#### Department of Veterans Affairs M21-1, Part III, Subpart iv

**Veterans Benefits Administration January 14, 2016**

**Washington, DC 20420**

#### Key Changes

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| Changes Included in This Revision | The table below describes the changes included in this revision of Veterans Benefits Manual M21-1, Part III, “General Claims Process,” Subpart iv, “General Rating Process.”  ***Notes***: Minor editorial changes have also been made to   * update incorrect or obsolete references, and * bring the document into conformance with M21-1 standards. |

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| Reason(s) for the Change | Citation |
| To correct the reference linking the manual section that provides guidance on developing claims for acquired immunodeficiency syndrome (AIDS). | [Part III, Subpart iv, Chapter 4, Section C, Topic 3, Block b (III.iv.4.C.3.b)](#Top3blockB) |

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| Rescissions | None |

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| Authority | By Direction of the Under Secretary for Benefits |

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| Signature | Thomas J. Murphy, Director  Compensation Service |

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| Distribution | LOCAL REPRODUCTION AUTHORIZED |

## Section C. Infectious Diseases, Immune Disorders, and Nutritional Deficiencies

#### Overview

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

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| Topic | Topic Name |
| 1 | Tropical Diseases |
| 2 | Rheumatic Fever |
| 3 | Human Immunodeficiency Virus (HIV) Related Illness |
| 4 | Chronic Fatigue Syndrome (CFS) |

#### 1. Tropical Diseases

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| Introduction | This topic contains information about tropical diseases, including   * specific tropical diseases * obtaining information about tropical diseases * incubation periods of tropical diseases, and * considering service connection (SC) for tropical diseases not of record. |

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| Change Date | December 13, 2005 |

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| a. Specific Tropical Diseases | The following tropical diseases, among others, may require attention in view of their incidence in areas of foreign service   * bacterial infections, including * bacillary dysentery * cholera * Hansen’s disease (leprosy) * Oroya fever * pinta * plague * relapsing fever, and * yaws * viral infections, including yellow fever * roundworm parasitic infections, including * dracontiasis * filariasis (Bancroft’s type) * hookworm infection * loiasis, and * onchocerciasis, and * other parasitic infections, including * amebiasis * blackwater fever * leishmaniasis * malaria, and * schistosomiasis.   ***Notes***:   * Rate amebiasis and schistosomiasis under the digestive system. * Rate pinta, verruga peruana (a late residual of Oroya fever), onchoceriasis, oriental sore, and espundia (old world cutaneous and American mucocutaneous leishmaniasis) under diseases of the skin. |

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| b. Obtaining Information About Tropical Diseases | An understanding of the locality, incubation period, and residuals of tropical diseases may be obtained from standard treatises.  ***Reference***: For more information on tropical diseases, see [*The Merck Manual of Diagnosis and Therapy*](http://www.merckmanuals.com/professional/index.html). |

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| c. Incubation Periods of Tropical Diseases | The table below contains the incubation periods of some tropical diseases. |

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| Tropical Disease | Incubation Period |
| dracontiasis (Guinea worm disease) | 14 months |
| filariasis, Bancroft’s type | up to 8 to 12 months |
| kala-azar (visceral leishmaniasis) | up to one year |
| Hansen’s disease (leprosy) | five years or more |
| loiasis, calabar swelling | three years |
| oriental sore, old world cutaneous leishmaniasis | up to 18 months |

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| d. Considering SC for Tropical Diseases Not of Record | When considering service connection (SC) for tropical diseases *not* of record during service always   * consider tropical residence other than that during military service, and * consult standard texts for disease factors, such as * locality of confinement * early symptoms * course of the disease, and * periods of incubation.   ***Reference***:For more information on developing claims for SC for tropical diseases, see M21-1, Part IV, Subpart ii, 1.I.2. |

#### 2. Rheumatic Fever

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| Introduction | This topic contains information about rheumatic fever, including   * the definition of rheumatic fever * complications of rheumatic fever * the prognosis of rheumatic fever, and * considering the effects of rheumatic heart disease. |

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| Change Date | December 13, 2005 |

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| a. Definition: Rheumatic Fever | Rheumatic feveris an acute, subacute, or chronic systemic disease that, for unknown reasons, is self-limiting or may lead to slowly progressive valve deformity of the heart. |

