RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXX BRANCH OF SERVICE: Army

CASE NUMBER: PD1100800 SEPARATION DATE: 20040229

BOARD DATE: 20120522

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SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was a National Guard SGT/E-5 (13R, Firefinder Radar Operator), medically separated for cervical spondylosis with neck pain and chronic mild left arm (non-dominant) weakness, with mild atrophy of biceps/triceps and forearm, without electrodiagnostic abnormality. The CI reported a 6-year history of intermittent pain of the left arm and forearm with numbness and paresthesias in the left fingers intermittently. He described symptoms of weakness and dropping objects as a result. 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 U3 profile for cervical stenosis and underwent a Medical Evaluation Board (MEB). Cervical spondylosis with neck pain and chronic mild left arm were forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW AR 40-501. Four other conditions, as identified in the rating chart below, were forwarded on the MEB submission as medically acceptable conditions. The PEB adjudicated the cervical spondylosis with neck pain and chronic mild left arm conditions as unfitting, rated at 20% for mild, incomplete paralysis. The CI made no appeals, and was medically separated with a 20% disability rating.

CI CONTENTION: The CI states: “On 9 May 02, I meet with the Chief Sergent of Neuro Surgery, Donald Patkins, MD, MAJ, MC, at BAMC Fort Sam Houston. At the time of our review, doctor Patkins mention to me that he was retiring soon. And that because of that their was nothing he could do to help me get better. And that because I am a guardmens it be best I got out of the Army. He put me on a profile and recommend me to the PEB for discharge under medical condition. I was given a 20% rating from the Army and sent on my way. The VA, after review of my medical problem, gave me a 30% for my cervical problem and now to date has me rated at 80%.” He elaborates no specific contentions regarding rating or coding and mentions no additionally contended conditions.

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.” No specific request for consideration of conditions determined to be not unfitting by the PEB is noted. 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 Army Board for the Correction of Military Records (BCMR).

RATING COMPARISON:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Service IPEB – Dated 20030327** | | | **VA 4 Months Pre-Separation**  **Effective Date 200311061 or 199904302** | | | | |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** | |
| Cervical Spondylosis, With Neck Pain And Chronic Mild Left (Non-Dominant) Arm Weakness, With Mild Atrophy Of Biceps/Triceps And Forearm, Without Electrodiagnostic Abnormality. | 8599-8513 | 20% | Cervical Spondylosis | 5242 | \*10%1 | 20040217 | |
| Neurological Impairment, Left Upper Extremity Associated With Cervical Spondylosis | 8599-8515 | \*10%1 | 20040217 | |
| Neurological Impairment, Right Upper Extremity Associated With Cervical Spondylosis | 8599-8515 | \*10%1 | 20040217 | |
| High Frequency Hearing Loss | Not Unfitting | | Hearing Loss | 6100 | 0%2 | 19990701 | |
| Hypertension, Controlled | Not Unfitting | | Hypertension | 7101 | 10%2 | Records | |
| Seasonal Allergic Rhinoconjunctivitis | Not Unfitting | | No VA Entry | | | | |
| Cubital Tunnel Syndrome | Not Unfitting | | Bilateral Elbow Condition | 5299-5213 | NSC | | STR |
| ↓No Additional MEB/PEB Entries↓ | | | Tinnitus | 6260 | 10%2 | | 20040219 |
| Lumbar Spondylosis | 5003-5292 | \*\*10%2 | | 19990720 |
| Left Knee Patellofemoral Syndrome | 5260 | \*\*10%1 | | 20040217 |
| 0%1 x 1 other/Nonservice connected x 1 other | | | | |
| **Combined: 20%** | | | **Combined: 50%\*\*\*\*** | | | | |

\*Cervical Spondylosis increased to 100% 20041115 (nine months after separation), decreased to 30% 20050601; Left and right upper extremity neuropathy increased to 20% each 20100426*.*

\*\*Lumbar Spondylosis increased to 20% 20050615.

\*\*\*Left Knee Patellofemoral Syndrome originally rated at 0% but increased to 10% with same effective date after a de novo review of the original examination.

\*\*\*\*Combined rating 60% effective 20050601, 70% effective 20050615, and 80% effective 20100426.

