RECORD OF PROCEEDINGS
PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXXXXXX
CASE NUMBER: PD1200942
BOARD DATE: 20121207

BRANCH OF SERVICE: ARMY
SEPARATION DATE: 20021130

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty, PFC/E-3, (92A/Automated Logistics Specialist), medically separated for right femoral neuropathic pain after removal of a lymph node and antibiotic treatment for a post-operative infection. Despite numerous invasive and therapeutic treatments, the CI's pain persisted and she was unable to meet the physical requirements of her Military Occupational Specialty or satisfy physical fitness standards. She was issued a permanent L3 profile and referred for a Medical Evaluation Board (MEB). The MEB forwarded only the right femoral neuropathic pain for Physical Evaluation Board (PEB) adjudication. The PEB adjudicated the femoral neuropathic pain after removal of lymph node and treatment of infections with antibiotics as unfitting and rated it 20% with application of the US Army Physical Disability Agency (USAPDA) pain policy. The CI made no appeals and was medically separated with a 20% disability rating.

CI CONTENTION: "Because I am unable to stand, sit, walk, exercise, for long periods of time. I am unable to eat certain foods. I am very emotional also. I never recovered to before or during my military career. To my full life unable to enter act *(sic)* with family and friends. Unable to have activities with my husband.

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

RATING COMPARISON:

Service PEB – Dated 20020802			VA (1.5 Months Pre-Separation) – All Effective Date 20120102			
Condition	**Code**	**Rating**	**Condition**	**Code**	**Rating**	**Exam**
R Femoral Neuropathic Pain	5099-5003	20%	P/O Residuals , R Femoral Neuropathic Condition, S/P Lymph Node Removal	8599-8526	20%	20021018
↓No Additional MEB/PEB Entries↓			0% x 1			
Rating: 20%			**Rating: 20%**			

ANALYSIS SUMMARY: The Board acknowledges the sentiment expressed in the CI's application regarding the significant impairment with which her service-incurred condition continues to burden her. It is a fact, however, that the Disability Evaluation System (DES) has neither the role nor the authority to compensate 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 (DVA). 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.

Right Femoral Neuropathic Pain Condition. The narrative summary (NARSUM) prepared 6-1/2 months prior to separation noted the CI's complaint of constant pain in right groin and leg that kept her up at night. On 3 December 2001, the CI underwent lymph node removal and exploration of the right groin to rule out a femoral hernia. Pathology report was consistent with a reactive lymph node, no hernia was identified and a post-operative bacterial infection was present and treated. She noted significant persistent numbness of the operative site with shooting pain into the right great toe. Hip extension and local massage eased the pain, while heat, ice and epidural steroids provided no relief. Aggravating factors included wearing any part of her pro gear, performing any part of the PT test, any walking at a fast pace, and any amount of running, standing more than 10 minutes, lifting more than 5-10 pounds, and carrying or firing a weapon also dramatically increased her nerve pain. She noted that she slept 2 to 3 hours and that she awakened and could not return to sleep. Timing and pain radiation pattern is consistent with right femoral nerve irritation after surgery. Clinically and functionally it was very debilitating. Physical exam revealed bilateral lower extremities were symmetric. Her gait favored the right lower extremity keeping her hip flexed with a shorter step on the right. Inspection also noted the old surgical site was well healed without bleeding or evidence of infection. There was tenderness to palpation over the site with positive Tinel's sign over the right femoral nerve and not on the left. The radiation pattern was consistent with that of the femoral motor and saphenous sensory nerve to the left great toe. Manual muscle testing was 5/5 on the left lower extremity. On the right, the majority of her strength testing was 4+/5 due to pain and some give way especially noted with knee extension, extension of the great toe, ankle extension and inversion. She could toe and heel walk. Reflexes were symmetric at 2+. Sensation was decreased at right great toe, medial calf and thigh by about 30% with some decrease associated to a lesser degree on the rest of her right lower extremity, intact sensation of the left lower extremity. She underwent electro-diagnostic testing of the right adductor magnus, vastus lateralis, vastus medialis and tibialis anterior, which were all normal and ruled out a right femoral motor neuropathy.

At the MEB exam prepared prior to separation, the CI reported sharp pains from right groin to right foot and "something" with her right knee both since surgery to inner thigh. The MEB physical exam noted pain in right leg going to the big toe worse with moving leg or hip, tender scar right inguinal and "cannot stand on right leg."

