RECORD OF PROCEEDINGS
PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXXX
BRANCH OF SERVICE: NAVY

CASE: PD-2022-00015
SEPARATION DATE: 20041208

SUMMARY OF CASE: Data extracted from the available evidence of record reflects this covered individual (CI) was an active duty E3, Yeoman, medically separated for "syndrome X" with a disability rating of 10%.

CI CONTENTION: "Not been found eligible for retirement. Syndrome X (microvascular angina)." The complete submission is at Exhibit A.

SCOPE OF REVIEW: The panel's scope of review is defined in DoDI 6040.44. It is limited to review of disability ratings assigned to those conditions determined by the Physical Evaluation Board (PEB) to be unfitting for continued military service, and when specifically requested by the CI, those conditions identified by the Medical Evaluation Board (MEB) but determined by the PEB to be not unfitting or non-compensable. Any conditions outside the panel's defined scope of review, and any contention not requested in this application, may remain eligible for future consideration by the Board for Correction of Military Records. The panel's authority is limited to assessing the fairness and accuracy of PEB rating determinations and recommending corrections when appropriate. The panel gives consideration to VA evidence, particularly within 12 months of separation, but only to the extent that it reasonably reflects the severity of disability at the time of separation.

RATING COMPARISON:

SERVICE PEB - 20041108			VARD – 20050916			
Condition	**Code**	**Rating**	**Condition**	**Code**	**Rating**	**Exam**
Syndrome X	7199-7005	10%	No VA Placement			
Migraine Headache	Cat II		Migraine Headaches	8100	0%	20050304
Chest Pain Syndrome	Cat II		No VA Placement			
COMBINED RATING: 10%			**COMBINED RATING OF ALL VA CONDITIONS: 0%**			

ANALYSIS SUMMARY:

Syndrome X. According to the service treatment record (STR) and MEB narrative summary (NARSUM), the CI's syndrome X (microvascular angina) began around 1996 with a history of episodic chest pain. An echocardiogram in August 2003 was normal, but an abnormal cardiac nuclear test led to a cardiac catheterization study of the left ventricle. The results showed mildly decreased left ventricular wall motion and "slow flow in the right coronary artery." In March 2004, a nuclear scan and echocardiogram showed normal left ventricle size, and an exercise stress test was normal "with no evidence of ischemia."

At a cardiology consultation on 11 May 2004, 7 months prior to separation, the CI reported an 8-year history of anginal-type chest pain. The examiner noted extensive workups by civilian

cardiologists that included two echocardiograms, two nuclear perfusion scans and a cardiac catheterization all within the previous year. The examiner stated that although the perfusion scans both showed depressed left ventricular function, the finding was not confirmed by echocardiogram. Additionally, the "slow flow" in the right coronary artery was of "uncertain significance." Physical findings were unremarkable. The cardiologist determined that the CI's condition met the definition of microvascular angina with no need for further cardiac evaluation, but recommended considering "other noncardiac causes" for the chest pain, such as GERD.

On 19 August 2004, an EKG revealed increased volts in the precordium "suggesting left ventricular hypertrophy or normal variant for age and race. During a cardiology visit on 1 September 2004, the CI complained of chest pain that interfered with work and emotional health, and led him to seek emergency room treatment; physical examination was unremarkable.

The 7 September 2004 MEB NARSUM examination, 3 months prior to separation, noted complaints of chest pain that occurred 3 times a week. The symptoms began as a migraine-type headache which was followed by left-sided chest pain that radiated down both arms and associated with sweating and increased saliva production. Physical findings showed normal blood pressure and pulse, as well as normal lung and heart examination. The examiner opined that the chest pain syndrome interfered with the CI's ability to perform his duties, noting no benefit from medical therapy. The migraines were noted as related to the chest pain syndrome.

During the 12 October 2004 MEB examination (recorded on DD Forms 2807-1 and 2808), 2 months before separation, the CI reported frequent heart palpitations with chest pain and headaches before and after the chest pains. Heart palpitations occurred daily, and he had trouble sleeping due to fear of a heart attack. He experienced chest pain while exercising and had shortness of breath. Medication had not resolved any symptoms, and he was being treated with talk therapy for depressive and anxiety symptoms with suicidal and homicidal ideation. The examiner documented irregular heart rhythm and depressed mood.