ANALYSIS SUMMARY: The Board acknowledges the CI’s assertions of, “At the time of our review, doctor Patkins mention to me that he was retiring soon. And that because of that their was nothing he could do to help me get better. And that because I am a guardmens it be best I got out of the Army.” It is noted for the record that the Board has neither the jurisdiction nor the authority to scrutinize or render opinions in reference to the CI’s statements in the application regarding suspected Service improprieties in the processing of his case. The Board also acknowledges the sentiment expressed in the CI’s application, i.e., that the gravity of his condition and predictable consequences which merit consideration for a higher separation rating. It is a fact, however, that the DES has neither the role nor the authority to compensate service members for anticipated future severity or potential complications of conditions resulting in medical separation. This role and authority is granted by Congress to the Department of Veterans' Affairs. The Board utilizes DVA evidence proximal to separation in arriving at its recommendations; and, DoDI 6040.44 defines a 12-month interval for special consideration to post-separation evidence. The Board’s authority as defined in DoDI 6040.44, however, resides in evaluating the fairness of DES fitness determinations and rating decisions for disability at the time of separation. Post-separation evidence therefore is probative only to the extent that it reasonably reflects the disability and fitness implications at the time of separation.

Cervical Spine Condition. The CI initially injured his upper back in September 1997 while he was serving in Bosnia. He fell off a ladder from a height of two feet and experienced tingling in his whole hand as well as upper back pain. He was treated conservatively for musculoskeletal back pain and also received trigger point injections. He continued to have pain and was evaluated by orthopedics in June 1998. At that time, he had full range of motion of his cervical spine and had no tenderness to palpation of the paraspinal muscles. His reflexes were diminished bilaterally but he had normal strength of 5/5 bilaterally and normal sensation. He was referred for further trigger point injections. He continued to have neck pain radiating into his left shoulder and down his left arm and was evaluated in May 2000 for difficulty gripping things with his left hand. In March 2002 he was referred to occupational therapy for pain, weakness, and numbness and tingling from his left shoulder down to the tips of the fingers in his left hand. Examination noted grip strength in left hand less than half that of his right hand (40 vs. 92 pounds) and decreased muscle mass in the left thenar eminence. He was seen multiple times by neurosurgery, occupational therapy (OT) and physical therapy (PT), and physical medicine and rehabilitation (PMR) over the next few years but his symptoms did not resolve. Magnetic Resonance Imaging (MRI) was performed in 2002 and although the radiologist’s report is not present in the record, both the original MEB NARSUM in May 2002 and the updated MEB NARSUM in December 2002 noted this test documented diffuse spondylitic changes from C3-4 to C6-7, severe spinal stenosis at C5-6, moderate spinal stenosis at C6-7, and mild to moderate spinal stenosis at C3-4 and C4-5. Both NARSUMs also noted the MRI showed moderate to severe neuroforaminal stenosis (worse on the right) at C5-6, moderate bilateral neuroforaminal stenosis at C4-5 and C6-7 (worse on the right at C6-7), and mild bilateral neuroforaminal stenosis at C3-4. An EMG completed 20020412 was reported as consistent with mild/possible chronic C-7 radiculopathy and very mild demyelinating sensory median neuropathy at the left wrist. However, EMG studies of 30 January 2003 and 28 February 2003 were reported as normal.

An MEB NARSUM was completed by a neurosurgeon on 9 May 2002 and it noted the CI continued to have pain in his neck, left shoulder, near the elbow, and an aching pain in the forearm and hand. He reported mild intermittent paresthesias in an ulnar distribution on the left side. Examination noted normal motor strength in both upper extremities with normal sensation and neurologic examination. The neck was supple with flexion of 90 degrees and extension of 30 degrees. Moderate myofascial tenderness was present in the interscapular region on the left as well as in the paraspinals at the base of the neck. Motor strength was noted as 5/5 throughout the upper extremities with some give away weakness in “various muscle groups” and sensation was intact to light touch and pinprick. Reflexes were 2+ throughout and gait and coordination were normal. The diagnosis was listed as cervical spondylosis with neck pain and radiculopathy with slight and constant pain.

