Neuropathy Support Network

A Guide to Successful Legal Cases and Affidavits used by Veterans suffering from exposure to Agent Orange including:

- Legal cases approved by the VA with service connection to peripheral neuropathy secondary to exposure to Agent Orange
- The Use of Affidavits in disability claims for military service veterans
- Introduction by Eugene B. Richardson, MDiv, EdM, MS LtCol, USA (Retired)
  President, Neuropathy Support Network LLC
  (Living with Agent Orange induced Neuropathy for over 40 years.)
To: All Veterans of our Armed Forces

From: Eugene B. Richardson, MDiv, EdM, MS
LtCol, USA (Retired) – Vietnam ’67-’78
President of the Neuropathy Support Network LLC
40+ years of living with Agent Orange induced Neuropathy

As a senior military career officer and now a 100% disabled veteran of the Vietnam War, I always thought that the U.S. Department of Veterans Affairs (VA) was doing a great job in serving our veterans and was committed to helping veterans while stopping fraud and false claims. I am sure that in many cases this is true and that the VA has served many veterans well.

Conversely, after submitting a claim to the VA in 2004, it was a slow growing disappointing revelation that the last statement was not always true. Following years of denials, false statements, repeated misstatements of fact, medical misinformation, medical incompetence by examining doctors, bureaucratic delays, a confusing mass of paper work, duplicate paper work, responses using legalize and confusing medical language beyond comprehension, followed by failure to even send significant documents to me as they claimed, six years after the initial claim was filed, in January 2010 my disability was approved!

Even given this fact, an appeal as to the effective date was sent to the VA in February 15, 2010 of the VA decision on October 2, 2009. The VA acknowledged the appeal on May 17, 2010. On January 13, 2011 a follow up letter was sent and to this date the VA in Bay Pines, Florida has not responded. If this experience was not common among thousands of veterans for decades, one could conclude that this is an isolated case in the failure of the VA system. I wish this were true as it would sit better as the VA fails so many of our veterans who have died without help or support for them or their families.

The only way I was able to “win” was through the use of notarized affidavits, as to the clearly recorded facts of record, signed and notarized by my treating Neurologist. This action clearly put expert testimony of a treating Board Certified Neurologist in the court on my behalf. Now there was no way around the facts of record. How disappointing it was then when I sent another veteran the same information only to have his treating doctor state that “they did not want to get involved in politics.” I asked myself, since when is a diagnosis and highly probable causes for their illness political in the medical system? The answer is when it involves Agent Orange exposure.

The current head of the Department, The Honorable Retired U.S. Army General Eric K. Shinseki is committed to make changes in the VA to address these issues. I have the greatest respect for this General, as he is an officer who tells it like it is to the troops he leads. Not long ago, General Shinseki asked the question, “Why has it taken decades to find out what Agent Orange (dioxin) has done to the troops?”

This great leader has made some progress in this regard. However, I fear that the answer to his question is the same answer he received years ago at the beginning of the Iraq War, when he testified before Congress as to his estimated number of troops it would take to win in Iraq. A lesser person of power stated that his estimate “was way over the top.” Why was this done to a military expert who was paid to know? The real answer was some in leadership positions did not want to know and the answer to his question about the medical problems caused by Agent Orange is again, ‘some in leadership positions do not want to know’.
Congress has time after time, added taxpayer funds to hire more reviewers for the VA yet the backlog has continued to grow for decades. Congressional committees have discussed the facts of the issue and acknowledge it is true. So why is it still an issue many decades later? Why are many widows, orphans and veterans asking the same question?

Repeatedly, the veterans’ organizations in articles over decades have noted the horrible growing backlog and in a March 2011 article the title was “Broken System.” For decades everyone acknowledges there is a problem and decades later it is the same broken system.

There are too many stories of veterans gone without help for themselves or their families with standard boiler plate answers from the VA that delayed any action and then the veterans were dead. Somewhere this behavior by some VA employees is being rewarded, as people tend to repeat behavior that has a reward and avoid behavior that is not rewarded. The current inexcusable backlog of appeals and disability applications is of the VA’s own internal creation.

Such is a sad commentary for a country I love and would serve again if able, yet it has all too often failed to help veterans with their applications for disability as intended in the laws established by Congress. Until this problem is addressed as it should be, by training of reviewers who are held accountable with the full support from Congress, it will continue to grow to the determent of current and future veterans and the country I love.

Meanwhile, for veterans fighting this system, the use of notarized affidavits, putting expert medical or other expert testimony into the court of opinion on their behalf, is one way to fight back at those who support the backlog by rewarded behavior in a broken system.

For God and Country:

Eugene B. Richardson

Eugene B. Richardson
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Citation Nr: 0606156   Decision Date: 03/03/06   Archive Date: 03/14/06

(DOCKET NO. 04-19 301)   DATE

On appeal from the Department of Veterans Affairs Regional Office in Phoenix, Arizona

THE ISSUES

1. Entitlement to service connection for peripheral neuropathy of both lower extremities, claimed as nerve damage to the legs and feet and also as circulatory damage to the feet as due to Agent Orange.

2. Entitlement to service connection for skin cancer, claimed as spots on the face, arms, and hands that tingle and also as nerve damage.

REPRESENTATION

Veteran represented by: Arizona Veterans Service Commission

WITNESS AT HEARING ON APPEAL

Veteran ATTORNEY FOR THE BOARD

J.W. Kim, Associate Counsel

INTRODUCTION

The veteran served on active duty from March 1963 to March 1966, including service in the Republic of Vietnam.

These matters come before the Board of Veterans' Appeals (Board) on appeal of rating decisions by the Department of Veterans Affairs (VA) Regional Office (RO) in Phoenix, Arizona. In a January 2003 rating decision, the RO denied service connection for peripheral neuropathy of the left and right lower extremities. In a December 2003 rating decision, the RO continued the prior denials of service connection for peripheral neuropathy and denied service connection for skin cancer, claimed as spots on the face, arms, and hands that tingle and also as nerve damage. The veteran timely perfected an appeal of these determinations to the Board. In September 2005, the veteran testified before the undersigned Veterans Law Judge at a Board hearing at the RO.

The issue of service connection for skin cancer, claimed as spots on the face, arms, and hands that tingle and also as nerve damage, is addressed in the REMAND portion of the decision below and is REMANDED to the RO via the Appeals Management Center (AMC), in Washington, DC.

FINDINGS OF FACT

Resolving all reasonable doubt in favor of the veteran, peripheral neuropathy of both lower extremities is related to service, specifically to exposure to Agent Orange.
CONCLUSION OF LAW

Peripheral neuropathy of both lower extremities was incurred in active service. 38 U.S.C.A. §§ 1101, 1110, 1112, 1113, 1116, 5107 (West 2002); 38 C.F.R. §§ 3.102, 3.303, 3.307, 3.309 (2005).

REASONS AND BASES FOR FINDINGS AND CONCLUSION

Initially, the Board finds that the agency of original jurisdiction has substantially satisfied the duties to notify and assist, as required by the Veterans Claims Assistance Act of 2000. 38 U.S.C.A. §§ 5100, 5102, 5103, 5103A, 5107, 5126 (West 2002 & Supp. 2005); 38 C.F.R. §§ 3.102, 3.156(a), 3.159 and 3.326(a) (2005). To the extent that there may be any deficiency of notice or assistance, there is no prejudice to the veteran in proceeding with this case given the favorable nature of the Board's decision.

Service connection may be granted for disability resulting from disease or injury incurred in or aggravated by service.

38 U.S.C.A. § 1110 (West 2002); 38 C.F.R. § 3.303(a) (2005). Service connection may also be awarded for a chronic condition when: (1) a chronic disease manifests itself and is identified as such in service (or within the presumptive period under 38 C.F.R. § 3.307) and the veteran presently has the same condition; or (2) a chronic disease manifests itself during service (or within the presumptive period) but is not identified until later and there is a showing of continuity of symptomatology after discharge. 38 C.F.R. § 3.303(b) (2005); see 38 C.F.R. §§ 3.307, 3.309 (2005).

A veteran who, during active military, naval, or air service, served in the Republic of Vietnam during the Vietnam era, and has a disease listed at 38 C.F.R. § 3.309(e), shall be presumed to have been exposed during such service to an herbicide agent, unless there is affirmative evidence to establish that the veteran was not exposed to any such agent during that service. 38 C.F.R. § 3.307(a)(6)(iii).

If a veteran was exposed to an herbicide agent during active military, naval, or air service, the following diseases shall be service connected if the requirements of 38 C.F.R. § 3.307(a)(6)(iii) are met, even though there is no record of such disease during service, provided further that the rebuttable presumption provisions of 38 C.F.R. § 3.307(d) are also satisfied: Chloracne or other acneform disease consistent with chloracne; Type II Diabetes; Hodgkin’s disease; multiple myeloma; non-Hodgkin’s lymphoma; acute and subacute peripheral neuropathy; porphyria cutanea tarda; prostate cancer; respiratory cancers (cancer of the lung, bronchus, larynx or trachea); and soft-tissue sarcoma (other than osteosarcoma, chondrosarcoma, Kaposi’s sarcoma, or mesothelioma). 38 C.F.R. § 3.309(e); 66 Fed. Reg. 23,166, 23,168-69 (May 8, 2001).

The term acute and subacute peripheral neuropathy means transient peripheral neuropathy that appears within weeks or months of exposure to an herbicide agent and resolves within two years of the date of onset. Note 2, 38 C.F.R. § 3.309(e).

The veteran contends, in essence, that he has peripheral neuropathy of both lower extremities due to exposure to Agent Orange during service. He asserts that symptoms developed in approximately 1970 and that they have gradually become worse, but that he did not seek treatment until April 2002.
The record shows that the veteran served in the Republic of Vietnam during the Vietnam era. Thus, exposure to Agent Orange is presumed. 38 C.F.R. § 3.307(a)(6)(iii).

Initially, the Board notes that only acute and subacute peripheral neuropathy are recognized by VA as diseases associated with exposure to Agent Orange. 38 C.F.R. § 3.309(e). In this regard, the record shows that the veteran does not have acute or subacute peripheral neuropathy as defined by VA regulations. The fact that the veteran is not entitled to the foregoing regulatory presumption of service connection does not preclude an evaluation as to whether he is entitled to service connection on a direct basis or entitled to presumptive service connection for a chronic disease. See Combee v. Brown, 34 F.3d 1039 (Fed. Cir. 1994).

After review, the Board notes a December 2002 VA neurological disorders examination report and a July 2003 letter from Dr. Durham, the veteran's private treating physician.

The VA examination report reflects the examiner's difficulty in determining the etiology of the veteran's peripheral neuropathy. The examiner stated that there is no clear cut evidence that exposure to herbicides caused the veteran's peripheral neuropathy and acknowledged the discomfort of defining the veteran's disorder as a neuropathy of unknown etiology. The examiner explained that unfortunately many peripheral neuropathies are of unknown etiology and to arbitrarily assign one to a caustic agent does not seem to be the best medical decision.

Dr. Durham begins his letter by noting that he has taken several comprehensive histories from the veteran and can find no other type of exposures either personal or industrial that could potentially account for the veteran's neuropathy. He also noted reviewing the veteran's VA medical records, including the above examination report, his own medical records, VA's Guide on Agent Orange Claims, and the veteran's rating decision. Dr. Durham acknowledged that the veteran's claim was denied because he did not complain of symptoms within the very short time period cited by VA after exposure to herbicides. He stated that it is clearly documented in the medical literature that neuropathy can be latent for a period of up to decades, and a denial based on short term exposure and short term initiation of acute complaints seems to be somewhat arbitrary. He opined that, given that the veteran does not have any evidence of any of the other major problems with which neuropathy is often associated, there is at least a 51 percent probability that the veteran's neuropathy may be directly linked to exposure to dioxin/Agent Orange.

The Board acknowledges that the veteran's claims file was not made available to Dr. Durham. The Board observes that review of the claims file is only required where necessary to ensure a fully informed examination or to provide an adequate basis for the examiner's findings and conclusions. See VAOPGCPREC 20-95; 61 Fed. Reg. 10,064 (1996). In this case, the Board finds that resort to the veteran's claims file was not necessary because the veteran provided an accurate account of his medical history, thus ensuring a fully informed examination. In this regard, the Board observes that the veteran's account as related to Dr. Durham essentially reflected the evidence of record at that time. Further, Dr. Durham did review several pertinent documents, including the VA examination report.

Given the above, and resolving all reasonable doubt in favor of the veteran, the Board finds that the veteran's peripheral neuropathy of both lower extremities is due to his exposure to Agent Orange during service.

ORDER

Service connection for peripheral neuropathy of both lower extremities is granted.
REMAND

The veteran contends, in essence, that he has spots on his face, arms, and hands that tingle due to nerve damage from exposure to Agent Orange. He also contends, in essence, that he has had skin cancers also from exposure to Agent Orange.

After review, the Board observes that further development is necessary prior to adjudicating this claim. In an August 2004 statement, the veteran indicated that he had submitted copies of medical records from two dermatologists. The Board observes that the above medical evidence is not of record. In light of VA's notice of the existence of outstanding medical evidence, the appeal must be remanded.

