted. The pain was constant, unremitting, and position dependent and it worsened with any tactile stimulation or activity. The symptoms were severe enough to interfere with sleep as well as all waking activities. Two weeks later she was less able to move her left hand and now noted numbness up to the level of her elbow. In early July 2003 complex regional pain syndrome was diagnosed and the CI was referred for pain management and occupational therapy. A magnetic resonance image (MRI) of the left hand and a bone scan were obtained and both were normal. An EMG (nerve conduction) was done in September and that was also normal. Despite aggressive conservative therapy significant hyperalgesia/ allodynia persisted although she did have some decrease in edema. She fell in July and was involved in a motor vehicle accident in September 2003 and both incidents led to transient worsening of symptoms. Pain management included a trial of gabapentin which brought only minimal relief and stellate ganglion blocks. These blocks resulted in a 25% reduction of her pain to the left arm and neck for two to three days after the injection but then the benefit would wear off. Medication adjustments resulted in a combination of zonisamide, Relafen, clonidine patch, and Gabitril with Vicodin for breakthrough pain. Her baseline and constant pain was 3/10 and various activities would lead to significant increases in pain.

The Medical Evaluation Board (MEB) Narrative Summary (NARSUM) examination revealed restricted range of motion of the left upper extremity due to pain, allodynia and hyperalgesia, worse over the dorsal aspect of the hand and thumb worse than the fifth digit but also extending more proximally at a lower level of severity. There was a sense of hyperpathia with a persistence of discomfort upon removal of stimulus. The changes in her skin had improvement somewhat as the edema has decreased. There was mild atrophy of the hand intrinsic muscles and a positive wrist Tinel’s. Biceps and triceps reflexes were present. Sensation was decreased to multiple modalities including vibration, proprioception, light touch and pinprick over the entire lateral left hand, more patchy medially and extending to the forearm. Muscle strength testing was difficult in the left upper extremity secondary to her symptoms. However, motor strength was at least 4/5 in the left upper extremity with the more proximal muscles easier to test. The right upper extremity and bilateral lower extremities had normal strength.

At the time of the NARSUM 20040209, the CI reported an approximate 25% decrease in pain but she had persistent, moderate to severe left (non-dominant) upper extremity functional impairment. Despite appropriate treatment and multimodal interventions from the pain clinic, the CI had only mild improvement in her symptoms over nine months. She had received maximal medical benefit and was not expected to be able to return to full duty within the time period allotted for limited duty. Her pain and weakness caused limitation of activities requiring flexion/extension of her fingers, wrist, or elbow, and those activities requiring tactile stimulation to those affected regions. She was not able to carry or fire a weapon, carry objects, and perform any other activities requiring fine motor or repetitive use of the left hand or arm. Her Commander reported that she was working outside her primary MOS of Military Policeman—she was working as the Training Clerk. She was gone from work due to appointments and treatment for 20 hours a week. She was not considered worldwide deployable and was not able to perform any MOS related tasks.

The service treatment record (STR) also documents persistent difficulty doing her hair on 20040109; activities of daily living only slightly improved with injections on 20031124; a temperature difference of 10 degrees between her hands, difficulty with cooking, buttons, zippers, and atrophy in the palm and hypothenar area of left hand on 20031014; inability to grasp a towel with left hand on 20030919; difficulty dressing, cooking, buttons, and zippers on 20030908. The PEB determined this condition made her unfit for continued Naval service and rated it analogous to peripheral nerve paralysis. The 8799-8713 code was used as all radicular groups of the arm were involved. The left was her non-dominant side and the condition was rated at 20% for mild incomplete paralysis. The 2004 VASRD was in effect at the time of separation and must be applied by the Board. However, the 2004 VASRD and the current VASRD have the same rating criteria for the 8713 and 8715 codes.

