RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: Army

CASE NUMBER: PD1100355 SEPARATION DATE: 20030826

BOARD DATE: 20120118

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty SSG/E-6 (55B30, Ammunition Specialist), medically separated for metabolic myopathy*.* He did not respond adequately to treatment and was unable to perform within his Military Occupational Specialty (MOS) or meet physical fitness standards. He was issued a permanent P3 profile and underwent a Medical Evaluation Board (MEB). Metabolic myopathy of uncertain origin, dyspnea on exertion and patellofemoral syndrome of the right knee were forwarded to the Physical Evaluation Board (PEB) as medically unacceptable. 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 (IPEB) adjudicated the metabolic myopathy of unknown etiology, with dyspnea on exertion, without limitation of motion condition as unfitting, rated 0%, with application of the Department of Defense Instruction (DoDI) 1332.39 and the Veterans’ Administration Schedule for Rating Disabilities (VASRD). The CI made no appeals, and was medically separated with a 0% disability rating.

CI CONTENTION: “Misdiagnosed.” In his letter dated 6 April 2011, the CI states he would like to see his case reversed and contends he is fit for continued military service.

RATING COMPARISON:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Service IPEB – Dated 20030609** | | | **VA (15 Mo. After Separation) – All Effective Date 20030827** | | | |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Metabolic Myopathy with Dyspnea on Exertion | 5099-5021 | 0% | Polymyositis | 5099-5025 | 20%\* | 20041109 |
| Patellofemoral Syndrome Right Knee | Not Unfitting | |  |  |  |  |
| ↓No Additional MEB/PEB Entries↓ | | | 0% x 1/Not Service Connected x 2 | | | 20041109 |
| **Combined: 0%** | | | **Combined: 20%** | | | |

\*VA increased condition to 40% on VARD dated 20091030 effective date 20090630

ANALYSIS SUMMARY: In the letter 6 April 2011 appended to the CI’s application for review, he states he was misdiagnosed and has no work limitations placed by his physicians and requests consideration for a fit for duty determination so that he may continue military service. He submits several medical statements from his physicians stating there are no medical restrictions for military service. It is noted for the record that the Board has neither the jurisdiction nor authority to review and recommend reversal of a PEB finding of unfit, or to render a determination that the CI is now fit for military service. 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 VASRD standards, based on severity at the time of separation and not based on future worsening or improvement. The CI’s contention that he was fit for military service at separation or is fit now, remains eligible for submission to the Army Board for Correction of Military Records. The 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 his degree of impairment vary over time.

Metabolic Myopathy. The CI experienced arthralgias and myalgias associated with fatigue beginning approximately November 2000. Evaluation subsequently led to diagnosis of a non-specific muscle disease concluded to be metabolic in origin. The muscle biopsy upon which the diagnosis was based was interpreted by specialists at the Medical College of Georgia. The rheumatology MEB narrative summary (NARSUM) reported muscle discomfort with exercise but without weakness, and difficulty running due to pain in the knees and legs. The physical examination was normal including muscle strength. The rheumatologist concluded that based on the diagnosis of a metabolic myopathy, there was an unacceptable risk for the serious complication of rhabdomyolysis in the setting of heavy exertion particularly in hot environments; a complication for which deployment to harsh, austere environments was inappropriate. The CI was advised to avoid very strenuous activity and to avoid exercise in extremely hot environments. The commander’s letter noted the CI was unable to perform strenuous aspects of his job or deploy due to the physical limitations. The PEB found the CI unfit and rated his muscle condition 0% under the diagnostic code for myositis (5021) which directs rating for loss of range of motion. The PEB subsumed his complaint of shortness of breath with exertion under the muscle condition as evaluation did not find a lung condition and it was concluded to represent a symptom of the muscle condition.

