## Section I. Conditions of Other Body Systems

#### Overview

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| In This Section | This section contains the following topics: |

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| Topic | Topic Name |
| 1 | Digestive Conditions |
| 2 | Hepatitis |
| 3 | Genitourinary Conditions |
| 4 | Gynecological Conditions |
| 5 | Hemic and Lymphatic Conditions |

#### 1. Digestive Conditions

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| Introduction | This topic contains information about rating digestive system conditions, including   * considering circumstances of service associated with gastrointestinal disorders * digestive condition evaluations under 38 CFR 4.114 which will not be combined with each other * establishing service connection (SC) for inguinal hernia * considering recurrence of hemorrhoids, and * causes of liver damage. |

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| a. Considering Circumstances of Service Associated With Gastrointestinal Disorders | If the issue is service connection (SC) for dysentery or other gastrointestinal disease, assign great weight to any service under the following conditions since these conditions may have been the etiological or aggravating factor   * tropical service * imprisonment or internment under unsanitary conditions, or * food deprivation.   ***Reference***: For more information on establishing SC for dysentery and other tropical diseases, see [38 CFR 3.309(b)](http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=7c54c98c7be24cd2f7b05eabb45f8a87&ty=HTML&h=L&r=SECTION&n=se38.1.3_1309). |

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| b. Digestive Condition Evaluations Under 38 CFR 4.114 Which Will Not Be Combined With Each Other | [38 CFR 4.114](http://www.ecfr.gov/cgi-bin/text-idx?SID=678e1a0b35110a17aae704e69f2701f2&mc=true&node=se38.1.4_1114&rgn=div8) specifies that evaluations of digestive conditions under certain diagnostic codes (DCs) will ***not*** be combined with each other or assigned separate evaluations. Instead, a single evaluation should be assigned under the DC which reflects the *predominant* disability, with elevation to the next higher evaluation when the severity of the overall disability warrants such elevation.  Do ***not*** combine separate evaluations of digestive conditions with each other under the following [38 CFR 4.114](http://www.ecfr.gov/cgi-bin/text-idx?SID=678e1a0b35110a17aae704e69f2701f2&mc=true&node=se38.1.4_1114&rgn=div8) DCs:   * 7301 to 7329, inclusive (meaning ***all*** the DCs from 7301 to 7329) * 7331 * 7342, and * 7345 to 7348, inclusive (meaning ***all*** the DCs from 7345 to 7348).   ***Example***: A Veteran with a duodenal ulcer, evaluated as 20-percent disabling under [38 CFR 4.114, DC 7305](http://www.ecfr.gov/cgi-bin/text-idx?SID=678e1a0b35110a17aae704e69f2701f2&mc=true&node=se38.1.4_1114&rgn=div8), and ulcerative colitis, evaluated as 30-percent disabling under [38 CFR 4.114, DC 7323](http://www.ecfr.gov/cgi-bin/text-idx?SID=678e1a0b35110a17aae704e69f2701f2&mc=true&node=se38.1.4_1114&rgn=div8), would be assigned a single 30-percent evaluation under [38 CFR 4.114, DC 7323](http://www.ecfr.gov/cgi-bin/text-idx?SID=678e1a0b35110a17aae704e69f2701f2&mc=true&node=se38.1.4_1114&rgn=div8) as ulcerative colitis represents the predominant disability picture. *Separate* evaluations for the duodenal ulcer and ulcerative colitis are not permitted under [38 CFR 4.114](http://www.ecfr.gov/cgi-bin/text-idx?SID=678e1a0b35110a17aae704e69f2701f2&mc=true&node=se38.1.4_1114&rgn=div8). |

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| c. Establishing SC for Inguinal Hernia | Do not assume the preexistence of a hernia. Determine preexistence on a factual basis.  The following conditions are sufficient bases for SC   * in-service initial manifestation of hernial protrusion, and * recurrence during service, by aggravation, of a hernia previously surgically repaired.   ***Note***: Operation for repair of a preexisting inguinal hernia is not necessarily evidence of aggravation.  ***Reference***: For information on the presumption of soundness at entrance into service, see [38 CFR 3.304(b)](http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=7c54c98c7be24cd2f7b05eabb45f8a87&ty=HTML&h=L&r=SECTION&n=se38.1.3_1304). |

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| d. Considering Recurrence of Hemorrhoids | Initial awards of SC for hemorrhoids are governed by customary rules for SC included in [38 CFR 3.303](http://www.ecfr.gov/cgi-bin/text-idx?SID=f4e5818587afc2385dc0a750e18eb7f4&mc=true&node=se38.1.3_1303&rgn=div8). After SC is initially established, unless the award of SC for hemorrhoids was in error, consider recurrences after service as service-connected (SC).  ***Reference***: For more information on reversing an erroneous decision, see   * [38 CFR 3.105(a)](http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=7c54c98c7be24cd2f7b05eabb45f8a87&ty=HTML&h=L&r=SECTION&n=se38.1.3_1105) * M21-1, Part III, Subpart iv, 2.B.4.a, and * M21-1, Part IV, Subpart ii, 3.A.2. |

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| **e. Causes of Liver Damage** | Hepatitis is the result of damage to the liver. The table below describes recognized causes of liver damage and provides examples of each cause. |

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| **Cause of Liver Damage** | **Example** |
| Infection | Virus |
| Systemic diseases | Lupus |
| Drugs | * Isoniazid * Acetaminophen * Phenytoin |
| Toxic substances | Alcohol |

**2. Hepatitis**

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| **Introduction** | This topic contains information about hepatitis, including   * categories of hepatitis recognized for rating purposes * diagnostic testing required for hepatitis diagnosis * interpreting lab reports for hepatitis B (HBV) * interpreting lab reports for hepatitis C (HCV) after 1992 * risk factors for HBV and HCV * development for hepatitis risk factors * considering drug abuse in hepatitis claims * evaluating claims for increase for SC hepatitis awarded due to drug abuse * considering in-service hepatitis findings * requesting exams and/or opinions for HBV or HCV * reviewing hepatitis exams and opinions for sufficiency, and * assigning a 0-percent evaluation for HCV. |

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| **a. Categories of Hepatitis Recognized for Rating Purposes** | There are three categories of hepatitis recognized for rating purposes. The table below describes each type of hepatitis and explains the transmission and prognosis for each. |

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| **Type of Hepatitis** | **Transmission** | **Prognosis** |
| hepatitis A Virus (HAV), previously called infectious hepatitis | fecal-oral route | acute—seldom severe and does not leave residuals  ***Note***: In order to award SC, there must be evidence of chronic residuals related to the hepatitis A infection. |
| hepatitis B Virus (HBV), previously called serum hepatitis | * blood products * sexual contact | * acute in 90-95 percent of cases, but acute disease can be severe and result in death * chronic in 5-10 percent of cases * Cirrhosis and liver cancer may develop. * A vaccine to prevent HBV infection is available. |
| hepatitis C (HCV), previously called non-A non-B hepatitis | infected blood | * clinically asymptomatic acute disease * Chronic disease develops in 80 percent of cases following acute phase. * Diagnosis is generally made incidentally many years later. |

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| ***Note***: Infectious hepatitis is common throughout the world and was especially prevalent during World War II (WWII) following administration of the yellow fever vaccine in 1942 and in the Mediterranean Theater.  ***Reference***: For more information on risk factors for HBV and HCV, see M21-1, Part III, Subpart iv, 4.I.2.e. |

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| **b. Diagnostic Testing Required for Hepatitis Diagnosis** | SC for hepatitis requires blood serology testing to establish a diagnosis and identify the type of hepatitis present. Liver function tests (LFTs) are necessary to assess the severity of the disease.  ***Notes***:   * The rating decision should always specify the type of hepatitis for which SC is awarded. * *Serological tests* determine the presence of antigens and antibodies to the specific virus. The presence of antibodies to the specific virus indicates the infection is present.   The table below describes types of serological testing required to confirm a diagnosis for each type of hepatitis. |

