PRESENTS…

VA Secondary Service Connection SECRETS!

"The INSIDER'S Guide to 100+ Possible VA Secondary Claims!"

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About the Author

Brian Reese is one of the world's leading Veteran Benefits Experts, former military officer, and founder of VA Claims Insider – ***"The #1 Most Trusted Name in VA Disability Claims."***

>> Learn more about VA Claims Insider HERE <<

Brian's frustration with the VA disability claims process led him to found and create "VA Claims Insider," which provides disabled veterans with tips, strategies, and lessons learned to win, service connect, prove disability symptoms, and get the VA disability rating and compensation they deserve in less time.

Captain Brian Reese - Afghanistan 2011

He is also the CEO of Military Disability Made Easy, which is the world's largest searchable database for all things related to DoD disability and VA disability and has served more than 6,000,000 military members and veterans since its founding in 2013.

Veterans can now download a **FREE** eBook copy of his #1 Amazon Bestseller, ***"The Veteran Benefits Bible,"*** right here, right now at the link below. Click the link below now to secure your instant free digital download:

>> Download Your FREE Copy of "You Deserve It: The Definitive Guide to Getting the Veteran Benefits You've Earned" by clicking HERE now.

Brian Reese is a former active duty Air Force officer with extensive experience leading hundreds of individuals and multi-functional teams in challenging international environments, including a combat tour to southern Afghanistan in 2011 in support of Operation Enduring Freedom.

Brian is a Distinguished Graduate of Management from the United States Air Force Academy (USAFA), Colorado Springs, CO and he holds an MBA from Oklahoma State University's Spears School of Business, Stillwater, OK, where he was a National Honor Scholar (Top 1% of Graduate School class).

💰 ***Dear Veteran, did you know < 15-minutes could get you $1,500 or more of tax free VA disability compensation you deserve every month for the rest of your life?*** ✅

Okay, maybe you already know that, **BUT** do you know **HOW** to do it?

This is your chance to join me right now in my brand-new **FREE 7-minute video training...**

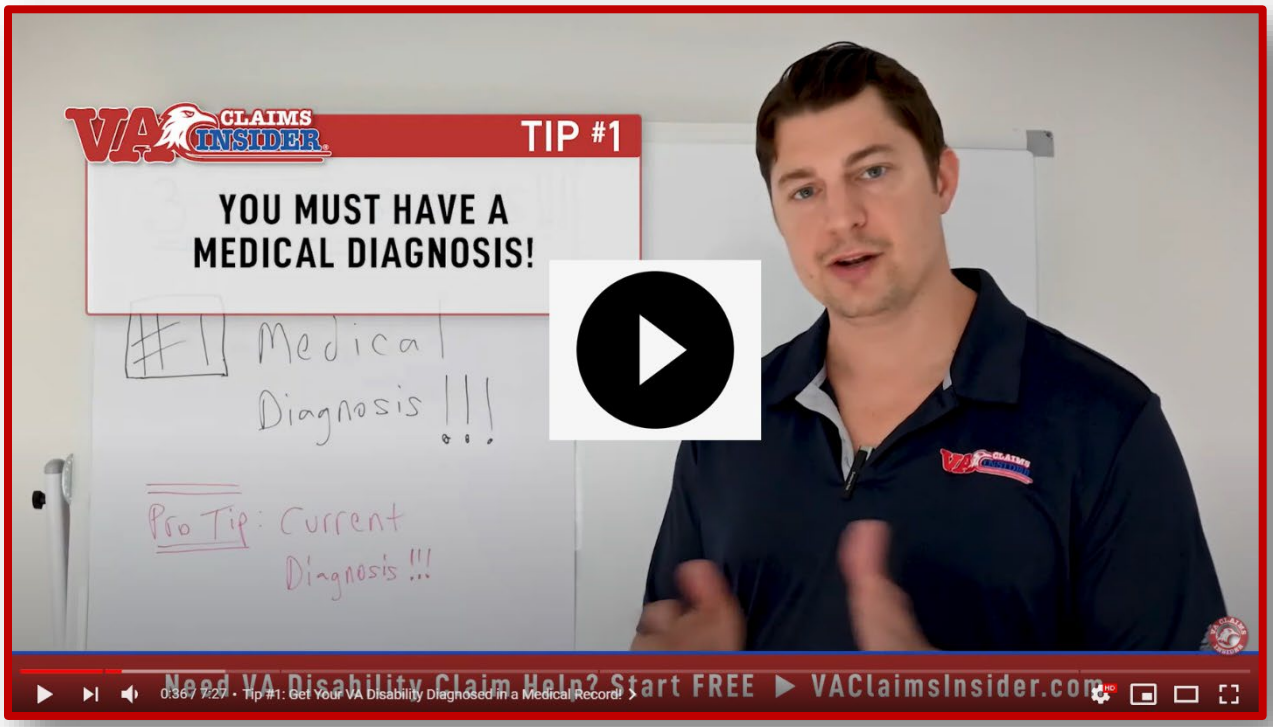
I'll be revealing **3 VA Disability SECRETS** (the VA doesn't want you to know...)

This training is **FREE** for a limited time; simply scroll down and click the play button on the video image below.

Brian Reese the VA Claims Insider Presents...

📢 **"3 SECRET Tips to INCREASE Your VA Rating FAST (even if you've already filed, been denied, or lost hope…)"** ✅

CLICK THE VIDEO BELOW NOW TO LAUNCH YOUR FREE VIDEO!



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Introduction

Dear Veteran, what you're about to discover in this guide could change your life. You'll uncover hundreds of little-known secondary claims as well as how to get your VA disabilities service connected via secondary service connection.

Currently, 8 out of 10 veterans reading this message right now are **NOT** receiving the VA benefits they deserve by law. Truth bomb: that means 80% of you reading this now are missing out on **FREE MONEY**. And that's if you have a VA disability rating at all. Did you know that of the roughly 20 million veterans alive today, about 5.2 million veterans or about 25% of you reading this book right now (yep that's about 1 in 4 veterans) receive any VA disability benefits at all. That's shameful and I'm on a mission to change it.

How is that possible? First, there's a lack of awareness, due in part to inadequate education. I didn't even know the VA—the U.S. Department of Veterans Affairs—existed until the day I took off the uniform. And even then, I didn't know about disability benefits. It would be YEARS before I learned I could receive help from the government for my service-related disabilities. Heck, it was years before I figured out the pain I suffered even was a disability.

But some of you were ahead of me. You might have even started an application...but then got so confused by the complexity of the system, the convoluted process, and the seemingly endless addendums and amendments to eligibility rules, that you just gave up.

Still others of you did apply. Except the response you received was either a denial or an “underrating” (meaning the VA acknowledged some kind of disability but disagreed about its severity or origin). If that’s you, you are understandably **FRUSTRATED**. You probably spent dozens of hours searching on Google, combing the VA website, collecting the documents you needed, and navigating the system—only to feel unseen or, worse, like you’ve been called a liar.

You’re not a liar. The problem isn’t you. Nor is it the VA, honestly! The VA is not trying to keep money from you. It wants to help you. The problem is the system. That’s where I come in. This book is a comprehensive guide to learn how to get your disability conditions service connected on a secondary basis, aka “secondary service connection” and I’ll reveal and explain over 100 common secondary VA claims. And I’ll tell you how to get your conditions service connected, if eligible by law, regardless of past denials.

But first, I need to change your mind about something.

YOU SERVED. YOU DESERVE.

A lot of veterans think the word “disabled” only applies to veterans who have it much worse than they do. They think, “I haven’t been in combat. I haven’t lost a limb. I don’t have cancer from Agent Orange. Heck, I’m lucky to have a job! I shouldn’t apply for benefits because those are for veterans who actually deserve them.” Frankly, that is complete bullshit. That is one of the LIES we tell ourselves. First of all, there are enough benefits to go around. Your benefits do not affect any other veterans’ benefits! But more important, if you have any kind of disability as a result of your service, then, guess what: you deserve benefits. Yes, you read that correctly, you **DESERVE** benefits for your honorable service.

Allow me to give you permission to be disabled. You don’t have to pretend you’re fine or suffer alone in silence. The notion of service before self may have served you well while you wore the uniform. Afterward, it causes pain

and suffering. Truth is, you're no good to your family, friends, or work unless you take care of you **FIRST**.

Further, not all disabilities are visible. Most—yes, most—veterans struggle with undiagnosed mental health issues, such as Post Traumatic Stress Disorder, anxiety, and depression. Often, these lead to substance abuse and almost always, they lead to isolation and loneliness. I want to tell you right now that you are important, and you matter. My colleagues and I have been where you are. I can be in a room full of people and feel alone, completely detached.

When you wear the uniform, you're connected with other people who've experienced the same stuff. Then you take the uniform off and are surrounded by people who can't possibly comprehend what you've experienced. You feel separate from the reality everybody else lives in. I hear stories like this **ALL** the time. People come to us not only for help applying for financial benefits, but because they crave identity, community, and purpose in life. They want to feel important again. Our fellow veterans tell us they feel lost after service. They feel like people hear the word veteran and immediately think they're broken or crazy. This leads them to try and pretend like everything's fine and ignore whatever struggles they face.

But you might not be fine—and that's okay. It's okay not to be okay! You experienced tough stuff while you served, and now you're processing it. This is exactly why there are resources to help you. The VA exists to help you. And my company VA Claims Insider exists to make sure you get that help.

Need Immediate Help Now?

I will cover mental health resources in depth later, but if you need help right now, or are thinking about taking your own life, I am directing you to dial 988 and press 1, or chat with someone online at VeteransCrisisLine.net. You can also send a text message to 838255. America loses roughly 22 veterans to suicide every day. Please don't be one of them. God created you for a reason and your life matters. I lived to tell you that!

Okay, let's get started.

Before we jump into the list of 100+ common VA secondary claims to include medical research studies and BVA case history examples, let's quickly cover the 5 types of service connection. While this guide is mainly focused on #2,

Secondary Service Connection, please don't limit yourself! The strategies taught in this eBook might not be a good fit for your VA disability conditions.

5 Types of Service Connection

#1. Direct Service Connection: This is the most common method of service connection for VA disability compensation benefits. You're telling the VA that your current disability condition is the direct result of your active duty military service. Perhaps it was a training incident, car accident, combat deployment, stress from the job, or other in-service incident, injury, event, or disease that directly caused or made your current disability condition worse. An example is combat PTSD due to constant rocket and mortar attacks in Afghanistan. The PTSD is due to your combat deployment, which is directly related to your military service.

#2. Secondary Service Connection: In accordance with 38 CFR § 3.310 current disability condition that is proximately due to or the result of a service-connected disease or injury shall also be service connected. Let's say, for example, you contracted tinnitus while serving. Today, even though you are no longer serving, that service-connected tinnitus might be causing migraine headaches, anxiety, and/or depression. Service connection on a secondary basis requires a "showing of causation." Instead of proving that your disability is directly service-connected, you'll need to prove that it's caused or made worse by a different disability (which is service-connected). In this example, you could file a VA disability claim for migraine headaches secondary to your service-connected tinnitus. Secondary Service Connection and related conditions that can be secondary VA claims are the primary focus of this eBook! **Pro Tip:** A medical nexus letter is highly recommended to help you prove secondary service connection

under the law. **>> Click HERE NOW <<** to sign up for our premier education-based Coaching/Consulting program VA Claims Insider Elite, start free today, connect with a Veteran Coach in minutes, and get high-quality Nexus Letters at reduced rates (if wanted and warranted by the evidence of record).

#3. Presumptive Service Connection: If your disability condition meets certain criteria (set forth by Congress), then your disability condition will be presumed to have been caused by service. Examples include certain chronic debilitating diseases, diseases specific to radiation exposure, diseases associated with herbicide agents (to include Blue Water Veterans), Persian Gulf War Veterans, and Camp Lejeune Veterans. (38 CFR § 3.309 discusses diseases subject to presumptive service-connection in more detail.) **Pro Tip:** While you are not required to provide a "Nexus" to establish presumptive service connection, it's highly recommended that you at least write a personal statement as to WHY you think your disability meets the legal requirements for presumptive service connection. You might want to obtain a medical nexus letter as well.

#4. Service Connection by Aggravation: Sometimes a pre-existing condition is worsened by military service. For example, a veteran may have had flat feet prior to entering service but wearing military boots and prolonged standing worsened his or her flat feet leading to a painful disability called plantar fasciitis, which is eligible for compensation under the law. Additionally, if a veteran has a service-connected knee condition that aggravates a non-service-connected back condition, they could get service connection for their back based on aggravation—provided they can

prove that their condition was worsened beyond its natural progression by military service.

#5. Service Connection by 38 U.S.C 1151: This refers to disabilities or death that result from "hospital care, medical or surgical treatment, or examination" by a VA medical professional or facility, or due to participation in a program of vocational rehabilitation. In my experience, this type of service connection is uncommon.

The "Insider's" Guide to the VA Disability List of Secondary Conditions: 100+ Disability Conditions for Secondary Service Connection Revealed!

Hi veterans, Brian Reese here with VA Claims Insider, and in this expert-level guide, I'm going to reveal and explain my **Top 100+ VA Disability List of Secondary Conditions.** This list is definitely not exhaustive although we tried to stick with the most common VA secondary claims.

You'll learn about VA secondary conditions as well as **HOW** to get your secondary VA claims "service connected" so you might become eligible for VA disability benefits under the law.

Can VA Secondary Conditions be Service Connected?

VA secondary conditions include any of the 834+ disabilities listed in **CFR Title 38, Part 4, the Schedule for Rating Disabilities** that can be service connected **SECONDARY** to a current VA disability you're already rated for at 0% or higher.

For example, let's say you've got Tinnitus service connected at 10%, but because of the severity of your Tinnitus, you've developed Migraine Headaches.

You can open a new VA claim on the **VA.gov** website, and file a claim for **Migraines Secondary to Tinnitus**, and get service connected and rated at 0%, 10%, 30%, or 50% for your Migraine (Headaches), depending on the

Frequency, Severity, and Duration of your symptoms as well as how your symptoms negatively affect your work, life, and/or social functioning.

What is Secondary Service Connection?

In accordance with **38 CFR § 3.310** disabilities that are proximately due to, or aggravated by, service-connected disease or injury, a current disability condition, which is proximately due to or the result of a service-connected disease or injury shall be service connected.

Service connection on a secondary basis requires a "showing of causation."

A showing of causation requires that the secondary VA disability claim is "proximately due to" or "aggravated by" another service-connected disability.

There are three evidentiary elements that must be satisfied to prove VA secondary service connection under the law:

- A medical diagnosis of the secondary VA disability you're attempting to link to the current service connected disability (must be documented in a medical record) **AND**

- A current service-connected primary disability (e.g., your current list of service connected disabilities from your VA.gov account) **AND**

- Medical nexus evidence establishing a connection between the service-connected primary condition **AND** the current disability you're trying to connect secondary (e.g., Migraines, Sleep Apnea, GERD, IBS, Erectile Disfunction / Female Sexual Arousal Disorder, Radiculopathy, etc.)

The **FIRST** part can be satisfied with any existing medical evidence in service treatment records, VA medical records, or any private medical records.

The **SECOND** part can be satisfied with a veteran's existing service-connected disability rated at 0% or higher.

The **THIRD** part, and often the missing link needed to establish secondary service connection, can be satisfied with a credible **Medical Nexus Letter** (Independent Medical Opinion) from a qualified medical provider.

>> Click HERE for a list of doctors who write nexus letters for veterans!

Did you know there are **HUNDREDS** of common secondary VA claims that you can get service connected by law?

Truth bomb 💣 here veterans…

You could be missing out on thousands of dollars of tax-free disability compensation you deserve by law, and not even realize that your current VA disability might be caused or aggravated by an existing service connected disability.

Pro Tip: A Nexus Letter is **HIGHLY RECOMMENDED** to help establish secondary service connection.

Why?

Because “Medical Nexus Evidence” is needed to satisfy the third evidentiary element that must be satisfied to prove your secondary VA claim on an “at least as likely as not” basis.

Need a Nexus Letter to Help Establish Secondary Service Connection?

Click **HERE now to join VA Claims Insider Elite**, our premier education-based membership program, which also gets you discounted access to independent medical providers in our referral network for medical examinations, VA disability evaluations, and credible Nexus Letters for a wide range of conditions! We’re a company **OF** veterans, **BY** veterans, **FOR** veterans. And we help veterans get the VA rating they deserve in less time, if they’ve already filed, been denied, or have given up hope.

