RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXXXXXXXXXX BRANCH OF SERVICE: Army

CASE NUMBER: PD1200380 SEPARATION DATE: 20060110

BOARD DATE: 20121026

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty SGT/E-5 (13P/Multiple Launch Rocket Fire Control Specialist) medically separated for atypical chest pain/extremity pain. He developed intermittent chest pain, periodic pain in all four extremities, and multiple associated symptoms during a 2003 deployment to Iraq. He underwent exhaustive ancillary evaluations and specialty consultations without a specific etiology identified for chest or extremity complaints. The symptoms could not be adequately controlled to meet the physical requirements of his Military Occupational Specialty (MOS) or satisfy physical fitness standards. He was issued a permanent P3/U3/L3 profile and referred for a Medical Evaluation Board (MEB). Two diagnoses, “atypical chest pain” and “extremity muscle cramps”, were forwarded to the Informal Physical Evaluation Board (IPEB) as separate conditions medically unacceptable IAW AR 40-501. No other conditions were submitted by the MEB. The IPEB adjudicated the two diagnoses as a single unfitting condition, “chronic atypical non-cardiac chest pain and extremity pain due to muscle cramps,” coded analogously to 5003 (degenerative arthritis) and rated 10%, referencing the US Army Physical Disability Agency (USAPDA) pain policy. The code and rating was unchanged by an informal reconsideration per the USAPDA; and the CI appealed to a Formal PEB (FPEB), which affirmed the prior determination. The CI was thus medically separated with a 10% disability rating.

CI CONTENTION: The application states: “I was evaluated under the PEB criteria that has been changed.” He does not elaborate further or specify a request for Board consideration of any additional conditions.

SCOPE OF REVIEW: The Board wishes to clarify that the scope of its review as defined in 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 rating for the unfitting chest and extremity pain condition(s) is addressed below; and, no additional conditions are within the DoDI 6040.44 defined purview of the Board. 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. Also, IAW DoDI 6040.44, the Board’s authority is limited to making recommendations on correcting disability determinations. 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 Veterans Administration Schedule for Rating Disabilities (VASRD) standards in effect at separation, and based on ratable severity at the time of separation.

RATING COMPARISON:

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| --- | --- |
| **Service FPEB – Dated 20051110** | **VA (10 Wks. Pre-Separation) – Effective 20060111** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Atypical Chest Pain and Extremity Pain | 5099-5003 | 10% | Coronary Artery Disease | 7005 | 30% | 20051026 |
| Peripheral Vascular Disease, Right Leg | 7114 | 20% | 20051026 |
| Peripheral Vascular Disease, Left Leg | 7114 | 20% | 20051026 |
| Cubital Tunnel Syndrome, Left Arm | 8517 | 10% | 20051026 |
| No Additional MEB/PEB Entries | Cervical Spine Strain | 5237 | 10% | 20051026 |
| Arthritis, Thoracolumbar Spine | 5242 | 10% | 20051026 |
| Meniscal Tear, Left Knee | 5262 | 10% | 20051026 |
| 0% X 7 / Not Service Connected x 1 | 20051026 |
| **Combined: 10%** | **Combined: 70%** |

ANALYSIS SUMMARY:

Chest and Extremity Pain Condition(s). The CI’s symptoms required medical evacuation from Iraq; and, on redeployment his multiple physical complaints did not abate, but rather gradually worsened. He underwent protracted and comprehensive evaluations for his symptoms. He initially ascribed them to Gulf War Syndrome, but consultants convincingly made the case that this was not the etiology. The CI did not serve in the Gulf War which has been the only source of these cases, and he did not meet the established diagnostic criteria for the syndrome regardless. The results of evaluations, as relevant to diagnostic options for Board rating recommendations, are as follows. A cardiology evaluation was the first priority and included an echocardiogram and exercise stress test (EST) which was normal; then a cardiac catheterization performed in May 2003 which demonstrated normal coronary arteries and ejection fraction. With continuing pain, a repeat EST was performed in July 2005 (achieving maximum exertion) and was normal except for non-specific cardiogram changes interpreted as “possible ischemia infero lateral.” A cardiac nuclear perfusion study was done in close follow-up which did not show inferior wall motion abnormality, and the ejection fraction was again normal (66%). That finding, coupled with the normal cardiac catheterization only 2 years previously, would quite comfortably exclude significant coronary artery disease. Magnetic resonance imaging (MRI) of the chest, lung scan and pulmonary function testing were normal. Evaluations of the extremities began with a normal arteriogram of the left arm performed concurrently with the cardiac catheterization. Cervical and thoracolumbar MRI’s were negative for nerve root pathology. Electrodiagnostic testing of all four extremities was normal. A neurology consultant found no evidence of peripheral neuropathy or other neurologic disease, and made the MEB-submitted diagnosis of non-specific extremity cramps. Doppler flow testing noted a left arterial brachial index (ABI) of 0.9 which is suggestive of peripheral vascular disease (PVD), although the right ABI was normal. The vascular consultant, however, did not support a diagnosis of PVD (or Reynaud’s); but, diagnosed “non-specific vasomotor instability” and recommended a return to duty. Further specialty consultations included rheumatology, immunology, and infectious disease; none of whom could identify a specific etiology for the CI’s symptoms.

The chest pain was variously characterized by multiple entries in the service treatment record (STR). Initial presentations described “pressure feeling like an elephant” with “a pounding sensation,” often associated with numbness of the left arm and shortness of breath, relieved by nitroglycerin, and precipitated by minimal exertion. Later entries (after the negative cardiac work up) describe transient vaguely described episodes without radiation or associated symptoms, with occasional onset at rest as well as with exertion or emotional stress. The extremity complaints included hand and foot cramping, reported color and temperature changes of the distal extremities, paresthesias in stocking and glove patterns, reported episodes of paralysis of the left arm, diffuse myalgias and arthralgias, and subjective weakness of all extremities. As with the chest pain, the symptoms were intermittent with variable frequency and duration; and, the symptom complex varied over numerous STR entries. Multiple medication trials of various analgesics, including psychoactive and peripherally acting neuropathic agents, are documented; with inconsistent reports of response. Occupational therapy, specialty pain management, chiropractic therapy and acupuncture were also met with variable success. Although providing a detailed history of the clinical course and numerous consultations and ancillary evaluations, the narrative summary (NARSUM) did not specifically elaborate the concurrent frequency, duration, and response to treatment of the numerous symptoms. A comprehensive primary care note, 3 months prior to separation and the most temporally probative outpatient evidence, noted the CI’s report that his extremity symptoms (predominantly hands at that time) “occur 1-2 times a month and last seconds up to 30 minutes.” Other entries in that note are excerpted below.

Patient continues to have chest pain with exertion and foot cramping is most frequent when going down stairs. ... Patient states that he has no trigger that causes his symptoms. It is not clear that if soldier is experiencing such brief episodes of pain only 1-2 times a month, and last no more than 30 minutes, how they could be as debilitating as he reports. His response to this was "too much work causes back pain and every bone in my body hurts".

This examiner cited “non-objective complaints that have prevented him from doing his job and deploying;” with a strongly worded impression of “malingering” in addition to diagnoses of “cramp of the limbs” and “atypical chest pain.” Also of note, an early mental health consultant listed an Axis I impression of “rule-out somatiform disorder;” although this was never pursued in service. A VA psychiatrist did make an Axis I diagnosis of “depression vs. somatization and conversion disorder;” but, this was 17 months after separation and therefore not applicable to Board recommendations for rating at separation.

The NARSUM physical examination was normal, as were numerous examinations (including comprehensive neurological and vascular findings) throughout the STR. At the VA Compensation and Pension (C&P) exam performed 10 weeks prior to separation, the CI’s multiple symptoms were listed; but frequency, duration, and response to treatment were not specified for the extremity complaints. The chest pain was reported to flare “from time to time lasting 30 minutes to an hour at a time.” The VA physical examination was normal except for “reduced sensation in the left ulnar nerve distribution.” All range-of-motion (ROM) measurements were normal or nearly so. The VA diagnosis of coronary artery disease rested solely on the history, “He was told that he had changes in the inferior wall of the heart...” This was presumably referencing the 2005 EST, cited above, although coronary ischemia was not supported by further study or likely based on all other evidence. The VA diagnoses of PVD of both lower extremities was premised only on the equivocal ABI findings which would account for the left leg only, and which was contrary to the opinion of the vascular surgeon. The likelihood of PVD is also mitigated by the normal coronary and subclavian arterial findings at catheterization. The VA diagnosis of left cubital tunnel syndrome was based solely on the examiner’s sensory neurologic finding cited above; and, was not supported by electrodiagnostic testing or specialty opinion.