An updated MEB NARSUM was completed in December 2002, but no new examination was completed. The provider noted an examination date of 14 May 2002 and referenced the MEB physical (DD Form 2808). An undated and unsigned DD Form 2808 was available in the record and the physical findings in this document matched those documented in the updated MEB NARSUM. This examiner noted a 6-year history of intermittent pain of the left arm and forearm with numbness and paresthesias in the left fingers intermittently. It also noted the CI was right-handed and that he described symptoms of weakness and dropping items. The physical examination noted mild atrophy in the left forearm in addition to motor weakness in the left upper extremity with strength noted to be 4/5 for grip, 4+/5 interosseus, and 4/5 for elbow extension. He also documented moderate myofascial tenderness in the interscapular region on the left and in the paraspinals at the base of the neck. The diagnosis was listed as cervical spondylosis with radiculopathy at left C6-7 with pain slight and constant. The CI continued to receive care and underwent trigger point injection of the left mid-trapezius with good pain relief in his left upper extremity.

The IPEB convened in late March 2003 and determined the CI was unfit for cervical spondylosis with neck pain and radiculopathy at C6-7 with slight and constant pain. This was rated analogous to mild incomplete paralysis of all radicular groups 8599-8513 at 20% for symptoms in the non-dominant side.

However, the CI continued to have symptoms and receive care after the date of the PEB but prior to his date of separation to the retired reserve in February 2004. In late March 2003 the CI was seen in PT for left upper extremity weakness, pain, numbness and tingling with pain at 4/10 at rest and 9/10 with a flare-up. Atrophy of the left biceps, triceps, and deltoid was noted as well as motor strength of 4/5 in the all muscles of the left upper extremity except finger abduction and thumb opposition which were 2/5. Decreased sensation over the left C5-8 and T1 dermatomes was also present. Home cervical traction and strengthening exercises were prescribed. The CI was seen in follow-up in PT on 20030421 and noted to have global atrophy of the left upper extremity and increasing weakness with deltoid, biceps, triceps, and finger flexion all 3/5 and interosseus at 2/5. Strength of wrist flexion was 4/5 and extension was 5/5. The CI was also seen twice in OT during April 2003 with continued left upper extremity weakness, numbness, tingling, and pain. His pain was now rated at 5/10 at rest and 8/10 with overhead work. On 10 April hand grip was noted to be 50 pounds on the left and 90 pounds on the right. On 14 April a more complete strength examination was completed with the results in the table below. Overall the strength of the left upper extremity was only 35% of that in the right upper extremity on average.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| All in #s | Elbow | | Wrist | |  | |
| Flex | Ext | Flex | Ext | Supination | Pronation |
| Left | 86 | 73 | 16 | 43 | 24 | 22 |
| Right | 274 | 231 | 68 | 88 | 63 | 61 |
| Coefficient of variation (CV) Left  (3 measurements) | 38% | 12% | 15% | 5% | 6% | 17% |
| CV right | 8% | 18% | 5% | 5% | 5% | 5% |
| Left % < Right | <68% | <68% | <76% | <51% | <62% | <64% |
| Average 35% | 31% | 32% | 24% | 49% | 38% | 36% |

A repeat Cervical MRI was completed 9 February 2004 (20 days prior to separation):

Impression: Spinal stenosis identified from C3 down through C6, caused by combination of spondylosis and degenerative changes. No disc herniation identified. Edema in the cord noted.

The posterior fossa structures are within normal limits. The spine demonstrates some increased signal in the area between C3 and C7, consistent with edema. No syrinx or masses are seen. The vertebral bodies show mild degenerative changes with disc desiccation at multiple levels. On the axial images, the following is seen:

C2-C3: Spondylosis but without significant impingement on the neural foraminal or central canal. Mild facet degeneration.

C3-C4: Spondylosis with degenerative changes of the facets. Impingement on the neural foramina bilaterally, left worse than right. Narrowing of the spinal canal to 1 cm. A bony spur is noted protruding from the disc space and impinging on the spinal canal inferiorly. Increased signal is identified within the spinal cord consistent with edema.

C4-C5: Spondylosis with significant impingement on the neural foraminal bilaterally, right worse than left. Significant narrowing of the central canal noted consistent with spinal stenosis.

C5-C6: Spondylosis is noted with severe narrowing of the spinal canal. Uncovertebral joint degeneration and facet degeneration also present with impingement on the neural foramina bilaterally.