Accordingly, the case is REMANDED for the following action:

1. The RO should attempt to obtain and associate with the claims file medical records from the two dermatologists referenced by the veteran in his August 2004 statement.

2. After all evidentiary development has been completed, including a VA examination if deemed necessary, the RO should readjudicate the issue of entitlement to service connection for skin cancer, claimed as spots on the face, arms, and hands that tingle and also as nerve damage.

3. If the benefit sought on appeal remains denied, the veteran and his representative should be furnished a supplemental statement of the case and afforded an appropriate opportunity for response before the claims file is returned to the Board for further appellate consideration.

Thereafter, the case should be returned to the Board, if in order. The Board intimates no opinion as to the ultimate outcome of this case. The veteran need take no action unless otherwise notified.

The veteran has the right to submit additional evidence and argument on the matter the Board has remanded. Kutscherousky v. West, 12 Vet. App. 369 (1999).

This claim must be afforded expeditious treatment. The law requires that all claims that are remanded by the Board of Veterans' Appeals or by the United States Court of Appeals for Veterans Claims for additional development or other appropriate action must be handled in an expeditious manner. See 38 U.S.C.A. §§ 5109B, 7112 (West Supp. 2005).

K. OSBORNE Acting Veterans Law Judge, Board of Veterans' Appeals

Department of Veterans Affairs
Case from Atlanta, Georgia

Citation Nr: 0802669
Decision Date: 01/24/08    Archive Date: 01/30/08

(DOCKET NO.  97-33 277 )    DATE

On appeal from the
Department of Veterans Affairs Regional Office in Atlanta,
Georgia

THE ISSUE

Entitlement to service connection for peripheral neuropathy, to include on a direct basis and as secondary
to Agent Orange Exposure.

REPRESENTATION

Appellant represented by:       Georgia Department of Veterans Services

WITNESSES AT HEARING ON APPEAL

Appellant and his spouse

ATTORNEY FOR THE BOARD

Tzu Wang, Associate Counsel

INTRODUCTION


This matter initially came before the Board of Veterans'Appeals (Board) from a January 1997 rating decision of the Department of Veterans Affairs (VA) Regional Office (RO) in Atlanta, Georgia.

In January 1998, the appellant and his spouse testified at the RO before a Decision Review Officer; a copy of the transcript has been associated with the claims file.

Subsequently, in December 1998 and August 2003, the Board remanded this case to the RO for further evidentiary development.  In September 2007, the Board referred this case to the VA's Veterans Health Administration (VHA) for a medical opinion.  The specialist's opinion, dated October 18,2007, has been associated with the claims folder and, as required by law and regulation, the Board provided the appellant and his representative copies of this opinion and afforded them time to respond with additional evidence or argument.  38 C.F.R. § 20.903(a) (2007).  The case is now before the Board for further appellate consideration.

FINDING OF FACT

There is competent medical evidence linking the veteran's peripheral neuropathy to military service.
CONCLUSION OF LAW


REASONS AND BASES FOR FINDING AND CONCLUSION


During the pendency of this appeal, the U.S. Court of Appeals for Veterans Claims (Court) issued a decision in the appeal of Dingess v. Nicholson, 19 Vet. App. 473 (2006), which held that the notice requirements of 38 U.S.C.A. § 5103(a) and 38 C.F.R. § 3.159(b) apply to all five elements of a service connection claim, including the degree of disability and the effective date of an award. In the present appeal, the appellant was not provided with notice of the type of evidence necessary to establish a disability rating or an effective date, if service connection was granted on appeal. When implementing the award, the RO will address any notice defect with respect to the initial disability rating and effective date elements. Significantly, the veteran retains the right to appeal any effective date or initial disability rating assigned by the RO.

Without deciding whether VA's notice and development requirements have been satisfied in the present case with respect to the issue of peripheral neuropathy, the Board is taking action favorable to the veteran by granting service connection for his peripheral neuropathy, as such the Board finds that there has been no prejudice to the veteran that would warrant further notice or development and the Board will proceed with appellate review. See, e.g., VAOPGCPREC 16-92, 57 Fed. Reg. 49,747 (1992); See Conway v. Principi,353 F.3d 1369 (Fed. Cir. 2004); Sutton v. Brown, 9 Vet. App. 553 (1996); Bernard v. Brown, 4 Vet. App. 384 (1993).

Analysis

Service connection may be granted for a disability resulting from disease or injury incurred in or aggravated by active military service. See 38 U.S.C.A. §§ 1131 (West 2002); 38 C.F.R. §§ 3.1(k), 3.303(a) (2007). In order to prevail in a claim for service connection there must be medical evidence of a current disability as established by a medical diagnosis; of incurrence or aggravation of a disease or injury in service, established by lay or medical evidence; and of a nexus between the in-service injury or disease and the current disability established by medical evidence. Boyer v. West, 210 F.3d 1351, 1353 (Fed. Cir. 2000).

Where a veteran who served for ninety days or more during a period of war or after December 31, 1946, develops certain chronic diseases to a degree of 10 percent or more within one year from separation from service, such diseases may be presumed to have been incurred in service even though there is no evidence of such disease during the period of service. This presumption is rebuttable by affirmative evidence to the contrary. See 38 U.S.C.A. §§ 1101, 1112, 1113, 1137 (West 2002); 38 C.F.R. §§ 3.307, 3.309 (2007). Service connection may also be granted for any disease diagnosed after discharge, when all the evidence, including that pertinent to service, establishes that the disease was incurred in service. 38 C.F.R. § 3.303(d) (2007). Further, if a condition noted during service is not shown to be chronic, then generally, a showing of continuity of symptoms after service is required for service connection. See 38 C.F.R. § 3.303(b) (2007).

Service connection can also be established under presumptive provisions; in particular, presumption applies to disease(s) associated with exposure to certain herbicide agents. Under 38 C.F.R. § 3.307(a)(6) (2007), a veteran who, during active military, naval or air service, served in the Republic of Vietnam during the period beginning on January 9, 1962, and ending on May 7, 1975, shall be presumed to have been exposed during such service to an herbicide agent, unless there is affirmative evidence to the contrary. See 38 C.F.R. § 3.307(a)(6), (d) (2007). In other words, if a veteran was exposed to an
herbicide agent during active service, then, any disease that he has incurred, if found under 38 C.F.R. § 3.309(e) (2007), shall be service connected, even though there is no record of such disease during service. Notwithstanding the foregoing presumption provisions, a claimant is not precluded from establishing service connection with proof of direct causation. Combee v. Brown, 34 F.3d 1039, 1042 (Fed. Cir. 1994).

38 C.F.R. § 3.309(e) (2007) lists the diseases associated with exposure to certain herbicide agents, to include: acute and subacute peripheral neuropathy; chloracne, Type II diabetes, Hodgkin's disease, multiple myeloma, non-Hodgkin's lymphoma, porphyria cutanea tarda, prostate cancer, respiratory cancers, and soft-tissue sarcomas. See also Notice, 67 Fed. Reg. 42600-42608 (2002) (determined that no other condition can warrant the presumption of service connection). These diseases shall have become manifest to a degree of 10 percent or more any time after service, except that chloracne and porphyria cutanea tarda shall have become manifest to a degree of 10 percent or more within a year after the last date on which the veteran was exposed to an herbicide agent during active military, naval, or air service. 38 C.F.R. § 3.307(a)(6)(ii) (2007).

Note 2 defines acute and subacute peripheral neuropathy to mean transient peripheral neuropathy that appears within weeks or months of exposure to an herbicide agent and resolves within two years of the date of onset. Id.

The standard of proof to be applied in decisions on claims for veterans' benefits is set forth in 38 U.S.C.A. § 5107. A veteran is entitled to the benefit of the doubt when there is an approximate balance of positive and negative evidence. See also 38 C.F.R. § 3.102. When a veteran seeks benefits and the evidence is in relative equipoise, the veteran prevails. See Gilbert v. Derwinski, 1 Vet. App. 49 (1990). The preponderance of the evidence must be against the claim for benefits to be denied. See Alemany v. Brown, 9 Vet. App. 518 (1996).

The veteran contends that his peripheral neuropathy was incurred in service and was the result of herbicide exposure while he served in Vietnam. At the aforementioned RO hearing, the veteran testified that he was exposed to Agent Orange in Vietnam and had experienced pain and sudden shocking sensations in his lower extremities.

As an initial matter, the Board notes that the veteran's DD Form 214 shows that he did have active service in Vietnam from September 4, 1967 to September 4, 1968. Thus, the veteran has the requisite type of service in the Republic of Vietnam as defined by 38 C.F.R. § 3.313(a) and § 3.307(a)(6)(iii), and the presumption of exposure to herbicides agents under 38 C.F.R. § 3.307 does apply. However, the Board finds that the veteran's diagnosed chronic peripheral neuropathy is not a listed disease associated with exposure to certain herbicide agents pursuant to 38 C.F.R. § 3.309(e). Contrary to the definition as provided in Note 2, the veteran's peripheral neuropathy was not resolved within two years of the date of onset. Treatment records show that the veteran was diagnosed with peripheral neuropathy in April 1989 and continues to suffer from peripheral neuropathy. Thus, although the veteran is presumed to have been exposed to certain herbicide agents, he cannot be service connected for peripheral neuropathy because it is not a disease found to be associated with herbicide exposure. Id.

Having determined that the veteran is not entitled to presumptive service connection, the Board turns to evaluate whether the veteran is entitled to service connection on a direct basis. See Combee v. Brown, 34 F.3d 1039 (Fed. Cir. 1994) (holding that the Veteran's Dioxin and Radiation Exposure Compensation Standards Act, Pub. L. No. 98-542, 98 Stat. 2724, 2727-29 (1984) does not preclude a veteran from establishing service connection with proof of actual direct causation).

Service medical records show treatment for painful feet and ankles starting in July 1969, which received no formal diagnosis. In May 1964, the veteran underwent a re-enlistment examination where he reported foot trouble with no diagnosis noted. At his separation examination in May 1969, the veteran again complained of foot trouble and was given the diagnosis of mild pes planus upon discharge.

Post-service medical records show that at a May 1971 VA examination the veteran complained of foot
pain and was diagnosed with foot strain. In August 1978, the veteran's complaints of numbness of the feet and ankles were diagnosed as second degree pes planus. Finally, in April 1989, the veteran was diagnosed with peripheral neuropathy by K. W. Johnston, M.D.

In December 2005 and April 2007, the veteran underwent VA examinations, which rendered differing medical opinions. After examination and review of the veteran's claims file, the December 2005 VA neurologist diagnosed the veteran with severe peripheral neuropathy and opined that it was due to herbicides exposure. Further, in a July 2006 addendum, the December 2005 VA examiner noted that, while in service, the veteran's neuropathic pains in the lower extremities were overlooked or misinterpreted due to the lack of understanding of his symptoms. In April 2007, the veteran was afforded another VA neurological examination to clarify the etiology of the veteran's peripheral neuropathy. The April 2007 VA examiner noted that the veteran was mostly wheelchair bound. Upon examination, the veteran's musculature was slightly atrophied in the lower extremities. Monofilament testing was abnormal to both plantar and dorsal surfaces of both feet. Motor functions were impaired but functional in the lower extremities. After a review of the veteran's electromyogram (EMG) study, the April 2007 VA examiner diagnosed the veteran with mild sensory polyneuropathy and opined that such a disease was unlikely related to exposure to Agent Orange.

In light of the differing medical opinions, the Board obtained a medical opinion from a VHA examiner, who was a specialist in neurology. This opinion dated in October 2007, was reviewed and approved by the Medical Chief of Staff. After reviewing and summarizing the veteran's claims file, the VHA examiner found that symptoms of peripheral neuropathy have been constant since military service. Further, given the veteran's medical history and available records, his peripheral neuropathy was chronic with a subjective progressive course. After a full review of the record and resolving all reasonable doubt in favor of the veteran, the Board concludes that service connection for peripheral neuropathy is established. Gilbert, supra. The veteran's contentions are corroborated by competent medical opinions. Further, the available medical evidence sufficiently documented the veteran's symptoms of peripheral neuropathy since his military service. See 38 C.F.R. § 3.303(b).

ORDER

Service connection for peripheral neuropathy is granted.

________________________________________
A. BRYANT
Veterans Law Judge, Board of Veterans' Appeals
Case from Milwaukee, Wisconsin

Milwaukee, Wisconsin: Veterans Affairs Administration approval of service connection of Peripheral Neuropathy due to dioxin exposure in the Vietnam War.

Citation Nr: 0306225
Decision Date: 04/01/03 Archive Date: 04/10/03
(DOCKET NO. 97-18169) DATE

On appeal from the Department of Veterans Affairs Regional Office in Milwaukee, Wisconsin

THE ISSUE
Entitlement to service connection for peripheral neuropathy as a result of exposure to Agent Orange.

REPRESENTATION
Appellant represented by: Edward A. Zimmerman, Attorney

ATTORNEY FOR THE BOARD
Robert E. P. Jones

INTRODUCTION
The veteran had active duty service from June 1967 to July 1969, and from December 1976 to December 1977.