The Board directs attention to its rating recommendation based on the above evidence. The PEB approach of combining multiple extremity complaints and chest pain under the analogous code 5003 (degenerative arthritis) was supported by AR 635-40; but, is not compliant with VASRD §4.71a and therefore not an option available to the Board. The Board has the option of ‘unbundling’ all of the conditions entrained in the PEB rating and recommending separate codes and ratings; but, each disability rating so derived must be supported as separately unfitting by a preponderance of the evidence. The atypical chest pain could be separately considered on this basis, since it was separately profiled and separately judged to fail retention standards by the MEB. All members agreed, however, that the “extremity muscle cramps” combined as a single diagnosis by the MEB was clearly a combined effect type disability; and, that no single extremity (or pair of extremities) could be established as separately unfitting by performance based evidence apparent at separation. All members concurred that separate ratings under the VA diagnoses was not supported; since the probative value of the VA examiner’s diagnostic opinions was considerably outweighed (in excess of the preponderance of the evidence standard) by the multiple specialty opinions backed by an abundance of irrefutable ancillary findings. Members deliberated the option of separate rating for the atypical chest pain under the analogous code 5399-5321 (muscle code for thoracic group) plus a combined rating for all of the extremity impairment under analogous 5003 (a very tenuous application of the code IAW §4.71a). Members then considered *analogous* rating under 5025 (fibromyalgia). Although fibromyalgia clearly was not the diagnosis in this case (as per rheumatology consultation), the rated symptoms are quite similar to those manifested in this case; since the 5025 description includes “anterior chest” pain as well as “widespread musculoskeletal pain,” “paresthesias,” and “Raynaud’s-like symptoms.” Although not elaborated above (since they were not unfitting), all of the other symptoms referenced under 5025 were also reported by the CI in the STR. VASRD §4.20 (analogous ratings) states, “When an unlisted condition is encountered it will be permissible to rate under a closely related disease or injury in which not only the functions affected, but the anatomical localization and symptomatology are closely analogous.” After considerable deliberation, all members agreed that a combined rating analogous to 5025 was preferable to the overly speculative route of attempting to derive separate ratings; that it was much more compatible with the total disability picture; and, that it was more (or at least equally) advantageous to rating.

Code 5025 offers a 10% rating for symptoms “that require continuous medication for control;” a 20% rating for those “that are episodic, with exacerbations often precipitated by environmental or emotional stress or by overexertion, but that are present more than one-third of the time;” and a 40% rating for those “that are constant, or nearly so, and refractory to therapy.” Members agreed that, since the symptoms were clearly not controlled, the 10% rating description does not accurately reflect the evidence. Deliberations ensued regarding a 20% vs. a 40% recommendation. At least the chest pain component was certainly exacerbated by the triggers elaborated in the 20% rating, but all of the symptoms were apparently ‘refractory to therapy’ as per the 40% description. The key distinguishing feature between the ratings, however, is the frequency and constancy of symptoms. The NARSUM and VA C&P examiners did not document frequency and duration of symptoms, but both made it clear that they were intermittent; and, the primary care note near separation would suggest that the symptoms were fairly sporadic by that point. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board recommends a disability rating of 20% for the chest and extremity pain condition under the analogous code 5099-5025.

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 and AR 635-40 for rating the chest and extremity pain condition was operant in this case; and, it was adjudicated independently of that policy and regulation by the Board. In the matter of the chest and extremity pain condition, the Board unanimously recommends a disability rating of 20%, coded 5099-5025, IAW VASRD §4.71a and §4.20. 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:

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| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Diffuse Myalgias and Arthralgias with Atypical Chest Pain  | 5099-5025 | 20% |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20120423, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans’ Affairs Treatment Record.

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 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 XXXXXXXXXXXXXXXXXXXXXXX, AR20120020019 (PD201200380)

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