VA Disability List of Secondary Conditions in Alphabetical Order from A to Z (Quick Reference)

- Anxiety secondary to Tinnitus
- Asthma secondary to GERD (acid reflux or heartburn)
- Asthma secondary to Obstructive Sleep Apnea

- Asthma secondary to Depression
- Asthma secondary to Anxiety
- Asthma secondary to Allergies
- Asthma secondary to Nasal polyps
- Asthma secondary to Vocal Cord Dysfunction (Inducible Laryngeal Obstruction)
- Asthma secondary to Asthma-COPD overlap syndrome
- Asthma secondary to Bronchiectasis
- Asthma secondary to Diabetes
- Bruxism secondary to PTSD
- Bruxism secondary to Depression
- Bruxism secondary to Anxiety
- Bruxism secondary to Tinnitus
- Depression secondary to Tinnitus
- Depression secondary to Migraines
- ED secondary to PTSD
- ED secondary to Depression
- ED secondary to Anxiety
- ED secondary to Medication Side Effects

- ED secondary to Heart Disease
- ED secondary to Atherosclerosis
- ED secondary to High Cholesterol
- ED secondary to Hypertension
- ED secondary to Diabetes
- ED secondary to Weight Gain Obesity as Interim Link
- ED secondary to Parkinson's Disease
- ED secondary to Multiple Sclerosis
- ED secondary to Prostate Cancer
- ED secondary to Spinal Cord Injuries
- Female Sexual Arousal Disorder secondary to PTSD
- Female Sexual Arousal Disorder secondary to Depression
- Female Sexual Arousal Disorder secondary to Anxiety
- Female Sexual Arousal Disorder secondary to Heart Disease
- Female Sexual Arousal Disorder secondary to Neurological Conditions
- Female Sexual Arousal Disorder secondary to Gynecological conditions, such as Vulvovaginal Atrophy, Infections or Lichen Sclerosis
- Female Sexual Arousal Disorder secondary to Medication Side Effects

- Fibromyalgia secondary to IBS
- Fibromyalgia secondary to Migraines
- Fibromyalgia secondary to Interstitial Cystitis or Painful Bladder Syndrome
- Fibromyalgia secondary to Temporomandibular Joint Disorders
- Fibromyalgia secondary to Anxiety
- Fibromyalgia secondary to Depression
- Fibromyalgia secondary to Postural Tachycardia Syndrome
- GERD secondary to Asthma
- GERD secondary to PTSD
- GERD secondary to Depression
- GERD secondary to Anxiety
- GERD secondary to Medication Side Effects
- GERD secondary to Weight Gain Obesity as Interim Link
- Hypertension secondary to Sleep Apnea
- Hypertension secondary to PTSD
- Hypertension secondary to Weight Gain Obesity as Interim Link
- Hypertension secondary to Kidney Disease
- Hypertension secondary to Diabetes

- Hypertension secondary to Hyperthyroidism
- Hypertension secondary to Lupus
- Hypertension secondary to Scleroderma
- IBS secondary to PTSD
- IBS secondary to Depression
- IBS secondary to Anxiety
- IBS secondary to Medication Side Effects
- IBS secondary to Weight Gain Obesity as Interim Link
- Meniere’s Syndrome secondary to Tinnitus
- Meniere’s Syndrome secondary to Hearing Loss
- Meniere’s Syndrome secondary to Migraines
- Meniere’s Syndrome secondary to TBI
- Migraines secondary to Tinnitus
- Migraines secondary to Cervical Strain
- Migraines secondary to GERD
- Migraines secondary to IBS
- Migraines secondary to PTSD
- Migraines secondary to Insomnia
- Migraines secondary to Depression

- Migraines secondary to Anxiety
- Migraines secondary to TBI
- Migraines secondary to Medication Side Effects
- Migraines secondary to Meniere’s Disease
- Migraines secondary to Fibromyalgia
- Migraines secondary to Heart Disease
- Migraines secondary to Asthma
- Plantar Fasciitis secondary to Foot Condition
- Plantar Fasciitis secondary to Back Condition
- Plantar Fasciitis secondary to Knees, Hips, Joint Instability
- Plantar Fasciitis secondary to Weight Gain Obesity as Interim Link
- Radiculopathy secondary to Back Pain
- Radiculopathy secondary to Lumbosacral or Cervical Strain
- Radiculopathy secondary to Spinal Stenosis
- Radiculopathy secondary to Spondylolisthesis
- Radiculopathy secondary to Ankylosing Spondylitis
- Radiculopathy secondary to Spinal Fusion
- Radiculopathy secondary to Spinal Fusion
- Radiculopathy secondary to Vertebral Fracture or Dislocation

- Restless Leg Syndrome secondary to Back Condition
- Restless Leg Syndrome secondary to Neck Condition
- Restless Leg Syndrome secondary to Medication Side Effects
- Restless Leg Syndrome secondary to Peripheral Neuropathy
- Sleep Apnea secondary to PTSD
- Sleep Apnea secondary to Sinusitis
- Sleep Apnea secondary to Rhinitis
- Sleep Apnea secondary to Deviated Septum
- Sleep Apnea secondary to Asthma
- Sleep Apnea secondary to Weight Gain Obesity as Interim Link
- Sleep Apnea secondary to GERD
- Somatic Symptom Disorder secondary to Tinnitus
- Somatic Symptom Disorder secondary to Back Condition
- Somatic Symptom Disorder secondary to Neck Condition
- Vertigo secondary to Tinnitus
- Vertigo secondary to Migraines
- Vertigo secondary to Medication Side Effects
- Vertigo secondary to Head or Neck Conditions
- Vertigo secondary to TBI

100+ Most Common VA Secondary Claims Explained with Medical Research Studies & BVA Case History Example (if applicable)

Anxiety secondary to Tinnitus

Plenty of medical research studies point to the prevalence of Anxiety and Depression mental disorders in veterans with Tinnitus.

For example, a 2015 joint study in coordination a VA Medical Center in California called, **"The Correlation of the Tinnitus Handicap Inventory with Depression and Anxiety in Veterans with Tinnitus,"** revealed that a shocking 79.1% of the 91 Tinnitus sufferers had a diagnosis of Anxiety, 59.3% had Depression, and 58.2% suffered from **BOTH** Anxiety and Depression.

According to the **American Tinnitus Association**, Anxiety and Depression issues can be both a contributing factor to Tinnitus and a consequence of burdensome Tinnitus. Tinnitus symptoms often result in feelings of anxiety and depression.

Current estimates suggest that 48-78% of patients with severe tinnitus also experience depression, anxiety, or some other behavioral disorder. 13% of ATA's membership self-identified as being diagnosed with a mental health

issue. At the same time, pre-existing behavioral conditions may make it more likely that the patient will experience tinnitus as a burdensome condition. For example, one large cohort population study found that people with Generalized Anxiety Disorder are nearly 7x more likely to experience chronic, burdensome tinnitus.

Can Anxiety be a secondary VA claim to Tinnitus?

Yes, Anxiety can be service connected secondary to Tinnitus.

The **VA Ratings for Anxiety** secondary to Tinnitus are 0%, 10%, 30%, 50%, 70%, or 100%, depending upon the severity of your anxiety disorder, and how your anxiety symptoms affect your work, life, and social functioning.

For example, a veteran may only have a 10% rating for Tinnitus but could possibly receive a 70% or 100% VA rating (lower or higher rating possible as well) for Anxiety secondary to Tinnitus.

VA Disability Ratings for Anxiety Explained:

How is Anxiety Rated by the VA?

Medical Research Study:

Tinnitus Among Patients with Anxiety Disorder: A Nationwide Longitudinal Study.

BVA Case History Example:

Generalized Anxiety Disorder and Major Depressive Disorder Secondary to Tinnitus Is Granted.

Asthma secondary to GERD (severe acid reflux / heartburn)

According to the **Mayo Clinic**, “Asthma and acid reflux often occur together. Acid reflux can worsen asthma and asthma can worsen acid reflux — especially severe acid reflux, a condition known as Gastroesophageal Reflux

Disease (GERD). Asthma and acid reflux can occur together in children as well as in adults."

Veterans with asthma are at higher risk of developing GERD. Asthma flare-ups can cause the lower esophageal sphincter to relax, allowing stomach contents to flow back, or reflux, into the esophagus. Some asthma medications, such as Theophylline may worsen reflux symptoms.

The prevalence of **GERD in asthma patients** has ranged from 25% to 80% in studies, many of which use self-reported GERD. In a study conducted by the American Lung Association Asthma Clinical Research Centers (ACRC) Network, 38% of asthma patients had GERD (as defined by a positive pH probe).

Acid reflux can also make asthma symptoms worse by irritating the airways and lungs, leading to progressively more serious asthma. Also, this irritation can trigger allergic reactions and make the airways more sensitive to environmental conditions such as smoke or cold air.

Can Asthma be service connected secondary to GERD?

Yes, asthma secondary to GERD is a common secondary VA claim, and it can be rated at 10%, 30%, 60%, or 100% depending upon the frequency, severity, and duration of your asthma symptoms.

Asthma is a bronchial disorder rated under **CFR 38, Part 4, VA Schedule of Ratings, Diagnostic Code 6602, Asthma, Bronchial.**

VA Rating for Asthma Explained:

What are the VA Disability Ratings for Asthma?

Medical Research Study:

Is There a Relationship Between GERD and Asthma?

BVA Case History Example:

Asthma Secondary to GERD Is Granted.

Asthma secondary to Obstructive Sleep Apnea

Plenty of medical research studies point to a bidirectional relationship between Asthma and Sleep Apnea. The more severe your Asthma, the more likely you are to have or develop Sleep Apnea.

Recent studies have shown that there is a link between bronchial Asthma and Obstructive Sleep Apnea (OSA) and there is a bidirectional relationship where each disorder adversely influences the other one. Patients of asthma appear to have an increased risk for OSA than general population. The first study that examines asthma and OSA was a case report by Hudgel and Shucard in 1979. Since then, several studies have shown an increased prevalence of sleep disturbances among asthmatic patients. Epidemiological studies demonstrate that asthma patients more frequently report snoring, excessive daytime sleepiness, and apnea. A recent population-based prospective epidemiological study showed that asthma is associated with an increased risk of new-onset OSA. In this landmark study, the incidence of OSA over 4 years in patients with self-reported asthma was 27%, compared with 16% without asthma. The relative risk adjusted for risk factors such as body mass index, age, and gender were 1.39 (95% confidence interval: 15%–19%).

A **2019 study** found that accumulating epidemiologic, physiologic, and biologic data converge to support a bidirectional interaction between asthma and Obstructive Sleep Apnea aside from shared factors, such that the nasal, pharyngeal, and lower airways are indeed “united” (e.g., the severity and duration of asthma impact the predisposition to Obstructive Sleep Apnea. Underlying pathways include 1) “spillover” systemic inflammation or neuroimmune cross-talk to alter breathing control mechanisms, and 2) the effects of ICS on upper-airway muscle and fat content, to alter the anatomy.

Can Asthma be secondary to Sleep Apnea?

Yes, asthma secondary to Sleep Apnea is a common secondary claim for secondary service connection, and it can be rated at 10%, 30%, 60%, or

100% depending upon the frequency, severity, and duration of your asthma symptoms.

Asthma is a bronchial disorder rated under **CFR 38, Part 4, VA Schedule of Ratings, Diagnostic Code 6602, Asthma, Bronchial.**

VA Rating for Asthma Explained:

What are the VA Disability Ratings for Asthma?

Medical Research Study:

Asthma and Obstructive Sleep Apnea: More Than an Association!

BVA Case History Example:

Asthma secondary to GERD and Sleep Apnea is granted.

Asthma secondary to Depression

On a physical level, stress does cause some issues that may contribute to asthma. For example, anxiety can release an excess of histamine (the chemical that causes allergies) that can lead to asthma attacks. Stress may also weaken your immune system in such a way that you become more vulnerable to viruses and external asthma triggers.

According to **Asthma and Allergy Foundation of America**, strong emotions and stress are well known triggers of asthma and there is evidence of a link between asthma, anxiety, and depression.

It is also proven that **anxiety and depression can negatively affect the course of asthma,** resulting in increased symptoms, increased use of health care services, and frequent asthma attacks / exacerbations.

Can Asthma be a secondary VA claim to Depression?

Yes, Asthma can be service-connected secondary to Depression.

The **VA Ratings for Asthma** secondary to Depression are 10%, 30%, 60%, or 100%, depending upon the severity of your Asthma, and how your Asthma symptoms affect your work, life, and social functioning.

For example, a veteran may only have a 10% rating (or higher) for Depression but could possibly receive a 60% or 100% VA rating (lower or higher rating possible as well) for Asthma secondary to Depression.

VA Disability Ratings for Asthma Explained:

How is Asthma Rated by the VA?

Medical Research Study:

Severe Asthma and Mental Health

BVA Case History Example:

Asthma secondary to Depression is remanded

Asthma secondary to Depression is remanded (2)

Asthma secondary to Anxiety

Studies show that stress and anxiety can trigger asthma attacks. At the same time, the wheezing and difficult breathing that you feel during an asthma attack can cause anxiety. In fact, 69 percent of people with asthma say that stress is a trigger for them According to Asthma UK in an article by **Premier Health.com**.

Living with constant stress may also cause you to be angry or to drink or smoke more, in an effort to relax. These actions can also trigger asthma, especially if your asthma is not well managed.

One **study** found a significant stressful life experience, such as the death of a close family member, increased the risk of an asthma attack by nearly twofold in children with asthma.

Research has also shown that the body's response to stress triggers the immune system and causes the release of certain hormones. This can lead to inflammation within the airways of the lungs, triggering an asthma attack.

Can Asthma be a secondary VA claim to Anxiety?

Yes, Asthma can be service-connected secondary to Anxiety.

The VA Ratings for Asthma secondary to Anxiety are 10%, 30%, 60%, or 100%, depending upon the severity of your Asthma, and how your Asthma symptoms affect your work, life, and social functioning.

For example, a veteran may only have a 10% rating (or higher) for Anxiety but could possibly receive a 60% or 100% VA rating (lower or higher rating possible as well) for Asthma secondary to Anxiety.

VA Disability Ratings for Asthma Explained:

How is Asthma Rated by the VA?

Medical Research Study:

Stress and Inflammation in Exacerbations of Asthma

BVA Case History Example:

As of this writing, a BVA case history example could not be located. However, it's still possible to connect the two conditions depending upon your medical evidence and medical research.

Asthma secondary to Allergies

A Mayo Clinic specialist stated and explained that Allergies and asthma are connected and often occur together. In some people, skin or food allergies can cause asthma symptoms and this is called allergic asthma or allergy-induced asthma.

James T C Li, M.D., Ph.D. said that an allergic response occurs when immune system proteins (antibodies) mistakenly identify a harmless

substance, such as tree pollen, as an invader. In an attempt to protect your body from the substance, antibodies bind to the allergen.

The chemicals released by your immune system lead to allergy signs and symptoms, such as nasal congestion, runny nose, itchy eyes or skin reactions. For some people, this same reaction also affects the lungs and airways, leading to asthma symptoms.

The symptoms that go along with allergic asthma show up after you breathe things called allergens (or allergy triggers) like pollen, dust mites, or mold

Can Asthma be a secondary VA claim to Allergies?

Yes, Asthma can be service-connected secondary to Allergies.

The **VA Ratings for Asthma** secondary to Allergies are 10%, 30%, 60%, or 100%, depending upon the severity of your Asthma, and how your Asthma symptoms affect your work, life, and social functioning.

VA Disability Ratings for Asthma Explained:

How is Asthma Rated by the VA?

Medical Research Studies:

The link between allergic rhinitis and asthma: A role for antileukotrienes?

Allergies and Asthma: Is there a Connection?

BVA Case History Example:

Asthma secondary to Allergies is granted

Asthma secondary to Allergic Rhinitis is granted

Asthma secondary to Nasal Polyps

A **study** concluded that among asthmatic subjects, those with Chronic Rhinosinusitis with Nasal Polyps (CRSwNP) presented more poorly

controlled asthma, increased airway obstruction, and marked lower airway inflammation than those without CRSwNP. The same authors have suggested that a subgroup of asthmatic patients may have a more intense lower airway inflammation in relation to the presence of CRSwNP. They observed that asthmatic subjects using intranasal corticosteroids (ICS) to treat nasal polyps had a more intense inflammation and poorer asthma control compared to patients with chronic rhinosinusitis without nasal polyps, reflecting a more severe subset of asthma.

Can Asthma be a secondary VA claim to Nasal Polyps?

Yes, Asthma can be service-connected secondary to Nasal Polyps.

The **VA Ratings for Asthma** secondary to Nasal Polyps are 10%, 30%, 60%, or 100%, depending upon the severity of your Asthma, and how your Asthma symptoms affect your work, life, and social functioning.

For example, a veteran may only have a 0% rating (or higher) for Nasal Polyps but could possibly receive a 60% or 100% VA rating (lower or higher rating possible as well) for Asthma secondary to Nasal Polyps.

VA Disability Ratings for Asthma Explained:

How is Asthma Rated by the VA?

Medical Research Studies:

The clinical relationship of nasal polyps to asthma

Nasal polyps in patients with asthma: prevalence, impact, and management challenges

BVA Case History Example:

Asthma secondary to Nasal Polyps (Allergic Rhinitis) is Granted

Asthma secondary to Vocal Cord Dysfunction (Inducible Laryngeal Obstruction)

It is recognized that Vocal Cord Dysfunction (Inducible Laryngeal Obstruction) could either mimic or coexist with asthma.

The percentage of asthma in patients with VCD alone was higher in a **study**, wherein among 95 patients with laryngoscopically proved VCD, 56% suffered concomitantly from asthma.

It was also **concluded** that one of the more common disorders associated with difficult-to-control asthma is inducible laryngeal obstruction.

Can Asthma be a secondary VA claim to Vocal Cord Dysfunction (Inducible Laryngeal Obstruction)?

