RECORD OF PROCEEDINGS
PHYSICAL DISABILITY BOARD OF REVIEW

NAME: DEVERE, XXXXXXXXXXXXXX
CASE NUMBER: PD1200276
BOARD DATE: 201211O1

BRANCH OF SERVICE: ARMY
SEPARATION DATE: 20061002

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an activated Army National Guard 1LT/0-2(15A, Aviation), medically separated for neurological constellation of symptoms of unknown etiology and a low back condition. He did not respond adequately to treatment and was unable to perform within his Military Occupational Specialty (MOS), meet worldwide deployment standards or meet physical fitness standards. He was issued a permanent P3L3 profile underwent a Medical Evaluation Board (MEB). Neurological constellation of symptoms to include shooting pain with sneezing from the neck down into the entire body, visual disturbance, and a decrease in his fine motor skills of his right hand of unknown etiology at this time; and chronic lower back pain with lumbar radiculopathy and herniated nucleus pulposus at L5-S1 central to the left were forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW AR 40-501. Four additional conditions, identified in the rating chart below, were forwarded on the MEB submission as medically acceptable conditions. The PEB adjudicated the neurological constellation of symptoms of unknown etiology; and low back condition as unfitting, rated 0% and 0% respectively, with application of the US Army Physical Disability Agency (USAPDA) pain policy. The CI made no appeals, and was medically separated with a 0% disability rating.

CI CONTENTION: The CI states: "I have continued pain, soreness, and additional surgeries on the open heart surgery site. Both knees have become completely disabled to the point where I cannot resume normal activities at all."

SCOPE OF REVIEW: The Board wishes to clarify that the scope of its review as defined in the Department of Defense Instruction (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 knee condition (Retropatellar Pain Syndrome) requested for consideration and the PEB unfitting conditions meet the criteria prescribed in DoDI 6040.44 for Board purview, and are accordingly addressed below. 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 20060913			VA (2 Mos. Post-Separation) – All Effective Date 20061003			
Condition	**Code**	**Rating**	**Condition**	**Code**	**Rating**	**Exam**
Severe Intermittent Fleeting Shooting Pains and Paresthesias Following Each Sneeze, Accompanied by Momentary Visual Disturbances and Brief Episodes of Incoordination of the R Dominant Hand	5099-5003	0%	Pre-Syncope and Dizziness (Claimed as Syncope and Neurological Disorder)	7010-8108	NSC	20061205
No MEB Entry			Cervical Strain	5237	10%	20061205
			Heart Murmur, Residual ASD surgery	7099-7000	0%	20061205
			Scars, Residual Atrial Septal Defect Surgery	7804	10%	20061205
			Mid-Chest Scar, Residual Atrial Septal Defect Surgery	7804	10%*	20061205 & 20081119
Chronic Radiating Low Back Pain	5243	0%	Intervertebral Disc Syndrome	5243	10%	20061205
Gastroesophageal Reflux Disease	Not Unfitting		No VA Entry			
Irritable Bowel Syndrome	Not Unfitting		No VA Entry			
Dyslipidemia	Not Unfitting		No VA Entry			
Retropatellar Pain Syndrome	Not Unfitting		Patellofemoral Pain Syndrome, L Knee	5260	10%	20061205
↓No Additional MEB/PEB Entries↓			0% X 2 / Not Service-Connected x 2			20061205
Combined: 0%			**Combined: 40%**			

*Added by a VARD increasing combined to 40%.