This matter comes before the Board of Veterans' Appeals (Board) on appeal from a March 1997 rating decision by the Department of Veterans Affairs (VA) Regional Office (RO) in Milwaukee, Wisconsin, which declined to reopen the veteran's claim of entitlement to service connection for peripheral neuropathy as a result of exposure to Agent Orange.

In April 1999, the Board issued a decision finding that new and material evidence had been submitted to reopen the veteran's claim for service connection for peripheral neuropathy as a result of exposure to Agent Orange. This decision also denied the veteran's reopened claim for entitlement to service connection for peripheral neuropathy as a result of exposure to Agent Orange. The veteran appealed the April 1999 decision. In October 2001, the United States Court of Appeals for Veterans Claims (Court) granted a joint motion of the parties for remand of the denial of the veteran's claim for service connection for peripheral neuropathy as a result of exposure to Agent Orange and vacated the Board's April 1999 decision.

FINDING OF FACT
Competent medical evidence indicates that the veteran has peripheral neuropathy as a result of exposure to Agent Orange in Vietnam.
CONCLUSION OF LAW

Peripheral neuropathy was incurred as a result of exposure to Agent Orange in service. 38 U.S.C.A. §§ 1110, 1131 (West Supp. 2002); 38 C.F.R. §§ 3.102, 3.303 (2002).

REASONS AND BASES FOR FINDING AND CONCLUSION

Recently enacted legislation has eliminated the well-grounded claim requirement, has expanded the duty of VA to notify the appellant and the representative of the information and evidence necessary to substantiate a claim, and has enhanced its duty to assist an appellant in developing the evidence necessary to substantiate a claim. See Veterans Claims Assistance Act of 2000 (VCAA), Pub. L. No. 106-475, 114 Stat. 2096 (Nov. 9, 2000) (codified at 38 U.S.C. §§ 5100, 5102, 5103, 5103A, 5106, 5107, 5126 (West Supp. 2002)).

The VCAA

The Board has given consideration to the provisions of the Veterans Claims Assistance Act of 2000, Pub. L. No. 106-475, 114 Stat. 2096 (2000) (VCAA) (codified at 38 U.S.C.A. §§ 5100, 5102, 5103, 5103A, 5106, 5107, 5126 (West Supp. 2002)). This law eliminated the former statutory requirement that claims be well grounded. Cf. 38 U.S.C.A. § 5107(a) (West 1991). The VCAA includes an enhanced duty on the part of VA to notify a claimant as to the information and evidence necessary to substantiate a claim for VA benefits, as well as the claimant's and VA respective development responsibilities. The VCAA also redefines the obligations of VA with respect to its statutory duty to assist claimants in the development of their claims. Regulations implementing the VCAA have been enacted. See 66 Fed. Reg. 45,620 (Aug. 29, 2001) [codified as amended at 38 C.F.R. §§ 3.102, 3.156(a), 3.159, and 3.326(a) (2002)].

The VCAA is applicable to all claims filed on or after the date of enactment, November 9, 2000, or filed before the date of enactment but not yet final as of that date. Except for provisions pertaining to claims to reopen based on the submission of new and material evidence, which are not applicable in the instant case, the implementing regulations were also effective November 9, 2000. In this case, the appellant's claims are not final and remain pending. The provisions of the VCAA and the implementing regulations are, accordingly, applicable. See Holliday v. Principi, 14 Vet. App. 282-83 (2001) [the Board must make a determination as to the applicability of the various provisions of the VCAA to a particular claim].

The Board has carefully considered the provisions of the VCAA and the implementing regulations in light of the record on appeal, and notes that the veteran was not provided the proper notice as required by the VCAA. However, considering the outcome of this decision, further development would not avail the veteran, or aid, in the Board's inquiry, and would only serve to unnecessarily delay a decision. See Reyes v. Brown, 7 Vet. App. 113, 116 (1994); Soyini v. Derwinski, 1 Vet. App. 540, 546 (1991). Due to the outcome of this decision, there is no prejudice to the veteran in proceeding to consider the matters before the Board. See Bernard v. Brown, 4 Vet. App. 384, 394 (1993). Accordingly, the Board will proceed to a decision on the merits.

Service connection may be granted for a disability resulting from a disease or injury incurred in or aggravated by service. 38 U.S.C.A. §§ 1110, 1131; 38 C.F.R. § 3.303(a). Furthermore, a disability which is proximately due to or results from another disease or injury for which service connection has been granted shall be considered a part of the original condition. See 38 C.F.R. § 3.310(a) (2002).

VA regulations provide that, if a veteran was exposed to an herbicide agent during active service, presumptive service connection is warranted for the following disorders: chloracne or other acneform disease consistent with chloracne; Hodgkin's disease; multiple myeloma; Non-Hodgkin's lymphoma;
acute and subacute peripheral neuropathy; porphyria cutanea tarda; prostate cancer; respiratory cancers (cancer of the lung, bronchus, larynx, or trachea); and soft-tissue sarcoma (other than osteosarcoma, chondrosarcoma, Kaposi's sarcoma, or mesothelioma). Presumptive service connection for these disorders as a result of Agent Orange exposure is warranted if the requirements of 38 C.F.R. § 3.307(a)(6) are met. 38 C.F.R. § 3.309(e) (2002).

On December 27, 2001, the President signed into law the Veterans Education and Benefits Expansion Act of 2001 (VEBEA). Veterans Education and Benefits Expansion Act of 2001, Pub. L. No. 107-103, 115 Stat. 976 (2001). This included changes relating to Agent Orange claims. Specifically, there is no time limit for developing respiratory cancers. 38 U.S.C. § 1116(a) (2) (F). Also, diabetes mellitus (Type 2) is now a presumptive disease under this section. 38 U.S.C.A. § 1116(a) (2) (G). As these changes do not affect the veteran's case, he is not prejudiced by the RO's not having initially reviewed them.

See Bernard, supra.

Another recent change is that a veteran is now presumed to have been exposed to Agent Orange if he served in the Republic of Vietnam during the period beginning on January 9, 1962, and ending on May 7, 1975. 38 U.S.C. § 1116(f), as added by § 201 of VEBEA. It is no longer required that a veteran have a presumptive disease for it to be presumed that he was exposed to Agent Orange. As the veteran served in Vietnam during this time, it is presumed that he was exposed to Agent Orange.

Notwithstanding the foregoing, the United States Court of Appeals for the Federal Circuit determined that the Veterans' Dioxin and Radiation Exposure Compensation Standards Act does not preclude a veteran from establishing service connection with proof of actual direct causation. See Combee v. Brown, 34 F.3d 1039 (Fed. Cir. 1994). However, the Court has held that, to establish service connection in this manner, the veteran is still required to present medical evidence of a nexus between the in-service injury or disease, or continuous post-service symptomatology, and the current disability. See Lathan v. Brown, 7 Vet. App. 359, 365 (1995); Grottveit v. Brown, 5 Vet. App. 91, 93 (1993).

The veteran's service medical records, including the separation examination report of November 1977, make no reference to any complaint or treatment for peripheral neuropathy.

Treatment reports from Wausau Medical Center dated from December 1983 to December 1991 show that the veteran first reported complaints of tingling and numbness in his left foot in July 1986. The assessment was tenonitis. A report of December 1991 noted the veteran's complaints of tingling in his hands and at the left side of his face. The physician stated that these complaints may have been associated with a demyelinating syndrome.

In several letters dated in 1992, R.J.S., D.O., indicated that he was unable to determine the etiology of the veteran's peripheral neuropathy. In a letter of March 1992, Dr. S. stated that a number of differential diagnostic considerations remained, including the possibility that the veteran had been exposed to something toxic.

In December 1992, the veteran was hospitalized by the VA to determine the nature and etiology of his peripheral neuropathy. The report of that hospitalization included the veteran's history of neuropathy of the feet dating back to 1986. The diagnosis was polyradiculoneuropathy of uncertain etiology, questionably chronic idiopathic demyelinating polyneuropathy. The physician concluded that it was quite doubtful that the veteran's neuropathy was related to Agent Orange exposure. However, the physician went on to say that the etiology of polyradiculopathy was unclear, and one could not entirely rule out a relation to military service.
The veteran was hospitalized again by the VA from August to September 1993 to determine whether his peripheral neuropathy was related to his service-connected malaria. The diagnosis upon admission was mild sensorimotor, chronic polyneuropathy. The veteran reported long-standing numbness and tingling of the feet and hands. EMG nerve studies showed electrophysiologic evidence of mild sensorimotor chronic polyneuropathy. These studies also showed improvement from EMG studies performed in December 1992. It was explained to the veteran that no literature supported his assertion that a relationship existed between polyneuropathy and malaria. It was further noted that exposure to Agent Orange could in fact cause polyneuropathy, but that the veteran's polyneuropathy began long after his exposure to Agent Orange.

A June 1996 letter from Dr. M.A.H. noted that he had treated the veteran for idiopathic polyneuropathy in April 1992. Dr. H. stated that, given the absence of any other well-identified etiology, and the recent evidence linking Agent Orange exposure to polyneuropathy, it could be presumed that the veteran's polyneuropathy was related to his exposure to Agent Orange.

The veteran was afforded an additional VA examination in July 1996. The veteran reported that his current symptoms included a pins and needles sensation in his feet, ankles, knees and hands. The diagnoses included chronic polyneuropathy, possible variation of chronic inflammatory demyelinating polyradiculopathy of unknown etiology.

In response to a request from the veteran, R.J. S., D.O., submitted two letters which addressed the etiology of the veteran's neuropathy. In a letter of July 1996, Dr. S. stated that an extensive evaluation did not disclose the etiology of the veteran's neuropathy. According to Dr. S., this raised a valid question as to whether the veteran's exposure to Agent Orange was responsible for his neuropathy.

Although he indicated this was a definite possibility, he said there was no way of proving this theory of causation. In a second letter dated in November 1997, Dr. S. said he considered the veteran's neuropathy to be related to Agent Orange exposure based on the fact that no underlying pathophysiology had been determined. According to Dr. S., Agent Orange exposure was the only factor historically, and from the standpoint of his overall evaluation, that had been uncovered to be a high probability.

In correspondence dated in August 1996, a VA neurologist identified the veteran's condition as chronic polyneuropathy as a possible variant of chronic inflammatory demyelinating polyradicular neuropathy. The neurologist opined that this diagnosis could be explained by the veteran's prior Agent Orange exposure. He related that the crux of the proof would have to be a review of the medical records from the Marshfield Clinic and the nerve biopsy which had been shown to be consistent with chronic inflammatory demyelinating neuropathy. He also stated that since lymphoma had also been associated with Agent Orange and that chronic inflammatory demyelinating polyneuropathy could be associated with lymphoma, the case could be made that a relationship existed between the veteran's condition and Agent Orange exposure.

That same neurologist, however, provided a contrary opinion as to the etiology of the veteran's peripheral neuropathy in August 1997. The neurologist noted that the veteran had been on thyroxine and had had a polyclonal aberration in gammaglobulin, each of which alone could be the basis for the veteran's neuropathic signs. He added that there was nothing in the medical records linking the veteran's neuropathy to his period of active duty service. The neurologist therefore concluded that it was unlikely that the veteran's polyneuropathy had any relationship to exposure to Agent Orange.

In October 2002, the VA neurologist again changed his opinion. He stated that he had reviewed the veteran's VA medical record dated July 1, 1968. He noted that the clinical symptoms described therein
were consistent with acute dioxin toxicity. He also noted that the pain could have been a sign of a subacute neuropathy. The VA neurologist stated that the evidence indicated, with a reasonable degree of medical certainty, that the veteran's illness could have been the start of a subacute neuropathy, that later worsened to give the veteran his current clinical condition.

In this case the evidence is conflicting as to whether the veteran currently has peripheral neuropathy due to exposure to Agent Orange. A VA physician in December 1992 expressed doubt that the veteran's peripheral neuropathy disability was related to Agent Orange exposure. However, that physician went on to say that he could not entirely rule out a relation to military service. While the August 1997 VA neurologist expressed an opinion that the veteran's peripheral neuropathy was unlikely due to exposure to Agent Orange, this neurologist changed his opinion in October 2002. After reexamining the veteran's service and post service medical records, the VA neurologist indicated that the veteran's current peripheral neuropathy was related to the veteran's exposure to Agent Orange during service. Furthermore, in a June 1996 letter, Dr. H. stated that it could be presumed that the veteran's polyneuropathy is related to his exposure to Agent Orange. Additionally, in a November 1997 letter, Dr. S. expressed the opinion that Agent Orange exposure was the only factor historically and from the standpoint of his overall evaluation that had been uncovered to be a high probability of causing the veteran's polyneuropathy.

As noted above, since the veteran served in Vietnam, he is presumed to have been exposed to Agent Orange. The record clearly shows that the veteran currently has peripheral neuropathy. There are several medical opinions, including an opinion from a VA neurologist, indicating that the veteran's current peripheral neuropathy is related to the veteran's exposure to Agent Orange in service. The Board is of the opinion that the medical evidence is at least in equipoise as to whether the veteran's peripheral neuropathy is related to his exposure to Agent Orange during service. Accordingly, service connection for peripheral neuropathy as secondary to exposure to Agent Orange is warranted.

ORDER

Service connection for peripheral neuropathy as a result of exposure to Agent Orange is granted.

