INDEX TO APPENDICES

NOTE: This order is nonprecedential.

United States Court of Appeals for the Federal Circuit

BURFORD EARL FREDERICK,
Claimant-Appellant

v.

DENIS MCDONOUGH, Secretary of Veterans Affairs,
Respondent-Appellee

2024-1539

Appeal from the United States Court of Appeals for Veterans Claims in No. 20-2112, Judge Scott Laurer.

ON MOTION

Before STOLL, CUNNINGHAM, and STARK, *Circuit Judges*.

PER CURIAM.

O R D E R

The Secretary of Veterans Affairs moves to waive the requirements of Federal Circuit Rule 27(f) and to dismiss this appeal for lack of jurisdiction on timeliness grounds.

ECF No. 9. Burford Earl Frederick states that he wants to "continue to pursue his appeal." ECF No. 10 at 1.[1]

The United States Court of Appeals for Veterans Claims entered judgment in this case on May 27, 2021, and received Mr. Frederick's notice of appeal 999 days later on February 20, 2024. To be timely, a notice of appeal must be "within the time and in the manner prescribed for appeal" from a district court to a court of appeals, which is 60 days. 38 U.S.C. § 7292(a); *see* 28 U.S.C. § 2107(b); Fed. R. App. P. 4(a)(1)(B); Fed. Cir. R. 1(a)(1)(D). Like appeals from district courts, the statutorily prescribed time for filing appeals from the Court of Appeals for Veterans Claims is jurisdictional. *See Wagner v. Shinseki*, 733 F.3d 1343, 1348 (Fed. Cir. 2013); *see also Henderson v. Shinseki*, 562 U.S. 428, 438–39 (2011) ("Because the time for taking an appeal from a district court to a court of appeals in a civil case has long been understood to be jurisdictional, th[e] language [of § 7292(a)] clearly signals an intent to impose the same restrictions on appeals from the [Court of Appeals for Veterans Claims] to the Federal Circuit." (citation omitted)). Because Mr. Frederick's notice of appeal was not filed within 60 days of the judgment, this court lacks jurisdiction and must dismiss.

Upon consideration thereof,

IT IS ORDERED THAT:

(1) The Secretary's motion to dismiss, ECF No. 9, is granted to the extent that the appeal is dismissed.

(2) ECF No. 3 is deemed withdrawn.

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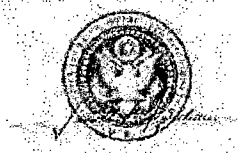
[1] Mr. Frederick also asks the court to "dismiss his motion to expedite review of his appeal." *Id.* That motion, ECF No. 3, is deemed withdrawn.

(3) Each side shall bear its own costs.

FOR THE COURT



June 25, 2024
Date

Jarrett B. Perlow
Clerk of Court

NOTE: This order is nonprecedential.

United States Court of Appeals for the Federal Circuit

BURFORD EARL FREDERICK,
Claimant-Appellant

v.

DENIS MCDONOUGH, SECRETARY OF VETERANS AFFAIRS,
Respondent-Appellee

2024-1539

Appeal from the United States Court of Appeals for Veterans Claims in No. 20-2112, Judge Scott Laurer.

ON PETITION FOR PANEL REHEARING

Before STOLL, CUNNINGHAM, and STARK, *Circuit Judges.*[1]

PER CURIAM.

ORDER

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[1] Circuit Judge Newman did not participate.

On July 8, 2024, Burford Earl Frederick filed a petition for panel rehearing [ECF No. 14].

Upon consideration thereof,

IT IS ORDERED THAT:

The petition for panel rehearing is denied.

FOR THE COURT

July 25, 2024
Date

Jarrett B. Perlow
Clerk of Court

United States Court of Appeals for the Federal Circuit

BURFORD EARL FREDERICK,
Claimant-Appellant

v.

DENIS MCDONOUGH, SECRETARY OF VETERANS AFFAIRS,
Respondent-Appellee

2024-1539

Appeal from the United States Court of Appeals for Veterans Claims in No. 20-2112, Judge Scott Laurer.

MANDATE

In accordance with the judgment of this Court, entered June 25, 2024, and pursuant to Rule 41 of the Federal Rules of Appellate Procedure, the formal mandate is hereby issued.

FOR THE COURT

August 16, 2024
Date

Jarrett B. Perlow
Clerk of Court

Designated for electronic publication only

UNITED STATES COURT OF APPEALS FOR VETERANS CLAIMS

No. 20-2112

BURFORD EARL FREDERICK, APPELLANT,

V.

DENIS MCDONOUGH,
SECRETARY OF VETERANS AFFAIRS, APPELLEE.

Before LAURER, *Judge*.

MEMORANDUM DECISION

Note: Pursuant to U.S. Vet. App. R. 30(a), this action may not be cited as precedent.

LAURER, *Judge*: Self-represented United States Marine Corps veteran Burford Earl Frederick appeals a December 3, 2019, Board of Veterans' Appeals (Board) decision denying service connection for residuals of rheumatic fever, to include a heart disorder, and for gout of the bilateral lower extremities, to include as secondary to residuals of rheumatic fever. Appellant argues that the Board erred in finding that he had no residuals of rheumatic fever and that his gout was unrelated to service. The Secretary disagrees. Because the Board had a plausible basis for finding that appellant's conditions did not relate to service, the Court affirms.

I. ANALYSIS

Establishing service connection generally requires evidence of (1) a current disability, (2) incurrence or aggravation of a disease or injury in service, and (3) a nexus between the claimed in-service disease or injury and the current disability.[1] Whether the record establishes entitlement to service connection is a finding of fact that the Court reviews under the "clearly erroneous"

[1] *See Holton v. Shinseki*, 557 F.3d 1362, 1366 (Fed. Cir. 2009); *Shedden v. Principi*, 381 F.3d 1163, 1166-67 (Fed. Cir. 2004); 38 C.F.R. § 3.303 (2020).

standard of review.[2] A finding of fact is clearly erroneous when the Court, after reviewing the entire evidence, "is left with the definite and firm conviction that a mistake has been committed."[3] The Board must explain its findings and conclusions on all material issues of fact and law.[4] Appellant "always bears the burden of persuasion."[5] That said, when an appellant is self-represented, the Court will liberally interpret the informal brief.[6]

A. Residuals of Rheumatoid Arthritis

The Board found that, while appellant had rheumatic fever in service and has a current heart condition, he did not have any current residuals of rheumatic fever and the evidence failed to show that his heart condition was related to service.[7] The Board noted that his rheumatic fever resolved in service and did not involve the heart.[8] Because there were no residuals of rheumatoid arthritis and no evidence of a nexus between his heart condition and service, the Board had a plausible basis for denying service connection.[9]

In denying service connection, the Board relied on the findings and opinions provided by an examiner in two July 2019 disability benefits questionnaires.[10] The examiner found that appellant's rheumatic fever resolved in 1964 and that his rheumatic fever was unrelated to his heart condition.[11] The examiner opined that appellant's heart condition had no relation to rheumatic fever, explaining that rheumatic heart disease involved the valves of the heart and appellant did not have any valve condition.[12] The Court notes that, while appellant argues that his 2011 and 2016 compensation and pension (C&P) exams were inadequate, he provides no support for this

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[2] *See Russo v. Brown*, 9 Vet.App. 46, 50 (1996).

[3] *United States v. U.S. Gypsum Co.*, 333 U.S. 364, 395 (1948); *see Gilbert v. Derwinski*, 1 Vet.App. 49, 52 (1990).

[4] *Allday v. Brown*, 7 Vet.App. 517, 527 (1995).

[5] *Berger v. Brown*, 10 Vet.App. 166, 169 (1997); *see Hilkert v. West*, 12 Vet.App. 145, 151 (1999) (en banc), *aff'd per curiam*, 232 F.3d 908 (Fed. Cir. 2000) (table).

[6] *See De Perez v. Derwinski*, 2 Vet.App. 85, 86 (1992).

[7] Record (R.) at 9-18.

[8] R. at 12; *see* R. at 424-25 (December 1964 separation exam reflecting no abnormalities of the heart or lower extremities), 433 (April 1961 service medical record showing a diagnosis of "rheumatic fever, active, without heart involvement").