C6-C7: Spondylosis with degenerative changes with impingement on the neural foramina bilaterally. Significant narrowing to the central canal consistent with stenosis.

C7-T1: Mild degenerative changes but without significant impingement on the neural foramina. Central canal is patent

The VA C&P completed on 17 February 2004, (12 days prior to separation) revealed the CI had cervical spinal stenosis diagnosed in 1997. He complained of pain from his neck radiating into both hands. He described the pain as aching, sticking, squeezing, pressing, cramping, sharp, burning, and stressful and rated it as an 8/10. Pain was elicited with physical activity, stress and daily work as well as coming by itself. It was alleviated with rest. He could function without medications. He did not require bed rest. He did cite functional impairment because he stated he had lost use of his left arm. He stated he had multiple days missed from work “on and off” for seven years, but did not quantify. On physical examination the neck appeared supple, without jugular venous distention or thyromegaly. Cervical spine ranges-of-motion (ROMs) included flexion at 45 degrees (normal); extension at 45 degrees (normal); right and left lateral flexion at 45 degrees (normal); right and left rotation at 80 degrees (normal). Biceps and triceps reflexes were 1+, bilaterally. Motor function was within normal limits and was 5/5. Sensation was normal to light touch, pinprick, and two point discrimination.

The second cervical spine MRI on 9 February 2004 noted spinal stenosis from C3 down through C6, caused by combination of spondylosis and degenerative changes. No disc Herniation identified. Edema in the cord noted. The spinal stenosis was severe at C5-6 and significant at C3-4, C4-5, and C6-7. Additionally a bony spur was impinging on the spinal cord at C3-4. Bilateral impingement on the neural foramina was noted at C3-4, C4-5, C5-6, and C6-7 with left side worse than right at C3-4 and right side worse than left at C4-5. The CI saw a civilian neurosurgeon on 3 March 2004 who noted this MRI showed evidence of spinal stenosis secondary to spondylosis mild degenerative change with facet arthropathy and ligamentum flavum thickening C3-C7. The stenosis was such that it produced "edema within the cord" manifested by increased signal. There was evidence of myelomalacia within the cervical cord. The CI was reported similar symptoms starting in right upper extremity now. The physical examination noted moderately limited ROM of the cervical spine in all directions, especially in forward flexion and extension. The range of motion exam produced some paresthesias in the upper extremities. Motor testing revealed generalized weakness, especially in the left hand. Sensory exam noted hypalgesia (decreased pain sensation) to pinprick diffusely over both hands but otherwise the sensory examination was normal and reflexes were symmetrically hypo to normative in the upper extremities but more brisk in the lower extremities. The neurosurgeon’s impression was cervical myeloradiculopathy due to spinal stenosis and spondylosis. The cord was compressed both anteriorly and posteriorly. Symptoms had progressed over seven years and there was evidence of myelomalacia within the cord extending from C3 down to C7. He stated he was concerned about the degree of stenosis, the progression of symptoms, the physical findings, and the myelomalacia seen on MRI scan. All of these pointed to a progressive condition, which was leading to potential damage to his cervical spinal cord that may or may not have been reversible at that point. Because of this, major surgery was recommended and discussed various surgical approaches with the CI. He noted this would be a major operation with serious potential risks and side effects that included, but were not limited to complete permanent paralysis from the neck down. Furthermore, there would be no guarantee of symptom relief or that he would be able to return to unrestricted activity and/or work following it. The CI underwent major surgery with diskectomy and fusion with bone graft and anterior plated of C3-4, C4-5, C5-6, and C6-7 in November 2004 approximately eight and a half months after separated. An EMG performed by the VA much later in August 2005 documented severe and chronic C5-T1 bilateral motor radiculopathy.

Although the VA examination was essentially normal, the VA considered the information from this neurosurgical evaluation in making its rating determination. The VA rated a combined 30% based on the February 2004 MRI and neurosurgical exam of 3 March 2004 that documented limited ROM in all directions, especially flexion and extension that produced paresthesias in the upper extremities (no goniometer) along with radiculopathy in each upper extremity. A rating of 10% was applied for painful motion and two 10% ratings were applied for sensory radiculopathy in each upper extremity. The VA increased the rating to a temporary 100% when the CI had his surgery and convalescence and then determined a 30% rating for the cervical spondylosis at the end of 100% rating (1 June 2005). The ratings for bilateral radiculopathy were later increased to 20% each, effective 6 April 2010, more than 6 years after the CI separated.

