RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: AIR FORCE

CASE NUMBER: PD1000863 SEPARATION DATE: 20091029

BOARD DATE: 20120301

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty TSgt/E6 (Service Craftsman / 3MOX1), medically separated for deep vein thrombosis (DVT) with chronic left leg pain. Despite both conservative and surgical management, he did not respond adequately to fully perform within his Air Force Specialty (AFS) or meet physical fitness testing (PFT) standards. He was issued a profile restricting him from PFT and underwent a Medical Evaluation Board (MEB). DVT with subsequent chronic left leg pain was forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW AFI 48-123. No other conditions appeared on the MEB’s submission. Other conditions included in the Disability Evaluation System (DES) packet will be discussed below. The PEB adjudicated the chronic left leg pain condition as unfitting, rated 20%, with application of the Veterans Administration Schedule for Rating Disabilities (VASRD). The CI appealed to a Formal PEB (FPEB) which reduced the disability rating to 10%. He made no further appeals and was medically separated with a 10% combined disability rating.

CI CONTENTION: “I have served 17 years and 3 months honorably before I was medically separated. My initial rating from the informal board was 20%. I then went before the formal board and received 10% with a disability code of 7121 which allows up to 30% disability rating which would have allowed me to retire.” In block 14 of the DD Form 294 he notes: “The following is the VA decision on disability: I was rated at 60% disabled with the following determinations: Right Kidney Cortical Atrophy with Compensatory Left Kidney Hypertrophy with Residual Thinning & Scarring, Aortic Valve Insufficiency with Regurgitation, Mitral Valve Regurgitation, Hypertension, DVT, Status Post Ablation Left Leg, TIA, migraine headaches.” Through counsel, the CI requests separate ratings of 20% for chronic pain and post phlebitic syndrome, or adopt the 60% rating granted by the VA for numerous bundled conditions. The CI contends leg pain and post phlebitic syndrome are separately unfitting and ratable conditions. The CI also contends that migraine headaches were unfitting for duty and warranted a disability rating at separation.

RATING COMPARISON:

|  |  |
| --- | --- |
| **Service FPEB – Dated 20090608** | **VA (7 Mo. After Separation) – All Effective 20091030** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| DVT with Chronic Left Leg Pain | 7121 | 10% | Right Kidney Cortical Atrophy with Compensatory Left Kidney Hypertrophy with Residual Thinning & Scarring, Aortic Valve Insufficiency with Regurgitation, Mitral Valve Regurgitation, Hypertension, DVT, Status Post Ablation Left Leg, TIA | 7599-7507 | 60% | 20091229 |
| ↓No Additional MEB/PEB Entries↓ | Migraine Headaches | 8100 | 10% | 20091229 |
| 0% x 1 /Not Service Connected x N/a | 20091229 |
| **Combined: 10%** | **Combined: 60%** |

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. The Board wishes to clarify that it is subject to the same laws for service disability entitlements as those under which the 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 Veterans’ Affairs (DVA), 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 also acknowledges the CI's contention suggesting that service ratings should have been conferred for other conditions documented at the time of separation and determined to be service-connected by the DVA. 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 is not sufficient to render a condition unfitting for service and, thereby, eligible for compensation from the DES. The DVA, however, is empowered to compensate all service-connected conditions without regard to fitness for military duty and to periodically re-evaluate said conditions for the purpose of adjusting the Veteran’s disability rating should the degree of impairment vary over time.

