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On appeal from the
Department of Veterans Affairs Regional Office in Columbia, South Carolina

THE ISSUE

Entitlement to service connection for a low back disability, including secondary to an already service-connected left knee disability.

REPRESENTATION

Appellant represented by: Sean A. Ravin, Attorney-at-Law

WITNESSES AT HEARING ON APPEAL

The appellant, his spouse, and C. B., MD.

ATTORNEY FOR THE BOARD

J. Fussell, Counsel

INTRODUCTION

The veteran had verified active duty from September 1970 to September 1972 and from January 1991 to May 1991. He also served in the reserves and had verified periods of active duty for training (ACDUTRA) in July and August 1974, and in July and August 1975.

This appeal to the Board of Veterans' Appeals (Board) arose from an October 1997 rating decision of the Department of Veterans (VA) Regional Office (RO) in Columbia, South Carolina - which denied service connection for a low back disability. But the RO granted service connection for a left knee disability and assigned an initial 10 percent rating for it. This is currently the veteran's only service-connected disability.

A hearing was held at the RO in November 2000 before a Veterans Law Judge (VLJ) of the Board. This type of hearing is often called a travel Board hearing. A transcript of that proceeding is of record.

The Board remanded the case to the RO in March 2001 for further development and consideration. In July 2002 the Board denied the claim for service connection for a low back disability on both direct and secondary bases. That Board decision was appealed to the United States Court of Appeals for Veterans Claims (Court). And pursuant to a February 2003 Joint Motion, the Court entered an Order in February 2003 vacating that July 2002 Board decision and remanding the case to the Board for compliance with the Veterans Claims Assistance Act (VCAA).

In response, the Board remanded the case to the RO in September 2003. And more recently, in March 2005, the veteran, his spouse, and Craig Bush, M.D., testified at a hearing at the Board's offices in Washington, DC, before the undersigned VLJ. A complete transcript of the hearing is of record.

The Board advanced this case on the docket pursuant to a motion filed under 38 C.F.R. § 20.900 (2004).

During the March 2005 hearing, the veteran and his attorney raised additional claims for a rating higher than 10 percent for the service-connected left knee disability and for a total disability rating based on individual unemployability (TDIU). See page 2 of the hearing transcript. These additional claims, however, have not been adjudicated by the RO, much less denied and timely appealed to the Board, so referral to the RO for initial development and consideration is required since the Board does not currently have jurisdiction to consider them. See 38 C.F.R. § 20.200 (2004).

FINDING OF FACT

Based on the medical and other evidence currently of record, it is just as likely as not the veteran's current low back disorder is attributable to functional impairment from his service-connected left knee disability.

CONCLUSION OF LAW

Resolving all reasonable doubt in the veteran's favor, his low back disorder is proximately due to and the result of his service-connected left knee disability. 38 C.F.R. § 3.310(a) (2004).

REASONS AND BASES FOR FINDING AND CONCLUSION

The Veterans Claims Assistance Act (VCAA)

The VCAA, codified at 38 U.S.C.A. §§ 5100, 5102, 5103, 5103A, 5106, 5107, 5126 (West 2002), became effective on November 9, 2000. Implementing regulations are codified at 38 C.F.R. §§ 3.102, 3.156(a), 3.159 and 3.326 (2004). The VCAA requires that VA notify the veteran of the type of evidence needed to substantiate his claim, including insofar as whose specific responsibility - his or VA's, it is for obtaining the supporting evidence. The VCAA also requires that VA assist the veteran in obtaining evidence necessary to substantiate a claim, but is not required to provide assistance if there is no reasonable possibility that it would aid in substantiating the claim. Charles v. Principi, 16 Vet. App. 370, 373-74 (2002); Quartuccio v. Principi, 16 Vet. App. 183, 186-87 (2002).

The Board has determined that the evidence and information currently of record supports a complete grant of the benefit requested. Therefore, no further notification and/or development is required to comply with the VCAA or the implementing regulations because it would be inconsequential. So the Board will address the merits of the veteran's claim for service connection for a low back disorder.

Legal Analysis

Disability that is proximately due to or the result of a service-connected disorder shall be service-connected. 38 C.F.R. § 3.310(a) (2004). Service connection will also be granted for aggravation of a nonservice-connected condition by a service-connected disorder, although compensation is limited to the degree of disability (and only that degree) over and above the degree of disability existing prior to the aggravation. See Allen v. Brown, 7 Vet. App. 439 (1995).

