RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXX BRANCH OF SERVICE: marine corps

CASE NUMBER: PD0900624 SEPARATION DATE: 20090228

BOARD DATE: 20110623

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty Sgt/E5, (0612/Field Wireman), medically separated for atrial fibrillation*.* He did not respond adequately to treatment, and was unable to perform within his Military Occupational Specialty (MOS) or to meet physical fitness standards. He was placed on limited duty (LIMDU) and underwent a Medical Evaluation Board (MEB).Atrial fibrillation, atrial flutter, and tachycardia were forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW SECNAVINST 1850.4E.No other conditions appeared on the MEB’s submission. Other conditions included in the Disability Evaluation System (DES) packet will be discussed below.The Informal PEB (IPEB) adjudicated the atrial fibrillation condition as unfitting, rated 10%, with application of SECNAVINST 1850.4E and Veterans’ Administration Schedule for Rating Disabilities. The CI initially appealed, then waived his right to a Formal PEB, and was medically separated with a 10% combined disability rating.

CI CONTENTION: “My condition rating should be changed due to how this condition has altered my life. I had planned on retiring from the Marines but was told by my cardiologist (Dr, Saul) that I would not be able to continue my duties as a Marine. My condition activated not only by exercise but, also it is adrenalin based. With it being caused by surges of adrenalin. This effect numerous that I do daily. From playing with my son to playing sports and occasionally having sex. My emotions have and effect on my condition such as being scared upset or angry. This condition will never get better or go away and it increases the chances of a stroke and heart failure, I am only 25.”

RATING COMPARISON:

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| --- | --- |
| **Service IPEB – Dated 20090108** | **VA (~1 Mo. After Separation) – All Effective Date 20090228** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Atrial fibrillation | 7010 | 10% | Atrial flutter, atrial fibrillation and ventricular tachycardia | 7010 | 10% | 20090408 |
| Atrial flutter  | CAT II |
| Tachycardia |
| ↓No Additional MEB/PEB Entries↓ | Tendonitis, left shoulder | 5019-5203 | 10% | 20090408 |
| Cervicalgia | 5237 | 10% | 20090408 |
| 0% x 0/Not Service Connected x 5 | 20090408 |
| **Combined: 10%** | **Combined: 30%** |

ANALYSIS SUMMARY:

Atrial Fibrillation. The CI presented initially with chest pain associated with exercise on 28 August 2007. After another episode on 10 October 2007 he was referred to Cardiology. Exercise stress test (EST), echocardiogram and nuclear stress test on 19 September 2007 were all normal. Holter monitor revealed nonsustained atrial tachycardia. He was started on a beta blocker medication (Toprol), but continued to have episodes of chest pain four to five times daily. Consultation with a Cardiologist in Savannah, GA resulted in recommendation to continue medication. He was referred to Walter Reed Army Medical Center (WRAMC) where he had a normal cardiac MRI, signal averaged electrocardiogram showing prolonged QRS complex duration, and electrophysiologic study that demonstrated inducible monomorphic ventricular tachycardia (VT) with right bundle branch block morphology with isuprel infusion. He was not inducible with programmed stimulation or burst pacing (atrial or ventricular). A planned ablation procedure was aborted due to the possibility of a catecholamine sensitive VT and it was recommended that he be fitted with a Lifecor Defibrillator vest and his dose of Toprol be increased to 100mg daily. He was referred to the Children’s Heart Center at the Medical University of South Carolina (MUSC). The Cardiologist reviewed the intracardiac electrograms which showed ventricular tachycardia, atrial flutter, and atrial fibrillation at three different points. His diagnoses were atrial fibrillation and anterior fascicular left ventricular tachycardia (Belhassens VT). On 18 July 2008 he underwent another electrophysiology study with tricuspid valve inferior vena cava catheter ablation. It was determined that he did not have catecholamine sensitive VT, he no longer required the Lifecor Defibrillator vest and his Toprol was discontinued. Follow-up at MUSC on 8 September 2008 showed recurrent atrial fibrillation on EST without VT or atrial flutter, and the Toprol was restarted. His last follow-up at MUSC was on 29 December 2008 where EST, on Toprol, confirmed atrial fibrillation at peak exercise that resolved as the heart rate decreased.

