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

JRE
Docket No: 7425-01
6 September 2002

[redacted]

[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 29 August 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. In addition, the Board considered the advisory opinion furnished by the Specialty Leader for Nephrology dated 1 July 2002, a copy of which is attached.

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 advisory opinion. 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

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Docket No. 07425-01
1 July 2002

From: CAPT [redacted] MC, USN
Navy SG Specialty Leader for Nephrology
To: Chairman, Board for Correction of Naval Records

Subj: **COMMENTS AND RECOMMENDATION IN THE CASE OF FORMER [redacted]**

Ref: (a) BCNR letter JRE:jdh Docket No. 07425-01 of 12 June 2002

1. I have reviewed former [redacted]s medical file, as provided by the Board for Correction of Naval Record. I have also reviewed [redacted] letter to the Board, dated 13 August 2001.

2. [redacted] currently suffers from:

a. end stage renal disease, for which he first received peritoneal dialysis and later (1996) a cadaveric renal transplant. Based on lab data and his weight as recorded in the record, in late summer-early fall 2001 his creatinine clearance was about 50-60 ml/minute, which is about one half of normal. By itself, this level of kidney functioning should not cause symptoms. However, the medicines he has to take to keep his kidney can have significant side effects, as noted below.

b. hypertension which was definitively diagnosed after he left the Navy. As side effects of his therapy, he has some mild leg edema or swelling (described as "1+" in the record on a scale that can go as high as 4+).

c. gingival hyperplasia (swollen and enlarged gum tissue) , which is a known side effect of his therapy with amlodipine (Norvasc) and cyclosporine. Those drugs were prescribed for his hypertension and kidney transplant, respectively.

d. diabetes mellitus type 2, which is a known side effect of his cyclosporine and prednisone therapy, which are needed to keep his kidney.

3. In his letter, [redacted] alleges that he should receive additional compensation because a Navy physician negligently permitted him to be discharged from the service without a thorough evaluation of his hypertension and the protein noted on his urinalysis. He appears to state that such an evaluation would have included referral to a nephrologist. In turn, that referral would have led to a medical discharge and institution of preventive therapy which could have saved his kidneys and prevented significant suffering.

4. I disagree with [redacted] statements on several grounds:

a. First, transient or intermittent proteinuria which is not associated with a significant kidney disease is fairly common. [redacted] had several urine tests while on active duty, mostly while evaluating him for infections. Some showed protein, but the majority did not. The final value in his record, 40 mg%, is not really high enough to warrant an invasive evaluation. Of note, a urinalysis in October 1992, more than a year after his separation, was negative for protein. If his Navy doctor had been really suspicious of a kidney disease, he would have obtained a serum creatinine level. In October 1992, his serum creatinine was 1.3 mg/dl, which is actually normal for an African-American male (African-Americans on average have higher creatinine levels than Caucasians).

b. Second, [redacted] did not meet criteria for a diagnosis of hypertension while he was on active duty. Many things can cause a temporary rise in blood pressure. A diagnosis of hypertension requires multiple consecutive high blood pressure readings. While [redacted] had a few borderline measurements recorded in his chart, most were completely normal. Some of the higher readings were taken during visits in which he complained of pain, which can raise blood pressure temporarily. His blood pressure at his separation physical was perfect at 120/72. It would have been wrong to say that he had hypertension at that time.

c. Third, it is highly unlikely that a reputable nephrologist would have recommended a kidney biopsy or specific treatment if presented with the history available in [redacted] chart: low-grade, intermittent proteinuria, a bland urinary sediment and normal blood pressure.

d. Fourth, there was no preventive treatment available for kidney diseases in 1991. The fact that treatment with an angiotensin-converting enzyme (ACE) inhibitor can sometimes slow down worsening of kidney diseases was not proven until several years after Mr. Thompson's separation from the Navy.

5. It is probable, but not at all certain, that [redacted] had the beginnings of kidney disease at the time of his separation from the Navy. I believe that it was reasonable for the VA to award him a disability rating for his hypertension and his renal failure as they became apparent from 1992-1996.

6. In summary, I do not find any significant problems with the medical care that [redacted] received while he was on active duty. I do not find evidence that his military physicians were negligent. I do not believe that his kidney failure could have been predicted. I do not believe

that he should have been placed on medical hold or referred to a nephrologists before being separated. I believe that documentation of the low-grade proteinuria on his SF 88 was the only action that needed to be taken at the time of his separation physical. Thus I do not support Mr. Thompson's claim for extraordinary benefits beyond those he already receives.