RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXXXX BRANCH OF SERVICE: Army

CASE NUMBER: PD1100946 SEPARATION DATE: 20060531

BOARD DATE: 20120511

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty SSG/E-6 (25B3O/Information System Analyst Operator), medically separated for fatigue, persistent status post (s/p) thyroidectomy. She did not respond adequately to treatment and was unable to perform within her Military Occupational Specialty (MOS) or meet physical fitness standards. She was issued a permanent P3/U3/L3 profile and underwent a Medical Evaluation Board (MEB). Chronic fatigue after thyroidectomy for papillary adenocarcinoma; carpal tunnel syndrome (CTS) and DeQuervain’s tenosynovitis bilateral; asthma; and cervical spondylosis C5-6 and C6-7 with herniated nucleus pulposus (HNP) were forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW AR 40-501. No other conditions appeared on the MEB’s submission. The PEB adjudicated fatigue persistent following thyroidectomy for papillary adenocarcinoma and the DeQuervain's synovitis bilateral thumbs condition as unfitting, rated 10% and 0% respectively, with application of the Veterans Administration Schedule for Rating Disabilities (VASRD). The CI made no appeals, and was medically separated with a 10% combined disability rating.

CI CONTENTION: “Upgrade rating due to conditions that were not rated and rendered a percentage or low percentage.”

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 carpal tunnel syndrome, asthma and cervical spondylosis C5-6 and C6-7 with herniated nucleus pulposus conditions as requested for consideration meet the criteria prescribed in DoDI 6040.44 for Board purview; and, are addressed below, in addition to a review of the ratings for the unfitting conditions. 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 (ABCMR).

RATING COMPARISON:

|  |  |
| --- | --- |
| **Service IPEB – Dated 20060320** | **VA (3 Mo. After Separation) – All Effective Date 20060601** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Persistent Fatigue S/P Thyroidectomy for Papillary Adenocarcinoma | 7914-7903 | 10% | Chronic Fatigue Syndrome | 6354 | 20% | 20060908 |
| Thyroid Cancer S/P Thyroidectomy | 7914-7903 | 10% | 20060908 |
| DeQuervain’s Synovitis Bilateral Thumbs | 5024 | 0% | DeQuervain’s Synovitis Bilateral Thumbs | 5024 | 0% | 20060908 |
| CTS | Not Unfitting | CTS Left Wrist | 8599-8515 | 10% | 20060908 |
| CTS Right Wrist | 8599-8515 | 10% | 20060908 |
| Asthma | Not Unfitting | Asthma | 6602 | 30% | 20060908 |
| Cervical Spondylosis | Not Unfitting | Chronic C-Spine Strain with Degenerative Disease | 5237-5242 | 10% | 20060908 |
| ↓No Additional MEB/PEB Entries↓ | 0% x 4/Not Service Connected x 3 | 20060908 |
| **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. 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 nor for conditions determined to be service-connected by the Department of Veteran Affairs’ (DVA) but not determined to be unfitting by the PEB. However the DVA, operating under a different set of laws (Title 38, United States Code), is empowered to compensate all service-connected conditions 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. 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. The Board notes that there are no service treatment records present in the available record prior to July 2005. Although many of the medical problems addressed in the DES began prior to July 2005, the Board concluded the medical documentation was adequate for review regarding disability rating recommendation at the time of separation.