[9] *Shedden*, 381 F.3d at 1166-67; *Gilbert*, 1 Vet.App. at 52.

[10] R. at 16-18.

[11] R. at 114-15, 129; *see* R. at 424-25, 433.

[12] R. at 129.

argument.[13] And the Board specifically found these exams to be less probative than the 2019 C&P exam, which it found to be "very probative."[14] Thus, even if there were problems with the 2016 and 2011 exams, they would appear harmless when the Board focused on the 2019 C&P exam.

Appellant's remaining arguments mostly focus on showing that he had symptoms of rheumatic fever in service—that he alleges were not treated properly—and that he has current difficulties with his heart. But these do not show that he has any current residuals of rheumatic fever or that his heart condition relates to service, nor do they contradict the Board's findings.[15] While appellant also cites a Social Security Administration record, the document lists his impairments as "rheumatoid arthritis coronary artery disease and pain" but does not reflect a medical opinion linking any of those impairments together or to any other condition.[16] While appellant states that some in-service records are unavailable or inadequate, he affirmatively stated that VA did not fail to obtain any record.[17] He also fails to show how those records could help substantiate his claim.[18]

And for his lay statements that his heart condition is related to his in-service rheumatic fever, the Board addressed these statements and explained that, while he was competent to report symptoms, he was not competent to prove nexus.[19] Appellant contends that he is competent to report symptoms, but this is not in dispute.[20] And he makes no argument that the Board erred in finding that he was not competent to opine on nexus. Besides contending that his conditions are related to service, appellant also presents no argument about the Board's findings. This is not

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[13] *See Berger*, 10 Vet.App. at 169.

[14] R. at 16-17.

[15] The Court notes that, although appellant argues that his heart condition and gout were aggravated by his non-service-connected, in-service rheumatic fever, the evidence reflects that he did not have residuals of rheumatic fever at separation and that his heart condition and gout began years after service. As appellant's heart condition and gout did not preexist service and his rheumatic fever resolved upon separation, a theory of aggravation is not relevant to appellant's claims.

[16] Appellant's Informal Brief (Br.) at 2, 8, 13; R. at 711.

[17] Appellant's Informal Br. at 2, 12-13.

[18] *Hilkert*, 12 Vet.App. at 151.

[19] R. at 18 (citing *Jandreau v. Nicholson*, 492 F.3d 1372 (Fed. Cir. 2007) (recognizing that lay evidence can be competent and sufficient to establish a diagnosis of a condition when a layperson is competent to identify the medical condition, or reporting a contemporaneous medical diagnosis, or the lay testimony describing symptoms at the time supports a later diagnosis by a medical professional)).

[20] Appellant's Informal Br. at 17; *see* R. at 17-18.

enough for the Court to remand. Though the Court must liberally construe appellant's brief, the Court generally affirms the Board's decision when an appellant fails to meaningfully dispute the Board's findings.[21] Because appellant provided insufficient arguments and because the Court's own review shows that the Board did not err, the Court affirms.

B. Gout of the Bilateral Lower Extremities

For similar reasons, the Court sees no error in the Board's analysis of the gout claim. Appellant again makes no argument that the Board overlooked evidence or misapplied the law when it found that appellant's gout is not related to service. As the Board noted, like his claim for residuals of rheumatoid arthritis, no medical evidence reflected a relation between his gout and service.[22] Although appellant asserts that his gout should be service connected on a secondary basis, he fails to identify error in the Board's denial.[23] There is thus no basis for secondary service connection. With no assertion of error in the Board's analysis, and a review of the Board's decision showing it had a plausible basis, the Court affirms.

II. CONCLUSION

For these reasons, the Court AFFIRMS the Board's December 3, 2019, decision.

DATED: May 3, 2021

Copies to:

Burford Earl Frederick

VA General Counsel (027)

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[21] *See Coker v. Nicholson*, 19 Vet.App. 439, 442 (2006) (per curiam), *rev'd on other grounds sub nom. Coker v. Peake*, 310 F. App'x 371 (Fed. Cir. 2008) (per curiam order).

[22] R. at 17, 24.

[23] 38 C.F.R. § 3.310(a) (2020) (allowing for secondary service connection when a service-connected condition causes or aggravates a non-service-connected condition).

DEPARTMENT OF VETERANS AFFAIRS
Board of Veterans' Appeals
Washington, DC

February 7, 2024

In Reply Refer To: 01C22838
SS XXX XX 9117
FREDERICK, Burford E

Burford Earl Frederick
14469 Marvin Street
Taylor, MI 48180

Ruling on Motion

Dear Mr. Frederick:

This letter responds to your Motion for Clear and Unmistakable Error (CUE) of the Board of Veterans' Appeals (Board) decision of December 3, 2019. The Motion was dated March 6, 2023, and received at the Board on March 9, 2023. I have been delegated the authority to rule on the Motion. *See* 38 C.F.R. § 20.109(b).

On May 23, 2020, a Notice of Appeal was filed with the United States Court of Appeals for Veterans Claims (Court). On March 3, 2021, the Court affirmed the Board's decision of December 3, 2019. A decision of the Court is final, and there is no further avenue of appeal except to the United States Court of Appeals for the Federal Circuit. *See Winsett v. Principi*, 341 F.3d 1329, 1331-32 (Fed. Cir. 2003) ("[I]f a superior court, such as the Court of Appeals for Veterans Claims, affirms the determination of the Board on a particular issue, that Board decision is replaced by the Court of Appeals for Veterans Claims decision on that issue. Thus, there is no longer any decision by the Board that can be subject to revision."). As a result, your Motion for CUE is dismissed.

If you would like to file a new claim, or a supplemental claim, you may submit that claim and any pertinent evidence to your local VA regional office. I hope this information is helpful to you.

Sincerely,

Tamia N. Gordon

Tamia N. Gordon
Deputy Vice Chairman
Board of Veterans' Appeals

cc: Veterans of Foreign Wars of the United States

BOARD OF VETERANS' APPEALS

Date: February 9, 2024 SS XXX XX 9117

BURFORD E. FREDERICK
14469 MARVIN ST
TAYLOR, MI 48180-6520

Dear Appellant:

The Board of Veterans' Appeals made a decision on your appeal.

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

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

Sincerely yours,

Outbound Operations
Office of the Clerk of the Board
Board of Veterans' Appeals

Enclosures (1)
CC: Veterans of Foreign Wars of the United States

BOARD OF VETERANS' APPEALS

IN THE APPEAL OF
BURFORD EARL FREDERICK
Represented by
Veterans of Foreign Wars of the United States

SS XXX XX 9117
Docket No. 231017-387362
Advanced on the Docket

DATE: February 9, 2024

ORDER

New and relevant evidence has not been submitted and the appeal to readjudicate the claim for service connection for coronary artery disease (CAD), to include as a residual of rheumatic fever, is denied.

New and relevant evidence has not been submitted and the appeal to readjudicate the claim for service connection gout of the bilateral lower extremities, to include as a residual of rheumatic fever, is denied.

FINDINGS OF FACT

1. Evidence submitted since the May 2021 Memorandum Decision is new but it is not relevant to the claim of service connection for CAD, to include as a residual of rheumatic fever, because it does not tend to prove or disprove a matter at issue.

2. Evidence submitted since the May 2021 Memorandum Decision is new but it is not relevant to the claim of service connection for gout of the bilateral lower extremities, to include as a residual of rheumatic fever, because it does not tend to prove or disprove a matter at issue.

CONCLUSIONS OF LAW

1. The criteria for readjudicating the claim of service connection for CAD, to include as a residual of rheumatic fever, have not been met. 38 C.F.R. §§ 3.156, 3.2501.

2. The criteria for readjudicating the claim of service connection for gout of the bilateral lower extremities, to include as a residual of rheumatic fever, have not been met. 38 C.F.R. §§ 3.156, 3.2501.

REASONS AND BASES FOR FINDINGS AND CONCLUSIONS

The Veteran served on active duty in the Marine Corps from December 1960 to December 1964.

This matter is before the Board of Veterans' Appeals (Board) on appeal of a March 2023 rating decision of the Department of Veterans Affairs (VA) Regional Office (RO) through submission of an October 2023 VA Form 10182 with election of the evidence submission docket.