Left Leg Condition. The CI experienced a deep vein thrombosis of the left leg in September 1997 and was treated with anticoagulant medication for six months. The medical record is then silent for further complaints until June 2006 when the CI presented with chronic left leg pain and swelling at the end of the day. Ultrasound imaging at that time disclosed chronic non-occlusive clot of the left common femoral vein and left greater saphenous vein. He was treated with compression support stockings and medication and advised to exercise and stop smoking. He deployed to Iraq in 2007 (May to September) and reported no complaints of extremity pain on the post deployment health assessment. In November 2007, he presented to the clinic reporting that he was in danger of administrative separation due to inability to pass the physical fitness test due to left leg pain with running (multiple failures). A neurology evaluation on 3 December 2007 concluded his leg pain was due to his vascular problem and not a neurologic problem. Vascular surgery evaluation in December 2007 documented a reflux of the normal blood flow in the left common femoral vein and left greater saphenous veins consistent with venous valvular incompetence causing venous insufficiency (at that time, there was no evidence of deep or superficial vein thrombosis). Evaluation for an increased tendency to clot revealed two genetic associations (a single mutation of the MTHRF gene A1298C and heterozygous for factor V Leiden mutation), which together may increase the CI’s risk for developing abnormal blood clots (the elevations of protein C, protein S and AT-III cited in some clinic notes are not abnormalities that cause abnormal clotting). In August 2008, the CI underwent laser ablation of the left greater saphenous vein. Follow up evaluation with his military primary care physician in November 2008 recorded persistent symptoms preventing passing the physical fitness test (it is noted in the record that he had not passed the test since 2004). He was being treated with aspirin to prevent clotting and compression support stockings. In the clinic, pain was reported as mild to moderate, but became severe with exertion. Examination at that time documented absence of edema, absence of skin lesions, and normal gait and strength. The MEB narrative summary (NARSUM), dated 23 December 2008, refers to the most recent medical record for examination results. The most recent medical record entry was 8 December 2008, 11 months prior to separation, at which time left leg pain was graded as mild (3) and no pain medications were listed. On examination, strength and gait were normal. There were no skin changes and no edema. The Homan’s test was negative and the extremity non-tender to palpation. The neurovascular exam was intact. The MEB NARSUM mentions that a referral to neurology was made in November 2008 for evaluation of neuropathic pain; however, this evaluation is not in the available records and this may have referred to the referral to neurology that is documented in November 2007. The neurology evaluation in December 2007 did not conclude there was neuropathic pain. The commander, in his letter dated 13 November 2008, noted the physical restrictions from the left leg pain prevented the CI from performing full duties in his AFS. The MEB was completed 30 December 2008 and referred “DVT with subsequent chronic left leg pain” as not meeting retention standards. The PEB on 16 April 2009 found the left leg condition unfit and rated it 20% using a non-specific code 7199 for diseases of arteries and veins. The CI appealed to the FPEB contending his condition “chronic left leg pain resulting from an incompetent venous valve in the proximal aspect of the greater saphenous vein” warranted a 40% rating and submitted a repeat ultrasound study of his left leg veins performed May 2009. This examination found no evidence of residual blood clot in the veins; however, it confirmed the incompetent venous valve in the proximal aspect of the greater saphenous vein previously documented by the vascular surgeon in December 2007. The FPEB, 8 June 2009 found the DVT with chronic left leg pain unfitting and rated it 10% using VASRD code 7121, post-phlebitic syndrome of any etiology. Beginning in April 2009, concurrent with the PEB, the CI presented to clinic complaining of increased pain due to having to be on his feet a lot and requested prescription for narcotic pain medication noting that it had previously helped with his pain. Prior to this time, medical records do not document prescription or use of narcotic pain medications, or any prescription pain medication (except one prescription for amitriptyline in 2006), for leg pain. Narcotics had been prescribed twice previously, March 2008 and September 2008, for abdominal pain related to a gall bladder condition and gall bladder surgery. A 26 June 2009 clinic encounter recorded severe pain by the end of the day. On examination there was no edema, no skin changes, and the gait was normal. The CI continued to wear his supportive compression stocking. A 3 August 2009 clinic encounter similarly recorded left leg pain with extended periods of standing “12+ hours.” At this examination, pain was graded as a 4, and there was a mottled appearance to the skin with engorged superficial veins consistent with his venous insufficiency / post phlebitic syndrome. A 15 September 2009 clinic encounter also documented left leg pain associated with prolonged standing at his current job where he was “standing for 12+ hours per day.” Pain was recorded as 0, the skin exam was normal and the peripheral vascular examination was recorded as normal without detail. The separation physical examination was accomplished 19 October 2009, ten days prior to separation. It was significant for complaint of persistent left lower extremity pain and swelling without change or new complaints. On examination, the CI was noted to be wearing the support hose, the musculoskeletal system was normal, and the skin showed no lesions. The VA compensation and pension (C&P) exam was 29 December 2009, two months after separation. It noted that the CI continued to wear the support hose daily, only removing it to shower. He had daily pain rated 4/10, but flares to 10/10 after exertion and severe pain was noted 15 days a month. On examination, neither varicose veins nor edema was present. No skin lesions or edema were noted either. Pulses and neurological exams were intact. The FPEB adjudicated the DVT with chronic left leg pain at a 10% disability rating, coded 7121, post-phlebitic syndrome of any etiology. The VA combined the LLE pain and DVT with several other conditions for a single rating, coded as 7599-7507, analogous to arterial nephrosclerosis. The CI contends that leg DVT and related leg pain are separately unfitting and ratable conditions: “DVT and chronic leg pain derive from different sources.” The CI argues that the leg pain is separate and apart from the DVT since pain is a different symptom than edema and treated differently than edema. At the time of the FPEB, the CI reported “chronic left leg pain resulting from an incompetent venous valve in the proximal aspect of the greater saphenous vein”, which is consistent with the medical evidence. The Board did not conclude the evidence of the medical documentation supported that the left leg pain was unrelated to the post phlebitic syndrome / venous insufficiency that was secondary to the history of DVT in 1997. Neurology evaluation in December 2007 did not conclude there was a neuropathic cause for his pain. The history of the DVT in 1997 and the genetic increased tendency to form blood clots did not interfere with performance of duty and were not unfitting. The record shows that the CI performed his duties well and deployed twice between 1997 and November 2007. The left leg pain interfering with duty was unfitting. The CI’s unfitting left leg pain was due to venous insufficiency secondary to the prior DVT ten years before, and is most appropriately rated using the code for post phlebitic syndrome. The Board noted that other than one time on 3 August 2009 when a mottled appearance of the skin was observed, no skin changes were documented on any exam prior or subsequent to this exam, and that neither stasis pigmentation nor eczema was ever documented, therefore a rating of 40% or higher is not supported. It then considered the difference between a 20% and 10% rating. A disability rating of 20% is met by persistent edema, incompletely relieved by elevation of extremity, with or without beginning stasis pigmentation or eczema whereas the 10% rating requires 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. The Board notes that the 10% rating is clearly met and that the difference between the two ratings hinges on whether or not the edema is or is not relieved by elevation of the extremity or by compression. The VA C&P exam clearly notes that the CI was using the compression stocking, but that no edema was present and that the skin exam was normal. All evidence considered, there is not reasonable doubt in the CI’s favor supporting a change from the PEB’s rating decision for the DVT with chronic left leg pain condition.