Fatigue Persistent Following Thyroidectomy for Papillary Adenocarcinoma Condition. In June 2004 the CI was diagnosed with papillary thyroid carcinoma and underwent total thyroidectomy followed by I-131 treatment in August 2004. Thyroid hormone replacement therapy was prescribed and no recurrence of the cancer was detected. In the following spring, the CI received permanent change of station (PCS) orders and reported for several months of training beginning in April 2005 enroute to her next permanent duty station. Her previous assignment was in an administrative management position at a military entrance processing unit. Her new assignment was with an operational military unit that routinely conducted deployments and training exercises. While at her training base she was evaluated by neurology and sleep specialists for complaints of sleep problems. On 29 July 2005, the neurologist recorded the CI report that she normally needed 9 hours of sleep to feel rested but due to the training schedule she was getting 6 hours per night. Testing in the sleep lab in August 2005 confirmed a state of sleep deprivation and diagnosis of insufficient sleep syndrome was rendered. While at her training base, the CI was also treated for adjustment disorder related to the stress of training and family separation. A P2 profile for “chronic fatigue from thyroid cancer treatment” was issued in September 2005 while at her training base. The CI arrived at her permanent base of assignment in November 2005. At the time of a sleep clinic follow up appointment on 2 December 2005, the CI reported getting only 4 to 6 hours of sleep per night. The sleep clinic specialist concluded that most of the CI’s sleep problems were related to poor sleep hygiene. A primary care clinic appointment on 7 December 2005 records “complains of chronic fatigue and unable to perform duty.” The physician issued a P3 profile and initiated a MEB for chronic fatigue status post thyroidectomy secondary to thyroid cancer, and for carpal tunnel syndrome. At the 3 January 2006 MEB endocrinology evaluation, the CI reported problems with fatigue since her thyroid surgery causing her to tire easily. The endocrinologist indicated that the CI had not been hypothyroid for some time since thyroid hormone treatment was adjusted following surgery.

The endocrinologist recorded CI report of Synthroid dose of 150mcg. However, the endocrinologist was apparently not aware that the pharmacy medication profile for the CI showed that while her Synthroid dose was 150mcg following recovery from surgery in 2004, was reduced to 125mcg beginning 29 July 2005, and reduced again to 112mcg beginning 26 September 2005. Service treatment records documenting the prescriptions for the two dose reductions are not available for review in the case file. The endocrinology note did not document any recent lab testing for adequacy of thyroid replacement and a blood test performed on 4 January 2006 demonstrated an elevated TSH consistent with an insufficient dose of replacement thyroid hormone. At the time of a civilian rheumatology evaluation on 12 Janaury 2006, the CI reported her Synthroid dose was 125mcg (an increase from the 112mcg shown on the pharmacy profile). The rheumatologist noted that lab testing indicated she was hypothyroid and also noted the sleep problem and the CI not feeling rested. Repeat testing in February 2006 showed decreased TSH on the increased dose of Synthroid (reflecting improving correction of hypothyroidism due to insufficient replacement dosage). A neurologic examination on 6 February 2006 documented a normal mental status examination and the examiner stated that the CI’s “capacity for sustained mental activity and abstract thinking was within normal limits.”

The MEB narrative summary (NARSUM) dated 1 March 2006 noted the persisting fatigue since thyroid surgery in June 2004 preventing full physical activities. The NARSUM examiner noted the sleep evaluation results and treatment for adjustment disorder. According to VA Compensation and Pension (C&P) examinations on 30 August 2006, 3 months after separation, the CI was employed fulltime. The mental disorders examination on 30 August 2006 documented normal psychomotor activity, normal cognition, memory, concentration and attention. At the time of the C&P examination on 8 September 2006, the CI reported Synthroid dose of 125mg controlled her thyroid function and reported persisting fatigue since her thyroid surgery, which she said was diagnosed as chronic fatigue syndrome. The examiner listed “chronic fatigue syndrome” in the list of final diagnoses. Approximately 2 months after separation, the CI was seen by a civilian endocrinologist who recorded the Synthroid dose of 125mcg, and noted fatigue. The dose was increased to 150mcg, the dose that was previously established by endocrinologists as effective prior to her PCS move in April 2005. A follow up civilian endocrinology record 3 years later recorded that since the prior visit in August 2006 when the Synthroid dose was increased back to 150mcg, the CI had been feeling well.