After reviewing the entire record, including the progression of disease after the PEB had made its determination but before the CI separated, it is clear that the CI had significant spinal stenosis with myelomalacia, not simple radiculopathy. While there was some impingement on neural foramina at multiple levels, the real problem was central stenosis and the spinal cord itself was damaged. While the CI had sensory issues in both upper extremities, he only had weakness on the left side prior to separation.

Spinal stenosis with evidence of damage to spinal cord itself (myelomalacia) as well as impingement of nerve roots was documented on MRI prior to separation and is consistent with the clinical picture. The spinal stenosis was severe at C5-6 and significant at C3-4, C4-5, and C6-7. Additionally, a bony spur was impinging on the spinal cord at C3-4. Bilateral impingement on the neural foramina was noted at C3-4, C4-5, C5-6, and C6-7 with left side worse than right at C3-4 and right side worse than left at C4-5. The 2004 MRI documents a worsening of the extensive disease noted on the previous MRI done in 2002 prior to the MEB NARSUM. Extensive surgery to attempt to prevent further damage to the spinal cord was completed within eight and a half months of separation. This clearly shows a worsening of the CI’s cervical spinal stenosis condition after the PEB convened but prior to separation from service to the retired Reserve on 29 February 2004. His symptoms of pain, weakness, muscle atrophy, and paresthesias more likely than not, resulted from the injury to the cervical spinal cord itself as a result of the significant to severe narrowing of the central canal rather than from the impingement of the nerve roots as they exited the neuroforaminal canals. This would explain the previously normal EMG and nerve conduction studies. However, an EMG performed in May 2005 documented severe and chronic motor radiculopathy bilaterally form C5 through T1 and if another EMG had been completed closer to the time of separation it most likely would have also been abnormal.

Visible atrophy of the muscles of the left upper extremity was noted as early as April 2002 in the left thenar eminence. Atrophy of the left forearm muscles was noted in May 2002 and global atrophy of the entire left upper extremity was noted in April 2003. This was consistently noted by a variety of providers over time. By April 2003 strength in left upper extremity was decreased to an average only 35% of the strength in right upper extremity. The CI was unable to lift things over his head and symptoms of increased pain and paresthesias occurred with lifting things greater than 10 pounds. His profile limited his lifting to 20 pounds. The Board discussed at length whether this constituted a mild or a moderate incomplete paralysis. After due deliberation in consideration of the totality of the evidence, a Board majority concluded that there was insufficient cause to recommend a change in the PEB fitness adjudication for this condition.

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 cervical myeloradiculopathy condition, the Board, by simple majority, recommends no change in the PEB adjudication at separation or permanently. The single voter for dissent (who recommended adopting the VA rating 8699-8613 at 30% for moderate incomplete paralysis based on the significant muscle weakness in the left upper extremity) submitted the addended minority opinion.

RECOMMENDATION: The Board, therefore, recommends that there be no recharacterization of the CI’s disability and separation determination, as follows:

|  |  |  |
| --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Cervical Spondylosis, With Neck Pain And Chronic Mild Left (Non-Dominant) Arm Weakness, With Mild Atrophy Of Biceps/Triceps And Forearm, Without Electrodiagnostic Abnormality | 8599-8513 | 20% |
| **COMBINED** | **20%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20110830, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

XXXXXXXXXXXX

President

Physical Disability Board of Review

MINORITY OPINION

After reviewing the entire record, including the progression of disease after the PEB had made its determination but before the CI separated, it is clear that the CI had significant spinal stenosis with myelomalacia, not simple radiculopathy. While there was some impingement on neural foramina at multiple levels, the pertinent medical issue was central stenosis and the spinal cord itself was damaged. While the CI had sensory issues in both upper extremities, he only had weakness on the left side prior to separation.

