RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: air force

CASE NUMBER: PD09000634 TDRL ENTRY DATE: 20030520

BOARD DATE: 20110616 tDRL Exit Date: 20040907

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SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty Senior Airman (2A651A, Aerospace Propulsion [Jet Engine Mechanic]) who was medically separated from the Air Force in 2003 after eight years of service. The medical basis for the separation was status post pulmonary emboli (PE), resolved. The CI began having episodes of exertional dyspnea, fatigue, chest pain and shortness of breath in 2001 that continued into 2002. The CI underwent an extensive evaluationfor oxygen desaturation of unknown etiology and was found to have bilateral PE, which were treated with long-term coumadin and resolved. However, intermittent hypoxemia persisted with an unknown etiology. He did not respond adequately to perform within his Air Force specialty (AFS) or participate in the fitness testing. He was issued a permanent P4 profile and underwent a Medical Evaluation Board (MEB). The MEB forwarded “arteriovenous (AV) fistula of pulmonary vessels, possible right to left pulmonary shunt; persistent exertional limitation with documented oxygen desaturation/hypoxia; mild obstructive sleep apnea syndrome (OSA); history of thromboembolic event: (bilateral PE); low back pain; arthralgias: pain in joint involving multiple sites; patellofemoral syndrome (PFS); unspecified coagulation defects; and weight gain” to the Physical Evaluation Board (PEB) on AF Form 618. The PEB found “chronic fatigue secondary to hypoxia from arteriovenous fistula of pulmonary vessels with history of PE, resolved” as the single unfitting condition with a rating of 40%. The PEB adjudicated OSA and PFS as category II (conditions that contribute to the unfitting condition) and obesity as category III (conditions that are not separately unfitting and do not contribute to the unfitting condition). The CI was placed on the Temporary Disability Retired List (TDRL), effective 30 May 2003. The CI was evaluated while in TDRL status and his final reevaluation was on 13 November 2003. The 7 September 2004 PEB found the CI unfit for status post PE, resolved, rated at 0% disability with category II and III (not unfitting/not compensable) diagnoses of OSA, PFS, myofascial pain (new diagnosis), chronic fatigue secondary to deconditioning, and obesity. The CI made no appeals and was medically separated with exit from TDRL with a 0% disability rating.

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CI CONTENTION: “The sole reason I was discharged from active duty was because I had pulmonary emboli and was declared unfit for service. I received a 0% rating for this condition.”

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RATING COMPARISON:

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Service IPEB – 20040907** | | | | **VA – All Effective 20030521** | | | |
| **Condition** | **Code** | **Rating** | | **Condition** | **Code** | **Rating** | **Exam** |
| **IPEB (TDRL) – 20030203** | **TDRL** | **Sep.** | **VA Rating at TDRL Entry** |
| Chronic Fatigue Secondary to Hypoxia from AV Fistula of Pulmonary Vessels w/Hx of Bilat PE, Resolved | 6354 | 40% | - | Chronic Fatigue Secondary to Hypoxia | 6354 | 20% | 20030730 |
| Chronic Fatigue Secondary to Deconditioning | CAT II | |
| Status Post Pulmonary Emboli, Resolved | 6817 | 0% | | Mild OSA with Bilateral PE | 6847 | 0%\* | 20030730 |
| Obstructive Sleep Apnea | 6847 | CAT II | |
| Patellofemoral Syndrome | 5003 | CAT II | | L. Knee PFS | 5260 | 0% | 20030730 |
| Obesity | CAT III | | | No VA Entry | | | 20030730 |
| Myofascial Pain (New Dx) | 5021 | CAT II | | Fibromyalgia | 5025 | 20% | 20030730 |
| ↓No Additional MEB/PEB Entries↓ | | | | Adjustment Disorder w/ Depression, Anxiety, Memory Loss | 9433 | 30% | 20030812 |
| 0% x 2/Not Service Connected x 8 | | | 20030730 |
| **Combined: 40%** | | | | **Combined: 60%** | | | |

\*OSA w/ Bilateral PE increased to 50% effective 20050110 (combined 80%) four months post-TDRL exit

ANALYSIS SUMMARY: This case has multiple diagnoses which overlap in symptoms and his diagnoses changed from entry into the TDRL to exit from the TDRL. The attribution of the CI’s chronic fatigue was a critical factor in rating. The PEB remarks at removal from the TDRL were: “[The CI’s] medical condition, PE has resolved since being placed on the TDRL and appears to have stabilized.” The PEB notes member's current limitations appear to be primarily not related to his previous medical complications, making his current state not ratable at the previous level since these are new (and non-compensable) conditions. The Board finds the member unfit and recommends discharge with severance pay, with a disability rating of 0% IAW DoD and the VA Schedule for Rating Disabilities (VASRD) guidelines.”