The PEB rated the persistent fatigue following thyroidectomy for thyroid cancer 10% coded 7914-7903, hypothyroidism (7903) as a residual of treatment for thyroid cancer (7914). Under the VASRD guidelines 10% is warranted for fatigability, or continuous medication required for control. The next higher rating of 30% is warranted for worse symptoms that include mental sluggishness. The CI’s mental status examinations were repeatedly normal and did not document mental sluggishness. The Board therefore concluded that the higher rating was not supported by the evidence of the record. The VA rated her hypothyroidism 10%. The VA also provided a separate rating for fatigue analogized to chronic fatigue syndrome. The Board considered rating using the VASRD code for chronic fatigue syndrome (6354) that was applied by the VA in arriving at a 20% rating for symptoms which are nearly constant and restrict routine daily activities by less than 25 percent of the pre-illness level, or; which wax and wane, resulting in periods of incapacitation of at least 2 but less than 4 weeks total duration per year. The Board noted that the CI was not diagnosed with chronic fatigue syndrome including by the rheumatologist, and that her fatigue was linked to her status post thyroidectomy status. The Board made note of VASRD §4.88a that states for VA purposes, a diagnosis of chronic fatigue syndrome requires the new onset of debilitating fatigue severe enough to reduce daily activity to less than 50 percent of the usual level for at least 6 months; and the exclusion, by history, physical examination, and laboratory tests, of all other clinical conditions that may produce similar symptoms. Although the CI’s fatigue was reported to have begun at the time of thyroid surgery in June 2004, her NCO evaluation report for the period August 2004 to April 2005 documented excellent duty performance and a recommendation for promotion. The Board noted the presence of other conditions present at the time of the MEB and PEB that can produce symptoms of fatigue including inadequate thyroid hormone replacement dose, and insufficient sleep. Therefore the Board concluded the CI’s persisting fatigue condition was appropriately rated by the PEB and that rating under the code for chronic fatigue syndrome was not warranted. After due deliberation in consideration of the totality of the evidence, the Board concluded that there was insufficient cause to recommend a change from the PEB fitness adjudication for the persistent fatigue after thyroidectomy condition.

DeQuervain's Synovitis Bilateral Thumbs Condition. The PEB found the CI unfit due to bilateral de Quervain’s tenosynovitis, rated 0% (5024) citing normal ROM. The VA assigned a 0% rating for de Quervain’s tenosynovitis (5024) also based on normal ROM, but granted 10% ratings for right and left carpal tunnel syndrome based on wrist pain (carpal tunnel syndrome is addressed below). The right handed CI had a history of de Quervain’s tenosynovitis of the thumbs since approximately 2000. The condition causes pain with lifting and grasping involving the abductor pollicus longus and extensor pollicus brevis tendons at the medial (radial) wrist which move the thumb away from the palm of the hand and backwards respectively. The CI experienced increased problems during military training in the summer of 2005 for which she received local injections and was offered an option for surgical treatment to relieve tendon friction at the medial (radial) wrist (a simple outpatient procedure with a high success rate of 80 to 90%).

Complaints of pain prevented performance of vigorous military duties including pushups, pull-ups, moderate lifting, or repetitive movement. On examinations by orthopedics and rheumatology, there was tenderness at the medial (radial) wrist, and pain with stretching of the affected tendons (Finkelstein test). ROM of the hand and wrist was recorded as normal by examiners including rheumatology and occupational therapy, and strength was recorded as normal. The orthopedic examiner noted that the right side was worse than the left. The rheumatologist recorded that the problem was intermittent. An MEB examination on 26 January 2006, noted the condition was “doing some better.” Medical records after separation show continued problems with the condition and recommendation for surgery in 2007. Tenosynovitis is rated under VASRD diagnostic code 5024 which directs rating based on limitation of motion or as arthritis degenerative (5003) which enables rating when limitation of motion does not attain a compensable level. In this case, there was pain with use and the Board considered whether a higher rating was supported by the evidence based on consideration of §4.59 (painful motion) or §4.40 (functional loss). The Board considered the objective findings of intact motion and strength, the subjective functional limitations, and the orthopedic surgeon’s indication that the right side was worse than the left. After due deliberation, and in consideration of all the evidence and VASRD §4.3 (reasonable doubt), the Board recommends a 10% rating for the right de Quervain’s tenosynovitis and 0% for the left de Quervain’s tenosynovitis.

