RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: Army

CASE NUMBER: PD1100277 SEPARATION DATE: 20051101

BOARD DATE: 20120117

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty Staff Sergeant / E-6 (13M3, Multiple Launch Rocket System Crewmember), medically separated for chronic pericarditis with exercise limiting chest pain. The CI had symptoms of palpitations and exertional dyspnea while in Iraq; however, he did not seek medical attention until he returned to Germany. The CI was found to be in atrial fibrillation with rapid ventricular response, underwent a transesophageal cardioversion and was transferred to Landstuhl Regional Medical Center (LRMC) for further management. The CI was diagnosed with post-viral cardiomyopathy with atrial fibrillation with moderate left ventricular function and was treated with aggressive medical management. Despite cardiac treatment, the CI continued to experience sharp stabbing chest pain with exercise which was determined to be likely related to the chronic pericarditis. The cardiac condition limited the CI’s ability to perform within his Military Occupational Specialty (MOS) or meet physical fitness standards and he was issued a permanent P3 H2 profile and underwent a Medical Evaluation Board (MEB). The MEB forwarded “status post (s/p) acute myopericarditis currently with normal ejection fraction (EF) on Medical Therapy New York Heart Association (NYHA), history of paroxysmal atrial fibrillation (PAF) medical controlled and chronic serous pericarditis” on a DA Form 3947 to the Physical Evaluation Board (PEB) as medically unacceptable IAW AR 40-501. Other conditions included in the Disability Evaluation System (DES) packet will be discussed below. The PEB adjudicated the “chronic pericarditis with exercise limiting chest pain secondary to acute viral myopericarditis” condition as unfitting, rated 0%, with application of the Department of Defense Instruction (DoDI) 1332.39). The CI made no appeals, and was medically separated with a 0% combined disability rating.

CI CONTENTION: The CI states: “Condition was and became much more severe than initially rated. As well as a PTSD rating was not included in my evaluation even though I was on PTSD medication when discharged for the service.” He additionally lists all of his VA conditions and ratings as per the rating chart below. A contention for their inclusion in the separation rating is therefore implied.

RATING COMPARISON:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Service IPEB – Dated 20050829** | | | **VA (3 Mos. Pre-Separation) – Effective Date 20051207** | | | |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Chronic Pericarditis with Exercise Limiting Chest Pain Secondary to Acute Viral Myopericarditis Chronic Serous Pericarditis | 7002 | 0% | Post-viral Cardiomyopathy w/Recurring Atrial Fibrillation | 7099-7020 | 10%\* | 20050802 |
| History of Paroxysmal Atrial Fibrillation Medically Controlled | Not Unfitting | |
| ↓No Additional MEB/PEB Entries↓ | | | PTSD | 9411 | 30%\*\* | STR |
| 0% x 0/Not Service Connected x 2 | | |  |
| **Combined: 0%** | | | **Combined: 40%\*\*\*** | | | |

\*Post-viral Cardiomyopathy w/Recurring Atrial Fibrillation increased to 30% effective 20060629 based on treatment records. \*\*PTSD added at 30% effective 20060629 and increased to 50% effective 20091119. \*\*\*Combined rating increased to 50% effective 20060629 and 80% effective 20091119.

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ANALYSIS SUMMARY: The Board acknowledges the CI’s contention that suggests Service ratings should have been conferred for other conditions documented at the time of separation. 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. 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 all Service connected conditions and to periodically reevaluate said conditions for the purpose of adjusting the Veteran’s disability rating should the degree of impairment vary over time.

Cardiac Condition. The CI’s cardiac symptoms of palpitations and dyspnea began near the end of his deployment in Iraq; however, the CI did not seek treatment until he returned to Germany in July 2004. The CI was evaluated at Baumholder TMC and was found to be in atrial fibrillation with rapid ventricular response. Because of the urgency, the CI was admitted to the nearest German hospital where he underwent a transesophageal echo (TEE) and a successful electrical cardioversion. The CI underwent an echocardiogram which revealed a dilated right ventricle. The CI was then transferred to LRMC and underwent a second cardiac catheterization which revealed a non-ischemic cardiomyopathy and a left ventriculogram revealed a moderate left ventricular dysfunction, mild left ventricular dilatation and the hemodynamic showed his heart failure to be well managed with the medication treatment regimen. The CI was started on a beta blocker (Atenolol), ace inhibitor (Ramapril), anticoagulation (Coumadin,) and an aspirin for cardioprotective effects. In October 2004, the CI complained of pleuritic chest pain and had a holtor monitor which was normal without atrial fibrillation. The MEB examination (14 February 2005) noted that the CI still complained of exertion induced chest pain, there was a possible pleural friction rub. Although previous echocardiograms had shown decreased ejection fraction (EF) as low as 27%, mitral and tricuspid valve regurgitation, and bilateral atrial enlargement, the CI had a normal echocardiogram on 31 January 2005 with an EF of 60-65%. A treadmill stress test also done in February 2005 and the CI went 13 minutes and 14 seconds on a full Bruce protocol achieving a maximum workload of 15.7 METs. He also experienced dyspnea prior to completion of Stage 3 and therefore prior to achieving 10.1 METs. He stopped exercise in Stage 5 secondary to chest pain. There were no ST-T wave changes or arrhythmias and the chest pain was felt to be non-ischemic and most likely related to the pericarditis. The examiner opined that the chronic pericarditis symptoms may improve with time and further adjustment of medications however that was a possibility that there would no further improvement and that there may still have been some underlying residual left ventricular dysfunction which required the use of an ace inhibitor and a beta blocker. The examiner noted that the atrial fibrillation had resolved. The CI also would require cardiology follow-up every three to six months. The CI was granted a permanent P3H2 profile for heart inflammation causing chronic chest pain and shortness of breath with any exertion (Chronic Myopericarditis) also mild high frequency hearing loss.

