RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: xxxxxxxxx BRANCH OF SERVICE: air force

CASE NUMBER: PD1001182 SEPARATION DATE: 20051114

BOARD DATE: 20120207

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty SRA/E-4 (4T051, Medical Laboratory Journeyman), medically separated for reflex sympathetic dystrophy (RSD) associated with depression. He did not respond adequately to treatment and was unable to perform within his Air Force Specialty (AFS) or meet physical fitness standards. He was issued a permanent U2/L4 profile and underwent a Medical Evaluation Board (MEB). Depression and pain disorder, RSD and gastro-esophageal reflux disease (GERD) were 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 reflex sympathetic dystrophy (pain disorder) associated with depression condition as unfitting, rated at 10%. The PEB also adjudicated four category II conditions (conditions that can be unfitting, but are not currently compensable or ratable) and two category III conditions (conditions that are not separately unfitting and not compensable or ratable) as charted below. The CI made no appeals and was medically separated with a 10% combined disability rating.

CI CONTENTION: The CI stated: “Discrepancy between Air Force Disability Rating and VA Disability Rating, dated 03MAY2007.”

RATING COMPARISON:

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| --- | --- |
| **Service IPEB – Dated 20050928** | **VA Gen. (1 Mo. After Separation) – All Effective Date 20051115****VA Psych (12 Mo. After Separation) – Effective Date 20051115** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Reflex Sympathetic Dystrophy (Pain Disorder) Associated with Depression | 8599-8520 | 10% | Complex Pain Syndrome, Right Leg | 8520 | 10% | 20051205 |
| Depression and Anxiety | 9434 | 30% | 20060119 |
| Chondromalacia | 5299-5003 | CAT II | Right Knee Torn Meniscus | 5261 | 20% | 20051205 |
| GERD | 7399-7346 | GERD | 7346 | 0% | 20051205 |
| Headaches | 8199-8100 | Migraine Headaches | 8100 | 30% | 20051205 |
| Seasonal Allergic Rhinitis (SAR) | 6522 | NO VA ENTRY |
| Obesity  | CAT III | NO VA ENTRY |
| Narcotic Dependence | NO VA ENTRY |
| ↓No Additional MEB/PEB Entries↓ | Fibromyalgia | 5025 | 40% | 20051205 |
| Intervertebral Disk Syndrome w spinal stenosis | 5238 | 40% | 20051205 |
| **Combined: 10%** | **Combined: 90%** |

ANALYSIS SUMMARY: The Disability Evaluation System (DES) is responsible for maintaining a fit and vital fighting force. 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. However, the Department of Veterans’ Affairs (DVA), operating under a different set of laws (Title 38, United States Code), 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 the degree of impairment vary over time.

