BOARD OF VETERANS' APPEALS

DEPARTMENT OF VETERANS AFFAIRS

WASHINGTON, DC 20038

Date: October 11, 2018

[redacted]

[redacted]

Dear Appellant:

The Board of Veterans' Appeals (Board) has made a decision in your appeal, and a copy is enclosed.

If your decision contains a	*What happens next*
Grant	The Department of Veterans Affairs (VA) will be contacting you regarding the next steps, which may include issuing payment. Please refer to VA Form 4597, which is attached to this decision, for additional options.
Remand	Additional development is needed. VA will be contacting you regarding the next steps.
Denial or Dismissal	Please refer to VA Form 4597, which is attached to this decision, for your options.

If you have any questions, please contact your representative, if you have one, or check the status of your appeal at http://www.vets.gov.

Sincerely yours,

K. Osborne

Deputy Vice Chairman

Enclosures (1)

CC: Disabled American Veterans

BOARD OF VETERANS' APPEALS

DEPARTMENT OF VETERANS AFFAIRS

IN THE APPEAL OF [redacted] [redacted]

REPRESENTED BY

Disabled American Veterans

DATE: October 11, 2018

ORDER

New and material evidence having been received, the claim for service connection for bilateral hearing loss is reopened; the appeal is granted to that extent.

Entitlement to service connection for bilateral hearing loss is granted.

Entitlement to a rating in excess of 30 percent for irritable bowel syndrome (IBS) is denied.

REMANDED

Entitlement to service connection for kidney cancer is remanded.

Entitlement to service connection for hemorrhoids, to include as secondary to service connected IBS, is remanded. GRANTED 12-6-2019

Entitlement to a total disability rating based on individual unemployability due to service-connected disabilities (TDIU) is remanded.

FINDINGS OF FACT

1. An unappealed November 2004 rating decision denied the claim for service connection for bilateral hearing loss.

2. Evidence added to the record since the last final denial in November 2004 raises a reasonable possibility of substantiating the Veteran's claim for service connection for bilateral hearing loss.

3. Resolving reasonable doubt in the Veteran's favor, his bilateral hearing loss is at least as likely as not related to his in-service noise exposure.

4. The Veteran's IBS has been manifested by severe symptomatology of diarrhea, or alternating diarrhea and constipation, with more or less constant abdominal distress.

CONCLUSIONS OF LAW

1. The November 2004 rating decision that denied reopening of the Veteran's claim of entitlement to bilateral hearing loss is final. 38 U.S.C. § 7105(c) (2012); 38 C.F.R. §§ 3.104, 20.302, 20.1103 (2017).

2. New and material evidence has been received to reopen the claim of entitlement to service connection for bilateral hearing loss. 38 U.S.C. § 5108 (2012); 38 C.F.R. § 3.156(a) (2017).

3. The criteria for service connection for hearing loss are met. 38 U.S.C. §§ 1110, 5107(b) (2012); 38 C.F.R. §§ 3.102, 3.303(a) (2017).

4. The criteria for a rating in excess of 30 percent for IBS are not met. 38 U.S.C. §§ 1155, 5107 (2012); 38 C.F.R. §§ 4.1-4.14, 4.114, Diagnostic Code 7319 (2017).

REASONS AND BASES FOR FINDINGS AND CONCLUSIONS

The Veteran served on active duty from October 1969 to August 1971.

This matter comes before the Board of Veterans' Appeals (Board) on appeal from an April 2014 (irritable bowel syndrome, hearing loss, and kidney cancer) and a

IN THE APPEAL OF [redacted] [redacted]

May 2016 (hemorrhoids) rating decisions by the Department of Veterans Affairs (VA) Regional Office (RO) in Philadelphia, Pennsylvania.