__________________________________________

U. R. POWELL

Veterans Law Judge, Board of Veterans' Appeals
Case from Nashville, Tennessee

Citation Nr: 0821251
Decision Date: 06/27/08    Archive Date: 07/02/08

( DOCKET NO.  05-17 482   )       DATE

On appeal from the
Department of Veterans Affairs Regional Office in Nashville,

Tennessee

THE ISSUE

Entitlement to service connection for peripheral neuropathy, to include as due to exposure to Agent Orange.

REPRESENTATION

Appellant represented by: Disabled American Veterans

ATTORNEY FOR THE BOARD

David Traskey, Associate Counsel

INTRODUCTION

The veteran had active service from April 1966 to January 1979.

This matter came before the Board of Veterans' Appeals (Board) on appeal from a decision of February 2004 by the Department of Veterans Affairs (VA) Nashville, Tennessee, Regional Office (RO).

The veteran's claim was previously remanded by the Board for additional evidentiary development in August 2007.  The claim is now before the Board for final appellate consideration.

FINDINGS OF FACT

1. Peripheral neuropathy was not present during service, or within one year after the last date on which the veteran was exposed to Agent Orange.

2. Competent medical evidence, however, links the veteran's peripheral neuropathy to his active military service, and specifically to his exposure to Agent Orange.

CONCLUSION OF LAW

Peripheral neuropathy was incurred in or aggravated by service.  38 U.S.C.A. § 1110 (West 2002); 38 C.F.R. §§ 3.303,3.304 (2007).

REASONS AND BASES FOR FINDINGS AND CONCLUSION

Service Connection and Agent Orange

According to 38 U.S.C.A. § 1116(f), for the purposes of establishing service connection for a disability or death resulting from exposure to an herbicide agent, including a presumption of service connection, a veteran who, during active military, naval, or air service, served in the Republic of Vietnam during the
period beginning on January 9, 1962, and ending on May 7, 1975, shall be presumed to have been exposed during such service to an herbicide agent containing dioxin or 2,4-dichlorophenoxyacetic acid, and may be presumed to have been exposed during such service to any other chemical compound in an herbicide agent, unless there is affirmative evidence to establish that the veteran was not exposed to any such agent during that service. See also 38 C.F.R. § 3.307(a)(6).

Under 38 C.F.R. § 3.309(e), certain diseases, including acute and subacute peripheral neuropathy, shall be presumed to have resulted from exposure to certain herbicide agents such as Agent Orange if the requirements of 38 C.F.R. § 3.307(a)(6) are met even though there is no record of such disease during service, provided further that the rebuttable presumptions of § 3.307(d) are also satisfied. For the purposes of this section, the term acute and subacute peripheral neuropathy means transient peripheral neuropathy that appears within weeks or months of exposure to an herbicide agent and resolves within two years of the date on onset. See 38 C.F.R. § 3.309(e), Note 2. According to 38 C.F.R. § 3.307(a)(6)(ii), acute and subacute peripheral neuropathy shall have become manifest to a degree of 10 percent or more within one year after the last date on which the veteran was exposed to an herbicide agent during active military, naval, or air service.

Thus, service connection may be presumed for residuals of Agent Orange exposure by showing two elements. First, a veteran must show that he served in the Republic of Vietnam during the Vietnam War Era. See 38 U.S.C.A. § 1116; 38 C.F.R. § 3.307(a)(6). Second, a veteran must be diagnosed with one of the specific diseases listed in 38 C.F.R. § 3.309(e).

Even if a veteran is not entitled to a regulatory presumption of service connection, the claim must still be reviewed to determine if service connection can be established on a direct basis. See Combee v. Brown, 34 F.3d 1039 (Fed. Cir. 1994) (holding that the veteran was not precluded under the Veterans' Dioxin and Radiation Exposure Compensation Standards Act from establishing service connection with proof of direct actual causation). However, where the issue involves a question of medical causation, competent evidence is required. Grottveit v. Brown, 5 Vet. App. 91, 93 (1993).

With respect to the claim that the veteran in this case has a disability which is due to Agent Orange exposure in service, the veteran stated in an Agent Orange Registry form dated October 1994 that he had service in the Republic of Vietnam from August 1969 to August 1970. The veteran's DD-214 Form indicated that he was awarded the Vietnam Service Medal and the Vietnam Campaign Medal. In addition, service treatment records (STRs) dated June 1970 revealed that the veteran was treated at the 366th Air Force Dispensary in Da Nang, Republic of Vietnam. Therefore, exposure to Agent Orange may be presumed.

The veteran must also show that he is diagnosed with one of the specific diseases listed in 38 C.F.R. § 3.309(e) to establish presumptive service connection based on exposure to Agent Orange. It is important to note that the diseases listed at 38 C.F.R. § 3.309(e) are based on findings provided from scientific data furnished by the National Academy of Sciences (NAS). The NAS conducts studies to "summarize the scientific evidence concerning the association between exposure to herbicides used in support of military operations in Vietnam during the Vietnam Era and each disease suspected to be associated with such exposure." 64 Fed. Reg. 59,232-59,243 (Nov. 2, 1999). Reports from NAS are submitted at two-year intervals to reflect the most recent findings. Based on input from the NAS reports, the Congress amends the statutory provisions of the Agent Orange Act found at 38 U.S.C.A. § 1116 and the Secretary promulgates the necessary regulatory changes to reflect the latest additions of diseases shown to be associated with exposure to herbicides.

While acute or subacute peripheral neuropathy is a disability found to have a scientific relationship such that it can be presumed that exposure to herbicides used in Vietnam during the Vietnam Era is a cause of the disease, the Board notes that there is no medical evidence of record, either during service or within one year after the last date on which the veteran was exposed to Agent Orange, to indicate that the veteran was diagnosed with or treated for acute or subacute peripheral neuropathy. Thus, the veteran is not entitled to the regulatory presumptions outlined in 38 U.S.C.A. § 1116(f) and 38 C.F.R. § 3.309(e).
Establishing Direct Service Connection

While the veteran is unable to satisfy the requirements discussed above to be entitled to the regulatory presumption for service connection for peripheral neuropathy as a result of exposure to Agent Orange, the Board is required to evaluate the veteran's claim on a direct basis as well.

Service connection may be granted for disease or injury incurred in or aggravated by service. 38 U.S.C.A. § 1110 (West 2002). Establishing service connection generally requires (1) medical evidence of a current disability; (2) medical, or in certain circumstances, lay evidence of in-service occurrence or aggravation of a disease or injury; and (3) medical evidence of a nexus between the claimed in-service disease or injury and the present disability. Hickson v. West, 12 Vet. App. 247, 253 (1999); 38 C.F.R. § 3.303(a) (2007).

Service connection may also be granted for any disease diagnosed after discharge, when all the evidence, including that pertinent to service, establishes that the disease was incurred in service. Presumptive periods are not intended to limit service connection to diseases so diagnosed when the evidence warrants direct service connection. The presumptive provisions of the statute and Department of Veterans Affairs regulations implementing them are intended as liberalizations applicable when the evidence would not warrant service connection without their aid. 38 C.F.R. § 3.303(d).

STRs associated with the claims file show that the veteran was afforded a clinical evaluation and physical examination in January 1966 prior to entrance into service. The clinical evaluation was normal and no neuropathic abnormalities were noted. The veteran provided a medical history in which he specifically denied ever having neuritis.

The veteran reported for an industrial physical in February 1969. A notation on the examination report noted that there were no abnormal signs or conditions since the veteran's last physical. The clinical evaluation was normal and no neuropathic abnormalities were noted. The veteran was also afforded a flight training clinical evaluation and physical examination in February 1970. The clinical evaluation was essentially normal and no neuropathic abnormalities were noted. The veteran described his health as "good," and provided a medical history in which he specifically denied ever having neuritis.

The veteran presented to sick call in December 1978 with numbness of the right leg and foot. There was no evidence of swelling or cyanosis on physical examination, but the veteran stated that the right leg and foot "gets colder than the left." The impression was "? vascular insufficiency to rt.lower leg + foot." The Board notes that the veteran's separation examination is not of record.

The first pertinent post-service medical evidence of record is dated September 1988. The veteran presented to C. Donohoe, M.D. with a two-year history of pain in the chest, back, shoulder girdles, and hip girdles. A motor examination revealed proximal muscle weakness in the hip and shoulder girdles bilaterally. The impression was proximal myopathy. Dr. Donohoe recommended that the veteran undergo an electromyography study (EMG). The veteran underwent an EMG study in October 1988. The examiner noted that the short duration polyphasic motor units in the biceps were suggestive of myopathic process. No other abnormalities were noted at that time.

The veteran also underwent a muscle biopsy in October 1988. The test results showed a moderate mixed fiber atrophy and type group consistent with a denervating and reinnervating process. No evidence of muscular dystrophy or myositis was noted.

In October 1994, the veteran participated in the Agent Orange Registry Program and reported that he was directly sprayed with Agent Orange and that he ate food or drink that could have been contaminated with the herbicide. The veteran indicated that he experienced muscle spasms, among other conditions. Upon physical examination, the examiner found no evidence of edema in the extremities. The examiner described the veteran's reflexes as "ok."

VA afforded the veteran a Compensation and Pension (C&P) Examination in February 1995 for the
purpose of assessing any neurological disorders. The veteran indicated that he developed “spasmy” pain and loss of strength in his back in 1970. The veteran reported having progressive episodes of pain in his back, arms, and legs since that time. The veteran stated that he also experienced frequent spasms in his feet, arms, and neck. The impression was recurrent muscle spasms, etiology undetermined.

The veteran underwent another private EMG study in March 2001, but the results were described as an "indeterminate study."

The veteran presented to R. Wendland, M.D. in December 2001 for treatment of relapsing, intermittent myalgias, upper extremity tremors, and possible neuropathy. Dr. Wendland noted that the veteran was exposed to Agent Orange in service. The impression was "myocytes vs. neuropathy vs.neuromuscular disorder."

The veteran presented to M. Box, M.D. in January 2002 for an evaluation of a potential connective tissue disease. The veteran reported a long-standing history of chronic, intermittent myalgias, upper extremity tremors, and neuropathic symptoms. At the time of the examination, the veteran indicated that he had tingling in his fingers and toes, frequent tremors in his hands, muscle twitches, and occasional loss of motor control in his legs. Dr. Box noted that the veteran served in Vietnam and was potentially exposed to Agent Orange. The impression was neuropathy, even though there was no evidence of this condition on the nerve conduction study. No evidence of myopathic processes was noted.

A letter dated July 2003 from R. Wendland, M.D. indicated that the veteran was diagnosed as having peripheral neuropathy.

In December 2003, VA sent the veteran a letter regarding his participation in the Agent Orange Registry Program. The examiner stated:
As discussed at the conclusion of your visit, results of your examination and laboratory tests indicate Agent Orange cause: Peripheral neuropathy. Other items discussed were: 1) headaches; 2) skin rash; and 3) tinnitus.

The veteran presented to the VA neurology clinic in April 2004 with concerns of numbness and tingling in the fingers and toes, pain and weakness in the back, upper arms, and thighs, and tremors in the hands, even while sleeping. The veteran stated that he had these symptoms since returning from Vietnam and that his condition worsened until the mid 1980s when the symptoms stabilized. The veteran reported constant symptoms since that time. The impression was myopathy, peripheral neuropathy, and gout.

The Board notes that the veteran's claim was remanded in August 2007 for additional evidentiary development. The veteran's wife submitted a statement in support of the current claim in August 2007. The veteran's wife indicated that the veteran had numbness and tingling in the hands and feet when they met in 1979. Over the years, the veteran’s condition got progressively worse and he had muscle pains, dropped items without warning, and had unintentional movements and twitching.

Also associated with the claims file is a letter dated August 2007 from the veteran's friend, B.G. B.G. recounted an incident where the veteran dropped his fork during dinner. The veteran allegedly told B.G. that he felt tingling in his hand at that time.

The veteran underwent a peripheral nerve C&P examination in connection with the current claim in October 2007. The examiner reviewed the veteran's claims file. The veteran reported having a chronic, gradual onset of numbness and tingling in his hands, fingers, and toes since 1972. The veteran stated that he was exposed to Agent Orange and that his condition had gotten progressively worse.

Upon motor examination, the examiner noted that the veteran had decreased grip strength bilaterally on resistance with flexion and extension. The examiner also noted the presence of decreased sensation in the upper and lower extremities bilaterally. No evidence of atrophy or abnormal muscle tone or bulk was noted. However, the examiner observed tremors in the veteran’s hands bilaterally. An EMG study was conducted at that time and interpreted to show primarily small fiber sensory peripheral neuropathy.
consistent with a toxic neuropathy such as Agent Orange.

It was noted that the veteran's peripheral neuropathy had significant effects on his employment, including decreased manual dexterity, problems with lifting and carrying, and decreased strength in the upper and lower extremities. The impression was peripheral neuropathy due to Agent Orange. In support of this conclusion, the examiner reviewed the claims file and indicated that other possible causes of the veteran's peripheral neuropathy were ruled out.