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| **Type of Hepatitis** | **Serology or Other Testing Required** | **Additional Notes** |
| HAV | anti-HAV (antibodies to hepatitis A virus) | * Anti-HAV are present in the blood one month after the acute illness and persist for life. * Serological blood testing showing the presence of anti-HAV indicates a past acute infection. |
| HBV | * anti-HBsAg (hepatitis B surface antigen) is present during the acute phase. * HBsAg that persists more than three to six months indicates probable chronic disease or carrier status. * A positive Australian antigen test is sufficient to confirm hepatitis B. | HBV has two antigens, a surface antigen and a core antigen   * HBsAg, and * HBcAg (hepatitis B core antigen).   Consequently, two types of antibodies appear in the blood   * anti-HBs (antibodies to the surface antigen), and * anti-HBc (antibodies to the core antigen). |
| HCV | * EIA (enzyme immunoassay) or ELISA (enzyme linked immunosorbent assay, also called Western blot) is the first test. * If EIA or ELISA is positive, RIBA (recombinant immunoblot assay) is needed to confirm the diagnosis of chronic HCV. * In lieu of EIA/ELISA followed by RIBA, a positive test for HCV RNA (hepatitis C viral ribonucleic acid) is sufficient by itself to confirm a diagnosis of HCV. * HCV RNA results can be * qualitative (positive or negative), or * quantitative (number of copies per milliliter (ml)). | The presence of anti-HCV (including EIA or ELISA) is ***not*** sufficient for a diagnosis of chronic HCV because it can be present in other diseases. |

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| ***Note***: Liver biopsy, ultrasound, and computed tomography (CT) scan tests can detect damage to the liver but will not identify the type of infection. |

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| c. Interpreting Lab Reports for HBV | The table below provides an example of a laboratory interpretation of serology test results for HBV. |

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| Test | Results | Interpretation |
| **Example 1** | | |
| HBsAg | negative | susceptible to infection |
| anti-HBc | negative | susceptible to infection (no hepatitis B) |
| anti-HBs | negative | no history of hepatitis B |
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| **Example 2** | | |
| HBsAg | negative | immune |
| anti-HBc | negative or positive | immune |
| anti-HBs | positive |  |
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| **Example 3** | | |
| HBsAg | positive | acute infection |
| anti-HBc | positive |  |
| Immunoglobulin M (IgM) anti-HBc | positive | acute infection |
| anti-HBs | negative |  |
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| **Example 4** | | |
| HBsAg | positive | chronic infection |
| anti-HBc | positive |  |
| IgM anti-HBc | negative | chronic infection |
| anti-HBs | negative |  |

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| d. Interpreting Lab Reports for HCV After 1992 | The table below provides an example of a laboratory interpretation of serology testing for HCV for testing performed after 1992. |

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| Tests | Results | Interpretation |
| anti-HCV | positive (probable chronic hepatitis) | need to verify diagnosis |
| EIA | positive | supplemental test required |
| RIBA | positive | diagnostic |
| HCVRNA | follow-up of chronic hepatitis C | not needed for rating |

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| e. Risk Factors for HBV and HCV | Risk factors for the development of HBV and HCV are similar. The table below describes the medically recognized risk factors for HBV and HCV infection, provides transmission information concerning those risk factors, and includes tips for confirming the risk factors.  ***Note***: Resolve reasonable doubt under [38 CFR 3.102](http://www.ecfr.gov/cgi-bin/text-idx?SID=11a8c42004846650332ce6e28ab91057&mc=true&node=se38.1.3_1102&rgn=div8) in favor of the Veteran when the evidence favoring risk factor(s) in service is equal to the evidence favoring risk factor(s) before or after service. |

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| **Risk Factor** | **Transmission Information** | **Rating Tips** |
| * transfusion of blood or blood product * before 1992 for HCV, or * before 1975 for HBV * organ transplant before 1992, or * hemodialysis | * Blood donor screening for HCV was not available until 1989 when HCV was identified. * In 1992, more effective screening of blood became possible for HCV. | * If blood transfusion is a claimed risk factor, obtain the relevant hospital records from service, if possible. * Look for evidence of blood transfusions in surgical reports, especially the * anesthesia sheet * surgical record * operative clinical records, or * post-operative clinical notes. |
| * tattoos * body piercing, and * acupuncture with non-sterile needles | transmitted through the use of unsterilized equipment | Review for indications of tattoos or piercings on induction and separation exams to help determine whether tattooing or piercing took place in service. |
| intravenous drug use | transmitted through the use of shared instruments | Records of drug treatment may reflect the type of drug abuse. |
| high-risk sexual activity | Transmission risk is relatively low but increases with multiple sexual partners. | Periodic health assessments or records of treatment for sexually transmitted diseases may document a history of high-risk sexual activity or multiple sexual partners. |
| intranasal cocaine use | transmitted through the use of shared instruments | Records of drug treatment may reflect the type of drug abuse. |
| accidental exposure to blood by percutaneous exposure or on mucous membranes | common for the following   * health care workers * combat medics, and * corpsmen | Consider service department or other records reflecting occupational history. |
| sharing of   * toothbrushes, or * shaving razors | transmitted through direct percutaneous exposure to blood | This type of in-service exposure will not generally be documented in service records. Consider buddy statements in the context of the entire evidence picture pertaining to risk factors. |
| immunization with a jet air gun injector | * *one* documented case of HBV transmission * Despite the lack of any scientific evidence to document transmission of HCV with air gun injectors, it is biologically possible. | A medical report linking hepatitis to air gun injectors must include a full discussion of all potential modes of transmission and a rationale as to why the examiner believes the air gun injector was the source for the hepatitis infection. |

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| **f. Development for Hepatitis Risk Factors** | As *VA Form 21-526EZ, Application for Disability Compensation and Related Compensation Benefits*, does not inform the claimant to submit evidence of hepatitis risk factors, development for risk factors is required in every hepatitis claim, even when hepatitis is diagnosed in service. Development is necessary to determine if pre- and post-service risk factors are present as well as to ensure that the risk factor is not substance abuse either before or during service.  Regardless of what claim form the Veteran submits, development for risk factors is required if the complete risk factor history has not already been provided. If risk factor history is not of record, use the table below to develop to the Veteran. |

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| **If the Veteran is claiming ...** | **Then generate a risk factors development letter in ...** |
| hepatitis C | the Veterans Benefits Management System (VBMS). |
| * hepatitis A or B, or * a non-specific form of hepatitis | * Modern Award Processing-Development (MAP-D), and * alter the letter to specify the type of hepatitis claimed by the Veteran (A, B, or none). |

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| ***References***: For more information on   * SC for hepatitis associated with drug use, see M21-1, Part III, Subpart iv, 4.I.2.g, and * examinations and medical opinions in hepatitis claims, see M21-1, Part III, Subpart iv, 4.I.2.j. |

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| **g. Considering Drug Abuse in Hepatitis Claims** | If one of the risk factors for hepatitis is intravenous or intramuscular drug use, or intranasal cocaine use, do ***not*** automatically assume the substance abuse is the cause of hepatitis and deny the claim on that basis.  Follow the steps in the table below when considering a claim for SC for hepatitis in which injection drug or intranasal cocaine use is a confirmed in-service risk factor. |

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| **Step** | **Action** |
| 1 | Review for all risk factors of hepatitis in addition to the drug use. |
| 2 | If injection drug or intranasal cocaine use is the only confirmed in-service risk factor present, then deny SC. If other in-service risk factors are found in addition to injection drug or intranasal cocaine use, go to Step 3. |
| 3 | * Request a medical opinion to determine which confirmed in-service risk factor is at least as likely as not the cause of the hepatitis infection. |
| 4 | Use the table below to determine how to proceed with the medical opinion.   |  |  | | --- | --- | | **If the medical opinion …** | **Then …** | | states that drug use is the cause of the hepatitis infection | deny the claim for SC for hepatitis. | | gives greater or equal weight to another confirmed in-service risk factor | * resolve reasonable doubt in the Veteran’s favor, and * award SC. | | is unable to state which risk factor is more likely than not to be the cause of the hepatitis | * weigh all evidence, and * apply the reasonable doubt doctrine if the evidence is found to be in equipoise.   ***Reference***: For more information on examiner statements that an opinion would be speculative, see M21-1, Part III, Subpart iv, 3.D.2.p. | |

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| ***Reference***: For more information on considering claims for SC based on drug use, see   * [38 CFR 3.301(c)(3)](http://www.ecfr.gov/cgi-bin/text-idx?SID=290d6d4d738a59a099fe3225e78f6388&node=se38.1.3_1301&rgn=div8), and * M21-1, Part IV, Subpart ii, 2.K.3. |

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| **h. Evaluating Claims for Increase for SC Hepatitis Awarded Due to Drug Abuse** | Follow the steps in the table below to determine the appropriate actions to take in a claim for increase when SC was previously awarded but the only apparent risk factor in service was drug abuse. |