Reflex Sympathetic Dystrophy (Pain Disorder) Associated with Depression: The CI initially presented with a four day history of right knee pain after he felt a “pop” while climbing stairs 11 May 2003. He was treated conservatively for a possible lateral meniscal tear and retinacular strain. At a physical therapy (PT) evaluation one month later, he was noted to have injured the same knee ten years earlier at which time a large bruise was present. The therapist also documented that the CI was walking up the stairs and heard an audible “pop” without any twisting. Despite PT, activity modification and medications, his pain persisted. Imaging, including multiple radiographs and MRI, was essentially normal other than increased signal in both menisci without evidence of tear. He re-injured his knee while running in August 2003 and again in November 2003. On 21 January 2004 a diagnostic and therapeutic arthroscopy revealed a small central tear of the medial meniscus and plica along the medial femoral condyle, both of which were repaired during the arthroscopy. At his two week post-operative check, he was released to full activities as tolerated. Three weeks later, while doing push-ups, he noted a pop in the right knee. On exam, he had limited range-of-motion (ROM) due to pain and was given a knee immobilizer. No swelling was noted and imaging was normal. At a follow-up orthopedic exam, one week later, he was found to have a moderate effusion and medial joint line tenderness, but otherwise a normal post-procedure exam other than poor tone of his quadriceps bilaterally. In April 2004, he was seen after a hyper-extension injury. At that visit he complained of decreased sensation of the right lower extremity (RLE) in a stocking distribution. A repeat MRI showed the post-surgical truncation of the medial meniscus, but was otherwise unremarkable. A neurological evaluation (4 May 2004) noted the sensory allodynia (pain to a stimulus that does not normally cause pain) without motor changes. A bone scan 12 July 2004 was significant only for increased uptake at the right knee consistent with the prior surgery but did not show blood flow changes associated with reflex sympathetic dystrophy (RSD). A follow-up orthopedic exam documented non-anatomic pain, but an otherwise normal exam with full ROM, ligamentous stability, intact menisci and no effusion. He was diagnosed with reflex sympathetic dystrophy (RSD). Subsequently, in September 2004 he reported pain in all four extremities and the back; the pain was described as “burning” and was present constantly, but aggravated by temperature change and light touch. He also complained of “blacking out” secondary to the pain. He was seen again in neurology on 3 November 2004. A normal neurological exam was documented other than some limitation in motor testing thought to be secondary to pain. The CI also complained of daily headaches which were thought to be both tension and cluster headaches. Nerve conduction velocity/electromyogram (NCV/EMG) testing was normal other than mild fasciculation of the vastus lateralis. The NCV was done for all four extremities whereas the EMG only for the affected RLE. Trials of different medications provided partial relief, but analgesia had to be balanced against sedation. Relief was obtained with Toradol and narcotics, including Morphine. The CI was referred to a pain center where spinal blocks provided some relief. He had also had some relief from hypnosis previously. A repeat three phase bone scan June 2005, to evaluate for the presence of RSD was again negative. The final neurology evaluation in service, two months prior to separation, noted the RSD was a questionable diagnosis. Although the initial post-operative right lower leg symptoms were compatible with the condition, the absence of objective findings after prolonged symptoms and the generalized symptoms were not consistent with the condition. The neurologist opined that fibromyalgia may be a more appropriate diagnosis based on the presence of diffuse pain that was not consistent with RSD. However tender points characteristic of fibromyalgia were not documented at this exam and other examinations documented tenderness in areas that are not consistent with the diagnosis. The psychiatry examiner noted psychological factors contributing to the pain complaints and listed a diagnosis of pain disorder on Axis I of the five axis psychiatric diagnoses. The MEB narrative summary was undated, but refers to a pain management note which was dated 16 June 2005 and most likely accomplished between this exam and the MEB on 14 September 2005. It noted bilateral quadriceps and hamstring atrophy, central obesity and limited flexibility, but without effusion, edema or ecchymoses. Passive ROM, deep tendon reflexes (DTRs) and sensory exams were normal.

The VA Compensation and Pension (C&P) exam was on 5 December 2005, three weeks after separation. It noted that the CI had been treated for RSD with changes in hair and nail growth, but that had then been diagnosed with fibromyalgia for “severe and disseminated arthralgias and myalgias.” The CI reported that he was only working 20 hours a week, napping three to four hours a day and suffered from poor sleep, GERD, headaches and depression. He noted constant cephalgia with exacerbations several times a week lasting six to eight hours. He estimated that he had lost 60 days from work over the previous 12 months. On exam, he was noted to have an antalgic gait and to use a cane which he held with the right hand. Examination of the lower extremities showed no abnormal findings such as dependant edema, varicosities or stasis changes. No specific comment was made regarding hair or nail loss. He was noted to be “clearly in pain with every motion.” He had “tenderness in multiple sites over the upper and lower thorax, arms, forearms, thighs and calves as well as over the skull.” ROM of the neck was full with “obvious pain in all planes.” Painful motion was noted for the back, shoulders, hips, knees and ankles. DTRs were normal as was the motor exam. Sensory exam showed painful dysethesia of all extremities. No abnormal wear of the shoes was seen. No muscle atrophy was documented. Imaging of the right knee was normal (without bone changes associated with chronic RSD). Although remote from the time of separation, the Board notes that at a follow-up exam on 6 January 2010 for fibromyalgia, accomplished by a surgeon, he was again noted to use a cane with an antalgic gait. However, no muscle atrophy was present and both strength and tone were normal. DTRs were normal as was the sensory examination.