The VA Compensation & Pension (C&P) examination three months prior to separation documented that the CI continued on cardiac medications and still experienced chest pain after walking approximately three flights of stairs along with some mild underlying residual left ventricular dysfunction. He was only able to perform light cardiovascular conditioning without raising his heart rate and light weightlifting. He was not able to run but could perform unlimited light walking. The CI was evaluated by cardiology and diagnosed with post viral cardiomyopathy with recurring atrial fibrillation. No further testing was completed but the echocardiogram of January 2005, treadmill stress test of February 2005, and Holter monitoring of 4 October 2004 were noted as normal. Based on these previous tests and the CI’s reported history, the examiner estimated the CI could participate at MET level 7.5 to 8 without difficulty. He also noted the CI may not have reached maximum medical improvement. Based on this examination and the examiner’s estimate of the highest MET level the CI could achieve without symptoms of dyspnea, fatigue, angina, dizziness, or syncope, the VA rated the condition at 10%.

While the VA initially rated this condition at 10% effective 7 December 2005, in a rating decision dated 23 January 2007 it noted the CI’s actual date of separation was 1 November 2005 and established 2 November 2005 as a corrected effective date. The VA also increased the rating for this condition to 30% based on his VAMC Durham treatment records and the objective test results. The CI had an episode of syncope while driving his car in June 2006, seven months after separation from service. An extensive work-up during a subsequent hospitalization included an echocardiogram with EF of 50%, stress test with undetermined results as CI’s symptoms limited his ability to perform the teat, and a Dobutamine stress test which documented left ventricular hypertrophy and enlargement. In a Dobutamine stress test nuclear imaging material is injected to take images of the heart both at rest and with the stress of Dobutamine. Dobutamine makes the heart beat faster simulating exercise and this test is used in people who cannot physically exercise. A Dobutamine stress test can be considered analogous to a combination of an echocardiogram and a treadmill stress test. This VARD stated these tests provided a more accurate evaluation of the CI’s cardiac status, whereas previous conclusions based upon his description of symptoms during his VA C&P evaluation were subjective. The rating decision stated, “When a medical opinion relies on a veteran's solitary testimony, we are not bound to accept the medical conclusion rendered from this testimony as fact, as this opinion has not greater probative value than the facts alleged by a Veteran (Swann v. Brown, 5 Vet. App. 229, 233 (1993)).”

As the presence of left ventricular hypertrophy (LVH) supports a 30% rating and an EF of 30%-50% supports a 60% rating, the Board looked closely at the evidence to determine if either was present at the time of separation from service. The echocardiogram done 31 January 2005 and mentioned in the MEB narrative summary (NARSUM) had no evidence of any left ventricular hypertrophy (LVH) but did show continuing left ventricular dysfunction and a low normal ejection fraction (EF) of 60%-65%. A repeat study done 18 May 2006 documented M mode measurements supporting mild LVH although the technician noted visually normal size. Ejection fraction was 50%. In the June 2006 hospital admission for syncope, an echocardiogram reported normal LV size but had M mode measurements similar to the report of the previous month. And again EF was 50%. A Dobutamine stress test during this same admission did show LVH and enlargement. All tests also showed continuing decreased LV function with low normal EF.

The evidence shows that LVH and an EF of 50% developed sometime between 31 January 2005 and 18 May 2006, and the separation date of 1 November 2005 is approximately nine months after the first date and approximately six and one half months prior to the second date. It is not possible to determine the exact date of the development of these findings but, giving the CI the benefit of the doubt, it is reasonable to assume one or both findings were present on the day of separation.

While the MEB NARSUM and original VA C&P examinations both implied a possibility of continued improvement in impairment over time, this did not occur. In fact, the CI developed increasing symptoms and problems over time. His chest pain increased in severity and frequency and his atrial fibrillation recurred during electrophysiologic testing. In September 2006, ten months after separation, the CI underwent the implantation of a loop monitor REVEAL device. This was followed by an implantation of a cardioverter-defibrillator device. In December 2006 thirteen months after separation, the cardiologist documented left ventricular hypertrophy with mild reduction in systolic function. The CI also had a recurrence of atrial fibrillation and a stroke in February of 2011. During this hospitalization his EF was 55%.