Chronic Fatigue Secondary to Hypoxia from AV Fistula of Pulmonary Vessels w/History of Bilateral PE, Resolved. Although he CI had been anticoagulated for six months with coumadin, and had resolution of bilateral PE, he was re-hospitalized for a work-up of his one year history of transient one-to-two-week episode of shortness of breath, pleuritic chest pain and ambulatory hypoxia. The ambulatory pulse oximetry on admission was 90-91%, with prior ambulatory oxygen saturations in the “80s” (84-87%). Computed tomography angiogram was negative for PE or for any evidence of an obstructive or restricted deficit with a normal diffusing capacity of the lung. A trans-thoracic echo revealed an ejection fraction of 60-65% (normal 55-70%), no trace regurgitation and no evidence of right ventricular hypertrophy. A perfusion scan to test for PE was normal. The CI continued to exhibit symptoms of shortness of breath and pleuritic chest pain, and the pulmonologist documented that the CI had “persistent exertional desaturation and exertional limitation, no alternate explanation to sequel from PE.” In August 2002, the CI was referred for a MEB evaluation. The CI complained of significant fatigue with prolonged standing or working, joint pain with repetitive motion, and episodes of short term memory loss. The examiner opined that the CI had a history of bilateral PE, but was doing well on coumadin therapy; however, the etiology of the chronic joint pain was unclear. The commander’s statement opined that the CI’s medical problems of trouble breathing, chronic arthritis, inability to stand or walk for a period longer than thirty minutes prevent him from performing the tasks associated with his jet engine mechanic duties. The member had duty profile restrictions to include exposure, to chemicals, vapors, fumes, and activities requiring extensive gripping, twisting, or strength movements with his hands. Additionally, he could not jump, run, march, do physical training/conditioning, ergometry, aerobics, or stand or walk for periods in excess of 30 minutes. The CI underwent a second MEB evaluation four months prior to TDRL entry*,* due to his pulmonary condition. The CI complained of exertional shortness of breath, fatigue and pleuritic chest pain. The examiner felt that the CI had documented hypoxic episodes during ambulatory pulse oximetry monitoring and that the CI had restrictions because of exertional limitation. The examiner recommended ongoing evaluation and treatment of unexplained exertional hypoxic episodes and that the CI was not worldwide qualified. He further recommended a final diagnosis of AV fistula of pulmonary vessels with a possible right to left pulmonary shunt. The CI was then referred to the PEB. The PEB found the CI unfit and recommended placing him on TDRL with a disability rating of 40%, effective 20 May 2003.

The VA compensation and pension examination two months into TDRL documented that the CI continued to suffer from chronic fatigue, with complaints that walking or talking more than two hours caused fatigue with hypoxia, headache and confusion. The CI was not taking any medication for these symptoms. The CI further reported that he suffered from chronic fatigue at work which required him to take off every other day. Regarding the pulmonary conditions, the CI’s oxygen saturation was 98% on room air (normal) and the lungs were clear, without dyspnea. The examiner opined that the PE condition was resolved and that the CI had an AV fistula of the pulmonary vessels; however, the chronic fatigue condition might be related to the hypoxia or mild obstructive sleep apnea.

The record has a comprehensive rheumatology evaluation dated 13 November 2003 which appears to be the narrative summary and is the most comprehensive evaluation prior to the final PEB and removal from the TDRL. The examiner documented complaints of fatigue, continued shortness of breath and pleuritic chest pain, with having had spells of tunnel vision. No pulmonary function or oximetry testing was performed. The exam noted obesity, history of inflammatory arthritis, hand osteoarthritis, wrist tendinopathy, fibromyalgia with costochondritis, history of abnormal bowel function, and no connection of history of PE with any inflammatory condition such as lupus. The CI was seen at the VA three days after final separation from TDRL where the examiner noted that the CI had diffuse pain and fatigue that was possibly related to the history of PE. OSA was noted as untreated. Depression was considered a component and medications were adjusted at that treatment visit.

The PEB applied the code 6354 (chronic fatigue syndrome [CFS]) for diagnoses of CFS to hypoxia from AV fistula of pulmonary vessels w/history of bilateral PE, resolved as unfitting at 40% for entry into the TDRL rating. Of note, the exercise oximetry testing was already normalized and indicated at most mild exercise induced hypoxemia which was at the lower end of normal. Proximate to TDRL entry, the VA rated the CI at 20% for CFS to hypoxia from AV fistula of pulmonary vessels w/history of bilateral PE, resolved; and for fibromyalgia at 20% which also considers “with or without associated fatigue, sleep disturbance.”