Given the evidence of record, the Board finds that the veteran is entitled to service connection in this case on a direct basis. See Combee, supra. As previously stated, entitlement to service connection requires a finding that there is a current disability that has a relationship to an in-service injury or disease. In the instant case, the veteran has a current diagnosis of peripheral neuropathy and the December 2003 letter from VA and the October 2007 VA C&P examination linked the veteran’s peripheral neuropathy to his period of active military service, and specifically, to his Agent Orange exposure. Accordingly, the veteran is entitled to service connection for peripheral neuropathy.

Duty to Notify and Assist

As provided for by the Veterans Claims Assistance Act of 2000 (VCAA), the United States Department of Veterans Affairs (VA) has a duty to notify and assist veterans in substantiating a claim for VA benefits. 38 U.S.C.A. §§ 5100, 5102, 5103, 5103A, 5107, 5126 (West 2002 & Supp. 2007); 38 C.F.R. §§ 3.102, 3.156(a), 3.159 and 3.326(a) (2007). In this case, the Board is granting in full the benefits sought on appeal. Accordingly, assuming, without deciding, that any error was committed with respect to either the duty to notify or the duty to assist, such error was harmless and will not be further discussed.

ORDER

Service connection for peripheral neuropathy is granted, subject to the law and regulations governing the payment of monetary benefits.

__________________________________________________________
S.S. TOOTH
Veterans Law Judge, Board of Veterans’ Appeals
The Use of Affidavits in disability claims for military service veterans

NOTE: Affidavits can be an effective tool to establish facts of record and to note competent medical opinion by experts in the field to counter any misstatements of fact and incompetent medical opinion by doctors who are not Board Certified in Neurology, not trained in neuromuscular neurology or have no current training in the field of neurology or have very little clinical training in peripheral neuropathy. Remember by VA law, the VA may use any medical doctor from any field to obtain a medical opinion of a complex diagnosis of a neurological illness.

After SIX years of mountains of paperwork, denial and delay, by the use of affidavits, my application for VA disability due to my diagnosed Peripheral Neuropathy and exposure to agent Orange was approved as service connected.

Sample Affidavit #1 on service connection and to counter repeated misstatements of fact by the VA and repeated denials of items clearly recorded in the veterans service medical record.

May 17, 2009

Subject: Military service connection for veterans diagnosed autoimmune neuropathy specifically his current diagnosed condition of chronic inflammatory demyelinating polyneuropathy with autonomic neuropathy and progressive polyneuropathy.

I, Dr. Waden Emery, III, MD, Neurologist, affirm that I have been treating Mr. X (Vietnam Veteran) since January 2005 for Chronic Inflammatory Demyelinating Polyneuropathy, Progressive Polyneuropathy, and as a part of his condition, Peripheral Autonomic Neuropathy.

Reference is made to my summary letter dated June 5, 2008 noting my review of Mr. X’s medical records, both during his active military service and subsequent to his retirement in 1987. This statement noted my medical opinion regarding both the service connection of his symptoms as well as his exposure to dioxin during the Vietnam War as the most likely cause of his current neurological condition. This statement is incorporated in this affidavit by reference.

Mr. X has been receiving gamma globulin IVlg since April 2004, to which his long standing symptoms of his diagnosed neurological medical condition, symptoms which are recorded in his military active duty medical records since 1969, all responded in positive ways to treatment with gamma globulin. Both the fact that all other causes of his symptoms were ruled out by objective medical testing and that these symptoms responded to treatment with gamma globulin, establish clearly the connection between his symptoms, while on active duty, to his current diagnosed neurological condition. An objective competent review of his military active duty medical records, clearly establish a military active service connection with his diagnosed neurological condition.

The Food and Drug Administration (FDA) in 2008 approved the use of gamma globulin (IVlg) (Gamunex) on label for treatment of Mr. X’s diagnosed condition. Immune globulin which the VA reviewers dismissed has been used for years, off label, for the effective treatment of all autoimmune neuropathies, based on the well established patient symptom response to immune globulin. This FDA and a multitude of approved medical studies of the best known medical experts in the field, note in this regard the identical medical symptoms, medical studies, diagnosis, tests and other observations by military medical doctors noted throughout Mr. Richardson’s medical history while on active duty during 1968 to 1987.

There exists extensive published medical research literature confirming the fact that Mr. X’s symptoms, recorded throughout his active duty medical records and subsequent medical records following retirement, with all other causes ruled out by medical tests and procedures, are symptoms of his diagnosed neurological disease.
The following information was noted, to the best of my knowledge, in a detailed review of the active military medical records of Mr. X and is completed to further clarify the summary letter dated June 5, 2008:

Significant problems of the symptom of spinning, dizziness, lightheadedness was reported by Mr. X to medical personnel beginning in 1969 not long after leaving Vietnam while stationed at Fort Knox KY and Camp Ames, Korea. Such a symptom would be consistent with a polyneuropathy and autonomic neuropathy. Although his military medical records for the period 1966 to 1973 were lost by personnel at the U.S. Army Medical Facility at Fort Hamilton, New York, there are several references to this symptom of this period of service in later pages of his medical history.

The patient reports that this symptom began while stationed at Fort Knox, KY in 1969, continued while stationed at Camp Ames, Korea in 1970 to 1971, and is noted in his medical records from Dec 12, 1973 to Jun 17, 1974 by the U.S. Army Health Clinic at Fort Hamilton, NY. This symptom again was noted in his medical records from August 21, 1975 to Nov 12, 1975 while at the Walter Reed Army Hospital. It again shows up in a remitting and relapsing pattern well known to his neurological diagnosis on May 12,1977 at USA Health Clinic of Edgewood Arsenal, APG, MD. The symptom is recorded in his medical records on Ju117, 1978 and May 2, 1979 at USATMC 189th Medical Detachment, APO NY 09227; and on Apr 30, 1978 and May 1, 1979 at the 30th Field Hospital, APO NY 09058. At Kenner Army Hospital Ft Lee, VA it is noted on Dec 7 & 9,1981; on Dec 22,1981; on Dec 28,1981; on Dec 30,1981; and on Jan 4,1982 at Kenner Army Hospital, Ft Lee, VA, at which time his medical record notes that this symptom was not due to his eyes.

On Jan 18, 1982 at Kenner Army Hospital, Ft Lee, VA, it was noted that the dizziness had again resolved and his medical records notes that a CT scan on his head was normal. No reason was ever identified for this condition and the fact that this symptom responded to the infusion of gamma globulin beginning in April 2004, confirms both its connection to his diagnosed neurological illness and his diagnosed neurological disease. The unexplained and untreated relapsing and remitting symptom of spinning, dizziness, lightheadedness reported by the patient since 1969, continues to respond to treatment with IVlg since 2004 through 2009 yet the patient is never totally without this sensation. The effects of this symptom have been noted by many medical doctors throughout his medical history. Without this treatment the patient is totally unable to function with this sensation occurring at severe levels without relief 24 hours a day.

The symptoms involving difficulty breathing with severe paralyzing pain radiating into the left scapula was noted in his medical records from 1970-71 at the Cutler Army Hospital in Ft Devens, MA and this fact is recorded In his medical record in 1978. This symptom of a neurological condition continued to reoccur in the well established remitting and relapsing pattern common to his neurological diagnosis. This reoccurrence is noted in his medical record on July 17, 1978 at the USATMC 189th Medical Detachment, APO NY 09227. Again it is noted that on May 1, 1979 at the 30th Field Hospital, APO NY 09058 with a vast array of neurological symptoms recorded in his medical record for years.

A neurological examination was ordered and the record notes that these tests were within normal limits stating "doubt neurological disease". Unlike other medical reasons for his symptoms which were ruled out, a neurological disease was never fully ruled out. Indeed it is well recorded as a medical fact that such tests can often show diminished reflexes, but not always in his diagnosed illness. The reoccurrence of temporary paralysis of all the extremities was noted by Endocrinology at Kenner Army Hospital, Ft Lee, VA on Nov 5, 1980. This symptom as well as a massive amount of other symptoms suggested a neurological condition which was never fully evaluated or resolved.

As recent as October 1, 2008 at Holy Cross Hospital in Fort Lauderdale, FL it was found that the patient has both an obstructive and restrictive issue with his lungs with significant reduction in lung volume. The test report also states that there is a "confusing and contradictory set of numbers that suggest restrictive lung disease. Yet there is always reversibility seen in airways that are not very restrictive and with a diffusing capacity that is normal." This is consistent both with an autoimmune disease and with damage done to the nerves that support the muscles of the chest which support breathing. This medical fact is
supported by the patient’s response to immune globulin beginning in April 2004 when breathing difficulties became life threatening on several occasions yet were reversed by the administration of gamma globulin. In short, immune globulin allowed damaged chest nerves to function, supporting the muscles of the chest necessary to support breathing. For this reason, to respond to the years in which the veteran suffered from nightly headaches beginning on active duty in 1985 and becoming severe in the 1980's and 1990's, suffering with severe extremely painful leg cramps, the veteran now uses a BIPAP machine at night to support breathing and to prevent him from failing to breath while he is sleeping. Every symptom reported by the patient for years has responded in positive ways to this machine at night and during the day to the infusion of gamma globulin beginning in 2004.

An autoimmune disease with which the patient is diagnosed would also connect the many allergies and diagnosis of rhinitis on 7 & 8 Dec, 1981 and bronchitis on April 24, 1982 at Kenner Army Hospital, Ft Lee, VA, later to progressing bronchial asthma and then to chronic severe asthma that the patient was diagnosed with, beginning in the 1990's. This progression of symptoms is consistent within the evolving of his neurological disease over the years. These facts are noted in published medical literature in this regard. No reason was ever identified for these conditions or the patients other symptoms and the fact that these symptoms responded to the infusion of gamma globulin beginning in April 2004, confirms both there connection to his diagnosed neurological disease and the military service connection.

The fact is that after all other causes are ruled out, what has been determined by objective testing of autonomic functions is the fact of peripheral autonomic neuropathy. These symptoms began showing up in the patient with kidney problems and a diagnosis of nephritis on August 21, 1971 with medical evacuation from his station in Korea. Unexplained causes for kidney problems continued to plague him which would be consistent with exposure to a toxin and known carcinogen such as dioxin. Dioxin which the VA now knows, has been shown in research completed at the University Of Pennsylvania School Of Veterinary Medicine, published in December 2007, causes a previously unknown destructive effect on the very cellular structure of the human body.

His medical record notes that on Sep 22, 1972 at Cutler Army Hospital, Ft Devens, MA tubular acidosis was ruled out as the cause of these symptoms. On July 17, 1975 an amino acid analysis was done at USA Health Clinic Edgewood, APG, MD with negative findings as the cause for his symptoms. From August 1975 through Mar 10, 1975 at Walter Reed Hospital, DC, endocrinology workups were negative, negative findings on insulinoma and hyperglycemia, and hyperabsorbsion of calcium were all normal.

From Dec 12, 1973 to Jun 17, 1974 at the U.S. Army Health Clinic at Ft Hamilton, NY, the symptoms of bloating and diarrhea are noted in his medical record. No cause was ever identified. By April 23, 1978 at the Emergency Room of Kirk Army Hospital, APG, MD, the patient reported severe digestive problems consistent with his evolving neurological illness of the autonomic nervous system with bloating, alternating diarrhea and constipation.

On May 12, 1977 the patient reported to the USA Health Clinic, EA,APG, MD the issues with frequency of urination and sensation of burning pain on urination. Over the years the patient was checked numerous times for a prostate problem or cancer with negative findings and with overflow incontinence increasing over the years the patient just took care of the problem himself by wearing depends for decades. His strong history of overflow incontinence is consistent with his neurological diagnosis and the service connection.

On July 21, 1983 at Patterson Army Hospital Ft Monmouth, NJ, the patient first reported that impotence and loss of sensation was a serious issue and sought help, but again with no discernable cause, treatment or help. All of these symptoms are consistent with damage to the involved sensory and motor nerves of his polyneuropathy involving toxic exposure. These symptoms continued for many years growing worse by the year 2000, with the patient finally just treating himself symptomatically until April 2004. Following the beginning of his treatment with gamma globulin, the pain on urination returned, signaling that the patient’s nerves were attempting to function again to help him gain some motor control and sensation over the overflow incontinence which plagued him over the years. No reasons were ever
identified for these conditions, while a prostate problem or cancer were ruled out multiple times and the fact that these symptoms all responded to the infusion of gamma globulin beginning in April 2004, confirms both their service connection and connection to his diagnosed neurological disease.

On July 17, 1978 the patient began reported the evolving weakness in his arms and legs at USATMC 189TH Medical Detachment, APO NY 09227 and again on May 1, 1979 at the 30 Field Hospital, APO NY 09058 and on May 2, 1979 at USATMC 189TH Medical Detachment APO NY 09227 and again from May 3, 1979 through June 14, 1979 at the 30th Field Hospital APO, NY 09058 and on April 22, 1982 at Kenner Army Hospital, Ft Lee, VA. From May 15, 1985 at Patterson Army Hospital Ft Monmouth, NY to his retirement in 1987, the patient reported these symptoms.

Recorded in his active duty medical records as a result of the multiple times of asking and seeking medical help for what he did not understand, are psychologically demeaning statements by treating doctors to include, “patient is well known to this clinic” and at Walter Reed Army Medical Center, ‘patient has an exaggerated reaction to hunger, until the veteran finally just gave up hope of getting the help he needed.