Other Contended Conditions. The CI’s application asserts that compensable ratings should be considered for the additional conditions bundled together by the VA with a single 60% rating (right kidney cortical atrophy with compensatory left kidney hypertrophy, aortic valve insufficiency and regurgitation, mitral valve regurgitation, hypertension, transient ischemic attacks, status post ablation left leg with residual scars), and migraine headaches. None of these conditions were referred by the MEB as not meeting medical retention standards, or contended by the CI at the time of the PEB. Ablation of the left leg vein, hypertension, and migraine headaches were in the DES file while the kidney, cardiac and transient ischemic attack conditions were not in the DES file. The Board’s threshold for countering 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. Furthermore, a “crystal ball” requirement is not imposed on the service PEB’s by the Board. The 12-month window specified in DoDI 6040.44 is appropriate for rating comparisons, but not for new developments after separation.

Status post ablation left leg vein with residual scars. In 2008, the CI had LASER ablation of the greater saphenous vein without improvement in his pain. The 20 October 2008 note annotates “patient states symptoms have not improved or changed.” There is no indication that the surgery aggravated the LLE pain already discussed and adjudicated. There is no evidence that the scars from the procedure interfered with performance of duties or the wear of military clothing in either the treatment notes or profiles. The MEB NARSUM examination stated there was no tenderness to palpation. Although the MEB examination did not specifically address scars, the VA C&P examiner recorded “on inspection, all of the following surgical scars appear smooth without inflammation or ulceration, are normally pigmented throughout, and have no gross asymmetry or distortion of features. On palpation, all of the following surgical scars are level with the surrounding skin, flexible, non-indurated, non-edematous, non-adherent, and non-tender and do not restrict range of motion.” Board members concluded there is no basis for an unfitting determination.

