RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: xxxxxxxxxxxxxxxxxxxxxxxx BRANCH OF SERVICE: navy

CASE NUMBER: PD1101024 SEPARATION DATE: 20040519

BOARD DATE: 20120627

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty Ensign/O-1E (1165/Ship Self Defense Systems Technician), medically separated for heterozygous factor V Leiden deficiency. He was placed on limited duty (LIMDU) and underwent a Medical Evaluation Board (MEB). Heterozygous factor V Leiden deficiency, requiring lifelong Coumadin therapy was forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW SECNAVINST 1850.4E. No other conditions appeared on the MEB’s submission. The PEB adjudicated the heterozygous factor V Leiden deficiency, requiring lifelong Coumadin therapy condition as unfitting, rated 0% with application of SECNAVINST 1850.4E. The CI appealed to a Formal PEB (FPEB) requesting to be found fit for continued Naval service. The FPEB also determined his condition was incompatible with Naval service and applied a 0% combined disability rating with application of SECNAVINST 1850.4E. The CI then requested a continuation on active duty (COAD) but this was denied and he was medically separated with a 0% combined disability rating.

CI CONTENTION: “My Navy disability rating for service connection for heterozygous factor V Leiden deficiency with deep vein thrombosis of both legs with post-phlebetic syndrome and chronic venous insufficiency caused by genetic insufficiencies and misdiagnosis was incorrectly rated at zero percent. The VA correctly rated my disability at 70% (40% for each leg). From the time of service and now I have had documented persistent edema, stasis pigmentation, and pain in both legs. My first blood clot occurred while at sea in the Persian Gulf. The doctor diagnosed it as a pulled muscle and gave me Tylenol. It wasn't until a month later in port when it was accurately discovered that I had a blood clot that went from my foot all the way to my thigh. The second blood clot occurred when I was in the Enlisted Commissioning program at school. I told the Navy doctor that the pain felt just like the pain I had with the first blood clot. The base doctor instructed me that just because I had a clot before doesn't mean I have a clot again and sent me home. No test were [*sic*] given to inspect for a blood clot for about a month. Both blood clots with delayed treatment of therapeutic anticoagulants resulted in chronic post-phlebetic syndrome as exhibited by persistent edema bilaterally to lower extremities, discoloration, pain, decreased circulation, and inflammation of veins and collateral vessels requiring compression hosiery to be worn on both legs. My condition was appropriately evaluated and diagnosed by the VA while still on active duty and continues to be monitored by the VA.” He 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.” The ratings for unfitting conditions will be reviewed in all cases. The conditions of history of deep vein thrombosis of the right and left lower extremities with post-phlebetic syndrome and chronic venous insufficiency as requested for consideration are the residuals that, IAW with the VASRD, should be used to rate the unfitting condition of heterozygous factor V Leiden deficiency and therefore they meet the criteria prescribed in DoDI 6040.44 for Board purview; and are addressed below, as part of the review of the rating for the unfitting condition. 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).

RATING COMPARISON:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Service FPEB – Dated 20030529** | | | **VA (~2 weeks Pre-Separation) – All Effective Date 20040520** | | | |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Heterozygous Factor V Leiden Deficiency | 7799-7121 | 0% | Heterozygous Factor V Leiden Deficiency with Thrombosis of the Right Lower Extremity | 7199-7120 | 40% | 20040505 |
| Heterozygous Factor V Leiden Deficiency with Deep Vein Thrombosis of the Left Leg with Post-Phlebitic Syndrome | 7199-7121 | 40% | 20040505 |
| ↓No Additional MEB/PEB Entries↓ | | | 0% X 0 / Not Service-Connected x 0 | | | |
| **Combined: 0%** | | | **Combined: 70%** | | | |

ANALYSIS SUMMARY: The Board acknowledges the sentiment expressed in the CI’s application, i.e., that the gravity of his condition merits consideration for a higher separation rating. The Board wishes to clarify that it is subject to the same laws for 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. 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.