In an appropriate period of time, the Veteran communicated that he wished to switch this appeal to the direct review docket. The Veteran was notified that this request was approved per a January 2024 AMA Notification Letter.

Therefore, the Board may only consider the evidence of record at the time of the agency of original jurisdiction (AOJ) decision on appeal. 38 C.F.R. § 20.301. Any evidence submitted after the AOJ decision on appeal cannot be considered by the Board. 38 C.F.R. §§ 20.300, 20.301, 20.801.

If the Veteran would like VA to consider any evidence that was submitted that the Board could not consider, the Veteran may file a Supplemental Claim (VA Form 20-0995) and submit or identify this evidence. 38 C.F.R. § 3.2501. If the evidence is new and relevant, VA will issue another decision on the claim[s], considering the new evidence in addition to the evidence previously considered. *Id.* Specific instructions for filing a Supplemental Claim are included with this decision.

The Board acknowledges a contention made by the Veteran in a December 2022 correspondence that there was clear and unmistakable error (CUE) in an April 2012 rating decision that denied the service connection claims on appeal. The Board does not have jurisdiction to adjudicate assertions of CUE in RO decisions in the first instance. *See Jarrell v. Nicholson*, 20 Vet. App. 326, 334 (2006) (en banc) (assertion of CUE in a RO decision must first be presented to and decided by the RO before the Board has jurisdiction to decide the matter). Therefore, an allegation of CUE in a prior rating decision is not currently before the Board. The Veteran is advised that if he wants VA to consider whether there is CUE in a prior rating decision, he will need to submit a formal claim. *See* 38 C.F.R. § 3.105(a) (defining what constitutes CUE).

The Board notes that the AOJ requested the Veteran submit any relevant private treatment records or submit information with which VA can assist the Veteran in obtaining private treatment records. VA requested records for which the Veteran submitted a proper release. The duty to assist is not a one-way street. If a Veteran desires help, he cannot passively wait for it in those circumstances where he may or should have information that is essential in obtaining evidence. *Wood v. Derwinski*, 1 Vet. App. 190 (1991). Thus, the Board finds that VA has satisfied the duty to assist. No further notice or assistance to the Veteran is required to fulfill VA's duty to assist in development. *Smith v. Gober*, 14 Vet. App. 227 (2000); *Dela Cruz v. Principi*, 15 Vet. App. 143 (2001); *Quartuccio v. Principi*, 16 Vet. App. 183 (2002).

The standard set forth in 38 C.F.R. § 3.103(c)(2)(iii) only permits constructive receipt of Veterans Health Administration (VHA) records that not only existed prior to the issuance of the AOJ decision on appeal, but also for which the claimant furnished sufficient information to make the Veterans Benefits Administration (VBA) aware of the existence of those records. Thus, the Board's consideration of VHA records is limited to the same. Here, the Board finds that VA treatment records were obtained and reviewed consistent with 38 C.F.R. § 3.103(c)(2)(iii) and the AMA framework.

IN THE APPEAL OF
BURFORD EARL FREDERICK

SSN XXX-XX-9[illegible]
Docket No. 231017-387362
Advanced on the Docket

New and Relevant Evidence

1. Service connection for CAD, to include as secondary to residuals of rheumatic fever is denied.

2. Service connection for gout of the bilateral lower extremities, to include as secondary to residuals of rheumatic fever is denied.

The service connection claims on appeal were denied most recently in a December 2019 Board decision. The Veteran appealed this decision to the United States Court of Appeals for Veterans Claims (Court). The Court affirmed the Board's denials in a May 2021 Memorandum Decision.

A claimant who disagrees with a prior VA decision may file a supplemental claim, and, if new and relevant evidence is presented or secured with respect to the supplemental claim, the agency of original jurisdiction, must readjudicate the claim taking into consideration all of the evidence of record. 38 C.F.R. §§ 3.156(d), 3.2501(a). New evidence is evidence not previously part of the actual record before agency adjudicators. 38 U.S.C. § 3.2501(a)(1). Relevant evidence is information that tends to prove or disprove a matter at issue in a claim. *Id.* Relevant evidence includes evidence that raises a theory of entitlement that was not previously addressed. *Id.*

The evidentiary record for a supplemental claim includes all evidence received by VA before VA issues notice of a decision on the supplemental claim. For VA to readjudicate the claim, the evidentiary record must include new and relevant evidence that was not of record as of the date of notice of the prior decision. 38 C.F.R. § 3.2501(b). Upon receipt of a substantially complete supplemental claim, VA's duty to assist in the gathering of evidence under § 3.159 is triggered and includes any such assistance that may help secure new and relevant evidence to complete the supplemental claim application. 38 C.F.R. § 3.2501(c). The standard shall not be construed to impose a higher evidentiary threshold than the standard

that was in effect prior to the date of the enactment of the modernized review system. *See* 38 U.S.C. § 5108; Pub. L. No. 115-55.

Since the May 2021 Memorandum Decision, the Veteran has submitted several Supplemental Claim forms (VA Form 20-0995). Eventually, after several interim rating decisions, the Veteran appealed the March 2023 rating decision to the Board. This rating decision denied to readjudicate the claims on the basis of new and relevant evidence having not been received. Favorable findings identified by the AOJ in this decision were that service treatment records (STRs) confirmed that the Veteran was diagnosed with and treated for rheumatic fever (the in-service event contended by the Veteran) during service and that the medical evidence confirms the presence of current disabilities of CAD and gouty arthritis of the bilateral lower extremities.

Based on the aforementioned new and relevant standard, the question for the Board becomes whether the Veteran has provided or identified new evidence that tends to prove or disprove that the claimed disabilities began during service, or are otherwise medically related to an event, disease or injury during service.

The Board has thoroughly reviewed the evidence submitted by the Veteran and finds that new and relevant evidence has not been received to warrant readjudication of these claims. The Veteran submitted several private treatment records noting his ongoing treatment for the disabilities claimed on appeal. He has also submitted multiple written statements reiterating his belief that entitlement to service connection for the above-claimed disabilities is warranted to include specifically that his CAD and gouty arthritis of the bilateral lower extremities are residuals of a rheumatic fever during service. Specifically, the Veteran again contended that he had strep throat which was not properly treated during service which led to the rheumatic fever for which in-service treatment has been conceded. He again contended that the in-service rheumatic fever is the cause of his current disabilities of CAD and gouty arthritis of the bilateral lower extremities.

These private treatment records and statements are new evidence because they were not previously part of the actual record before agency adjudicators. However, they are not relevant evidence because they do not provide information that tends

to prove or disprove a matter at issue with these claims. At issue with these claims is whether and how the current disabilities of CAD and gouty arthritis of the bilateral lower extremities were incurred in or are related to the Veteran's service, to include as residuals of his in-service rheumatic fever. The Veteran's contentions regarding the in-service onset of his rheumatic fever due to untreated strep throat which he believes led to the current disabilities of CAD and gouty arthritis of the bilateral lower extremities are arguments which had previously been submitted and are therefore cumulative and redundant of those that were previously before agency adjudicators. None of the statements contain probative information or evidence which would otherwise tend to prove or disprove the causal relationship (nexus) elements at issue with these claims. The Veteran also did not raise any theories of entitlement that have not been previously addressed.

Thus, with no new and relevant evidence having been submitted, the Board concludes that readjudication of the Veteran's claims for service connection for his CAD and gouty arthritis of the bilateral lower extremities is not warranted and the appeals are denied.

Jennifer White
Veterans Law Judge
Board of Veterans' Appeals

Attorney for the Board Mckone, Kyle

The Board's decision in this matter was rendered with regard to the instant matter docket. This decision is binding on the agencies of original jurisdiction in the absence of [illegible] 38 U.S.C. § 7104(a).