Hypertension. The CI was identified as having hypertension (HTN) in 1998 and placed on medications with good control. There is no evidence of end organ damage or of duty impairment.

Migraine Headaches. The CI contends he experienced migraine headaches over a protracted period of time since October 2001 requiring multiple medications and that the headaches never abated. He asserts the MEB narrative summary lacked depth and substance regarding the headaches, and by implication, due to the absence of narrative summary evidence to the contrary, the headache condition should be presumed to have been unfitting. Review of the service medical records show the CI first noted lightheadedness/dizzy spells in 1998 and was diagnosed with migraines. He was placed on quarters for 48 hours. This is the only instance in the record in which the CI was given quarters for his headaches. He was seen by a neurologist on 4 October 2001 at which time he gave a history of frequent migraines as a child. MRI of the brain was normal. The neurologist made the diagnosis of classic migraine with aura and started Depakote for prophylaxis and also prescribed Zomig as an abortant. Although initially not very effective, eventually the CI enjoyed good control from the Depakote and remained on it for the duration of his career. At a clinic encounter on 14 October 2003, CI reported that he hadn’t had a migraine since starting Depakote. An 8 April 2005 clinic appointment records headaches very well controlled on Depakote with rare use of Zomig which, when needed, seemed to work every time. A 27 October 2006 clinic encounter records report of a stable pattern of migraine headaches one to two times per month for which Zomig was effective. A clinic encounter 1 October 2008 for refill of migraine medications makes no mention of difficulties with headaches. There are no acute visits for headaches or other neurological issues until the last two months of active duty. These visits are discussed under the TIA heading below. Accordingly, the control seen by the CI was sufficient to allow continued duty for over six years (including two deployments) without identified impairment. There were no duty limiting profiles after 2001 for headaches in evidence, enlisted performance reports document excellent duty performance, and limitations related to headaches were not mentioned in the commander’s statement. The CI did not complain of headaches during clinic encounters, including clinic encounters for refill of his migraine medications. At the time of the VA C&P evaluation, the CI reported no missed days of work due to the claimed conditions. The Board concluded there was no evidence that the CI’s long history of migraine headaches interfered with performance of duty. At the time of the FPEB, the CI did not contend his migraine headaches interfered with performance of duty and should be considered by the PEB. There was no evidence for concluding that the status post ablation left leg vein with residual scars, hypertension, or migraine headache conditions interfered with duty performance to a degree that could be argued as unfitting. The commander’s letter mentions no duty limitations other than those from the left leg pain with activity. Only migraine headaches were profiled, however that was limited to the initial evaluation and treatment, seven years prior to separation; the profile was removed once adequate control was achieved. The Board notes that at the VA C&P exam, the CI stated that he had missed no days of work the previous year secondary to the conditions under evaluation, which include those addressed above. The Board determined therefore that ablation of the left leg vein, hypertension, and migraine headache conditions were not subject to service disability rating as separate unfitting conditions.

The contended right kidney cortical atrophy with compensatory left kidney hypertrophy, aortic valve insufficiency and regurgitation, mitral valve regurgitation, and transient ischemic attacks were not addressed by the PEB and were not in the DES file. Although the Board has limited its scope to conditions contained in the DES file, these conditions are summarized below.

Right kidney cortical atrophy with compensatory left kidney hypertrophy. Right kidney atrophy with compensatory left kidney hypertrophy was discovered incidentally during evaluation of the left leg post phlebitic condition in January 2008. The specific cause of the right kidney atrophy was not apparent (thought to be prior injury), but no current active disease process was identified. The presence of compensatory left kidney hypertrophy indicated the right condition had been present for several years. Renal function tests from 1997 until separation consistently showed a normal serum creatinine and a blood urea nitrogen which varied from high normal to slightly elevated, but without a trend over the 12 years of values. Several urinalyses were free of protein. The evidence does not support renal function impairment or related impairment interfering with performance of duties or otherwise disqualifying for continued military service.