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| **Step** | **Action** |
| **1** | Was SC for hepatitis due to drug abuse awarded by rating decision on or before October 31, 1990?     * If *yes*, then continue the finding of SC for hepatitis as the award of SC was proper based on regulations and procedures at that time. Go to Step 5. * If *no*, then go to Step 2. |
| 2 | Does the evidence clearly show that the hepatitis is due to in-service drug abuse?   * If *yes*, go to Step 4. * If *no*, go to Step 3. |
| 3 | If SC was awarded but there is no evidence clearly linking the hepatitis to drug abuse or if there were multiple risk factors in service, one of which was drug abuse, and no prior opinion was obtained, request a medical opinion to determine whether the hepatitis is due to the drug abuse.  If the resulting opinion   * clearly links hepatitis to drug abuse, go to Step 4. * cannot resolve whether hepatitis is due to drug abuse or another in-service risk factor, or the hepatitis is attributed to another non-drug abuse in-service risk factor, then * resolve reasonable doubt in favor of the Veteran and continue the finding of SC, and * award an increased evaluation for hepatitis if the medical evidence otherwise shows the increase is warranted. |
| 4 | If the evidence clearly shows that the hepatitis is due to in-service drug abuse and SC was awarded by rating decision after October 31, 1990, determine whether the award of SC is protected per [38 CFR 3.957](http://www.ecfr.gov/cgi-bin/text-idx?SID=eb7e5f1a68f287026d33281f48329284&node=se38.1.3_1957&rgn=div8).     * If SC is protected, go to Step 5. * If SC is not protected, then propose to sever SC per [38 CFR 3.105(a)](http://www.ecfr.gov/cgi-bin/text-idx?SID=642574e012687e22e2367579161048b5&node=se38.1.3_1105&rgn=div8). |
| 5 | If SC was properly established for hepatitis due to drug abuse by rating decision on or before October 31, 1990, and/or if the award of SC for hepatitis is protected, do not award an increased evaluation for hepatitis due to drug abuse. |

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| ***Notes***:   * The Omnibus Reconciliation Act of 1990 (*Public Law 101-508 Section 8052*) prohibited the grant of SC for disability or death resulting from alcohol or drug abuse for claims filed after October 31, 1990. * [VAOPGCPREC 2-98](http://www.va.gov/ogc/docs/1998/prc02-98.doc) found that an increased evaluation may not be awarded when SC was previously properly established as due to drug abuse by rating decision on or before October 31, 1990. |

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| i. Considering In-Service Hepatitis Findings | When a Veteran submits a claim for SC of hepatitis, assess the lay evidence, service treatment records (STRs), and current medical records to ascertain whether a current disability, an in-service event or injury, and an indication of an association are present as required in [38 CFR 3.159(c)(4)](http://www.ecfr.gov/cgi-bin/text-idx?SID=1e324e06ebb226eb099aa96f320959d2&node=se38.1.3_1159&rgn=div8) prior to requesting examination and/or medical opinion.  Use the table below to determine the proper rating action for in-service findings related to hepatitis. |

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| If STRs show... | Then ... |
| diagnosis of non-specific hepatitis and SC is claimed many years later | request an exam with serology testing and LFTs (if not already of record) and opinion to determine if a relationship exists between the episode of hepatitis in service and the current type of hepatitis unless there is sufficient evidence of a clearly-established diagnosis and continuous symptoms present to satisfy the nexus standard under [38 CFR 3.303(a)](http://www.ecfr.gov/cgi-bin/text-idx?SID=7ba4ca19cef35152b0b6015d80b0df65&node=se38.1.3_1303&rgn=div8). |
| laboratory findings confirming HAV or HBV | do not automatically SC HCV since each type of hepatitis can be acquired at different times and through different means.  ***Notes***:   * SC for HAV is not warranted as HAV is an acute condition. * Consider SC for HBV if a chronic disability is present and linked to the in-service finding and/or risk factors. * Consider SC for HCV if a medical opinion links the condition to the confirmed in-service findings and/or risk factors. |
| a diagnosis of non-A, non-B hepatitis (old name for hepatitis C) and the current medical evidence confirms a diagnosis of HCV | SC is likely warranted.   * If medical evidence establishes the presence of continuous symptoms since service, then award SC. * If evidence of continuous symptoms since service is not present, request a nexus opinion. |
| non-specific hepatitis and current evidence shows HCV **or** chronic HBV only | HCV or chronic HBV *may* warrant SC based on reasonable doubt. Request a medical opinion and any necessary diagnostic testing to confirm the diagnosis.  ***Reference***: For more information on diagnostic testing required for hepatitis, see M21-1, Part III, Subpart iv, 4.I.2.b. |
| non-specific hepatitis and current evidence shows HCV **or** chronic HBV as well as a history of HAV | a medical opinion is necessary to determine whether the current disability is a result of the non-specific hepatitis diagnosed in service. |

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| j. Requesting Exams and/or Opinions for HBV or HCV | Follow the steps in the table below when requesting an examination and/or opinion for HCV or chronic HBV. |

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| Step | Action |
| 1 | Identify and request the examiner review of all relevant evidence in the claims folder. |
| 2 | List any risk factors identified by the Veteran. |
| 3 | Identify all risk factors confirmed by the evidence in the claims folder, whether claimed by the Veteran or not.  ***Important***: In addition to in-service risk factors, ensure that all documented pre- and post-service risk factors are noted in the exam request. |
| 4 | Request the *Department of Veterans Affairs (VA) Form 21-0960G-5, Hepatitis, Cirrhosis And Other Liver Conditions Disability Benefits Questionnaire* (DBQ), which will include diagnostic testing as well as LFTs and a detailed description of clinical findings and reported symptoms. |
| 5 | Request a medical opinion about the relationship between the current HBV or HCV infection and confirmed or supported risk factor(s). |
| 6 | Notify the examiner that a positive nexus opinion, if warranted, should take only confirmed risk factors as shown by the objective evidence of record into consideration. |

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| ***References***: For more information on   * confirming risk factors, see M21-1, Part III, Subpart iv, 4.I.2.e, and * evaluating evidence, see M21-1, Part III, Subpart iv, 5. |

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| **k. Reviewing Hepatitis Exams and Opinions for Sufficiency** | Review the examination or opinion to ensure sufficiency and return insufficient examinations when warranted. Common reasons for insufficient examinations are   * lack of proper confirmatory testing to support the diagnosis * failure to include complete clinical findings and symptoms in the report * failure to address all known risk factors in the opinion * opinions linking HCV or chronic HBV to a risk factor that is not confirmed in the evidence of record, and * opinions improperly linking HCV or chronic HBV to a risk factor that is not medically recognized as a source of infection. |

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| **l. Assigning a 0-Percent Evaluation for HCV** | A 0-percent evaluation should only be assigned for HCV when the condition is asymptomatic and the infection has healed.  Use the table below to determine when it is appropriate to assign a 0-percent evaluation for HCV. |

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| **If medical evidence shows...** | **Then a 0-percent disability evaluation is ...** |
| even mild symptoms related to HCV infection | not appropriate because the Veteran is symptomatic. |
| there is evidence of liver damage on liver function tests, liver biopsy, or other testing | not appropriate because this means the infection is not *healed*. |
| HCV has responded to therapy to the extent that RNA test results are negative and the Veteran is now asymptomatic with no evidence of liver damage | appropriate. However, HCV remains dormant in the system and may flare up again later. |

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| ***Reference***: For additional information on evaluation of HCV, see [38 CFR 4.114, DC 7354](http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=7c54c98c7be24cd2f7b05eabb45f8a87&ty=HTML&h=L&r=SECTION&n=se38.1.4_1114). |

#### 3. Genitourinary Conditions

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| Introduction | This topic contains information about evaluating genitourinary conditions, including   * deformity of the penis with loss of erectile power * entitlement to special monthly compensation (SMC) associated with erectile dysfunction (ED) * evaluating ED associated with multiple sclerosis or diabetes mellitus * determining SC for residuals of venereal disease or human immunodeficiency virus (HIV)-related illness * evaluating benign prostatic hypertrophy (BPH) * diagnosis of prostate cancer by biopsy * rating considerations for prostate cancer * considering SC for ED and entitlement to SMC due to prostate cancer * evaluating renal conditions using * blood urea nitrogen testing (BUN), and * creatinine * evaluating nephropathy * annual review of evaluations based on hemodialysis * use of an appliance and voiding dysfunction, and * considering claims for SC of kidney donation. |

