RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXXXXXXXX BRANCH OF SERVICE: marine corps

CASE NUMBER: PD1000125 TDRL EnTRY DATE: 20030228

BOARD DATE: 20111007 TDRL EXIT date: 20050401

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty SGT/E-5 (0621, Field Radio Operator) medically separated for left lower extremity deep vein thrombosis (DVT) following surgery of the left foot. His treatment precluded his ability to perform within his military occupational specialty. He underwent a Medical Evaluation Board (MEB). Left lower extremity DVT and May-Thurner Syndrome were forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW SECNAVINST 1850.4E. Three other conditions, as identified in the rating chart below, were forwarded on the MEB submission as medically acceptable conditions. The Informal PEB (IPEB) recommended separation and adjudicated the left lower extremity DVT condition as unfitting, rated 10%, and the May-Thurner Syndrome as a Category II with SECNAVINST 1850.4E and Veterans’ Administration Schedule for Rating Disabilities (VASRD). The CI appealed to the Formal PEB (FPEB), and was then placed on Temporary Disability Retired List (TDRL) with a 40% disability rating effective 1 March 2003. He was reevaluated by the IPEB on 2 August 2004 and noted to be stable and working full-time, yet remained at high risk in a combat environment while on Coumadin. Separation at 10% disability was recommended. The CI initially did not concur with the IPEB and requested a FPEB, but later accepted the IPEB on 11 January 2005 and was medically separated with a 10% combined disability rating with a TDRL exit on 1 April 2005.

CI CONTENTION: ‘’Since the surgery that cleared my deep vein thrombosis and that found my compressed iliac vein, I have been force to change the way that I live my life. I am required to stay on blood thinner due to the S.M.A.R.T. (shape memory alloy recoverable technology) stent that was placed in my iliac vein. I am also limited to avoiding several things that I love and grew up doing such as contact sports, weight-lifting, and etc. It has also been found that the ICD-9 codes were misdiagnosis; May-Thurner Syndrome (45181): Compress iliac vein; Left Lower Extremity Deep Venous Thrombosis (4539): Blood clot. Based on vascular anatomical chart, the vein is responsible for flowing the blood back to the heart. If your iliac vein is compressed then that would slow down that effect. Thus if the vein is not responding as normal then it will clot. My entire military career and prior to enlisting, I never had concerns of clotting disorders nor vascular disorders.” He also lists VA conditions.

RATING COMPARISON:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Final Service IPEB – Dated 20041029** | | | | **VA\* – All Effective Date 20030301** | | | |
| **Condition** | **Code** | **Rating** | | **Condition** | **Code** | **Rating** | **Exam** |
| **On TDRL – 20030228** |  | **TDRL** | **Sep.** |
| Left Lower Extremity DVT | 7199-7121 | 40% | 10% | DVT LLE secondary to May-Thurner Syndrome | 7114-7121 | 10% | 20021007 |
| May-Thurner Syndrome | Category II | | |
| Hallux Limitus Bilateral | | Cat III | | No VA Entry | | | |
| Hallux Valgus Right Foot | | Cat III | | Hallux valgus R foot | 5010-5280 | 0% | 20021007 |
| Pes Planus Bilateral | | Cat III | | Bilateral Pes Planus | 5276 | 0% | 20021007 |
| ↓No Additional MEB/PEB Entries↓ | | | | Bursitis Right Hip | 5003-5019 | 10% | 20021007 |
| Plantar Fascitis R Foot | 5284-5020 | 10%\* | 20021007 |
| Plantar Fascitis L Foot | 5284-5020 | 10%\* | 20021007 |
| L Knee Patellofemoral Syndrome | 5024 | 10%\* | 20021007 |
| R Knee Condition | 5024 | 10%\* | 20021007 |
| Lumbar Strain | 5237 | 10%\*\* | 20021007 |
| Cervical Strain | 5237 | 10%\*\* | 20021007 |
| Degenerative Arthritis R Hip | 5003-5252 | 10% | 20021007 |
| Bunionectomy L Foot | 5010-5280 | 10% | 20021007 |
| Pseudofolliculitis Barbae | 7813-7800 | 0%\* | 20021007 |
| Scar L Foot | 7804 | 10% | 20021007 |
| Left Ventricular hypertrophy | 7099-7000 | 30%\*\*\* | 20021007 |
| 0% x 12 /Not Service Connected x 17 (total inclusive of above) | | | |
| **Final Combined: 10%** | | | | **Total Combined: 80%** | | | |