Yes, Asthma can be service-connected secondary to Vocal Cord Dysfunction (Inducible Laryngeal Obstruction).

The **VA Ratings for Asthma** secondary to Vocal Cord Dysfunction (Inducible Laryngeal Obstruction) are 10%, 30%, 60%, or 100%, depending upon the severity of your Asthma, and how your Asthma symptoms affect your work, life, and social functioning.

For example, a veteran may only have a 0% rating (or higher) for Vocal Cord Dysfunction (Inducible Laryngeal Obstruction) but could possibly receive a 60% or 100% VA rating (lower or higher rating possible as well) for Asthma secondary to Vocal Cord Dysfunction.

VA Disability Ratings for Asthma Explained:

How is Asthma Rated by the VA?

Medical Research Studies:

Differentiating vocal cord dysfunction from asthma

Inducible Laryngeal Obstruction/Vocal Cord Dysfunction and the Role It Plays in Refractory Asthma

BVA Case History Example:

Asthma secondary to Vocal Cord Dysfunction (Inducible Laryngeal Obstruction) is granted

Asthma secondary to Asthma-COPD overlap syndrome

Asthma-COPD overlap syndrome (ACOS) is diagnosed when you have symptoms of both asthma and COPD. Chronic obstructive pulmonary disease (COPD) is the name for a group of lung conditions that cause breathing difficulties.

People with a diagnosis of ACOS tend to have more symptoms than people with either asthma or COPD alone and have more severe attacks, leading to more emergency room visits and hospitalizations. It is important to find out if you have ACOS because it can be more serious than having either asthma or COPD alone.

Asthma-COPD overlap syndrome (ACOS) has a higher disease burden than either condition alone. Patients with ACOS have frequent exacerbations, poor quality of life, a more rapid decline in lung function, and high mortality.

Can Asthma be a secondary VA claim to Asthma-COPD overlap syndrome?

Yes, Asthma can be service-connected secondary to Asthma-COPD overlap syndrome.

The **VA Ratings for Asthma** secondary to Asthma-COPD overlap syndrome are 10%, 30%, 60%, or 100%, depending upon the severity of your Asthma, and how your Asthma symptoms affect your work, life, and social functioning.

For example, a veteran may only have a 0% rating (or higher) for Asthma-COPD overlap syndrome but could possibly receive a 60% or 100% VA rating (lower or higher rating possible as well) for Asthma secondary to Asthma-COPD overlap syndrome.

VA Disability Ratings for Asthma Explained:

How is Asthma Rated by the VA?

Medical Research Studies:

Is It Asthma, COPD or Both?

The Asthma-COPD Overlap Syndrome

BVA Case History Example:

As of this writing, a BVA case history example could not be located. However, it's still possible to connect the two conditions depending upon your medical evidence and medical research.

Asthma secondary to Bronchiectasis

A **study** concluded that Bronchiectasis is associated with difficult asthma control.

The annual incidence of asthma exacerbation was higher in patients with asthma and bronchiectasis than in patients with asthma alone (1.08±1.68 vs. 0.35±0.42, p=0.004).

The reported prevalence of asthma in patients with bronchiectasis ranges from 2.7% to 42% in different series.

Although Bronchiectasis is common among patients with severe uncontrolled asthma, it might even make their asthma worse, as **concluded** by a study of the **Sotiria Chest Diseases Hospital** in Athens, Greece.

In fact, the type of inflammation seen in patients with both asthma and bronchiectasis might render them insensitive to typical asthma treatment.

Can Asthma be a secondary VA claim to Bronchiectasis?

Yes, Asthma can be service-connected secondary to Bronchiectasis.

The **VA Ratings for Asthma** secondary to Bronchiectasis are 10%, 30%, 60%, or 100%, depending upon the severity of your Asthma, and how your Asthma symptoms affect your work, life, and social functioning.

For example, a veteran may only have a 0% rating (or higher) for Bronchiectasis but could possibly receive a 60% or 100% VA rating (lower or higher rating possible as well) for Asthma secondary to Bronchiectasis.

VA Disability Ratings for Asthma Explained:

How is Asthma Rated by the VA?

Medical Research Study:

The Effects of Bronchiectasis on Asthma Exacerbation

Differences Between Asthma and Bronchiectasis

BVA Case History Example: Asthma secondary to Bronchiectasis is remanded

Asthma secondary to Diabetes

Years of research conducted by health care experts proved that people with poorly controlled diabetes are more prone to the weak functioning of lungs than those who have balanced and well controlled diabetes. In addition, studies showed that diabetics suffer from higher rates of asthma attacks than as compared to people without Diabetes.

On the reverse side, **studies** also concluded that people who suffer from asthma are at a higher risk of developing diabetes and need to be careful.

Diabetic patients also tend to have a hard time maintaining their blood glucose levels and keeping their asthma under control.

Can Asthma be a secondary VA claim to Diabetes?

Yes, Asthma can be service-connected secondary to Diabetes.

The **VA Ratings for Asthma** secondary to Diabetes are 10%, 30%, 60%, or 100%, depending upon the severity of your Asthma, and how your Asthma symptoms affect your work, life, and social functioning.

For example, a veteran may only have a 10% rating (or higher) for Diabetes but could possibly receive a 60% or 100% VA rating (lower or higher rating possible as well) for Asthma secondary to Diabetes.

VA Disability Ratings for Asthma Explained:

How is Asthma Rated by the VA?

Medical Research Study:

Asthma and Diabetes: What's the Connection?

BVA Case History Example:

Asthma secondary to Diabetes is remanded

Bruxism secondary to PTSD

Bruxism, which is the medical term for excessive teeth grinding or clenching, is often seen in those with TMD, as well as in those with PTSD. For VA purposes, bruxism can only be evaluated on a secondary basis as a symptom of another service-connected disability.

According to **Sebastian Ciancio, D.D.S.**, professor and chair in the Department of Periodontology in the University of Buffalo School of Dental Medicine and senior author of a study, his patients, because of their illness, do not carry out good oral hygiene compared to non-PTSD patients. "This wearing away of the tooth surface along the neck of the tooth where the enamel meets the root surface may be caused by bruxism and clenching, which is high in this group of patients," he said.

Can Bruxism be a secondary VA claim to PTSD?

Yes, Bruxism can be service-connected secondary to PTSD.

The VA Schedule of Ratings for Dental and Oral Conditions does not provide a specific diagnostic code for Bruxism. However, this condition is usually rated under diagnostic code 9905 or 9913 depending on the symptoms the veteran is experiencing. VA has determined that only secondary service connection for treatment purposes is warranted for this condition, both because it is only a secondary condition, not a primary condition.

VA Disability Ratings for Bruxism Explained:

How is Bruxism Rated by the VA?

Medical Research Study:

PTSD Patients Damage Teeth Through Involuntary Grinding, Clenching, University of Buffalo Study Finds

BVA Case History Example:

Bruxism secondary to PTSD is granted

Bruxism secondary to Depression

Bruxism is the clinical term for the grinding or clenching of teeth while asleep. The consequences of chronic bruxism are many, ranging from a sore jaw, facial pain, and irritating one's sleeping partner, to exposing the inner layers of teeth from the repetitive wearing of enamel, tooth loss, hearing loss, and temporomandibular joint disorder. While this relatively common sleep disorder is thought to have a complex etiology, many have noted psychological antecedents. In particular, bruxism seems to be more severe during periods of heightened stress and anxiety.

The grinding of teeth has long been held as one physical manifestation of stress and anxiety. For example, individuals who grind their teeth tend to report more symptoms of anxiety and depression than non-bruxers **(Gungormus & Erciyas, 2009; Manfredini, Landi, Romagnoli, & Bosco, 2004)**. And, compared to non-bruxers, those who grind their teeth tend to report greater life stress and are more likely to suffer from DSM-defined depression and anxiety disorders **(Ohayon, Li, & Guilleminault, 2001)**.

Even in rats, experimentally inducing emotional stress leads to brux-like symptoms, compared to controls **(Rosales et al., 2002).**

Can Bruxism be a secondary VA claim to Depression?

Yes, Bruxism can be service-connected secondary to Depression.

The VA Schedule of Ratings for Dental and Oral Conditions does not provide a specific diagnostic code for Bruxism. However, this condition is usually rated under diagnostic code 9905 or 9913 depending on the symptoms the veteran is experiencing. VA has determined that only secondary service connection for treatment purposes is warranted for this condition, both because it is only a secondary condition, not a primary condition.

VA Disability Ratings for Bruxism Explained:

How is Bruxism Rated by the VA?

Medical Research Studies:

Getting to The Crux of Bruxism

Causes of Bruxism

BVA Case History Example:

Bruxism secondary to Depression is granted

Bruxism secondary to Anxiety

According to board-certified rheumatologist **Mark BorgInI M.D.**, while bruxism is more common in individuals with depression and anxiety disorders, the catch is that many of the medications used to treat anxiety and depression can themselves often create new bruxism, or make worse the pre-existing bruxism. And while it may not be reassuring, we humans are not alone when it comes to those afflicted with bruxism: it is interesting to note that bruxism is a not unusual mammalian response to stress.

Mental disorders, anxiety, stress and adverse psychosocial factors are significantly related to tooth grinding during sleep and it has been found that nearly 70% of bruxism occurs as a result of stress or anxiety.

Also, the use of psychoactive substances (tobacco, alcohol, caffeine, or medications for sleep, depression, and anxiety) increases arousal and leads to problems falling asleep, staying asleep and daytime sleepiness. Bruxism is significantly higher in individuals whose lifestyle includes the use of these psychoactive substances.

Can Bruxism be a secondary VA claim to Anxiety?

Yes, Bruxism can be service-connected secondary to Anxiety.

The VA Schedule of Ratings for Dental and Oral Conditions does not provide a specific diagnostic code for Bruxism. However, this condition is usually rated under diagnostic code 9905 or 9913 depending on the symptoms the veteran is experiencing. VA has determined that only secondary service connection for treatment purposes is warranted for this condition, both because it is only a secondary condition, not a primary condition.

VA Disability Ratings for Bruxism Explained:

How is Bruxism Rated by the VA?

Medical Research Studies:

Getting to The Crux of Bruxism

Causes of Bruxism

BVA Case History Example:

Bruxism secondary to Anxiety is granted

Bruxism secondary to Tinnitus

Tinnitus and bruxism go together and the relationship between the two is quite elaborate.

Tinnitus frequency was higher in patients with sleep bruxism and chronic facial pain according to a clinical evaluation of the prevalence and characteristics of tinnitus in a Brazilian series of sleep bruxism patients.

Moreover, according to an **article** published by Amplifon, a global hearing care provider, dysfunctions of the temporomandibular joint are characterized, in some cases, by the presence of ringing in the ear, balance disorders and ear pain. The relationship between ear diseases and alterations of the temporomandibular joint was described for the first time in 1934 by the American otolaryngologist James Bray Costen who noted how many patients complained of severe ear pain despite having a completely healthy ear. Costen attributed these symptoms to a malfunction of the temporomandibular joint. When pressure is put on the joint, it radiates into the ears since they are in close proximity. The pressure irradiated to the ear causes a ringing feeling due to the bone structure responding to the teeth grinding and clenching.

Can Bruxism be a secondary VA claim to Tinnitus?

Yes, Bruxism can be service-connected secondary to Tinnitus.

The VA Schedule of Ratings for Dental and Oral Conditions does not provide a specific diagnostic code for Bruxism. However, this condition is usually rated under diagnostic code 9905 or 9913 depending on the symptoms the veteran is experiencing. VA has determined that only secondary service connection for treatment purposes is warranted for this condition, both because it is only a secondary condition, not a primary condition.

VA Disability Ratings for Bruxism Explained:

How is Bruxism Rated by the VA?

Medical Research Study:

All about the Relationship between Bruxism and Tinnitus

BVA Case History Example:

[Bruxism secondary to Tinnitus is granted]

Depression Secondary to Tinnitus

There are two types of depression that the VA recognizes under this category: major depressive disorder and dysthymic disorder. A diagnosis of major depressive disorder requires at least two major episodes of depression lasting at least two weeks**.**

In a **recent study** conducted on veterans with tinnitus, clinicians found that 59.3 percent of the study participants had depression and 58.2 percent of the study participants had both depression and anxiety. These findings align with research done by other otolaryngologists in the field, who found that the likelihood of someone developing lifetime depression and anxiety is significantly higher among individuals with tinnitus than it is for the general population.

Severe, constant tinnitus can make it difficult to accomplish routine daily tasks. Despite the severe effects tinnitus can have on your life, the maximum schedular disability rating for tinnitus is only 10 percent; however, due to the intense effects tinnitus can have on daily living, many veterans with this condition are unable to hold substantially gainful occupations and are therefore eligible for a total disability rating based on individual unemployability (a TDIU rating), especially if they are able to obtain service connection for depression secondary to their tinnitus.

Can Depression be a secondary VA claim to Tinnitus?

Yes, Depression can be service-connected secondary to Tinnitus.

The **VA disability rates for depression** are determined using a “General Rating Formula for Mental Disorders.” This category includes a scale of how severely your depression affects or impairs your daily ability to function. The assigned VA disability rates for depression may be 0%, 10%, 30%, 50%, 70%, or 100%.

For example, a veteran may only have a 10% rating for Tinnitus but could possibly receive a 30%, 50%, 70%, or even 100% VA rating (lower or higher rating possible as well) for Depression secondary to Tinnitus.

VA Disability Ratings for Depression Explained:

5 Tips to Increase Your VA Rating for Depression

Medical Research Study:

The Correlation of the Tinnitus Handicap Inventory with Depression and Anxiety in Veterans with Tinnitus

BVA Case History Example:

Depression secondary to Tinnitus is granted

Depression Secondary to Migraines

People with chronic migraine often experience depression or anxiety disorders. It's not uncommon for people with chronic migraine to struggle with lost productivity. They may also experience poor quality of life. Some of this is due to mood disorders like depression, which may accompany migraines. In some instances, people with this condition also abuse substances.

Chronic migraine was once called transformative migraine. It's defined as a headache that lasts 15 days or more a month, for more than three months. You might expect that someone living with chronic pain would also become depressed. **Research** shows that people with other chronic pain conditions, such as lower back pain, do not get depressed as often as people who have migraines. Because of this, there's thought to be a link between migraine and mood disorders that is not necessarily due to the constant pain itself.

Dawn Buse, PhD, the director of behavioral medicine at the Montefiore Headache Center and an associate professor in the Department of Neurology at Albert Einstein College of Medicine in New York said: "It's very logical when you're living with a chronic disease like migraine, which is

affecting your life in such a big way, that you're going to feel sad, down and frustrated about how it's affecting your life."

Buse said that about 20% of people with episodic migraine—headaches on 14 or fewer days per month—may also have depression, and that number goes up as the number of headache attack days per month increases.

Can Depression be a secondary VA claim to Migraines?

Yes, Depression can be service-connected secondary to Migraines.

The **VA disability rates for depression** are determined using a "General Rating Formula for Mental Disorders." This category includes a scale of how severely your depression affects or impairs your daily ability to function. The assigned VA disability rates for depression may be 0%, 10%, 30%, 50%, 70%, or 100%.

For example, a veteran may only have a 10% rating (or higher) for Migraines but could possibly receive a 30%, 50%, or 100% VA rating (lower rating possible as well) for Depression secondary to Migraines.

VA Disability Ratings for Depression Explained:

5 Tips to Increase Your VA Rating for Depression

Medical Research Study:

The Link Between Migraines, Depression and Anxiety

BVA Case History Example:

Depression secondary to Migraines is granted

ED secondary to PTSD

Veterans with post-traumatic stress disorder (PTSD) experience high rates of sexual dysfunction.

A review study published by the **Journal of Sexual Medicine** in February 2015 found that male Veterans with PTSD were significantly more likely than their civilian counterparts to report erectile dysfunction or other sexual problems.

In another **study** of male combat Veterans diagnosed with PTSD, 85 percent reported erectile dysfunction, compared with a 22 percent rate among male combat Veterans without any mental health diagnosis.

Post-traumatic stress syndrome involves anxiety, stress, and often, interpersonal communication problems and depression. Antidepressants and anti-anxiety drugs, which may be prescribed for veterans who develop PTSD symptoms, can cause erectile dysfunction, as can other medications.

Can ED be a secondary VA claim to PTSD?

Yes, ED can be service-connected secondary to PTSD.

While ED is assigned a 0% rating under SMC-K, there are five other scheduler rating categories that are related to Erectile Dysfunction, the penis, and testicles, which are rated as follows:

DC 7520: If half or more of the penis is removed, then it is rated 30%. This condition can also be rated under the urinary rating system if that can result in a higher rating than 30%.

DC 7521: If the Glans is removed, it is rated 20%. This condition can also be rated under the urinary rating system if that can result in a higher rating than 20%.

DC 7522: If the penis is deformed and cannot erect, then it is rated 20%. The following two requirements must be met before a 20% evaluation can be assigned for deformity of the penis with loss of erectile power under **38 CFR 4.115b, DC 7522**:

- The deformity must be evident, **AND**
- The deformity *must* be accompanied by loss of erectile power.

DC 7523: Atrophy of the testicles is when they shrink and become nonfunctional. If one testicle is atrophied, then it is rated 0%. If both testicles are atrophied, then it is rated 20%.