The PEB and VA both rated the RSD condition at 10%. The PEB coded it 8599-8520; the VA coded it 8520 (and used the most current terminology for the condition, complex regional pain syndrome). The VA also awarded a 40% disability rating for fibromyalgia, coded 5025, and attributed most of the symptoms to it which the PEB had considered under the RSD. The Board notes that the diagnosis of fibromyalgia was based on a single neurology note two months prior to separation which stated “fibromyalgia is a more appropriate diagnosis.” While the neurologist opined this diagnosis was more appropriate than RSD because of a complaint of diffuse pain, there was tenderness diffusely in locations not typical for fibromyalgia. Furthermore, he lacked other key features of FMS, and his excellent duty performance also argued against significant associated symptoms of the condition.

The Board then considered the PEB adjudication of a 10% disability rating for RSD. The Board noted that the commander had restricted his duties to preclude prolonged standing and that his work schedule was condensed to 0800-1600 to allow for transport to and from work. Nonetheless, the CI worked a full shift. It noted that he had been placed on quarters twice for a total of 96 hours in the previous 12 months. The Board considered the severity of the subjective complaints and noted the paucity of objective findings: absence of skin findings, normal imaging and NCV/EMG, absence of abnormal wear of shoes, absence of muscle atrophy on both VA exams including one almost five years after separation, and normal DTRs. The limitations in ROM and motor function were both attributed to pain. The Board considered the inconsistencies between the histories provided to the VA with the service treatment record. The Board also noted the laudatory enlisted performance report for the one year period ending 23 October 2005, three weeks before separation. Although restricted to sedentary activities the CI received highest marks in all categories with a recommendation for immediate promotion. All evidence considered, there is not reasonable doubt in the CI’s favor supporting re-characterization of the PEB fitness adjudication.

Depression (and anxiety). The PEB adjudicated the depression condition as associated with RSD, but did not rate the conditions separately. The Board, therefore, considered if the depression was a separately unfitting condition. The CI initially presented to life skills clinic on 13 September 2004 feeling “overwhelmed and helpless” from his pain. He was noted to have depression and anxiety. An MPI (multi-dimensional pain inventory) noted that he had a dysfunctional coping style in managing his pain. He was taught pain management techniques with fair success and stopped attending treatment sessions in late 2004, leading to disenrollment in January 2005. The MEB psychiatric evaluation on 24 August 2005 noted that he had a significant improvement in his mood and that he denied depression or neuro-vegetative signs. He was thought to have to have had a major depressive disorder, in partial remission, and was assigned a S3 profile. A Global Assessment of Function (GAF) score of 75 was assigned, consistent with either transient symptoms or slight impairment of function. No further treatment in mental health was deemed necessary. At his next profile on 21 September 2005, he was noted to be S1 and only profiled for his physical limitations. The performance report which closed out 23 October 2005, three weeks prior to separation, recommended promotion ahead of his peers and described him as an “elite airman” and “top performer.” The Board acknowledges that the CI was still on medications for the chronic pain issues, some of which are also used for depression, and makes note of the significant problems he had from his depression four years after separation. However, the evidence does not support a contention of significant duty impairment from his mental health issues at the time of separation. Rather, the record reflects superior duty performance despite the presence of depression and generalized pain disorder. The VA C&P examination is neither consistent with the degree of symptomatology documented by the MEB examiner nor the work performance seen by his supervisors. Although not a diagnosis referred to the PEB, the Board discussed the possible diagnosis of fibromyalgia and the generalized symptoms. The Board concluded the generalized symptoms were appropriately included and considered with the depression and pain disorder diagnoses on the Axis I diagnosis. All evidence considered, there is not reasonable doubt in the CI’s favor supporting the addition of depression as a separately unfitting condition.

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Other PEB Conditions. The other conditions forwarded by the MEB and adjudicated as not unfitting by the PEB were the following: chondromalacia, gastroesophageal reflux disease (GERD), seasonal allergic rhinitis (SAR), headaches, obesity, and narcotic dependence. With the exception of the chondromalacia condition, these conditions were not profiled, implicated in the commander’s statement or noted as failing retention standards.

