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Dept. Of Vet. Affairs
Board of Veterans Appeals
P.O. Box 27063
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3/28/2019

In reply to: [redacted]

Appellant's Brief

Record Before the Agency (RBA)-Appellant relies on the claims file provided him dated 1/05/2018 of 817 pages. See In reply, refer to: 376/275/TJM File Number [redacted].

In reference to the RBA, appellant has supplied a Chronology with cites to the RBA of pertinent records. **See Exhibit A.**

Facts

Appellant contends he contracted gonorrhea during his tour of duty at Udorn RTAFB in 1969-1970. While his military medical records are absent, appellant is competent to report symptoms and the medical treatment in layman's terms. See Layno v. Brown, 6 Vet. App. 465, 469 (1994) (a Veteran is competent to report on that of which he or she has personal knowledge).

Appellant has been very forthcoming and honest in reciting his personal history-indeed to the possible detriment of his own claim. Appellant felt the knowledge of a sexually transmitted disease (STD) was personally embarrassing and immaterial to the acquisition of hepatitis C. Medical science states otherwise. In fact, the VA's own "Risk Factors For Hepatitis Questionnaire" asks respondents in Question #3 "Have you engaged in high-risk sexual activity?". In retrospect, appellant concedes having sexual relations with a prostitute, taking no precautions and contracting a STD probably falls into the category of high-risk sexual behavior. Failure to earlier divulge these facts was caused by personal embarrassment and the social stigma of having to admit contracting a STD.

The DBQ conducted by QTC c&p doctor, Roger M. Tauran, MD in Occupational Medicine, on 9/27/2017 confirms the severity of the chronic infection and hence, the longevity. RBA@ 141-152. In his own words, the VA examiner explains it as "a serious, lifelong illness that attacks the liver." This is precisely what appellant contends. VA examiners may not see any history of treatment of the Hepatitis C but that in no way diminishes the cryptological nature of the disease.

Appellant claims this as entitlement under 38 CFR §3.310(b). By 2002, it became apparent to appellant that something chronic had been affecting his health for decades. Using VA's hypothetical infection date of 1988, appellant would have been infected a mere 14 years. Fatigue and malaise rarely manifest earlier than 20-25 years according to VA's own medical literature.

Records Management Center Memorandum

As an initial matter, the VA's Records Management Center, hereinafter referred to as the RMC, issued a Memorandum of Record on 7/ 19/2017 (RMC/sw) that the VBA was unable to obtain any Service Treatment Records(STRs) for appellant. **See Exhibit B**. From the claims file, it is clear there are 166 pages of

contemporary service department records. 155 pages are personnel records, troop movement orders or promotions. Only eleven pages can legitimately be called bona fide medical records.

The Secretary relies on the absence of records of Hepatitis C, or a diagnosis of any other hepatitis (presumably HAV or HBV)for that matter, as the first element of denial of the claim on appeal. Appellant contends he contracted hepatitis, not otherwise specified, during his active duty service in the United States Air Force. As there was no test for Hepatitis C in 1970, there would be no reason to find such an annotation in appellant's STRs were they even available. See also Kahana v. Shinseki, 24 Vet. App. 428 (2011); McLendon v. Nicholson, 20 Vet.App. 79, 85 (2006 (In any event, the lack of medical evidence in service does not constitute substantive negative evidence).

The available STRs consist of eleven pages of mostly ophthalmological records and one reference to broken bones in the left foot in a Physical Profile. The legal standard of review in this case is derived from several cases. When service records are incomplete the Board has a heightened obligation to explain its findings and conclusions and carefully consider the benefit-of-the-doubt rule. See Cuevas v. Principi, 3 Vet. App. 542, 548 (1992); O'Hare v. Derwinski, 1 Vet. App. 365, 367 (1991). However, the case law does not lower the legal standard for proving a claim of service connection, but rather increases the Board's obligation to evaluate and discuss in its decision all of the evidence that may be favorable to the Veteran. See Russo v. Brown, 9 Vet. App. 46 (1996).