ANALYSIS SUMMARY: The Board acknowledges the sentiment expressed in the CI's application regarding the significant impairment with which his service-incurred condition continues to burden him. 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. The DES has neither the role nor the authority to compensate members for anticipated future severity or potential complications of conditions resulting in medical separation. That role and authority is granted by Congress to the Department of Veterans' Affairs (DVA), operating under a different set of laws (Title 38, United States Code). The Board evaluates DVA evidence proximal to separation in arriving at its recommendations, but its authority resides in evaluating the fairness of DES fitness decisions and rating determinations for disability at the time of separation. The Board acknowledges that an electroencephalography (EEG) was referenced in the service treatment record (STR) but the results were not available in the evidence before it, and could not be located after the appropriate inquiries. However, the CI responded that he had had the study which had been scheduled prior to the MEB, in addition at the VA exam he reported he did not have a seizure disorder thus he likely was referencing the normal results. Further attempts at obtaining the relevant documentation would likely be futile and introduce

additional delay in processing the case. The missing evidence will be referenced below in relevant context, and it is not suspected that the missing evidence would significantly alter the Board's recommendations.

Neurological Constellation of Symptoms of Unknown Etiology Condition. The CI began having episodes of sneezing which resulted in "extreme pain shooting from my neck down throughout my entire body, and will see starts and dots, and lose my peripheral vision" which would last 3-4 minutes. He had 3-4 in the summer of 2005 prior to seeing his flight surgeon in the fall of 2005. The CI underwent an extensive evaluation by Cardiology, Neurology, Optometry and Internal medicine. The Cardiology evaluation revealed a defect of the heart, (Atrial Septal defect [ASD]), which may have contributed to his symptoms and therefore this was repaired. The postoperative course was uneventful and even a month later the cardiologist documented his prior symptoms of lightheadedness or losing his vision with sneezing had gone away. However, the episodes reoccurred, became more frequent and gradually worsened. A transesphogeal echocardiogram was performed which revealed the "the heart was fine, and the repair was holding." The Internal Medicine evaluation included; Cervical Spine (C-Spine) and brain Magnetic Resonance Imaging (MRI) studies which were within normal limits. In late April 2006 the CI reported new symptoms of "losing the fine motor skills in my right hand". Multiple neurologic evaluations were conducted which included; physical exams, laboratory evaluations, a repeat MRI of his C-spine, and new images of his Thoracic (T-spine) and Lumbar (L-spine) spine, nerve conduction studies of the upper and lower extremities, and a lumbar puncture that were all were within normal limits. The neurologist could not find any specific etiology for his symptoms and opined the ASD was a coincidental finding. The Optometry evaluation documented no abnormalities except for farsightedness. The neurologist summarized for the MEB; the CI was evaluated extensively for Valsalva related paresthesias in extremities (L'hermitte's sign) with negative results for organic causes to include; multiple sclerosis, cervical stenosis and neuropathy and diagnosised tingling (paresthesias) with subjective complaints related to neck flexion without definitive etiology and no neurologic diagnosis. An electroencephalography (EEG) was scheduled after the neurology opinion and prior to the MEB yet the result was not in evidence. The profile allowed for wearing of protective mask and chemical equipment only and otherwise was limited in all functional activities. The commander's statement additionally documented the CI was reassigned to medical hold and that his paresthesias impacted his fine motor skills in his hands which made it difficult for him to be a pilot and with writing.

At the MEB exam, the CI reported the episodes were occurring 2 to 3 times a week lasting 1 to 4 minutes with all symptoms occurring 30% of the time and just visual symptoms 70% of the time. These had been occurring only with sneezing; however, more recently he would occasionally get the visual symptomatology with having a bowel movement. The episodes did not occur with coughing or with a regular Valsalva maneuver to clear his ears. He also reported gradually worsening in his fine motor skills in his right hand. He did not report abnormalities with his gait or other neurologic symptoms. He was concerned with his sneezing episodes which "could be catastrophic as a pilot" and that he had difficultly handling the instruments with his right hand. The MEB physical exam documented a very fine intension tremor on the right, and possibly very slight on the left otherwise normal neurologic and cardiac findings. The examiner cited the unremarkable laboratory; X-rays and other studies completed for the evaluation and added no new diagnoses. At the VA Compensation and Pension (C&P) exam, the CI additionally reported having; recurring headaches which were not migraines which happened after sneezing, 3 times per week lasting 10 minutes and dizziness 3 times per week. He reported he did not suffer from a seizure disorder and he was able to work with medications. The C&P exam additionally demonstrated a heart murmur without evidence of

congestive heart failure, cardiomegaly, or cor pulmonale, noted normal neurologic findings and was silent to a tremor exam.