BOARD OF VETERANS' APPEALS

FOR THE SECRETARY OF VETERANS AFFAIRS

WASHINGTON, DC 20038

Date: December 3, 2019

SS xxx xx 9117

BURFORD E. FREDERICK
14469 MARVIN ST
TAYLOR, MI 48180
USA

Dear Appellant:

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

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

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

Sincerely yours,

K. Osborne
Deputy Vice Chairman

Enclosures (1)
CC: Veterans of Foreign Wars of the United States
Honorable Debbie Dingell

BOARD OF VETERANS' APPEALS

FOR THE SECRETARY OF VETERANS AFFAIRS

IN THE APPEAL OF
BURFORD E. FREDERICK
Represented by
Veterans of Foreign Wars of the United States

SS XXX XX 9117
Docket No. 12-26 696
Advanced on the Docket

DATE: December 3, 2019

ORDER

Service connection for residuals of rheumatic fever, to include a heart disorder, is denied.

Service connection for gout of the bilateral lower extremities, to include as secondary to residuals of rheumatic fever, is denied.

FINDINGS OF FACT

1. The Veteran does not currently have residuals of rheumatic fever. A heart disorder was not present during service, or for many years thereafter, and was not caused by any incident of service.

2. The Veteran's gout of the bilateral lower extremities was not present during service, or for many years thereafter, and was not caused by any incident of service. The Veteran also claims service connection for gout of the bilateral lower extremities secondary to residuals of rheumatic fever, but he is not currently service-connected for residuals of rheumatic fever.

IN THE APPEAL OF
BURFORD E. FREDERICK

SS xxx xx 9117
Docket No. 12-26 696
Advanced on the Docket

CONCLUSIONS OF LAW

1. The criteria for service connection for residuals of a rheumatic fever, to include a heart disorder, have not been met. 38 U.S.C. §§ 1101, 1110, 1112, 1113, 1131, 1137, 1154(a), 5107 (West 2014); 38 C.F.R. §§ 3.102, 3.303, 3.307, 3.309 (2018).

2. The criteria for service connection for gout of the bilateral lower extremities, to include as secondary to residuals of rheumatic fever, have not been met. 38 U.S.C. §§ 1101, 1110, 1112, 1113, 1131, 1137, 1154(a), 5107 (West 2014); 38 C.F.R. §§ 3.102, 3.303, 3.307, 3.309, 3.310 (2018).

REASONS AND BASES FOR FINDINGS AND CONCLUSIONS

The Veteran served on active duty in the Marine Corps from December 1960 to December 1964.

This matter is before the Board of Veterans' Appeals (Board) on appeal of an April 2012 rating decision of the Department of Veterans Affairs (VA) Regional Office in Detroit, Michigan, that denied service connection for residuals of rheumatic fever, to include a heart disorder and for gout of the bilateral lower extremities, to include as secondary to residuals of rheumatic fever.

In September 2015, the Veteran appeared at a Board videoconference hearing before the undersigned Veterans Law Judge.

In November 2015 and September 2018, the Board remanded the issues of entitlement to service connection for residuals of rheumatic fever, to include a heart disorder, and entitlement to service connection for gout of the bilateral lower extremities, to include as secondary to residuals of rheumatic fever, for further development.

IN THE APPEAL OF
BURFORD E. FREDERICK

SS xxx xx 9117
Docket No. 12-26 696
Advanced on the Docket

1. Residuals of Rheumatic Fever, to include a Heart Disorder

Establishing service connection generally requires medical or, in certain circumstances, lay evidence of (1) a current disability; (2) an in-service incurrence or aggravation of a disease or injury; and (3) a nexus between the claimed in-service disease or injury and the present disability. *See Davidson v. Shinseki*, 581 F.3d 1313 (Fed. Cir. 2009); *Hickson v. West*, 12 Vet. App. 247, 253 (1999); *Caluza v. Brown*, 7 Vet. App. 498, 506 (1995), aff'd per curiam, 78 F. 3d 604 (Fed. Cir. 1996) (table).

Determinations as to service connection will be based on review of the entire evidence of record, to include all pertinent medical and lay evidence, with due consideration to VA's policy to administer the law under a broad and liberal interpretation consistent with the facts in each individual case. 38 U.S.C. § 1154(a); 38 C.F.R. § 3.303(a).

Secondary service connection may be granted for a disability that is proximately due to, the result of, or aggravated by an established service-connected disability. 38 C.F.R. § 3.310 (2015); *see also Allen v. Brown*, 7 Vet. App. 439 (1995).

In making all determinations, the Board must fully consider the lay assertions of record. A layperson is competent to report on the onset and recurrence of symptoms. *See Layno v. Brown*, 6 Vet. App. 465, 470 (1994) (a Veteran is competent to report on that of which he or she has personal knowledge). Lay evidence can also be competent and sufficient evidence of a diagnosis or to establish etiology if (1) the layperson is competent to identify the medical condition, (2) the layperson is reporting a contemporaneous medical diagnosis, or (3) lay testimony describing symptoms at the time supports a later diagnosis by a medical professional. *Davidson v. Shinseki*, 581 F.3d 1313, 1316 (Fed. Cir. 2009); *Jandreau v. Nicholson*, 492 F.3d 1372, 1376-77 (Fed. Cir. 2007). When considering whether lay evidence is competent the Board must determine, on a case by case basis, whether the Veteran's particular disability is the type of disability for which lay evidence may be competent. *Kahana v. Shinseki*, 24 Vet. App. 428 (2011); *see also Jandreau v. Nicholson*, 492 F.3d at 1377 (Fed. Cir. 2007)

(holding that "[w]hether lay evidence is competent and sufficient in a particular case is a factual issue to be addressed by the Board").

The Board is charged with the duty to assess the credibility and weight given to evidence. *Madden v. Gober*, 125 F.3d 1477, 1481 (Fed. Cir. 1997), *cert. denied*, 523 U.S. 1046 (1998); *Wensch v. Principi*, 15 Vet. App. 362, 367 (2001). Indeed, in *Jefferson v. Principi*, 271 F.3d 1072 (Fed. Cir. 2001), the United States Court of Appeals for the Federal Circuit (Federal Circuit), citing its decision in *Madden*, recognized that that Board had inherent fact-finding ability. *Id.* at 1076; *see also* 38 U.S.C. § 7104(a) (West 2002). Moreover, the United States Court of Appeals for Veterans Claims (Court) has declared that in adjudicating a claim, the Board has the responsibility to weigh and assess the evidence. *Bryan v. West*, 13 Vet. App. 482, 488-89 (2000); *Wilson v. Derwinski*, 2 Vet. App. 614, 618 (1992).

As a finder of fact, when considering whether lay evidence is satisfactory, the Board may also properly consider internal inconsistency of the statements, facial plausibility, consistency with other evidence submitted on behalf of the Veteran, and the Veteran's demeanor when testifying at a hearing. *See Dalton v. Nicholson*, 21 Vet. App. 23, 38 (2007); *Caluza v. Brown*, 7 Vet. App. 498, 511 (1995), *aff'd per curiam*, 78 F.3d 604 (Fed. Cir. 1996).

In determining the probative value to be assigned to a medical opinion, the Board must consider three factors. *See Nieves-Rodriguez v. Peake*, 22 Vet. App. 295 (2008). The initial inquiry in determining probative value is to assess whether a medical expert was fully informed of the pertinent factual premises (i.e., medical history) of the case. A review of the claims file is not required, since a medical professional can also become aware of the relevant medical history by having treated a Veteran for a long period of time or through a factually accurate medical history reported by a Veteran. *See Id.* at 303-04. The second inquiry involves consideration of whether the medical expert provided a fully articulated opinion. *See Id.* A medical opinion that is equivocal in nature or expressed in speculative language does not provide the degree of certainty required for medical nexus evidence. *See McLendon v. Nicholson*, 20 Vet. App. 79 (2006).

The third and final factor in determining the probative value of an opinion involves consideration of whether the opinion is supported by a reasoned analysis. The most probative value of a medical opinion comes from its reasoning. Therefore, a medical opinion containing only data and conclusions is not entitled to any weight. In fact, a review of the claims file does not substitute for a lack of a reasoned analysis. *See Nieves-Rodriguez*, 22 Vet. App. at 304; *see also Stefl v. Nicholson*, 21 Vet. App. 120, 124 (2007) ("[A] medical opinion... must support its conclusion with an analysis that the Board can consider and weigh against contrary opinions.").