Contended PEB Conditions. The contended conditions adjudicated as not unfitting by the PEB were carpal tunnel syndrome, asthma, and cervical spondylosis which the PEB stated “are long standing and do not adversely impact performance of his (sic) duties.” The Board’s first charge with respect to these conditions is an assessment of the appropriateness of the PEB’s fitness adjudications. The Board’s threshold for countering fitness determinations is higher than the VASRD §4.3 (reasonable doubt) standard used for its rating recommendations, but remains adherent to the DoDI 6040.44 “fair and equitable” standard. The CI had a history of carpal tunnel syndrome since approximately 2000. She reported increased problems with training in the summer of 2005. Mild sensory but not motor component changes were noted on electrodiagnostic testing. Rheumatology examination noted mild decreased sensation.

Multiple examiners documented normal strength and sensation. The Board noted that the functional complaint impairing duty was pain with use that was considered under the de Quervain’s tenosynovitis condition. There were no separate manifestations of carpal tunnel syndrome that could be considered unfitting for continued military service. Although profiled, the asthma condition was present since 2000 without interfering with performance of duties. At the time of the MEB, spirometry was completely normal, and methacholine bronchoprovocation testing was negative for bronchospasm or induction of respiratory functional impairment. There was no objective respiratory impairment to cause the subjective symptoms and no evidence of worsening of the condition to explain why she could not continue to perform duties with the condition as before. The subjective decline in exercise capacity was best explained by her subjective complaint of fatigue and not the asthma condition. Neck pain is variously reported as beginning in 1999 during training while wearing heavy equipment or falling down a hill, and aggravated by a motor vehicle accident on 12 May 2005 when her car was rear-ended by another car. According to the MEB NARSUM, the CI experienced acute neck pain and spasm after the crash, followed by chronic residual pain and spasm with difficulty turning and bending the neck, and performing physically demanding military activities including sit-ups, pushups, running and wearing combat gear.

At a neurology evaluation on 29 July 2005, 10 weeks after the accident, the examiner recorded a history of intermittent headaches for a year that had worsened in the prior month associated with neck pain and stiffness. Neurologic examination was normal. Evaluation by a chiropractor noted constant pain, and tenderness on examination consistent with myofascial pain. An MRI on 13 January 2006 showed C5-6 and C6-7 disc bulge but with patent neuroforamina. There were no examination findings of radiculopathy by the chiropractor, or by the neurosurgeon on 6 February 2006, and an electromyogram in September 2005 was normal (no evidence for radiculopathy). A post-service X-ray of the cervical spine on 30 August 2006 and an MRI on 23 October 2007 were both normal. Report of neck pain was noted to be variable and the CI was indicated to have pain ratings of 0 at some appointments. On 8 December 2005, the CI sought care in the emergency room for recurrent neck pain without trauma and was placed on quarters overnight. On the report of medical assessment, DD Form 2697, completed by the CI on 13 December 2005, no mention of neck pain is made. The MEB NARSUM reported cervical spine ROM results performed 6 January 2006: flexion was 30 degrees, extension was 30 degrees, and rotation 45 degrees, all limited by pain with muscle spasm. Chiropractic examinations in January and February 2006 recorded normal posture with tenderness but no muscle spasm was recorded. The rheumatology evaluation on 12 January 2006 makes no reference to complaint of neck pain. The neurosurgery examination on 6 February 2006 recorded moderate limitation of motion with pain. Examination findings recorded by an allergist and endocrinologist noted no reduced suppleness of the neck, and no neck weakness. At the VA C&P examination on 30 August 2006, three months after separation, the examiner recorded complaints of neck pain with muscle spasm, pain with turning the head and lifting above the shoulder level. The CI reported flare ups lasting one to two days on four or five occasions during the prior year. On examination, the cervical spine range-of-motion (ROM) was flexion of 45 degrees, extension 35 degrees, lateral bending 15 degrees bilaterally, and rotation 60 degrees bilaterally. There was no evidence of additional limitation due to pain, weakness, fatigue, lack of endurance after repetitive motion. The examiner concluded that there was no evidence of adverse impact on activities of daily living, personal grooming, hygiene, transportation or occupation. The Board discussed whether the neck condition in isolation from the other medical complaints would have been separately unfitting. As noted, the CI’s neck pain was aggravated by a motor vehicle accident. The Board considered the evidence of the service treatment record including examination results by the chiropractor and neurosurgeon. The Board also considered the results of the C&P examination since it was closer to the time of separation. After due deliberation, the Board agreed that the preponderance of the evidence with regard to the functional impairment of the neck pain condition favors its recommendation as an additionally unfitting condition for separation rating. It is appropriately coded 5237 and meets the VASRD §4.71a criteria for a 10% rating under that code. Regarding the carpal tunnel syndrome and asthma, there was no indication from the record that these significantly interfered with satisfactory duty performance. All evidence considered, there is not reasonable doubt in the CI’s favor supporting recharacterization of the PEB fitness adjudication for carpal tunnel syndrome and asthma.