By way of procedural history, the Board notes that the Veteran requested that his claim for hearing loss be reopened in January 2009 and filed a claim for an increased rating for irritable bowel in February 2009. In April 2009, the RO issued a rating decision that denied the Veteran's request that his claim for hearing loss be reopened and increased to 30 percent the Veteran's rating for irritable bowel syndrome. Within a year, the Veteran submitted a statement requesting an appeal for his claims. In November 2011, the Board noted these claims and referred them to the RO for appropriate action. The RO only issued a rating decision on these claims in April 2014. In May 2016, the Veteran separately filed a claim for service connection for hemorrhoids. In May 2016, the RO issued a rating decision denying the claim for service connection for hemorrhoids.

The issue of entitlement to a TDIU has been raised by the record and has been added to the appeal. See *Rice v. Shinseki*, 22 Vet. App. 447, 453, 54 (2009) (holding that a request for a TDIU, whether expressly raised by a veteran or reasonably raised by the record, is not a separate "claim" for benefits, but rather, can be part of a claim for increased compensation); see also *Roberson v. Principi*, 251 F.3d 1378 (Fed. Cir. 2001) (holding that a separate, formal claim is not required in cases where an informal claim for TDIU has been reasonably raised). The issue of entitlement to a TDIU has been raised by the record and has been added to the appeal. *See Rice v. Shinseki*, 22 Vet. App. 447, 453, 54 (2009) (holding that a request for a TDIU, whether expressly raised by a veteran or reasonably raised by the record, is not a separate "claim" for benefits, but rather, can be part of a claim for increased compensation); *see also Roberson v. Principi*, 251 F.3d 1378 (Fed. Cir. 2001) (holding that a separate, formal claim is not required in cases where an informal claim for TDIU has been reasonably raised).

1. Entitlement to service connection for hearing loss

Generally, if a claim of entitlement to service connection has been previously denied and that decision has become final, the claim can be reopened and reconsidered only if new and material evidence is presented with respect to that claim. 38 U.S.C. § 5108. New evidence is defined as existing evidence not

previously submitted to agency decision makers. Material evidence means evidence that, by itself or when considered with previous evidence of record, relates to an unestablished fact necessary to substantiate the claim. New and material evidence can be neither cumulative nor redundant of the evidence previously of record and must raise a reasonable possibility of substantiating the claim. 38 C.F.R. § 3.156(a). *Shade v. Shinseki*, 24 Vet. App. 110, 118 (2010).

In the instant appeal, the Agency of Original Jurisdiction (AOJ) denied the Veteran's claim seeking service connection for hearing loss in November 2004. The Veteran did not appeal the denial of the claim and no new and material evidence relevant to the claim was associated with the claims file within one year of the decision. 38 C.F.R. § 3.156(b). The November 2004 decision is final. 38 U.S.C. § 7105; 38 C.F.R. § 20.1103.

At the time of the November 2004 AOJ decision, evidence relevant to the Veteran's claim included the Veteran's DD Form 214, service medical records from October 1969 to August 1971, a VA examination dated in September 2004, private treatment records dated December 2002 to April 2004, and medical records from Dr. S. dated June 2004. The RO denied the claim for service connection as the evidence did not show that the Veteran had a chronic bilateral hearing loss that was related to service.

The VA has received additional evidence since the November 2004 decision. The Veteran submitted statements from Dr. C. and Dr. B. that opined that the Veteran's current hearing loss was related to the in-service noise exposure. The Veteran also underwent a June 2009 VA audiological examination.

The Board finds that some of the evidence submitted by the Veteran was not previously submitted, and therefore is new. The medical statements by Dr. C. and Dr. B. relate to an unestablished fact – whether the Veteran's current hearing loss is related to his in-service noise exposure. The petition to reopen the claim of entitlement to service connection for hearing loss is granted.

The Veteran seeks service connection for hearing loss, which he asserts was caused by in-service noise exposure.

In order to establish service connection there must be competent, credible evidence of (1) a current disability, (2) in-service incurrence or aggravation of an injury or disease, and (3) a nexus, or link, between the current disability and the in-service disease or injury. *See, e.g., Davidson v. Shinseki*, 581 F.3d 1313 (Fed. Cir. 2009); *Pond v. West*, 12 Vet. App. 341 (1999).

