RECORD OF PROCEEDINGS
PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXX
CASE NUMBER: PD1200539
BOARD DATE: 20121219

BRANCH OF SERVICE: MARINE CORPS
SEPARATION DATE: 20031215

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty, SGT/E-5 (0311/Rifleman), medically separated for chronic right inguinal neuropathic pain. The CI's history of chronic right inguinal pain began in October 2000 when he presented complaining of a painful mass in the right inguinal area. He subsequently underwent two surgical procedures and three different selective nerve-blocking procedures. He was then prescribed chronic narcotic medications when the above mentioned procedures did not resolve his pain. The CI did not improve adequately with treatment to meet the physical requirements of his Military Occupational Specialty or satisfy physical fitness standards and he was referred for a Medical Evaluation Board (MEB). The MEB forwarded chronic right inguinal neuropathic pain as the only condition for Physical Evaluation Board (PEB) adjudication. The PEB adjudicated the right inguinal neuropathic pain condition as unfitting and rated it 10%, with application of the Veterans Affairs Schedule for Rating Disabilities (VASRD). The CI made no appeals, and was medically separated with a 10% disability rating.

CI CONTENTION: "Do *(sic)* to my injury (femoral nerve entrapment) I have been dealing with severe chronic pain, the pain is so intense that I take large amounts of medications daily. The injury combined with the meds (MS Contin 150 mg 3xday) make finding work impossible and everyday life is a constant struggle. I have tried every option presented to me to try and fix the problem. Nerve transaction, spine injections, acupuncture even surgical implants not only did all these things not work but caused more damage and pain. As evidence, I include 18 pages from my military record while on active duty."

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 Board for Correction of Naval Records.

RATING COMPARISON:

Service IPEB – Dated 20030925			**VA (1 Month Post-Separation) – All Effective Date 20031216**			
Condition	**Code**	**Rating**	**Condition**	**Code**	**Rating**	**Exam**
Right Inguinal neuropathic pain	8726	10%	Right nerve resection w/residual ilioinguinal nerve neuropathy	8699-8626	30%	20040122
↓No Additional MEB/PEB Entries↓			0% x2			
Combined: 10%			**Combined: 30%**			

ANALYSIS SUMMARY: The Board acknowledges the sentiment expressed in the CI's application regarding the significant impact that his service-incurred condition has had on his current earning ability and quality of life. 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 Inguinal Neuropathic Condition. The undated narrative summary prepared between 23 May and 30 June 2003 noted the CI had a history of chronic right inguinal pain despite maximal medical therapy. His symptoms began in November 2000, when he noticed a right inguinal mass. The mass became painful and after evaluation with ultrasound and CT scanning was consistent with a right inguinal hernia, he underwent an open right inguinal hernia repair. His surgery was successful; it did not detail any complications and his post-operative course was uneventful. Within 2 months of the initial surgical procedure, the CI presented for re-evaluation of his right groin following a sudden increase in groin pain while shooting on the range. The evaluating physician was unable to identify a recurrent inguinal hernia; however, the severity of symptoms prompted a referral to a general surgeon. After further evaluation, the CI underwent a laparoscopic right inguinal hernia revision and again, no complications were detailed during the surgery, and the patient was discharged. Despite post-operative convalescence leave and extensive light duty; the CI continued to experience right inguinal pain with any physical exertion. He then underwent a right inguinal nerve transection, followed by a right ilioinguinal nerve block by a pain management specialist, and finally underwent a diagnostic right L1-L2 paravertebral blockade which resulted in no resolution of his symptoms. The CI had been placed on a long-term narcotic program, including oxycontin IR and oxycontin SR with close follow-up care by the pain management clinic. Despite dosing with oxycontin SR and oxycontin IR; he continued to be unable to run, jump, or march prolonged distances. He was not worldwide deployable. Physical exam revealed multiple scars in the right lower quadrant, full range-of-motion, and normal strength throughout the musculoskeletal system.

At the MEB exam performed approximately 7 months prior to separation, the CI reported "after nerve trans-section needed to get pain medications, Hernia repair and laparoscopic hernia repair, femoral nerve entrapment nerve transection." The MEB physical exam noted "multiple scars right lower quadrant all well healed no hernia and chronic right inguinal pain."