The Board directs attention to its rating recommendation based on the above evidence. The PEB assigned a rating of 0% coded analogous to 5003 (arthritis, degenerative) for infrequent episodes with sneezing and for moderate, intermittent pain. The VA coded analogous to 8108 (Narcolepsy) with 7010 (Supraventricular arrhythmias), a neurologic and cardiac VASRD code respectively, for pre-syncope and dizziness symptoms which could be related to a heart, neurologic or cervical spine condition. Since these symptoms were not actually diagnosed the VA denied service-connection. The Board considered multiple coding options, including; the PEB's recommendation to code under a musculoskeletal code for pain due to possible C-spine pathology, the VA's analogous coding to the neurologic code 8108, the analogous cardiac code 7010 (Supraventricular arrhythmias), an analogous code to 8210, (tenth (vagus) nerve paralysis) for autonomic vasovagal symptoms, an analogous cardiac code 7000 (Valvular heart disease) for vasovagal symptoms related to heart disease and finally an analogous code to 8911 (petit mal seizure) for vasovagal symptoms and the other residual neurologic symptoms and signs, specifically the tremor. Due to lack of evidence for C-spine pathology and residual heart pathology the Board agreed that a VASRD musculoskeletal or cardiac code is not applicable to the clinical unfitting pathology of neurologic constellations of symptoms. This disability is not specifically listed in the rating schedule; therefore, therefore the Board considered rating analogous to a disability in which not only the functions affected, but anatomical localization and symptoms, are closely related. The Board considered the 8210 code and the 8911 code neurologic codes. The VASRD specifies if syncope is seizure-associated to analogize to 8911 and if vasovagal related to analogize to 8210. The Board agreed the evidence does not reflect a diagnosis of seizures, and the symptoms were more valsalva (vasovagal) related and therefore the Board agreed the 8210 code best captures the residual neurologic impairments without a diagnosis. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board recommends a disability rating of 10% for the neurologic constellation of symptoms of unknown etiology condition.

Low Back Condition. During one of his neurologic exams the CI reported atraumatic low back pain with sitting which radiated into his left leg and left foot. An MRI of the L-Spine revealed a moderately large central and to the left, herniated nucleus pulposus (HNP) at L5-S1, which seemed to affect the S1 nerve root and a mild bulge at L4-5. He was referred to a pain specialist and underwent 2 epidural steroid injections with a week of improvement with the first and little improvement with the second. He was further recommended to seek care with chiropractic treatment which resulted in no manipulations. He reported he would seek possible surgical treatment at a later date. 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.

DOS 20061002

Thoracolumbar ROM	MED Exam ~4 Mo. Pre-Sep	MEB ~2 Mo. Pre-Sep	VA C&P ~2 Mo. Post-Sep
Flexion (90° Normal)	45/45/48°	64/63/68°	90°
Ext (0-30)	10/10/10°	30°	30°
R Lat Flex (0-30)	30/30/30°	30/27/32°	30°
L Lat Flex 0-30)	30/28/30°	28/28/27°	30°
R Rotation (0-30)	20/20/20°	42/44/44°	30°
L Rotation (0-30)	20/20/20°	43/45/46°	30°
Combined (240°)	155°	215°	240°
Comment		painful motion, no	painful motion normal

		spasm, normal gait and posture	posture, curvature, gait
§4.71a Rating	20%	10%	10%*

*Conceding painful motion 4.59

At the MEB exam, the CI reported an average pain level is "6 to 7", aggravated by; running, lifting and carrying (max 20 pounds), prolonged sitting and standing (max 45 minutes each), sit-ups and push-ups, biking, swimming and prolonged walking (max a half a mile). The back and leg pain were improved with the use of narcotic pain medications. The MEB physical exam demonstrated no tenderness over the lumbar spine or SI joint and normal neuromuscular findings. At the C&P exam the CI additionally reported his condition did not cause incapacitation and he could function with medication. He also reported difficulty moving during a flare-up but there was no evidence of the frequency of flare-ups. The C&P exam demonstrated a sensory deficit of the bilateral posterior thighs otherwise normal neuromuscular findings and no DeLuca observations. The lumbar spine X-ray findings were within normal limits.