For VA compensation purposes, impaired hearing will be considered a disability when the auditory threshold in any of the frequencies 500, 1000, 2000, 3000, or 4000 Hertz is 40 decibels or greater; or when the auditory thresholds for at least three of the frequencies 500, 1000, 2000, 3000, or 4000 Hertz are 26 decibels or greater; or when speech recognition scores using the Maryland CNC Test are less than 94 percent. 38 C.F.R. § 3.385.

The Board concludes that the Veteran has a current diagnosis of hearing loss and tinnitus that is related to his in-service noise exposure. 38 U.S.C. §§ 1110, 1131, 5107(b); *Holton v. Shinseki*, 557 F.3d 1363, 1366 (Fed. Cir. 2009); 38 C.F.R. § 3.303(a).

A June 2009 VA audiological examination shows that the Veteran has a current diagnosis of hearing loss for VA purposes. Additionally, the Veteran's Maryland CNC test scores were 92 percent in the right ear and 80 percent in the left ear.

The Veteran's pure tone thresholds, in decibels, were as follows:

	HERTZ				
	500	**1000**	**2000**	**3000**	**4000**
RIGHT	20	30	55	75	75
LEFT	20	25	65	70	70

The auditory findings obtained from testing at the private audiological evaluation and VA examination satisfy the requirements of 38 C.F.R. § 3.385. The Veteran's bilateral hearing loss is considered a disability for VA purposes.

The Veteran reported that he was exposed to loud high pitched noise from diesel turbines that were used to power Pershing missiles systems that he worked on. The Veteran's DD Form 214 shows that military occupational specialty was as a missile crewman. The Veteran also completed training in a Pershing Laying Specialist Course and in Army Field Artillery School. As such, the Board finds that the Veteran's report of in-service noise exposure is consistent with the place, type, and circumstances of his service. *See* 38 U.S.C. § 1154(b). Therefore, his reported in-service noise exposure is conceded.

The Veteran's August 1971 separation audiometric test reveals that the Veteran's pure tone thresholds, in decibels, were as follows:

	HERTZ				
	500	**1000**	**2000**	**3000**	**4000**
RIGHT	10	5	5	15	10
LEFT	10	5	5	15	5

Based on these findings, a hearing loss disability was not shown in service.

The remaining question is whether the Veteran's current bilateral hearing loss is related to his in-service noise exposure. An April 2009 opinion from Dr. S. C., a private audiologist, indicates that the Veteran was exposed to noise during service, that he denied post-service occupational noise exposure and that his audiometric testing results indicate a noise induced pattern of hearing loss. The audiologist therefore opined that his current hearing loss condition was at least as likely as not related to his service. Several etiology opinions were submitted from Dr. C. B., including a September 2013 opinion in which he opined that it was at least the 50

percent probability level that the Veteran's current hearing loss was due to his in-service experiences and traumas. The physician reasoned that the Veteran was likely exposed to loud noise and acoustic trauma during service, that the lay statements of record show a chronicity of symptoms and that his records do not support another more probable etiology or risk factors other than his service experiences. The physician further reasoned that the time lag between loud noises in service and current acoustic pathology is consistent with known medical principles and the natural history of the disease and that the literature supports a relationship between loud noise and hearing loss.

In contrast, a June 2009 VA audiologist opined that the Veteran's bilateral hearing loss was not caused by or a result of his in-service noise exposure. The audiologist reasoned that it was well documented that hearing loss due to noise exposure is not delayed in developing, that the onset of the present hearing loss occurred after the Veteran's service as the separation physical clearly indicates that his hearing was normal in both years and that his hearing impairment is not due to noise experienced during service. No etiology opinion was provided for the Veteran's tinnitus.

Given the evidence and the medical opinions already of record, the Board concludes that the evidence is, at least, in relative equipoise on the nexus question. Accordingly, further evidentiary development is not necessary. *Cf. Mariano v. Principi*, 17 Vet. App. 305, 312 (2003).