\*Increased from 0% to 10% 20050323 effective 20030301

\*\*Reduced to 0% effective 20100401 for failure to show for a follow-up exam

\*\*\*Increased 20100426 from 0% to 30% effective 20030301 and 60% effective 20080926 for clear and unmistakable error

ANALYSIS SUMMARY: The Board acknowledges the sentiment expressed in the CI’s application regarding the significant impairment with which his service-incurred condition continues to burden him. The Board wishes to clarify that it is subject to the same laws for Service disability entitlements as those under which the Disability Evaluation System (DES) operates. The DES has neither the role nor the authority to compensate service members for anticipated future severity or potential complications of conditions resulting in medical separation. That role and authority is granted by Congress to the Department of Veteran Affairs, operating under a different set of laws (Title 38, United States Code). The Board evaluates VA evidence proximal to separation in arriving at its recommendations, but its authority resides in evaluating the fairness of DES fitness decisions and rating determinations for disability at the time of separation. The Board acknowledges the CI’s contention for service ratings for other conditions documented at the time of separation, and notes that its recommendations in that regard must comply with the same governance. While the DES considers all of the service member's medical conditions, compensation can only be offered for those medical conditions that cut short a service member’s career, and then only to the degree of severity present at the time of final disposition. The mere presence of a diagnosis does not render a condition unfitting. The VA, however, is empowered to compensate service connected conditions and to periodically re-evaluate said conditions for the purpose of adjusting the veteran’s disability rating should his degree of impairment vary over time without tie to fitness.

Left Lower Extremity DVT. In early 2001, the CI was evaluated for bilateral hallux valgus (bunions) and underwent left bunionectomy on 22 June 2001. The wound healed well except for persistent edema. He was noted to have a DVT on 25 July 2001, after several days of increased edema, and admitted for anti-coagulation and intravenous tissue plasminogen activator thrombolysis. He was found to have narrowing of the left common iliac vein with discreet proximal narrowing consistent with May-Thurner Syndrome (compression of the vein by the artery) and a stent was placed in both the left common iliac vein and the left external iliac vein. He was discharged on Coumadin. At the MEB examination, dictated 20 August 2001, he was noted to have had 1-2+ edema of the lower left extremity at discharge, but that a follow-up exam on 15 August 2001 in the vascular clinic was normal. However, duplex ultrasound that day showed a small amount of residual thrombus in the left external iliac vein. A follow up venous duplex ultrasound, accomplished on 28 April 2002, showed no evidence for either for deep venous thrombosis or for venous insufficiency. He was placed on TDRL with 40% disability, effective 1 March 2003 coded 7199-7121 (post-phlebotic syndrome of any etiology.) The FPEB noted that the disability was most consistent with 10%; however, in consideration of SECNAVINST 1850.4E, it was determined to place him on TDRL as he was less than one year out from resolution of the thrombus. The VA compensation and pension (C&P) exam dated 7 October 2002 showed an absence of current pathology, including edema, stasis, pigmentation or exzema of the lower left extremity, and adjudicated the disability at 10% and coded it 7114-7121 (arterioscleosis obliterans and post-phlebitic syndrome of any etiology) rating under 7121. It upheld this adjudication on subsequent review dated 25 March 2005, one week prior to the end of TDRL. At the time of the TDRL exit evaluation on 15 September 2004, he had had no further thrombotic episodes and was still taking Coumadin. He was employed and had not lost work due to his condition. The IPEB adjudicated a 10% disability and retained the coding of 7199-7121. The Board first considered the TDRL entry rating and notes that the FPEB IAW SECNAVINST 1850.4E rating increased the 40% rating during the period of TDRL solely due to the recency of the DVT. It also notes that the VA awarded a 10% rating and continued it on review. A 10% rating under 7121 is defined as, “intermittent edema of extremity or aching and fatigue in leg after prolonged standing or walking, with symptoms relieved by elevation of extremity or compression hosiery.” A 20% rating would require, “persistent edema, incompletely relieved by elevation of extremity, with or without beginning stasis pigmentation or eczema.” For the TDRL exit rating, the Board notes that the findings were again consistent with a 10% exam and that the CI had had no further thrombotic episodes. After due deliberation in consideration of the totality of the evidence, the Board concluded that there was insufficient cause to recommend a change from the PEB fitness adjudication for the lower left extremity DVT condition secondary to May-Thurner syndrome.

