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

JRE
Docket No: 431-01
18 June 2001

[redacted]

Dear [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 7 June 2001. 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 rationale of the hearing panel of the Physical Evaluation Board which considered your case on 6 June 2000, 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

[redacted] 265-63-5007

RATIONALE:

THE MEMBER IS A 39 YEAR OLD NC1, USN(RET) WITH ABOUT 12 AND ½ YEARS OF SERVICE AT THE TIME SHE WAS PLACED ON THE TDRL ON 12 MAY 1998 WITH A DISABILITY RATING OF 60% UNDER V.A. CODE 6350 FOR THE DIAGNOSIS:

(1) SYSTEMIC LUPUS ERYTHEMATOSUS.

ADDITIONAL DIAGNOSES THAT WERE CONSIDERED CATEGORY II CONDITIONS WERE:

(2) LEUKOPENIA SECONDARY TO #1;
(3) ARTHRITIS SECONDARY TO #1;
(4) HISTORY CONSISTENT WITH PATELLOFEMORAL SYNDROME; AND
(5) SEROSITIS SECONDARY TO #1.

AN ADDITIONAL DIAGNOSIS THAT WAS CONSIDERED A CATEGORY III CONDITION WAS:

(6) MAJOR DEPRESSIVE DISORDER SINGLE EPISODE IN FULL REMISSION.

THE MEMBER UNDERWENT TDRL EVALUATION ON 13 DECEMBER 1999 AT WRIGHT-PATTERSON AIR FORCE BASE. THE INFORMAL PEB CONSIDERED THE CASE ON 3 MARCH 2000 AND FOUND THE MEMBER UNFIT FOR DUTY BECAUSE OF PHYSICAL DISABILITY BASED ON DIAGNOSIS NUMBER (1) AND RATABLE AT 10% UNDER V.A. CODE 6350. THE OTHER DIAGNOSES REMAINED CLASSIFIED AS ABOVE. THE MEMBER DISAGREED WITH THIS FINDING AND DEMANDED A FORMAL HEARING.

A FORMAL HEARING WAS CONDUCTED ON 06 JUNE, 2000 AT BETHESDA, MARYLAND WITH [redacted], USNR, AS PRESIDING OFFICER, [redacted], USMCR, AND [redacted], MC, USN, AS PANEL MEMBERS. THE MEMBER WAS REPRESENTED BY [redacted], JAGC, USN.

THE MEMBER APPEARED AT THE HEARING REQUESTING TO BE FOUND UNFIT FOR DUTY AND RETAINED ON THE TDRL AT HER PREVIOUS RATING OF 60% UNDER V.A. CODE 6350. TO SUPPORT HER REQUEST THE MEMBER PRESENTED TESTIMONY, COPIES OF HER V.A. TREATMENT RECORDS, COPIES OF HER V.A. RATING DECISIONS OF 9 OCTOBER 1998 AND 6 APRIL 1999, A COPY OF HER VOCATIONAL REHABILITATION ASSESSMENT OF 20 DECEMBER 1998, AND NON-MEDICAL EVIDENCE LETTERS FROM HER MOTHER AND HER FATHER.

AFTER CAREFUL REVIEW OF ALL THE AVAILABLE EVIDENCE AND BASED ON UNANIMOUS OPINION, THE FORMAL PEB FINDS THE MEMBER REMAINS UNFIT FOR DUTY IN THE U.S. NAVY BECAUSE OF PHYSICAL DISABILITY. THE RECORD DOCUMENTS THAT THE MEMBER HAS SYSTEMIC LUPUS ERYTHEMATOSUS, A CHRONIC INFLAMATORY CONDITION AFFECTING MULTIPLE BODY ORGAN SYSTEMS WITH UNPREDICTABLE EPISODES OF EXACERBATION THAT LIMIT THE MEMBER'S ACTIVITIES AND ASSIGNABILITY SUCH THAT IT WOULD INTERFERE WITH THE ADEQUATE PERFORMANCE OF DUTIES.