Further, in statements of record, the Veteran reported that he had hearing problems in service that have continued to the present. Lay assertions may serve to support a claim for service connection by supporting the occurrence of lay-observable events or the presence of disability or symptoms of disability subject to lay observation. 38 U.S.C. § 1153(a); 38 C.F.R. § 3.303(a); *Jandreau v. Nicholson*, 492 F.3d 1372 (Fed. Cir. 2007); see *Buchanan v. Nicholson*, 451 F.3d 1331, 1336 (Fed. Cir. 2006) (addressing lay evidence as potentially competent to support presence of disability even where not corroborated by contemporaneous medical evidence). Thus, there is evidence of continuity of symptomatology. *See Walker v. Shinseki*, 708 F.3d 1331 (Fed. Cir. 2013).

In conclusion, the evidence shows significant noise exposure during service, a current diagnosis of bilateral hearing loss as well as medical and lay evidence showing a link between the current bilateral hearing loss and service. In sum, based on the analysis above, when resolving the benefit of the doubt in favor of the Veteran, the Board finds that service connection for bilateral hearing loss is warranted. The Board notes that, in reaching this conclusion, the evidence is at least in equipoise and the benefit of the doubt doctrine has been applied where appropriate. 38 U.S.C. § 5107; 38 C.F.R. § 3.102; *see also Gilbert v. Derwinski*, 1 Vet. App. 49, 53 (1990).

2. Entitlement to a rating in excess of 30 percent for irritable bowel syndrome (IBS)

The Veteran seeks a rating in excess of 30 percent for IBS. The Veteran is service-connected for IBS, which is assigned a 30 percent rating effective February 27, 2009, pursuant to 38 C.F.R. § 4.114, Diagnostic Code 7319. This is the highest schedular rating available under the diagnostic code.

Disability evaluations are determined by the application of the facts presented to VA's Schedule for Rating Disabilities (Rating Schedule) at 38 C.F.R. Part 4. The percentage ratings contained in the Rating Schedule represent, as far as can be practicably determined, the average impairment in earning capacity resulting from diseases and injuries incurred or aggravated during military service and the residual conditions in civilian occupations. 38 U.S.C. § 1155; 38 C.F.R. § 4.1.

Under Diagnostic Code 7319, mild irritable colon syndrome, with disturbances of bowel function with occasional episodes of abdominal distress, is evaluated as noncompensably disabling. Moderate colon syndrome, with frequent episodes of bowel disturbance, is rated 10 percent disabling. Severe irritable colon syndrome, with diarrhea, or alternating diarrhea and constipation, with more or less constant abdominal distress, is rated 30 percent disabling. 38 C.F.R. § 4.114.

The Board notes that words such as "frequent," "occasional," "severe," "moderate," and "mild" are not defined in the Rating Schedule. Rather than applying a mechanical formula, VA must evaluate all evidence, to the end that decisions will be just. *See* 38 C.F.R. § 4.6. Although the use of similar

terminology by medical professionals should be considered, it is not dispositive of an issue.

Under Diagnostic Code 7332, impairment of sphincter control healed or slight, without leakage, is noncompensably disabling. Constant slight or occasional moderate leakage is 10 percent disabling. Occasional involuntary bowel movements, necessitating wearing a pad, is 30 percent disabling. Extensive leakage and fairly frequent involuntary bowel movements is 60 percent disabling. Complete loss of sphincter control is 100 percent disabling.

A rating of 50 percent could potentially be assigned under Diagnostic Code 7301 (adhesions) for definite partial obstruction shown by X-ray and frequent and prolonged episodes of severe colic distention, nausea or vomiting. A rating of 60 percent could potentially be assigned under DC 7307 (gastritis) for severe hemorrhages or large ulcerated or eroded areas. A rating of 60 percent could potentially be assigned under DC 7323 (colitis) for severe ulcerative colitis with numerous attacks a year and malnutrition. Finally, a rating of 60 percent could potentially be assigned under DC 7346 (gastroesophageal reflux disease) for symptoms of pain, vomiting, material weight loss and hematemesis or melena with moderate anemia or for other symptom combinations productive of severe impairment of health. 38 C.F.R. § 4.114, Diagnostic Codes 7301, 7307, 7323, 7336, 7346.