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| b. Complications of Rheumatic Fever | Complications of rheumatic fever include   * cardiac arrhythmias * pericarditis * rheumatic pneumonitis * pulmonary embolism * pulmonary infarction * valve deformity, and * in extreme cases, congestive heart failure. |

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| c. Prognosis of Rheumatic Fever | The prognosis is good in cases of rheumatic fever.  If the age of onset is post-adolescence, residual heart damage   * occurs in less than 20 percent of the cases, and * is generally less severe than if the onset is during childhood.   ***Note***: Mitral valve insufficiency is the most common residual. |

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| d. Considering the Effects of Rheumatic Heart Disease | For more information on the effects of rheumatic heart disease, see M21-1, Part III, Subpart iv, 4.E.1.p. |

**3. HIV Related Illness**

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| Introduction | This topic contains information about HIV and related illness, including   * definition of HIV * residuals of HIV * how HIV infection is diagnosed * definition of CD4 T cells * how long it takes HIV infection to lead to acquired immunodeficiency syndrome (AIDS) * how HIV is transmitted * how HIV is not transmitted * treatment for HIV/AIDS * rating considerations for HIV-related illness, and * rating AIDS. |

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| Change Date | January 14, 2016 |

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| **a. Definition:**  **HIV** | ***Human immunodeficiency virus*** (HIV) is spread through body fluids that affect specific cells of the immune system, called CD4 cells, or T cells. Over time, HIV can destroy so many of these cells that the body cannot fight off infections and disease. |

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| **b. Residuals of HIV** | Acquired immunodeficiency syndrome (AIDS) is a secondary infection and results from HIV infection. It is not a single distinct disease, but rather a disorder characterized by a severe suppression of the immune system, rendering the body susceptible to and unable to fight off a variety of normally manageable infections, cancers, and other diseases.  AIDS patients suffer infections called “opportunistic” because they take the opportunity to attack when the immune system is weak. This may involve the intestinal tract, lungs, brain, eyes and other organs, as well as debilitating weight loss, diarrhea, and neurologic conditions. Some of the illnesses seen with advanced HIV infection include   * candidiasis * cervical cancer * herpes simplex or zoster (shingles)   Later stages of AIDS can develop some of the following   * HIV dementia – called AIDS dementia complex (ADC), involves damage to the central nervous system with early symptoms resembling depression and include apathy, loss of interest in surroundings, etc; later symptoms include cognitive and motor problems as well as memory loss. * HIV wasting syndrome – unintended and progressive weight loss of more than 10 percent of body weight, often accompanied by weakness, fever, nutritional deficiencies, and diarrhea * Kaposi’s sarcoma (KS) – an opportunistic cancer with multicentric lesions that appear on toes, feet, or nose, then slowly spread over the skin, increasing in size and number, and may involve the mouth and lymph nodes, and * Non-Hodgkins Lymphoma (NHL) – cancerous tumors of the lymphatic system which often develop outside the lymph nodes in the liver, bone marrow, stomach, brain, mouth, or anus.   ***References***: For more information on   * the Medical Electronic Performance Support System, see [Medical EPSS](http://cptraining.vba.va.gov/C&P_Training/Job_Aids/Medical_EPSS.htm) * HIV/AIDS residuals, see [HIV Basics | HIV/AIDS | CDC](http://www.cdc.gov/hiv/basics/index.html) * HIV/AIDS tests and treatment options, see [VA HIV/AIDS](http://www.hiv.va.gov/), and * HIV/AIDS claims development, see M21-1, Part IV, Subpart ii, 1.I.4. |

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| **c. How HIV Is Diagnosed** | HIV is primarily detected by testing a person’s blood for the presence of antibodies (disease-fighting proteins) to HIV. Two antibody tests ELISA (enzyme-linked immunosorbent assay) and Western blot assay (a confirmatory test) are used. An alternative test, IFA (indirect immunofluorescence assay), may also be used.  The ELISA and Western blot may be negative for as long as three to six months after exposure to HIV.  If a person is highly likely to be infected with HIV, but both tests are negative, a test for the presence of HIV itself in the blood may be done. |