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 persistent fatigue following thyroidectomy for papillary adenocarcinoma and IAW VASRD §4.120, the Board unanimously recommends no change in the PEB adjudication. In the matter of the right de Quervain’s tenosynovitis condition, the Board unanimously recommends a rating of 10% coded 5024 IAW VASRD §4.71a. In the matter of the left de Quervain’s tenosynovitis condition, the Board unanimously recommends a rating of 0% coded 5024 IAW VASRD §4.71a. In the matter of the chronic neck pain condition, the Board unanimously recommends that it be added as an additionally unfitting condition for separation rating; coded 5237 and rated 10% IAW VASRD §4.71a. In the matter of the carpal tunnel syndrome and asthma conditions, the Board unanimously recommends no change from the PEB adjudication as not unfitting. 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 her prior medical separation:

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| --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Persistent Fatigue s/p Thyroidectomy for Thyroid Cancer | 7914-7903 | 10% |
| De Quervain’s Tenosynovitis, Right | 5024 | 10% |
| De Quervain’s Tenosynovitis, Left | 5024 | 0% |
| Cervical Spondylosis, Chronic Neck Pain | 5237 | 10% |
| **COMBINED (Incorporating BLF)** | **30%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20111019, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans Affairs Treatment Record.

 XXXXXXXXXXXX

 President

 Physical Disability Board of Review

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 XXXXXXXXXXXXXXXX, AR20120009407 (PD201100946)

1. Under the authority of Title 10, United States Code, section 1554(a), I accept in part so much of the enclosed recommendation of the Department of Defense Physical Disability Board of Review (DoD PDBR) pertaining to the subject individual to increase the rating for De Quervain’s Tenosynovitis, Right from 0% to 10% and to modify the individual’s disability rating to 20% without recharacterization of the individual’s separation. There is insufficient justification to support the Board’s full recommendation in accordance with Army and Department of Defense regulations. I reject the PDBR recommendation to change Cervical Spondylosis (chronic neck pain) to “unfitting.” The PDBR discusses the positive and negative objective findings as well as the individual’s Range of Motion and symptoms. They do not, however, address the factors pertinent to a fitness determination. They do not address the limitations imposed by the Physical Profile due to neck pain, nor do they mention the individual’s MOS and the affect that neck pain had on her ability to perform the duties of her MOS. Likewise, the Commander’s letter to the PEB which discusses the individual’s limitations that affect duty performance is not mentioned. The Army has, in effect, stated that it was willing to accommodate any limitations imposed by the individual’s neck pain and the PDBR has not shown this to be an error.

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.

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 XXXXXXXXXXXXX

 Deputy Assistant Secretary

 (Army Review Boards)

CF:

( ) DoD PDBR

( ) DVA