RECORD OF PROCEEDINGS
PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXXXX
CASE NUMBER: PD1200401
BOARD DATE: 20121218

BRANCH OF SERVICE: ARMY
DATE OF PLACEMENT ON TDRL: 20060517
DATE OF PERMANENT SEPARATION: 20070517

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty SPS/E-4 (11B10/Infantryman), medically separated for right common peroneal nerve injury and chronic abdominal pain. The CI was shot in the abdomen while on patrol in Iraq on 13 February 2005. He was treated surgically in theater, en route and after redeployment. He suffered a compression injury to the right common peroneal nerve in the immediate post-injury period with persistent foot drop and dysthesia. He could not be adequately rehabilitated to meet the physical requirements of his Military Occupational Specialty (MOS) or satisfy physical fitness standards. He was issued a permanent P3L3H3 profile and referred for a Medical Evaluation Board (MEB). The MEB determined that the right common peroneal nerve neuropathy and intractable abdominal pain status post (s/p) gunshot wound (GSW) did not meet retention standards. Bilateral tinnitus, moderate high frequency hearing loss (HFHL) and a depressive disorder, largely in remission, conditions were determined to be meet retention standards. All five conditions were forwarded by the MEB to the Physical Evaluation Board (PEB) for adjudication, although the tinnitus and HFHL were combined into a single condition. The PEB adjudicated the right common peroneal nerve injury and chronic abdominal pain secondary to a GSW as unfitting, rated 20% and 10% respectively, with application of the Veteran's Affairs Schedule for Rating Disabilities (VASRD) and placed the CI on the temporary disability retirement list (TDRL). The tinnitus, HFHL and depressive conditions were determined to be not unfitting conditions. The CI next met the PEB on 15 May 2007. His conditions were determined to have stabilized and permanent retirement recommended. The right common peroneal nerve condition was determined to have improved and rated at 10%. The rating for the abdominal pain was left at 10%, although the VASRD code was changed. The CI made no appeals at either TDRL entry or exit. He was medically separated with a 20% permanent disability rating.

CI CONTENTION: "The bases to lower my rating was made because I stopped using the AFO that was made for me, the AFO was causing my right leg muscle to shrink. The range of motion tests showed no improvement as well as no improvement in sensation or strength. Even now 7 years after injury I still have strength, range of motion issues and decreased sensitivity in my right leg and foot. The findings state that I had improvements in nerve Function and no longer needed to use the AFO the only reason I stopped wearing the brace was because it was causing a noticeable difference in the size of my calf muscles. I still have numbness in my leg, as well as reduced range of motion and strength."

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 right peroneal nerve condition and chronic abdominal pain meet the criteria prescribed in DoDI 6040.44 for Board purview, and are accordingly addressed below. No other condition is within the Board's purview. 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 Correction of Military Records.

TDRL RATING COMPARISON:

Service IPEB – Dated 20050515			
Condition	**Code**	**Rating**	
On TDRL – 20060517		**TDRL**	**Sep.**
R Common Peroneal N Inj	8521	20%	10%
Chronic Abd Pain	7301		10%
Chronic Abd Pain	5319	10%	
↓No Additional MEB/PEB Entries↓			
Combined: 20%			

VA* – All Effective Date 20060517			
Condition	**Code**	**Rating**	**Exam**
Right Common Peroneal Nerve Neuropathy …	8521	20%*	20060816
Intractable Abd Pain s/p GSW	5319	30%	20060816
PTSD; MDD	9411	50%	20060919
Tinnitus	6260	10%	20060816
0% x 1/Not Service Connected x 3			*20061128*
*Combined: 80%*******			

*Initially rated 20% then reduced to 10% effective 20110315; LS DDD rated at 10% effective 20100710; OSA rated 50% effective 20120105; Abd scar rated 10% effective 20110315; IBS rated 10% effective 20120105;** Initially rated 80% then rated 90% effective 20120105.

ANALYSIS SUMMARY: On 13 February 2005, the CI sustained a life threatening GSW to the abdomen necessitating emergency surgical intervention in theater and rapid air evacuation to Germany and then CONUS (continental US) for further treatment and convalescence. During the evacuation he was sedated and suffered a compressive neuropathy of the right common peroneal nerve. Despite extensive rehabilitation, neither condition improved sufficiently to allow the CI to return to duty. He was entered into the Disability Evaluation System (DES) process.

The Right Common Peroneal Nerve Injury Condition. There were three goniometric range-of-motion (ROM) evaluations in evidence, with documentation of additional ratable criteria, which the Board weighed in arriving at its rating recommendation; as summarized in the chart below.