DC 7524: If both testicles are removed, it is rated 30%. If only one testicle is removed, it is rated 0%. There are a few conditions for this code. If the testicle was removed because it was not fully developed or did not descend, then it is not ratable since this is a pre-existing condition and not directly related to military service. If the testicle had to be removed because of an injury or condition that is related to military service, and the remaining testicle is not functioning (whether it is related to service), it is rated 30%.

The **VA Ratings for ED** secondary to PTSD depends upon the severity of your ED, and how your ED symptoms affect your work, life, and social functioning.

For example, a veteran might have a 50% rating for PTSD but could possibly receive a 0% service connected SMC-K VA rating for ED secondary to PTSD. ED can be rated differently depending upon the specifics of your medical diagnoses and severity of symptoms in accordance with one of the five other DCs listed above.

VA Disability Ratings for ED Explained:

How is Erectile Dysfunction rated by the VA?

Medical Research Study:

Sexual dysfunction in veterans with post-traumatic stress disorder

BVA Case History Example:

ED secondary to PTSD is granted

ED secondary to Depression

Depression and erectile dysfunction (ED) clearly are associated. Although urologists and psychiatrists have long recognized that antidepressant

medications affect erectile function negatively, the interplay between the two conditions remains underappreciated.

Low testosterone, also known as "**low T**," is common in men with mental health issues like depression and anxiety who experience erectile dysfunction.

According to one research study, up to 47% of people with depression have unhealthy sex lives. 61% of people with severe depression have some sort of sexual problem. 40% of them end up taking antidepressants which may also affect their sexual lives. Over 80% of men with erectile dysfunction have had depression at some point in their lives.

Can ED be a secondary VA claim to Depression?

Yes, ED can be service-connected secondary to Depression.

While ED is assigned a 0% rating under SMC-K, there are five other scheduler rating categories that are related to Erectile Dysfunction, the penis, and testicles, which are rated as follows:

DC 7520: If half or more of the penis is removed, then it is rated 30%. This condition can also be rated under the **urinary rating system** if that can result in a higher rating than 30%.

DC 7521: If the Glans is removed, it is rated 20%. This condition can also be rated under the urinary rating system if that can result in a higher rating than 20%.

DC 7522: If the penis is deformed and cannot erect, then it is rated 20%. The following two requirements must be met before a 20% evaluation can be assigned for deformity of the penis with loss of erectile power under **38 CFR 4.115b, DC 7522**:

- The deformity must be evident, **AND**
- The deformity *must* be accompanied by loss of erectile power.

DC 7523: Atrophy of the testicles is when they shrink and become nonfunctional. If one testicle is atrophied, then it is rated 0%. If both testicles are atrophied, then it is rated 20%.

DC 7524: If both testicles are removed, it is rated 30%. If only one testicle is removed, it is rated 0%. There are a few conditions for this code. If the testicle was removed because it was not fully developed or did not descend, then it is not ratable since this is a pre-existing condition and not directly related to military service. If the testicle had to be removed because of an injury or condition that is related to military service, and the remaining testicle is not functioning (whether it is related to service), it is rated 30%.

The **VA Ratings for ED** secondary to Depression depends upon the severity of your ED, and how your ED symptoms affect your work, life, and social functioning.

For example, a veteran might have a 70% rating for Depression but could possibly receive a 0% service connected SMC-K VA rating for ED secondary to Depression. ED can be rated differently depending upon the specifics of your medical diagnoses and severity of symptoms in accordance with one of the five other DCs listed above.

VA Disability Ratings for ED Explained:

How is Erectile Dysfunction rated by the VA?

Medical Research Study:

Relationships between erectile dysfunction, depression, and anxiety in Japanese subjects

BVA Case History Example:

ED secondary to Depression is granted

ED secondary to Anxiety

Anxiety, especially severe anxiety, can cause a host of different issues that affect your libido and erectile function is one of them.

Ultimately, anxiety may trigger different **changes that could induce impotence**. Some of these include:

Overwhelmed Brain When you have severe anxiety, it essentially overwhelms your brain. Not just on a mental level either - it overloads your brain on a neurochemical level as well. Studies have shown that when you have severe anxiety, parts of your brain that are not linked to immediate physical survival may be less active, since they're not as important as the parts of your brain dealing with anxiety, which helps you to respond to a threat (this is the fight or flight response).

Negative Emotions Anxiety also brings some profoundly negative emotions. Unfortunately, these emotions can become problematic when it comes to sexual energy. It's harder for many men to become sexually aroused when they’re preoccupied with negative emotions.

Distracted Mind If you're too worried about your anxieties and the symptoms, then it becomes much harder to keep a focus on the present moment, which is necessary if you hope to also obtain physical arousal during intimate moments.

Over Focused Mind Some anxiety - especially panic disorder - causes someone to become too focused on the moment, especially if the moment is also causing a bit of anxiety (which sexual arousal may do). If you're paying too much attention to the moment, then you may not be able to experience the natural energy necessary to become aroused.

Cortisol and Hormones Cortisol is a hormone released during times of stress. Anxiety releases these hormones regularly. During stress, cortisol is released in excess, while testosterone decreases by a significant amount. Similarly, studies have shown that cortisol has an effect on both the brain and body that could lead to impotence and sexual dysfunction.

Can ED be a secondary VA claim to Anxiety?

Yes, ED can be service-connected secondary to Anxiety.

While ED is assigned a 0% rating under SMC-K, there are five other scheduler rating categories that are related to Erectile Dysfunction, the penis, and testicles, which are rated as follows:

DC 7520: If half or more of the penis is removed, then it is rated 30%. This condition can also be rated under the **urinary rating system** if that can result in a higher rating than 30%.

DC 7521: If the Glans is removed, it is rated 20%. This condition can also be rated under the urinary rating system if that can result in a higher rating than 20%.

DC 7522: If the penis is deformed and cannot erect, then it is rated 20%. The following two requirements must be met before a 20% evaluation can be assigned for deformity of the penis with loss of erectile power under **38 CFR 4.115b, DC 7522**:

- The deformity must be evident, **AND**
- The deformity *must* be accompanied by loss of erectile power.

DC 7523: Atrophy of the testicles is when they shrink and become nonfunctional. If one testicle is atrophied, then it is rated 0%. If both testicles are atrophied, then it is rated 20%.

DC 7524: If both testicles are removed, it is rated 30%. If only one testicle is removed, it is rated 0%. There are a few conditions for this code. If the testicle was removed because it was not fully developed or did not descend, then it is not ratable since this is a pre-existing condition and not directly related to military service. If the testicle had to be removed because of an injury or condition that is related to military service, and the remaining testicle is not functioning (whether it is related to service), it is rated 30%.

The **VA Ratings for ED** secondary to Anxiety depends upon the severity of your ED, and how your ED symptoms affect your work, life, and social functioning.

For example, a veteran might have a 50% rating for Anxiety but could possibly receive a 0% service connected SMC-K VA rating for ED secondary to Anxiety. ED can be rated differently depending upon the specifics of your medical diagnoses and severity of symptoms in accordance with one of the five other DCs listed above.

VA Disability Ratings for ED Explained:

How is Erectile Dysfunction rated by the VA?

Medical Research Study:

Relationships between erectile dysfunction, depression, and anxiety in Japanese subjects

BVA Case History Example:

ED secondary to Anxiety is granted

ED secondary to Medication Side Effects

Erectile Dysfunction is a very common side effect to psychotropic medications (those used to treat mental health issues such as PTSD, depression, and anxiety). The medications for these conditions tend to decrease sex drive which in turn, leads to ED. It is also prevalent in veterans who take pain medications for back pain.

Various risk factors can contribute to erectile dysfunction, including: medical conditions**,** particularly diabetes or heart conditions, tobacco use, being overweight, certain medical treatments, such as prostate surgery or radiation treatment for cancer Injuries, particularly if they damage the nerves or arteries that control erections, psychological conditions, such as stress, anxiety or depression and last but not the least, medications, including antidepressants, antihistamines and medications to treat high blood

pressure, pain or prostate conditions. Given the prevalence of sexual dysfunction in subjects with mental conditions like depression, it is necessary for health care providers to give a full assessment and explanation of potential side effects of antidepressants.

Can ED be a secondary VA claim to Medication Side Effects?

Yes, ED can be service-connected secondary to Medication Side Effects.

While ED is assigned a 0% rating under SMC-K, there are five other scheduler rating categories that are related to Erectile Dysfunction, the penis, and testicles, which are rated as follows:

DC 7520: If half or more of the penis is removed, then it is rated 30%. This condition can also be rated under the **urinary rating system** if that can result in a higher rating than 30%.

DC 7521: If the Glans is removed, it is rated 20%. This condition can also be rated under the urinary rating system if that can result in a higher rating than 20%.

DC 7522: If the penis is deformed and cannot erect, then it is rated 20%. The following two requirements must be met before a 20% evaluation can be assigned for deformity of the penis with loss of erectile power under **38 CFR 4.115b, DC 7522**:

- The deformity must be evident, **AND**
- The deformity *must* be accompanied by loss of erectile power.

DC 7523: Atrophy of the testicles is when they shrink and become nonfunctional. If one testicle is atrophied, then it is rated 0%. If both testicles are atrophied, then it is rated 20%.

DC 7524: If both testicles are removed, it is rated 30%. If only one testicle is removed, it is rated 0%. There are a few conditions for this code. If the testicle was removed because it was not fully developed or did not descend, then it is not ratable since this is a pre-existing condition and not directly related to military service. If the testicle had to be removed because of an injury or

condition that is related to military service, and the remaining testicle is not functioning (whether it is related to service), it is rated 30%.

The **VA Ratings for ED** secondary to Medication Side Effects depends upon the severity of your ED, and how your ED symptoms affect your work, life, and social functioning.

VA Disability Ratings for ED Explained:

How is Erectile Dysfunction rated by the VA?

Medical Research Study:

Sexual dysfunction in selective serotonin reuptake inhibitors (SSRIs) and potential solutions: A narrative literature review

BVA Case History Example:

ED secondary to Medication Side Effects is granted

ED secondary to Heart Disease

The connection between heart disease and erectile dysfunction isn't far-fetched at all. Both follow the same age-related trajectory and become increasingly common from age 45 onward. They even share common causes.

Some conditions that cause erectile dysfunction can be serious and might worsen with time, such as heart disease. Many people who have heart attacks or get bypass surgery have ED, which makes sense as heart disease can affect blood flow.

One **study published by the NIH** found that around 50% of men with coronary artery disease (CAD) also experienced erectile dysfunction, and that, in another study, 67% percent of **patients with CAD and ED** experienced ED for about three years before CAD developed. These results show a strong correlation between **erectile dysfunction and coronary artery disease**.

Another study showed 64 percent of men hospitalized for a heart attack have dealt with ED at least once.

If a serious heart condition is also causing you to have erectile dysfunction, discuss your treatment options with a doctor. Sildenafil (Viagra), vardenafil (Levitra), and tadalafil (Cialis) are all drugs that can help you get an erection by relaxing muscles and increasing blood flow to the penis.

At the same time, these drugs can affect the cardiovascular system. For example, there are a variety of conditions, including any history of heart attack, that are important to discuss with a doctor when a drug like Viagra is being considered.

Can ED be a secondary VA claim to Heart Disease?

Yes, ED can be service-connected secondary to Heart Disease.

While ED is assigned a 0% rating under SMC-K, there are five other scheduler rating categories that are related to Erectile Dysfunction, the penis, and testicles, which are rated as follows:

DC 7520: If half or more of the penis is removed, then it is rated 30%. This condition can also be rated under the **urinary rating system** if that can result in a higher rating than 30%.

DC 7521: If the Glans is removed, it is rated 20%. This condition can also be rated under the urinary rating system if that can result in a higher rating than 20%.

DC 7522: If the penis is deformed and cannot erect, then it is rated 20%. The following two requirements must be met before a 20% evaluation can be assigned for deformity of the penis with loss of erectile power under **38 CFR 4.115b, DC 7522**:

- The deformity must be evident, **AND**
- The deformity *must* be accompanied by loss of erectile power.

DC 7523: Atrophy of the testicles is when they shrink and become nonfunctional. If one testicle is atrophied, then it is rated 0%. If both testicles are atrophied, then it is rated 20%.

DC 7524: If both testicles are removed, it is rated 30%. If only one testicle is removed, it is rated 0%. There are a few conditions for this code. If the testicle was removed because it was not fully developed or did not descend, then it is not ratable since this is a pre-existing condition and not directly related to military service. If the testicle had to be removed because of an injury or condition that is related to military service, and the remaining testicle is not functioning (whether it is related to service), it is rated 30%.

The **VA Ratings for ED** secondary to Heart Disease depends upon the severity of your ED, and how your ED symptoms affect your work, life, and social functioning.

VA Disability Ratings for ED Explained:

How is Erectile Dysfunction rated by the VA?

Medical Research Study:

ERECTILE DYSFUNCTION AND HEART DISEASE: WHAT'S THE CONNECTION?

BVA Case History Example:

ED secondary to Heart Disease is granted

ED secondary to Atherosclerosis

The buildup of plaques in the arteries of your body (atherosclerosis) is also believed to be the reason why erectile dysfunction often precedes heart problems. The idea was that plaque buildup reduces blood flow in the penis, making an erection difficult.

An advanced imaging study using fluorine-18 sodium fluoride PET determined that there is a relationship between atherosclerosis and erectile

dysfunction, researchers reported at the American College of Cardiology Scientific Session.

In the **study** of 437 men with prostate cancer (mean age, 67 years) who underwent a series of fluorine-18 sodium fluoride PET scans, each increment of a measure of atherosclerosis in the penile arteries corresponded to an increased likelihood of erectile dysfunction, according to the researchers, who simultaneously published their findings in the Journal of the American College of Cardiology.

Can ED be a secondary VA claim to Atherosclerosis?

Yes, ED can be service-connected secondary to Atherosclerosis.

While ED is assigned a 0% rating under SMC-K, there are five other scheduler rating categories that are related to Erectile Dysfunction, the penis, and testicles, which are rated as follows:

DC 7520: If half or more of the penis is removed, then it is rated 30%. This condition can also be rated under the **urinary rating system** if that can result in a higher rating than 30%.

DC 7521: If the Glans is removed, it is rated 20%. This condition can also be rated under the urinary rating system if that can result in a higher rating than 20%.

DC 7522: If the penis is deformed and cannot erect, then it is rated 20%. The following two requirements must be met before a 20% evaluation can be assigned for deformity of the penis with loss of erectile power under **38 CFR 4.115b, DC 7522**:

- The deformity must be evident, **AND**
- The deformity must be accompanied by loss of erectile power.

DC 7523: Atrophy of the testicles is when they shrink and become nonfunctional. If one testicle is atrophied, then it is rated 0%. If both testicles are atrophied, then it is rated 20%.

DC 7524: If both testicles are removed, it is rated 30%. If only one testicle is removed, it is rated 0%. There are a few conditions for this code. If the testicle was removed because it was not fully developed or did not descend, then it is not ratable since this is a pre-existing condition and not directly related to military service. If the testicle had to be removed because of an injury or condition that is related to military service, and the remaining testicle is not functioning (whether it is related to service), it is rated 30%.

The **VA Ratings for ED** secondary to Atherosclerosis depends upon the severity of your ED, and how your ED symptoms affect your work, life, and social functioning.

VA Disability Ratings for ED Explained:

How is Erectile Dysfunction rated by the VA?

Medical Research Study:

Link between atherosclerosis, erectile dysfunction strengthened in imaging study

BVA Case History Example:

ED secondary to Hypertension is granted

Hypertension secondary to Atherosclerosis is granted

ED secondary to High Cholesterol

High cholesterol resulting in the build-up of cholesterol plaque is one of the leading causes of **vasculogenic erectile dysfunction**.

The higher your LDL levels the more likely to develop erection problems and severe cases lead to impotence. Also, **high cholesterol** can make the body more difficult to produce the necessary chemicals to create an erection. High cholesterol affects the body's ability to properly release nitric oxide into the bloodstream.

Another way in which high cholesterol interferes with erectile dysfunction is by affecting the testosterone production. Testosterone is a hormone which is typically found in a male's testicles (contrary to popular belief, women also make testosterone, which is found in their ovaries).

This hormone is responsible for the male's sex drive, but is also an important part of the reproduction process, because it helps create sperm. When testosterone levels are low, a number of different problems may arise: men feel less energetic, depressed, are moody, have a decreased sexual appetite, thinner bones, and less body hair.

Can ED be a secondary VA claim to High Cholesterol?

Yes, ED can be service-connected secondary to High Cholesterol.

While ED is assigned a 0% rating under SMC-K, there are five other scheduler rating categories that are related to Erectile Dysfunction, the penis, and testicles, which are rated as follows:

DC 7520: If half or more of the penis is removed, then it is rated 30%. This condition can also be rated under the **urinary rating system** if that can result in a higher rating than 30%.

DC 7521: If the Glans is removed, it is rated 20%. This condition can also be rated under the urinary rating system if that can result in a higher rating than 20%.