In March 2009, the Veteran underwent a VA examination for IBS. The Veteran reported dull cramping pain, stools 6 times per week, solid stool every 2 week, and abdominal cramping. Exam findings indicated fair health, no significant weight loss, signs of anemia, fistula, abdominal mass, or abdominal tenderness.

In June 2009, Dr. B. provided a medical opinion regarding the Veteran's IBS. Dr. B. indicated that after reviewing the record, the Veteran experienced almost constant pain, lots of diarrhea and at times constipation, sudden and urgent bowel movements at times uncontrollable, severe hemorrhoid pain, and extensive diverticulosis. Dr. B. further indicated that the IBS problems cause daily leakages of stool and opined that the Veteran should be given a 60 percent rating for this problem due to daily leakages which occur frequently and soil his clothes. A

February 2010 report, January 2011 report, and September 2013 report similarly opined the Veteran should be given a 60 percent rating due to leakages.

In June 2010, the Veteran underwent a VA examination for IBS. The Veteran reported worsening IBS symptoms, weekly constipation, persistent diarrhea, and constant or near-constant abdominal pain. Examination findings showed positive abdominal tenderness, no signs of malnutrition, anemia, fistula, or abdominal mass. An associated colonoscopy indicated extensive diverticulosis and internal hemorrhoids.

In September 2013, the Veteran underwent an updated VA examination. The Veteran reported diarrhea and fecal incontinence. An associated colonoscopy further noted diverticulosis, hemorrhoids, and a small colon polyp.

In April 2016, the Veteran underwent his most recent VA exam. The Veteran reported abdominal pain, frequent episodes of diarrhea, constipation, and fecal incontinence requiring him to wear an adult diaper. The Veteran reported 7 or more episodes of abdominal distress or bowel disturbance within the past 12 months. No malnutrition, weight loss, or other pertinent physical findings were noted by the examiner.

As the Veteran is currently in receipt of the highest schedular rating under Diagnostic Code 7319, the Board has considered the application of other diagnostic codes. The Veteran has indicated that his IBS has caused frequent leakage and involuntary bowel movements and more recently reported that he has had to wear an adult diaper due to fecal incontinence. Treatment notes from office visits in March 2016, September 2015, and June 2014, however, are silent for bladder or bowel incontinence complaints. The Veteran has not alleged, the record does not show, the complete loss of sphincter control. The Board finds the treatment record and Veteran's symptoms do not establish both extensive leakage and fairly frequent involuntary bowel movements to warrant a rating under Diagnostic Code 7332 higher than the currently assigned rating of 30 percent.

The record does not show, and the Veteran has not alleged, definite partial obstruction, adhesions, colic distention, large ulcerated or eroded areas, hemorrhages, severe ulcerative colitis with numerous attacks a year, anemia,

malnutrition, or material weight loss. Therefore, higher ratings for adhesions of the peritoneum, gastritis, ulcerative colitis or a hiatal hernia are not warranted.

The Board has considered whether the Veteran is entitled to a separate or higher rating under other potentially applicable diagnostic codes; however, 38 C.F.R. § 4.113 provides that there are diseases of the digestive system, particularly within the abdomen, which, while differing in the site of pathology, produce a common disability picture characterized in the main by varying degrees of abdominal distress or pain, anemia and disturbances in nutrition. Consequently, certain coexisting diseases in this area, as indicated in the instruction under the title "Diseases of the Digestive System," do not lend themselves to distinct and separate disability evaluations without violating the fundamental principle relating to pyramiding as outlined in § 4.14. Additionally, 38 C.F.R. § 4.114 indicates that ratings under diagnostic codes 7301 to 7329, inclusive, 7331, 7342, and 7345 to 7348 inclusive, will not be combined with each other. Rather, a single evaluation will be assigned under the diagnostic code which reflects the predominant disability picture, with elevation to the next higher evaluation where the severity of the overall disability warrants such evaluation. Therefore, as the Veteran's IBS is evaluated under Diagnostic Code 7319, he is not entitled to a higher or separate rating under any other potentially applicable diagnostic code.