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| a. Deformity of the Penis With Loss of Erectile Power | The following two requirements must be met before a 20-percent evaluation can be assigned for deformity of the penis with loss of erectile power under [38 CFR 4.115b, DC 7522](http://www.ecfr.gov/cgi-bin/text-idx?SID=4cc8543fd8f53bd5c478fce653e7430d&mc=true&node=se38.1.4_1115b&rgn=div8http://www.ecfr.gov/cgi-bin/text-idx?SID=4cc8543fd8f53bd5c478fce653e7430d&mc=true&node=se38.1.4_1115b&rgn=div8)   * deformity must be evident, and * the deformity *must* be accompanied by loss of erectile power.   ***Important***: The condition is *not* compensable in the absence of penile deformity. |

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| **b. Entitlement to SMC Associated With ED** | Entitlement to special monthly compensation (SMC) at the (k) rate for loss of use (LOU) of a creative organ due to erectile dysfunction (ED) is a factual determination. When the evidence shows LOU of a creative organ due to an SC condition, entitlement to SMC (k) will be awarded even though   * the Veteran can achieve erection and penetration with the use of medication, or * the Veteran had a vasectomy prior to the development of the LOU of a creative organ, as vasectomies may be reversible while LOU is not.   ***References***: For additional information on   * entitlement to SMC (k) for LOU of a creative organ, see * [38 CFR 3.350(a)(1)](http://www.ecfr.gov/cgi-bin/text-idx?SID=5d769dc0ed6f3118319651df52a3079c&mc=true&node=se38.1.3_1350&rgn=div8), and * M21-1, Part IV, Subpart ii, 2.H.4 * entitlement to SMC (k) associated with prostate cancer, see M21-1, Part III, Subpart iv, 4.I.3.h, and * evaluating ED, see * [38 CFR 4.115b, DC 7522](http://www.ecfr.gov/cgi-bin/text-idx?SID=c5cb25770aed6e2e512c2997757a9c9e&mc=true&node=se38.1.4_1115b&rgn=div8), and * M21-1, Part III, Subpart iv, 4.I.3.a. |

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| c. Evaluating ED Associated With Multiple Sclerosis or Diabetes Mellitus | When evaluating residuals of multiple sclerosis (MS) or diabetes mellitus (DM) and associated loss of erectile power is shown but penile deformity is not present, award SC for loss of erectile power rated with the disease process.  ***Example***: [38 CFR 4.119, DC 7913](http://www.ecfr.gov/cgi-bin/text-idx?SID=4cc8543fd8f53bd5c478fce653e7430d&mc=true&node=se38.1.4_1119&rgn=div8), diabetes mellitus with loss of erectile power. |

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| d. Determining SC for Residuals of Venereal Disease or HIV-Related Illness | Do ***not*** consider specific residuals of venereal disease or human immunodeficiency virus (HIV)-related illness to be the result of willful misconduct.  Determine SC for residuals of venereal disease or HIV-related illness by the same general principles applicable to resolution of the issue of SC for other diseases.  ***References***: For more information on   * willful misconduct and venereal disease, see [38 CFR 3.301(c)(1)](http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=7c54c98c7be24cd2f7b05eabb45f8a87&ty=HTML&h=L&r=SECTION&n=se38.1.3_1301) * considering claims for SC of human papillomavirus infection (HPV), see M21-1, Part III, Subpart iv, 4.I.4.f, and * disability or death from use of drugs, see M21-1, Part IV, Subpart ii, 2.K.3. |

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| **e. Evaluating BPH** | Benign prostatic hypertrophy (BPH) is generally evaluated under [38 CFR 4.115b, DC 7527](http://www.ecfr.gov/cgi-bin/text-idx?SID=6c3a70b2672bd39e52a4f1bf53f43098&mc=true&node=se38.1.4_1115b&rgn=div8) based on associated voiding dysfunction or urinary tract infection, but can be evaluated as renal dysfunction or obstructed voiding when applicable. Consider the following when rating BPH.   * BPH and some types of treatment for BPH, such as alpha blocker drugs, finasteride, or balloon dilation, can cause incontinence. * Retrograde ejaculation can result from some types of BPH treatment, especially transurethral resection of the prostate (TURP). * SMC (k) may be warranted if there is associated ED or retrograde ejaculation as a result of treatment or if hormone therapy is used. SMC entitlement is determined on a factual basis. |

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| **f. Diagnosis of Prostate Cancer by Biopsy** | A diagnosis of prostate cancer is made only on the basis of a prostate biopsy. An elevated prostate-specific antigen (PSA) test is ***not*** diagnostic of cancer. |

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| **g. Rating Considerations for Prostate Cancer** | The table below describes common treatments for prostate cancer as well as the side effects and rating considerations associated with the treatment. |

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| **Type of Treatment** | **Potential Side Effects** | **Rating Considerations** |
| watchful waiting   * also called * conservative management * observation, or * surveillance. * No immediate specific therapy is being used, but cancer is active. | * none, except for the continued presence and potential metastasis of cancer * often used when life expectancy is short due to age or other illness since prostate cancer is slow- growing. | * Review to confirm the continuation of active cancer previously confirmed by biopsy. * Evaluate at 100 percent, despite the lack of treatment and possible lack of symptoms. |
| radical prostatectomy surgery which is characterized by   * removal of prostate gland and seminal vesicles * most common treatment for localized cancer * can be curative, and * nerve-sparing procedure can be performed to improve chances that the patient will retain normal erectile function. | * impotence, and/or * incontinence. | * In all cases of radical prostatectomy, award SMC (k) for loss of use of a creative organ. * Consider SC for ED on a facts-found basis. |
| ***Cryotherapy***, also known as cryosurgery or cryoablation, is a procedure by which the prostate and nearby tissues are frozen with liquid nitrogen via probes in the perineum. | * impotence * incontinence * urethral scarring, and * rectourethral fistula (rare). | Consider SMC (k) on a facts-found basis. |
| Radiation   * can be curative if cancer is confined to the prostate and surrounding tissues and PSA is 15 nanograms (ng)/ml or less * is also used as palliative therapy to relieve symptoms of advanced cancer, such as bone pain due to metastasis * can be * internal radiation therapy, or brachytherapy, in which radioactive seeds are implanted in the prostate. * high dose radiation (HDR) seeds are implanted for less than a day and then removed. Radiation is present only while seeds are in place. * low dose radiation (LDR) seeds are permanently implanted and give off radiation for weeks to months, depending on the radioisotope used. * external radiation therapy, in which radiation is delivered by high-energy eternal radiation for six to eight weeks. | * after external beam radiation * impotence, and/or * incontinence * after brachytherapy * impotence * incontinence * bowel problems, and/or * urethral complications. | * After internal HDR * the radiation continues only for hours or days, so a six-month assignment of temporary 100 percent under [38 CFR 4.115b, DC 7528](http://www.ecfr.gov/cgi-bin/text-idx?SID=35ef52f6227f4eabafb59020ae1d9dbf&mc=true&node=se38.1.4_1115b&rgn=div8) is appropriate, and * consider SMC (k) for impotence on a facts-found basis. * After internal LDR * the effective radiation should be gone by one year * assign a 100-percent evaluation for one year, and * schedule a review exam six months following the cessation of the one-year treatment period.   ***Note***: If radiation is used only as palliative therapy in advanced cancer, the 100-percent evaluation will continue because the cancer will remain active. Therefore   * review for metastatic disease, and * consider permanency. |
| Hormone therapy is primarily for palliation of prostate cancer which is not confined to the prostate for the purpose of testosterone deprivation.    Types of hormone therapy include   * ***orchiectomy***, the removal of testes to prevent testosterone production * luteinizing hormone releasing hormone agonists (LHRH analogs), which can lower the testosterone as effectively as orchiectomy such as * Lupron (leuprolide) * Zoladex (goserelin), and * busrelin * estrogens or estrogen-like drugs, which lower the level of testosterone * second-line hormonal drugs, which are used when first-line hormone therapy fails * anti-androgens, which block the ability of the body to use androgens, such as * Eulexin (flutamide) * Casodex (bicalutamide), and * Nilandron (nilutamide), and * combined hormone therapy, which is an anti-androgen combined with orchiectomy or an LHRH agonist (analog). | * after any hormone therapy * hot flashes * osteoporosis * loss of muscle mass * after orchiectomy * impotence * sterility * loss of sex drive * after anti-androgen therapy * gastrointestinal upset * breast tenderness * gynecomastia * decreased libido * impotence * hot flashes * after LHRH analogs * impotence * hot flashes, and * gynecomastia. | * Orchiectomy results in anatomical loss of a creative organ; therefore * evaluate under [38 CFR 4.115b, DC 7524](http://www.ecfr.gov/cgi-bin/text-idx?SID=72261cd9b25e4292a9f5a93cf52f6aa3&mc=true&node=se38.1.4_1115b&rgn=div8), and * award SMC. * Hormone therapy may continue for many years; therefore * review treatment records for expected duration of treatment, and * consider permanence. |
| chemotherapy | Depending on the type of chemotherapy used, there are multiple possible side effects. | Chemotherapy is used for palliation as current agents will not eradicate prostate cancer; therefore   * evaluate as 100 percent * consider permanence * review for metastatic disease, and * if metastatic disease affects body systems other than the genitourinary system, award a separate evaluation for confirmed metastatic disease under the appropriate code for that body system. |