DC 7522: If the penis is deformed and cannot erect, then it is rated 20%. The following two requirements must be met before a 20% evaluation can be assigned for deformity of the penis with loss of erectile power under **38 CFR 4.115b, DC 7522**:

- The deformity must be evident, **AND**
- The deformity *must* be accompanied by loss of erectile power.

DC 7523: Atrophy of the testicles is when they shrink and become nonfunctional. If one testicle is atrophied, then it is rated 0%. If both testicles are atrophied, then it is rated 20%.

DC 7524: If both testicles are removed, it is rated 30%. If only one testicle is removed, it is rated 0%. There are a few conditions for this code. If the testicle was removed because it was not fully developed or did not descend, then it is not ratable since this is a pre-existing condition and not directly related to military service. If the testicle had to be removed because of an injury or condition that is related to military service, and the remaining testicle is not functioning (whether it is related to service), it is rated 30%.

The **VA Ratings for ED** secondary to High Cholesterol depends upon the severity of your ED, and how your ED symptoms affect your work, life, and social functioning.

VA Disability Ratings for ED Explained:

How is Erectile Dysfunction rated by the VA?

Medical Research Study:

Is There a Link Between High Cholesterol and Erectile Dysfunction (ED)?

BVA Case History Example:

As of this writing, a BVA case history example could not be located. However, it's still possible to connect the two conditions depending upon your medical evidence and medical research.

ED secondary to Hypertension

Hypertension and erectile dysfunction are closely intertwined diseases, which have endothelial dysfunction as a common base.

During hypertension and/or erectile dysfunction, disturbance of endothelium-derived factors can lead to an increase in vascular smooth muscle (VSM) contraction.

Hypertension can lead to erectile dysfunction as a consequence of high blood pressure (BP) or due to antihypertensive treatment.

A study in the *Journal of the American Geriatrics Society* found that about 49% of men ages 40 to 79 with **high blood pressure** had **erectile dysfunction**.

Can ED be a secondary VA claim to Hypertension?

Yes, ED can be service-connected secondary to Hypertension.

While ED is assigned a 0% rating under SMC-K, there are five other scheduler rating categories that are related to Erectile Dysfunction, the penis, and testicles, which are rated as follows:

DC 7520: If half or more of the penis is removed, then it is rated 30%. This condition can also be rated under the **urinary rating system** if that can result in a higher rating than 30%.

DC 7521: If the Glans is removed, it is rated 20%. This condition can also be rated under the urinary rating system if that can result in a higher rating than 20%.

DC 7522: If the penis is deformed and cannot erect, then it is rated 20%. The following two requirements must be met before a 20% evaluation can be assigned for deformity of the penis with loss of erectile power under **38 CFR 4.115b, DC 7522**:

- The deformity must be evident, **AND**
- The deformity must be accompanied by loss of erectile power.

DC 7523: Atrophy of the testicles is when they shrink and become nonfunctional. If one testicle is atrophied, then it is rated 0%. If both testicles are atrophied, then it is rated 20%.

DC 7524: If both testicles are removed, it is rated 30%. If only one testicle is removed, it is rated 0%. There are a few conditions for this code. If the testicle was removed because it was not fully developed or did not descend, then it is not ratable since this is a pre-existing condition and not directly related to military service. If the testicle had to be removed because of an injury or

condition that is related to military service, and the remaining testicle is not functioning (whether it is related to service), it is rated 30%.

The **VA Ratings for ED** secondary to Hypertension depends upon the severity of your ED, and how your ED symptoms affect your work, life, and social functioning.

For example, a veteran might have a 10% rating for Hypertension but could possibly receive a 0% service connected SMC-K VA rating for ED secondary to Hypertension. ED can be rated differently depending upon the specifics of your medical diagnoses and severity of symptoms in accordance with one of the five other DCs listed above.

VA Disability Ratings for ED Explained:

How is Erectile Dysfunction rated by the VA?

Medical Research Studies:

New insights into hypertension-associated erectile dysfunction

How High Blood Pressure Leads to Erectile Dysfunction

BVA Case History Example:

ED secondary to Hypertension is granted

ED secondary to Diabetes

Persons suffering from diabetes mellitus (DM) are at higher risk of developing erectile dysfunction (ED). Several factors contribute to ED in patients of DM.

Erectile dysfunction is extremely common among type 2 diabetic patients

A **study** concluded that the Prevalence of ED among diabetic patients is high compared to general population. Both physical and psychosocial factors predict the occurrence of ED in this group. So, both physicians and

psychiatrists should remain aware about the multi-faceted causative role of ED in DM.

Erectile dysfunction can also be linked to other conditions common in men with diabetes, such as high blood pressure and heart disease. Erectile dysfunction might occur earlier in men with diabetes than in men without the disease.

Can ED be a secondary VA claim to Diabetes?

Yes, ED can be service-connected secondary to Diabetes.

While ED is assigned a 0% rating under SMC-K, there are five other scheduler rating categories that are related to Erectile Dysfunction, the penis, and testicles, which are rated as follows:

DC 7520: If half or more of the penis is removed, then it is rated 30%. This condition can also be rated under the **urinary rating system** if that can result in a higher rating than 30%.

DC 7521: If the Glans is removed, it is rated 20%. This condition can also be rated under the urinary rating system if that can result in a higher rating than 20%.

DC 7522: If the penis is deformed and cannot erect, then it is rated 20%. The following two requirements must be met before a 20% evaluation can be assigned for deformity of the penis with loss of erectile power under **38 CFR 4.115b, DC 7522**:

- The deformity must be evident, **AND**
- The deformity *must* be accompanied by loss of erectile power.

DC 7523: Atrophy of the testicles is when they shrink and become nonfunctional. If one testicle is atrophied, then it is rated 0%. If both testicles are atrophied, then it is rated 20%.

DC 7524: If both testicles are removed, it is rated 30%. If only one testicle is removed, it is rated 0%. There are a few conditions for this code. If the testicle

was removed because it was not fully developed or did not descend, then it is not ratable since this is a pre-existing condition and not directly related to military service. If the testicle had to be removed because of an injury or condition that is related to military service, and the remaining testicle is not functioning (whether it is related to service), it is rated 30%.

The **VA Ratings for ED** secondary to Diabetes depends upon the severity of your ED, and how your ED symptoms affect your work, life, and social functioning.

For example, a veteran might have a 10% rating for Diabetes but could possibly receive a 0% service connected SMC-K VA rating for ED secondary to Diabetes. ED can possibly be rated differently depending upon the specifics of your medical diagnoses and severity of symptoms in accordance with one of the five other DCs listed above.

VA Disability Ratings for ED Explained:

How is Erectile Dysfunction rated by the VA?

Medical Research Study:

Erectile dysfunction in patients with diabetes mellitus: its magnitude, predictors and their bio-psycho-social interaction: a study from a developing country

BVA Case History Example:

ED secondary to Diabetes is granted

ED secondary to Weight Gain Obesity as Interim Link

Erectile dysfunction has long been associated with obesity.

Obesity generally causes insulin insensitivity in the body which in turn leads to high blood glucose levels, a pre-diabetic state. Over time, high glucose levels (diabetes) causes damage to blood vessels that carry blood to the

penis. Diabetes also causes damage to nerves that innervate the penis and facilitate erections.

The occurrence of erectile dysfunction in patients with obesity is caused by a number of complications which are characteristic for an excessive amount of fat tissue, in example: cardiovascular diseases, diabetes or dyslipidemia. In the United States diabetes and obesity are responsible for 8 million cases of erectile dysfunction.

A new study shows that obesity has a significant impact on male sexual health. The study, published in *The Journal of Sexual Medicine*, focused on 2,435 Italian male patients who sought outpatient treatment for sexual dysfunction between 2001 and 2007. Among participants, 41.5% were normal weight, 42.4% were overweight, 12.1% were obese, and 4% were severely obese. The mean age was 52.

Patients had lab blood tests and a penile Doppler ultrasound to measure penile blood flow. They also were interviewed about their erectile dysfunction and completed a mental health questionnaire.

Giovanni Corona, MD, from the University of Florence, and colleagues found that the degree of obesity correlated with decrease in testosterone level. Among study participants, the more severe the obesity, the lower the level of testosterone.

The study also concluded that conditions related to obesity, particularly hypertension (or high blood pressure), are the most significant causes of obesity-related mental health. Abnormal penile blood flow was found to be linked to high blood pressure.

Can ED be a secondary VA claim to Weight Gain Obesity as Interim Link?

Yes, **ED can be service-connected secondary to Weight Gain Obesity as Interim Link.**

While ED is assigned a 0% rating under SMC-K, there are five other scheduler rating categories that are related to Erectile Dysfunction, the penis, and testicles, which are rated as follows:

DC 7520: If half or more of the penis is removed, then it is rated 30%. This condition can also be rated under the **urinary rating system** if that can result in a higher rating than 30%.

DC 7521: If the Glans is removed, it is rated 20%. This condition can also be rated under the urinary rating system if that can result in a higher rating than 20%.

DC 7522: If the penis is deformed and cannot erect, then it is rated 20%. The following two requirements must be met before a 20% evaluation can be assigned for deformity of the penis with loss of erectile power under **38 CFR 4.115b, DC 7522**:

- The deformity must be evident, **AND**
- The deformity *must* be accompanied by loss of erectile power.

DC 7523: Atrophy of the testicles is when they shrink and become nonfunctional. If one testicle is atrophied, then it is rated 0%. If both testicles are atrophied, then it is rated 20%.

DC 7524: If both testicles are removed, it is rated 30%. If only one testicle is removed, it is rated 0%. There are a few conditions for this code. If the testicle was removed because it was not fully developed or did not descend, then it is not ratable since this is a pre-existing condition and not directly related to military service. If the testicle had to be removed because of an injury or condition that is related to military service, and the remaining testicle is not functioning (whether it is related to service), it is rated 30%.

The **VA Ratings for ED** secondary to Weight Gain Obesity as Interim Link depends upon the severity of your ED, and how your ED symptoms affect your work, life, and social functioning.

For example, while a veteran can't be rated for Weight Gain Obesity, if a service connected disability causes/aggravates Weight Gain Obesity, it can be used as an "Interim Link" for service connection. You could possibly receive a 0% service connected SMC-K VA rating for ED secondary to Weight Gain Obesity as an Interim Link to another service connected condition. ED can also be rated differently depending upon the specifics of your medical diagnoses and severity of symptoms in accordance with one of the five other DCs listed above.

VA Disability Ratings for ED Explained:

How is Erectile Dysfunction rated by the VA?

Medical Research Study:

Obesity Linked to Erectile Dysfunction

BVA Case History Example:

ED secondary to Weight Gain Obesity as Interim Link is granted

ED secondary to Parkinson's Disease

One of the most common problem found for men with Parkinson's are erectile dysfunction and problems with ejaculation.

Since **Parkinson's Disease** impacts the central nervous system, men with Parkinson's Disease may find themselves unable to attain or maintain an erection, let alone ejaculate. Issues with blood circulation to the penis and pelvic muscles can further lend themselves to ED.

The physical and psychological challenges of Parkinson's are in many ways inescapable, ultimately impacting a couple's relationship. One 2000 study out of the Medical University of Lübeck in Germany found that patients with Parkinson's were more dissatisfied with their sexual functioning and relationship than healthier counterparts. This is no surprise given that sexual dynamics are affected by matters like how each partner handles the Parkinson's diagnosis, daily demands and lovers' changing roles.

Can ED be a secondary VA claim to Parkinson's Disease?

Yes, ED can be service-connected secondary to Parkinson's Disease.

While ED is assigned a 0% rating under SMC-K, there are five other scheduler rating categories that are related to Erectile Dysfunction, the penis, and testicles, which are rated as follows:

DC 7520: If half or more of the penis is removed, then it is rated 30%. This condition can also be rated under the **urinary rating system** if that can result in a higher rating than 30%.

DC 7521: If the Glans is removed, it is rated 20%. This condition can also be rated under the urinary rating system if that can result in a higher rating than 20%.

DC 7522: If the penis is deformed and cannot erect, then it is rated 20%. The following two requirements must be met before a 20% evaluation can be assigned for deformity of the penis with loss of erectile power under **38 CFR 4.115b, DC 7522**:

- The deformity must be evident, **AND**
- The deformity *must* be accompanied by loss of erectile power.

DC 7523: Atrophy of the testicles is when they shrink and become nonfunctional. If one testicle is atrophied, then it is rated 0%. If both testicles are atrophied, then it is rated 20%.

DC 7524: If both testicles are removed, it is rated 30%. If only one testicle is removed, it is rated 0%. There are a few conditions for this code. If the testicle was removed because it was not fully developed or did not descend, then it is not ratable since this is a pre-existing condition and not directly related to military service. If the testicle had to be removed because of an injury or condition that is related to military service, and the remaining testicle is not functioning (whether it is related to service), it is rated 30%.

The **VA Ratings for ED** secondary to Parkinson's Disease depends upon the severity of your ED, and how your ED symptoms affect your work, life, and social functioning.

VA Disability Ratings for ED Explained:

How is Erectile Dysfunction rated by the VA?

Medical Research Study:

Management of sexual dysfunction in Parkinson's disease

BVA Case History Example:

ED secondary to Parkinson's Disease is granted

ED secondary to Multiple Sclerosis

Erectile Dysfunction (ED) is one of the most common symptoms of multiple sclerosis (MS) in men, affecting 23 percent to 91 percent of men. MS is a disease characterized by the progressive damage of nerves. When nerves associated with the erectile response are involved, ED can occur or worsen, leading to impaired stimulation and/or arousal.

In MS, nerve damage is caused by a process called demyelination wherein the immune system attacks and strips away the insulating membrane surrounding a nerve called the myelin sheath. When this happens, the lines of communication between nerves can be severely affected.

Depending on where the demyelination occurs, the cause and **symptoms of ED** can vary.

Can ED be a secondary VA claim to Multiple Sclerosis?

Yes, ED can be service-connected secondary to Multiple Sclerosis.

While ED is assigned a 0% rating under SMC-K, there are five other scheduler rating categories that are related to Erectile Dysfunction, the penis, and testicles, which are rated as follows:

DC 7520: If half or more of the penis is removed, then it is rated 30%. This condition can also be rated under the **urinary rating system** if that can result in a higher rating than 30%.

DC 7521: If the Glans is removed, it is rated 20%. This condition can also be rated under the urinary rating system if that can result in a higher rating than 20%.

DC 7522: If the penis is deformed and cannot erect, then it is rated 20%. The following two requirements must be met before a 20% evaluation can be assigned for deformity of the penis with loss of erectile power under **38 CFR 4.115b, DC 7522**:

- The deformity must be evident, **AND**
- The deformity *must* be accompanied by loss of erectile power.

DC 7523: Atrophy of the testicles is when they shrink and become nonfunctional. If one testicle is atrophied, then it is rated 0%. If both testicles are atrophied, then it is rated 20%.

DC 7524: If both testicles are removed, it is rated 30%. If only one testicle is removed, it is rated 0%. There are a few conditions for this code. If the testicle was removed because it was not fully developed or did not descend, then it is not ratable since this is a pre-existing condition and not directly related to military service. If the testicle had to be removed because of an injury or condition that is related to military service, and the remaining testicle is not functioning (whether it is related to service), it is rated 30%.

The **VA Ratings for ED** secondary to Multiple Sclerosis depends upon the severity of your ED, and how your ED symptoms affect your work, life, and social functioning.

VA Disability Ratings for ED Explained:

How is Erectile Dysfunction rated by the VA?

Medical Research Study:

Assessment and Treatment of Sexual Dysfunction in Multiple Sclerosis

BVA Case History Example:

ED secondary to Multiple Sclerosis is granted

ED secondary to Prostate Cancer

Regardless of whether the nerves were spared during surgery or whether the most precise dose planning was used during radiation therapy (cancer), erectile dysfunction remains the most common side effect after treatment. This is because the nerves and blood vessels that control the physical aspect of an erection are incredibly delicate, and any trauma to the area can result in changes.

Erectile dysfunction following radical prostatectomy for clinically localized prostate cancer is a known potential complication of the surgery. But thanks to the advent of the nerve-sparing radical prostatectomy technique, many men can expect to recover erectile function in the current era.

Radiation therapy: Like surgery, damage to blood vessels and nerves after radiation therapy can result in decreased erectile function over time. In general, radiation therapy has less of an impact on erectile function in the first 5 to 10 years after treatment compared with surgery, and approximately 70% of men who have baseline erectile function before treatment will keep erectile function after treatment. However, radiation therapy has a slower delay in erectile function decline than surgery; 15 years after treatment, the rates are like those who underwent surgery.

Can ED be a secondary VA claim to Prostate Cancer?

Yes, ED can be service-connected secondary to Prostate Cancer.

While ED is assigned a 0% rating under SMC-K, there are five other scheduler rating categories that are related to Erectile Dysfunction, the penis, and testicles, which are rated as follows:

DC 7520: If half or more of the penis is removed, then it is rated 30%. This condition can also be rated under the **urinary rating system** if that can result in a higher rating than 30%.

DC 7521: If the Glans is removed, it is rated 20%. This condition can also be rated under the urinary rating system if that can result in a higher rating than 20%.