Ankle ROM Degrees	MEB ~ 7 Mos. Pre-TDRL entry		VA C&P ~3 Mos. Post TDRL entry		PT ~1 Mo. Pre TDRL exit	
	Left	Right	Left	Right	Left	Right
Dorsiflexion (0-20)	#	0		0 after repetition	10	0
Plantar Flexion (0-45)	#	20		25	45	45
Comment	Mechanical limit to ROM			Motion painful		Motion limited by sensation of weakness
§4.71a Rating	--	20%	--	20%	N/A	10%

The CI began physical therapy (PT) once he had sufficiently stabilized from his injuries. At a 6 July 2005 PT visit, he was noted to have foot drop and weakness (4/5) of the right foot dorsi-flexors, but normal ROM. On 30 August 2005, he was again seen in PT and noted to have full active ROM. His strength was improved to 4+/5 and 5/5 for the muscles of dorsi-flexion and slight foot drop remained. Paresthesias of the right deep fibular cutaneous nerve was noted along with diminished sensation to light touch. However, ROM measurements on 13 October were limited in dorsiflexion and plantar flexion. On 26 October 2005, he was seen in neurology. It noted that electrodiagnostic studies showed an incomplete, but severe, focal lesion of the right peroneal nerve. The sensory deficit had improved, but the motor deficit was unchanged from previous examinations. However, sensation remained impaired in the distribution of the

right common peroneal nerve. Muscle bulk and tone was normal, but strength reduced to 4+/5 for dorsiflexion and 4-/5 for extension of the right great toe. The ROM was noted to be reduced and the gait showed mild right circumduction with slight foot slap. This is consistent with the weakened dorsiflexion observed. Toe and tandem gait were normal although the CI was unable to heel walk, also secondary to impaired dorsiflexion. At the MEB examination on 11 October 2005, 8 months prior to TDRL entry, the CI reported persistent numbness and loss of motion for which he used an orthotic device. The MEB examiner noted the sensory loss and limited ROM for both plantar and dorsiflexion. The narrative summary (NARSUM) was dictated on 14 December 2005, 6 months prior to TDRL entry. It reproduced the neurology examination from 26 October 2005. At the VA Compensation and Pension (C&P) examination on 16 August 2006, 3 months after TDRL entry, the CI reported continued numbness of the right lower extremity, but no pain. He used an orthotic, but only when he wore work boots. He reported weakness in dorsiflexion. A very minimal right foot drop was noted; posture and gait were otherwise normal. Sensation was diminished in the right peroneal nerve distribution. Strength was reduced to 4/5 for both dorsiflexion and extension of the right great toe. He was working for his uncle at the latter's ranch and planned to return to school. His job included installing decking and hand rails, building a handicapped ramp and taking care of the horses. He was noted to have not been limited in these activities. The Board directs attention to its rating recommendation at TDRL entry based on the above evidence. The PEB and VA both rated the right peroneal neuropathy condition at 20% for moderate disability and coded it 8521, incomplete paralysis of the common peroneal nerve. There was no evidence that the sensory loss significantly impaired duty and the Board determined that it was not separately unfitting. The minimal change in gait did not rise to the severe level of disability. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board concluded that there was insufficient cause to recommend a change in the PEB adjudication for the right common peroneal nerve neuropathy condition for TDRL entry. The Board then turned its attention to the permanent disability rating. The TDRL exit examination was accomplished on 12 April 2007, a month prior to permanent separation, in the neurology clinic. The CI reported minimal improvement in his weakness, but endorsed the ability to run. He no longer used the orthotic. On examination, sensation was normal. Strength was reduced to 5-/5 in dorsiflexion, improved from the previous PEB and VA examinations. Muscle bulk was noted as abnormal, but not specified. Gait was normal other than the inability to heel walk. He was thought to have stabilized in his disability. The VA did not re-address the right peroneal neuropathy until the 9 October 2010 C&P, over 3 years after permanent separation. Ankle dorsi and plantar flexion were both noted to be normal at 5/5 strength and tone was normal without atrophy. Gait was normal. The PEB determined that the CI had improved and that a 10% rating, consistent with a mild disability was appropriate. The VA did not readjudicate the peroneal neuropathy until 17 May 2011 when it reduced the rating to 10% using the October 2010 C&P. The Board determined that neither examination supported an evaluation higher than moderate and that the C&P examination, although remote from permanent separation, supported the improvement observed on the TDRL exit examination and the PEB permanent adjudication. After due deliberation in consideration of the preponderance of the evidence, the Board concluded that there was insufficient cause to recommend a change in the PEB fitness determination for the right common peroneal neuropathy condition at permanent separation.

