RECORD OF PROCEEDINGS
PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: NAVY
CASE NUMBER: PD1100774 DATE OF PLACEMENT ON TDRL: 20000121
BOARD DATE: 20121004 DATE OF PERMANENT SEPARATION: 20050519

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty PR3/E-4 (Aircrew Survival Equipmentman Third Class), medically separated for a chronic left lung condition. He did not respond adequately to treatment and was unable to fulfill the physical demands within his Rating, meet worldwide deployment standards or meet physical fitness standards. He was placed on limited duty and underwent a Medical Evaluation Board (MEB). Severe pulmonary coccidioidomycosis left lung was forwarded to the Physical Evaluation Board (PEB) IAW SECNAVINST 1850.4E. Three other conditions, identified in the rating chart below, were also identified and forwarded by the MEB. The CI was placed on Temporary Disability Retired List (TDRL) with ratings as reflected in the chart below. The PEB adjudicated the chronic left lung condition as unfitting, rated 10%, five years after being placed on TDRL, with application of the Veteran's Affairs Schedule for Rating Disabilities (VASRD). The CI made no appeals, and was medically separated with a 10% disability rating.

CI CONTENTION: The final TDRL report examination dated 14 Dec 2004 states under (Final Diagnosis): The board recommends transfer of the member to the Permanent Disability List. Then, 3 months later, dated 18 Mar 2005 in the findings of the PEB proceedings under (diagnosis & ratings) I was to be separated from TDRL with a 10% rating.

SCOPE OF REVIEW: The Board wishes to clarify that the scope of its review as defined in DoDI 6040.44, Enclosure 3, paragraph 5.e. (2) is limited to those conditions which were determined by the PEB to be specifically unfitting for continued military service; or, when requested by the CI, those condition(s) "identified but not determined to be unfitting by the PEB." The ratings for unfitting conditions will be reviewed in all cases. Any conditions or contention not requested in this application, or otherwise outside the Board's defined scope of review, remain eligible for future consideration by the Board for Correction of Naval Records (BCNR).

TDRL RATING COMPARISON:

Service PEB – Dated 20050318				VA* – All Effective Date 20000120			
Condition	**Code**	**Rating**		**Condition**	**Code**	**Rating**	**Exam**
On TDRL – 200XXXXX		**TDRL**	**Sep.**				
Severe Pulmonary Coccidioidomycosis	6835-6899-6829	50%	10%	Coccidial Mycosis, S/P Decortication	6835	50%*	20000616
Left Thoracotomy with Decortication		Not identified by MEB	MEB entry,Not adjudicated				
Chronic costalchondritis		Not indentified by MEB	MEB entry, Not adjudicated	Costochondritis of L/Anterior Rib Cage	5299-5291	0%	20000616
Autosomal-Dominant Polycystic Kidney Disease	Preexisting Condition	EPTE	EPTE	Polycystic Kidney Disease	7533	0%	20000616
				Anterior Cruciate Ligament Tear of L/knee, S/P Repair	5299-5257	10%	20000616
				Not Service Connected x 1			20000616
Combined: 10%				Combined: 60%			

*VARD 20110915 decreased rating to 0% effective 20111201 for failure to report to VA exam

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ANALYSIS SUMMARY: The Board acknowledges the CI's assertions that the final TDRL MEB recommended that he be transferred to the TDRL; however, 3 months later the PEB recommendation was to separate for 10%. It is noted for the record that the Board has neither the jurisdiction nor authority to scrutinize or render opinions in reference to asserted service improprieties in the disposition of a case. 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. It must also judge the fairness of PEB fitness adjudications based on the fitness consequences of conditions as they existed at the time of separation.