The Board directs attention to its rating recommendation based on the above evidence. The PEB and VA both applied the code 5243 (Intervertebral disc syndrome) which is appropriate to the diagnosis and rated IAW §4.71a—Schedule of Ratings–Musculoskeletal System under the general rating formula for diseases and injuries of the spine. Although there are no relevant differences in the ratable parameters between the MEB and VA exams, it was agreed that the MEB evidence, 2 months prior to separation, was most probative for its proximity to the date of separation. The Board notes the MEB evidence, 4 months prior to separation reflects a more limited flexion from either of the other exams likely reflective of the waxing and waning functional pain impairment of his back condition. The PEB's 0% rating, derived from the USAPDA pain policy, is not compliant with VASRD §4.71a criteria. The ROM measurements by both the MEB and VA are consistent with a 10% rating IAW §4.71a. The Board considered whether additional rating could be recommended under a peripheral nerve code for the residual sciatic radiculopathy at separation. Firm Board precedent requires a functional impairment tied to fitness is required to support a recommendation for addition of a peripheral nerve rating to disability in spine cases. The pain component of a radiculopathy is subsumed under the general spine rating as specified in §4.71a. The sensory component in this case has no functional implications; and no motor weakness was in evidence. Since no evidence of functional impairment exists in this case, the Board cannot support a recommendation for additional rating based on peripheral nerve impairment. There was no documentation of incapacitating episodes which would provide for higher rating. 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 low back condition.

Contended PEB Conditions. The contended conditions adjudicated as not unfitting by the PEB was retropatellar pain syndrome. 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. This condition was not profiled, not implicated in the commander's statement, and, not judged to fail retention standards. This was reviewed by the action officer and considered by the Board. There was no indication from the record that any of these conditions significantly interfered with satisfactory duty performance. 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 retropatellar pain syndrome and, therefore, no additional disability ratings can be recommended.

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. As discussed above, PEB reliance on the USAPDA pain policy for rating the unfitting and fitting conditions was operant in this case and the conditions were adjudicated independently of that policy by the Board. In the matter of the neurologic constellation of symptoms of unknown etiology condition, the Board unanimously recommends a disability rating of 10%, with the analogous code 8299-8210 IAW VASRD §4.124a. In the matter of the low back condition, the Board unanimously recommends a disability rating of 10%, coded 5243 IAW VASRD §4.71a. In the matter of the contended retropatellar pain condition, the Board unanimously recommends no change from the PEB determination 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, effective as of the date of his prior medical separation:

UNFITTING CONDITION	VASRD CODE	RATING
Severe Intermittent Fleeting Shooting Pains and Paresthesias Following Each Sneeze, Accompanied by Momentary Visual Disturbances and Brief Episodes of Incoordination of the R Dominant Hand	8299-8210	10%
Chronic Radiating Low Back Pain	5243	10%
	COMBINED	**20%**

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20120314, w/atchs
Exhibit B. Service Treatment Record
Exhibit C. Department of Veterans' Affairs Treatment Record

XXXXXXXXXXXXXXXXXX
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 22202-3557

SUBJECT: Department of Defense Physical Disability Board of Review Recommendation for XXXXXXXXXXXXXXXXX, AR20120020916 (PD201200276)

1. 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 to modify the individual's disability rating to 20% without recharacterization of the individual's separation. This decision is final.

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

XXXXXXXXXXXXXXXXXXXXXX
Deputy Assistant Secretary
(Army Review Boards)

CF:
( ) DoD PDBR
( ) DVA