By the year 2005, the peripheral nerves were so damaged that his lower extremities from the waist down would turn to a feeling of numb cement on walking stairs or walking any distance, making it impossible for the patient to function at all. This serious problem occurred after the VA examiner Dr. X told the patient that he did not need the wheel chair. The patient still not understanding his condition wanted desperately to believe the doctor. As a result he attempted to climb the stairs against the advice of his treating physical therapist located in my office. The veteran collapsed at the top of the stairs unable to move. From the upper waist down his body had turned into a feeling of numb heavy cement. No reasons were ever identified for these conditions prior to year 2000. The fact that these symptoms all responded to the infusion of gamma globulin beginning in April 2004, confirms both their service connection and connection to his diagnosed neurological disease.

Beginning on August 21, 1975 to February 3, 1976 at Walter Reed Army Hospital, D.C. the patient reported the sense of severe fatigue, loss of stamina, and total physical and mental exhaustion he was feeling over the years. This symptom would eventually lead to a U-P3 (permanent) profile being issued. This remitting and relapsing symptom is well known as a symptom of the patient's diagnosed neurological illness. This symptom was recorded in his medical record again on May 21, 1979 and June 11, 1979 at the 30th Field Hospital, APO, NY 09058 This symptom again showed up April 22, 1982 at Kenner Army Hospital, Ft Lee, VA as the patient reported he was tired and exhausted and again on October 30, 1985 at Patterson Army Hospital, Ft Monmouth, NJ. No reasons were ever identified for these symptoms with all other causes ruled out and the fact that these symptoms all responded to a limited degree to the infusion of gamma globulin beginning in April 2004, confirms both their service connection and connection to his diagnosed neurological disease.

Other symptoms consistent with the patient’s diagnosed neurological illness would include the following, as recorded in his military medical record:

1. Dry mouth and eyes April 5, and 30th, 1979 at 30th Field Hospital, APO NY 09058.

2. Burning mouth and tongue reported April 30, 1979 at 30th Field Hospital, APO NY 09058.

3. Tingling sensation in fingers and feet are noted on May 1, 1979 at the 30th Field Hospital APO NY 09058.

4. Parathesia and uncontrolled spasms of hands and feet are reported on May 2, 1979 by USATMC 189TH Medical Detachment, APO NY 09227.
(5) Burning sensation in the tongue, substernal and chest pain were noted on May 3, and June 14, 1979 at the 30th Field Hospital APO NY 09058. A neurological work up was done May 1, 1979 at the 30th Field Hospital APO NY 09058 as this was the first time with all the history that a neurological problem was suspected, but this workup was reported as within normal limits and the neurologist doubted a neurological disease yet a neurological disease was never clearly ruled out. The next month because of clear neurological symptoms of this veteran while on active military duty, an ECG was done and reported as "probably within normal limits" on June 12, 1979 at the 130th Station Hospital in Heidelberg, Germany. But once again a neurological disease was never clearly ruled out. Testing limits and the lack of a broadly understood or accepted criterion for diagnosis of the patient's diagnosed neurological illness were still in development and in fact are evolving even in 2009. Nerve damage often does not appear in the available tests used, until severe damage is done to the nerves.

(6) The patient reported nausea, shakes, confusion from exhaustion and the paralysis of all extremities for a few days resolving spontaneously reported on November 5, 1980 at the 97th G.H. FKT, APO NY 09757. Hypoglycemia as a cause was ruled out at Walter Reed Army Hospital soon thereafter and hypokalemic periodic paralysis was considered at the Kenner Army Hospital, Ft Lee, VA. Nausea was again reported on Dec 2, 1981 at Kenner Army Hospital Ft lee VA. On Dec 17, 1981 an acute episode of neurological symptoms are recorded and a note that the doctor doubts central origin was entered on the medical record, but then the doctor dismissed a rather long history of dizziness. On Dec 22, 1981 at Kenner Army Hospital, Ft Lee, VA the medical record notes "some neurological findings" but nothing more. A CT scan was done on the head on Jan 18, 1982 at Kenner Army Hospital, Ft Lee, VA, which was normal.

In the year 2000, a nerve conduct test was done for this patent following his first diagnosis of a peripheral neuropathy other than the suggestion in his military active duty medical records of possible Sjogren's syndrome in 1986. This diagnosis was in part based on the patients long extensive medical history of related symptoms noted in his active duty medical record. This diagnosis confirmed the remitting and relapsing progressive symptoms of his neurological disease.

An EMG and Nerve Conduct Study were ordered in 2000 to look for damage from his slowly progressive developing neurological illness. The test results confirmed an abnormal EMG and confirmed significant damage to the Peripheral Nervous system yet affirm diagnosis was not made because of his atypical presentation until April 2004.

Subsequent neurological tests were conducted later that same year confirming the damage to the peripheral nervous system at SHANDS Medical Center with a diagnosis of a general polyneuropathy. However, autonomic neuropathy was dismissed without testing, ignoring the long history of symptoms and the statements by multiple doctors as to this diagnosis.

In January 2005 I conducted a number of tests including an EMG and significant damage to the peripheral nervous system was for the third time confirmed. All of these objective tests were sent to the VA in the original application but were never mentioned in any VA review or by the VA Dr. X in his examination.

It is to be noted that the chest pain recorded in his active duty medical record since 1970 and forward, resolves on the administration of gamma globulin and failure to administer the product in a timely fashion results in the return of the chest pain along with extreme difficulties in breathing, all life threatening symptoms. These responses have been reported numerous times and not the least of which was his March 2005 trip to the Emergency Room at Imperial Point Medical Center in Pompano Beach, FL because he was denied the product due to poor Medicare reimbursement policies, delaying the timely infusion of gamma globulin.

The history of electrical shocks from 1978 through 2004, responded to the infusion of gamma globulin IVlg, and especially when considered in concert with the large volume of neurological systems and significant history of neurological symptoms recorded in the veteran's medical record. All these symptoms and significant neurological symptoms, point collectively to a serious chronic neurological condition with
the now understood remitting and relapsing and progressive features of his diagnosed illness. On their own, the electric shocks appear to present with a standard cervical spine issue, but with no accident or incident to point to a reason for such injury. In concert with all the neurological symptoms noted above, including the intermittent loss of stamina with total exhaustion which made physical training on active military duty impossible, beginning in 1978 the symptoms of electrical shocks (which eventually spread to the patient’s entire body by 2000) became a major issue. The veteran appeared before a military medical retention board on April 29, 1986 and because of his commitment convinced them to retain him on active duty. However, his symptoms and the loss of stamina became major factors in the veterans decision to retire from the military in 1987 as they left the neck partial paralyzed. The veteran decided there was to be no help for his medical problems and that he could no longer perform his duties to his high standards.

The electric shocks first appeared July 17, 1978 at the USATMC 189th Medical Detachment, APO NY 09227 and are recorded as T3 radiating to left scapula and to the front of the chest. The left cervical pain with electric shocks was reported on April 5, and 30th, 1979 at the 30th Field Hospital APO NY 09058. These shocks continued mentioned on Sep 10 and 21, 1984 at Patterson Army Hospital, Ft Monmouth, NJ, with left side of neck paralysis with the electric shocks under the left scapula radiating into the left hand and fingers. On Nov 8, 1984 at Patterson Army Hospital, Ft Monmouth, NJ, the active duty medical record notes pain in left shoulder, under left scapula, upper arm and electric shocks under axilla. On Nov 21, 1984 patient reported arm numbness, pain left shoulder radiating down arm at Patterson Army Hospital, Ft Monmouth, NJ. Radiological reports on the shoulder and cervical spine were normal. The medical fact of a partial paralysis of the veteran’s neck was recognized on active duty as noted in the veterans medical record on Sep 10, 1984 at Patterson Army Hospital, Ft Monmouth, NJ, yet both the Army and the VA did not acknowledge this disability until 2006, but then for the wrong reasons. The VA clinic in Oakland Park, FL used an x-ray to state that there is a herniated cervical disk in spite of the fact that this diagnosis was ruled out three times while the veteran was on active duty using extensive nuclear radiological studies and this diagnosis was denied at his separation at retirement which noted only a "cervical strain" or "spinal problem".

On May 20, 1985 at Patterson Army Hospital, Ft Monmouth, NJ his medical record reads cervical spine examination is normal with no changes.

On Oct 30, 1985, the following symptoms are noted several times: severe headache (later to be connected to failure to breath at night), numbness over entire face, fingers, with nausea and weakness in the neck. Radiating neck pain, radiating pain to left arm, and a referral to neurology was made. The neurological examination recorded in the veterans record notes diminished reflexes, but then the neurologist without ruling out a neurological condition, states, "doubt neurological disease". The medical record states the patient was sent to the emergency room by physical therapy due to increase total numbness to entire head, jaw heaviness, occipital headache, and inability to rotate head, neck muscle spasms, radiating sharp pain to arm and under shoulder blade. Again on Nov 8, 1985 at Patterson Army Hospital, a radiologic report notes a normal cervical spine.

On Nov 13, 1985 between Patterson Army Hospital, the Fort Dix Hospital and Walter Reed Medical Center, a Neurosurgery Clinic workup noted electrical pain, parathesia of all upper extremities and neck, shooting pain to fingers, and now left leg parathesia.

On Jan 13, 1986 at Watson Army Hospital, Ft Dix NJ his medical records note possible Sjogren's syndrome which would account for many of his clearly neurological symptoms reported throughout his medical record, but not all of them, and then the treating physician notes, "many questions remain", without adequate follow up. In 2007 new findings and presentations of Sjogren's syndrome within the scope of the peripheral neuropathies are increasing neurology's understanding of the various presentations of atypical chronic neuropathies related to Sjogren's.

On Feb 7, 1986 a nuclear medicine consult at Ft Dix, NJ notes the cervical spine is normal and the diagnosis at that time was chronic cervical strain on Feb 24, 1986. The veteran was granted first a temporary profile UT3 for cervical radiculopathy on Feb 24, 1986 at the Orthopedic Clinic of Watson
Army Hospital Ft Dix, NJ and a permanent profile UP3 for "cervical strain chronic" on Mar 7, 1986 at Watson Army Hospital, Ft Dix, NJ.

Yet it is noted that the VA documented responses to the veteran's claim, state that the veteran was never diagnosed for "cervical radiculopathy" while on active duty, Three times while on active duty and one time by radiological studies at the University of Miami Neurology on 19 and 20 July 2000 the cervical spine is noted as normal with no issues. Yet what was diagnosed by objective evidence and history both at the University of Miami Neurology and at SHANDS Neurological Center University of Florida was a Generalized Polyneuropathy which medical experts where still attempting to fully diagnose,

In addition, the electrical shocks that eventually spread to the veteran's entire body, responded in positive ways to the administration of IVig beginning in April 2004, confirming the connection of the electrical shocks to his diagnosed chronic neurological condition regardless of whatever damage was done to the cervical spine, leaving a permanent paralysis of the neck as noted by the VA examiner. It is also noted that throughout the development of the veterans neurological illness, periods of temporary paralysis of upper and lower extremities occurred quite frequently, and more often by the year 2000 prior to the administration of gamma globulin in April 2004.

Objective testing in 2005 by my office confirmed the findings of numerous neurologists who have treated Mr. X and confirmed the presence of autonomic, sensory, and motor deficits, with recorded significant damage to the peripheral nervous system including the peripheral autonomic nervous system.

Documented published medical research findings indicate clearly that Mr. X's diagnosis is confirmed by his response to gamma globulin rather than dismissed by the lack of symptoms as has been done by the VA system all of which are errors of established medical fact. The medical history clearly recorded in Mr. X's active military medical record; clearly and strongly establish the military service connection of his diagnosed neurological illness.

Please feel free to contact me for any additional information at 954-771-8300.

Sincerely yours,

WADEN E. EMERY, MD, FAAN. Neurologist SHERRY LYNN HANNAKA, MY COMMISSION #DO 674554 EXPIRES: May 15,2011
Sample Affidavit #2 addresses misstatements of fact by the VA.

May 17, 2009

Subject: Veterans Administration misstatements of fact in the VA multiple responses to Veteran’s application for disability.

I, Dr. Waden Emery, III, MD, Neurologist, affirm that I have been treating (the veterans name) since January 2005 for Chronic Inflammatory Demyelinating Polyneuropathy, Progressive Polyneuropathy, and as a part of his condition, Peripheral Autonomic Neuropathy.

Reference is made to my summary letter dated June 5, 2008 noting my summary review of Mr. X medical records, both during his active military service and subsequent to his retirement in 1987. This statement noted my medical opinion regarding both the service connection of his symptoms as well as his exposure to dioxin during the Vietnam War as the most likely cause of his current neurological condition. This statement is incorporated in this affidavit by reference.

Reference is made to my affidavit dated March 17, 2009 noting my medical opinion regarding the effect of immune gamma globulin (IVlg) on the symptoms of the veteran's diagnosed neurological illness and the medical fact that this infusion significantly affected the findings of (the VA doctor), who examined the veteran on April 17, 2006 as stated in the VA document dated May 9, 2006. This statement is incorporated in this affidavit by reference.