A VA Compensation and Pension (C&P) examination was completed 20040812, approximately six months after the NARSUM examination but two months prior to separation from service. The examination was similar to the NARSUM examination and noted tenderness to palpation and hyperesthesia. It documented decreased range of motion (ROM) of the left elbow due to pain, decreased ROM of the left wrist due to pain, fatigue, weakness, lack of endurance, and incoordination with pain having the major functional impact. It also noted markedly decreased strength of the left hand. The CI had difficulty tying shoelaces, fastening buttons, and picking up a piece of paper and tearing it with the left hand. The exam also noted 4/5 muscle strength secondary to pain just as the NARSUM exam did. Reflexes were 2+ in bilateral biceps and triceps and sensation was intact and equal bilaterally to pain and touch. The examiner concluded the CI was able to provide limited self-care due to tenderness to palpation of the left, elbow, forearm, and wrist; decreased range of motion of the left elbow and left wrist; and hyperesthesia and weakness of the left upper extremity.The CI was limited in using her left arm for heavy lifting and carrying, pushing and pulling, handling, torquing, and grasping. The VA used 8599-8515 Median Nerve to evaluate this condition. They determined the CI had a moderate disability based on tenderness to palpation at the left elbow and left wrist joints, evidence of painful motion of the left elbow, limited and painful motion of the left wrist with additional impairment due to fatigue, weakness, lack of endurance, and incoordination with pain having the major functional impact; neurological testing revealed decreased motor strength in the left upper extremity at 4/5 due to pain. While the median nerve alone cannot explain the presence of all the symptoms and affected areas and the 8713 code which includes All Radicular Groups appears to be more appropriate, both the PEB and the VA rated the condition at 20%. VASRD 8512 Lower Radicular Group could also be used but the rating criteria are identical to 8513. The condition had impact on activities of daily living and the condition involves both sensory (pain, numbness, and paresthesias) and motor functioning. She was unable to perform both non-strenuous and strenuous activities with her left hand including holding anything, performing hygiene on her hair, fastening buttons, and tying her shoes.

Other Conditions:

Knee Pain. The CI contended she had a bilateral knee condition that was unfitting at the time of separation from service. No right knee condition was mentioned anywhere in the Disability Evaluation System (DES) and is therefore outside the scope of the Board. The MEB History and Physical mentioned a history of left knee trouble since high school which was noted to have preceded enlistment and a diagnosis of patellar instability. However, the CI’s enlistment History and Physical of 20010822 had a “no” marked next to the question of a history of knee problems and the physical examination of the lower extremities was normal. Four visits with complaint of bilateral knee pain was part of the CI’s VA treatment record. These occurred between September and December 2009 and included visits to physical therapy. On 20090901 The CI reported she had had chronic knee pain since 2002 and a history of arthroscopy of the right knee. However, there was no record of any outpatient visit for knee pain or of an arthroscopy in the STR. There is no evidence in the STR of any duty restriction attributable to knee pain. The Commander’s letter does not mention any specific condition as causing her inability to function in her MOS. No limited duty board or Abbreviated Medical Board was available for review.

Other Conditions Not in the DES: Right Knee Pain, Tinnitus, Post-Traumatic Stress Disorder (PTSD)

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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 determined by simple majority that the CI’s condition is most appropriately rated at 20% for 8799-8713 Complex Regional Pain Syndrome, Left Upper Extremity. The CI had an incomplete paralysis of all left upper extremity radicular groups which is considered mild and is based on tenderness to palpation at the left elbow and left wrist joints, evidence of painful motion of the left elbow, limited and painful motion of the left wrist with additional impairment due to fatigue, weakness, lack of endurance, and incoordination with pain having the major functional impact; neurological testing revealed decreased motor strength in the left upper extremity at 4/5 due to pain. She also had allodynia, numbness, and paresthesias. She was not able to carry or fire a weapon, carry objects, and perform any other activities requiring fine motor or repetitive use of the left hand or arm. Her condition interfered with her ability to perform activities of daily living such as cooking, dressing herself, tying her shoes, and performing hygiene on her hair and involves both sensory (pain, numbness, and paresthesias) and motor functioning.

The single voter for dissent (who recommended rating 8799-8713 at 30% for moderate incomplete paralysis) did not elect to submit a minority opinion.

The Board also considered Left Knee Pain and unanimously determined that this condition was not unfitting at the time of separation from service and therefore no disability rating is applied. There was no evidence of inability to perform any required duties as a result of this condition. The Right Knee Pain, Tinnitus, and PTSD were not mentioned in the Disability Evaluation System and are therefore outside the scope of the Board. The CI retains the right to request her service 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 20090916, 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

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 XXXXX 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)