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| ***References***: For more information on   * assigning staged evaluations for prostate cancer, see * [*Tatum v. Shinseki*](http://vbaw.vba.va.gov/bl/21/advisory/DADS/2010dads/Tatum2.doc), 24 Vet.App 139, 141 (2010), and * M21-1, Part IV, Subpart ii, 2.J.e and f, and * considering entitlement to SC for ED and SMC for loss of use of a creative organ associated with prostate cancer, see M21-1, Part III, Subpart iv, 4.I.3.h. |

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| **h. Considering SC for ED and Entitlement to SMC Due to Prostate Cancer** | SC for prostate cancer does ***not*** automatically result in   * SC for ED, or * entitlement to SMC (k).   There are various treatments for prostate cancer, such as hormonal therapy, that may result in ED. General guidelines under [38 CFR 3.400](http://www.ecfr.gov/cgi-bin/text-idx?SID=f93b52b98906ac6c4e0978043b1b051a&mc=true&node=se38.1.3_1400&rgn=div8) should be followed when determining the effective date for ED.  ***Notes***:   * If ED is the basis for SMC (k), the effective date for the SMC will generally coincide with the date SC is awarded for ED. * Radical prostatectomy is a special case. In all cases where prostate cancer is treated with radical prostatectomy, award entitlement to SMC (k) for LOU of a creative organ without additional examination or medical opinion. * Radical prostatectomy results in loss of ejaculatory power and will warrant SMC (k) from the date of the procedure, assuming that the Veteran is already SC for prostate cancer from that date. * Entitlement to SC for ED associated with the radical prostatectomy is a separate factual determination. For the purposes of determining SMC entitlement following radical prostatectomy, it is irrelevant whether ED also exists at the time the SMC is awarded. |

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| **i. Evaluating Renal Conditions Using BUN** | Do not use elevated blood urea nitrogen (BUN) levels between 20mg% and 40mg% to support a finding of definite decrease in kidney function for assignment of a 60-percent disability evaluation for a renal disability. BUN values can vary due to many factors such as   * age and sex of the individual * blood loss through the gastrointestinal tract * use of steroids for treatment of other chronic diseases * level of hydration in the body, and * the prescription of too much protein for patients receiving intravenous nutrition in the hospital.   BUN testing is typically employed to screen for kidney disease or for a general assessment of the condition of the kidneys. BUN is analyzed with respect to the other laboratory values such as creatinine and the glomerular filtration rate (eGFR) to provide a better assessment of kidney function.  ***Important***:   * Elevated BUN of 40mg% or greater can be used to support an evaluation of 80 or 100 percent for renal disease as described in [38 CFR 4.115a](http://www.ecfr.gov/cgi-bin/text-idx?SID=bedbb0298fe1c799dee9a9811dfff0a0&mc=true&node=se38.1.4_1115a&rgn=div8). * When the BUN is elevated at greater than 20mg% but less than 40mg%, do ***not*** enter the BUN value in the Evaluation Builder or use this value alone to support a finding of definite decrease in kidney function. |

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| **j. Evaluating Renal Conditions Using Creatinine** | Creatinine is a normal breakdown product from muscle which  the kidneys cleanse from blood. As the kidneys become impaired, the creatinine level in the blood will increase due to poor clearance of creatinine by the kidneys.  Creatinine levels above normal but less than 4mg% are abnormal and  indicate decreased renal function that would warrant a 60-percent  evaluation.  ***Important***: Normal creatinine levels vary between men and women and by laboratory. The lab report should note the normal level used by that particular laboratory for the patient.  ***Example***: A Veteran files for an increased evaluation of his SC renal disease, evaluated as renal dysfunction. He submits a lab report, which notes the lab’s highest normal level is 1.2mg%. The Veteran’s results show a creatinine level of 1.4mg%.  ***Result***: Assign a 60-percent evaluation for renal dysfunction under [38 CFR 4.115b](http://www.ecfr.gov/cgi-bin/text-idx?SID=161568346b4bf24fe0bc758c70020db1&mc=true&node=se38.1.4_1115a&rgn=div8). |

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| **k. Evaluating Nephropathy** | The provisions of [38 CFR 4.115](http://www.ecfr.gov/cgi-bin/text-idx?SID=54c96c965aea2c1b50e0224171bc3e6e&mc=true&node=se38.1.4_1115&rgn=div8) pertaining to nephritis (which is an inflammation of the kidneys) do *not* apply when evaluating nephropathy because nephropathy and nephritis, are two distinct and separate clinical entities.  ***Important***: Nephropathy is generally defined as a condition encompassing disease or damage of the kidneys. Nephropathy is evaluated as renal dysfunction under [38 CFR 4.115a](http://www.ecfr.gov/cgi-bin/text-idx?SID=54c96c965aea2c1b50e0224171bc3e6e&mc=true&node=se38.1.4_1115a&rgn=div8). |

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| l. Annual Review of Evaluations Based on Hemodialysis | Each year regional offices (ROs) must review 100-percent evaluations that are based on the need for regular hemodialysis to determine whether the Veteran has discontinued hemodialysis because of kidney transplant surgery.  Follow the steps in the table below to perform this annual review. |

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| Step | Action |
| 1 | The RO receives 800-series Work Items for cases under its jurisdiction that contain a single 100-percent genitourinary evaluation. |
| 2 | The authorization activity   * establishes an end product (EP) 680 on each case under review, and * refers the case to the rating activity. |
| 3 | The rating activity reviews the claims folder.  Do the records show the Veteran has a single 100-percent genitourinary evaluation that is based on the need for regular hemodialysis?   * If *yes*, go to Step 4. * If *no*, * in a paper claims folder, date, initial, and annotate the write-out or Work Item *NAN (No Action Necessary)* * in an electronic claims folder (eFolder) in VBMS * utilize a working note within the bookmark function to date, initial, and annotate the write-out or Work Item *NAN*, and * include a permanent global note indicating the review of the hemodialysis evaluation has occurred, and * refer the case to the authorization activity to cancel (PCAN) the EP 680. (This ends the procedure.) |
| 4 | Is the evaluation protected under [38 CFR 3.951?](http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=7c54c98c7be24cd2f7b05eabb45f8a87&ty=HTML&h=L&r=SECTION&n=se38.1.3_1951)   * If *yes*, * in a paper claims folder, date, initial, and annotate the write-out or Work Item *Evaluation Protected Under 38 CFR 3.951,* * in an eFolder in VBMS * utilize a working note within the bookmark function to date, initial, and annotate the write-out or Work Item *Evaluation Protected Under 38 CFR 3.951*, and * include a permanent global note indicating the review of the hemodialysis evaluation has occurred, and * refer the case to the authorization activity to clear (PCLR) the EP 680. (This ends the procedure.) * If *no*, refer the case to the development activity. |
| 5 | The development activity advises the Veteran in a locally generated letter that   * compensation is based on a continuing need for hemodialysis, and * he/she must report the date and place of any kidney transplant surgery immediately after undergoing the procedure. |
| 6 | The development activity reviews the claims folder to identify the facility where the Veteran is last known to have received hemodialysis.  Do the records show the Veteran last received hemodialysis at a VA facility?   * If *yes*, * review the Veteran’s records in the Compensation and Pension Record Interchange (CAPRI) to confirm that hemodialysis is continuing or to obtain the date of kidney transplant surgery, if hemodialysis has been discontinued, and * go to Step 9. * If *no*, go to Step 7. |
| 7 | |  |  | | --- | --- | | **If the claims folder …** | **Then the development activity …** | | shows the name and address of a non-VA facility where the Veteran last received hemodialysis | sends the Veteran a[*VA Form (VAF) 21-4142, Authorization to Disclose Information to the Department of Veterans Affairs (VA)*](http://vbaw.vba.va.gov/bl/20/cio/20s5/forms/VBA-21-4142-ARE.pdf), and[*VAF 21-4142a, General Release for Medical Provider Information to the Department of Veterans Affairs (VA)*](http://vbaw.vba.va.gov/bl/20/cio/20s5/forms/VBA-21-4142a-ARE.pdf)*,* to authorize VA to obtain the private records. | | does *not* show the name and address of the facility where the Veteran last received hemodialysis | sends the Veteran a *VA Form 21-4142* and *VA Form 21-4142a* on which to   * provide the name and address of the facility furnishing hemodialysis, and * authorize VA to obtain the records. | |
| 8 | Upon receipt of the completed *VA Form 21-4142* and *VA Form 21-4142a*, the authorization activity contacts the facility that last furnished the Veteran hemodialysis to   * confirm hemodialysis is continuing, or * obtain the date of kidney transplant surgery, if hemodialysis has been discontinued.   ***Note***: If the Veteran does not return the *VA Form 21-4142* and *VA Form 21-4142a* within 60 days, initiate action to adjust the award under [38 CFR 3.652](http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=7c54c98c7be24cd2f7b05eabb45f8a87&ty=HTML&h=L&r=SECTION&n=se38.1.3_1652). |
| 9 | Following completion of development, the RO evaluates each case on the basis of facts found. The authorization activity   * dates, initials, and annotates the write-out or Work Item *EP 680* * promulgates the rating decision, if appropriate * notifies the Veteran of the action taken * PCLRs the EP 680, and * if reduction in evaluation under [38 CFR 3.105(e)](http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=7c54c98c7be24cd2f7b05eabb45f8a87&ty=HTML&h=L&r=SECTION&n=se38.1.3_1105) is necessary, establishes EP 600 for control of the adverse action proposal period. |

