RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: Army

CASE NUMBER: PD1001230 SEPARATION DATE: 20060817

BOARD DATE: 20120319

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was a National Guard Specialist (E-4) (21B10/Combat Engineer), medically separated for conversion disorder, manifesting as weakness, numbness and loss of function of the right leg. He was unable to perform within his Military Occupational Specialty (MOS) or meet physical fitness standards. He was issued a permanent profile and underwent a Medical Evaluation Board (MEB). Weakness, numbness, loss of function, right leg, attributed to compartment syndrome was forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW AR 40-501. Two other conditions, as identified in the rating chart below, were forwarded on the MEB submission as medically acceptable conditions. The PEB adjudicated the conversion disorder as unfitting, rated 10%, with application of the Veterans’ Administration Schedule for Rating Disabilities (VASRD). The CI appealed to the Formal PEB (FPEB), followed by a USAPDA review, and was then medically separated with a 10% disability rating.

CI CONTENTION: “Rated 10% for Conversion Disorder by the Army, given medical discharge. Not rated for PTSD but was diagnosed with and treated for PTSD while at Walter Reed Army Medical Center. I am currently rated at 100% for PTSD by the VBA, 20 % for Compartment Syndrome, and 30 % for Migraines, 40% TBI.”

RATING COMPARISON:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Service USAPDA Review – Dated 20060717** | | | **VA (6 Mo. After Separation) – All Effective 20060818** | | | |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Conversion D/O | 9424 | 10% | PTSD (claimed as Sleep D/O) | 9411 | 50% | 20070109 |
| Rt Leg Compartment Syndrome S/P Fasciotomy | Not Unfitting | | Rt Lower Extremity Compartment Syndrome S/P Fasciotomy) | 5399-5311 | 10% | 20070112 |
| Low back pain | Not Unfitting | | Facet Degenerative Changes of  L-Spine (Chronic Back Pain) | 5242 | 0% | 20070112 |
| Leishmaniasis, resolved | Not Unfitting | | Cutaneous Leishmaniasis | 7808-7806 | 0% | 20070112 |
| ↓No Additional MEB/PEB Entries↓ | | | Not Service Connected x 1 | | | 20070112 |
| **Combined: 10%** | | | **Combined: 60%** | | | |

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, and not based on possible future worsening. However the Department of Veterans' Affairs (DVA), operating under a different set of laws (Title 38, United States Code), is empowered to compensate all service-connected conditions without regard to fitness for military duties 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.