Moreover, there is no presumption, either in favor of the claimant or against VA, arising from missing records. See Cromer v. Nicholson, 19 Vet. App. 215, 217-18 (2005) (wherein the Court declined to apply an "adverse presumption" where records have been lost or destroyed while in government control which would have required VA to disprove a claimant's allegation of injury or disease).

The Hickson Elements

The three elements essential to service connection are well known. See Hickson v. West, 12 Vet. App. 247, 253 (1999), Caluza v. Brown, 7 Vet. App. 498, 506 (1995), Shedden v. Principi, 381 F.3d 1163, 1167 (Fed. Cir. 2004). In the instant case, the appellant must show, inter alia, risk factors in service to contract a chronic disease such as Hepatitis C, exposure to a presumptive risk of infection via unsanitary, herd immunity vaccinations procedures or other blood exposure via unsanitary dental procedures, shared, communal barber razors or documented high-risk sex . Secondly, he would need to have medical proof of the same current disease presently or residuals of the service connected disease. Last, but not least, the appellant would need an independent medical opinion (IMO) by a subject matter expert that linked the disease in service (or risk factor in combination with all of the evidence of record) to the current disease process. Appellant presents with all three. He does not dispute the evidence of record. On the contrary, appellant relies on the admission as positive evidence that the brief drug use in1988 is not the etiology of the disease. A chance encounter 18 years post-service with cocaine undeniably constitutes risk but the diagnosis of extreme stage 4 cirrhosis points to infection far, far earlier.

A VA Fast Letter (FL) issued in June 2004 (FL 04-13, June 29, 2004) identified several "key points" that include the fact that hepatitis C is spread primarily by contact with blood and blood products, with the highest prevalence of hepatitis C infection among those with repeated, direct percutaneous (through the skin) exposure to blood (i.e., intravenous drug users, recipients of blood transfusions before screening of the blood supply began in 1992, and hemophiliacs treated with clotting factor before 1987). Another key point was the fact that hepatitis C can potentially be transmitted with the reuse of needles for tattoos, body piercings, and acupuncture. It was concluded, that although transmission with air gun injectors is biologically possible, there is no scientific evidence documenting such transmission and that the large majority of hepatitis C infections can be accounted for by known modes of transmission, primarily transfusion of blood products before 1992 and injection drug use.

The unvarnished takeaway from VA FAST Letter 04-13 is that there is no mention of intranasal cocaine use with shared straws. That does not mitigate in favor of appellant's claim. The letter focuses, in pertinent part, on two elements. Hepatitis C is transmitted by blood –most frequently via percutaneous exposure(injection drug use). Secondly, while it has not yet been proven medically, it is biologically possible to transmit Hepatitis B and C via an air inoculation device. This is generally conceded inasmuch as the Department of Defense acceded to the incontrovertible evidence from the Centers for Disease Control (CDC) in 12/1997 that they could no longer assure the sterility of the device. Air inoculation devices were withdrawn from usage . **See Exhibit C.** Given the strong pro-veteran canon of statutory construction, absent any evidence of willful misconduct in service, the appellant should be accorded the benefit of the doubt as to whether it is biologically plausible to transmit the Hepatitis C disease, as Dr. Cecil opines in his IMO.

Appellant would also welcome a Criminal Background Investigation (CBI) which would exonerate him of any history of arrests for drug possession, usage or incarceration for these offenses.

The credibility and weight to be attached to medical opinions is within the providence of the Board as adjudicators. Guerrieri v. Brown, 4 Vet. App. 467, 470-71 (1993). Greater weight may be placed on one physician's opinion over another depending on factors such as reasoning employed by the physicians and the extent to which they reviewed prior clinical records and other evidence. Gabrielson v. Brown, 7 Vet. App. 36, 40 (1994).