Chronic Abdominal Pain with Occasional Cramps and Bowel Dysfunction Presumed Due To Peritoneal Adhesions From Prior Wounding and Surgeries Condition. As noted above, the CI sustained a GSW to the abdomen while deployed. He underwent multiple surgical procedures with delayed closure of the abdominal wall secondary to edema. He noted abdominal "crampy" pain with activity starting several months after the injury. He took no medications for this and denied change in bowel habits. A CT scan performed on 14 July 2005 showed post-operative changes and a retained bullet, the latter was subsequently removed in minor surgery. He continued to have abdominal pain with cramping, unrelieved by medications or position, with numbness over the abdominal scar when seen in general surgery on 24 October 2005. The

scar was noted to be well healed and tenderness was diffuse, but greater in the left lower quadrant. The CI also noted irregular bowel habits. At the MEB examination, the CI reported continued "stomach" pains and loose bowel movements. The MEB examiner noted mild discomfort in all quadrants and a healed scar. At the NARSUM, the CI reported continued abdominal pain in both the wall muscles and intestines. On examination, he was noted to have a large amount of scar tissue. He had diffuse tenderness which was greatest in the left lower quadrant. Bowel sounds were present. There was no rebound tenderness or guarding indicative of peritoneal irritation. The entry wound in the left lower quadrant was well healed. The pain was thought to be secondary to the scar formation. At the C&P examination 3 months after TDRL entry, the CI reported daily pain along the incision line with occasional loose stools and cramping. He took no medications for this. He denied nausea, vomiting, blood in his stools or weight change. A tender, well healed midline abdominal scar was noted. The mesh was palpable. Tenderness was present particularly in the left lower quadrant, but without rebound or guarding. He had no herniation and was noted to be muscular without weakness other than from the peroneal neuropathy. He was noted to have intractable abdominal pain and scar pain. As already noted above, he was working part time for his uncle on his ranch. His job included installing decking and hand rails, building a handicapped ramp and taking care of the horses. He was noted to have not been limited in these activities. The Board directs attention to its rating recommendation for TDRL entry based on the above evidence. The PEB rated the abdominal pain at 10% for moderate disability and coded it 5319, abdominal muscular dysfunction. The VA rated the abdominal condition at 30% for moderately severe disability, but also coded it 5319. The Board considered the descriptions for both levels of disability and determined that the description for the moderate level of disability best fit the findings in evidence. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board concluded that there was insufficient cause to recommend a change in the PEB adjudication for the abdominal pain condition for TDRL entry. The Board then considered the permanent disability rating at TDRL exit. The PEB rated the condition at 10%, but changed to coding to 7301, adhesions of the peritoneum. The VA did not readdress the abdominal pain until over three years after permanent separation. The 22 April 2007 NARSUM noted that the CI had persistent abdominal pain. It was typically 4/10 and occurred 3-4 times per week. It was not associated with either food or meals. He noted several bowel movements per day. His weight was noted as stable. He stated that he was unable to do sit ups and also that his abdomen hurt after running. On examination he had a benign abdomen with well-healed scars. He had mild tenderness to palpation in the periumbilical region. It was uncertain if the persistent pain was secondary to the multiple surgical procedures or from the scars. The VA reexamined the CI on 1 April 2011, 4 years after permanent separation, well outside the 12-month window typically used for Board adjudication. He complained of weakness and fatigability of the abdominal musculature. On examination, he was noted to have reduced strength, but without tissue loss or intramuscular scarring. The superficial scar was tender to palpation. This was thought to have a moderately severe effect on function. The VA continued him at a 30% level of disability. The Board noted that this examination showed more impairment than either the PEB examination proximate to the TDRL exit or the initial C&P accomplished during the TDRL period. The Board also noted that the initial VA C&P was performed during the one year TDRL period. After due deliberation in consideration of the preponderance of the evidence, the Board concluded that there was insufficient cause to recommend a change in the PEB permanent disability rating for the abdominal pain condition at permanent separation.

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 right common peroneal nerve and abdominal pain conditions and IAW VASRD §4.124a and §4.114, the Board, by a vote of 2:1, recommends no change in the PEB adjudication. The single voter for dissent, who recommended adopting the VA rating 8521 at 20% for the right common peroneal nerve condition at permanent separation, did not elect to submit a minority opinion. There were no other conditions within the Board's scope of review for consideration.

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	
		TDRL	PERMANENT
Right Common Peroneal Nerve Neuropathy	8521	20%	10%
Chronic Abdominal Pain	5319	10%	--
Chronic Abdominal Pain	7301	--	10%
	COMBINED	**30%**	**20%**

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20120430, w/atchs
Exhibit B. Service Treatment Record
Exhibit C. Department of Veterans' Affairs Treatment Record

XXXXXXXXXXX, DAF
President
Physical Disability Board of Review

SFMR-RB

MEMORANDUM FOR Commander, US Army Physical Disability Agency
(TAPD-ZB / XXXXXXXXXX), 2900 Crystal Drive, Suite 300, Arlington, VA 22202-3557

SUBJECT: Department of Defense Physical Disability Board of Review Recommendation for XXXXXXXXXXXXXXX, AR20130000155 (PD201200401)

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