Heterozygous Factor V Leiden Deficiency. The CI initially presented with 3 days of left calf pain in March 1998 while at sea. At an initial visit his left calf was noted to have edema, was tender to palpation, and its circumference was 40.5 compared to 39.5 on the right. He was given nonsteroidal anti-inflammatory (NSAID) medication and was given sick in quarters for 24 hours. On follow-up visit, a 2 week history of left lower extremity pain was noted. Physical examination noted the CI was walking with a limp favoring his left leg. He had edema of the left lower leg with tenderness to palpation of the proximal gastrocnemius, a normal neurologic examination, and a positive Homan’s sign. The assessment was a gastrocnemius pull and his treatment was changed to a different NSAID. However, the plan also included education on the signs and symptoms of pulmonary embolism and the CI was instructed to keep his leg elevated as much as possible. He was given light duty for 14 days with no prolonged standing or walking greater than 10 minutes. No other clinical notes are available until 24 April 1998 when an ultrasound noted a deep venous thrombosis (DVT) of the superficial femoral and popliteal veins. The ultrasound reports states this was in the right lower extremity; however, all other notes refer to the left lower extremity and this is felt to be an error. The CI was started on anticoagulant therapy with Lovanox and Coumadin and a LIMDU Board was completed with limitation of no strenuous activity, no running, no PRT, and no shipboard duty. The CI was also to remain well-hydrated. The LIMDU was set to expire in December 1998. The plan was treatment with Coumadin for 6 months and he had several visits for adjustments of his dose. In June 1998 he was noted to have 2+ pitting edema of the pretibial area of the left lower extremity and a dusky forefoot but good pulses. His Coumadin was continued. A visit in September 1998 noted no interim complications and the plan was to continue the Coumadin until late October 1998 and then discontinue anticoagulant therapy and return to full duty.

The CI then applied for an enlisted commissioning program and this history of DVT was disqualifying. At a clinical visit in February 1999 an assessment of DVT with mild post-phlebitic syndrome was made. The CI had been able to score 292 points on his PRT and did not have left leg pain with exertion. His left calf measured 16 3/8 inches and the right was 16 1/8 inches and both ankles were 9 3/8 inches. Minimal venous dilation of the left leg was noted, pulses were full and symmetric, sensation was intact to touch, and both lower extremities were warm. This examiner recommended a waiver so the CI could enter the enlisted commissioning program. In a memorandum dated 18 February 1999, the Chief, Bureau of Medicine and Surgery (BUMED) recommended a waiver of the physical standards. A memorandum dated 31 March 1999 to the CI noted the waiver was granted for history of deep vein thrombosis.

In July 1999 a consult to surgery was requested and he was evaluated by general surgery on 30 August 1999. This examination noted varicose veins and recommended the CI continue support hose. An ultrasound was ordered and the CI was supposed to follow-up after the ultrasound was completed. A January 2000 clinical note states the CI was out to sea and had been unable to get the ultrasound ordered by the surgery clinic. The CI reported intermittent paresthesias of the left foot and swelling after exercise. Physical examination noted mildly dilated superficial vessels of the left lower extremity, no calf tenderness and a negative Homan’s sign. The assessment was history of left lower extremity DVT with postphlebitic changes.

A lab test performed on 17 October 2001 documented a positive test for the heterozygous presence of the factor V gene for Leiden mutation. However, no further notes are available until an annual certificate of physical condition dated 11 November 2001 which stated the CI had had a blood clot in his right leg in December 2000 and had taken Coumadin within the past 12 months. (This would not have been referring to the previous Coumadin treatment for the left lower extremity DVT as that treatment had ended in October 1998.) The record contains a copy of an email dated 10 December 2001 stating that on 24 January 2001 BUMED had recommended a waiver for a December 2000 right leg DVT and it had been approved by CNET on 1 February 2001. A clinical note from June 2002 noted the CI had recently been commissioned as an officer and that hematology recommended the Coumadin be continued indefinitely.

Clinical visit notes from July and August 2002 contains the complete history of the CI’s two DVTs, one in the left lower extremity in March 1998 and one in the right lower extremity in December 2000. The CI had been on Coumadin since December 2000 and was using compression stockings. With the factor V deficiency, recurrent DVTs, and need for lifelong Coumadin therapy, the CI was unfit for sea duty and was referred for an MEB. The July note did not have a physical exam but the August note documented the absence of edema. An examination in May 2003 at the hematology clinic at Bethesda National Naval Medical Center also notes the absence of edema. Compression stockings were prescribed and long term anticoagulation was required but could be accomplished with a low-intensity regimen. No other physical examination reports are available in the record for Board review until a clinical visit in February 2004. This note documents a report of discoloration of the foot (unspecified right or left) and chronic swelling of bilateral lower extremities with chronic pain. The CI also reported tingling of both feet after prolongedstanding or sitting. His leg pain was rated at 5/10. The physical exam noted bilateral edema with normal sensation and positive discoloration of the left foot and the examiner assessed positive sequelae of thrombosis bilateral legs. Previous notes documented a dusky color of the left foot.