But compare Nieves-Rodriguez v. Peake, 22 Vet. App. 295, 301 (2008) (stating that a medical examination report must contain not only clear conclusions with supporting data, but also a reasoned medical explanation connecting the two); see also Stefl v. Nicholson, 21 Vet. App. 120, 124 (2007) (stating that a medical opinion must support its conclusion with an analysis that the Board can consider and weigh against contrary opinions). While appellant respects Nurse [redacted] NP's medical competence, the etiology rhetoric is predicated entirely on a history provided to her by the appellant with no discussion whatsoever on any of the appellant's other risk factors. **See Exhibit D.**

As for a well- reasoned medical explanation connecting cocaine use in 1988 to contraction of Hepatitis C, appellant is unable to find it in the Record Before the Agency. See Nieves-Rodriguez, 304 (*supra*). ([A] VA medical examination report is entitled to no weight if it contains only data and conclusions. See also Reonal v. Brown, 5 Vet. App. 458, 460-61 (1993) (holding that medical opinions based on incomplete or inaccurate factual premise are not probative).

Competency of evidence differs from weight and credibility. The former is a legal concept determining whether testimony may be heard and considered by the trier of fact, while the latter is a factual determination going to the probative value of the evidence to be made after the evidence has been admitted. Rucker v. Brown, 10 Vet. App. 67, 74 (1997); Layno v. Brown, (*supra*); see also Cartright v. Derwinski, 2 Vet. App. 24, 25 (1991) ("although interest may affect the credibility of testimony, it does not affect competency to testify"). If the evidence is credible, the Board, as fact finder, must determine the probative value or weight of the admissible evidence, that is, does the evidence tend to prove a material fact. Washington v. Nicholson, 19 Vet. App. 362, 369 (2005). If the evidence is not credible, the evidence has no probative value. Provided that it offers an adequate statement of reasons or bases, the Board may favor one medical opinion over another. See Owens v. Brown, 7 Vet. App. 429, 433 (1995).

Dr. Bennet Cecil, a noted gastroenterologist, has opined that appellant's brief cocaine use was "less likely to be the origin of your HCV". The VA examiner cites to review of ophthalmological service treatment records as being more probative than a well-noted specialist in the field of hepatology. Dr. Cecil, who provided the IMO, is also a former Veterans Health Administration Gastroenterologist and specializes in Hepatology.

The medical history of the Hepatitis C RNA virus shows it's discovery in 1989. A commercial test for it was not available until 1992 as the Red Cross was given first access to protect the nation's blood bank supply. The SOC further states that appellant first tested positive on 10/11/2002. This date, however, is merely the earliest date it can be ascertained he was indeed infected with HCV.

Risk Factors

The VA recognizes risk factors for hepatitis C to include intravenous (IV) drug use, blood transfusions before 1992, hemodialysis, intranasal cocaine abuse, high-risk sexual activity, accidental exposure while a health care worker, and various percutaneous exposures such as tattoos, body piercing, acupuncture with non-sterile needles, shared toothbrushes, or razor blades. See Veterans Benefits Administration (VBA), Director Bulletin, 211B (98-110) (Nov. 30, 1998).

On 6/21/2017, appellant cited to several risk factors he was exposed to on active service to include, inter alia, unsanitary use of air inoculation devices to administer vaccines, shared razors at barbershops which were not sanitized or autoclaved between uses, and exposure to unsanitary dental practices. **See Exhibit D.** At this time, appellant wishes to include high-risk sexual practices as he was infected with gonorrhea during his overseas tour in Thailand. As infection with a STD is not considered willful misconduct by the military or VA (38 CFR §3.301(c)(1)), it is not an impediment to entitlement to service connection for Hepatitis C.

If it would please the Board Member, appellant would be happy to provide a laboratory blood sample to prove antibodies to gonorrhea are still present in his system from his 1969 infection. This would at least confirm appellant was infected at some time after enlistment and prior to today's hearing. While it would not be dispositive that the gonorrhea infection did not occur in the intercurrent period after service, it at least would confirm appellant's contentions as to a bona fide risk factor of high-risk sex. Appellant is competent to testify and his credibility has not been compromised throughout this adjudication.