Chronic left lung condition. In October 1998, the CI sought treatment for fevers, chills, night sweats, left pleuritic chest pain and weight loss. He was admitted and treated for a presumptive diagnosis of pneumonia with a chest X-Ray demonstrating a left lung infiltrate and effusion of the lower lobe. A chest computer tomography (CT) further revealed a left lower infiltrate and a large pleural effusion, extensive lympadenopathy, bilateral renal masses and splenomegaly. He was transferred to a different hospital and underwent an extensive evaluation by urology, infectious disease, cardiology, and surgery. He had multiple procedures to include bronchoscopy, thoracentesis, and finally underwent a thoracotomy (surgical incision into the lung space) with a left lung decortication procedure (removal of the pleural lining), three chest tube placements to remove the fluid from his lung, 5-6 blood transfusions, and a lumbar puncture (LP) which required a 6 day ICU stay. He had a negative LP for coccidioidomycosis. He remained in the hospital for 8 more days and was treated with the antifungal medication, Diflucan (Fluconazole) and a narcotic based pain medication. He responded well with abatement of fever, chills, and cough, but continued to have pleuritic chest pain. On discharge he was diagnosed with severe dissemeniated coccidioidomycosis and autosomal dominant polycystic kidney disease. By May 1999 he had not regained his weight and had unfavorable trend of his serology's and increasing pleuritic chest pain. Another chest CT revealed a reaccumulation of pleural fluid necessitating another thoracentesis and prolonged treatment with a catheter in the pleural space with noted slight improvement of his

chest pain. He was continued on his antifungal medication as well as narcotic pain medication and underwent a MEB in August 1999. The non-medical assessment (NMA) documented the CI was not working in his Rating, was missing 25 hours of work a week for medical appointments, that his medical condition was unstable and documented he was no longer physically capable of performing his rating ashore or afloat.

The first MEB exam demonstrated a well-healed throacotomy incision and a healing chest tube insertion site, clear lungs, no hepatosplenomegaly and a coccidioidomycosis compliment fixation titer of 1:32 (normal <2). The examiner opined the CI would require prolong antifungal medication for minimum of 2 years and depending on the response may be life long, and further documented relapse of this condition was 40% off medication. The examiner stated until the stability of his disease was proven, he was not worldwide qualified. At the VA Compensation and Pension (C&P) exam, performed 7 months after TDRL placement, the CI reported a similar historical account and symptoms of non-progressive dyspnea, chest pain 3/4 of 10 in intensity, increased with inspiration, climbing or walking, left rib chest pain 50% of the day, daily headaches which he attributed to Diflucan and that he continued to take narcotic pain medication. His weight was stable, appetite was fair, and he did not report cough, night sweats, fever or chills. He also reported he was not working. The exam demonstrated similar findings as in the MEB. Pulmonary function tests (PFT) before bronchodilator revealed a FEV1 of 3.87 which was 67% of predicted and after bronchodilator an FEV1 of 4.64, 87% of predicted. The examiner diagnosised coccidioidomycosis, currently under chronic treatment previously treated with decortication of the left lung, chronic pleuritic pain of the left posterior rib cage and costochondritis of the left anterior rib cage.

Subsequently, the CI had two TDRL exams prior to the final exam at the time of separation. The exams documented improving weight, negative serology titers for coccidiomycosis yet continued symptoms of dyspnea on exertion (DOE), chest pain and headaches. By his second exam he had a new onset of night sweats that had not been clarified as to an etiology by his final exam. At the final TDRL MEB exam, the CI reported no improvement. He continued to have constant left chest pain, 4/5 of 10 in intensity, worst with exertion and at its worst 5/6 of 10 in intensity. He required daily medication to control his pain to include chronic nonsteroidal medication, non narcotic medication and intermittent narcotic medication when the pain was the worst. He had DOE with two flights of stairs, had new night sweats that occurred one to two times per week for the past 2 years and continued to have an intermittent nonproductive cough. His weight was stable and he reported seeing an infectious disease physician every 2 months. The exam demonstrated a weight of 210 pounds, a well-healed left thoracotomy scar and tenderness over the left lower anterior chest wall, coccidioides antibody IGG by enzyme immunoassay was negative and PFT's were improved from the prior exam with overall demonstration of normal lung volumes and flow. The examiner diagnosed severe pulmonary coccidioidomycosis with resultant chronic pain and DOE and chronic night seats of unclear etiology possibly due to chronic coccidioidomycosis. The examiner opined the CI's chronic pain in his chest was caused by scarring from the coccidioidomycosis infection which required chronic oral narcotics for control and this was incompatible with return to active duty. Further, his chronic dyspnea prevented him from performing all duties of his rating. There were no future VA exams for consideration.