The MEB narrative summary (NARSUM) dated 25 November 2002 (18 months prior to separation) does not contain any physical exam findings and is not signed. It does note a history of two episodes of DVT, one in March 1998 and one in December 2000. It does not specify which leg was involved, but does note each episode was treated with 6 months of Coumadin. It also reports the finding of heterozygous factor V Leiden deficiency in October 2001 and the need for lifelong Coumadin.

A VA Compensation and Pension (C&P) examination was completed on 5 May 2004, 2 weeks prior to separation from service. It noted the same clinical history described above. The CI reported he continued to have swelling and of both of his legs if he sits for greater than 10 minutes or if he stands for more than 10 minutes (the same thing he reported in February 2004) or if he sits then stands. He also reported he had sensations as if standing on glass at these times as well. He also reported an aching type pain rated at 6/10 and he usually tries to move his legs to get relief. His pain is normally 0-1/10. He also reported the need for lifelong Coumadin. The physical examination noted bilateral lower extremity non-pitting edema and non-tender tortuous veins. The skin was reported as intact with a bluish discoloration of the feet. The left calf was 43cm and the right was 43.5cm and the gait was normal.

On 13 March 2003, the PEB determined the CI was unfit and recommended a rating of 0% for code 7799-7121, heterozygous factor V Leiden deficiency. The CI requested a formal hearing. The FPEB convened 29 May 2003, almost a full year prior to separation, and the CI requested to be found fit to continue Naval service. The FPEB noted the CI made a strongly compelling argument for retention, but ultimately determined the CI’s hypercoagulable state requiring chronic use of anticoagulants was incompatible with military service. The FPEB recommended separation with a 0% disability rating and its rationale stated: SECNAVINST 1850.4E paragraph 9004 requires a rating of zero percent if there has been no thrombophlebitis or embolus in the past year. The now rescinded DoDI 1332.39 also states that hypercoagulable states will be rated at zero percent rating if there have been no episodes of thrombophlebitis or embolus in the past year. However, the DoDI further states that higher ratings are based on residuals to emboli or thrombophlebitis. Neither the PEB nor the FPEB addressed the presence or absence of any residuals. The VASRD does not include any similar instructions and the VA rated the CI’s condition based on the residuals of the hypercoagulable state which were present in each lower extremity. The VA applied a 40% rating for each lower extremity. Although it used two different codes 7199-7120 and 7199-7121, both of these codes have identical rating criteria. The 40% rating requires persistent edema and stasis pigmentation or eczema, with or without intermittent ulceration. The VA presumably based their ratings on bilateral non-pitting edema and bluish discoloration of the feet.

The PEB rated heterozygous factor V Leiden deficiency with two episodes of deep venous thrombosis, requiring lifelong Coumadin therapy under the single analogous 7799-7121 code. This coding approach is countenanced by SECNAVINST 1850.4E and DoDI 1332.39, but the DoDI also stated that higher ratings are based on residuals to emboli or thrombophlebitis. However, IAW DoDI 6040.44 the Board must apply only VASRD guidance to its recommendation. The VASRD does not have a specific code for hypercoagulability due to heterozygous factor V Leiden deficiency and the ratings under codes 7121 Post-phlebitic Syndrome of any etiology and 7120 Varicose Veins are for involvement of a single extremity. If more than one extremity is involved, each extremity is to be evaluated separately and combined under §4.25, using the bilateral factor §4.26 if applicable. The Board must therefore apply separate codes and ratings in its recommendations if compensable ratings for each lower extremity is achieved IAW VASRD §4.104. If the Board judges that two or more separate ratings are warranted in such cases; however, it must satisfy the requirement that each “unbundled” condition was unfitting in and of itself. Since §4.104 criteria are met for separate lower extremity ratings in this case, the Board is pursuing separate rating and fitness evaluations as follows.

The Board first considered if hypercoagulability due to heterozygous factor V Leiden deficiency with left lower extremity post-phlebitic syndrome, having been de-coupled from the combined PEB adjudication, remained independently unfitting as established above. This condition by itself would require lifelong Coumadin treatment. The Board determined that left lower extremity post-phlebitis syndrome, as an isolated condition, would have rendered the CI incapable of continued service within his Rating, and accordingly merits a separate rating. The Board next considered if hypercoagulability due to heterozygous factor V Leiden deficiency with right lower extremity post-phlebitic syndrome, having been de-coupled from the combined PEB adjudication, remained independently unfitting as established above. This condition by itself would require lifelong Coumadin treatment. The Board determined that right lower extremity post-phlebitis syndrome, as an isolated condition, would have rendered the CI incapable of continued service within his Rating, and accordingly merits a separate rating.