38 USC §1154(a)

Appellant seeks no adverse presumption over the missing or lost records. He merely wishes to present what reasonable medical experts can medically agree is the truth- that his greatest exposure to risk was during his active duty service. Additionally, based solely on 38 USC §1154a- due consideration should be given to the places, types, and circumstances of such veteran's service as shown by such veteran's service record, the official history of each organization in which such veteran served, such veteran's medical records, and **all pertinent medical and lay evidence.** In the instant case, even absent the contemporary records which would not show causation, the chronic, residual evidence is medical and unequivocal. Mr. [redacted] would not be so far along in his liver cirrhosis with ascites and esophageal varices if he contracted this disease in 1988. That date would occur 50 years in the future from 1988-or approximately 2038.

Rebuttal of Statement of the Case dated 9/24/2018 (re 343/215/fm)

The SOC contends the VBA examiner's opinion "was more persuasive because it was better supported in its rationale and conclusions." The Rating Board further opined

"The medical opinion we received from the VA examiner was more persuasive than your private physician's opinion because it was based on a thorough review of your relevant military and personal history and contained a more convincing rationale."

Counsel for appellant wishes to rebut the above statement. Initially, appellant has presented the three Hickson elements of service connection as required by law. VA has presented rebuttal but relies on an opinion with only data and conclusions.

Moreover, counsel personally obtained the claims file and all available military and personal service department records, to include appellant's more recent VA CAPRI records during the relevant period that were available. Many of the records were downloaded and printed by counsel from the VA's VBMS portal. Assuming everyone is looking at the very same electronic files, appellant's IMO doctor, Dr. Bennet Cecil, reviewed each and every file the Secretary made available to the VA examiner. As an officer of the Court (CAVC), counsel can attest he sent everything in both the VA's electronic and claims files to Dr. Cecil. Ignoring the military documents which have no probative medical value, and considering the paucity of ***any*** probative medical documents, appellant wonders which records the VA examiner feels were relevant. Appellant's personal history is that provided by himself. The balance of the evidence is post service and reasonable minds can concur the age of the disease is far older than 30 years. Absent any discussion of *all* the risk factors makes the Compensation and Pension examination fairly useless for ratings purposes.

Based on both of the opinions being equal and compelling in their logic, the appeal is in equipoise. Nevertheless, to ensure the record is truly independent, counsel for appellant sought yet another Independent Medical Opinion (IMO) based on new evidence.

Medical science can now tell from the presence of antibodies in the bloodstream if any individual has ever been infected with gonorrhea. See https://www.stdcheck.com/blog/everything-about-gonorrhea-and-gonorrhea-testing/ (last visited 3/24/2019) The article states:

Blood Samples

A small blood sample is drawn and then tested for antibodies to *Neisseria gonorrhoeae*. Gonorrhea very rarely passes into the bloodstream. The body creates antibodies to respond to various diseases and infections, and these can be found in the blood. These tests can result in a false-positive, and cannot tell for certain that an individual has gonorrhea at the time of the test, **but can tell whether or not the individual has had it in the past.**

When appellant first entered the VA medical system in 2002 and was positively diagnosed with Hepatitis C, no medical personnel surveyed him as to all his possible risk factors. A rush to judgement and an "Aha!" moment ensued in 2015 upon his admission of having sniffed cocaine with "shared bloody dollar bill(s)."After review of ***all*** the risk factors known to be associated with the transmission of Hepatitis C, appellant reluctantly and belatedly concedes high-risk sex is applicable in light of his 1969 STD, contracted from a prostitute. Based on this, he asks for de novo review. As he is not a doctor, he cannot opine as to the causation of his Hepatitis C. However, under Layno, the risk factor of contraction of a STD is probative evidence that must be reviewed de novo.