The narrative summary (NARSUM) on 28 October 2008 noted that CI continued to take Toprol 50 mg daily. He reported that he still felt his heart flutter when he performed exertional activities such as climbing stairs, playing with his child, or if he became upset. He avoided strenuous activity and had no prolonged episodes of palpitations since the ablation. It was the opinion of the MEB that the CI, because of his physical limitations, would be unable to fulfill his duties as an active duty Marine and his case was referred to the PEB for final disposition. The Non-Medical Assessment (NMA) on 25 November 2008 noted only the cardiac issues, stating that he was unable to perform his training requirements and should be found unfit for duty. Atrial fibrillation, atrial flutter and tachycardia unspecified were considered by the PEB on 14 January 2009. Recurrent atrial fibrillation with peak exercise was found unfitting, code 7010 (supraventricular arrhythmias), with a 10% rating. The PEB also found history of inducible ventricular tachycardia and easily inducible atrial flutter with subsequent atrial fibrillation, noninducible post ablation, to be related category II conditions.

The VA C&P examination on 8 April 2009, one month after separation, noted that he was taking medication with no episodes of atrial fibrillation since separation; however, he had not performed any heavy exertional activities due to the order from his Cardiologists to not exercise due to the occurrence of atrial arrhythmias whenever his heart rate increased. The VA Rating Decision dated 3 June 2009, three months after separation, service connected history of atrial flutter, atrial fibrillation and ventricular tachycardia status post inferior vena cava isthmus ablation, code 7010 (supraventricular arrhythmia), with a 10% rating.

A 30% rating requires paroxysmal atrial fibrillation or other supraventricular tachycardia, with more than four episodes per year documented by ECG or Holter monitor. The Board discussed at length whether the episodes of atrial fibrillation that were induced during the ablation procedure should be included to meet the rating criteria for a 30% versus 10% rating. Following the ablation procedure there were also two testing appointments where multiple atrial fibrillation episodes were documented during exercise stress testing or heart rate pacing totaling more than four. The result of this testing was that the Cardiologist forbid the CI from exercising at all, expecting the occurrence of atrial arrythmia with any increase in heart rate. The CI did report ongoing recurrent episodes of heart fluttering with exertion; however, those episodes were not captured by UCG or Holter monitor. With reasonable doubt in the CI’s favor, a 30% rating was considered for these recurrent episodes that likely occur more than four times per year, and for the inclusion of multiple induced episodes during cardiac testing. The Board also noted that with strict application of criteria requiring ECG or Holter documentation of the atrial fibrillation and not considering the atrial fibrillation induced during the ablation procedure, the 10% rating was appropriate, as granted by both the PEB and the VA. The single voter for a 30% rating considered it inappropriate to ignore the multiple episodes which occurred and were documented during cardiac testing and the subjective episodes which have resulted in the CI needing to severely restrict his activities. All evidence considered the Board determined, by simple majority, that there was not reasonable doubt in the CI’s favor supporting recharacterization of the PEB adjudication for the recurrent atrial fibrillation.

Remaining Conditions. Other conditions identified in the DES file were sinusitis, knee trouble and upper back pain. None of these conditions were clinically active during the MEB period, none were the bases for limited duty, and none were implicated in the NMA. These conditions were reviewed by the action officer and considered by the Board. It was determined that none could be argued as unfitting and subject to separation rating. Additionally tendinitis left shoulder, cervicalgia and several other non-acute conditions were noted in the VA rating decision proximal to separation, but were not documented in the DES file. The Board does not have the authority under DoDI 6040.44 to render fitness or rating recommendations for any conditions not considered by the DES. The Board, therefore, has no reasonable basis for recommending any additional unfitting conditions for separation rating.

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. In the matter of the recurrent atrial fibrillation with peak exercise condition, the Board, by simple majority, recommends no change in the VASRD Code (7010) and rating of 10%. The single voter for dissent (who recommended a 30% rating, code 7010) did not elect to submit a minority opinion. In the matter of the sinusitis, left knee trouble, upper back pain condition or any other medical condition eligible for Board consideration; the Board unanimously agrees that it cannot recommend any findings of unfit for additional rating at separation.

RECOMMENDATION: The Board, therefore, recommends that there be no recharacterization of the CI’s disability and separation determination, as follows:

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| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Atrial Fibrillation | 7010 | 10% |
| **COMBINED** | **10%** |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20090929, 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, FORMER USMC

Ref: (a) DoDI 6040.44

 (b) PDBR ltr dtd 7 Jul 11

 I have reviewed the subject case pursuant to reference (a) and, for the reasons set forth in reference (b), approve the recommendation of the Physical Disability Board of Review 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.

 Assistant General Counsel

 (Manpower & Reserve Affairs)