Deep venous thromboses had occurred in each lower extremity and bilateral edema was noted with intact skin and bluish discoloration of the feet on the VA C&P examination completed 2 weeks prior to separation. The MEB NARSUM was completed 18 months prior to separation and does not contain any physical exam findings and is not signed. The MEB history and physical is not dated and does not contain any abnormal physical findings. None of these exams specifically comment on the presence or absence of stasis pigmentation, eczema, or ulcerations. However, a clinical visit note on 5 February 2004, 3 months prior to separation documents a report of discoloration of the left foot and chronic swelling of bilateral lower extremities with chronic pain. The CI also reported tingling of both feet after standing or sitting. His leg pain was rated at 5/10. The physical exam noted bilateral edema with normal sensation and positive discoloration of the left foot and the examiner assessed positive sequelae of thrombosis bilateral legs. This examination documents findings similar to the VA C&P examination and both of these examinations occurred prior to separation. Neither examination addresses whether the swelling resolves with elevation or compression. Both state the pain and/or swelling occurs with prolonged sitting or standing, implying it is not present at all times.

The VA C&P examination noted the CI would get pain relief after moving his legs and the pain would be 0-1/10 and this implies some periods of at least incomplete, if not full, relief. He also had stasis pigmentation documented in his left foot on more than one visit in this service treatment record (STR) and on both the VA C&P and the exam of February 2004 and this indicates a more severe problem. While there is incomplete information about the persistence and degree of relief of the bilateral lower extremity edema, the presence of stasis pigmentation warrants a rating greater than 10% in the left lower extremity.

After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board recommends a separation rating of 20% for the heterozygous factor V Leiden deficiency with deep vein thrombosis of the left leg with post-phlebetic syndrome condition. The presence of stasis pigmentation in the right lower extremity is noted only on the VA C&P examination. Although this examination occurred prior to separation, this finding is not documented on any other examination in the record. The Board deliberated at length as to whether the heterozygous factor V leiden deficiency with deep vein thrombosis of the right leg with post-phlebetic syndrome condition would be appropriately rated at 10% or 20%. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board recommends a separation rating of 10% for the right lower extremity.

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. As discussed above, PEB reliance on SECNAVINST 1850.4E and DoDI 1332.39 for rating heterozygous factor V Leiden deficiency was operant in this case and the condition was adjudicated independently of that instruction by the Board. In the matter of the heterozygous factor V Leiden deficiency with deep vein thrombosis of the left leg with post-phlebetic syndrome condition, the Board unanimously recommends a disability rating of 20%, coded 7199-7121 IAW VASRD §4.104. In the matter of the heterozygous factor V Leiden deficiency with deep vein thrombosis of the right leg with post-phlebitic syndrome condition, the Board unanimously recommends a disability rating of 10%, coded 7199-7121 IAW VASRD §4.104. 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:

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| --- | --- | --- | --- |
| **UNFITTING CONDITION** | | **VASRD CODE** | **RATING** |
| Heterozygous Factor V Leiden Deficiency with Deep Vein Thrombosis of the Left Leg with Post-Phlebitic Syndrome | | 7199-7121 | 20% |
| Heterozygous Factor V Leiden Deficiency with Deep Vein Thrombosis of the Right Leg with Post-Phlebitic Syndrome | | 7199-7121 | 10% |
| **COMBINED (w/BLF 2.8)** | | **30%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20111026, w/atchs

Exhibit B. Service Treatment Record

Exhibit C. Department of Veterans’ Affairs Treatment Record

President

Physical Disability Board of Review

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

(c) PDBR ltr dtd

(d) PDBR ltr dtd

(d) PDBR ltr dtd

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: Placement on the Permanent Disability Retired List with a 30% disability rating effective 19 May 2004.

b. former USMC: Placement on the Permanent Disability Retired List with a 30% disability rating effective 15 April 2006.

c. former USN: Disability separation with entitlement to disability severance pay with a rating of 20% (increased from 10%) effective 3 February 2005.

d. former USMC: Placement on the Permanent Disability Retired List with a 60% disability rating effective 30 January 2008.

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.

Assistant General Counsel

(Manpower & Reserve Affairs)