A comparison of the 2002 MRI with the 2004 MRI clearly documents significant progression of cervical spinal stenosis. The 2002 study noted severe spinal stenosis at C5-6, moderate spinal stenosis at C6-7, and mild to moderate spinal stenosis at C3-4 and C4-5. The 2004 study noted the spinal stenosis remained severe at C5-6 and was now significant at C3-4, C4-5, and C6-7. Additionally a bony spur was impinging on the spinal cord at C3-4.

Muscle atrophy and weakness was noted on the updated December 2002 MEB NARSUM, multiple occupational and physical therapy outpatient visits, and the early March 2004 civilian neurosurgery examination. The areas of the left upper extremity affected by atrophy progressed over time, as did the muscle weakness, except as reported on the February 2004 VA C&P examination. This VA examination did not document the presence or absence of muscle atrophy and reported 5/5 motor strength in both upper extremities. It is not clear why this examination failed to document muscle weakness but a preponderance of examinations from December 2002 forward did show weakness. The VA rating decision noted this one VA examination was not indicative of a significant impairment but noted that the preponderance of medical information available did demonstrate a more serious impairment. Multiple objective measurements of grip strength showed significant weakness in the left hand as compared to the right, much greater than what would be expected based on right hand dominance. The occupational therapy examination of April 2003 as noted in the chart on page 4 of the Record of Proceedings provided a more accurate measurement of motor strength as compared to the usual measurement of strength on a 1 to 5 scale which is typically reported on routine physical examinations. This type of exam, with reported pounds of strength, allows for a more consistent and objective comparison of the affected to the unaffected upper extremity. The low coefficient of variation in all but one measurement demonstrates supports the accuracy of these measurements and there was no indication of lack of effort by the CI. These measurements document that the left upper extremity had only 35% of the strength of the right upper extremity. This loss of more than half of the strength expected cannot be considered mild.

Visible atrophy of the muscles of the left upper extremity was noted as early as April 2002 in the left thenar eminence. Atrophy of the left forearm muscles was noted in May 2002 and global atrophy of the entire left upper extremity was noted in April 2003. This was consistently noted by a variety of providers over time. By April 2003 strength in left upper extremity was decreased to an average only 35% of the strength in right upper extremity. The CI was unable to lift things over his head and symptoms of increased pain and paresthesias occurred with lifting things greater than 10 pounds. His profile limited his lifting to 20 pounds. Extensive surgery was completed within eight and a half months of separation in an attempt to prevent further damage to the spinal cord.

The evidence presented here clearly shows a worsening of the CI’s cervical spinal stenosis condition after the PEB convened but prior to separation from service to the retired reserve on 29 February 2004. His symptoms of pain, weakness, muscle atrophy, and paresthesias more likely than not, resulted from the injury to the cervical spinal cord itself as a result of the significant to severe narrowing of the central canal rather than from the impingement of the nerve roots as they exited the neuroforaminal canals. This would explain the previously normal EMG and nerve conduction studies. However, an EMG performed in May 2005 documented severe and chronic motor radiculopathy bilaterally form C5 through T1 and if another EMG had been completed closer to the time of separation it most likely would have also been abnormal.

As discussed in VASRD §4.123 Neuritis, neuritis is characterized by loss of reflexes, muscle atrophy, sensory disturbances, and constant pain whereas neuralgia is characterized by a dull and intermittent pain as described in VASRD §4.124 Neuralgia. This CI did not have dull, intermittent pain secondary to a nerve root impingement at the neuroforamina; he had a much more significant condition with injury to the spinal cord secondary to serious and significant cervical spinal stenosis and spondylosis that resulted in muscle atrophy, the loss of more than half the normal strength throughout his left upper extremity, and significant paresthesias, including the loss of perception of pain. This is best characterized as neuritis and rated 8699-8613 at 30% for myeloradiculopathy with moderate incomplete paralysis.

SFMR-RB

MEMORANDUM FOR Commander, US Army Physical Disability Agency

(TAPD-ZB / ), 2900 Crystal Drive, Suite 300, Arlington, VA 22202

SUBJECT: Department of Defense Physical Disability Board of Review Recommendation for XXXXXXXXXXX, AR20120009747 (PD201100800)

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 XXXXXXXXXXXX

Deputy Assistant Secretary

(Army Review Boards)

CF:

( ) DoD PDBR

( ) DVA