The Veteran contends that he has residuals of rheumatic fever, to include a heart disorder, that are related to service. He specifically maintains that he was treated for rheumatic fever during service, and that he has current residuals of such condition, including heart disorders. The Veteran reports that he had a strep throat during service and that he subsequently developed rheumatic fever. He indicates that he was later found to have coronary artery blockages, coronary artery disease, and that he underwent open heart surgery.

The service treatment records do not show treatment for any heart disorders. Such records do indicate that the Veteran was treated for rheumatic fever.

A March 1961 hospital narrative summary indicates that the Veteran was transferred from a dispensary because of a chief complaint of swollen joints. The examiner reported that the Veteran was apparently healthy until eleven days prior to his admission, when he noted pain, which was followed by swelling, in his left knee. It was noted that the Veteran subsequently had pain in his left foot the following day. The examiner indicated that on the third day, the Veteran was seen in sick bay and that he was started on hot soaks. The examiner reported that the pain and swelling migrated to the Veteran's right foot, which caused him to limp. The examiner stated that the Veteran was finally admitted to sick bay and started on bedrest, Bicillin, and aspirin. It was noted that the Veteran's joint swelling abated after approximately four to five days.

The examiner reported that positive findings on admission included a normal temperature, as well as a normal pulse and blood pressure reading. The examiner

stated that the positive findings also included a negative chest, a sinus bradycardia to auscultation, and no murmurs, but a third heart sound at the apex, with the remainder of the examination within normal limits. It was noted that laboratory studies on admission, included a normal urinalysis and a white count of 11,050, with a shift to the left and a sedimentation rate of 56. The examiner reported that the Veteran's hematocrit was 37, and that alpha streptococci were cultured from his throat. The examiner stated that the Veteran's chest x-ray was normal, as was an electrocardiogram.

The examiner indicated that the Veteran was placed on bedrest and that he continued the aspirin therapy along with a course of Procaine Penicillin, intramuscularly, and that he continued to show gradual improvement in his laboratory findings. It was noted that twice weekly, the Veteran's C-Reactive Protein, sedimentation rate, and ASO titer were drawn, which showed gradual improvement.

The diagnosis was rheumatic fever, active, without heart involvement. The examiner indicated that such disorder was incurred in the line of duty and was not due to any misconduct.

A December 1964 objective separation examination report includes notations that the Veteran's mouth and throat, heart, vascular system, and lower extremities, were all normal.

Post-service private and VA treatment records, including examination reports, show treatment for variously diagnosed heart disorders, including coronary artery disease; ischemic heart disease; ischemic heart disease, status post a coronary artery bypass graft; coronary artery bypass surgery; coronary artery disease, status post coronary artery bypass surgery, twice, with multiple angioplasties, and stent placements; and coronary artery disease, congestive heart failure, a coronary artery bypass graft, and hyperlipidemia.

A May 2011 VA heart examination report includes a notation that the Veteran's claims file and medical records were not available. The Veteran reported that he was diagnosed with rheumatic fever in boot camp during his active military

service, that he was treated in a hospital for about three months at that time, and that his rheumatic fever resolved. He stated that he received Penicillin injections, intermittently, for about two years subsequently. It was noted that the Veteran denied that he had any chronic residuals problems related to his rheumatic fever. The Veteran denied that he had any recurrence of his rheumatic fever or any valvular disease or heart failure related to rheumatic fever. He denied that he had any subsequent heart problems or rheumatic fever during his military service, as well as in the subsequent years after he left active military service. It was noted that the Veteran denied that he had any chronic residuals of rheumatic fever subsequently in his adult life and recently. It was noted that no valvular lesions were noted or diagnosed by the Veteran's physicians.

The Veteran reported that he had anginal chest pain in May 1978, and that he was treated with medication. He stated that he subsequently had a four-graft coronary bypass surgery in September 1978. The Veteran indicated that he continued to have anginal pains over the years, and that in 1986, he had a three-graft coronary artery bypass surgery. It was noted that in 1990, he had unstable angina and had an angioplasty, and that in 1993, he had an angioplasty with two grafts. The Veteran stated that in 1997, he again had unstable angina and underwent a heart catheterization which revealed significant obstruction. It was noted that the Veteran underwent another heart catheterization in May 2010, and he was told that he had no significant obstructive coronary arteries. The Veteran indicated that he has been continuing his medical treatment for coronary artery disease.

The diagnoses included coronary artery disease, status post coronary artery bypass surgery, twice, and multiple angioplasties and stent placements since 1978, with stable angina, as well as rheumatic fever in 1962, treated and resolved during active military service, with no chronic residuals on examination. The examiner indicated that there was no valvular heart disease related to the Veteran's rheumatic fever as per the examination. The examiner maintained that it was his opinion that the Veteran's coronary artery disease was not likely related to his active military service and rheumatic fever.

A January 2016 infectious diseases examination report includes a notation that the Veteran's claims file was reviewed. The examiner reported that the Veteran was in

the service from 1960 to 1964, and that he was diagnosed with, and treated for, rheumatic fever. It was noted that the Veteran was treated with Penicillin. The examiner stated that the Veteran was sent back to duty after completion of the antibiotic therapy, and that he was discharged in 1964, with no residuals.

As to a diagnosis, the examiner indicated that the Veteran was diagnosed with, and treated for, rheumatic fever in service, with no residuals on the current examination. 2018

In an August 2016 addendum, the examiner who performed that January 2016 VA infectious diseases examination, indicated that the Veteran's claims file was reviewed. The examiner reported that the Veteran was diagnosed and treated for rheumatic fever in March 1961 during service. The examiner stated that the Veteran's discharge examination was unremarkable, with no residuals of infection to cause any heart condition at his time of discharge in 1964.

A July 2019 VA infectious diseases examination report includes a notation that the Veteran's claims file was reviewed. The examiner reported that the Veteran had a strep throat during service, was treated with antibiotics, and then developed rheumatic fever. The examiner stated that that the rheumatic fever resolved but that the developed heart disease. It was noted that the Veteran had current heart problems, with dyspnea, and that he had undergone heart surgeries.

The diagnosis was rheumatic fever, with a date of diagnosis in 1964.

A July 2019 VA heart conditions examination report, by the same examiner who performed the July 2019 VA infectious diseases examination, includes a notation that the Veteran's claims file was reviewed. The examiner reported that the Veteran stated that he had strep throat during service and that subsequently developed rheumatic fever. The examiner indicated that many years later, the Veteran was noted to have coronary artery blockages, and coronary artery disease, which needed open heart surgery. It was noted that the Veteran's heart condition had progressively worsened. The examiner related that the Veteran's current symptoms were dyspnea, chest pain, and weakness, with ambulation.

The diagnoses were coronary artery disease; congestive heart failure; a coronary artery bypass graft; and hyperlipidemia.

The examiner indicated that the Veteran had no residuals of rheumatic fever. The examiner reported that the Veteran felt that his heart conditions were due to rheumatic fever, but that there was no scientific/medical connection at that point in time. The examiner opined that the it was less likely that the Veteran's heart condition was a residual of his in-service rheumatic fever. The examiner explained that rheumatic heart disease involved the valves of the heart, and that the Veteran did not have any valve conditions. The examiner reported that the Veteran had functional impairments due to his heart conditions, including dyspnea on exertions, which were unrelated to his rheumatic fever.

The probative value of medical opinion evidence "is based on the medical expert's personal examination of the patient, the physician's knowledge and skill in analyzing the data, and the medical conclusion that the physician reaches.... As is true with any piece of evidence, the credibility and weight to be attached to these opinions [are] within the province of the adjudicators..." *Guerrieri v. Brown*, 4 Vet. App. 467, 470-71 (1993). The determination of credibility is the province of the Board. It is not error for the Board to favor the opinion of one competent medical expert over that of another when the Board gives an adequate statement of reasons or bases. *See Owens v. Brown*, 7 Vet. App. 429, 433 (1995).

