RECORD OF PROCEEDINGS
PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: ARMY
CASE NUMBER: PD1200669 SEPARATION DATE: 20030604
BOARD DATE: 20121120

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty SPC/E4 (92A/Automated Logistics Supply Specialist), medically separated for Raynaud's disease and asthma. The CI first experienced Raynaud's disease, exclusively during cold exposure, in January 2000 and after complete evaluation failed to reveal an underlying cause, preventive measures instituted. She also began experiencing asthma symptoms in mid-2000 and after complete evaluation confirmed the diagnosis of asthma, medical treatment was instituted. The Raynaud's disease and asthma conditions did not improve adequately with treatment to meet the physical requirements of her Military Occupational Specialty (MOS) or satisfy physical fitness standards. She was issued a permanent P3/L2 profile and referred for a Medical Evaluation Board (MEB). In addition to the Raynaud's disease and asthma conditions, the MEB identified the left knee pain, bilateral plantar fasciitis, lumbar and thoracic back pain and acne vulgaris conditions (annotated in the rating comparison chart below) and forwarded all conditions for Physical Evaluation Board (PEB) adjudication. The PEB adjudicated the Raynaud's disease and asthma conditions as unfitting and rated each 0% with application of the Veteran's Affairs Schedule for Rating Disabilities (VASRD). The left knee pain, bilateral plantar fasciitis, lumbar and thoracic back pain conditions were each identified as "not disqualifying" while the acne vulgaris condition was designated "not unfitting." The CI made no appeals, and was medically separated with a 0% disability rating.

CI CONTENTION: "Raynaud's Disease-MEB board rated me at 0%; however, the VA recently found me to be rated at 10% for this condition. I regularly see a civilian non-VA Rheumatologist for treatment of my Raynaud's condition. My Rheumatologist's name I regularly see is Dr ---- at the Center for Arthritis in Chesapeake, VA. Asthma-MEB board rated me at 0%; however, the VA found me to be rated 30% for this condition. I take a number of medications regularly to treat my asthma condition and keep it under control. I see my civilian Primary Care Provider for treatment of my asthma and her name is Dr --- at the Family Physicians of Chesapeake."

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 conditions Raynaud's disease and asthma as requested for consideration meet the criteria prescribed in DoDI 6040.44 for Board purview and are 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 the Correction of Military Records

RATING COMPARISON:

Service PEB – Dated 20030303			VA (3 Mos. Post-Separation) – All Effective Date 20030605			
Condition	**Code**	**Rating**	**Condition**	**Code**	**Rating**	**Exam**
Raynaud's disease	7117-6602	0%	Raynaud's Phenomenon	7117	0%*	20030319
Asthma	6602	0%	Asthma	6602	30%	20030319
Left Knee Pain, s/p Surgery for Meniscal Tear	Not disqualifying		Postoperative Residuals of Injury, Left Knee	5260	0%	20030319
Bilateral Plantar Fasciitis	Not disqualifying		Morton's Neuroma and Plantar Fasciitis Right Foot	5279	10%	20030319
Lumbar & Thoracic Back Pain	Not disqualifying		Chronic Lumbar Strain w/Mild Dextroscoliosis	5295	10%	20030319
			Chronic Thoracic Strain	5291	0%	20030319
Acne Vulgaris	Not Unfitting		Chronic Acne	7819	0%	20030319
↓No Additional MEB/PEB Entries↓			Left Chronic Achilles Tendonitis	5099-5024	10%	20030319
			Chronic Right Ankle Sprain	5271	10%	20030319
			0% X 6 others/ Not Service-Connected x 3			
Combined: 0%			**Combined: 60% (Bilateral Factor 2.7%)**			

*7117: increased to 100% effective 20031211 then decreased to 10% effective 20040201

ANALYSIS SUMMARY: The Board notes the current VA ratings listed by the CI for all of her service-connected conditions, but must emphasize that its recommendations are premised on severity at the time of separation. The VA ratings which it considers in that regard are those rendered most proximate to separation. 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. That role and authority is granted by Congress to the Department of Veterans Affairs (DVA).