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| **d. Definition: CD4 T Cells** | A ***CD4 T*** ***cell*** is a type of lymphocyte, the white blood cell that bears the major responsibility for the activities of the immune system. The other major type is the B cell. Together, they fight off invading viruses, bacteria, parasites, and fungi. The "T4," "helper-T," or "CD4" cell helps regulate and direct immune activity.  A healthy, uninfected person has 800-1200 (or 500 to 1500 by some references) CD4 T cells per cubic millimeter of blood.   * During HIV, the number of these cells in the blood progressively declines. * When the count falls below 200, the person is vulnerable to the opportunistic infections and cancers that typify AIDS. |

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| **e. How Long it Takes HIV to Lead to AIDS** | The median time for progression of HIV to AIDS has been about 10 years. However, this varies widely. About 10 percent progress to AIDS within two to three years, while 5 to10 percent have no symptoms even after 12 years. |

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| **f. How HIV Is Transmitted** | Major means of transmission are   * sexual contact * infected blood, and * needle stick accidents. |

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| **g. How HIV Is *Not* Transmitted** | No evidence exists that HIV is transmitted through   * saliva, sweat, tears, urine, or feces * casual contact such as the sharing of food utensils, towels and bedding, swimming pools, telephones, or toilet seats, or * biting insects such as mosquitoes, flies, ticks, fleas, bees, wasps, or bedbugs. |

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| **h. Treatment for HIV/AIDS** | In 1996 the advent of potent combination antiretroviral therapy (ART), sometimes called HAART (highly active antiretroviral therapy) or cART (effective combination antiretroviral therapy), changed the course of the HIV epidemic.  These drugs significantly improved life expectancy from months to decades. However, they have short-term adverse effects and long-term complications.  ***References***: For more information on   * treatment options, see [www.cdc.gov/hiv](http://www.cdc.gov/hiv/prevention/research/tap/) * medication side effects, see [http://aidsinfo.nih.govsideeffectanithivmeds](http://aidsinfo.nih.gov/contentfiles/sideeffectanithivmeds_cbrochure_en.pdf). |

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| **i. Rating**  **Considerations**  **for HIV** | Only HIV patients with no symptoms from HIV or its treatment should be rated at 0 percent. While CD4 counts are part of the rating criteria, these counts can be modified by treatment. Evaluation should be based on the disabling signs and symptoms rather than on the laboratory finding alone.  When rating an HIV case, the term “approved medication(s)” includes medications prescribed as part of a research protocol at an accredited medical institution.  For patients on HAART   * a number of side effects and complications are likely, and * it will be the unusual case where less than 30 percent level of disability evaluation will be warranted.   An evaluation of 30 percent should be the minimum if there are recurrent constitutional symptoms, even if they have responded to appropriate treatment.  In rating later stages, but *before* AIDS develops, consider the following   * rating may be based on diagnostic code (DC) 6351 criteria only ([38 CFR 4.88b](http://www.ecfr.gov/cgi-bin/text-idx?SID=b24d4b4bbeed8036aa9263ef5ebeb4a1&node=se38.1.4_188b&rgn=div8)), or * separate evaluations may be warranted under the appropriate diagnostic codes if other defined conditions due to HIV infection or its treatment develop. This could include psychiatric or central nervous system, opportunistic infections, and neoplasms.   ***Examples***:   * With enlarged lymph nodes and fatigue, 10 percent might be appropriate, depending on the severity of fatigue. But if there is pelvic inflammatory disease (PID) that does not respond to treatment, 30 percent or more might be called for. * If there is a CD4 count of 400, the Veteran is on HAART, and there are symptoms of depression but no other significant signs or symptoms of the infection or its treatment, it would be appropriate to assign 10 percent. However, if the depression rises to the level of a diagnosed major depression or dysthymic disorder, consider evaluating it separately as a secondary condition, with the potential of a higher rating. The HIV infection would still warrant a 10 percent evaluation under 6351, based on findings not related to symptoms of depression—low CD4 count and treatment.   ***Note***: If there is evidence indicating that the HIV-related illness was the result of intravenous drug abuse, ensure that the authorization activity has conducted a Line of Duty/Willful Misconduct administrative decision prior to rating.  ***References***: For more information on   * rating HIV/AIDS, see [38 CFR 4.88b Schedule of Ratings-Infectious Diseases, Immune Disorders and Nutritional Deficiencies](http://vbaw.vba.va.gov/bl/21/Publicat/Regs/Part4/4_88b.htm) * avoidance of pyramiding, see [38 CFR 4.14](http://www.ecfr.gov/cgi-bin/text-idx?SID=557fe860e9ed20916f342aeec564b03b&mc=true&node=se38.1.4_114&rgn=div8) * multiple evaluations and pyramiding, see [Esteban v. Brown](http://vbaw.vba.va.gov/bl/21/advisory/CAVCDAD.htm#bme), 6 Vet.App. 259 (1994) * information on HIV/AIDS, see [Medical EPSS](https://www.ttande.org/CPTraining/Job_Aids/Medical_EPSS.htm), and * willful misconduct and line of duty determinations, see M21-1, Part III, Subpart v, 1.D. |