THE CURRENT TDRL EVALUATION REPORTED CURRENT SYMPTOMS OF OCCASIONAL LOW BACK AND TAILBONE AREA PAIN, OCCASIONAL WRIST SWELLING, OCCASIONAL SHARP CHEST PAINS THAT ARE POSITIONAL DEPENDENT, A FLAT, RED MILDLY PRURITIC RASH ON HER LEGS THAT IS CURRENTLY RESOLVED, OCCASIONAL PAINFUL ORAL ULCERS THAT LAST 7 TO 10 DAYS OCCURRING MAINLY DURING THE SUMMER, AND MILD FATIGUE. THE MEMBER WAS NOT WORKING. THE PHYSICAL EXAM WAS REPORTED TO SHOW NO ORAL ULCERATIONS, A GRADE II/VI SYSTOLIC EJECTION MURMUR AT THE RIGHT UPPER STERNAL BORDER THAT CHANGES WITH VALSALVA MANEUVER, NO HEPATOSPLENOMEGALY, NO SKIN RASHES, AND NO EVIDENCE OF SYNOVITIS. LAB VALUES WERE REPORTED AS A WBC OF 3600 WITH 39% LYMPHOCYTES, HEMOGLOBIN AND HEMATOCRIT AT 12.9 AND 38.8, RESPECTIVELY, AND AN ANA TITER OF 1:320 WITH A SPECKLED PATTERN. CREATININE AND LIVER FUNCTION TESTS WERE NORMAL. X-RAYS OF THE CHEST AND THE KNEES WERE ESSENTIALLY NORMAL. THE EKG WAS NORMAL WITH NO ST OR T-WAVE CHANGES. THE MEMBER'S CONDITION WAS SUMMARIZED AS CURRENTLY IN A STATE OF REMISSION WITH NO EVIDENCE OF RASH, PLEURITIS, ARTHRITIS, OR PERICARDITIS, BUT WITH CONTINUED FATIGUE AND A MILD LEUKOPENIA. THE MEMBER IS CURRENTLY UNDER TREATMENT WITH PLAQUENIL. THE RECORDS PRESENTED DID NOT SHOW ANY INCAPACITATING EXACERBATIONS OF THE LUPUS. ALTHOUGH THE MEMBER CLAIMED TO CONTINUE TO HAVE CHEST PAIN, IRREGULAR HEART BEAT, DIZZY SPELLS, SHORTNESS OF BREATH, STIFF JOINTS, NUMBNESS AND TINGLING IN THE FINGERS, PLUS CHRONIC FATIGUE WITH SLEEPING 12 TO 15 HOURS PER DAY, THE FORMAL PEB DID NOT FIND THE TESTIMONY CONVINCING THAT THE SLEEPING 12 TO 15 HOURS PER DAY WAS ATTRIBUTABLE TO THE LUPUS. THE RECORDS SHOW THIS IS MORE RELATED TO HER DEPRESSIVE SYMPTOMS. THEREFORE, THE LUPUS IS MOST APPROPRIATELY RATED AT 10% UNDER V.A. CODE 6350. DIAGNOSES 2, 3, 4, AND 5 REMAIN CATEGORY II CONDITIONS THAT CONTRIBUTE TO DIAGNOSIS NUMBER 1.

THE RECORDS PRESENTED SHOW THE MEMBER CONTINUES TO HAVE SIGNIFICANT DEPRESSION REQUIRING ONGOING TREATMENT WITH ZOLOFT AND INDIVIDUAL PSYCHOTHERAPY FOR DIAGNOSES OF RECURRENT DEPRESSIVE DISORDER, DYSTHYMIC DISORDER, AND PANIC DISORDER. ALTHOUGH DEPRESSION CAN BE A MANIFESTATION OF SYSTEMIC LUPUS ERYTHEMATOSUS, IN THIS CASE THE ORIGINAL EPISODE OF MAJOR DEPRESSION PRECEDED THE

DIAGNOSIS OF SYSTEMIC LUPUS AND WAS MORE REACTIVE IN NATURE RELATED TO HER JOB AND FEELING OVERWHELMED WITH THE DEMANDS PLACED ON HER AFTER COMPLETING NAVY COUNSELOR SCHOOL. ALSO, THERE WAS A PRIOR HISTORY OF DEPRESSIVE SYMPTOMS IN 1993 RELATED TO JOB STRESSES AND A PARTIAL HYSTERECTOMY. FURTHER, THERE WAS A FAMILY HISTORY OF DEPRESSION IN THE MEMBER'S MOTHER THAT HAD REQUIRED HOSPITALIZATION AND TREATMENT. THEREFORE, THE DIAGNOSIS OF MAJOR DEPRESSIVE DISORDER IS NOT CONSIDERED RELATED TO THE SYSTEMIC LUPUS. AT THE TIME OF THE ORIGINAL MEDICAL BOARD FOR THE LUPUS IN AUGUST 1997, THE MEMBER HAD BEEN RETURNED TO FULL DUTY BY A MEDICAL BOARD FROM PSYCHIATRY DATED 24 MAY 1997 INDICATING THE DEPRESSION WAS IN FULL REMISSION ON MEDICATION. THEREFORE, THE DEPRESSION DIAGNOSIS WAS APPROPRIATELY CONSIDERED A CATEGORY III CONDITION AT THE TIME OF PLACEMENT ON THE TDRL. CONSEQUENTLY, IT IS NOT RATABLE AND REMAINS A CATEGORY III CONDITION.

[redacted] 14 July 00

CAPT J. [redacted] USNR, PRESIDING DATE

[redacted] 14 Jul 2000

COL D. L. [redacted], USMCR, PANEL DATE

[redacted] 5 July '00

CAPT [redacted], MC, USN, PANEL DATE