In determining whether service connection is warranted for a disability alleged, VA is responsible for considering evidence both for and against the claim. If the evidence, as a whole, supports the claim or is in relative equipoise (i.e., about evenly balanced), then the veteran prevails. Conversely, if the preponderance of the evidence is against the claim, then it must be denied. See 38 C.F.R. § 3.102; Gilbert v. Derwinski, 1 Vet. App. 49 (1990); Alemany v. Brown, 9 Vet. App. 518, 519 (1996).

The veteran's only service-connected disability is impairment of the left knee, which currently has a 10 percent rating. In a January 2004 report, Dr. Craig Bash stated that

he had reviewed the veteran's claims file for the purpose of providing a medical opinion concerning his low back disability. Dr. Bash pointed out this case was well within his area of expertise. And after reviewing the record he stated, in pertinent part, that:

It is my opinion based on the medical record, x-ray findings, and the patient's statements that this patient's spine is most likely secondary to his longstanding service connected lower leg disability and his accompanying abnormal gait, which likely damaged his perivertebral spinal ligaments due to undue and abnormal stress.

It is also my opinion that this patient's spine disc disease presented with sciatica, nerve damage, gait abnormalities and muscle atrophy in 1997 ....

A great deal of confusion is present in the C-File record concerning this patient's spine disease. He currently has very severe advanced degenerative spine disease with sciatica, antalgic gait, uses a cane for ambulation, has muscle atrophy, and has had multiple epidural steroid injections and a herniated disc. The question presented in the file is whether or not the spine disease is related to his service connected abnormal knee and not whether his currently [sic] spine disease was caused by his knee surgery in 1996 ..... It is well known that patient's [sic] with lower extremity orthopedic problems often have abnormal gaits and these patients often rapidly develop abnormal painful spines. The abnormal forces which are secondary to the gait problems places excessive stresses across the vertebral column, which in turn damages the ligaments. As Turik states in the following, once ligaments are damaged then the patient will experience advanced degenerative arthritis:

"... At the onset, tearing of ligaments and subluxation are manifest by local symptoms of low back pain accentuated by the motion which stretches the ligaments ... Eventually, symptoms of localized degenerative arthritis are superimposed ... (Turik page 853)

It is my opinion that this patient's spine disease is most likely secondary to this longstanding service connected lower leg disability and his accompanying abnormal gait, which likely damaged his perivertebral spinal ligaments due to undue and abnormal stress for the following reasons:

1. The patient entered service with normal legs and spine.
2. The patient had a serious in service leg injury which is service connected.
3. The patient has had a longstanding abnormal gait.
4. The patient now has advanced premature degenerative spine disease with sciatica, atrophy and a herniated disc.
5. The patient does not have another plausible etiology for his spine disease.
6. The literature supports an association between advance spine disease and a longstanding abnormal gait.
7. The medical opinions stating that this patients [sic] spine is not related to his leg surgery are non germane [sic] to the case because this patient's spine disease is most likely secondary to his longstanding abnormal gait.

The veteran underwent a VA orthopedic examination in May 2004, also to obtain a medical opinion concerning the etiology of his low back disability at issue. His claims file was apparently available for review by the evaluating physician inasmuch as the examiner related the veteran's medical history. In doing so it was reported that, in February 1997, about six months after his left knee surgery, he experienced the sudden onset of severe low back pain, for which he underwent an MRI that revealed bulging discs. After a physical examination it was reported that:

Given the apparently routine nature of the left knee arthroscopy, and the subsequent negative history relative to that joint as well as currently normal examination of that joint, it is, in my mind, very unlikely that the left knee condition would have led to significant lumbar spine abnormalities. While it is known that chronic gait abnormalities can lead to lumbar spine injury and wear and tear, the length of time involved here makes this unlikely in my opinion. [The veteran's] surgery was in August of 1996 and his onset of low back pain was six months later in February 1997. Again, given the apparently satisfactory outcome of his knee arthroscopic surgery, it is in my

opinion very unlikely that the degree and duration of gait abnormality subsequent to that surgery was sufficient to cause the currently observed degenerative disk disease in the lumbar spine. The question relating to the unusual physical therapy exercises is a highly speculative one. Given the veteran's description of what he did during these exercises they do sound a bit unusual, but not potential [sic] traumatic enough to have caused severe lumbar spine injury without first significantly exacerbating the knee symptoms. It is my opinion, therefore, that it is less likely than not that his degenerative disk disease of the lumbar spine was secondary to either the knee injury with gait abnormalities or to the physical therapy used subsequent to the knee surgery.