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| **j. Rating AIDS** | Once AIDS develops the range of possible ratings is wide, depending on specific findings. |

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| **In instances of...** | **Note that...** |
| opportunistic infections | * once an opportunistic infection or neoplasm appears, the rating will be 60 percent or above * many of the opportunistic infections will warrant a 100 percent evaluation, at least for a time (TB, lymphoma, etc.), and * special monthly compensation (SMC) will be a frequent consideration. |
| cancer | it should be rated separately, if advantageous to the Veteran, as long as its symptomatologies are not also used to support a 60 or 100-percent evaluation under DC 6351. |
| episodic problems | * the possibility exists that a particular examination may have been done at a time between episodes of opportunistic infections when findings are relatively few, and * the overall history for the past year or so should be considered when rating, since some AIDS complications can be episodic. |

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| ***References***: For more information on,   * rating evaluations, see [38 CFR 4.88b Schedule of Ratings-Infectious Diseases, Immune Disorders and Nutritional Deficiencies](http://vbaw.vba.va.gov/bl/21/Publicat/Regs/Part4/4_88b.htm) * treatment options, see * [HIV Basics | HIV/AIDS | CDC](http://www.cdc.gov/hiv/basics/index.html) * [VA HIV/AIDS](http://www.hiv.va.gov/), and * [Medical EPSS](https://www.ttande.org/CPTraining/Job_Aids/Medical_EPSS.htm). |

**4. Chronic Fatigue Syndrome (CFS)**

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| Introduction | This topic contains information about chronic fatigue syndrome, including   * definition of CFS, and * rating considerations for CFS. |

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| Change Date | April 24, 2015 |

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| **a. Definition:**  **CFS** | ***Chronic fatigue syndrome*** (CFS) is a complex, multisymptom, debilitating illness characterized by physical and mental manifestations. |

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| **b. Rating**  **Considerations**  **for CFS** | When rating a CFS case, keep in mind that a diagnosis requires the following:   * new onset of debilitating fatigue severe enough to reduce daily activity to less than 50 percent of the usual level for at least six months, and * the exclusion, by way of a thorough evaluation, of all other clinical conditions that may produce similar symptoms based on history, physical examination, and laboratory tests.   In addition, six or more of the following criteria must be met   * acute onset of the condition * low grade fever * sore throat with no secretions (nonexudative pharyngitis) * palpable or tender cervical or axillary lymph nodes * generalized muscle aches or weakness * fatigue lasting 24 hours or longer after exercise * headaches (of a type, severity, or pattern that is different from headaches in the pre-morbid state) * migratory joint pains * neuropsychological symptoms, and * sleep disturbance   ***Reference***: For more information on CFS, see   * [38 CFR 4.88a](http://www.ecfr.gov/cgi-bin/text-idx?SID=ae97f740618da48a7a1781cd4615b1f4&node=se38.1.4_188a&rgn=div8) * [38 CFR 4.88b](http://www.ecfr.gov/cgi-bin/text-idx?SID=ae97f740618da48a7a1781cd4615b1f4&node=se38.1.4_188b&rgn=div8) * [Medical EPSS](https://www.ttande.org/CPTraining/Job_Aids/Medical_EPSS.htm), and * M21-1, Part IV, Subpart ii, 2.D.1.i. |