DC 7522: If the penis is deformed and cannot erect, then it is rated 20%. The following two requirements must be met before a 20% evaluation can be assigned for deformity of the penis with loss of erectile power under **38 CFR 4.115b, DC 7522**:

- The deformity must be evident, **AND**
- The deformity *must* be accompanied by loss of erectile power.

DC 7523: Atrophy of the testicles is when they shrink and become nonfunctional. If one testicle is atrophied, then it is rated 0%. If both testicles are atrophied, then it is rated 20%.

DC 7524: If both testicles are removed, it is rated 30%. If only one testicle is removed, it is rated 0%. There are a few conditions for this code. If the testicle was removed because it was not fully developed or did not descend, then it is not ratable since this is a pre-existing condition and not directly related to military service. If the testicle had to be removed because of an injury or condition that is related to military service, and the remaining testicle is not functioning (whether it is related to service), it is rated 30%.

The **VA Ratings for ED** secondary to Prostate Cancer depends upon the severity of your ED, and how your ED symptoms affect your work, life, and social functioning.

VA Disability Ratings for ED Explained:

How is Erectile Dysfunction rated by the VA?

Medical Research Studies:

Comparison of penile size and erectile function after high-intensity focused ultrasound and targeted cryoablation for localized prostate cancer: a prospective pilot study

Erectile dysfunction after radiotherapy for prostate cancer

BVA Case History Example:

ED secondary to Prostate Cancer is granted

ED secondary to Spinal Cord Injuries

A spinal cord injury can cause erectile dysfunction. Depending on the severity of the injury, it may partly or completely block signals going from the brain to the penis. These are the signals that cause an erection when a man is thinking about sex.

Dr. Ramin Raiszadeh, an orthopedic spine surgeon at the **Advanced Spine Institute and Minimally Invasive Spine Center** at Alvarado Hospital, said patients experiencing chronic sexual problems and chronic back or pelvic pain, or incontinence, should consult with a specialist as quickly as possible.

“These problems are usually musculoskeletal in nature, but other medical conditions, including cardiovascular disease, diabetes, infection, inflammation and tumors, can cause these symptoms as well," Dr. Raiszadeh said. "The **spinal disorders that may impair sexual dysfunction**, include nerve compression by a **disc herniation**, **muscle spasms** from weakness and inactivity, long-standing **spinal stenosis** and even **trauma** from a fall or an accident."

A **study** also concluded that lumbar spinal stenosis is associated with a neglected prevalence of erectile dysfunction.

Can ED be a secondary VA claim to Spinal Cord Injuries?

Yes, ED can be service-connected secondary to Spinal Cord Injuries.

While ED is assigned a 0% rating under SMC-K, there are five other scheduler rating categories that are related to Erectile Dysfunction, the penis, and testicles, which are rated as follows:

DC 7520: If half or more of the penis is removed, then it is rated 30%. This condition can also be rated under the **urinary rating system** if that can result in a higher rating than 30%.

DC 7521: If the Glans is removed, it is rated 20%. This condition can also be rated under the urinary rating system if that can result in a higher rating than 20%.

DC 7522: If the penis is deformed and cannot erect, then it is rated 20%. The following two requirements must be met before a 20% evaluation can be assigned for deformity of the penis with loss of erectile power under **38 CFR 4.115b, DC 7522**:

- The deformity must be evident, **AND**
- The deformity *must* be accompanied by loss of erectile power.

DC 7523: Atrophy of the testicles is when they shrink and become nonfunctional. If one testicle is atrophied, then it is rated 0%. If both testicles are atrophied, then it is rated 20%.

DC 7524: If both testicles are removed, it is rated 30%. If only one testicle is removed, it is rated 0%. There are a few conditions for this code. If the testicle was removed because it was not fully developed or did not descend, then it is not ratable since this is a pre-existing condition and not directly related to military service. If the testicle had to be removed because of an injury or condition that is related to military service, and the remaining testicle is not functioning (whether it is related to service), it is rated 30%.

The **VA Ratings for ED** secondary to Spinal Cord Injuries depends upon the severity of your ED, and how your ED symptoms affect your work, life, and social functioning.

VA Disability Ratings for ED Explained:

How is Erectile Dysfunction rated by the VA?

Medical Research Study:

Management of Erectile Dysfunction and Infertility in the Male Spinal Cord Injury Patient

Performance and safety of treatment options for erectile dysfunction in patients with spinal cord injury: A review of the literature

BVA Case History Example:

ED secondary to Spinal Cord Injuries is granted

Female Sexual Arousal Disorder secondary to PTSD

About 90% of women with PTSD report sexual dysfunction, according to **Rachel Yehuda, Ph.D.** at the conference for the International Society for the Study of Women's Sexual Health (ISSWSH).

Women who have PTSD are in a state of being numb. They tend to avoid the feelings of general arousal (not sexual, but more what we think of as alertness and vigilance) because it takes them out of their numbness. That is stressful and exhausting.

Arousal (the sexual kind) is required for sexual interest and response, but it is very difficult for women to choose to be aroused since it requires that they not be numb.

PTSD from a military sexual trauma can also cause FSAD.

Can Female Sexual Arousal Disorder be a secondary VA claim to PTSD?

Yes, Female Sexual Arousal Disorder (FSAD) can be service-connected secondary to PTSD.

The **VA Ratings for Female Sexual Arousal Disorder (FSAD)** secondary to PTSD depends upon the severity of your FSAD, and how your FSAD symptoms affect your work, life, and social functioning.

VA rates FSAD under 38 CFR § 4.116, Schedule of Ratings – Gynecological Conditions and Disorders of the Breast, Diagnostic Code 7632. Service-connected FSAD is rated at 0 percent unless there is physical damage to the genitals, in which case, it is rated under the diagnostic codes for the affected parts. FSAD may be entitled to additional compensation under Special Monthly Compensation (SMC) level K. However, in order to be awarded SMC(K), it must qualify as loss of use of the reproductive organs, leading to infertility.

For example, a veteran might have a 70% rating for PTSD but could possibly receive a 0% service connected SMC-K VA rating for FSAD secondary to PTSD. Other Diagnostic Codes (DCs) and VA ratings are possible for the Female Reproductive System, and can be viewed **HERE.**

VA Disability Ratings for Female Sexual Arousal Disorder Explained:

How is FSAD Rated by the VA?

Medical Research Study:

PTSD and Sexual Dysfunction in Men and Women

BVA Case History Example:

As of this writing, a BVA case history example could not be located. However, it's still possible to connect the two conditions depending upon your medical evidence and medical research.

Female Sexual Arousal Disorder secondary to Depression

Low sexual desire is strongly linked to Depression. Impairment of mental health is the most important risk factor for female sexual dysfunction. Women living with psychiatric illness, despite their frequent sexual difficulties, consider sexuality to be an important aspect of their quality of life.

Antidepressant and antipsychotic medication, the neurobiology and symptoms of the illness, past trauma, difficulties in establishing relationships and stigmatization can all contribute to sexual dysfunction.

For many women, a noticeably decreased sex drive that differs from their typical pattern can point to something more serious: major depressive disorder, says **Jennifer Payne, M.D.**, director of the **Women's Mood Disorders Center at Johns Hopkins.**

Can Female Sexual Arousal Disorder be a secondary VA claim to Depression?

Yes, Female Sexual Arousal Disorder can be service-connected secondary to Depression.

The **VA Ratings for Female Sexual Arousal Disorder (FSAD)** secondary to Depression depends upon the severity of your FSAD, and how your FSAD symptoms affect your work, life, and social functioning.

VA rates FSAD under 38 CFR § 4.116, Schedule of Ratings – Gynecological Conditions and Disorders of the Breast, Diagnostic Code 7632. Service-connected FSAD is rated at 0 percent unless there is physical damage to the genitals, in which case, it is rated under the diagnostic codes for the affected parts. FSAD may be entitled to additional compensation under Special Monthly Compensation (SMC) level K. However, in order to be awarded SMC(K), it must qualify as loss of use of the reproductive organs, leading to infertility.

For example, a veteran might have a 70% rating for Depression but could possibly receive a 0% service connected SMC-K VA rating for FSAD secondary to Depression. Other Diagnostic Codes (DCs) and VA ratings are possible for the Female Reproductive System, and can be viewed **HERE.**

VA Disability Ratings for Female Sexual Arousal Disorder Explained:

How is FSAD Rated by the VA?

Medical Research Study:

[Women's sexual dysfunction associated with psychiatric disorders and their treatment]

BVA Case History Example:

[Female Sexual Arousal Disorder secondary to Depression]

Female Sexual Arousal Disorder secondary to Anxiety

Impairment of mental health is the most important risk factor for female sexual dysfunction.

According to **Anxiety.org**, Anxiety prevents or inhibits autonomic nervous system response, which in turn prevents physiological arousal.

Many people with anxiety or mood disorders experience sexual dysfunction[8], but the degree varies greatly. Some people can experience dysfunction just a few times, while others will experience it in every instance of attempted sexual activity.

In addition, a variety of anxiety and related disorders are linked to sexual dysfunction: generalized anxiety disorder (GAD), social anxiety disorder, and obsessive-compulsive disorder (OCD).

Can Female Sexual Arousal Disorder be a secondary VA claim to Anxiety?

Yes, Female Sexual Arousal Disorder can be service-connected secondary to Anxiety.

The **VA Ratings for Female Sexual Arousal Disorder (FSAD)** secondary to Anxiety depends upon the severity of your FSAD, and how your FSAD symptoms affect your work, life, and social functioning.

VA rates FSAD under 38 CFR § 4.116, Schedule of Ratings – Gynecological Conditions and Disorders of the Breast, Diagnostic Code 7632. Service-connected FSAD is rated at 0 percent unless there is physical damage to the genitals, in which case, it is rated under the diagnostic codes for the affected

parts. FSAD may be entitled to additional compensation under Special Monthly Compensation (SMC) level K. However, in order to be awarded SMC(K), it must qualify as loss of use of the reproductive organs, leading to infertility.

For example, a veteran might have a 70% rating for PTSD but could possibly receive a 0% service connected SMC-K VA rating for FSAD secondary to PTSD. Other Diagnostic Codes (DCs) and VA ratings are possible for the Female Reproductive System, and can be viewed **HERE.**

VA Disability Ratings for Female Sexual Arousal Disorder Explained:

How is FSAD Rated by the VA?

Medical Research Studies:

The Relationship Between Anxiety Disorders and Sexual Dysfunction

Stress, anxiety, depression, and sexual dysfunction among postmenopausal women in Shiraz, Iran, 2015

BVA Case History Example:

Female Sexual Arousal Disorder secondary to Anxiety is remanded

Female Sexual Arousal Disorder secondary to Heart Disease

Anything that impairs the feeling of satisfaction during intimacy and inability to sustain the sexual excitement can produce an arousal disorder. Similar to hypoactive sexual desire disorder, a number of causative agents have been identified as possible triggers: medications that cause vaginal dryness, menopause or Low estrogen levels that lead to vaginal dryness, and any medical illness (diabetes, heart disease**,** cancer, arthritis, spinal cord injury etc.)

A **study** found out that female patients reported significantly more often 'not enjoying having sex', 'being insecure about having sex', and 'not being aroused while having sex', and experienced more distress at 'being insecure

about having sex' than male patients. Congenital heart disease patients reported significantly fewer 'not enjoying having sex' and 'worrying about your sex life' than healthy counterparts but experienced more distress at 'worrying about your sex life'.

Another **study** found out that patients with heart failure as an example for a chronic but often compensated condition, demonstrated a higher than expected rate of sexual dysfunction.

Can Female Sexual Arousal Disorder be a secondary VA claim to Heart Disease?

Yes, Female Sexual Arousal Disorder can be service-connected secondary to Heart Disease.

The **VA Ratings for Female Sexual Arousal Disorder (FSAD)** secondary to Heart Disease depends upon the severity of your FSAD, and how your FSAD symptoms affect your work, life, and social functioning.

VA rates FSAD under 38 CFR § 4.116, Schedule of Ratings – Gynecological Conditions and Disorders of the Breast, Diagnostic Code 7632. Service-connected FSAD is rated at 0 percent unless there is physical damage to the genitals, in which case, it is rated under the diagnostic codes for the affected parts. FSAD may be entitled to additional compensation under Special Monthly Compensation (SMC) level K. However, in order to be awarded SMC(K), it must qualify as loss of use of the reproductive organs, leading to infertility.

For example, a veteran might have a 10% rating for Heart Disease but could possibly receive a 0% service connected SMC-K VA rating for FSAD secondary to Heart Disease. Other Diagnostic Codes (DCs) and VA ratings are possible for the Female Reproductive System, and can be viewed **HERE.**

VA Disability Ratings for Female Sexual Arousal Disorder Explained:

How is FSAD Rated by the VA?

Medical Research Studies:

Sexual functioning and congenital heart disease: Something to worry about?

Sexual Dysfunction in Women With Cardiovascular Disease

BVA Case History Example:

As of this writing, a BVA case history example could not be located. However, it's still possible to connect the two conditions depending upon your medical evidence and medical research.

Female Sexual Arousal Disorder secondary to Neurological Conditions

According to **Biology Reference**, the most common neurological disorders include stroke, Alzheimer's Disease, migraine headaches, epilepsy, Parkinson's disease, sleep disorders, multiple sclerosis, pain, brain and spinal cord injuries, brain tumors, and peripheral nerve disorders.

The brain's forebrain areas regulate the initiation and execution of sexual behavior; the medial preoptic area integrates sensory and hormonal signals; and the amygdala and other nuclei play a role in the execution and reward aspects of sexual function.

There are three **sexual female dysfunctions** (SFD): primary, secondary, tertiary. In the primary one, sexual dysfunction (SD) is correlated to the neurological disease. In the secondary the SD derives from the symptoms of the neurological disease and in the tertiary the SD is the psychological reaction to the effects of the disease.

Specifically, Medical therapy worsens female sexuality as in case of epilepsy. Emotional and behavioral disorders involve sexual dysfunctions in women with Alzheimer's and in Parkinson's, reduction of sexual desire involves break of sexual intercourses.

Can Female Sexual Arousal Disorder be a secondary VA claim to Neurological Conditions?

Yes, Female Sexual Arousal Disorder can be service-connected secondary to Neurological Conditions.

The **VA Ratings for Female Sexual Arousal Disorder (FSAD)** secondary to Neurological Conditions depends upon the severity of your FSAD, and how your FSAD symptoms affect your work, life, and social functioning.

VA rates FSAD under 38 CFR § 4.116, Schedule of Ratings – Gynecological Conditions and Disorders of the Breast, Diagnostic Code 7632. Service-connected FSAD is rated at 0 percent unless there is physical damage to the genitals, in which case, it is rated under the diagnostic codes for the affected parts. FSAD may be entitled to additional compensation under Special Monthly Compensation (SMC) level K. However, in order to be awarded SMC(K), it must qualify as loss of use of the reproductive organs, leading to infertility.

For example, a veteran might have a 10% rating for **Neurological Disorders** but could possibly receive a 0% service connected SMC-K VA rating for FSAD secondary to a Neurological Condition. Other Diagnostic Codes (DCs) and VA ratings are possible for the Female Reproductive System, and can be viewed **HERE.**

VA Disability Ratings for Female Sexual Arousal Disorder Explained:

How is FSAD Rated by the VA?

Medical Research Study:

Sexual dysfunctions in female with neurological disorders

BVA Case History Example:

Female Sexual Arousal Disorder secondary to Neurological Conditions previously granted

Female Sexual Arousal Disorder secondary to Gynecological conditions, such as Vulvovaginal Atrophy, Infections or Lichen Sclerosis

In addition to anatomic factors related to estrogen deficiency, such as genitourinary syndrome of menopause, **vulvovaginal atrophy**, and pelvic organ prolaps, psychosocial factors, including prior sexual trauma, play an important role in sexual function in women.

Hormonal therapies for low sexual desire include estrogen treatment and tibolone therapy. Estrogen treatment is particularly efficacious for desire problems that stem from vulvovaginal atrophy.

Researchers have also shown reduced sexual arousal in patients with multiple **sclerosis**.

Can Female Sexual Arousal Disorder be a secondary VA claim to Gynecological conditions, such as Vulvovaginal Atrophy, Infections or Lichen Sclerosis?

Yes, Female Sexual Arousal Disorder can be service-connected secondary to Gynecological conditions, such as Vulvovaginal Atrophy, Infections or Lichen Sclerosis.

The **VA Ratings for Female Sexual Arousal Disorder (FSAD)** secondary to Gynecological conditions, such as Vulvovaginal Atrophy, Infections or Lichen Sclerosis depends upon the severity of your FSAD, and how your FSAD symptoms affect your work, life, and social functioning.

VA rates FSAD under 38 CFR § 4.116, Schedule of Ratings – Gynecological Conditions and Disorders of the Breast, Diagnostic Code 7632. Service-connected FSAD is rated at 0 percent unless there is physical damage to the genitals, in which case, it is rated under the diagnostic codes for the affected parts. FSAD may be entitled to additional compensation under Special Monthly Compensation (SMC) level K. However, in order to be awarded SMC(K), it must qualify as loss of use of the reproductive organs, leading to infertility.

VA Disability Ratings for Female Sexual Arousal Disorder Explained:

How is FSAD Rated by the VA?

