RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXX BRANCH OF SERVICE: marine corps

CASE NUMBER: PD1000658 SEPARATION DATE: 20060906

BOARD DATE: 20110823

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was a Reserve LCpl /E-3 (0311/Rifleman) medically separated for a right knee condition (lower extremity traumatic arthrotomy). The CI sustained multiple shrapnel wounds to his lower extremities and an intra-articular injury to his right knee which required arthroscopic debridement. During the CI’s post-operative recovery, he developed a deep venous thrombosis (DVT) and pulmonary embolis (PE). The CI was treated with Coumadin and determined to possibly have a genetic predisposition to DVT/PE. The CI’s knee condition did not respond adequately to treatment and he was unable to perform within his military occupational specialty (MOS) or meet physical fitness standards. The CI was referred to a Medical Evaluation Board (MEB). The MEB forwarded “injury due to war operations by antipersonnel bomb (fragments), venous embolism and thrombosis of unspecified deep vessels of lower extremity and personal history of venous thrombosis and embolism” to the Physical Evaluation Board (PEB) on NAVMED 6100/1. The PEB adjudicated the right lower extremity traumatic arthrotomy status post washout as unfitting rated 10% with application of SECNAVINST 1850.4E and DoDI1332.39, and multiple shrapnel wounds as a related category II diagnosis (conditions that contribute to the unfitting condition). The PEB also adjudicated DVT with subsequent PE by report secondary to genetic hypercoagulable state as a preexisting condition. The CI made no appeals, and was medically separated with a 10% combined disability rating.

CI CONTENTION: “At the time of my rating, I was not diagnosed with or evaluated for posttraumatic stress disorder (PTSD) or traumatic brain injury (TBI). I have since been diagnosed with severe PTSD and a blast induced TBI. Also, immediately following the first of two surgeries to remove shrapnel from the joint of my knee, I developed a deep vein thrombosis in my right calf which led to pulmonary emboli. After my first surgery in Germany, I was not properly evaluated or treated for possible blood clots. I was not provided with stockings or Lovinox to prevent coagulation. After leaving Germany, I was sent to Camp Lejeune and housed in a regular barracks living quarters with no medical follow-up. At this time I developed the deep vein thrombosis. I informed medical staff regarding the severe swelling and pain in my calf and I was told it was typical pain from post-surgery. I was then flown back to Pittsburgh alone and returned to my apartment. Several weeks later I began experiencing extreme chest pain and was rushed to St. Clair Hospital where I was diagnosed with 5 pulmonary emboli. In regards to PTSD, the symptoms I have experienced have been devastating. I am currently in my second inpatient stay for PTSD and TBI and will be attending my third treatment center shortly.”

RATING COMPARISON:

|  |  |
| --- | --- |
| **Service IPEB – Dated 20060628** | **VA – All Effective Date 20070426** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Right Lower Extremity Traumatic Arthrotomy | 5299-5003 | 10% | Right Lower Extremity Traumatic Arthrotomy\* | 5299-5003 | 10% | STR |
| Multiple Shrapnel Wounds | CAT II | Residuals Shrapnel Wound Left Shin\*\* | 5311 | 10% | 20081105 |
| Residuals of Shrapnel, Scars Right Knee\*\* | 7804 | 10% | 20081105 |
| Residuals Shrapnel Wound Right Forearm\*\* | 8516 | 10% | 20081105 |
| Residuals Shrapnel Wound Right Abdomen\*\* | 5318 | 0% | 20081105 |
| DVT with Subsequent PE by Report Secondary toGenetic Hyper-coagulable State | Pre Existing Condition | PE | Not Service Connected, Not Incurred/Caused by Service |
| ↓No Additional MEB/PEB Entries↓ | Posttraumatic Stress Disorder | 9411 | 10% | 20070820 |
| **Combined: 10%** | **Combined: 40%** |

VA effective date is date claim received, not day after separation.

\* Initial VARD 20071102 rated R L Ex traumatic arthrotomy and PTSD for combined 20%.