The Board observes that a May 2011 VA heart examination report relates diagnoses, including coronary artery disease, status post coronary artery bypass surgery, twice, and multiple angioplasties and stent placements since 1978, with stable angina, as well as rheumatic fever in 1962, treated and resolved during active military service, with no chronic residuals on examination. The examiner indicated that there was no valvular heart disease related to the Veteran's rheumatic fever as per the examination. The examiner maintained that it was his opinion that the Veteran's coronary artery disease was not likely related to his active military service and rheumatic fever. The Board observes that the examiner specifically indicated that the Veteran's claims file and medical records were not available. Although claims file review is not necessary, the probative value of a medical opinion is based on its reasoning and its predicate in the record so that the opinion

is fully informed. *See Nieves-Rodriguez v. Peake*, 22 Vet. App. 295 (2008). Additionally, the Board notes that the examiner reported that the Veteran denied that he had subsequent heart problems or rheumatic fever during his military service, as well as in subsequent years after he left military service. The Board observes, however, that the Veteran has specifically claimed that he has current residuals of rheumatic fever and heart problems. Additionally, the Board notes that the examiner did not provide much rationale for the opinion that the Veteran's coronary artery disease was not likely related to his military service and rheumatic fever. Therefore, the Board finds that the examiner's opinion, pursuant to the May 2011 VA heart examination report, is not very probative in this matter.

The Board observes that the examiner, pursuant to a January 2016 infectious diseases examination report, indicated, as to a diagnosis, that the Veteran was diagnosed with, and treated for, rheumatic fever in service, with no residuals on the current examination. In an August 2016 addendum, and following a review of the claims file, the examiner reported that the Veteran was diagnosed and treated for rheumatic fever in March 1961 during service. The examiner stated that the Veteran's discharge examination was unremarkable, with no residuals of infection to cause any heart condition at his time of discharge in 1964. The Board observes that the examiner did not specifically address whether the Veteran's claimed heart disorder was related to his period of service, to include his rheumatic fever during service. The examiner solely stated that there were no residuals of the infection to cause any heart condition at the time of the Veteran's discharge from service. Therefore, the Board finds that the examiner's opinion, pursuant to the January 2016 infectious diseases examination report, with the August 2016 addendum, is less probative in this matter.

The Board notes that the examiner, pursuant to a July 2019 VA infectious diseases examination report, related a diagnosis of rheumatic fever, with a date of diagnosis in 1964. The same examiner, pursuant to a July 2019 VA heart conditions examination report, indicated diagnoses of coronary artery disease; congestive heart failure; a coronary artery bypass graft; and hyperlipidemia. The examiner, following a review of the claims file, stated that the Veteran had no residuals of rheumatic fever. The examiner also reported that the Veteran felt that his heart conditions were due to rheumatic fever, but that there was no scientific/medical

connection at that point in time. The examiner maintained that it was less likely that the Veteran's heart condition was a residual of his in-service rheumatic fever. The examiner stated that rheumatic heart disease involved the valves of the heart, and that the Veteran did not have any valve conditions. The examiner further indicated that the Veteran had functional impairments due to his heart conditions, including dyspnea on exertions, which were unrelated to his rheumatic fever. The Board observes that the examiner, pursuant to the July 2019 VA infectious diseases examination report, and the July 2019 VA heart conditions examination report, reviewed the Veteran's claims file, provided rationales for his opinions, and specifically addressed whether the Veteran's claimed heart disorder was related to his rheumatic fever during service. Therefore, the Board finds that the opinions provided by the examiner, pursuant to the July 2019 VA infectious diseases examination report, and the July 2019 VA heart conditions examination report, are very probative in this matter. *See Wensch v. Principi*, 15 Vet. App. 362 (2001).

The Board observes that the evidence shows that the Veteran is not currently diagnosed with any residuals of rheumatic fever. The examiner, pursuant to the July 2019 VA infectious diseases examination report, and the July 2019 VA heart conditions examination report, in probative opinions, specifically found that the Veteran had no residuals of rheumatic fever. In fact, all the opinions of record indicate that the Veteran does not have residuals of rheumatic fever.

Additionally, the Board observes that the medical evidence does not suggest that the Veteran's heart disorder is related to his period of service. In fact, the medical evidence provides negative evidence against this finding, indicating that the Veteran's claimed heart disorder began many years after service, without any relationship to any incident of service. Additionally, a VA examiner, in probative opinions, pursuant to a July 2019 VA infectious diseases examination report, and the July 2019 VA heart conditions examination report, found that the Veteran's claimed heart disorder was not related to not related to his period of service, to include his rheumatic fever during service.

The Veteran has asserted that his claimed residuals of rheumatic fever, to include a heart disorder, had their onset during his period of service. The Board observes that while the Veteran is competent to report symptoms, he thought were due to

rheumatic fever and/or heart problems during service, or after service, he is not competent to diagnose his claimed residuals of rheumatic fever, to include a heart disorder, as related to service. *Jandreau v. Nicholson*, 492 F.3d 1372 (Fed. Cir. 2007) (lay evidence can be competent and sufficient to establish a diagnosis of a condition when a layperson is competent to identify the medical condition, or reporting a contemporaneous medical diagnosis, or the lay testimony describing symptoms at the time supports a later diagnosis by a medical professional); *Buchanan v. Nicholson*, 451 F.3d. 1331 (Fed. Cir. 2006) (lay evidence is one type of evidence that must be considered and competent lay evidence can be sufficient in and of itself). A lay opinion is not sufficient in this case to prove nexus.

The weight of the competent demonstrates that the Veteran's has no current residuals of rheumatic fever, and that his claimed heart disorder, began years after his period of service and was not caused by any incident of service. Such disorders were neither incurred in nor aggravated by service.

In sum, the preponderance of the evidence is against the claim for entitlement to service connection for residuals of rheumatic fever, to include a heart disorder; there is no doubt to be resolved; and service connection is not warranted. 38 U.S.C. § 5107(b); 38 C.F.R. § 3.102; *Gilbert v. Derwinski*, 1 Vet. App. 49 (1990).

2. Gout of the Bilateral Lower Extremities, to include as Secondary to Residuals of Rheumatic Fever

The Veteran contends that he has gout of the bilateral lower extremities that is related to service. He specifically maintains that he was treated for rheumatic fever during service, and that he has current gout of the bilateral lower extremities from his rheumatic fever. He also reports that his gout of the bilateral lower extremities is secondary to his residuals of rheumatic fever. The Veteran reports that he had a strep throat during service and that he subsequently developed rheumatic fever, with symptoms of joint pain in his toes, feet, ankles, and knees that was unbearable. The Veteran further reports that due to his occupational specialty as a light artillery specialist during service, he currently has problems with his bilateral lower extremities.

The service treatment records do not show treatment for gout of right or left lower extremities. Such records do indicate that the Veteran was treated for a possible stress fracture of the left foot, with a subsequently negative x-ray report. His service treatment records do indicate that he was treated for rheumatic fever.

A March 1961 hospital narrative summary indicates that the Veteran was transferred from a dispensary because of a chief complaint of swollen joints. The examiner reported that the Veteran was apparently healthy until eleven days prior to his admission, when he noted pain, which was followed by swelling, in his left knee. It was noted that the Veteran subsequently had pain in his left foot the following day. The examiner indicated that on the third day, the Veteran was seen in sick bay and that he was started on hot soaks. The examiner reported that the pain and swelling migrated to the Veteran's right foot, which caused him to limp. The examiner stated that the Veteran was finally admitted to sick bay and started on bedrest, Bicillin, and aspirin. It was noted that the Veteran's joint swelling abated after approximately four to five days.

The examiner reported that positive findings on admission included a normal temperature, as well as a normal pulse and blood pressure reading. The examiner stated that the positive findings also included a negative chest, a sinus bradycardia to auscultation, and no murmurs, but a third heart sound at the apex, with the remainder of the examination within normal limits. It was noted that laboratory studies on admission, including a normal urinalysis and a white count of 11,050, with a shift to the left and a sedimentation rate of 56. The examiner reported that the Veteran's hematocrit was 37, and that alpha streptococci were cultured from his throat. The examiner stated that the Veteran's chest x-ray was normal, as was an electrocardiogram.

The examiner indicated that the Veteran was placed on bedrest and that he continued the aspirin therapy along with a course of Procaine Penicillin, intramuscularly, and that he continued to show gradual improvement in his laboratory findings. It was noted that twice weekly, the Veteran's C-Reactive Protein, sedimentation rate, and ASO titer were drawn, which showed gradual improvement.