Medical Research Studies:

Female Sexual Interest/Arousal Disorders

Female Sexual Function at Midlife and Beyond

BVA Case History Example:

Female Sexual Arousal Disorder secondary to Gynecological conditions, is granted

Female Sexual Arousal Disorder secondary to Medication Side Effects

It is well known that many **psychoactive medications** affect sexual desire. There are both intra-class and inter-class variations among antidepressants with respect to sexual dysfunction and particularly sexual desire.

There's several causes and consequences of low sexual interest (HSDD) in women and low sexual arousal (FSAD). These elements are broken down into biological factors including medical health, hormones, and medications, and psychological factors including stress, relationships, comorbid mental illness, and history of sexual abuse.

Antidepressants may reduce your sex drive or your ability to have an orgasm. Selective serotonin uptake inhibitors (SSRIs) are especially likely to cause sexual side effects. Chemotherapy and other cancer treatments can also affect hormone levels and cause problems.

Can Female Sexual Arousal Disorder be a secondary VA claim to Medication Side Effects?

Yes, Female Sexual Arousal Disorder can be service-connected secondary to Medication Side Effects.

The **VA Ratings for Female Sexual Arousal Disorder (FSAD)** secondary to Medication Side Effects depends upon the severity of your FSAD, and how your FSAD symptoms affect your work, life, and social functioning.

VA rates FSAD under 38 CFR § 4.116, Schedule of Ratings – Gynecological Conditions and Disorders of the Breast, Diagnostic Code 7632. Service-connected FSAD is rated at 0 percent unless there is physical damage to the genitals, in which case, it is rated under the diagnostic codes for the affected parts. FSAD may be entitled to additional compensation under Special Monthly Compensation (SMC) level K. However, in order to be awarded SMC(K), it must qualify as loss of use of the reproductive organs, leading to infertility.

While Medication Side Effects are not a ratable VA disability on its own, Medication Side Effects may be used as an "Interim Link" for secondary service connection. How? For example, if a veteran takes medications to manage symptoms of a service connected disability and those medications cause side effects of a (new) non service connected disability, the new disability can be connected as a secondary VA claim to the service connected condition with Medication Side Effects as the Interim Link. The best example would be a veteran who is taking antidepressants to manage symptoms of PTSD, and those antidepressants have side effects leading to FSAD. Thus, while the PTSD might not necessarily "cause" the FSAD, the side effects of the medications taken to manage PTSD symptoms can be used as the "Interim Link" for service connecting FSAD secondary to PTSD.

VA Disability Ratings for Female Sexual Arousal Disorder Explained:

How is FSAD Rated by the VA?

Medical Research Study: Sexual side-effects of antidepressant and antipsychotic drugs

BVA Case History Example: Female Sexual Arousal Disorder secondary to Medication Side Effects is remanded

Fibromyalgia secondary to IBS

Only a small number of people in the U.S. have fibromyalgia. But for people with IBS, it's much more common. Over half (50%) of IBS patients also have symptoms of fibromyalgia.

"In general, it is likely that they coexist for years, but they can flare at the same time or at different times," says **Lin Chang, MD,** co-director of the Oppenheimer Center for Neurobiology of Stress.

IBS and fibromyalgia fall into a broad category called functional disorders. This is when your body isn't working as it should, but doctors can't see anything wrong with you.

The pain of IBS is centered inside your body, in the internal organs. With fibromyalgia you have another kind of pain, which is in the skin and deep tissue. Even though the source of discomfort stems from different places, researchers and doctors believe the causes are related.

Can Fibromyalgia be a secondary VA claim to IBS?

Yes, Fibromyalgia can be service-connected secondary to IBS.

The **VA ratings for Fibromyalgia** secondary to IBS are 10%, 20%, or 40% and depends upon the severity of your Fibromyalgia, and how your Fibromyalgia symptoms affect your work, life, and social functioning.

Let's discuss in detail how the VA rate Fibromyalgia for Veterans diagnosed. Fibromyalgia is a disease that causes pain and sensitivity throughout the entire body. The pain must be present on both sides of the body, and both above and below the waist to be rated under VASRD Code 5025. A Rheumatologist needs to evaluate and diagnose you with this condition for it to be assessed under this code.

VASRD Diagnostic Code 5025 provides that Fibromyalgia (fibrositis, primary fibromyalgia syndrome) with widespread musculoskeletal pain and tender points, with or without associated fatigue, sleep disturbance, stiffness,

paresthesias, headache, irritable bowel symptoms, depression, anxiety, or Raynaud's-like symptoms will be rated:

- 10 percent disabling if the symptoms require continuous medication for control
- 20 percent disabling if the symptoms are episodic, with exacerbations often precipitated by environmental or emotional stress or by overexertion, but symptoms that are present more than one-third of the time.
- 40 percent disabling if the symptoms are constant or nearly constant, and are refractory to therapy.

For example, a veteran might only have a 10% rating for IBS but could possibly receive a 40% VA rating (lower rating possible as well) for Fibromyalgia secondary to IBS.

VA Disability Ratings for Fibromyalgia Explained:

How is Fibromyalgia rated by the VA?

Medical Research Studies:

The severity of irritable bowel syndrome or the presence of fibromyalgia influencing the perception of visceral and somatic stimuli

The early diagnosis of fibromyalgia in irritable bowel syndrome patients

BVA Case History Example:

Fibromyalgia secondary to IBS is remanded

Fibromyalgia secondary to Migraines

One of the most common symptoms of fibromyalgia is migraines (headaches). In addition, to muscle tension headaches (brought about by back and neck muscles that will not relax) are migraine headaches. In fact, migraines and fibromyalgia have many similarities. Comparing them side by

side reveals that many causes and ways to care for them overlap. Those who are successfully treated for migraines often find that their FM improves as well.

A **study** also claimed that the frequency of fibromyalgia is significantly higher among patients who have chronic migraine headaches than in patients who have chronic tension-type headaches, and patients with chronic migraines experience more severe symptoms of fibromyalgia.

Can Fibromyalgia be a secondary VA claim to Migraines?

Yes, Fibromyalgia can be service-connected secondary to Migraines.

The **VA ratings for Fibromyalgia** secondary to Migraines are 10%, 20%, or 40% and depends upon the severity of your Fibromyalgia, and how your Fibromyalgia symptoms affect your work, life, and social functioning.

Let's discuss in detail how the VA rate Fibromyalgia for Veterans diagnosed. Fibromyalgia is a disease that causes pain and sensitivity throughout the entire body. The pain must be present on both sides of the body, and both above and below the waist to be rated under VASRD Code 5025. A Rheumatologist needs to evaluate and diagnose you with this condition for it to be assessed under this code.

VASRD Diagnostic Code 5025 provides that Fibromyalgia (fibrositis, primary fibromyalgia syndrome) with widespread musculoskeletal pain and tender points, with or without associated fatigue, sleep disturbance, stiffness, paresthesias, headache, irritable bowel symptoms, depression, anxiety, or Raynaud's-like symptoms will be rated:

- 10 percent disabling if the symptoms require continuous medication for control
- 20 percent disabling if the symptoms are episodic, with exacerbations often precipitated by environmental or emotional stress or by overexertion, but symptoms that are present more than one-third of the time

- 40 percent disabling if the symptoms are constant or nearly constant, and are refractory to therapy.

For example, a veteran may only have a 30% rating for Migraines but could possibly receive a 40% VA rating (lower rating possible as well) for Fibromyalgia secondary to Migraines.

VA Disability Ratings for Fibromyalgia Explained:

How is Fibromyalgia rated by the VA?

Medical Research Studies:

Bidirectional association between migraine and fibromyalgia: retrospective cohort analyses of two populations

Fibromyalgia Tied to Chronic Migraines

BVA Case History Example:

As of this writing, a BVA case history example could not be located. However, it's still possible to connect the two conditions depending upon your medical evidence and medical research.

Fibromyalgia secondary to Interstitial Cystitis or Painful Bladder Syndrome

Many people who are affected with Interstitial Cystitis or Painful Bladder Syndrome (IC/PBS) also suffer from other conditions such as Irritable Bowel Syndrome and Fibromyalgia. As such, researchers think that **IC/PBS** may be a response of the bladder to a more generalized condition elsewhere in the body that causes overall inflammation.

In a **study**, a subset of interstitial cystitis (IC) patients have fibromyalgia (FM). Although 80 to 90 percent of those affected are women, men and children can have fibromyalgia, too. The cause of FM is not known, but many researchers believe that FM is the result of abnormal pain processing resulting from "central sensitization."

The theory is that chronic pain changes the brain's sensitivity to pain, making people feel pain from stimuli that would not normally be painful. FM patients seem to have changes in nerve-signaling chemicals and nervous system-related hormones. There is also a sensory hypersensitivity which not only causes a greater sensitivity to pain but higher levels of sensitivity to light, noise, and smell. (Research has found that IC patients are "super tasters." Perhaps the enhanced taste buds relate to the hypersensitivity of smell?

Another **study** concluded that Irritable bowel syndrome, fibromyalgia and chronic fatigue syndrome are more prevalent in patients with interstitial cystitis/painful bladder syndrome than in asymptomatic control subjects, and result in significant impact.

Can Fibromyalgia be a secondary VA claim to Interstitial Cystitis or Painful Bladder Syndrome (IC/PBS)?

Yes, Fibromyalgia can be service-connected secondary to Interstitial Cystitis or Painful Bladder Syndrome (IC/PBS).

The **VA ratings for Fibromyalgia** secondary to Interstitial Cystitis or Painful Bladder Syndrome are 10%, 20%, or 40% and depends upon the severity of your Fibromyalgia, and how your Fibromyalgia symptoms affect your work, life, and social functioning.

Let's discuss in detail how the VA rate Fibromyalgia for Veterans diagnosed. Fibromyalgia is a disease that causes pain and sensitivity throughout the entire body. The pain must be present on both sides of the body, and both above and below the waist to be rated under VASRD Code 5025. A Rheumatologist needs to evaluate and diagnose you with this condition for it to be assessed under this code.

VASRD Diagnostic Code 5025 provides that Fibromyalgia (fibrositis, primary fibromyalgia syndrome) with widespread musculoskeletal pain and tender points, with or without associated fatigue, sleep disturbance, stiffness, paresthesias, headache, irritable bowel symptoms, depression, anxiety, or Raynaud's-like symptoms will be rated:

- 10 percent disabling if the symptoms require continuous medication for control
- 20 percent disabling if the symptoms are episodic, with exacerbations often precipitated by environmental or emotional stress or by overexertion, but symptoms that are present more than one-third of the time
- 40 percent disabling if the symptoms are constant or nearly constant, and are refractory to therapy.

VA Disability Ratings for Fibromyalgia Explained:

How is Fibromyalgia rated by the VA?

Medical Research Studies:

Interstitial cystitis/painful bladder syndrome and associated medical conditions with an emphasis on irritable bowel syndrome, fibromyalgia and chronic fatigue syndrome

The Fibromyalgia bladder index

BVA Case History Example:

Fibromyalgia secondary to Interstitial Cystitis or Painful Bladder Syndrome is remanded

Fibromyalgia secondary to Temporomandibular Joint Disorders

Considering the fact that **fibromyalgia** is a musculoskeletal disorder, there is a high possibility that one can experience fibromyalgia pain as an outcome of TMD/J disorders.

People who already have one chronic pain condition often develop another one, or even more. In fact, many people newly diagnosed with TMD have previously experienced fluctuating pain in various parts of the body, suggesting a connection to fibromyalgia. And according to one study, three-fourths of fibromyalgia patients also have TMD. Yet many chronic pain

conditions are known to occur together. What's more, chronic pain conditions have shared characteristics that suggest common underlying disease mechanisms.

Fibromyalgia and temporomandibular disorders with muscle pain both have profiles that affect the muscular system and therefore share many epidemiological, clinical, and physio pathological symptoms. Because of this, we are led to think that there is, if not a common etiology, at least a common pathogenesis.

Can Fibromyalgia be a secondary VA claim to Temporomandibular Joint Disorders (TMD/J)?

Yes, Fibromyalgia can be service-connected secondary to Temporomandibular Joint Disorders.

The **VA ratings for Fibromyalgia** secondary to Temporomandibular Joint Disorders are 10%, 20%, or 40% and depends upon the severity of your Fibromyalgia, and how your Fibromyalgia symptoms affect your work, life, and social functioning.

Let's discuss in detail how the VA rate Fibromyalgia for Veterans diagnosed. Fibromyalgia is a disease that causes pain and sensitivity throughout the entire body. The pain must be present on both sides of the body, and both above and below the waist to be rated under VASRD Code 5025. A Rheumatologist needs to evaluate and diagnose you with this condition for it to be assessed under this code.

VASRD Diagnostic Code 5025 provides that Fibromyalgia (fibrositis, primary fibromyalgia syndrome) with widespread musculoskeletal pain and tender points, with or without associated fatigue, sleep disturbance, stiffness, paresthesias, headache, irritable bowel symptoms, depression, anxiety, or Raynaud's-like symptoms will be rated:

- 10 percent disabling if the symptoms require continuous medication for control

- 20 percent disabling if the symptoms are episodic, with exacerbations often precipitated by environmental or emotional stress or by overexertion, but symptoms that are present more than one-third of the time
- 40 percent disabling if the symptoms are constant or nearly constant and are refractory to therapy.

VA Disability Ratings for Fibromyalgia Explained:

How is Fibromyalgia rated by the VA?

Medical Research Studies:

The relationship between fibromyalgia and temporomandibular disorders: prevalence and symptom severity

Fibromyalgia syndrome and temporomandibular disorders with muscular pain. A review

BVA Case History Example:

As of this writing, a BVA case history example could not be located. However, it's still possible to connect the two conditions depending upon your medical evidence and medical research.

Fibromyalgia secondary to Anxiety

The **connection** between fibromyalgia and anxiety is complex due to its bidirectional nature — as fibromyalgia symptoms worsen, anxiety increases, and as anxiety symptoms worsen, fibromyalgia symptoms will increase as well.

It's possible that anxiety triggers a neurotransmitter response that increases nerve firing or inflammation within certain parts of your body. It's also possible that the stress from anxiety damages something in your body that makes fibromyalgia occur. It's not how exactly anxiety might cause or exacerbate fibromyalgia, but a link does appear to exist and anxiety may play a causal role.

Anxiety Contributing to Fibromyalgia more likely, however, is that you may be prone to some mild form of fibromyalgia and anxiety simply makes it more pronounced. Anxiety can cause what's known as "hypersensitivity," which is when your mind and body are more attuned to physical sensations, thus amplifying the symptoms. This would create not only more pain, but more noticeable pain.

Can Fibromyalgia be a secondary VA claim to Anxiety?

Yes, Fibromyalgia can be service-connected secondary to Anxiety.

The **VA ratings for Fibromyalgia** secondary to Anxiety are 10%, 20%, or 40% and depends upon the severity of your Fibromyalgia, and how your Fibromyalgia symptoms affect your work, life, and social functioning.

Let’s discuss in detail how the VA rate Fibromyalgia for Veterans diagnosed. Fibromyalgia is a disease that causes pain and sensitivity throughout the entire body. The pain must be present on both sides of the body, and both above and below the waist to be rated under VASRD Code 5025. A Rheumatologist needs to evaluate and diagnose you with this condition for it to be assessed under this code.

VASRD Diagnostic Code 5025 provides that Fibromyalgia (fibrositis, primary fibromyalgia syndrome) with widespread musculoskeletal pain and tender points, with or without associated fatigue, sleep disturbance, stiffness, paresthesias, headache, irritable bowel symptoms, depression, anxiety, or Raynaud’s-like symptoms will be rated:

- 10 percent disabling if the symptoms require continuous medication for control
- 20 percent disabling if the symptoms are episodic, with exacerbations often precipitated by environmental or emotional stress or by overexertion, but symptoms that are present more than one-third of the time
- 40 percent disabling if the symptoms are constant or nearly constant, and are refractory to therapy.

For example, a veteran may have a 50% VA rating for Anxiety but could possibly receive a 40% VA disability rating (lower rating possible as well) for Fibromyalgia secondary to Anxiety.

VA Disability Ratings for Fibromyalgia Explained:

How is Fibromyalgia rated by the VA?

Medical Research Study:

Effects of depression and anxiety on quality of life of patients with rheumatoid arthritis, knee osteoarthritis and fibromyalgia syndrome

BVA Case History Example:

As of this writing, a BVA case history example could not be located. However, it's still possible to connect the two conditions depending upon your medical evidence and medical research.

Fibromyalgia secondary to Depression

Fibromyalgia and depression might represent two manifestations of affective spectrum disorder. They share **similar** pathophysiology and are largely targeted by the same drugs with dual action on serotoninergic and noradrenergic systems. These two can also greatly interfere with the way you manage your activities at home or at work.

Some people with fibromyalgia and chronic pain may be aware they are depressed. Others may not be sure they are depressed. Nevertheless, they probably realize something is wrong with them.

Having a depressive disorder also increases the risk of developing chronic pain. Patients who are depressed have greater pain. They describe greater hindrance from pain and display more pain behaviors than pain patients who are not depressed.

Can Fibromyalgia be a secondary VA claim to Depression?

Yes, Fibromyalgia can be service-connected secondary to Depression.