\*\* Subsequent VARD 20090316 added 10% ratings for shrapnel wounds and scars right forearm (8516), left shin (5311), and right knee scar (7804), and 0% for abdomen wound with scar (5318) after being deferred on the original, for combined 40%.

ANALYSIS SUMMARY: The Board acknowledges the sentiment expressed in the CI’s application regarding the significant impact that his service-incurred conditions have had on his quality of life. However, the military services, by law, can only rate and compensate for those conditions that were found unfitting for continued military service based on the severity of the condition at the time of separation and not based on possible future changes. The VA, however, can rate and compensate all service connected conditions without regard to their impact on performance of military duties, including conditions developing after separation that are direct complications of a service connected condition. The VA can also increase or decrease ratings based on the changing severity of each condition over time. The Board’s role is confined to the review of medical records and all evidence at hand to assess the fairness of PEB rating determinations, compared to VA Schedule for Rating Disabilities (VASRD) standards, based on severity at the time of separation. It must also judge the fairness of PEB fitness adjudications based on the fitness consequences of conditions as they existed at the time of separation. The Board’s threshold for countering Disability Evaluation System (DES) fitness determinations is higher than the VASRD §4.3 reasonable doubt standard used for its rating recommendations; but remains adherent to the DoDI 6040.44 “fair and equitable” standard. It is noted for the record that the Board has neither the jurisdiction nor authority to scrutinize or render opinions in reference to the CI’s statements in the application regarding medical care.

Right Knee Condition. There were three goniometric range of motion (ROM) evaluations in evidence which the Board weighed in arriving at its rating recommendation. These exams are summarized in the following chart.

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| Goniometric ROMRight Knee | VA Medical Clinic ~ 6 Mo. Pre-Sep(20060324) | MEB ~ 4 Mo. Pre-Sep(20060522) | VA C&P ~ 26 Mo. After-Sep(20081107) |
| Flexion (140⁰ normal) | 90-100⁰ | 140⁰ | 130⁰ with pain |
| Extension (0⁰ normal) | Not recorded | 0⁰ | 0⁰ |
| Comment | Gait with minimal guarding of the right leg; Crepitus, pain and popping thru exam; ½ inch difference in knee from right to left. | Significant Quad atrophy; 1+ anterior drawer over the solid end point; palpable patellar crepitus. | Increased pain on repetitive motion; tenderness to palpation in lateral aspect; strength 4/5 with slight give away; Gait normal except when walking on heels/toes –limp  |
| §4.71a Rating\* | 10% | 10% | 10% |

The CI sustained multiple shrapnel wounds to his lower extremities in April 2005 as a result of an indirect fire explosion (variously referred to as a landmine or mortar in records) while conducting combat operations in Iraq. The most significant shrapnel injury was to the right knee requiring arthroscopic debridement/washout for removal of retained fragments. Following return to the U.S., he continued to have right knee pain and underwent a second arthroscopic surgery by his civilian orthopedic surgeon in August 2005. A retained foreign body was removed, that was noted to have worn a partial thickness groove in the articular cartilage of the medial femoral condyle joint surface (2cm long, 2mm wide, 3mm deep, but not full thickness). The remainder of the knee was documented as normal in the operative report including collateral ligaments and other joint surfaces. Intraoperative examination of both knees demonstrated a symmetric ligamentous examination (i.e., the ligaments were intact and normal in the injured knee). Seven months later, a VA medical clinic exam documented that there was minimal guarding of the right leg with walking, but the CI was unable to hop on the right leg. There was crepitus and pain on ROM examination. The MEB orthopedic narrative summary (NARSUM), four months prior to separation, recorded that the CI had significant pain on running. The surgeon noted atrophy of the thigh muscles related to decreased use from the injury. A June 13, 2006 pulmonary evaluation records the CI was active, walks a lot, has knee pain, but walks fine. Although remote from the time of separation, the Board noted the VA compensation and pension (C&P) examination on November 7, 2008, 26 months after separation, showing similar findings. The CI complained of right knee pain with walking one mile, going up and down steps, running and squatting. The CI further reported weakness; occasional numbness and tingling; and instability with “knee gives away at times” (approximately once per week). His gait was normal except when attempting walking on toes or heels. All exams indicated that the CI had pain on motion of the right knee as well as pain with activities of exercise and running. All exams were adjudged to meet the intent of §4.59 painful motion. Although the CI complained of laxity and giving away, there was no anatomic or mechanical abnormality that would cause instability (all ligaments intact and the injured knee ligament exam the same as the uninjured knee). Alternate coding of 5257 knee, other impairment of: recurrent subluxation or lateral instability (10%) was not considered predominate, and there was no evidence of meniscus pathology to support coding of 5258 cartilage, semi lunar, dislocated, with frequent episodes of “locking” pain and effusion into the joint. The PEB and the VA chose the same code 5299 analogous to 5003 (arthritis, degenerative (hypertrophic or osteoarthritis) rated 10%. All evidence considered there is not reasonable doubt in the CI’s favor therefore to justify a Board recommendation for other than the 10% rating assigned by the PEB for the right knee condition (right lower extremity traumatic arthrotomy).