The May 2004 VA examiner further stated that he had reviewed Dr. Bash's opinion, and that it appeared that Dr. Bash had not examined the veteran to ascertain the severity of the degenerative disc disease or, more importantly, of the knee. Given an essentially normal examination of the knee and an admission on the part of the veteran that he has had very little symptomatology from the knee since his convalescence, the May 2004 VA examiner felt justified in disagreeing with Dr. Bash's January 2004 opinion.

An addendum to the May 2004 VA examination report indicates that X-rays revealed three compartment osteoarthritis of the left knee associated with a large Baker's cyst containing multiple osteochondral fragments.

At the March 2005 hearing at the Board before the undersigned VLJ, Dr. Bash testified that he had reviewed the veteran's claims files on two occasions. See pages 11 and 12 of the transcript.

He said there was no evidence of a spinal herniated nucleus pulposis (HNP) or back pain prior to the veteran's left knee injury, and that he first developed back pain after the left knee injury. See pages 14 and 15 of the transcript.

After Dr. Bash had rendered his January 2004 opinion and after the VA examination in May 2004, Dr. Bash had personally examined the veteran in March 2005 - just a day prior to the hearing. See Page 16 of the transcript.

That examination found many more positive clinical findings as to the veteran's left knee than were found on the May 2004 VA examination. Page 17.

Of particular note, the veteran's left thigh was smaller in circumference than his right thigh - so atrophied, and he had crepitus (a grinding, clicking sensation) in his left knee. Page 20.

Dr. Bash felt that it was most likely the veteran's left knee pain and abnormal gait (due to his service-connected left knee disability) contributed to his current spinal pathology. Page 22.

Dr. Bash further stated that he felt the report of the May 2004 VA examination was inaccurate because it did not incorporate the results of imaging and the veteran did not have a normal left knee, as indicated in the May 2004 VA examination report. Page 22.

So in substance, said Dr. Bash, the fact that the veteran does not have a normal left knee invalidates the opinion to the contrary expressed by the May 2004 VA examiner. Page 23.

The veteran testified that the May 2004 VA examination only lasted about 30 to 35 minutes, but that, in comparison, Dr. Bash's examination was for an hour or even an hour and 15 minutes. Page 26.

The veteran's wife, a nurse, also testified that he had no complaints of low back problems prior to June 1996, but since that time has experienced an abnormal gait. Page 32.

Also during the March 2005 hearing, another statement from Dr. Bash was submitted into evidence (it is dated in March 2005), along with a waiver of initial consideration by the

RO. In the statement Dr. Bash reported that he had reviewed the veteran's claims files for, in part, the purpose of providing a medical opinion regarding the relationship between his left knee and spinal disabilities. Dr. Bash reiterated this case is well within his area of expertise because he is a Board Certified Radiologist with subspecialty training as a Neuroradiologist and has special knowledge in the area of spine disease. He submitted a copy of his curriculum vitae as proof of his qualifications. He further stated that:

It is my opinion that certain medical opinions and certain findings provided by Dr. Anderson are clearly erroneous and have no basis in fact. Further, [the] opinion [of the May 2004 VA examiner] is inconsistent with my recent physical exam finding of 1 March; the patient's medical history; and the radiology imaging evidence as I have outlined in the table below:

Dr. Bash went on to state:

In addition to the above discrepancies, I noted that the patient could not squat, bend, stoop, walk un-aided or lift from chair without assistance. The patient also was using a left knee brace, cane, lumbar spine TENS unit/wet-heat device.

The report [of the May 2004 VA examiner] is, in my opinion very inaccurate, which may be due to the fact that he dictated his findings about a different patient into this patient's record or that he did not integrate his addendum or the imaging finding or his physical findings with his medical history and/or that his medical training in preventive/occupational medicine provides him with an inadequate background to interpret this complicated multi-joint/spine set of problems and/or that he did not reference any literature to support his opinions.

