DEPARTMENT OF THE NAVY
BOARD FOR CORRECTION OF NAVAL RECORDS
2 NAVY ANNEX
WASHINGTON DC 20370-5100

JRE
Docket No: 4882-02
21 January 2003

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[redacted]

This is in reference to your application for correction of your naval record pursuant to the provisions of title 10 of the United States Code, section 1552.

A three-member panel of the Board for Correction of Naval Records, sitting in executive session, considered your application on 16 January 2002. Your allegations of error and injustice were reviewed in accordance with administrative regulations and procedures applicable to the proceedings of this Board. Documentary material considered by the Board consisted of your application, together with all material submitted in support thereof, your naval record and applicable statutes, regulations and policies.

After careful and conscientious consideration of the entire record, the Board found that the evidence submitted was insufficient to establish the existence of probable material error or injustice. In this connection, the Board substantially concurred with the comments contained in the rationale of the hearing panel of the Physical Evaluation Board that considered your case on 28 July 1999, a copy of which is attached. Accordingly, your application has been denied. The names and votes of the members of the panel will be furnished upon request.

It is regretted that the circumstances of your case are such that favorable action cannot be taken. You are entitled to have the Board reconsider its decision upon submission of new and material evidence or other matter not previously considered by the Board. In this regard, it is important to keep in mind that a presumption of regularity attaches to all official records.

Consequently, when applying for a correction of an official naval record, the burden is on the applicant to demonstrate the existence of probable material error or injustice.

Sincerely,

W. DEAN PFEIFFER
Executive Director

Enclosure

SAN DIEGO FORMAL PEB RATIONALE
IN THE CASE OF
[redacted]

A medical board was held at [redacted]
on 07 January 1999 with the following diagnoses:

1. Fibromyalgia (7291)
2. Lumbar degenerative disk disease (72293)
3. Left supraspinatus tendinitis (7260)
4. Orthostatic hypotension (4580)
5. Hypoglycemia (2512)
6. Bilateral hallux valgus (7350)
7. Gastroesophageal reflux (53081)
8. Mitral valve prolapse (4240)
9. Migraine headaches (3469)
10. Pelvic pain (71945)
11. Failed bunion reconstruction (7350)

The informal Physical Evaluation Board found the member unfit for duty on 17 May 1999 under VA Code 5025, rated her condition at 20% disability and separation with severance pay.

This member appeared before the formal PEB on 28 July 1999 requesting to be found unfit for duty under VA Codes 5025 at 20% (fibromyalgia), 8100 (migraines) at 10%, and 5295 (lumbosacral strain) at 10% for a total of 40% disability and placed on the TDRL.

Accepted documentary evidence consisted of:

Exhibit A - PEB Case File
Exhibit B - Additional Medical Evidence
Exhibit C - Fitness Reports
Exhibit D - PRT Data
Exhibit E - Ltr from Orthopedic Association of Corpus Christi Dtd 16 Jul 99
Exhibit F - Ltr from Major M. D. Harris, MC, USAF dtd 10 Jun 99
Exhibit G - Ltr from Neurology dtd 22 Jun 99

The member's medical board of 7 January 1999 reports 11 diagnoses. The member appears requesting ratings for three diagnoses: fibromyalgia, migraines, and lumbosacral strain. Besides the 11 diagnoses in the medical board, the member's medical record indicates that she has been worked up and extensively evaluated for pain complaints referable to every organ system in the body. The leitmotif of all these complaints has been a combination of dramatic subjective symptoms with little or no objective signs. The member's three diagnoses for which she seeks ratings will be addressed seriatum.

The first diagnosis for which the member seeks a rating is fibromyalgia. The medical board notes that, in the six months preceding the board, the

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members evaluations had been primarily for her right shoulder and low back pain. The member was diagnosed with mild tendinitis in the left supraspinatus tendon. Subsequently, the member was referred both to a neurologist and rheumatologist to evaluate the numbness in her left arm associated with the low back pain and the shoulder pain. The evaluating physician felt that the member probably suffered from fibromyalgia. A work-up for rheumatologic etiologies was negative. The member was given a presumptive diagnosis of fibromyalgia.

The member submitted additional medical evidence in Exhibit F, which is a letter from a staff rheumatologist at Wilford Hall Medical Center. In this letter, the rheumatologist, Major Mark D. Harris, MC, USAF, notes that the member has the classical features of fibromyalgia. He then goes on to state that fibromyalgia is simply a chronic pain disorder for which the treatments are palliative rather than curative. Dr. Harris then discusses the possible disability from fibromyalgia. He notes that, in the civilian community, approximately 25% of fibromyalgia patients have received some form of disability payment. Conversely, 75% of such patients do not receive disability. He stated that the sequelae of fibromyalgia may significantly erode the ability of an individual to perform work requirements of regular and consist work hours in attendance, as well as accurate and complete work.