Other PEB Conditions. One other condition, multiple shrapnel wounds, was forwarded by the MEB and adjudicated as category II by the PEB. The CI sustained shrapnel wounds to the right knee (previously discussed), left shin, right forearm and right side of abdomen. At the time of the MEB history and physical examination on March 24, 2006, the CI complained of occasional numbness and cramping of his left foot and toes. He was evaluated by neurology for the left calf and foot symptoms. The neurologist felt that the shrapnel injury was likely causing irritation to the tibial nerve and saphenous nerve depending on the position or stretch placed on those nerves. He recommended referral for surgical removal of the irritating fragment but the records show no evidence of further evaluation, care, or complaint of this specific injury. C&P examination on July 14, 2009 documented normal strength and sensation of the lower extremity (except paresthesia of a circumscribed area on the left anterolateral thigh unrelated to the shin shrapnel injury) with normal gait. Except for the right knee injury (previously discussed), there were no residuals from the other shrapnel injuries that would have interfered with performance of military duties. The commander’s assessment did not mention the shrapnel wounds; nor was there a limited duty period for these wounds. By precedent, the Board does not recommend separation rating for scars unless their presence imposes a direct limitation on fitness.

DVT with subsequent PE, by report secondary to genetic hypercoagulable state, was forwarded by the MEB and adjudicated as a pre-existing condition. While home on convalescent leave in May 2005, the CI developed a right lower extremity DVT with subsequent PE approximately one month after the shrapnel injury (hospitalized May 30, 2005) and was treated with anti-coagulation for nine months. Of note and with regard to his contentions, shortly after arriving home on convalescent leave, and two weeks prior to developing the DVT, a Doppler ultrasound study of the right lower extremity (ordered by his civilian physician on May 11, 2005) was negative for evidence of DVT. Although there was a report of genetic tendency for abnormal blood clotting in multiple family members, the CI did not have a personal history of spontaneous DVT or PE (his DVT was provoked by injury, surgery, and immobilization), and prophylactic anticoagulation was apparently not instituted. The MEB NARSUM noted that Coumadin was stopped in March 2006 and no further treatment for the DVT/PE was required. There was no recurrence of anticoagulation and no objective residuals that would interfere with performance of military duties. A June 13, 2006 pulmonary evaluation noted absence of complaint of shortness of breath. The CI was reported as active and walking a lot. Pulmonary function testing was normal (including diffusion study). VA medical documentation two years later recorded no recurrence of DVT or PE with normal pulmonary function testing. There was no evidence of chronic or recurrent DVT or PE or residual impairments (peripheral vein or pulmonary) that would significantly interfere with satisfactory performance of MOS requirements to be considered as unfitting. The family history of hypercoagulability was of concern; however, this genetic predisposition, if present in the CI (testing was negative), is not by itself ratable or compensable under the rules of the DES. This condition was reviewed by the action officer and considered by the Board. All evidence considered there is not reasonable doubt in the CI’s favor supporting recharacterization of the PEB fitness adjudication for the DVT with subsequent PE by report secondary to genetic hypercoagulable state condition.