At the VA Compensation and Pension exam performed 5 weeks after separation, the CI relayed a similar history to that outlined above with the following pertinent additions: He reported suffering from tingling, numbness and chronic pain in the right groin in the area of surgery which radiates to the right buttock. He reported that he could not stand for prolonged periods of time longer than 30 minutes. He had trouble climbing stairs and could not walk any long distances. The pain also interfered with his sleep. The pain was constant. He had been treated with Oxycontin 40 mg three times a day and Oxycodone 5 mg two times a day. He also had been prescribed non-steroidal anti-inflammatory, tri-cyclic anti-depressant and other medications used for control of chronic pain. He had functional impairment of being debilitated by the pain. He was unable to function. He was currently not employed and was having difficulty finding employment as he could not sit or stand for any length of time. Physical examination revealed a scar in the right groin consistent with right inguinal hernia repair which measures 4 cm x 0.4 cm. It was non-tender to light touch. It had no ulceration or adherence. There was no tissue loss, keloid, hypo or hyper pigmentation. There was no burn scar. By history, the ilioinguinal nerve on the right side was the nerve involved in this pain. It radiated from the groin to the right buttock. It is increased with walking, standing or movement. Lower extremity motor function was normal. Sensory examination revealed an

area of decreased sensitivity to light touch surrounding the scar from the right inguinal surgery. Reflexes, knee was 3+ on the right and 3+ on the left. Ankle was 1+ on the right and 1+ on the left.

Detailed review of the CI's service treatment records revealed that his pain was consistently described as a constant, dull throbbing pain mainly localized in the right groin area with some radiation around to the buttock. There was no evidence of muscle weakness or atrophy, no documentation of abnormal reflexes and a limited decrease in sensation was documented.

The Board directs attention to its rating recommendation based on the above evidence. The PEB coded the CI's chronic right inguinal neuropathic pain as 8726, neuralgia of the anterior crural (femoral) nerve, and rated it 10% signifying their adjudication of a mild partial paralysis of that nerve. The VA applied the analogous code of 8699-8626 and rated it 30% indicating a severe neuritis of the femoral nerve. This 30% evaluation was based on VA examination findings of symptoms which included pain which radiated from the groin to the right buttock, was aggravated by walking, standing, and movement and was considered to be severe. There was a decrease in sensitivity to light touch in the scar area. Treatment included the use of high-dose narcotics. In order to proceed with the proper coding and rating recommendation for this case, the Board must identify which nerve is causing the CI's disability. The two possibilities are the right femoral or the right ilioinguinal nerves. All documentation present indicates that the CI's chronic pain involved the right groin and the surgical procedures performed in that area. Anatomically, of the two nerves potentially involved in this disability, only the ilioinguinal nerve resides in the location where the surgical procedures were performed and therefore, the nerve responsible for the disability in this case is the ilioinguinal nerve. This conclusion also matches the documentation present for review. Characterization of nerve pain as a neuritis or neuralgia is critical to the proper coding and rating of this peripheral nerve disability. The Board utilizes the following definitions and applicable rating guidelines present in the VASRD for neuritis. Neuritis, §4.123, "is characterized by loss of reflexes, muscle atrophy, sensory disturbances, and constant pain, at times excruciating, is to be rated on the scale provided for injury of the nerve involved, with a maximum equal to severe, incomplete, paralysis. The maximum rating which may be assigned for neuritis not characterized by organic changes referred to in this section will be that for moderate...." The severity and constant throbbing nature of the CI's pain along with the lack of muscle atrophy, normal reflexes and very limited local sensory disturbance fits a pattern most consistent with a neuritis not characterized by organic changes. Rating this neuritis of the ilioinguinal nerve IAW § 4.123 would require assigning a 0% rating. However, IAW with DoDI 6040.44, the Board may not recommend a rating lower than that received prior to the application for review. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (Resolution of reasonable doubt), the Board concluded that there was insufficient cause to recommend a change in the PEB adjudication for the chronic right inguinal 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. 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 chronic right inguinal 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, as follows:

UNFITTING CONDITION	VASRD CODE	RATING
Chronic Right Inguinal Neuropathic Pain	8726	10%
	COMBINED	10%

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20120601, w/atchs
Exhibit B. Service Treatment Record
Exhibit C. Department of Veterans' Affairs Treatment Record

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Director
Physical Disability Board of Review

MEMORANDUM FOR DIRECTOR, SECRETARY OF THE NAVY COUNCIL OF REVIEW BOARDS

Subj: PHYSICAL DISABILITY BOARD OF REVIEW (PDBR) RECOMMENDATIONS

Ref: (a) DoDI 6040.44
(b) CORB ltr dtd 08 Feb 13

In accordance with reference (a), I have reviewed the cases forwarded by reference (b), and, for the reasons provided in their forwarding memorandum, approve the recommendations of the PDBR that the following individual's records not be corrected to reflect a change in either characterization of separation or in the disability rating previously assigned by the Department of the Navy's Physical Evaluation Board:

- xx former USMC
- xx former USMC
- xx former USN
- xx former USMC
- xx former USMC
- xx former USN

xxxxx
Assistant General Counsel
(Manpower & Reserve Affairs)