At the 4 March 2005 VA Compensation and Pension (C&P) examination, 4 months after separation, the CI reported sharp, left-sided chest pain which occurred 3-4 times a week and lasted 5-9 minutes with each episode. The heart examination was unremarkable showing a regular rate without murmur, rub, or gallop. A chest X-ray on the same day showed normal heart size, and there was no mention of left ventricular hypertrophy in EKG or echocardiogram findings. An exercise stress test recorded METs of 8.8 with no ischemic changes. The test lasted 7 minutes and 11 seconds before the CI stopped because of shortness of breath and the inability to keep the pace with the treadmill. The examiner assessed "atypical chest pain, etiology unknown."

The panel directed attention to its rating recommendation based on the above evidence. The PEB rated the syndrome X 10%, analogously coded 7199-7005 (arteriosclerotic heart disease), and listed migraine headaches and chest pain syndrome as Category II conditions (related and contribute to the primary unfitting condition). The VA did not service connect the syndrome X.

The panel's first charge was to assess whether the related Category II diagnoses could be reasonably justified as separately unfitting for rating consideration. Panel members noted that the chest pain syndrome was intrinsic to the rated condition and a separate rating could not be supported without pyramiding (VASRD §4.14); thus, it was appropriately subsumed under the same rating. The panel next assessed whether the migraine headaches were reasonably justified as separately unfitting for rating consideration. The headaches were not listed on the limited duty report, and the non-medical assessment (NMA) did not specifically implicate the headaches as interfering with the CIs ability to do his job. The commander mentioned the CI was away from his duties for treatment and evaluation and/or recuperation for 16-24 hours per week, however, panel members could not speculate on how much of that time was related to the migraines. The NMA made no mention of headaches severe enough to require work stoppage, periods of rest,

a change in the work environment (i.e., dark room), or the need to go home. The NARSUM examiner attributed the headaches to the syndrome X condition, and treatment with prophylactic medication was not documented in the record; nor was there evidence of prostrating attacks. At the C&P examination, the CI reported the headaches occurred mostly in the morning, awakening him from sleep and lasting for 10 minutes. They recurred 3-4 times a week, and he was not receiving any therapy for them. After careful consideration, panel members agreed that a preponderance of evidence did not justify the migraine headaches as separately unfitting. After due deliberation, considering all the evidence, the panel concluded there was insufficient cause to recommend a change in the PEB adjudication for the migraine headaches and therefore no additional rating is recommended.

The panel next considered a rating recommendation for the syndrome X, and noted that radiology, nuclear, EKG, and echocardiogram tests were assessed as normal proximate to separation. Additionally, was no evidence of less than 7 METs on any of the stress tests performed before or after separation. Thus, panel members agreed that a 10% rating, but no higher, was justified for the heart condition. A 30% rating was not warranted for "demonstrated cardiac workload of greater than 5 METS (metabolic equivalents), but not greater than 7 METS, that results in dyspnea, fatigue, angina, dizziness, or syncope; or evidence of cardiac hypertrophy or dilatation on electrocardiogram, echocardiogram, or X-ray." After due deliberation, considering all the evidence and mindful of VASRD §4.3 (reasonable doubt), the panel concluded there was insufficient cause to recommend a change in the PEB adjudication for the heart condition.

BOARD FINDINGS: In the matter of the heart condition and IAW VASRD §4.104 the panel recommends no change in the PEB adjudication. In the matter of the migraine headaches, the panel agrees it cannot recommend the condition for additional disability rating. There are no other conditions within the panel's scope of review for consideration. Therefore, the panel recommends no modification or re-characterization of the CI's disability and separation determination.

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20210518, w/atchs
Exhibit B. Service Treatment Record
Exhibit C. Department of Veterans Affairs Record

3/9/2023

DEPARTMENT OF THE NAVY
SECRETARY OF THE NAVY COUNCIL OF REVIEW BOARDS
720 KENNON STREET SE STE 309
WASHINGTON NAVY YARD, DC 20374-5023

IN REPLY REFER TO
6040
CORB: 001
24 May 23

From: Director, Secretary of the Navy Council of Review Boards
To: Samuel Johnson

Subj: Physical Disability Board of Review Determination

Ref: (a) DODI 6040.44(Series)

1. The Physical Disability Board of Review (PDBR) reviewed your case in accordance with reference (a) and forwarded their recommendation for action.

2. On 23 May 2023, the Assistant Secretary of the Navy (Manpower and Reserve Affairs) accepted the PDBR's recommendation of no change to your characterization of separation or disability rating assigned.

3. The PDBR determination is final and not subject to appeal or review.