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| **m. Use of an Appliance and Voiding Dysfunction** | The term ***appliance***, as used in the criteria for voiding dysfunction under [38 CFR 4.115a](http://www.ecfr.gov/cgi-bin/text-idx?SID=f0927e0449515a9d9a73c8c631159550&mc=true&node=se38.1.4_1115a&rgn=div8), includes *all* types of catheters, as well as any other assistive device for urination.  ***Important***: Appliances, including catheters, may be used to treat urine leakage and/or urine retention. The rating activity should review the evidence carefully to determine whether the appliance is required to treat urine leakage or urine retention and evaluate on the predominant disability.  ***Example 1***: A Veteran is SC for a bladder injury. Medical records show a catheter is required for *urine leakage* due to the bladder injury.  ***Result***: A 60-percent evaluation should be assigned for this disability based on voiding dysfunction.  ***Example 2***: A Veteran is SC for a bladder injury. Medical records show a catheter is required for *urine retention* due to the bladder injury.  ***Result***: A 30-percent evaluation should be assigned for this disability based on obstructed voiding.  ***Reference***: For more information on ratings of the genitourinary system based on voiding dysfunction, see [38 CFR 4.115a](http://www.ecfr.gov/cgi-bin/text-idx?SID=f0927e0449515a9d9a73c8c631159550&mc=true&node=se38.1.4_1115a&rgn=div8). |

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| **n. Considering Claims for SC of Kidney Donation** | Kidney donation and any expected residual effects thereof are *not* subject to SC. Kidney donation is considered an elective surgery, and therefore, does not meet the provisions of a disease or injury incurred coincident with service.  ***Reference***: For more information about the principles relating to SC, see   * [38 CFR 3.303](http://www.ecfr.gov/cgi-bin/text-idx?SID=faf94b4af1bc629e74a43b1bdf68a224&mc=true&node=se38.1.3_1303&rgn=div8), and * M21-1, Part IV, Subpart ii, 2.B. |

#### 4. Gynecological Conditions

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| **Introduction** | This topic contains information about evaluating gynecological conditions including   * definition of Female Sexual Arousal Disorder (FSAD) * requesting examinations for FSAD claims * evaluating FSAD * considering claims for SC of fibrocystic breast disease * considering claims for SC of cervical dysplasia, and * considering claims for SC of HPV, and * considering claims for SC of elective breast surgery. |

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| **Change Date** | December 16, 2015 |

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| a. Definition: FSAD | ***Female Sexual Arousal Disorder (FSAD)*** is the lack of, or significantly reduced, sexual interest/arousal.  There are both psychological and biological causes of FSAD, and the two often overlap. |

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| **b. Requesting Examinations for FSAD Claims** | Use the table below to determine which examinations are necessary to evaluate a claim for FSAD. |

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| **If a Female Veteran Claims SC for...** | **Then ...** |
| FSAD or other sexual dysfunction and the examination threshold described in [38 CFR 3.159(c)(4)](http://www.ecfr.gov/cgi-bin/text-idx?SID=53b7538e3271abcd838e0d5d233834c7&mc=true&node=se38.1.3_1159&rgn=div8) is met | request a *VA Form 21-0969K-2, Gynecological Condition Disability Benefits Questionnaire* (DBQ).  Include a statement on the DBQ request directing the examiner to address whether the Veteran has a diagnosis of FSAD. |
| FSAD or sexual dysfunction as secondary to a mental health disability and the examination threshold described in [38 CFR 3.159(c)(4)](http://www.ecfr.gov/cgi-bin/text-idx?SID=53b7538e3271abcd838e0d5d233834c7&mc=true&node=se38.1.3_1159&rgn=div8) is met | order the appropriate mental health DBQ as well as the gynecological DBQ. |
| any gynecological condition and the examination threshold described in [38 CFR 3.159(c)(4)](http://www.ecfr.gov/cgi-bin/text-idx?SID=53b7538e3271abcd838e0d5d233834c7&mc=true&node=se38.1.3_1159&rgn=div8) is met | ask the examiner to determine whether FSAD is present. |

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| ***Important***: Include the following language in all gynecological exam requests, even if FSAD is not specifically claimed:  *Examiner: Please state whether the Veteran has a diagnosis of Female Sexual Arousal Disorder (FSAD). If additional examination(s) are required, please request and/or perform as necessary.*  ***Note***: If SC for FSAD is not expressly claimed, it will not be inferred unless a claim for sexual dysfunction or other gynecological disability can be reasonably interpreted as a claim for FSAD. |

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| c. Evaluating FSAD | When the requirements for SC are met, FSAD will be awarded as a stand-alone disability using [38 CFR 4.116, DC 7699-7611](http://www.ecfr.gov/cgi-bin/text-idx?SID=f93b52b98906ac6c4e0978043b1b051a&mc=true&node=se38.1.3_1400&rgn=div8) with a 0-percent evaluation.  This is the maximum evaluation available for FSAD.  ***Notes***:   * Entitlement to SMC (k) for loss of use of a creative organ will be inferred and awarded whenever SC for FSAD is granted. * If SC was previously established for FSAD but SMC was not awarded, place entitlement to SMC at issue and grant. The effective date for the award of SMC will be the date SC for FSAD was established. * The clarification that FSAD is a disorder subject to SC is not a regulatory change. Consequently, the provisions of [38 CFR 3.114](http://www.ecfr.gov/cgi-bin/text-idx?SID=bb790b7db78d279bd670911757fb42af&mc=true&node=se38.1.3_1114&rgn=div8) do not apply for assignment of the effective date. |

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| **d. Considering Claims for SC of Fibrocystic Breast Disease** | Do not routinely award SC for fibrocystic breast disease. Although this condition is termed a disease, it is actually a physiologic finding that is generally acute and transient. In the absence of associated pathology, SC is not warranted. Additionally, fibrocystic breasts are not associated with increased risk of breast cancer unless the changes are associated with atypical hyperplasia.  Examples of associated pathology that *may* warrant SC for fibrocystic breast disease are   * persistent lumps or thickening requiring surgical excision, or * fibrocystic breast changes with associated atypical hyperplasia.   Use the table below to determine when SC for pathology associated with claimed fibrocystic breast disease is warranted as well as the proper DC to use in the evaluation. |