While the introduction of the risk factor of a STD is competent evidence, appellant feels it is also credible evidence and should not be viewed as a last-minute Hail Mary attempt to obtain service connection for his residuals of hepatitis C. The VA records show (RBA @ 307-318) "severe fibrosis (~F4) Metavir" and suspected cirrhosis". See also http://www.hepctrust.org.uk/information/impact-hepatitis-c-liver/progression-hepatitis-c (last visited 3/24/2019)

In addition, a 6/29/2017 endoscopic study (RBA @261) of appellant's esophagus revealed "3 channels of esophageal varices, longest one extending from 33 cm to 40mm from the incisors, 3+, 2 smaller varices 2+ each were noted." These symptoms are indicative and confirm his diagnosis of portal hypertension of the liver- it's too clogged (scarred) to permit the free passage of blood. The blood starts to come to the surface of the esophagus and liquid pools in the abdomen (ascites). These disease processes indicate End Stage Liver Disease or ESLD. The liver can regenerate itself and it is hoped appellant's recent cure with the Zepatier treatment regime came soon enough, will remain in remission and permit him to live a while longer than currently predicted. Appellant is not considered a candidate for liver transplant per VA regulations.

New and Material IMO

Appellant submits today a new and material IMO authored by Maria V. Rivero, M.D. Board Certified, Internal Medicine-- a subject matter expert who has had extensive contact with Hepatitis C-positive patients and is extremely well-versed in viral etiology. She was asked to opine on the new lay evidence introduced of risk based on high-risk sex. **See Exhibit E.**

Appellant would point out that, undoubtedly, medical inquiry can be undertaken with a view towards further developing the appeal. However, in this regard, the Court has cautioned VA against seeking additional medical opinions where favorable evidence in the record is unrefuted, and indicated that it would not be permissible to undertake further development if the sole purpose was to obtain evidence against an appellant's claim. See Mariano v. Principi, 17 Vet. App. 305, 312 (2003). Kahana v. Shinseki, (*supra*) McLendon v. Nicholson, 20 Vet.App. 79, 85 (2006 (In any event, the lack of medical evidence in service does not constitute substantive negative evidence).

No less than two doctors -both experts in their fields- have opined based on the risk factors appellant reported. Both have opined that the age of the infection and the greatest number of risk factors were present during appellant's active duty service. The VA nurse practitioner, with little or no expert training in the etiology of Hepatitis C, categorically opined that this was unequivocally related to his brief (twice or three times) encounter with the nasal ingestion of cocaine using a shared device. The author of the notes recording the etiology of the Hepatitis C, is [redacted] MS, NP. Nurse [redacted] is a VA nurse practitioner with no specialty in any medical field and practices under the supervision of a medical doctor. The VBA forbids VHA medical personnel from opining on the etiology of the diseases they treat. The VBA insists on making any and all decisions regarding causation and service connection. Appellant is disturbed to think that VBA examiners are reliant on the ruminations of a VHA nurse over four years ago with no access to any probative STRs.

Presumption of Regularity

The presumption of regularity provides that, in the absence of clear evidence to the contrary, the court will presume that public officers have properly discharged their official duties. Butler v. Principi, 244 F.3d 1337, 1339 (Fed. Cir. 2001). Further, in Rizzo v. Shinseki, 580 F.3d 1288, 1290–91 (Fed. Cir. 2009), it was held: "what appears regular is regular and what appears irregular is irregular- the burden of proof of irregularity falling on the appellant to rebut."

Sickels v. Shinseki, 643 F.3d 1362 (Fed. Cir. 2011) deals with the presumption of competence of VA medical personnel. Appellant feels the presumption has been rebutted. The clear and unmistakable medical evidence of record yields only one logical conclusion. Appellant's Hepatitis C predates the post-service exposure in 1988 by almost two decades. The Secretary presents nothing but data and a conclusion to support the VA examiner's finding of fact.

The Secretary advances no convincing rationale to support infection by shared cocaine instruments, probative peer-reviewed articles or other supportive evidence to buttress the opinion. As such, it is merely speculative conjecture with no evidentiary argument and bases. Appellant contends the opinions of two Board certified medical doctors with additional degrees in the pertinent fields of hepatology and internal medicine are more probative and thus must be accorded greater weight. As the VA doesn't subscribe to the Treating Physician Rule, Nurse [redacted]'s IMO cannot be accorded more probative value, either.