Raynaud's Disease Condition. At the MEB exam prepared approximately 9 months prior to separation, the CI documented nothing specific concerning the Raynaud's disease. The MEB physical exam noted the reason for the MEB was Raynaud's phenomenon. It also contained the statement, "A cold weather injury involving the CI's hands in 1999." The narrative summary (NARSUM) prepared approximately 4 months prior to separation noted the beginning of her Raynaud's symptoms in January 2000 after suffering a cold weather injury to her hands. After that initial injury, the CI experienced symptoms of cyanotic and numb hands, feet, ears and nose with any cold exposure, then significant pain when the circulation returned to those areas. The CI also noted some blistering of her feet after training along with minimal peeling and sloughing on her hands. All reasonable preventative measures were attempted but did not sufficiently prevent the attacks from negatively impacting her duty performance. She was evaluated by a Rheumatologist who confirmed the history and performed capillaroscopy that was remarkable for capillary loop dilation with no drop out. The final assessment was a history compatible with Raynaud's phenomenon with recent unremarkable serologic and laboratory evaluations and no overt clinical physical findings to suggest an underling connective tissue disease. Physical exam revealed skin notable for only mild acne lesions. Cardiovascular exam was normal. The commander's letter includes the statement that the CI was "…limited to working inside during the winter due to her permanent profile when the temperature is below fifty degrees."

At the VA Compensation and Pension (C&P) exam performed approximately 3 months prior to separation, the CI reported a similar history to that given above with the following additional comments: suffering "1% frostbite" on her fingers while deployed in November 1999, advised by the Rheumatologist not to remain in an area where the temperature is less than 50 degrees Fahrenheit. She denied any changes of her fingernails and toenails, and also denied any loss of tissue at the extremities. When she was not suffering from Raynaud's phenomenon she denied any difficulty in the hands and feet except for numbness when carrying objects. Physical exam

revealed the following: the fingers and toes were cold to touch. The Allen test was positive bilaterally at the hands; the peripheral pulses of the upper and lower extremities were palpable (2+ bilaterally). There was no erythromelalgia at the extremities. When the hands and feet were placed in cold running tap water, the fingers and toes turn white after 2 minutes, and blue after 5 minutes. The color of the toes and fingers returned to normal after about an hour. In addition to the above, the Rheumatology consult prepared in approximately 11 months prior to separation provided historical information useful for rating purposes. It documented that the episodes of Raynaud's phenomenon occur almost exclusively with cold weather exposure. "The patient had these episodes occur almost on a daily basis especially early in the morning." No skin necrosis. The Rheumatologist recommended cold exposure avoidance measures and the CI was offered a trial of Nifedipine which she declined but would consider should her symptoms become more prominent.

The Board directs attention to its rating recommendation based on the above evidence. The PEB applied the analogous code 7117-6602 for the Raynaud's disease citing "description more consistent with Raynaud's phenomenon, only symptomatic if exposed to cold for more than 5 minutes," and rated at 0% due to "does not meet minimal rating criteria and symptoms only occur if exposed to cold as noted." The VA applied code 7117, Raynaud's syndrome, and rated it 0% citing normal appearance of with no tissue loss of the bilateral hands and feet. This rating was subsequently increased to 100% after the CI had a surgical procedure to her foot, resection of the right second metatarsal head due to avascular necrosis, then was decreased to 10% (based on characteristic attacks occurring one to three times a week) after her convalescent period. The rating criteria for Raynaud's syndrome include tissue damage (auto-amputation or ulcers) and the frequency of characteristic attacks. There were no auto-amputation or ulcers noted in this case and therefore the 100% and 60% criteria were not met. The 40% evaluation requires the characteristic attacks to occur at least daily, again not consistently present in this case. The 20% rating requires the attacks to occur four to six times per week while the 10% rating calls for one to three attacks per week. This case documents attacks occurring almost exclusively during cold exposure which during some times of the year was daily while other times of the year less frequently. A potential method of determining the frequency of attacks is to estimate the number of attacks that occur over a year timeframe and divide that figure by the number of weeks in a year. During the cold season, it was documented that the CI could experience characteristic attacks daily, while in the warmer times of the year not experience these attacks at all. Assuming a cold season of 3 months, that is 90 attacks a year divided by 52 weeks a year yields an estimate of 1.7 attacks a week, which meets the 10% rating threshold. The Board deliberations centered on which frequency of attacks best fit the pattern documented in the records. 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 Raynaud's disease condition.

Asthma Condition. There are three pulmonary function tests (PFTs) 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.