The Board directs attention to its rating recommendation based on the above evidence. The PEB decision, transferring the CI to TDRL, and VA rating decision chose to use the code 6835 (Coccidioidomycosis) for the left lung condition IAW §4.97—schedule of ratings–respiratory system under general rating formula for mycotic lung disease at the 50% rating. All Board members considered and agreed the evidence meets the 50% rating criteria at the time of placement on TDRL which specifically states "chronic pulmonary mycosis requiring suppressive therapy with no more than minimal symptoms such as occasional minor hemoptysis or

productive cough" and further agreed the evidence did not meet the 100% criteria which specifically states "chronic pulmonary mycosis with persistent fever, weight loss, night sweats, or massive hemoptysis." At the time of the final TDRL MEB exam the PEB chose to rate with the primary code 6829 (Drug-induced pulmonary pneumonitis and fibrosis) analogous to the 6899 code and the 6835 code ,respectively and rated 10% based on normal PFT's with residual chest pain and dyspnea on exertion. The Board agreed the evidence does not reflect any clinical reference to the criteria of the 6829 code and therefore the Board did agreed not to consider this code in its permanent rating recommendation. The Board agreed the clinical evidence predominantly reflects a diagnosis of coccidioidomycosis and its residuals and therefore agreed to rate with the clinically specific 6835 code. The final TDRL exam reflects completion of antifungal medication and residuals of pain, DOE night sweats of unknown etiology and intermittent nonproductive cough. The Board agreed the evidence does not meet the 50%criteria as the CI is no longer on suppression medication but meets the 30% criteria which specifically states "chronic pulmonary mycosis with minimal symptoms such as occasional minor hemoptysis or productive cough." After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board recommends a disability rating of 30% for a final disability 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. The Board did not surmise from the record or PEB ruling in this case that any prerogatives outside the VASRD were exercised. In the matter of the chronic left lung condition, the Board unanimously recommends a final disability rating of 30% coded 5835 IAW VASRD §4.97. There were no other conditions within the Board's scope of review for consideration.

RECOMMENDATION: The Board recommends that the CI's prior determination be modified as follows; and, that the discharge with severance pay be recharacterized to reflect permanent disability retirement, effective as of the date of his prior medical separation:

UNFITTING CONDITION	VASRD CODE	RATING
		PERMANENT
Severe Pulmonary Coccidioidomycosis	6835	30%
	COMBINED	**30%**

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20110913, w/atchs
Exhibit B. Service Treatment Record
Exhibit C. Department of Veterans' Affairs Treatment Record

MEMORANDUM FOR DEPUTY COMMANDANT, MANPOWER & RESERVE AFFAIRS
COMMANDER, NAVY PERSONNEL COMMAND

Subj: PHYSICAL DISABILITY BOARD OF REVIEW (PDBR) RECOMMENDATIONS

Ref: (a) DoDI 6040.44
(b) PDBR ltr dtd 12 Oct 12 ICO
(c) PDBR ltr dtd 17 Oct 12 ICO
(d) PDBR ltr dtd 22 Oct 12 ICO

1. Pursuant to reference (a) I approve the recommendations of the Physical Disability Board of Review set forth in references (b) through (d).

2. The official records of the following individuals are to be corrected to reflect the stated disposition:

a. former USN: Disability retirement with a final disability rating of 30% with assignment to the Permanent Disability Retired List effective 18 March 2005.

b. former USMC: Disability retirement with a final disability rating of 40% with assignment to the Permanent Disability Retired List effective 28 November 2008.

c. former USMC: Disability retirement with a final disability rating of 30% and assignment to the Permanent Disability Retired List effective 15 March 2006.

3. Please ensure all necessary actions are taken, included the recoupment of disability severance pay if warranted, to implement these decisions and that subject members are notified once those actions are completed.