The Veteran's representative has contended that the symptoms of irritable bowel syndrome warrant extraschedular consideration for an evaluation in excess of 30 percent.

"Whether a claimant is entitled to an extraschedular rating under § 3.321(b) is a three-step inquiry": If (1) the schedular evaluation does not contemplate the claimant's level of disability and symptomatology, and (2) the disability picture exhibits other related factors such as marked interference with employment or frequent periods of hospitalization, then (3) the case must be referred to an authorized official to determine whether, to accord justice, an extraschedular rating is warranted. *Thun v. Peake*, 22 Vet. App. 111, 115 (2008), aff'd sub nom. *Thun v. Shinseki*, 572 F.3d 1366 (Fed. Cir. 2009). "[T]he first Thun element compares a claimant's symptoms to the rating criteria, while the second addresses the resulting effects of those symptoms." *Yancy v. McDonald*, 27 Vet. App. 484, 494 (2016). Although the first and second elements are interrelated, they involve separate and

distinct analyses. *Id.* Thus, "an error with respect to one element does not necessarily affect the Board's analysis of the other element." *Id.* "If either element is not met, then referral for extraschedular consideration is not appropriate." *Id.* at 494-95.

The Board finds that the symptomatology associated with the service-connected IBS addressed in this decision is fully addressed by the rating criteria. Indeed, with respect to the IBS disability, the Veteran's 30 percent rating contemplates the functional limitations caused by the various symptoms caused by this disability, including alternating episodes of constipation and diarrhea, abdominal pain and abdominal cramping. The Board also notes that the rating criteria used to evaluate the Veteran's service-connected IBS provide symptoms upon which to award higher ratings than those currently assigned. Therefore, the Board finds that the rating criteria reasonably describe the Veteran's disability level and symptomatology associated with his service connected IBS.

REASONS FOR REMAND

1. Entitlement to service connection for kidney cancer is remanded.

The Veteran seeks service connection for kidney cancer related to in-service exposure to radiation as a crewman for Pershing missiles. The Veteran also alleges exposure while stationed at Fort Dix as the result of a nuclear accident at nearby McGuire Air Force Base in 1960. The Board finds that further development of this appeal is needed before a determination may be made.

The Veteran's service personnel records are not currently of record, and must be obtained in order to determine whether they support his contention of in-service radiation exposure. In addition, it does not appear that a request has been made to obtain relevant records pertaining to the Veteran's potential exposure to radiation during service. Upon remand, this must be undertaken.

Second, the Veteran has alleged that his kidney cancer was caused by daily use of NSAIDs that were prescribed by the VA. The Board acknowledges the September 2013 opinion by Dr. B., opining that the Veteran's right renal tumor was caused by

the Veteran's service time experiences with plutonium and post service ibuprofen prescribed for service connected conditions. Dr. B.'s opinion presumes, at least in part, exposure to ionizing radiation. Given the forgoing, the Board finds that the Veteran has a current kidney disability that may be related to service. VA has a duty to provide the Veteran with an examination to evaluate the nature and etiology of his condition. 38 U.S.C. § 5103A(d); 38 C.F.R. § 3.159(c)(4); *McLendon v. Nicholson*, 20 Vet. App. 79 (2006). Therefore, an etiology opinion should be obtained on remand.

2. Entitlement to service connection for hemorrhoids is remanded.

The Veteran filed a claim for service connection for hemorrhoids in May 2016. The Veteran reports that his hemorrhoids are secondary to his service-connected irritable bowel syndrome.

An April 2013 colonoscopy reviewed by the VA examiner documented moderate diverticulosis throughout the colon and hemorrhoids. VA treatment records show ongoing treatment for both hemorrhoid and service-connected irritable bowel symptoms together. A June 2010 VA examination considered hemorrhoidal irritation as clinically significant in evaluating the Veteran's service-connected IBS. Given the forgoing, the Board finds that the Veteran has ongoing hemorrhoids symptomology that may be related to service. VA has a duty to provide the Veteran with an examination to evaluate the nature and etiology of his condition. 38 U.S.C. § 5103A(d); 38 C.F.R. § 3.159(c)(4); *McLendon v. Nicholson*, 20 Vet. App. 79 (2006). Remand is required to obtain an etiology opinion.