Conversion Disorder. Conversion disorder was diagnosed in March 2006 due to persisting right lower leg pain and weakness that was not completely explained by thorough medical evaluation. Right leg symptoms began in January 2005 while the CI was in Germany awaiting medical evacuation to the United States for an unrelated problem, cutaneous leishmaniasis. The CI was deployed to Iraq in March 2004. The service treatment record (STR) shows the CI sought care on 6 December 2004 for unusual skin lesions that had been present for three weeks. He was medically evacuated from Iraq on 31 December 2004 for treatment of cutaneous leishmaniasis. The STR prior to this time are silent with regard to right leg injury or complaint. Aeromedical evacuation progress notes document the first complaint of right leg pain on 8 January 2005. On 9 January 2005, there was swelling and pain of the right anterior lower leg and the CI was evaluated in the emergency department. Ultrasound imaging failed to show deep vein thrombosis, initially suspected due to the absence of trauma and recent air travel. The clinical concern for compartment syndrome prompted surgical compartment release (fasciotomy) 9 January 2005. Completion of surgical treatment was accomplished at Walter Reed Medical Center on 12 January 2005 (irrigation, debridement and closure) with unremarkable post-operative healing of the surgical wounds. Following discharge from the hospital, the CI was treated with physical therapy but reported persisting right leg pain and weakness that prevented return to duty. He did not exhibit the expected improvement, reported pain that comes and goes with walking long distances, and continued to wear a brace (cam walker) and use a cane for ambulation. Physical examination demonstrated variable levels of right lower leg weakness, and variable sensory examinations. Magnetic resonance imaging (MRI) of the right lower leg on 21 July 2005 was normal. Electrodiagnostic testing in August 2005 demonstrated normal sensory and motor nerve conduction and “minimal”, “nonspecific” changes on electromyogram needle examination. Although an ultrasound examination by physical medicine suggested some differences in the lower leg muscle compared to the left side, the recent MRI was normal, and a follow up ultrasound was also normal showing only slight changes suggestive of edema. Further evaluation for lumbar spine nerve root impingement as a cause was negative (MRI and spine surgery evaluation May and June 2005 respectively). A pain clinic evaluation on 18 October 2005 documented absence of clinical signs of complex regional pain syndrome. The orthopedic MEB narrative summary (NARSUM) dated 13 January 2006, one year after surgery, recorded persisting pain and weakness of the right lower leg. The CI wore a cam walker and walked with a cane. On physical examination, there was no active movement of the ankle or toes when the CI was asked to move them. There was markedly diminished sensation reported in response to pinprick of the entire right ankle and foot. There was no visible atrophy, and the measured calf circumference was equal in both calves. Passive motion of the ankle was normal and the Achilles reflex was intact and normal, producing plantar flexion at the ankle. The orthopedic surgeon noted the weakness and sensory loss exhibited by the CI was not consistent with the expected severity based on the known pathology (status post fasciotomy with uncomplicated healing) normal MRI, unremarkable EMG and NCV, and findings of an intact Achilles reflex and absence of muscle atrophy. The PEB requested a psychiatry examination, performed March 2006, that concluded with a diagnosis of conversion disorder. The psychiatry NARSUM dated 28 March 2006 recorded that the CI endorsed anxiety about his experiences in Iraq and stated he could not go back because of the fear of being hurt or dying. The CI endorsed handling dead body parts during clean up sweeps, and claimed he witnessed a vehicle in front of his convoy that was hit by an IED (no injuries / deaths) as well as witnessing an IED/RPG causing injuries to fellow soldiers. The CI endorsed feelings of intense fear because he was near these incidents as well as current mild intermittent nightmares, avoidance of trash and parts of roads, and continued startle response. However, the CI did not endorse any feelings of detachment or feelings of numbness, and stated that these symptoms had not affected him enough to be an issue of concern (thus a posttraumatic stress disorder (PTSD) diagnosis was not rendered). The CI denied signs or symptoms of depression, mania, psychosis, illicit substance use, alcohol misuse, and panic attacks. On mental status examination (MSE), the CI’s mood was serious but euthymic with congruent affect. Psychomotor activity was normal with normal speech. Thought processes were normal without hallucination, delusion, or suicidal or homicidal ideation. Memory, concentration and cognition were intact. Judgment was intact while insight was recorded as limited. The psychiatrist documented that the CI was performing sedentary administrative duties for the prior one year without difficulty, missing work only for medical appointments. He recorded that the CI stated his illness had no impact on his duties and responsibilities because there was no prolonged standing or walking involved. The psychiatrist concluded the CI was fully capable of working full time in a civilian employment position that did not require prolonged standing or walking. The reported traumatic stressors recorded in the psychiatry NARSUM are not reported elsewhere in the record; however, the CI was deployed to a combat zone as a combat engineer. The CI completed a post deployment health assessment (PDHA) on 3 February 2005. He checked “no” in response to question seven regarding seeing anyone wounded, killed or dead during the deployment (coalition, enemy or civilian). He checked “no” in response to question eight regarding being in direct combat. The CI checked “yes” to question nine, feeling in great danger while deployed. The CI checked “no” to question 17 regarding whether he was in, entered or closely inspected any destroyed military vehicles. The CI checked “no” to question 12 regarding whether he had any experience that were so frightening, horrible, or upsetting, that in the prior month he had had nightmares, unwanted thoughts about it, avoidance of reminders, was hypervigilant, experienced an exaggerated startle response, felt numb or felt detached from others, activities, or surroundings. He also checked “no” to questions regarding presence of thoughts or concerns about having serious conflicts, loss of control, depressed mood, suicidal thoughts, headaches or tinnitus. At the time of the MEB history and physical examination on 13 December 2005, the CI completed DD Form 2807 and checked “no” to question 17 regarding presence of nervous trouble of any sort (anxiety or panic attacks), loss of memory or amnesia or neurological symptoms, frequent trouble sleeping, depression, or excessive worry. The CI discharge certificate does not show receipt of a Purple Heart or Combat Action Badge (the Combat Action Badge requires presence in combat with satisfactory performance of duties and does not require that the soldier returned fire).

The PEB found the CI unfit due to conversion disorder rated 10%. The FPEB upheld the findings of the PEB. The CI appealed to the USAPDA for reconsideration and contended his right leg condition was not a mental condition but a real medical condition. The findings of the FPEB were upheld on reconsideration. Following the FPEB, the CI presented to the mental health clinic and was diagnosed with posttraumatic stress disorder (PTSD), delayed onset, stemming from feeling responsible for causing an accident in which another vehicle was hit with a rocket propelled grenade. The Board next addressed whether the tenant of §4.129 (mental disorders due to traumatic stress) was applicable. IAW VASRD §4.129, when a mental disorder that develops in service as a result of a highly stressful event is severe enough to bring about the CI’s release from active military service, the rating agency should assign an initial evaluation of not less than 50%. The subsequent permanent rating should be based on the CI’s functioning six months following separation. While examiners may have readily accepted an account of a stressor given in the setting of an evaluation, the actual existence of a stressor is a factual determination that must be based on a review of the entire record. Clinicians routinely accept and report statements of history given by patients, ordinarily without efforts at independent verification, and with scant ability by the examiner to objectively confirm events. Thus the clinician is in the role of a conduit of information that does not involve the application of actual medical expertise. Unless the clinician was present at that time, he or she cannot assume the role of witness to past events advanced as stressors, or validate symptoms and severity. The Board noted that although the CI later reported combat stressors and combat wounds from IED blasts, there is no primary documentary evidence of combat, no combat awards, and no references to combat injuries in medical documentation contemporaneous to his deployment and medical evacuation from the theater of operations. There was no “highly stressful event” for which provisions of §4.129 would apply. The Board concludes therefore that the application of §4.129 is not appropriate to this case, and will premise its rating recommendation on the psychiatric acuity at separation.