At the VA Compensation and Pension (C&P) exam performed 1-/2 months prior to separation, the CI reported that in December 2001, she had a groin abscess where she was hospitalized at a German hospital for a lymph node removal and exploration to rule out a femoral hernia. Three days later, she was seen by military providers with a post op wound infection that was lanced and drained and she went through iodoform packing daily for 3 weeks. Since that time, she has had a constant, non-pulsatile, sharp pain that is 8-9/10 in intensity from the right groin down to the great toe. The pain is exacerbated by walking, standing, lifting, and sitting. The only thing that made it feel better was to lie down and stretch out and try to "ignore it." She tried Tramadol, Elavil, and Percocet, all of which had not helped decrease the pain. She was awakened periodically throughout the night. She could lift something as minimal as a 5 pound weight on the right side and that would dramatically increase her pain. An epidural steroid injection was tried but was not successful. Physical exam revealed a well-healed post surgical scar in the right inguinal area. She did tend to favor the right leg in weight bearing. She used a shorter step on the right and pushed her weight to the lateral aspect of the foot. She had a

hypersensitivity to light touch from the right groin following the pathway of the femoral nerve and the saphenous nerve down to the ankle on the medial aspect. Her motor strength on the left was 5/5 while on the right it was 2/5. Lying supine with the leg straight, the CI had difficulty raising the leg without resistance, trembled and was able to go approximately 60 degrees with evidence of extreme pain. She had increased pain in abduction as well. She limited the movement of the right leg as much as possible to decrease her pain. She had normal reflexes bilaterally. There was no ankle clonus and a normal Babinski response. She had decreased sensation to sharp and dull testing on the medial right calf by about 30% to 40% and down to the right great toe. She did have dorsiflexion capabilities of the right great toe. It was weaker than the left. She could bear weight on her right foot but she was unsteady and could only bear weight for a few seconds and the pain was escalated. She was able to walk on her toes and on her heels but she limps when she walks on her toes. She limps favoring the right foot. She is able to tandem walk. No muscle wasting was noted. Electromyography was within normal limits.

The Board directs attention to its rating recommendation based on the above evidence. The PEB coded the CI's condition analogously as 5099-5003 and rated it 20% based on pain using the USAPDA pain policy. The USADPA pain policy was widely used at the time of the PEB's adjudication of this case, however, the Board will rely solely on the VASRD rules in effect at the time of separation. Additionally, the 5003 code directly refers to degenerative arthritis of a joint which is not present in this case. The VA utilized the analogous code of 8599-8526 and rated it 20% based on a moderate paralysis of the femoral nerve. The initial consideration for the Board is to determine if the CI's disability represents neuritis or neuralgia, as there are potential rating implications that depend on that determination. The VASRD section §4.123 defines neuritis as characterized by loss of reflexes, muscle atrophy, sensory disturbances, and constant pain, at times excruciating; while §4.124 defines neuralgia as characterized usually by a dull and intermittent pain, of typical distribution so as to identify the nerve. The predominant disability in this case is one of a painful peripheral nerve which presented after a surgical procedure involving the immediate area surrounding the femoral nerve. The CI's complaint of constant, sharp sometimes excruciating pain with numbness around the surgical site along with decreased sensation following the distribution of the femoral nerve more closely fits with the VASRD definition of neuritis. The VASRD code 8626 refers to neuritis of the femoral nerve and relies on the subjective descriptors of mild, moderate or a maximum of severe, incomplete, paralysis if there is organic involvement. There is some evidence of weakness on physical examination, but this is due to pain as evidenced by the "give-away" weakness on knee extension, there is no muscle wasting noted and normal EMG testing of the muscles innervated by the femoral nerve all argue against any organic changes to the nerve. The evidence supporting any organic changes to the nerve is the decreased sensation in the distribution of the femoral nerve. As delineated in §4.123, the maximum rating which may be assigned for neuritis not characterized by organic changes will be that for moderate. In this case, the majority of the evidence present for review suggests minimal if any organic changes to the femoral nerve required to elevate the evaluation to 30%, severe, incomplete paralysis. The CI demonstrates an abnormal gait and sleep disturbance due to pain along with significant functional impairment due to her painful neuritis. The documentation reviewed is consistent with and more closely resembles a moderate, 20%, level of disability as opposed to a 30%, severe, incomplete paralysis. The PEB adjudicated the CI's disability rating at 20%, as did the VA who utilized a different VASRD analogous code. Although the Board recognizes that VASRD code 8626 is a better fit for the actual disability present, there is no benefit to the CI in changing the code, as the Board's final rating recommendation would be the same as the 20% rating adjudicated by the PEB. 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 femoral neuropathic pain 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. As discussed above, PEB reliance on the USAPDA pain policy for rating right femoral neuropathic pain was operant in this case and the condition was adjudicated independently of that policy by the Board. In the matter of the right femoral neuropathic pain condition and IAW VASRD §4.124a, the Board unanimously recommends no change in the PEB adjudication. 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.

UNFITTING CONDITION	VASRD CODE	RATING
Right Femoral Neuropathic Pain	5099-5003	20%
	COMBINED	**20%**

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20120607, w/atchs
Exhibit B. Service Treatment Record
Exhibit C. Department of Veterans' Affairs Treatment Record

XXXXXXXXXX, DAF
President
Physical Disability Board of Review

SFMR-RB

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

SUBJECT: Department of Defense Physical Disability Board of Review Recommendation for XXXXXXXXXXXXXXXXX, AR20120022735 (PD201200942)

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

XXXXXXXXXXX
Deputy Assistant Secretary
(Army Review Boards)

CF:
( ) DoD PDBR
( ) DVA