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| **If the STRs Show…** | **And Medical Evidence Shows…** | **Then Award SC for…** |
| fibrocystic breasts | continuous symptoms and/or nexus to subsequent post-service excision of persistent lumps or thickening | residuals of surgery under appropriate DCs including     * the [38 CFR 4.118, DC 7800](http://www.ecfr.gov/cgi-bin/text-idx?SID=34f5be5bd7a22201187835c9489d743d&mc=true&node=se38.1.4_1118&rgn=div8) series for scars, and * [38 CFR 4.116, DC 7626](http://www.ecfr.gov/cgi-bin/text-idx?SID=235eda989da86f124d10851943899cce&mc=true&node=se38.1.4_1116&rgn=div8) for breast, surgery of. |
| fibrocystic breasts | * the (in-service or post-service) development of atypical hyperplasia associated with the fibrocystic breasts * subsequent development of breast cancer, and * nexus between the fibrocystic breasts with associated atypical hyperplasia and the development of breast cancer | breast cancer and/or residuals under appropriate DCs including   * [38 CFR 4.116, DC 7627](http://www.ecfr.gov/cgi-bin/text-idx?SID=235eda989da86f124d10851943899cce&mc=true&node=se38.1.4_1116&rgn=div8), or * [38 CFR 4.116, DC 7626](http://www.ecfr.gov/cgi-bin/text-idx?SID=235eda989da86f124d10851943899cce&mc=true&node=se38.1.4_1116&rgn=div8). |

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| **e. Considering Claims for SC of Cervical Dysplasia** | Do not routinely award SC for cervical dysplasia, also referred to as cervical intraepithelial neoplasia (CIN). Cervical dysplasia/CIN is not a disease or injury. It is a cellular abnormality of the cervix revealed by Papanicolaou (Pap) smear testing that generally resolves without treatment or residuals. In these cases, there is an abnormal laboratory finding but no disability, and SC is not warranted.  SC may be warranted if cervical dysplasia/CIN   * requires treatment that leaves residuals, or * is linked to the subsequent development of cervical cancer.   Use the table below to determine the appropriate actions to take when SC is claimed following an in-service confirmed finding of cervical dysplasia/CIN. |

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| **If Medical Evidence Shows the Subsequent Development of…** | **Then Award SC for…** | **Additional Information to Consider** |
| * chronic or severe dysplasia/CIN requiring treatment, *and* * chronic residuals of the required treatment | residuals of cervical dysplasia/CIN. | Common procedures for treatment of chronic or severe dysplasia/CIN include   * cauterization * laser surgery * cryosurgery, or * loop electrosurgical excision procedure (LEEP). |
| * cervical cancer, *and* * a link between the in-service dysplasia/CIN and the cancer | cervical cancer and/or residuals. | In-service cervical dysplasia that resolved without residuals is less likely to be related to later-developing cervical cancer. However, these cases require a medical opinion to determine whether a relationship exists between the conditions. |

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| ***Note***: Cervical dysplasia is often associated with human papillomavirus (HPV) infection. There are over 60 types of HPV infection, and only certain types are associated with high-grade cervical dysplasia and cancer.  ***Reference***: For more information on considering claims for SC of HPV and/or genital warts, see M21-1, Part III, Subpart iv, 4.I.3.f. |

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| **f. Considering Claims for SC of HPV** | Do not routinely award SC for HPV infection. Usually, HPV infections are asymptomatic and identified only as a finding on a Pap smear. Most resolve spontaneously without residuals requiring only periodic pap smears for follow-up. In these cases, there is an abnormal laboratory finding but no disability, and SC is not warranted.  SC may be warranted if a disability develops as a result of an in-service HPV infection. Two circumstances that may warrant SC are   * genital warts that are shown in service or by nexus to be associated with the HPV infection, and * HPV resulting in persistent infection that progresses to cervical dysplasia and subsequently to cervical cancer.   ***Important***: A medical nexus is required to establish an association between genital warts and in-service HPV infection or cervical cancer and in-service HPV infection.  ***Note***: There are multiple varieties of HPV infection which can cause common warts, plantar warts, and other findings. HPV is not limited to sexual transmission.  ***References***: For more information on   * considering claims for SC for cervical dysplasia, see M21-1, Part III, Subpart iv, 4.I.4.e, and * considering claims for SC associated with sexually transmitted diseases, see * [38 CFR 3.301(c)(1)](http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=7c54c98c7be24cd2f7b05eabb45f8a87&ty=HTML&h=L&r=SECTION&n=se38.1.3_1301), and * M21-1, Part III, Subpart iv, 4.I.3.d. |

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| **g. Considering Claims for SC of Elective Breast Surgery** | Breast surgeries that are not medically necessitated, such as reduction mammoplasty for cosmetic purposes, and any expected residual effects thereof, are *not* subject to SC. Such procedures are considered elective surgeries, and therefore, do not meet the provisions of a disease or injury incurred coincident with service.  ***Important***: If reduction mammoplasty is recommended to alleviate physical discomfort, such as back, shoulder, or neck pain, SC should be considered on the basis of aggravation only, and if so established, SMC (k) would be payable if the resultant tissue loss meets the requirements of the statute.  ***References***: For more information about   * principles relating to SC, see * [38 CFR 3.303](http://www.ecfr.gov/cgi-bin/text-idx?SID=faf94b4af1bc629e74a43b1bdf68a224&mc=true&node=se38.1.3_1303&rgn=div8), and * M21-1, Part IV, Subpart ii, 2.B * aggravation of pre-service disability, see * [38 CFR 3.306](http://www.ecfr.gov/cgi-bin/text-idx?SID=c2324cb278e04b66400e0e3d539f72a1&mc=true&node=se38.1.3_1306&rgn=div8), and * M21-1, Part IV, Subpart ii, 2.B.4, and * entitlement to SMC (k), see * [38 CFR 3.350(a)](http://www.ecfr.gov/cgi-bin/text-idx?SID=c2324cb278e04b66400e0e3d539f72a1&mc=true&node=se38.1.3_1350&rgn=div8), and * M21-1, Part IV, Subpart ii, 2.H.4. |

**5.** **Hemic and Lymphatic Conditions**

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| Introduction | This topic contains information about hemic and lymphatic conditions, including   * definition of sickle cell disease * definition of sickle cell anemia * definition of bone marrow transplant and stem cell transplant * inheritance of sickle cell trait * inheritance of sickle cell anemia * characteristics of sickle cell anemia * mechanism of inheritance of sickle hemoglobin * assigning a permanent and total evaluation for multiple myeloma * assigning a permanent and total evaluation for amyloid light chains (AL) amyloidosis (primary amyloidosis) * assigning a permanent and total evaluation for chronic lymphocytic leukemia (CLL) * review examinations of non-Hodgkin’s Lymphoma (NHL) and other persistent cancers * considering claims for SC of mycosis fungoides, and * evaluating mycosis fungoides. |

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| Change Date | January 28, 2016 |

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| a. Definition: Sickle Cell Disease | ***Sickle cell disease*** is a generic term for all disorders characterized by the presence of sickle hemoglobin (Hb S), in the red blood cells and includes   * sickle cell anemia * sickle cell trait, and * other hemoglobinopathies such as * sickle cell thalassemia, and * sickle-hemoglobin C disease.   ***Note***: The phenomenon of sickling of red blood cells is a hereditary abnormality that of itself usually produces few ill effects. |

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| b. Definition: Sickle Cell Anemia | ***Sickle cell anemia*** is a hereditary and familial disorder characterized clinically by symptoms of   * anemia * arthritis * leg ulcers, and * acute attacks of pain.   ***Note***: The age of onset is generally early childhood. |

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| c. Definition: Bone Marrow Transplant and Stem Cell Transplant | A ***bone marrow transplant***, also called a ***stem cell transplant***, is a procedure used to infuse healthy cells, called stem cells, into the body to replace damaged or diseased bone marrow.  ***Important***:There is no difference between a bone marrow transplant and a stem cell transplant; therefore, an SC hemic-lymphatic disability requiring a stem cell transplant should be evaluated by analogy to [38 CFR 4.117, DC 7716](http://www.ecfr.gov/cgi-bin/text-idx?SID=f07e5a8db80d2c2d4f3bce30a40c115a&mc=true&node=pt38.1.4&rgn=div5#se38.1.4_1117).  ***Notes***:   * Assign the 100-percent evaluation from the date of hospital admission and continue with a mandatory VA examination six months following hospital discharge. * Any change in evaluation based on that or any subsequent examination shall be subject to the provisions of [38 CFR 3.105(e)](http://www.ecfr.gov/cgi-bin/text-idx?SID=f07e5a8db80d2c2d4f3bce30a40c115a&mc=true&node=pt38.1.3&rgn=div5#se38.1.3_1105). * If no local recurrence or metastasis has occurred, then evaluate on residuals. |