Other PEB Conditions. The other conditions forwarded by the MEB and adjudicated as not unfitting by the PEB were bilateral hallux limitus, right hallux valgus, and bilateral pes planus. None of these conditions were profiled, implicated in the non medical assessment or noted as failing retention standards. All were reviewed by the action officer and considered by the Board. There was no indication that any of these conditions significantly interfered with duty performance. All evidence considered, there is not reasonable doubt in the CI’s favor supporting recharacterization of the PEB fitness adjudication for any of the stated conditions.

Other Contended Conditions. These include right knee, left knee, bilateral flat feet, scar from bunion surgery left foot, arthritis right hip, arthritis left hip, left bunionectomy, cervical strain, lumbar strain, bilateral heel spurs, shaving bumps face, left ventricular hypertrophy, and right foot bunion. The bilateral flat feet and right bunion were determined by the PEB to be not unfitting (see above). None of the remaining conditions were clinically significant during the MEB period, carried attached profile, were the basis for limited duty or were implicated in the commander’s statement. The Board notes the VA subsequently rated the left ventricular hypertrophy at 30% and then 60% despite the C&P determination on 28 February 2005 stating that this was not a firm diagnosis and that the electrocardiogram variation was not uncommon in African Americans. With the exception of the shaving bumps, none of the remaining conditions were 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. IAW DoDI 1332.38, E5.1.2.12, pseudofolliculitis barbae is does not constitute a physical disability and is not ratable in the absence of an underlying ratable causative disorder. The Board therefore has no reasonable basis for recommending any additional unfitting conditions for separation rating.

Remaining Conditions. Other conditions identified in the DES file were onychomycosis, gastroesophageal reflux disease, lip laceration repair, and abdominal pain from old. Several additional non-acute conditions or medical complaints were also documented. None of these conditions were clinically significant during the MEB period, carried attached profiles or were the basis for limited duty, except for the umbilical herniorrhaphy seven years prior to MEB, and none were implicated in the non-medical assessment. 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, many other non-acute conditions were noted in the VA rating decision proximal to separation including vasomotor rhinitis, varicocele, right wrist pain, bilateral ankle pain, thoracic scoliosis, fatigue, atypical chest pain, history of pneumomediastinum, excision of dermatofibromata, bilateral gynecomastia, increased creatinine, spermatocele, lid lag/hand tremors, myopia, and two scars. None were documented in the DES file. As already noted, 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 lower left extremity DVT and May-Thurner Syndrome, the Board unanimously recommends no change in the IPEB adjudication. In the matter of the bilateral hallux limitus, right hallux valgus, bilateral pes planus, left and right knees, left foot scar, left and right hip arthritis, left bunionectomy, vervical and lumbar strain, bilateral heel spurs (pes planus), pseudofolliculitis barbae, left ventricular hypertrophy, right foot bunion or any other conditions eligible for Board consideration, the Board unanimously recommends no change in the PEB adjudication.

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

|  |  |  |  |
| --- | --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **TDRL RATING** | **PERMANENT**  **RATING** |
| Lower Left Extremity DVT with May-Thurner Syndrome | 7199-7121 | 40% | 10% |
| **COMBINED** | **40%** | **10%** |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20100303, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

President

Physical Disability Board of Review