Pulmonary Function Tests	PFT results ~8 Mo. Pre-Sep Post-bronchodilator values Used in NARSUM	VA C&P~3 Mo. Pre-Sep Pre-bronchodilator values only*	~3 Mo. Pre-Sep Post-bronchodilator values
FEV1 (% Predicted)	77%	67%	78%
FEV1/FVC	90%	89%	106%
Meds	Albuterol as needed Advair & Singulair discussed Lungs were clear + 8% bronchodilator response	Albuterol 30min prior to exercise No Advair use documented Singulair used Normal lung exam	Albuterol as needed No Advair use documented Lung exam was normal
§4.97 Rating	10%	30%	10%

* §4.96 (d) 4 states post-bronchodilator PFT studies required for disability evaluation

At the MEB exam prepared approximately 9 months prior to separation, the CI reported "Asthma-Had an attack and was put on an inhaler in Korea." The MEB physical exam noted "lungs clear to auscultation all fields." A specialty care consult prepared 8 months prior to separation contained the following additional information not contained in the NARSUM: The CI experienced no problems with breathing as a child, actually ran track in high school without problems and completed all military training without problems. Lungs were clear to auscultation. PFT results are noted in the chart above and were used in preparation of the NARSUM. The NARSUM notes the CI's asthma symptoms began while she was stationed in Korea and began to fall out of run formations. She was sent to remedial physical training twice daily and experienced increased shortness of breath and chest tightness and had an episode of syncope while running. She was evaluated at the troop medical clinic and given an inhaler. Her symptoms continued and she was referred to the pulmonary clinic at her new post. When her PFTs and Methacholine challenge tests were positive and consistent with asthma, she was started on "maximal medical therapy" (Singulair, Advair and Albuterol) and had no attacks on those medications. The CI experienced wheezing with upper respiratory infections. PFTs and pertinent physical exam findings are summarized in the chart above.

At the VA Compensation and Pension (C&P) exam performed almost 3 months prior to separation, the CI reported developing cold and exercise induced asthma in 2000. She stated she was given albuterol and Singulair to use and used her albuterol inhaler 30 minutes prior to exercise. She developed shortness of breath at night and needed to sleep upright. Current medications were Albuterol and Singulair (dosage and frequency not given). PFT results and pertinent physical exam finding are summarized in the chart above.

The Board directs attention to its rating recommendation based on the above evidence. The PEB utilized VASRD code 6602; asthma, bronchial, and rated it 0% specifically based on "intermittent use of medications with last set of prescriptions in Nov. '02." The CI did have a verified history of asthmatic attacks and was using her inhaler medications intermittently. The VA applied the same 6602 code but rated her asthma at 30% based on her PFT results noted on the C&P examination. The ratings for code 6602 are based on post-bronchodilator PFT results, frequency of medication use and exacerbations/physician visits for disease management. It is clear in the records present for review that the CI did not require bronchodilator medications on a daily basis, monthly provider visits for disease management or any courses of oral steroids. She was using an oral medication, Singulair, at unknown frequency and intermittently used inhaled bronchodilator medication. In asthma, Singulair-mediated effects include airway edema, smooth muscle contraction, and altered cellular activity associated with the inflammatory process. These effects are broad in scope and do not exclusively act as a bronchodilator or anti-inflammatory medication. The PFT results present in the record proximate to separation provide additional data for rating purposes. The VASRD §4.96 states that post-bronchodilator values are to be used for rating purposes and the PFT values

contained in the C&P exam are pre-bronchodilator values. The two other PFT results present, both within 12-months of separation, are post-bronchodilator values one of which was used by the PEB for adjudication. Both of these PFT results document values that meet the threshold for the 10% VASRD rating, along with the intermittent use of inhaled bronchodilator therapy. The next higher, 30%, rating requires daily bronchodilator medications, any use of inhalational anti-inflammatory medications or post-bronchodilator PFT values worse than those present in this case. 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 asthma 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 Raynaud's disease condition, the Board unanimously recommends a disability rating of 10%, coded 7117 IAW VASRD §4.104. In the matter of the asthma condition, the Board unanimously recommends a disability rating of 10%, coded 6602 IAW VASRD §4.97. 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 her prior medical separation:

UNFITTING CONDITION	VASRD CODE	RATING
Raynaud's Disease	7117	10%
Asthma	6602	10%
	COMBINED	**20%**

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20120603, w/atchs
Exhibit B. Service Treatment Record
Exhibit C. Department of Veterans' Affairs Treatment Record

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

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

Deputy Assistant Secretary
(Army Review Boards)