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| d. Inheritance of Sickle Cell Trait | Inheritance of sickle cell trait may be from one or both parents.  If sickle hemoglobin is inherited from one parent and normal hemoglobin from the other, the combination (Hb S + Hb A) is referred to as sickle cell trait.  ***Note***: Except for unusual circumstances, this is a benign asymptomatic condition and is not associated with increased morbidity. |

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| e. Inheritance of Sickle Cell Anemia | The inheritance of sickle hemoglobin from each parent results in the combination (Hb S + Hb S), referred to as sickle cell anemia.  Sickle cell anemia is usually accompanied by   * moderate to severe anemia, and * appropriate clinical signs and symptoms, such as * enlargement of the heart * abnormalities of the musculoskeletal system * bone and joint pain, and/or * fever. |

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| f. Characteristics of Sickle Cell Anemia | Sickle cell anemia is a morbid state characterized by hemolytic anemia and the following manifestations   * the presence of peculiar sickle-shaped, or oat-shaped, red blood cells * signs of excessive blood destruction and active blood formation, and * repeated vaso-occlusive episodes. |

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| g. Mechanism of Inheritance of Sickle Hemoglobin | The presence of sickle hemoglobin, Hb S, a variant of the normal hemoglobin in human red blood cells, is subject to the usual mechanisms of biologic inheritance. |

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| **h. Assigning a Permanent and Total Evaluation for Multiple Myeloma** | Assign a permanent and total evaluation for multiple myeloma. Multiple myeloma is considered an incurable malignancy.  ***Notes***:   * This is a general rule, and there may be rare exceptions based on the facts in a particular case. If the evidence clearly shows that the multiple myeloma is no longer active, then a permanent and total evaluation is not warranted. * Consider ancillary benefits associated with the award of a permanent and total disability evaluation. * Multiple myeloma is a disability that is presumptively associated with herbicide exposure.   ***Reference***: For more information on rating disabilities associated with herbicide exposure, see M21-1, Part IV, Subpart ii, 2.C.3. |

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| **i. Assigning a Permanent and Total Evaluation for AL Amyloidosis** | Assign a permanent and total evaluation for amyloid light chains (AL) amyloidosis (primary amyloidosis). AL amyloidosis is considered incurable and progressive.  ***Notes***:   * Evaluate AL amyloidosis under [38 CFR 4.117, DC 7717](http://www.ecfr.gov/cgi-bin/text-idx?SID=92398e0de1640534d66e4a66e3188669&mc=true&node=se38.1.4_1117&rgn=div8). * Consider ancillary benefits associated with the award of permanent and total disability evaluations. * AL amyloidosis is a disability that is presumptively associated with herbicide exposure.   ***Reference***: For more information on rating disabilities associated with herbicide exposure, see M21-1, Part IV, Subpart ii, 2.c.3. |

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| **j. Assigning a Permanent and Total Evaluation for CLL** | Assign a permanent and total evaluation for chronic lymphocytic leukemia (CLL). CLL is considered an incurable malignancy.  ***Note***:   * Evaluate CLL under [38 CFR 4.117, DC 7703](http://www.ecfr.gov/cgi-bin/text-idx?SID=f93b52b98906ac6c4e0978043b1b051a&mc=true&node=se38.1.3_1400&rgn=div8). * Consider ancillary benefits associated with the award of a permanent and total disability evaluation. * CLL is a disability that is presumptively associated with herbicide exposure.   ***Reference***: For more information on rating disabilities associated with herbicide exposure, see M21-1, Part IV, Subpart ii, 2.C.3. |

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| **k. Review Examinations of NHL and Other Persistent Cancers** | When evaluating the need for a review examination six months following discontinuance of the treatment phase for non-Hodgkin’s lymphoma (NHL), or any other persistent cancer with a high mortality rate, consider that the various therapeutic treatment modalities may continue at intervals greater than the six-month period indicated in the note under [38 CFR 4.117, DC 7715](http://www.ecfr.gov/cgi-bin/text-idx?SID=bdbc1eef3a9816189007dd0ac2a2bc18&mc=true&node=se38.1.4_1117&rgn=div8).  If the disease has actively persisted for several years, thoroughly examine the medical record to determine whether the disease is   * actually in remission, or * still active and being regularly treated over extended periods of time.   Do ***not*** schedule a review examination unless the record clearly shows a long-term and stable remission.  ***Important***: Consider assigning a permanent and total evaluation when a provision under [38 CFR 3.327(b)(2)](http://www.ecfr.gov/cgi-bin/text-idx?SID=bdbc1eef3a9816189007dd0ac2a2bc18&mc=true&node=se38.1.3_1327&rgn=div8) applies.  ***Reference***: For more information about when not to schedule a review examination, see M21-1, Part III, Subpart iv, 3.B.2.c. |

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| **l. Considering Claims for SC of Mycosis Fungoides** | Mycosis fungoides is a cutaneous T-cell lymphoma which is a type of non-Hodgkin’s lymphoma (NHL). For the purposes of determining SC, the disease should be considered the same as NHL and subject to presumptive SC under the provisions of [38 CFR 3.309](http://www.ecfr.gov/cgi-bin/text-idx?SID=6390bb1b40e832f32444e98878fe1c38&mc=true&node=se38.1.3_1309&rgn=div8) as well as SC under [38 CFR 3.313](http://www.ecfr.gov/cgi-bin/text-idx?SID=6390bb1b40e832f32444e98878fe1c38&mc=true&node=se38.1.3_1313&rgn=div8).   * Mycosis fungoides often manifests as skin symptoms including * patches * plaques, or * tumors. * Treatment for mycosis fungoides depends on the involvement and staging and can range from * topical therapies such as ultraviolet/light therapy, to * the requirement for systemic chemotherapy or radiation in advanced stages.   ***Note***: If SC for mycosis fungoides was previously denied, the evidence of record at the time of the prior denial shows a diagnosis of mycosis fungoides and confirms the Veteran’s service in Vietnam, review the decision in accordance with [38 CFR 3.105(e)](http://www.ecfr.gov/cgi-bin/text-idx?SID=5f1da950188caf4374c9596d21a95802&mc=true&node=se38.1.3_1105&rgn=div8) and take appropriate action to correct the decision.  ***Reference***: For more information on clear and unmistakable error (CUE) determinations, see   * M21-1, Part III, Subpart iv, 2.B.4, and * M21-1, Part IV, Subpart ii, 3.A.2. |

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| **m. Evaluating Mycosis Fungoides** | For the purposes of evaluating SC mycosis fungoides, review the medical evidence to identify the manifestations of the disease and/or the treatment required. Mycosis fungoides can potentially be evaluated as   * skin malignancy under [38 CFR 4.118, DC 7715-7818](http://www.ecfr.gov/cgi-bin/text-idx?SID=6390bb1b40e832f32444e98878fe1c38&mc=true&node=se38.1.4_1118&rgn=div8), or * NHL under [38 CFR 4.117, DC 7715](http://www.ecfr.gov/cgi-bin/text-idx?SID=6390bb1b40e832f32444e98878fe1c38&mc=true&node=sg38.1.4_1116.sg9&rgn=div7).   Use the table below to determine whether to evaluate active mycosis fungoides under [38 CFR 4.118, DC 7715-7818](http://www.ecfr.gov/cgi-bin/text-idx?SID=6390bb1b40e832f32444e98878fe1c38&mc=true&node=se38.1.4_1118&rgn=div8) or [38 CFR 4.117, DC 7715](http://www.ecfr.gov/cgi-bin/text-idx?SID=6390bb1b40e832f32444e98878fe1c38&mc=true&node=sg38.1.4_1116.sg9&rgn=div7). |

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| **If Active Mycosis Fungoides...** | **Then Evaluate Under...** |
| manifests as cutaneous lesions only and treatment is confined to   * localized topical therapy only, or * surgery consisting of wide local excision or less extensive excision | [38 CFR 4.118, DC 7715-7818](http://www.ecfr.gov/cgi-bin/text-idx?SID=6390bb1b40e832f32444e98878fe1c38&mc=true&node=se38.1.4_1118&rgn=div8). |
| manifests as systemic disease with the requirement for therapy comparable to that for systemic malignancies such as   * chemotherapy * radiation therapy more extensive than to the skin, and/or * surgery more extensive than wide local excision | [38 CFR 4.117, DC 7715](http://www.ecfr.gov/cgi-bin/text-idx?SID=6390bb1b40e832f32444e98878fe1c38&mc=true&node=sg38.1.4_1116.sg9&rgn=div7). |