The diagnosis was rheumatic fever, active, without heart involvement. The examiner indicated that such disorder was incurred in the line of duty and was not due to any misconduct.

A December 1964 objective separation examination report includes notations that the Veteran's mouth and throat, heart, vascular system, and lower extremities, were all normal.

Post-service private and VA treatment records, including examination reports, show treatment for gout, including in the right and left lower extremities.

A May 2011 VA heart examination report includes a notation that the Veteran's claims file and medical records were not available. The Veteran reported that he was diagnosed with rheumatic fever in boot camp during his active military service, that he was treated in a hospital for about three months at that time, and that his rheumatic fever resolved. He stated that he received Penicillin injections, intermittently, for about two years subsequently. It was noted that the Veteran denied that he had any chronic residuals problems related to his chronic rheumatic fever. The Veteran denied that he had any recurrence of his rheumatic fever. He also denied that he had any subsequent rheumatic fever during his military service, as well as in the subsequent years after he left active military service. It was noted that the Veteran denied that he had any chronic residuals of rheumatic fever subsequently in his adult life and recently.

The Veteran reported that he had been having gouty arthritis since the later 1980s, which mostly involved his big toes, both knee joints, and wrist and elbow joints. He stated that he would have pain and swelling in the above joints during acute gouty arthritis, and that the symptoms would usually last for a few weeks and subside. He related that he used to take pain medication and rest. The Veteran maintained that he would have gouty arthritis involving one of the above joints on an average of once a month for several years until 1994. He reported that in 1994, his physician started him on Allopurinol and that since then, he had not been having gouty arthritis.

The diagnoses included gouty arthritis, involving multiple joints (both knee joints, both elbow joints, both wrist joints, both big toe joints). The examiner reported that the Veteran had been taking Allopurinol since 1994, with no acute gouty arthritis for the last several years. The examiner maintained that the Veteran denied that he had gouty arthritis while he was in service. The examiner indicated that the Veteran's gouty arthritis was not likely related to his active military service.

A January 2016 VA non-degenerative arthritis and dysbaric osteonecrosis examination report includes a notation that the Veteran's claims file was reviewed. The examiner reported that the Veteran was diagnosed with gouty arthritis of both big toes, as well as the left ring finger, since 1994. The examiner stated that the Veteran was taking Allopurinol on a daily basis.

The diagnosis was gout, with a date of diagnosis in 1994. The examiner maintained that Veteran's condition was not caused by, or a result of, his period of service. The examiner stated that the Veteran's separation in December 1964 was unremarkable, and that his diagnosis of gout was in 1994, twenty years after his discharge from the service.

In an August 2016 addendum, the examiner who performed the January 2016 VA non-degenerative arthritis and dysbaric osteonecrosis examination, indicated that the Veteran's claims file was reviewed. The examiner reported that the Veteran was diagnosed and treated for rheumatic fever in March 1961 during service, and that his discharge examination was unremarkable, with no residuals of infection. The examiner maintained that a review of medical literature showed that rheumatic fever did not cause gouty arthritis.

A July 2019 VA foot conditions examination report includes a notation that the Veteran's claims file was reviewed. The examiner reported that the Veteran stated that in approximately 1994, he had swelling, pain, and difficulty with range of motion in his right and left feet. It was noted that the condition had stayed the same. The examiner indicated that the Veteran was taking Allopurinol. The diagnosis was gout of both feet.

A July 2019 VA non-degenerative arthritis and dysbaric osteonecrosis examination report, by the same examiner who performed the July 2019 VA foot conditions examination report, includes that the Veteran's claims file was reviewed. The examiner reported that in 1994, the Veteran had pain and swelling in the feet and toes, with difficulty on ambulation. The examiner stated that the Veteran had on and off flare-ups with pain, burning, and decreased motion. It was noted that the Veteran's symptoms had stayed the same and that he was taking Allopurinol. The diagnosis was gout.

The examiner indicated that the Veteran felt that hs gout was due to his rheumatic fever, but that there was no scientific and medical connection at that point in time. The examiner also maintained that the Veteran's gout was not a currently related condition to rheumatic fever. The examiner stated that the Veteran's gout was unrelated to his in-service rheumatic fever.

The probative value of medical opinion evidence "is based on the medical expert's personal examination of the patient, the physician's knowledge and skill in analyzing the data, and the medical conclusion that the physician reaches.... As is true with any piece of evidence, the credibility and weight to be attached to these opinions [are] within the province of the adjudicators..." *Guerrieri*, 4 Vet. App. at 467, 470-71. The determination of credibility is the province of the Board. It is not error for the Board to favor the opinion of one competent medical expert over that of another when the Board gives an adequate statement of reasons or bases. *See Owens*, 7 Vet. App. at 429, 433.

The Board observes that a May 2011 VA heart examination report relates diagnoses including gouty arthritis involving multiple joints. The examiner indicated that the Veteran's gouty arthritis was not likely related to his active military service. The Board notes that the examiner specifically indicated that the Veteran's claims file and medical records were not available. Although claims file review is not necessary, the probative value of a medical opinion is based on its reasoning and its predicate in the record so that the opinion is fully informed. *See Nieves-Rodriguez*, 22 Vet. App. at 295. Additionally, the Board observes that the examiner reported that the Veteran had been taking Allopurinol since 1994, with no acute gouty arthritis for the last several years. The Board notes that the examiner appeared to

indicate that the Veteran did not currently have gouty arthritis, but such conclusion seems inconsistent with the fact that the Veteran was currently on medication for gouty arthritis. Therefore, the Board finds that the opinion provided by the examiner, pursuant to the May 2011 VA heart examination report, is not very probative in this matter.

The Board observes that the examiner, pursuant to the January 2016 VA non-degenerative arthritis and dysbaric osteonecrosis examination report, related a diagnosis of gout. The examiner, following a review of the claims file, maintained that Veteran's condition was not caused by, or a result of, his period of service. The examiner stated that the Veteran's separation in December 1964 was unremarkable, and that his diagnosis of gout was in 1994, twenty years after his discharge from the service. In an August 2016 addendum, the same examiner reported that the Veteran was diagnosed and treated for rheumatic fever in March 1961 during service, and that his discharge examination was unremarkable, with no residuals of infection. The examiner maintained that a review of medical literature showed that rheumatic fever did not cause gouty arthritis. The Board observes that the examiner reviewed the Veteran's claims file and provided rationales for her opinions. Therefore, the Board finds that the opinions by the VA examiner, pursuant to the January 2016 VA non-degenerative arthritis and dysbaric osteonecrosis examination report, with an August 2016 addendum, are very probative in this matter. *See also Wensch v. Principi*, 15 Vet. App. at 362.

The Board observes that the examiner, pursuant to the July 2019 VA foot examination report, and the July 2019 VA non-degenerative arthritis and dysbaric osteonecrosis examination report, related diagnoses of gout both feet, and gout, respectively. The examiner, following a review of the claims file, indicated that the Veteran felt that hs gout was due to his rheumatic fever, but that there was no scientific and medical connection at that point in time. The examiner also maintained that the Veteran's gout was not a currently related condition to rheumatic fever. The examiner further that the Veteran's gout was unrelated to his in-service rheumatic fever. The Board observes that the examiner reviewed the Veteran's claims file and provided rationales for his opinions. Therefore, the Board finds that the opinions provided by the examiner, pursuant to July 2019 VA foot examination report, and the July 2019 VA non-degenerative arthritis and dysbaric

osteonecrosis examination report, are also very probative in this matter. *See also Wensch v. Principi*, 15 Vet. App. at 362.

The Board observes that the medical evidence does not suggest that the Veteran's claimed gout of the bilateral lower extremities is related to his period of service. In fact, the medical evidence provides negative evidence against this finding, indicating that his claimed gout of the bilateral lower extremities began many years after service, without any relationship to any incident of service. Additionally, VA examiners, in probative opinions, pursuant to a January 2016 VA non-degenerative arthritis and dysbaric osteonecrosis examination report, with an August 2016 addendum, as well as a July 2019 VA foot examination report, and a July 2019 VA non-degenerative arthritis and dysbaric osteonecrosis examination report, have all found that the Veteran's claimed gout of the bilateral lower extremities is not related to his period of service, to include his rheumatic fever in service.