The Board considered the TDRL entry rating using alternate analogous ratings under codes 6354 (CFS) at 60% (for symptoms which are nearly constant and restrict routine daily activities to less than 50 percent of the pre-illness level) or under 6817 (pulmonary vascular disease) at 60% (for chronic pulmonary thromboembolism requiring anticoagulant therapy). However, the higher level of disability was not well documented in the record. The CI met the 6354 (CFS) 40% rating criteria for symptoms: “nearly constant and restrict routine daily activities to 50 to 75 percent of the pre-illness level or which wax and wane, resulting in periods of incapacitation of at least four but less than six weeks total duration per year.” The Board agreed that the PEB 40% rating for entry into TDRL was appropriate, matched the level of the CI’s condition, and was in the CI’s interest, but should indicate analogous rating by coding 6399-6354 as the CI was never diagnosed with CFS.

Regarding the rating for removal from the TDRL, the Board also considered the VA records after removal from the TDRL including the fatigue evaluation and sleep study two months post TDRL; as well as the C&P exam five months post TDRL. Chronic fatigue was well documented as was OSA requiring CPAP. Although the VA noted the CI suffered from chronic fatigue at work which required him to take off every other day early in the TDRL period, similar disability was not indicated at the exam proximate to TDRL removal. The VA rated that exam as mild OSA with bilateral PE at 50% with likely application of §4.96 (special provisions regarding evaluation of respiratory conditions) to rate and code under the higher-rated OSA since coexisting respiratory conditions (6600 through 6817 and 6822 through 6847) will not be combined with each other.

On removal from the TDRL, the PEB separated the TDRL-entry diagnoses and adjudicated 6354, CFS secondary to deconditioning (versus AV fistula of pulmonary vessels) as not unfitting or ratable, with status post PE, resolved coded 6817 as unfitting at 0%. The reattribution of chronic fatigue from being caused from either an AV fistula of pulmonary vessels or as a residual “of bilateral PE, resolved” had little supporting objective evidence for reattribution of the etiology of fatigue. The CI had continued symptoms of shortness of breath and pleuritic chest pain which are as likely as not attributed to residuals of PE or myofasial pain/fibromyalgia. The CI’s additional diagnoses of OSA and VA diagnosis of fibromyalgia versus PEB myofascial pain adjudicated as category II not compensable, as well as the CI’s obesity further complicated the final adjudication picture regarding attribution of chronic fatigue symptoms. Proximate to removal from the TDRL, the VA rated the CI for 6354 at 20% rated for CFS and 6847 at 50% for OSA w/history of bilateral PE and 5025 at 20% for fibromyalgia. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board recommends a permanent separation rating of 30% coded as 6354-6817, CFS and symptoms s/p PE, resolved.

Chronic Fatigue Secondary to Deconditioning. The PEB at TDRL removal adjudged the CI’s CFS secondary to deconditioning condition as a category II condition. The CI was seen by a pulmonologist four months prior to TDRL who documented that when the CI attempted to jog, he had an elevated pulse rate (166) and felt less energetic. The examiner opined that the deconditioning was multifactorial. The VA exam three days after final separation from TDRL noted the possibility that a further episode of PE contributed to a fatigue and reduced exercise capacity which could have led to deconditioning and further fatigue symptoms. These symptoms were considered in the above unfitting diagnosis and coding.

Obstructive Sleep Apnea. The PEBs at TDRL-entry and exit adjudged the CI’s OSA condition as a category II condition. The VA rated this condition as mild OSA with bilateral PE at 50% proximate to TDRL removal. OSA may have overlapped with the CI’s primary unfitting diagnosis and been a source of fatigue; however, there is insufficient evidence to overturn the PEB’s adjudication as not unfitting when his fatigue symptoms are rated as above.

Patellofemoral Syndrome. The PEBs at TDRL-entry and exit adjudged the CI’s PFS knee conditions as a category II condition. The VA rated this condition at 0%. The CI was seen in rheumatology clinic for knee pain and was diagnosed with PFS causing knee pain due to tight hamstrings, with relatively weak quadriceps. This exam was cited by the pre-TDRL MEB examiner. However, the VA C&P exam two months into the TDRL documented that the CI had bilateral knee strength 5/5 and range of motion was normal. All evidence considered, there is not reasonable doubt in the CI’s favor supporting recharacterization of the PEB fitness adjudication for the PFS condition.