The Board concluded that leg weakness and pain with use was the occupationally limiting condition and noted that any psychological symptoms (e.g. anxiety) that were present did not interfere with occupational or social functioning. Board members agreed that the 10% rating adjudicated by the PEB was consistent with the §4.130 rating criteria.

The Board also considered alternatively rating the condition as residuals of fasciotomy under VASRD codes for muscle or peripheral nerve conditions but did not conclude a rating higher than 10% was warranted based on objective evidence of the medical condition. The pattern of manual muscle strength testing was highly variable ranging from complete paralysis to milder weakness graded 4/5 in the same month. The VA Compensation and Pension (C&P) examination on 9 January 2007, four months after separation, recorded strength at 4/5, while an examination three weeks later recorded strength as 1/5. The weakness was not consistent with the objectively documented pathology, MRI, and EMG results. There were non-organic exam findings indicating the CI was not making a voluntary effort during examination. The absence of atrophy documented by physical therapy and orthopedic surgery examiners ten months to a year after surgery is also inconsistent with the degree of weakness and inconsistent with disuse regardless of cause. Rather, the absence of atrophy and presence of symmetric leg circumferences documented indicates use of the right leg to a similar level as the left leg. The normal ankle passive range-of-motion (ROM) is also unexpected after a period of immobility of ten months. After due deliberation in consideration of the totality of the evidence, the Board does not find adequate reasonable doubt in the CI’s favor for recommending a change from the PEB adjudication for the right leg weakness condition diagnosed as conversion disorder.

Other PEB Conditions. The other conditions forwarded by the MEB and adjudicated as not unfitting by the PEB were low back pain, and leishmaniasis, resolved. The CI incurred a low back strain in a motor vehicle crash in November 2004 while home on leave. The orthopedic surgeon noted intermittent back spasms from time to time and concluded the condition was medically acceptable for continued military service. The cutaneous leishmaniasis was treated and resolved. Compartment syndrome, as initially referred by the MEB was considered by the Board under the discussion of conversion disorder and is subsumed under the rating for conversion disorder. All 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 performance of MOS duty requirements. 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. The CI’s application asserts that compensable ratings should be considered for PTSD, migraines, and traumatic brain injury (TBI). Following separation, the CI filed a claim with the VA for PTSD and TBI. These conditions were not noted in the NARSUM, identified by the CI on the MEB physical or found elsewhere 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. However, PTSD was considered by the Board above with conversion disorder. There was no evidence prior to separation that any of the PTSD symptoms that were present interfered with performance of duties separate from the conversion disorder. Following separation, the CI claimed TBI due to two IED blast injuries with loss of consciousness and retrograde amnesia. He also reported his vehicle was hit by an IED and he was hurled around the vehicle and caught his leg under some equipment. These incidents could not be corroborated in the STR. The STR shows no care for, or reference to injuries incurred while deployed to Iraq. The CI completed a PDHA on 3 February 2005 and makes no mention of head injury and checked “no” to headaches. At the time of the MEB history and physical examination on 13 December 2005, the CI completed DD Form 2807 and checked “no” to question 15, regarding any history of head injury, periods of unconsciousness, concussion, dizziness, fainting spells, frequent or severe headaches, memory loss, or amnesia. The CI also reported a shrapnel injury to his back by an IED. Although DA Form 2173 completed on 28 January 2005 reported that during a controlled detonation on 8 May 2004, shrapnel hit his lower back, there are no contemporaneous records showing care for any injury. The STR and MEB history and physical examination documented the presence of skin lesions on the back due to medical causes but no scars or history of shrapnel injury. Although the CI lists PTSD, TBI and headaches on his application, even if their presence in the DES file is conceded, there was no evidence for concluding that any of them interfered with duty performance to a degree that could be argued as unfitting. 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 conversion disorder condition manifesting as right leg pain, numbness and weakness, IAW VASRD §4.130, the Board unanimously recommends no change in the PEB adjudication at separation. In the matter of low back pain, leishmaniasis resolved, 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. In the matter of contended PTSD, TBI, and headaches, 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** |
| Conversion Disorder | 9424 | 10% |
| **COMBINED** | **10%** |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20101104, w/atchs

Exhibit B. Service Treatment Record

Exhibit C. Department of Veterans' Affairs Treatment Record

President

Physical Disability Board of Review

SFMR-RB

MEMORANDUM FOR Commander, US Army Physical Disability Agency

SUBJECT: Department of Defense Physical Disability Board of Review Recommendation

I have reviewed the enclosed Department of Defense Physical Disability Board of Review (DoD PDBR) recommendation and record of proceedings pertaining to the subject individual. Under the authority of Title 10, United States Code, section 1554a, I accept the Board’s recommendation and hereby deny the individual’s application.

This decision is final. The individual concerned, counsel (if any), and any Members of Congress who have shown interest in this application have been notified of this decision by mail.

BY ORDER OF THE SECRETARY OF THE ARMY:

Encl

Deputy Assistant Secretary

(Army Review Boards)