Right Knee Chondromalacia Condition. The PEB adjudicated this as a category II condition. The CI had a successful debridement of plica and the anterior medial meniscus of the right knee in early 2004. The CI reinjured the knee several times, but responded well to conservative management. The Board notes that the CI had an antalgic gait and utilized a cane. However, these findings have already been attributed to the RSD condition and utilized in its rating and cannot be used for a separate condition IAW VASRD §4.14 (avoidance of pyramiding). While the CI was seen on a regular basis for the chronic pain from the RSD, the last visit for the right knee independent of the RSD was over one year prior to separation. An orthopedic exam was normal. There was no effusion or erythema, range of motion full, focal tenderness absent (but with global pain over the knee to movement), ligaments were stable and McMurray negative. Imaging including plain films, MRI and bone scan was significant only for expected post-operative changes. The MEB exam noted normal range of motion.

GERD. The Board notes that the CI was diagnosed with GERD one year prior to separation. Two months prior to separation, he presented for evaluation of a possible gastrointestinal bleed. Colonoscopy and esophageal gastro-duodenoscopy were unremarkable except for mild duodenitis. He was advised to continue his medications; no duty restrictions were given.

SAR. SAR was noted on the MEB summary, but was not found elsewhere in the medical record. There is no evidence of duty impairment from or even medical care for this condition.

Headaches. The CI was given diagnoses of occipital neuralgia, tension headaches, migraines and cluster headaches during various visits. There is no record of the CI leaving work secondary to a headache. He was seen in the emergency room twice. The second time was during duty hours and he was sent home on 24 hour quarters. This is the only instance documented in which he was placed on quarters for headaches in the 12 months prior to separation. The different treatment notes address different medical management options for a chronic problem. While the record supports a chronic problem from headaches, it does not support significant duty impairment or time away from work, even for medical management.

Obesity and narcotic dependence. These were rated as category III conditions which are not separately unfitting nor compensable or ratable conditions IAW both DoDI and VA regulations. Therefore, there is no basis for further consideration.

All conditions were reviewed by the action officer and considered by the Board. There was no indication from the record that any of these conditions significantly interfered with satisfactory duty performance to a degree which could be considered unfitting. All evidence considered, there is not reasonable doubt in the CI’s favor supporting re-characterization of the PEB fitness adjudication for any of the stated conditions.

Remaining Conditions. Other conditions identified in the DES file were herniated discs and spinal stenosis. The Board notes that the CI was placed on quarters for back pain one time for 24 hours in the year prior to separation. A MRI showed minimal disc bulging at L3-4, L4-5, and L5-S1. There were no radicular symptoms. This degree of disc degeneration is not uncommon finding in the age group of the CI and correlates poorly with back pain. The spinal stenosis at L3-4 was noted to be congenital. Several additional non-acute conditions or medical complaints were also documented. None of these conditions were clinically or occupationally significant during the MEB period, none carried attached profiles, and none were implicated in the commander’s statement. 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. No additional conditions were noted in the VA proximal to separation, other than what has already been discussed above. 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 RSD condition and IAW VASRD §4.124, the Board unanimously recommends no change in the PEB adjudication. In the matter of the depression condition the Board unanimously recommends no change in the PEB adjudication. In the matter of the right knee, GERD, SAR, headaches, obesity, narcotic dependence, back conditions, or any other medical conditions eligible for Board consideration, 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** |
| RSD with Depression | 8599-8520 | 10% |
| **COMBINED** | **10%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20101018, w/atchs

Exhibit B. Service Treatment Record

Exhibit C. Department of Veterans Affairs Treatment Record

 xxxxxxxxxx

 President

 Physical Disability Board of Review

SAF/MRB

1500 West Perimeter Road, Suite 3700

Joint Base Andrews MD 20762

Dear XXXXXXXX:

 Reference your application submitted under the provisions of DoDI 6040.44 (Title 10 U.S.C. §  1554a), PDBR Case Number PD-2010-01182

 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