One month after separation, 29 September 2003, the CI was evaluated by a civilian rheumatologist with similar findings of normal strength and a diagnostic impression that favored a metabolic myopathy over polymyositis (an inflammatory myopathy). A 1 December 2003 follow up note recorded CI report that he can become fatigued in his legs a bit more quickly when lifting weights. He was observed to be very strong on muscle testing. A subsequent repeat muscle biopsy in February 2004 was interpreted to show inflammatory myopathy consistent with polymyositis. Based on this biopsy report, his rheumatologist initiated standard immunosuppressive treatment for polymyositis. The CI underwent VA Compensation and Pension (C&P) examination, 9 November 2004, 14 months after separation. The CI reported overall diffuse muscle aches and pain, with associated fatigue without weakness. He reported problems with fasciculations and twitches of both hands in the preceding six months, and intermittent joint pain of knees and hips. He was able to walk one mile, and go up and down one to two flights of stairs without difficulty. Upper extremity function was stated to be normal. On examination, the CI was “quite muscular,” symmetric musculature with no atrophy, and normal strength on manual muscle testing (5/5). The gait was normal and the joint examination was normal. The VA assigned a 20% rating for polymyositis. The VA rating decision rationale indicated rating analogously using rating criteria for fibromyalgia citing his diffuse muscle symptoms, fatigue, diarrhea (analogized to irritable bowel syndrome), moodiness without depression, and intermittent knee pain all subsumed under the rating for polymyositis. A 19 June 2009 general surgery pre-muscle biopsy evaluation recorded a functional capacity similar to the initial C&P examination (some general body muscle weakness and right knee hip pain; some shortness of breath, can walk one mile, climb two flights of stairs before getting short of breath). The 14 August 2009 C&P examination recorded worsened symptoms upon which an increased evaluation of 40% was based. The examination recorded that the CI still had mild diffuse muscle pain after exercise, but that Ibuprofen 800mg relieved his symptoms. The Board made note of the submitted medical statements indicating no functional occupational limitations and employment as a railroad locomotive engineer. The 10 November 2010 C&P examination, noted the CI was able to walk more than two miles, exercise at the gym five to six times per week (rides bike 3-9 miles), and could go up and down one to two flights of stairs with shortness of breath. On examination, strength and gait were normal.

While the CI’s contention that he was misdiagnosed in service is not within the purview of the Board, the Board noted he did not respond to treatment for polymyositis and subsequent specialty evaluations including a third muscle biopsy did not establish a firm diagnosis. In 2008, over four years after separation, specialists were considering a diagnosis of a muscular dystrophy with inflammatory features; however, a firm diagnosis remained un-established. Regardless, a specific diagnosis is not necessary for rating purposes. There is no specific diagnostic code for metabolic myopathy, polymyositis, or muscular dystrophy. The Board noted the initial C&P examination was over one-year after separation and has limited probative value with regard to rating the condition at separation. Although the VA chose to rate analogously using the code for fibromyalgia, the Board noted the CI was not diagnosed with fibromyalgia. The Board also made note of the CI’s January 2003 Army Physical Fitness Test (APFT) (seven months before separation) in which he performed 65 pushups, 64 sit-ups and ran 2-miles in 14 minutes and 30 seconds for a very good passing score. Post-separation medical evidence documented stable symptoms characterized as mild aching with exercise, regular exercise in the gym several times per week, normal strength on examinations, and full time employment. All evidence considered there is not reasonable doubt in the CI’s favor supporting a change from the PEB’s rating decision for the muscle syndrome condition.

Other PEB Conditions. The other condition forwarded by the MEB and adjudicated as not unfitting by the PEB was patellofemoral syndrome of the right knee and dyspnea on exertion. Dyspnea on exertion was attributed to the metabolic myopathy and subsumed under the rating for that condition. Chest x-ray was normal and pulmonary function tests showed mild obstruction for which an inhaler was prescribed. The CI experienced right knee pain with running and was periodically issued physical profiles from May 2001 to May 2002. No duty limiting profile for the knee was in evidence after May 2002 and the CI was playing soccer in October 2002 when he sought care for being kicked in the knee. The 3 March 2003 rheumatology clinic record noted difficulty running due to pain in the knees and diagnosed patellofemoral syndrome of the right knee. The commander’s letter noted that pain in the joints and muscles prevented performance of duties. The physical profile dated 4 March 2003 was L1, no restrictions with regard to the lower extremities. The CI passed his APFT in January 2003 including completing the 2-mile run in 14 minutes and 30 seconds, considered a very good time. The C&P examination 14 months after separation recorded complaint of right knee pain with walking and stairs. CI was able to walk one mile and go up and down one to two flights of stairs without difficulty. His gait and knee examination was normal. Tests for patellofemoral pain were negative at that examination and he was able to squat and duck walk without pain. The 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 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.

Remaining Conditions. Other conditions identified in the DES file were chronic diarrhea, fatigue, memory loss, back pain, shoulder pain, joint pain. The CI underwent specialty evaluation for his chronic diarrhea without abnormal findings, and at time of rheumatology MEB NARSUM, the CI reported this had improved quite a bit since he discontinued milk and dairy products. Several additional non-acute conditions or medical complaints were also documented (cystic acne, left great toenail fungus, mild headaches, bronchitis). None of these conditions were clinically 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 degenerative joint disease of the left acromioclavicular joint and several other non-acute conditions 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 muscle condition, the Board unanimously recommends no change in the PEB adjudication. In the matter of the dyspnea, and right knee condition, the Board unanimously agrees that it cannot recommend a finding of unfit for additional rating at separation. The Board unanimously agrees that there were no other conditions eligible for Board consideration which could be recommended as additionally unfitting for 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** |
| Metabolic Myopathy | 5099-5021 | 0% |
| **COMBINED** | **0%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20110410, w/atchs

Exhibit B. Service Treatment Record

Exhibit C. Department of Veterans' Affairs Treatment Record

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