The PEB and the VA chose different coding options for the condition. The PEB chose to code the cardiac condition 7002 (pericarditis) rated 0%. The VA coded 7099 analogous to 7020 Cardiomyopathy initially rated as 10%, however the VA acknowledged a fatally flawed decision and increased the rating to 30% based on the evidence that gated spectrometry revealed the left ventricle to be mildly enlarged and hypertrophied along with mild reduction in systolic function. The Board notes that the rating criteria for percentage disability ratings are the same for both codes.

The evidence demonstrated a dilated right ventricle during the ECHO done while the CI was in the civilian German hospital, and consistently demonstrated left ventricular dysfunction and left ventricular dilatation. At the MEB exam, the examiner opined that there might still be some underlying residual left ventricular dysfunction (indicating left ventricular hypertrophy). The VA examiner also noted mild underlying residual left ventricular dysfunction. An echocardiogram done in May 2006 and the Dobutamine stress test done during the June 2006 admission, six to seven months post separation, indicated left ventricular hypertrophy and enlargement The CI was started on cardiac medication in 2004 and this will be a lifelong treatment. The Board reviewed the tenants of 7002 Pericarditis (Workload of greater than 5 METs but not greater than 7 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; evidence of cardiac hypertrophy or dilatation on electro-cardiogram, echocardiogram, or X-ray) rated 30% and the descriptors for a 10% rating (Workload of greater than 7 METs but not greater than 10 METs results in dyspnea, fatigue, angina, dizziness, or syncope, or; continuous medication required). On METs criteria alone, the CI’s condition warrants a 10% rating because dyspnea developed on the treadmill prior to the achievement of 10.1 METs. However, the presence of LVH warrants a 30% rating. After due deliberation, considering all of the evidence, and applying reasonable doubt, the Board recommends a separation rating of 30% for the chronic pericarditis with exercise limiting chest pain secondary to acute viral myopericarditis chronic serous pericarditis condition.

All evidence considered, there is not reasonable doubt in the CI’s favor supporting recharacterization of the PEB fitness adjudication for the history of PAF medical controlled condition.

Other PEB Condition: The other condition forwarded by the MEB and adjudicated as not unfitting by the PEB was history of paroxysmal atrial fibrillation medical controlled; however, this condition was included under the cardiac condition discussion. Although the CI did have one episode of atrial fibrillation prior to separation, this condition was well-controlled at the time of separation and there is insufficient evidence to determine it was a separately unfitting condition.

Remaining Conditions. Other conditions identified in the DES file were the following: mild high frequency hearing loss; residual pain from broken wrist; childhood jaundice; bronchitis; kidney stones; depression/anxiety. Several additional non-acute conditions or medical complaints were also documented. None of these conditions were significantly clinically or occupationally active 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. Additionally migraine headaches and posttraumatic stress disorder (PTSD) were noted in the VA rating decision proximal to separation, but were not 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. 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 chronic pericarditis with exercise limiting chest pain secondary to acute viral myopericarditis chronic serous pericarditis condition, the Board by a vote of 2:1 recommends a rating of 30% coded 5025 IAW VASRD §4.104a. The single voter for dissent who recommended adopting the IPEB rating 7002 at 10% did nto submit a minority opinion. In the matter of history of PAF medical controlled, the Board unanimously agrees that it cannot recommend a finding of unfit for additional rating at separation. In the matter of the mild high frequency hearing loss; residual pain from broken wrist; childhood jaundice; bronchitis; kidney stones; depression/anxiety, PTSD and migraine headaches 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 recommends that the CI’s prior determination be modified as follows, effective as of the date of his prior medical separation:

|  |  |  |
| --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Chronic Pericarditis with Exercise Limiting Chest Pain Secondary to Acute Viral Myopericarditis Chronic Serous Pericarditis | 7002 | 30% |
| **COMBINED** | **30%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20110331, 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

1. Under the authority of Title 10, United States Code, section 1554(a), I approve the enclosed recommendation of the Department of Defense Physical Disability Board of Review (DoD PDBR) pertaining to the individual named in the subject line above to recharacterize the individual’s separation as a permanent disability retirement with the combined disability rating of 30% effective the date of the individual’s original medical separation for disability with severance pay.

2. I direct that all the Department of the Army records of the individual concerned be corrected accordingly no later than 120 days from the date of this memorandum:

a. Providing a correction to the individual’s separation document showing that the individual was separated by reason of permanent disability retirement effective the date of the original medical separation for disability with severance pay.

b. Providing orders showing that the individual was retired with permanent disability effective the date of the original medical separation for disability with severance pay.

c. Adjusting pay and allowances accordingly. Pay and allowance adjustment will account for recoupment of severance pay, and payment of permanent retired pay at 30% effective the date of the original medical separation for disability with severance pay.

d. Affording the individual the opportunity to elect Survivor Benefit Plan (SBP) and medical TRICARE retiree options.

3. I request that a copy of the corrections and any related correspondence be provided to the individual concerned, counsel (if any), any Members of Congress who have shown interest, and to the Army Review Boards Agency with a copy of this memorandum without enclosures.

BY ORDER OF THE SECRETARY OF THE ARMY:

Encl

Deputy Assistant Secretary

(Army Review Boards)