Obesity. The PEBs at TDRL-entry and exit adjudged the CI’s obesity as category III. The VA did not rate this condition. At the second MEB evaluation four months prior to TDRL entry*,* the CI complained that he had a weight gain since January 2002 and was unable to exercise due to exercise –induced shortness of breath/fatigue. All evidence considered, there is not reasonable doubt in the CI’s favor supporting recharacterization of the PEB adjudication as category III.

Myofascial Pain. The TDRL re-evaluation PEB adjudged the CI’smyofascial pain (new diagnosis) as category II. The VA coded this condition as fibromyalgia. The initial VA rating was changed to 20% based on civilian rheumatologist (October 2003-February 2004) and VA treatment (July-December 2004) records indicating “widespread musculoskeletal pain and tender points that are episodic, with exacerbations that often precipitated by overexertion.” Although myofascial pain may have been unfitting or contributed to the CI’s unfitting condition, there was not reasonable doubt to overturn the PEB not compensable adjudication.

Adjustment Disorder with Depression, Anxiety, and Memory Loss. The VA rated this condition at 30%. However, adjustment disorder is a condition which does not constitute a physical disability and is not ratable or compensable by the military DES IAW DoDI 1332.38. Encl 5. Prior to the PEB, the CI was evaluated for his complaints of memory loss by neuropsychiatry eight months prior to TDRL entry. The report stated that the CI produced an essentially normal neuropsychological profile and that only on a single memory test did the CI’s performance fall in the mild range of impairment. The examiner further opined that the CI’s generally normal cognitive status would not likely result in impairment of social/industrial adaptability. The Board determined therefore that adjustment disorder was not subject to Service disability rating.

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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. In the matter of the CFS secondary to hypoxia from AV fistula of pulmonary vessels w/history of bilateral PE, resolved condition, the Board unanimously recommends no change in the TDRL-entry rating level of 40% but coded as 6399-6354 IAW VASRD §4.88b. In the matter of the status post PE, resolved condition, and CFS secondary to deconditioning condition, the Board unanimously recommends combining the conditions and ratings to symptomatic, following resolution of pulmonary thromboembolism coded 6399-6817 and rated at 30% IAW VASRD §4.100. In the matter of OSA, PFS, myofascial pain, and obesity conditions, the Board unanimously recommends no recharacterization of the PEB adjudication as not unfitting. In the matter of the adjustment disorder with depression, anxiety and memory loss condition or any other medical conditions eligible for Board consideration, the Board unanimously agrees that it cannot recommend any findings of unfit for additional rating at separation.

RECOMMENDATION: The Board recommends that the CI’s prior determination be modified as follows: no change in the TDRL-entry rating and that the discharge with severance pay upon removal from the TDRL be recharacterized to reflect permanent disability retirement, effective as of the date of his prior separation:

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| --- | --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **TDRL RATING** | **PERMANENT**  **RATING** |
| Chronic Fatigue Secondary to Hypoxia from AV Fistula of Pulmonary Vessels w/Hx of Bilat PE, Resolved | 6399-6354 | 40% |  |
| Symptomatic, Following Resolution of Acute Pulmonary Embolism | 6399-6817 |  | 30% |
| **COMBINED** | **40%** | **30%** |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20090713, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

Deputy Director

Physical Disability Board of Review

SAF/MRB

1500 West Perimeter Road, Suite 3700

Joint Base Andrews NAF, Washington MD 20762

Reference your application submitted under the provisions of DoDI 6040.44 (Section 1554, 10 USC), PDBR Case Number PD-2009-00634.

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.

Sincerely,

Director

Air Force Review Boards Agency

Attachments:

1. Record of Proceedings

2. Directive

cc:

SAF/MRBR

DFAS-IN

PDBR PD-2009-00634

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 xxxxxxxxxxx are corrected to show that:

a. The diagnosis in her finding of unfitness was for Chronic Fatigue Secondary to Hypoxia from AV Fistula of Pulmonary Vessels with History of Bilateral Pulmonary Emboli, Resolved, VASRD Code 6399-6354 rather than VASRD Code 6354.

b. Upon removal from the Temporary Disability Retired List the diagnosis in her finding of unfitness was Symptomatic, Following Resolution of Acute Pulmonary Embolism, VASRD Code 6399-6817, rated at 30%.

c. On 7 September 2004, her name was removed from the Temporary Disability Retired List (TDRL), and on 8 September 2004, her name was placed on the Permanent Disability Retired List, rather than discharged with severance pay.

Director

Air Force Review Boards Agency