Reference is made to my affidavit dated May 17, 2009 noting my detailed review of Mr.X's medical records, both during his active military service and subsequent to his retirement in 1987. This statement noted my medical opinion regarding the service connection of his symptoms as well as his exposure to dioxin during the Vietnam War as the most likely cause of his current neurological condition. This statement is incorporated in this affidavit by reference.

Reference is made to the veterans APPEAL to the VA dated November 11, 2006 documenting proof of the following misstatements of fact, yet these same misstatements of fact are repeated in every document issued by the VA from that date forward.

In review of the medical records of Mr. X, the following misstatements of fact are noted in the VA reviews:

1. The VA report 317NSC/POST/FH C22652496 dated May 9, 2006 states that service medical records are "silent for any treatment or diagnosis of radiculopathy, left upper extremity” and claims he was never diagnosed with cervical radiculopathy while on active duty. On May 15, 1985 and again on June 7,1985, cervical radiculopathy is noted in his medical record at the Patterson Army Hospital, Ft Monmouth, N.J.. The in-patient treatment record of the service member notes a diagnosis of cervical radiculopathy, left upper extremity, at the Watson Army Hospital, Ft Dix, NJ on January 31, 1986. The discharge record of the service member notes this diagnosis on February 24,1986. The temporary U-T3 profile granted to the service member notes the reasons as “cervical radiculopathy” at the same hospital. A permanent U-P3 profile granted to the service member by the Orthopedic Clinic, Ft Dix, N.J. notes cervical strain with mild radicular symptoms which is dated March 13, 1986. The multiple statements by the VA that the patient's active duty medical records are silent for any treatment or diagnosis of radiculopathy, left upper extremity radicular are continued misstatements of fact.

2. The VA report VSC/PST4/MAC C226 52 496 dated March 14,2006 states that the digestive disorder claimed by the service member while on active duty and subsequently, was due to a diagnosis of acid reflex disease in the “private medical records” of Dr. X. Therefore any digestive disorder is denied as service connected since there never was any diagnosis of acid reflux disease while on active duty. Dr. Sheldon T. Warman, MD issued a signed statement dated May 9, 2006 that there was no diagnosis of Gastroesophageal Reflux Disease for Mr. X. This statement was given to the VA on submission of the Appeal dated November 11, 2006.
Dr. Philip N Styne, MD on September 18, 1997 had ruled out any evidence of reflux Esophagitis by gastroscope and this medical report was given to the VA on submission of the appeal dated November 11, 2006. The issue of acid reflux disease was raised by treating physicians seeking to understand why Mr. X was having so much difficulty breathing and years of difficulty with his chronic asthma. Both his asthma and his breathing difficulties have responded to the administration of gamma globulin thus confirming that they are symptoms of his autoimmune polyneuropathy which is affecting his peripheral autonomic nervous system for which he continues to be treated.

As to the service connection of the digestive problems it is noted in the veteran's active duty medical record, that from Dec 12, 1973 to Jun 17, 1974 at the U.S. Army Health Clinic at Ft Hamilton, NY, the symptoms of bloating and diarrhea are noted in his medical record. No cause was ever identified. By April 23, 1978 at the Emergency Room of Kirk Army Hospital, APG, MD, the patient reported severe digestive problems consistent with his evolving neurological illness of the autonomic nervous system with bloating, alternating diarrhea and constipation. These symptoms continued to plague the veteran for years, growing worse in 2000, until they responded in positive ways to the infusion of gamma globulin in April 2004, establishing the connection of the symptoms to his active duty service and to his current diagnosed neurological disease.

The statement by the VA in their report dated March 14, 2006 and subsequent multiple statements regarding acid reflux disease as the cause of his history of digestive problems are VA repeated misstatements of fact.

3. The VA report 317NSC/POST/FH C22652496 dated May 9, 2006 denies service connection for "neurogenic bladder as secondary to idiopathic polyneuropathy". The VA used this preliminary diagnosis of idiopathic polyneuropathy from 2000 to dismiss the veteran's current well established diagnosis in 2004 of Chronic Inflammatory Demyelinating Polyneuropathy, Progressive Polyneuropathy, and as a part of his condition Peripheral Autonomic Neuropathy which was diagnosed by objective testing in 2005.

On May 12, 1977 the patient reported to the USA Health Clinic, EA, APG, MD the issues with frequency of urination and sensation of burning pain on urination. Over the years the patient was checked numerous times for a prostate problem or cancer with negative findings and with overflow incontinence increasing over the years the patient just took care of the problem himself by wearing depends for decades. His strong history of overflow incontinence is consistent with the significant history of neurological symptoms, his neurological diagnosis and the service connection.

On July 21, 1983 at Patterson Army Hospital Ft Monmouth, NJ, the patient first reported that impotence and loss of sensation was a serious issue and sought help, but again with no discernable cause or treatment. All of these symptoms are consistent with damage to the involved sensory and motor nerves of his polyneuropathy involving toxic exposure.

Following retirement in 1987 and years of these neurological symptoms noted in the Veteran's post retirement medical records, Dr. Steven Kester, MD, Urologist, notes the following in 2000-2001. Patient has burning on urination, urinary overflow incontinence, with electric shocks over the entire body, urinary frequency, all probably due to peripheral neuropathy. These records were provided to the VA in the original application of the veteran.

In April 2004, all of these symptoms responded in positive ways to treatment with gamma globulin IVlg confirming neurogenic bladder due to his diagnosed chronic neurological diagnosis.

The VA noted that in the year 2000, Dr. (X a Neurologist), while diagnosing a General Polyneuropathy, dismissed the diagnosis of autonomic neuropathy, but did so without testing autonomic functions and by ignoring the long history of autonomic symptoms and the diagnosis of autonomic neuropathy by numerous doctors.

In January 2005, this office conducted the standard tests and confirmed by objective testing that peripheral autonomic neuropathy is present secondary to the veteran's CIDP. Copies of these tests were provided to the VA at the time of the veteran's initial application.
Following the beginning of his treatment with gamma globulin, the pain on urination returned, signaling that the patient's nerves were attempting to function again to help him gain some motor control and sensation over the overflow incontinence which plagued him over the years. No reasons were ever identified for these conditions, while a prostate problem or cancer were ruled out multiple times and the fact that these symptoms, including his overflow incontinence, all responded to the infusion of gamma globulin beginning in April 2004, confirms both their service connection and connection to his diagnosed neurological disease.

The multiple statements by the VA denying service connection for neurogenic bladder as secondary to idiopathic polyneuropathy are based upon continued misstatements of fact not the least of which is the denial of the veteran's current diagnosis of an autoimmune polyneuropathy confirmed by several Board Certified Neuromuscular Neurologists.

4. The VA report 317NSC/POSTIFH C22652496 dated May 9, 2006 establishes the VA diagnosis of a herniated nucleus pulposus C6, which is an erroneous diagnosis for a known symptom of permanent partial paralysis of the veteran's neck.

In searching for a cause of these symptoms, it is noted in the service member's medical record following years of autonomic symptoms that these electric shocks first appeared acutely and without any known physical cause, on July 17, 1978 at the USATMC 189TH Medical Detachment, APO NY 09227 and are recorded as T3 radiating to left scapula and to the front of the chest. The veteran's medical record notes the pain and symptoms were paralyzing, making breathing with support of the chest muscles very difficult. The left cervical pain with electric shocks was reported on April 5, and 30th, 1979 at the 30th Field Hospital APO NY 09058 Then followed a time when the well established remitting pattern of his diagnosed autoimmune polyneuropathy resolved, only to relapse again in 1984.

The relapsing of these electric shocks are noted in his active duty medical record on Sep 10 and 21,1984 at Patterson Army Hospital, Ft Monmouth, NJ, with left side of neck paralysis with the electric shocks under the left scapula radiating into the left hand and fingers. A normal cervical spine was found by C-spine series on September 24,1984 at Patterson Army Hospital, Ft Monmouth, N.J.

On Nov 8, 1984 at Patterson Army Hospital, Ft Monmouth, NJ, the active duty medical record notes pain in left shoulder, under left scapula, upper arm and electric shocks under axilla. On Nov 21,1984 patient reported arm numbness, pain left shoulder radiating down arm at Patterson Army Hospital, Ft Monmouth, NJ. Radiological reports on the shoulder and cervical spine were normal.

From Sep 6 to Oct 7, 1985 the veteran's medical record at Patterson Army Hospital, Ft Monmouth, N.J. notes cervical pain, left arm numbness, radiating pain into left 2nd phalanx.

A normal cervical spine was found in radiological studies on May 20 and May 30, 1985 and November 8, 1985 at Patterson Army Hospital, Ft Monmouth, N.J. and on November 25, 1985 by the Orthopedic Clinic, Ft Dix, N.J.

The medical record states the patient in Oct 1985 was sent to the emergency room at Patterson Army Hospital, Ft Monmouth, N.J. by physical therapy due to increase total numbness to entire head, jaw heaviness, occipital headache, and inability to rotate head, neck muscle spasms, radiating sharp pain to arm and under shoulder blade.

On Oct 30, 1985, in a report from Walter Reed Medical Center, the following symptoms are noted several times: severe headache (later to be connected to failure to breath at night), numbness over entire face, fingers, with nausea and weakness in the neck. Radiating neck pain, radiating pain to left arm, and a referral to neurology was made. The neurological examination recorded in the veterans' record notes diminished reflexes, but then the neurologist without ruling out a neurological condition, states, "doubt neurological disease".
On Nov 13, 1985 between Patterson Army Hospital, the Fort Dix Hospital and Walter Reed Medical Center, a Neurosurgery Clinic workup noted electrical pain, parathesia of all upper extremities and neck, shooting pain to fingers, and now left leg parathesia.

On Jan 13, 1986 at Watson Army Hospital, Ft Dix NJ his medical records note possible Sjogren's syndrome which would account for many of his clearly neurological symptoms reported throughout his medical record, but not all of them. The treating physician notes, "many questions remain", without adequate follow up or support from referrals. In 2007 new findings and presentations of Sjogren's syndrome within the scope of the peripheral neuropathies are increasing neurology's understanding of the various presentations of atypical chronic neuropathies related to Sjogren's.

On Feb 7, 1986 a nuclear medicine consult at Ft Dix, NJ notes the cervical spine is normal and the diagnosis at that time was chronic cervical strain on Feb 24, 1986. The veteran was granted first a temporary profile U T3 for cervical radiculopathy on Feb 24, 1986 at the Orthopedic Clinic of Watson Army Hospital Ft Dix, NJ and a permanent profile U P3 for "cervical strain chronic" on Mar 7,1986 at Watson Army Hospital, Ft Dix, NJ.

Following retirement these same electrical shocks spread to his entire body, and on July 30, 2000 a normal cervical spine was found in radiological studies at the University of Miami Neurological Clinic in Miami, Florida as reported by Dr. Martinez-Arizala, Neurologist.

Since a herniated cervical disk, spinal stenosis, and degenerative disk disease were all eliminated by significant medical studies of the service member while on active duty and these electrical shocks eventually spread to his entire body over the years of no treatment, this left the service member with the partial paralysis of the neck not recognized by the VA until 2006.

Numerous published articles now refer to paralysis upper limb predominant with weakness and abnormal sensations in the upper limbs and sometimes only in one arm following what may be initial symptoms of progressive CIDP as the symptoms persist. Dr. Joel S. Steinberg, MD., PhD, Board Certified Neurologist, notes this fact in his published reports within the GBS/CIOP Foundation.

It is a fact of record that the electrical shocks and other neurological symptoms which were left untreated spread to the service member's entire body by 2000 as noted in his medical records, yet were significantly reduced or eliminated following treatment with gamma globulin beginning in April 2004. Again this response establishes the connection between the symptoms and the veteran's current neurological diagnosis. The medical fact of a partial paralysis of the veteran's neck was recognized on active duty as noted in the veterans medical record on Sep 10, 1984 at Patterson Army Hospital, Ft Monmouth, NJ, yet both the Army and the VA did not acknowledge this disability until 2006, but then for the wrong reasons.

The VA clinic in Oakland Park, FL used an x-ray to state that there is a herniated cervical disk in spite of the fact that this diagnosis was ruled out three times while the veteran was on active duty using extensive nuclear radiological studies and this diagnosis was denied at his separation at retirement which noted only a "cervical strain" or "spinal problem".

Many times while on active duty and one time by radiological studies at the University of Miami Neurology on 19 and 20 July 2000 responding to the same symptoms and a preliminary diagnosis of Peripheral Neuropathy, the cervical spine is noted as normal with no issues. The fact is for years any question or diagnosis of any herniated cervical disk was ruled out numerous times by objective medical tests and procedures. Yet what was diagnosed by objective evidence and history both at the University of Miami Neurology and at SHANDS Neurological Center University of Florida was a Generalized Polyneuropathy which medical experts where still attempting to fully diagnose.

In addition, the electrical shocks that eventually spread to the veteran's entire body, responded in positive ways to the administration of IVlg beginning in April 2004, confirming the connection of the electrical
shocks to his diagnosed chronic neurological condition, regardless of whatever damage was done to the cervical spine. This well established medical fact has left a permanent partial paralysis of the neck as noted even by the VA examiner.