The Veteran has asserted that his claimed gout of the bilateral lower extremities had its onset during his period of service. The Board observes that while the Veteran is competent to report symptoms, he thought were due to gout of the right and left lower extremities, during service, or after service, he is not competent to diagnose his claimed gout of the bilateral lower extremities as related to service. *Jandreau*, 492 F.3d at 1372 (lay evidence can be competent and sufficient to establish a diagnosis of a condition when a layperson is competent to identify the medical condition, or reporting a contemporaneous medical diagnosis, or the lay testimony describing symptoms at the time supports a later diagnosis by a medical professional); *Buchanan*, 451 F.3d. at 1331 (lay evidence is one type of evidence that must be considered and competent lay evidence can be sufficient in and of itself). A lay opinion is not sufficient in this case to prove nexus.

The weight of the competent demonstrates that the Veteran's claimed gout of the bilateral lower extremities began years after his period of service and was not caused by any incident of service. Such disorder was neither incurred in nor aggravated by service.

Additionally, the Veteran is also attempting to establish service connection for gout of the bilateral lower extremities, as secondary to residuals of rheumatic fever.

IN THE APPEAL OF
BURFORD E. FREDERICK

[redacted]
Docket No. 12-26 696
Advanced on the Docket

However, secondary service connection presupposes the existence of an established service-connected disability. The Board notes that residuals of rheumatic fever are not service-connected, and thus, secondary service connection for any condition allegedly due to residuals of rheumatic fever is not warranted.

In sum, the preponderance of the evidence is against the claim for entitlement to service connection for gout of the bilateral lower extremities; there is no doubt to be resolved; and service connection is not warranted. 38 U.S.C. § 5107(b); 38 C.F.R. § 3.102; *Gilbert*, 1 Vet. App. at 49.

STEVEN D. REISS
Veterans Law Judge
Board of Veterans' Appeals

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February 20, 2018

Ms. Diane Emerson
Board of Veterans Appeals
801 Vermont Ave, NW
Washington, DC 20420-0001

Dear Ms. Emerson,

I am contacting you on behalf of my constituent, Mr. Burford Frederick who lives at 14469 Marvin Street, Taylor, MI 48180. Mr. Frederick has contacted my office regarding receiving his final docket letter from the Board of Veteran Appeals. Could you please look into this matter?

I am enclosing a copy of the privacy release letter for your review. I will look forward to hearing from you soon.

Sincerely,

Debbie Dingell

Debbie Dingell
Member of Congress

DD/dm

DEBBIE DINGELL
12TH DISTRICT, MICHIGAN

116 CANNON HOUSE OFFICE BUILDING
WASHINGTON, DC 20515
(202) 225-4071

HOUSE COMMITTEE ON
ENERGY AND COMMERCE

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COMMUNICATIONS AND TECHNOLOGY
DIGITAL COMMERCE AND CONSUMER PROTECTION
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Washington, DC 20515

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(313) 278-2936

301 WEST MICHIGAN AVENUE
SUITE 400
YPSILANTI, MI 48197
(734) 481-1100

WEBSITE: DEBBIEDINGELL.HOUSE.GOV

June 6, 2018

Mr. Burford E. Frederick
14469 Marvin Street
Taylor, MI 48180-6520

Dear Mr. Frederick:

This is in reference to your concerns surrounding your appeal in your claim for Department of Veterans Affairs (VA) benefits. I appreciate your continued patience with this matter.

Below is the response that I received today via email from the Department of Veterans Affairs Appeals Management Office in Washington, DC regarding my inquiry on your behalf.

Upon receipt of your inquiry, we reviewed Mr. Frederick's record and determined that his appeal was prematurely closed. The issues of residuals of rheumatic fever, to include a heart condition and service connection for gout of the bilateral lower extremities have not been adjudicated. We have instructed the Appeals Resource Center to review the file in its entirety and take the necessary actions to advance the appeal.

We regret the delay in processing Mr. Frederick's appeal. Although VA's appeal rate has remained steady for decades, the volume of appeals has grown in proportion to our increased claim production. However, I am pleased to report that on August 23, 2017, President Trump signed into law the Veterans Appeals Improvement and Modernization Act of 2017, which establishes a new, more efficient review process for Veterans who disagree with VA's decision on their benefit claims.

I believe the information provided will help to clarify this matter for you.

If I can be of further assistance to you in the future regarding this or any other matter of federal concern, please do not hesitate to contact my office.

Sincerely,

Debbie Dingell

Debbie Dingell
Member of Congress

DD/dm

STATE OF MICHIGAN

DEPARTMENT OF EDUCATION

PHILIP E. RUNKEL
Superintendent of Public Instruction

MICHIGAN REHABILITATION SERVICES
Detroit Southwest Office
Michigan Plaza Building
1200 Sixth, 10th Floor
Detroit, Michigan 48226
256-2750

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May 23, 1983

Mr. Buford E. Frederick
2006 Michigan
Lincoln Park, MI 48146

Dear Mr. Frederick:

Please find enclosed a wallet-sized Handicapped Worker's Certificate. This document should assist you in finding employment.

Under legislation effective in Michigan July 1, 1972, persons certified by our agency as having back, epilepsy, diabetes or heart conditions become covered by the Second Injury Fund for Workmen's Compensation.

We have found the reason employers are reluctant to hire persons with your disability is that they feel it can be aggravated or made worse in work situations and if this occurred, they might be liable to pay you Workmen's Compensation benefits for the rest of your life. If you are certified and hired and then reinjure yourself, you still receive all benefits you are entitled to, but after a while they are paid by the State's Second Injury Fund instead of your new employer. This takes away the financial risk in hiring you in the first place, and if fully understood by the employer, should make him favorably disposed to hiring you on the basis of your ability rather than disability.

If you have any questions, please contact us; and be sure to contact us prior to employment. You can reach me at 256-2750.

Sincerely,

William C. White

William C. White
Services Supervisor

Enclosure

Statement of the Case	*Department of Veterans Affairs* *DEPARTMENT OF VETERANS AFFAIRS*		Page 1 09/04/2012
NAME OF VETERAN BURFORD E. FREDERICK	VA FILE NUMBER 379 38 9117	SOCIAL SECURITY NR 379 38 9117	POA Veterans of Foreign Wars

Your appeal was reviewed by a Decision Review Officer under 38 CFR 3.2600. Review under this section encompasses only the decision with which you have expressed disagreement in the Notice of Disagreement. All evidence of record has been given de novo review. This review is a new and complete review with no deference given to the decision being reviewed.

ISSUE:

1. Service connection for residuals of rheumatic fever.
2. Service connection for gouty arthritis of both knees.
3. Service connection for recurrent left wrist fracture.

EVIDENCE:

- VA Form 21-526, Application for Compensation and Pension Benefits (VONAPP) received August 27, 2010
- DD 214, Certificate of Separation from Active Duty
- Service treatment records covering the period from December 30, 1960 through December 15, 1964
- Veterans Claims Assistance Act (VCAA) letter dated September 2, 2010, and September 13, 2010
- Treatment records, Henry Ford Hospital and Health System, from November 17, 1998 through January 5, 2011
- Treatment reports, Harper Hospital, dated November 24, 1986
- Treatment reports, Texas Heart Institute, from September 24, 1978 through October 5, 1978
- Statements from Veteran received September 3, 2010 and February 1, 2011
- VA form 21-0820, Report of General Information dated September 13, 2010
- VA Form 21-4138, Statement in Support of Claim received September 10, 2010
- VCAA Notice Response received September 10, 2010
- VA examination, Detroit VAMC, on May 6, 2011 and May 7, 2011
- VA medical opinions dated January 6, 2012, and January 11, 2012
- Social Security Administration records for disability

ADJUDICATIVE ACTIONS:

08-27-2010	Claim received.
09-02-2010	You were told by letter of our duty to assist you in obtaining evidence to substantiate your claim before making a decision. There was also an explanation of what type of evidence you needed to submit to support your claim.