3. Entitlement to a TDIU.

Additionally, as noted in the Introduction, the issue of entitlement to a TDIU has been raised by the record. Specifically, during his July 2013 VA examination the Veteran reported that he had not been able to work due to his service connected IBS. He reported that he had started his own business in the farming and timbering industries in a January 2010 VA examination.

On remand, the Veteran should be provided VCAA notice regarding the information and evidence necessary to substantiate a TDIU claim, and be requested to complete and return VA Form 21-8940 (Veteran's Application for Increased Compensation Based on Unemployability).

The matter is REMANDED for the following action:

1. Contact the National Personnel Records Center and obtain copies of the Veteran's complete service personnel records.

2. Prepare a Personnel Information Exchange System (PIES) request to obtain a copy of the record of occupational exposure to ionizing radiation from the Official Military Personnel File (OMPF), service treatment records (STRs), or any other record that contains radiation exposure information. Undertake appropriate development to confirm the Veteran's contentions that he was exposed to radiation during service.

3. Send the Veteran a VCAA notice letter informing him of what is needed to substantiate entitlement to TDIU and of the allocation of responsibilities between the Veteran and VA for obtaining relevant evidence on his behalf.

4. Perform any additional development with respect to the claim for a TDIU, to include obtaining from the Veteran a detailed statement regarding his educational attainment, post-service work history, and additional training (VA Form 21-8940).

5. After such development is completed, obtain a VA medical opinion by an appropriate clinician to determine the nature and etiology of the Veteran's kidney cancer. The need for a physical examination is left to the

discretion of the medical professional providing the opinion.

The clinician is asked to answer the following questions:

(a) Is it at least as likely as not (a 50 percent or greater probability) that the Veteran's kidney cancer is related to his active military service?

(b) Is it at least as likely as not the Veteran's kidney cancer is proximately due to his service connected rheumatoid arthritis and treatment, to include ibuprofen or painkiller use? The clinician should specifically address the Veteran's contention that scholarly research has established that there a 50 percent or more increased risk of kidney cancer due to use of NSAIDs.

(c) Is it at least as likely as not that the Veteran's kidney cancer is aggravated beyond its natural progression by his service connected rheumatoid arthritis and treatment?

The clinician should recognize that this requires two opinions: one for proximate causation and another for aggravation. The term "aggravation" means a permanent worsening for a disability beyond its natural progression. If aggravation is found, then, to the extent possible, the examiner should attempt to establish a baseline for the kidney cancer prior to the aggravation.

A complete rationale must be provided for all opinions expressed. The pertinent evidence of record should be considered and discussed in the rationale, to include the Veteran's lay statements.

6. After the development listed in items number one and two are completed, obtain a VA medical opinion by an

appropriate clinician to determine the nature and etiology of the Veteran's claimed hemorrhoids. The need for a physical examination is left to the discretion of the medical professional providing the opinion.

The clinician is asked to answer the following questions:

(a) Is it at least as likely as not (a 50 percent or greater probability) that the Veteran's hemorrhoids are related to his active military service?

(b) Is it at least as likely as not the Veteran's hemorrhoids are proximately due to his service connected IBS?

(c) Is it at least as likely as not that the Veteran's hemorrhoids are aggravated beyond its natural progression by his service connected IBS?

The clinician should recognize that this requires two opinions: one for proximate causation and another for aggravation. The term "aggravation" means a permanent worsening for a disability beyond its natural progression. If aggravation is found, then, to the extent possible, the examiner should attempt to establish a baseline for the kidney cancer prior to the aggravation.

A complete rationale must be provided for all opinions expressed. The pertinent evidence of record should be

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considered and discussed in the rationale, to include the Veteran's lay statements.

Kristy L. Zadora
Acting Veterans Law Judge
Board of Veterans' Appeals

ATTORNEY FOR THE BOARD D. Lauritzen, Associate Counsel