It is also noted that throughout the development of the veterans neurological illness, periods of temporary paralysis of upper and lower extremities occurred quite frequently, and more often by the year 2000.

In April 2004 these extensive electric shocks were affecting his entire body, including the upper and lower body, with skin so painful too touch it would cause the veteran to scream in pain with the electric shocks involving even his genital organs, were reduced or eliminated following the administration of gamma globulin IVlg.

The VA claim of a herniated nucleus pulposus C6 is an erroneous diagnosis for a known condition of permanent partial paralysis of his neck, caused by his chronic diagnosed neurological disease and thus is a misstatement of fact as shown by the patient's history and his medical records both active military duty and post retirement.

Please feel free to contact me for any additional information at 954-771-8300.

Sincerely yours,

CERTIFICATION
WADEN E. EMERY, III, M. F.A.A.N. Neurologist NOTARY SEAL AND SHERRY LYNN HANNA;· MY COMMISSION' DO 574;" 15,2011 5340
Sample Affidavit #3 the Neurologist notes the failures to diagnose in the veterans medical records and responds to the claims by the VA contract medical doctor, who conducted the C&P examination, fully illustrating this issue and its impact on the veteran's claim.

March 17, 2009

Subject: The effect of gamma globulin (IVlg) on the Neurological symptoms and deficits in chronic inflammatory demyelinating polyneuropathy, progressive polyneuropathy, multifocal motor neuropathy, peripheral autonomic neuropathy and the immune mediated neuropathies.

I, Dr. Waden Emery, III, MD, Neurologist, affirm that I have been treating (the veterans name) since January 2005 for Chronic Inflammatory Demyelinating Polyneuropathy, Progressive Polyneuropathy, and as a part of his condition, Peripheral Autonomic Neuropathy.

'Mr. X (Vietnam Veteran) has been receiving gamma globulin IVlg since April 2004 to which his long standing symptoms since 1969 all responded in positive ways to this treatment thus confirming his diagnosis and the medical necessity of the treatment as noted in published medical research literature.


My summary letter dated June 5, 2008 noting my review of Mr. X medical records, both during his active military service and subsequent to his retirement in 1987, and noting my medical opinion regarding both the service connection of his symptoms as well as his exposure to dioxin during the Vietnam War as the most likely cause of his current neurological condition are incorporated in this affidavit by reference.

The following information was noted in review of the medical records of the (Veteran):

Following many failures to diagnose his neurological disease since 1969, in year 2000 a Neurologist, diagnosed the patient with Generalized Polyneuropathy with no treatment recommended other than pain medication. Again the EMG and Nerve Conduct Studies were abnormal, but the autonomic symptoms mentioned by three previous physicians were not evaluated by testing and were dismissed.

Soon thereafter in 2001 the patient was referred by his primary care doctor to a second Neurologist in Ft Lauderdale, Florida. The Neurologist noted the EMG and nerve conduct studies, including those done at the University of Miami Neurology Clinic in early 2000, were abnormal. After following Mr. (Veteran's) condition for about three years, with the patient continuing to worsen in his neurological illness with no apparent cause for his symptoms, this Neurologist based on the research noted above, decided to do a trial of gamma globulin IVlg. This was done in April 2004, with Neurologist doing numerous follow-ups seven days post infusion noting the significant improvements to Mr. X's symptoms including those associated with reflexes as well as his autonomic, sensory and motor function deficits clearly recorded throughout his military and post retirement medical records.
Objective testing in 2005 by my office confirmed the findings of numerous Neurologists who have treated Mr. X and confirmed the presence of autonomic, sensory, and motor deficits, with recorded significant damage to the Peripheral Nervous system.

In a statement dated May 9, 2006, the Department of Veterans Affairs for Mr. X, page 3 notes the following:

"The VA examination conducted on April 17, 2006, states that your file was reviewed with regards to your idiopathic polyneuropathy. The examiner provided a statement of chronology of the history behind your current diagnosis and treatment of your polyneuropathy. The examiner stated that an MRI of your cervical spine done on January 19, 2000 was reviewed as well. The MRI showed normal spinal cord size and no evidence of intramedullary or leptomeningeal signal abnormality or abnormal enhancement. There was no evidence of AVM cord compression. The physical exam found you to have normal cranial nerves II through XII except for hearing loss. You were able to ambulate unassisted and had a slow but not ataxic gait. There was no evidence of cog wheeling, tremor, rigidity or fasciculations. There was no sensory loss to suggest peripheral neuropathy. Your reflexes were 1+ and symmetrical in the upper extremities, 2+ in the left knee, 1 + in the right knee, and absent at both ankles. The plantar responses were mute. There was no finger-to-nose dymetria, dysdiadochokinesis or heel-to-shin ataxia. The examiner concluded that based on the historical data and results of the present neurological examination, he was unable to provide any diagnosis to account for your symptoms. No link to your cervical spine condition was made since the MRI was negative for radiculopathy."

According to the records for the Florida Department of Health, State of Florida, license xxxxxx, the VA neurological examination on April 17, 2006 was conducted by retired non-practicing Dr. X, Board Certified as a Doctor of Internal Medicine and not Neurology. While this does meet the VA standard that reviews and examinations within the VA medical system require only that the doctor be a licensed medical doctor, the diagnosis of complex neurological illnesses such as that which is affecting Mr. X, requires the skill of a fully qualified neuromuscular neurologist familiar with such diagnosis of the polyneuropathies.

Furthermore such an examination requires that the doctor be familiar with the scientifically documented facts as to the affect of gamma globulin IVg on the symptoms of the patient. (The VA doctor’s) statement notes many issues that were ruled out in the process of the final diagnosis of the patient's polyneuropathy and thus are relevant only in this sense. At the time of the examination, Mr. X required the use of a wheelchair or cane to walk, and was unable to walk significant distances without total loss of the use of his legs.

Sensory losses have been noted by many qualified neurologists and noted in the objective testing including at least two EMG and nerve conduct studies done prior to the examination by the (VA doctor). Neither of these objective tests were noted by the (VA doctor) and according to Mr. X, no review of the patients medical record was done during the examination as claimed by the VA other than the statement by the (VA Doctor) to Mr. X that "he did not have time to look at all of this", referring to the thickness of Mr. X's medical file.

However, the most significant issue is Dr. Bletz's lack of current knowledge as this doctor did not understand the medically recognized, significant effect of gamma globulin on the symptoms of the patient's diagnosed condition. Mr. X was given gamma globulin seven days prior to the VA examination. This is, as medical evidence indicates, the peak time for the mediating, reducing, or eliminating many of the neurological symptoms and deficits following the patient's positive response to the administration of gamma globulin. The patient's neurological symptoms which were reduced in the examination, except for the absent reflexes at both ankles as noted by Dr. Bietz, directly as the result of this positive response to gamma globulin. In fact, Medicare in Florida requires that the patient's symptom response to gamma globulin be documented for them to make payment under the Medicare system. Such documentation has been done by several Neurologists over the past five years during which gamma globulin has been administered to Mr. X. I am unable to explain the VA doctor's statement that Mr. X walks without assistance in that he has required since year 2000 the use of a cane or wheelchair, and since late 2005 a motorized vehicle.
Documented published medical research findings indicate clearly that Mr. X's diagnosis is confirmed by his response to gamma globulin rather than dismissed by the lack of symptoms as has been done by the VA system all of which are errors of established medical fact.

Please feel free to contact me for any additional information at 954-771-8300.

Sincerely yours,

WADEN E. EMERY, III, MD .AAN.
Neurologist
SHERRY L .VNN HANNIJ
MY COMMISSION 674554
EXPIRES: May 15. 2011
**Affidavits in the application for social security disability**

In applying for social security disability the applicant must remember that this is different from a VA disability claim. In this system you are establishing the fact of your diagnosis and that this diagnosed condition results in a significant disability preventing you from doing work that would earn you a minimum salary amount established by Social Security system. In other words, before I had this disease or condition I could do this, but now I am unable to ________________________.

The following was taken from the Neuropathy Association web site:

**Winning Your Disability Case with the Help of Co-Workers, Family Members and Friends** by Scott E. Davis, Disability Attorney ImmuneSupport.com  09-19-2001

In a social security disability claim, the credibility of the client is often the determining factor of whether the claim is approved or denied. For cases involving chronic pain or fatigue, such as fibromyalgia or chronic fatigue syndrome, or the neuropathies, the credibility of the client is usually crucial to success. The reason for this of course is due to the fact that those diagnoses involve subjective symptoms and limitations that usually cannot be objectively quantified by medical or laboratory tests. Thus, SSA and judges will listen to the client’s story about why they are unable to work due to the frequency, severity and duration of their symptoms; but they will also look for corroborating evidence from other sources such as doctors or individuals who know the client.

As you may know, my practice is exclusively disability law and I specialize in chronic pain and fatigue cases representing clients throughout the United States. Over the past several years I have been very successful in winning disability cases before SSA and judges throughout the United States. While winning hundreds of cases and losing only a small percentage of them, I have learned a great deal about how to win chronic pain and fatigue disability cases as well as the importance of a client’s credibility.

A tool I have used extensively for the past several years is to obtain affidavits or statements from a client’s former co-worker (or preferably a supervisor), family member or long-time friends.

What is an affidavit? It is simply a notarized document that essentially is a narrative letter regarding a person’s observations of problems the client has functioning on a daily basis due the symptoms and limitations, with a conclusion that they are unable to work in any occupation as a result.

In my opinion, it is essential that SSA and a judge have corroborating evidence from those who know a client the best and the affidavit performs that function. Because I view a client’s credibility as paramount to the case, I want to protect it, develop it and support it from as many different independent sources as possible.

The quality of the affidavits or statements and from whom they are from matters more than having a large volume of them by people who do not know the client well. I know thoughtful affidavits have a big impact on SSA and judges because I have seen countless of them from all over the country reference them as a reason why they approved my client’s claim. I have also talked with judges after a hearing and they have told me the affidavits provided persuasive support of my client’s allegations regarding their limitations.

It must be noted that it is unlikely an affidavit alone will win a disability case; but along with other corroborating medical records and doctor’s opinions it can be a powerful tool. Use this article as a foundation for developing this important part of your claim.
**Tip #1 The Affidavit should be Brief**  
To avoid lulling weary SSA personnel or a judge to sleep, I believe the affidavit should be no more than two (2) pages in length. Please remember your file will contain several hundreds of pages of records...you want the affidavit to be read and be factored into your claim.

**Tip #2 The Affidavit should be on regular paper and be Notarized**  
The document itself can be on any regular paper (preferably 8 ½ x 11 inches), preferably typewritten and should be titled “Affidavit.” However, any paper will do and a handwritten one is better than nothing. It should be notarized because this will confirm that the person who purported to draft the affidavit actually signed it before a notary public. The notary stamp and signature should go at the end of the text and after your signature (remember not to sign it until you are before the notary!). Having the affidavit notarized eliminates any question with regard to authenticity of the document (i.e. you are not trying to pull one over on SSA or a judge!). If it is not possible to obtain a notary then simply submit a handwritten statement.

**Tip #3 The Content of the Affidavit is Critical**  
The contents of the affidavit determine whether it is a piece of evidence that will be persuasive in the case. The affidavit should always conclude with a sentence that the client is unable to engage in any occupation and due to what reasons. The contents should be organized by paragraph, numbered and should discuss the following in a separate paragraph or less: the background of the person making the affidavit (i.e. occupational status and title, address); how long they have known the client, how they met (family, work, friends), and how often they have in person or telephone contact; discuss what the client’s activity/work (work ethic) level was like **before they became unable to work**. The bulk of the affidavit and several paragraphs should be devoted to discussing the physical or psychological **changes that the client exhibited at the time they last worked** (i.e. observations of chronic pain and fatigue, spending days in bed, dramatic changes in appearance, lack of stamina, absences from work, being unreliable); discuss the physical limitations they have (the ability to sit, stand, walk, or do anything for only short periods of time); a medical treatment/medications/therapy they have tried without success; discuss how limited the are in **activities of daily living**. The idea is to share what you could do before disabled as compared to what you can do now.

The last two (2) paragraphs must conclude with a statement that due to the above discussed reasons the client is not able to work in any occupation and that you are willing to discuss your affidavit with the judge if necessary.

**Tip #4 How Many Affidavits should you obtain?**  
With regard to quantity, less is better, the nature of the relationship with the client and content of the affidavit are the issues. I like to obtain as many as we can from former co-workers or supervisors. Then I like to obtain one from a spouse or long-time significant other, family members and then finally long-time friends. Generally, the complete story of the client can be told with three (3) or at most four (4) affidavits from those people who know them the best. Best of luck in your pursuit of disability benefits and remember never to quit!

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Scott E. Davis is a social security and long-term disability insurance attorney in Phoenix, Arizona. Mr. Davis represents clients throughout the United States. Although Mr. Davis has experience representing clients with a broad spectrum of physical and/or psychological disorders, the majority of his practice is devoted to representing individuals with chronic pain and chronic fatigue disorders. In almost every case, a fee is charged only if his client obtains benefits. Mr. Davis invites your questions and inquiries regarding representation via telephone (602) 482-4300, or email: harris.davis@azbar.org.