In addition, his report contains several medical logic disconnects. For example, he basically says that this patient's left knee is normal and without crepitus but he also states that the knee has moderate three-compartmental osteoarthritis. This is a disconnect. This osteoarthritis is the imaging equivalent to the crepitus that I felt and heard on my exam. He also states that the patient has had very little symptomatology over the years but he also states that the patient uses a cane and crutches, takes large doss of pain medications, has difficulty with bathroom duties and had to use a bed pain [sic] recently. This is another disconnect.

Overall, I do not find any basis for his opinion concerning the severity of this patient's left knee or why/why not this patient's knee problems contributed to his spine problems.

In my opinion this patient has had a longstanding knee problems [sic] since service, which required surgery and subsequently developed osteoarthritis as documented on both imaging and exam. The patient has had left knee pain for years and an abnormal gait that has been documented in his records and he now uses a cane/crutches and knee brace and he has left knee swelling. The patient developed back pain several months (9 months to be exact - please note that [the May 2004 VA examiner] inaccurately stated 6 months) following his knee surgery. In my opinion 9 months is a long enough period of time to develop serious back problems secondary to an abnormal gait and or chronic knee pain. I have seen back pain develop immediately after an acute injury and within several days following chronic gait abnormalities. It is my opinion that this patient's longstanding gait problems have caused his lumbar spine to fail with resultant sciatica ... I have reviewed his current MRI images dated 2 Aug 2004 and I agree with [the May 2004 VA examiner] that this patient has multilevel lumbar disc disease. It is my opinion that this patient's physical exam (back pain-spasm as documented on attached ER reports and sciatica), medical history and imaging findings are all consistent with his multilevel lumbar disc disease and that this disease is due to his longstanding service induced left knee gait problems as his medical record does not contain another likely etiology.

In summary, I do not find any new information in this patient's medical record that convinces me to change my previous opinion. On the contrary, my recent medical exam supports my previous opinions that this patient has serious service induced left

knee and spine problems ....

It is the obligation of the Board to weigh any contrasting or conflicting medical diagnoses or opinions. See Schoolman v. West, 12 Vet. App. 307, 310-11 (1999); Evans v. West, 12 Vet. App. 22, 30 (1998), citing Owens v. Brown, 7 Vet. App. 429, 433 (1995). This responsibility is more difficult when medical opinions diverge. The Board cannot make its own independent medical determination and there must be plausible reasons for favoring one medical opinion over another. Evans v. West, 12 Vet. App. 22, 31 (1998); see also Rucker v. Brown, 10 Vet. App. 67, 74 (1997), citing Colvin v. Derwinski, 1 Vet. App. 171 (1991). Probative weight should not be given to medical opinions when the veteran's records were not reviewed. See Bielby v. Brown, 7 Vet. App. 260, 269 (1994) (medical opinion is of no evidentiary value when doctor failed to review veteran's record before rendering an opinion).

Here, though, both the May 2004 VA examiner and Dr. Bash have reviewed the veteran's claims files. Nevertheless, it must be noted that Dr. Bash reviewed the claims files on two separate occasions - and, like the evaluating VA physician, has now actually examined the veteran to complement this. So there are legitimate reasons for accepting this private physician's medical opinion over the VA examiner's medical opinion to the contrary.

The private physician's opinions are much more focused by addressing the impairment cause by the veteran abnormal gait. Also, Dr. Bash cited more specific evidence in the record to support his opinion. In fact, Dr. Bash noted inconsistencies in the May 2004 VA examiner's opinion and, in particular, the fact that the VA examiner indicated the veteran's left knee was essentially normal; whereas, X-rays revealed three-compartment osteoarthritis in this knee.

So resolving all reasonable doubt in the veteran's favor, it is certainly just as likely as not that his current low back disorder is a residual of the functional impairment (especially his abnormal gait) stemming from his already service-connected left knee disability. Thus, service connection for a low back disorder, as secondary to his service-connected left knee disability, is warranted.

ORDER

Service connection for a low back disability is granted.

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Keith W. Allen
Veterans Law Judge, Board of Veterans' Appeals