With regard to the member, her fitness reports are an official documentation of her work performance. In fact, the member's performance over the past five years has always been at or above standards in all categories. In the most recent report covering the period from February 1998 to January 1999, the member was rated overall "must promote". She was rated above standards in all categories except the standard for military bearing. This actually has represented a gradual improvement in the past five years. In the comments section, the member is noted to be involved in multiple activities beyond her job requirements. These include volunteering at the Salvation Army and Secretary of the National Naval Officer's Association and an active planner for the Black Heritage month activities for that organization. The member also attended courses for medical surgical nursing conference, assessing and managing COPD, and re-certified as a basic life support instructor and certified in ACLS. Thus, the member's fitness reports make clear that the member does not have evidence of the kinds of deterioration to which Dr. Harris referred when discussing possible disability from fibromyalgia.

With regard to the member's complaint of migraine headaches, the member testified that she loses up to two days of work per week because of her headaches. However, a review of the member's medical record since 1990 indicates only approximate a dozen visits complaining of headaches. There is no evidence that the member was sent SIQ for this headaches. Moreover, there is no evidence of prostrating headaches any where in the member's medical record.

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The member submitted additional medical evidence contained in Exhibit G, which is a letter from a neurologist at Wilford Hall Medical Center. This notes that the member takes Fiorinal for her headaches, which relieves the headaches 75% of the time. It then states that, if the Fiorinal does not work, the member goes to sick call and receives an injection of Demerol. However, there is no documentation of frequent visits to sick call for injections of Demerol, a controlled drug. The letter notes that the member states she misses 18 to 20 hours per week, but that is not documented any where in the member's record.

Again, referring to the member's performance evaluations, contained in her fitness reports, there is no documentation of the member's missing half her work week on a regular basis. This is contradicted by the member's above average performance, as well as her very significant involvement in activities beyond the Navy.

With regard to the member's request for a rating on lumbosacral strain, the member wished to have this separated from her chronic pain of fibromyalgia. The medical board notes an MRI of the lumbosacral area, which showed a **mild**, broad based, disk bulge at L4-5 with a small, right paracentral disk protrusion at L5-S1 with no significant effect on the nerve roots. The physical examination in the medical board notes that the member's back was tender to palpation along the L4 and sacral area and the sacral iliac joints bilaterally. The member had some decreased range of motion, but could still reach her hands to within six inches of the floor on forward flexion and could extend to approximately 30 degrees. The deep tendon reflexes were plus 2 and symmetrical. There was no evidence of muscle wasting, and no asymmetry. There were no areas of motor weakness or sensory loss any where in the examination.

The member submitted a civilian orthopedic evaluation contained in Exhibit E. The civilian physician spoke of a right herniated L5 nucleus pulposus based on a reading of the same MRI, where the Navy physicians had read it as only a mild disk bulge. The physical examination from the civilian was consistent with the Navy evaluation with one exception. Neurologic testing showed a 4+/5 muscle strength in the right foot peroneals versus the left. Apart from that, the only other discrepancy was that back extension was only to 15 degrees versus the 30 degrees found by the Navy physician. However, there was still no evidence of abnormal reflexes, or muscle wasting, or sensory deficits. Furthermore, an evaluation done by the same civilian orthopedic associates, but a different orthopod, on 23 June 1999, found an entirely normal neurologic examination, including no weakness and normal sensation. That physician specifically noted no muscle atrophy in the calf muscles and a negative straight leg raise test.

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Again, referring to the member's performance evaluations, there is no documentation that the member's low back pain has adversely effected her ability to function.

In evaluating any individual, it is of paramount importance to remember that the mere presence of a diagnosis is not synonymous with disability. It must be established that the medical disease or condition underlying the diagnosis actually interferes significantly with the member's ability to carry out the duties of her rank and rate. In the instant case, the member has been evaluated for subjective pain complaints referable to every organ system in the body. Her medical board lists 11 diagnoses. The member seeks ratings for three of these diagnoses. However, on careful review of the documentary record, it is quite clear that the member has performed adequately. While the member has multiple, dramatic subjective complaints, she has minimal corroborating objective findings. Her fitness reports indicate not simply that she has performed adequately, but rather that her performance has actually improved over the past five years. Therefore, after careful consideration of all relevant medical evidence, the formal board finds the member fit for continued Naval Service.