Posttraumatic Stress Disorder and Traumatic Brain Injury. The CI deployed to Iraq arriving in theater on March 4, 2005 and was medically evacuated April 27, 2005 following the shrapnel injury previously discussed. On the post-deployment health assessment on May 9, 2005, the CI indicated presence of nightmares but no thoughts of losing control and harming anyone, and no interpersonal conflicts. One year later during the MEB history and physical examination, the CI checked “yes” to having a history of nervous trouble, frequent trouble sleeping, depression or excess worry, citing, “after returning from Iraq I began experiencing and still do experience significant anxiety regarding just about everything. I cannot fall asleep until very late and I wake up multiple times per night. I consulted a psychiatrist several times and was diagnosed with adjustment disorder and possible PTSD. I was prescribed Zoloft which I still periodically take.” At the time of a follow up post-deployment assessment on March 25, 2006, the CI endorsed symptoms of PTSD (nightmares, hypervigilance, easily startled, feeling numb detached) and indicated he was receiving care at the VA. In response to the question, “If you checked off any problems or concerns on this questionnaire how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people,” the CI checked “Not difficult at all.” He also indicated no suicidal thoughts or thoughts that he might lose control and hurt others. The CI declined mental health referral stating he was being seen at the VA. During an April 4, 2006 VA examination, the CI denied current psychological symptoms: “He reports that with Iraq he noticed an increased anxiety and has been diagnosed with readjustment and PTSD symptoms which have essentially stopped.” The CI was home beginning late November 2005, and, according to VA documentation, returned to college to complete his bachelor’s degree in August 2006. In November 2006, two months following separation from the service, the CI sought care for worsened PTSD symptoms (including anxiety, depression, sleep disturbance) without suicidal or homicidal ideation. On mental status examination, his memory, judgment, insight, thought processes, and affect were normal. The psychiatrist estimated the global assessment of functioning of 60 for moderate symptoms. The August 20, 2007 VA C&P PTSD examination, one year after separation, documented increasing problems with substance abuse and chronic PTSD symptoms, with the latter characterized as mild. The evaluator concluded substance abuse was the predominant cause of symptoms and impairment.

With regard to TBI, during the MEB history and physical examination, the CI checked “yes” to having a history of loss of consciousness or concussion during the land mine explosion; however, previous service medical records are silent with regard to head injury except for an in theater progress note documenting a nose bleed at the time of the explosion. Evidence of VA records report the CI completed his college degree during the year leading up to separation. Neuropsychological testing nearly three years after separation did not find objective evidence of cognitive disorder. There is no evidence that symptoms of PTSD or TBI were clinically or occupationally significant during the MEB period, nor were they the basis for limited duty and none were implicated in the commander’s assessment. These conditions were reviewed by the action officer and considered by the Board. All evidence considered, there is not reasonable doubt in the CI’s favor supporting addition of PTSD and TBI conditions as unfitting conditions for separation rating.

Remaining Conditions. Several additional non-acute conditions or medical complaints were also documented. None of these conditions were clinically active during the MEB period, none were basis for limited duty and none were implicated in the commander’s 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. 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 right lower extremity traumatic arthrotomy condition and IAW VASRD §4.71a, the Board unanimously recommends no change in the PEB adjudication. In the matter of the multiple shrapnel wounds and DVT with subsequent PE by report secondary to genetic hypercoagulable state conditions, the Board unanimously recommends no recharacterization of the PEB adjudications as not unfitting. In the matter of the PTSD and TBI conditions 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 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** |
| Right Lower Extremity Traumatic Arthrotomy | 5299-5003 | 10% |
| **COMBINED** | **10%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20100319, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

 President

 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, FORMER USMC, XXX XX XXXX

Ref: (a) DoDI 6040.44

 (b) PDBR ltr dtd 25 Aug 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. XXXX’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)