Aortic and mitral regurgitation. In 2002, the CI had a routine ECG which showed an incomplete right bundle branch block; a chest X-ray showed an increased cardiac silhouette. An echocardiogram, January 2003, revealed mild to moderate aortic valve insufficiency and trivial pulmonic valve insufficiency. Cardiac function was normal and an exercise stress test was normal. Five years later, August 2008, repeat echocardiogram demonstrated moderate aortic valve insufficiency ad mild mitral valve regurgitation, with normal heart function and normal chamber sizes. The aortic valve was determined to be bicuspid (an abnormal condition due to the fusion of two of the three leaflets; typically, this is congenital). The cardiologist recommended periodic follow up, but placed no activity limitations. Neither the aortic insufficiency nor the mitral regurgitation contributed to any duty impairment and were not otherwise disqualifying for continued military service.

TIAs. On 25 August 2009, after evaluation in the DES was concluded and two months prior to separation, the CI was seen in the emergency room (ER) for a several minute spell at home in which he was minimally responsive before fully recovering. His exam was unremarkable that night and again at a follow-up appointment two days later. A CT of the brain was notable only for moderate prominence of some of the superior posterior sulci which was thought to be of “doubtful significance.” He had another episode one month later, this time of left arm numbness and aphasia. Again, he had a normal exam and complete recovery. No definitive diagnosis was made at the time of separation. The Board notes that this was not mentioned in the exam ten days prior to separation, and that the neurologic and cardiac examination was normal. The VA also noted a normal neurological and cardiac exam other than a short diastolic murmur (expected with the aortic insufficiency). The Board also noted that the CI had several episodes of lightheadedness over a three year period starting in 1998 for which no etiology was found but were thought to be due to high blood pressure or migraine headaches. In the absence of impairment or clear diagnosis, the Board finds no evidence to support finding these two episodes unfitting.

By policy and precedent the Board has limited its jurisdiction for recommending unadjudicated conditions as unfitting and subject to additional separation rating to those conditions which are evidenced in the core DES file. The core DES file consists of the MEB referral document (AF IMT Form 618), the PEB adjudication document (AF Form 356), the NARSUM (including any addendums or referenced examinations), the commander’s statement, the physical profile(s), and any written appeals or DES correspondence. Contended conditions which are not eligible for Board recommendations on this basis remain eligible for submission to the Air Force Board for Corrections of Military Records (AFBCMR). Even if their presence in the DES file were conceded, there was no evidence for concluding that any of them interfered with duty performance to a degree that could be argued as unfitting.

Remaining Conditions. The only condition identified in the DES file not already discussed was hyperlipidemia. This is a laboratory finding and neither ratable nor compensable. 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 DVT with chronic left leg pain condition and IAW VASRD §4.104, the Board unanimously recommends no change in the PEB adjudication. In the matter of the right kidney cortical atrophy with compensatory left kidney hypertrophy, aortic valve insufficiency and regurgitation, mitral valve regurgitation, hypertension, transient ischemic attacks, status post ablation left leg with residual scars and migraine headache conditions, the Board unanimously agrees that it cannot recommend a finding 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** |
| DVT with Chronic Left Leg Pain | 7121 | 10% |
| **COMBINED** | **10%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20100630, w/atchs

Exhibit B. Service Treatment Record

Exhibit C. Department of Veterans Affairs Treatment Record

 President

 Physical Disability Board of Review

SAF/MRB

1500 West Perimeter Road, Suite 3700

Joint Base Andrews MD 20762

 Reference your application submitted under the provisions of DoDI 6040.44 (Title 10 U.S.C. §  1554a), PDBR Case Number PD-2010-00863

 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 appropriate. Accordingly, the Board recommended no re-characterization or modification of your separation with severance pay.

 I have carefully reviewed the evidence of record and the recommendation of the Board. I concur with that finding and their conclusion that re-characterization of your separation is not warranted. Accordingly, I accept their recommendation that your application be denied.

 Sincerely,

Director

Air Force Review Boards Agency

Attachment:

Record of Proceedings