Application of McWhorter

Appellant contended in his initial pro se filing, and further identified, that he was exposed to certain risk factors for contraction of the Hepatitis C virus. While he

did identify a new probative risk factor (high-risk sex) which can be supported by a simple blood test, the examiner failed to address even the initial list of potential culprits **(Exhibit D).** Now, following the Notice of Disagreement (NOD) filed on 4/17/2018 and submission of a probative nexus, the VA examiner again fails to address these potential risks in the Statement of the Case. 38 CFR §19.29 states:

§ 19.29 Statement of the Case.

The Statement of the Case must be complete enough to allow the appellant to present written and/or oral arguments before the Board of Veterans' Appeals. It must contain:

(a) A summary of the evidence in the case relating to the issue or issues with which the appellant or representative has expressed disagreement;

(b) A summary of the applicable laws and regulations, with appropriate citations, and a discussion of how such laws and regulations affect the determination; and

(c) The determination of the agency of original jurisdiction on each issue and the reasons for each such determination with respect to which disagreement has been expressed.

(Authority: 38 U.S.C. 7105(d)(1))

Based entirely on the SOC, appellant presumes the Secretary concedes the risks mentioned. Nowhere in the four corners of the SOC are there rebuttal of these identified, plausible risks.

Application of Clemons

Appellant has been asked by medical examiners to opine on how he might have contracted this disease. Based on Hepatitis C jurisprudence at the Board of Veterans Appeals, the legal standard of review is simple. Absence of any contemporary medical evidence of any symptoms reflecting possible infection

with the Hepatitis C virus is not fatal to a claim to attain service connection. As most opinions are speculative in regard to this disease, clear and concise medical knowledge is crucial to the adjudication. See Colvin v. Derwinski, 1 Vet. App. 171 (1991).

In addition, asking the appellant to opine on what may, or may have not, been the causative etiology violates Layno (supra). See also Clemons v. Shinseki 23 Vet. App. 1 (2009). (Appellant is not competent to identify his condition). See also Espiritu v. Derwinski, 2 Vet. App. 492, 494-95 (1992) (However, the capability of a witness to offer such evidence is different from the capability of a witness to offer evidence that requires medical knowledge).

Conclusion

Appellant has two Independent Medical Opinions with supportive rationale which unequivocally hold that it is at least as likely as not the Hepatitis C he contracted occurred during his time in service. In rebuttal, the Secretary provides hearsay from a history recited by appellant to his treating VA nurse in 2015 as probative medical evidence. Greater weight should be given to the Veteran's statements made to a physician in connection with seeking appropriate medical care than on those he has made in pursuit of his claim for compensation. See Rucker v. Brown, 10 Vet. App. 67, 73 (1997) (lay statements found in medical records when medical treatment was being rendered may be afforded greater probative value; statements made to physicians for purposes of diagnosis and treatment are exceptionally trustworthy because the declarant has a strong motive to tell the truth in order to receive proper care); see also Curry v. Brown, 7 Vet. App. 59, 68 (1994) (noting that contemporaneous evidence has greater probative value than history as reported by a Veteran).

While the admission of cocaine use certainly bears heavily on this appeal, there are no supporting facts or rationale to buttress the opinion. The Secretary has held there is one, and only one, risk factor at play here and goes so far as to pointedly ignore any others. See McWhorter *(supra)*. Appellant should thus be tasked with only having to rebut the single finding of fact with new and material evidence. Nevertheless, appellant has provided multiple etiologies with supportive IMO evidence.

Appellant asks the Board to consider all the evidence de novo as demanded by statute and regulation. He feels it is at least essentially in equipoise and therefore asks for consideration under 38 CFR §3.102.

Respectfully submitted,

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Gordon A. Graham VA #39029 POA E1P
Counsel for appellant [redacted]

Attachments:

Exhibit A [redacted] Chronology related to RBA cites

Exhibit B RMC Memorandum of Record (duplicate in claims file)

Exhibit C 12/05/1997 recall of air inoculation devices.

Exhibit D VAF 21-4138 listing risk factors " "

Exhibit E New and material IMO by Maria Rivero, M.D.