The **VA ratings for Fibromyalgia** secondary to Depression are 10%, 20%, or 40% and depends upon the severity of your Fibromyalgia, and how your Fibromyalgia symptoms affect your work, life, and social functioning.

Let's discuss in detail how the VA rate Fibromyalgia for Veterans diagnosed. Fibromyalgia is a disease that causes pain and sensitivity throughout the entire body. The pain must be present on both sides of the body, and both above and below the waist to be rated under VASRD Code 5025. A Rheumatologist needs to evaluate and diagnose you with this condition for it to be assessed under this code.

VASRD Diagnostic Code 5025 provides that Fibromyalgia (fibrositis, primary fibromyalgia syndrome) with widespread musculoskeletal pain and tender points, with or without associated fatigue, sleep disturbance, stiffness, paresthesias, headache, irritable bowel symptoms, depression, anxiety, or Raynaud's-like symptoms will be rated:

- 10 percent disabling if the symptoms require continuous medication for control
- 20 percent disabling if the symptoms are episodic, with exacerbations often precipitated by environmental or emotional stress or by overexertion, but symptoms that are present more than one-third of the time
- 40 percent disabling if the symptoms are constant or nearly constant, and are refractory to therapy.

For example, a veteran may have a 70% VA rating for Depression but could possibly receive a 40% VA disability rating (lower rating possible as well) for Fibromyalgia secondary to Depression.

VA Disability Ratings for Fibromyalgia Explained:

How is Fibromyalgia rated by the VA?

Medical Research Studies:

Effects of depression and anxiety on quality of life of patients with rheumatoid arthritis, knee osteoarthritis and fibromyalgia syndrome

Smoking, depression, & stress: predictors of fibromyalgia health status

BVA Case History Example:

Fibromyalgia secondary to Depression is granted

Fibromyalgia secondary to Postural Tachycardia Syndrome

Fibromyalgia (FM) and Postural Orthostatic Syndrome (POTS) often occur together. Both conditions affect women predominantly and the exact causes can be hard to detect. Symptoms of POTS and fibromyalgia may crossover with other chronic conditions too, like irritable bowel syndrome (IBS), joint hypermobility, and Chronic Fatigue Syndrome (CFS).

POTS is a common dysautonomia, characterized by remarkable increased heart rate during the assumption of the upright posture (>30 bpm). According to a **clinical trials study**, FM is found, at least, in 15% of their POTS patients.

The Fibromyalgia and Chronic Fatigue Clinic on Mayo Clinic's campus in Rochester, Minnesota, offers comprehensive evaluation by doctors with expertise in caring for people with fibromyalgia, chronic fatigue and postural tachycardia syndrome (POTS). You will need a referral from your doctor to schedule an appointment at the clinic.

Can Fibromyalgia be a secondary VA claim to Postural Tachycardia Syndrome (POTS)?

Yes, Fibromyalgia can be service-connected secondary to Postural Tachycardia Syndrome (POTS).

The **VA ratings for Fibromyalgia** secondary to Postural Tachycardia Syndrome are 10%, 20%, or 40% and depends upon the severity of your Fibromyalgia, and how your Fibromyalgia symptoms affect your work, life, and social functioning.

Let's discuss in detail how the VA rate Fibromyalgia for Veterans diagnosed. Fibromyalgia is a disease that causes pain and sensitivity throughout the entire body. The pain must be present on both sides of the body, and both above and below the waist to be rated under VASRD Code 5025. A Rheumatologist needs to evaluate and diagnose you with this condition for it to be assessed under this code.

VASRD Diagnostic Code 5025 provides that Fibromyalgia (fibrositis, primary fibromyalgia syndrome) with widespread musculoskeletal pain and tender points, with or without associated fatigue, sleep disturbance, stiffness, paresthesias, headache, irritable bowel symptoms, depression, anxiety, or Raynaud's-like symptoms will be rated:

- 10% disabling if the symptoms require continuous medication for control
- 20% disabling if the symptoms are episodic, with exacerbations often precipitated by environmental or emotional stress or by overexertion, but symptoms that are present more than one-third of the time
- 40% disabling if the symptoms are constant or nearly constant, and are refractory to therapy.

What is the VA disability rating for Postural Tachycardia Syndrome (POTS)?

The **VASRD** does not have its own Diagnostic Code (DC) for POTS, so you'll want to check analogous conditions / ratings that most closely resembles your POTS symptoms. Here's a solid **Blog post** we wrote about POTS to help veterans and VA Raters assign the proper DC for POTS, or DC analogous to it.

VA Disability Ratings for Fibromyalgia Explained:

How is Fibromyalgia rated by the VA?

Medical Research Study:

Autonomic dysfunction in fibromyalgia syndrome: postural orthostatic tachycardia

BVA Case History Example:

As of this writing, a BVA case history example could not be located. However, it's still possible to connect the two conditions depending upon your medical evidence and medical research.

GERD secondary to Asthma

According to **Mayo Clinic**, acid reflux and Asthma often occur together. It isn't clear why, but it's known that acid reflux can worsen asthma and asthma can worsen acid reflux — especially severe acid reflux, a condition known as Gastroesophageal Reflux Disease (GERD).

A **theory** postulates that bronchospasm may cause GERD. Another theory is that medicines used to treat asthma may cause GERD. For instance, systemic steroids are known to cause reflux. An older asthma medicine, one sometimes still used for difficult to treat asthma, is theophylline. It works similar to caffeine and may relax the esophageal sphincter. Bronchodilaors like albuterol may also cause the esophageal sphincter to relax, resulting in GERD. Another medicine that is commonly used to treat asthma, **beta-adrenergic bronchodilators**, may aggravate acid reflux.

Can GERD be a secondary VA claim to Asthma?

Yes, GERD can be service-connected secondary to Asthma.

The **VA Ratings for GERD** secondary to Asthma are 10%, 30%, or 60% depending upon the severity of your GERD, and how your GERD symptoms affect your work, life, and social functioning. It also depends upon the frequency and duration of your symptoms, meaning, the more severe your symptoms, the higher the VA rating for GERD.

For example, a veteran may only have a 10% rating for Asthma but could possibly receive a 30% or 60% VA rating (lower rating possible as well) for GERD secondary to Asthma.

VA Disability Ratings for GERD Explained:

How is GERD Rated by the VA?

Medical Research Studies:

Review article: gastro-esophageal reflux disease in asthma and chronic obstructive pulmonary disease

Asthma, GERD and Obesity: Triangle of Inflammation

BVA Case History Example:

GERD Secondary to Asthma is Granted

GERD secondary to PTSD

GERD can develop when the symptoms of PTSD, such as anxiety, stress, and depression, lead to an overproduction of stomach acid. In some veterans, medications taken to treat PTSD can also lead to GERD as a side effect. For further reading, please see sections in this eBook where we discuss Medication Side Effects as an “Interim Link” for secondary service connection.

In a **study** where information about GI (Gastrointestinal) symptoms such as diarrhea, constipation, abdominal pain, and gastroesophageal reflux disease (GERD) were extracted from the clinic notes to determine if there is a relationship between PTSD and depression screenings and GI symptoms. Results state that 28% of the participants had GERD and a positive screening of PTSD was significantly associated with these GI symptoms.

Other medical research studies support a connection between GERD and PTSD. For example, both veteran and non-veteran studies have reported

high rates of comorbidity between PTSD, Depression, and Gastrointestinal (GI) symptoms.

A **2013 study of veterans who deployed to Iraq and Afghanistan** found that nearly 45% of patients screened positive for PTSD and 23% screened positive for depression symptoms.

While only 11% of patients reported GI symptoms, 73.4% of these patients had a positive screen for PTSD, ***indicative of a significant relationship.***

Many veterans with GERD or acid reflux, especially those who were diagnosed long after leaving the military are eligible under the law for **GERD secondary to PTSD.**

For example, if veterans are taking SSRIs to help manage their PTSD symptoms, perhaps you're suffering from **side effects of those SSRI medications**, which can lead to digestive system issues.

Can GERD be a secondary VA claim to PTSD?

Yes, GERD can be service-connected secondary to PTSD.

The **VA Ratings for GERD** secondary to PTSD are 10%, 30%, or 60% depending upon the severity of your GERD, and how your GERD symptoms affect your work, life, and social functioning. It also depends upon the frequency and duration of your symptoms, meaning, the more severe your symptoms, the higher the VA rating for GERD.

For example, a veteran might have a 30% rating for PTSD (lower or higher rating possible for PTSD) but could possibly receive a 10%, 30% or 60% VA rating for GERD secondary to PTSD.

VA Disability Ratings for GERD Explained:

How is GERD Rated by the VA?

Medical Research Studies:

Effect of asthma and PTSD on persistence and onset of gastroesophageal reflux symptoms among adults exposed to the September 11, 2001, terrorist attacks

Posttraumatic Stress Disorder and Gastrointestinal Disorders in the Danish Population

BVA Case History Example:

GERD Secondary to PTSD is Granted

GERD secondary to Depression

GERD can develop when the symptoms of anxiety, stress, and depression, among others, lead to an overproduction of stomach acid.

In a **study** where information about GI (Gastrointestinal) symptoms such as diarrhea, constipation, abdominal pain, and gastroesophageal reflux disease (GERD) were extracted from the clinic notes to determine if there is a relationship between PTSD and depression screenings and GI symptoms. Results state that 28% of the participants had GERD and a positive screening of depression was significantly associated with these GI symptoms.

Can GERD be a secondary VA claim to Depression?

Yes, GERD can be service-connected secondary to Depression.

The **VA Ratings for GERD** secondary to Depression are 10%, 30%, or 60% depending upon the severity of your GERD, and how your GERD symptoms affect your work, life, and social functioning. It also depends upon the frequency and duration of your symptoms, meaning, the more severe your symptoms, the higher the VA rating for GERD.

For example, a veteran may only have a 10% rating for Depression but could possibly receive a 30% or 60% VA rating (lower rating possible as well) for GERD secondary to Depression.

VA Disability Ratings for GERD Explained:

How is GERD Rated by the VA?

Medical Research Study:

PTSD, Depression, and Gastrointestinal Symptoms in Veterans of the Afghanistan and Iraq Conflicts: What's the Relation?

BVA Case History Example:

GERD Secondary to Depression is granted

GERD secondary to Anxiety

GERD can develop when mental health symptoms such as anxiety, stress, and depression, among many others, lead to an overproduction of stomach acid.

According to the **National Library of Medicine**, Anxiety sufferers have a higher lifetime prevalence of various medical problems. Chronic medical conditions furthermore increase the likelihood of psychiatric disorders and overall dysfunction. Lifetime rates of cardiovascular, respiratory, gastrointestinal, and other medical problems are disproportionately high in anxiety and panic/fear sufferers.

The heightened comorbidity is not surprising as many symptoms of anxiety and panic/fear mimic symptoms of medical conditions.

Stress can worsen acid reflux symptoms, and anxiety is a natural response to stress in the body. Paradoxically, experiencing anxiety can also in itself be stressful, which can perpetuate the acid reflux cycle.

There is some evidence to suggest that stress and anxiety may provoke acid reflux or make the symptoms worse. For instance, a **2018 study** involving more than 19,000 people found that those with anxiety were more likely to experience GERD symptoms.

Can GERD be a secondary VA claim to Anxiety?

Yes, GERD can be service-connected secondary to Anxiety.

The **VA Ratings for GERD** secondary to Anxiety are 10%, 30%, or 60% depending upon the severity of your GERD, and how your GERD symptoms affect your work, life, and social functioning. It also depends upon the frequency and duration of your symptoms, meaning, the more severe your symptoms, the higher the VA disability rating for GERD.

For example, a veteran may have a 50% rating for Anxiety (lower or higher rating possible as well) but could possibly receive a 10%, 30% or 60% VA rating for GERD secondary to Anxiety.

VA Disability Ratings for GERD Explained:

How is GERD Rated by the VA?

Medical Research Studies:

Association Between Anxiety and Depression and Gastroesophageal Reflux Disease: Results From a Large Cross-sectional Study

Anxiety Disorders and Medical Comorbidity: Treatment Implications

BVA Case History Example:

GERD Secondary to Anxiety is granted

GERD secondary to Medication Side Effects

GERD can develop when the symptoms of mental health conditions, such as anxiety, stress, and depression, lead to an overproduction of stomach acid. In some people, medications taken to treat PTSD and other mental health conditions can lead to GERD (acid reflux) as a side effect.

A **study** claimed that Gastroesophageal reflux disease (GERD), which is common in many communities, is associated with structural factors, eating habits, and the use of certain medications. The use of such medications

(whether over the count or prescribed) can lead to the emergence of GERD and can also exacerbate existing reflux symptoms. These drugs can contribute to GERD by directly causing mucosal damage, by reducing lower esophageal sphincter pressure (LESP), or by affecting esophagogastric motility.

Can GERD be a secondary VA claim to Medication Side Effects?

Yes, GERD can be service-connected secondary to Medication Side Effects as an “Interim Link” to another service connected condition.

The **VA Ratings for GERD** secondary to Medication Side Effects are 10%, 30%, or 60% depending upon the severity of your GERD, and how your GERD symptoms affect your work, life, and social functioning. It also depends upon the frequency and duration of your symptoms, meaning, the more severe your symptoms, the higher the VA rating for GERD.

While Medication Side Effects are not a ratable VA disability on its own, Medication Side Effects may be used as an “Interim Link” for secondary service connection. How? For example, if a veteran takes medications to manage symptoms of a service connected disability (PTSD in this example) and those medications cause side effects of a (new) non service connected disability, the new disability can be connected as a secondary VA claim to the service connected condition with Medication Side Effects as the Interim Link. The best example would be a veteran who is taking antidepressants to manage symptoms of PTSD, and those antidepressants have side effects leading to GERD (acid reflux). Thus, while the PTSD might not necessarily “cause” the GERD, the side effects of the medications taken to manage PTSD symptoms can be used as the “Interim Link” for service connecting GERD secondary to PTSD.

VA Disability Ratings for GERD Explained:

How is GERD Rated by the VA?

Medical Research Study:

Which drugs are risk factors for the development of gastroesophageal reflux disease?

BVA Case History Example:

GERD Secondary to Medication Side Effects is granted

GERD secondary to Weight Gain Obesity as Interim Link

Gastroesophageal reflux disease (GERD) is a common condition with multifactorial pathogenesis, affecting up to 40% of the population. Obesity is also common. Obesity and GERD are clearly related, both from a prevalence and causality association.

A **study** stated that GERD symptoms increase in severity when people gain weight. Obese patients tend to have more severe erosive esophagitis and obesity is a risk factor for the development of Barrett's esophagus and adenocarcinoma of the esophagus. Patients report improvement in GERD when they lose weight and there are several reports suggesting a decrease in GERD symptoms after bariatric surgery.

According to another **study**, an increase in GERD symptoms has been shown to occur in individuals who gain weight but continue to have a body mass index (BMI) in the normal range, contributing to the epidemiological evidence for a possible dose-response relationship between BMI and increasing GERD.

Can GERD be a secondary VA claim to Weight Gain Obesity as Interim Link?

Yes, GERD can be service-connected secondary to Weight Gain Obesity as Interim Link.

The **VA Ratings for GERD** secondary to Weight Gain Obesity as Interim Link are 10%, 30%, or 60% depending upon the severity of your GERD, and how your GERD symptoms affect your work, life, and social functioning. It

also depends upon the frequency and duration of your symptoms, meaning, the more severe your symptoms, the higher the VA rating for GERD.

While a veteran can't be rated for Weight Gain Obesity, if a service connected disability such as PTSD or Depression causes/aggravates Weight Gain Obesity, it can be used as an "Interim Link" for service connection. For example, you could possibly receive a 60% service connected VA rating for GERD secondary to Weight Gain Obesity as an Interim Link to another service connected condition, which in this example was PTSD or Depression (which you already have service connected and rated).

VA Disability Ratings for GERD Explained:

How is GERD Rated by the VA?

Medical Research Studies:

Gastroesophageal reflux disease and obesity

The association between obesity and GERD: a review of the epidemiological evidence

BVA Case History Example:

As of this writing, a BVA case history example could not be located. However, it's still possible to connect the two conditions depending upon your medical evidence and medical research.

Hypertension secondary to Sleep Apnea

It has been **widely accepted** by the medical community that obstructive sleep apnea (OSA) is a risk factor for the development of hypertension (high blood pressure).

Sleep apnea can have a **definite negative impact** on your blood pressure. Since the sleep disorder is characterized by repeated pauses in breathing throughout the night, your blood oxygen levels drop suddenly when you're

not breathing. This increases your blood pressure and puts a strain on your entire cardiovascular system.

One **study** found out and concluded that OSA (Obstructive Sleep Apnea) is related to an increased risk of resistant hypertension. Mild, moderate, and severe OSA are associated essential hypertension, as well a dose-response manner relationship is manifested. The associations are relatively stronger among Caucasians and male OSA patients.

Can Hypertension be a secondary VA claim to Sleep Apnea?

Yes, Hypertension can be service-connected secondary to Sleep Apnea.

The **VA Ratings for Hypertension** secondary to Sleep Apnea are 10%, 20%, 40%, or 60%, depending upon the severity of your Hypertension, and how your Hypertension symptoms affect your work, life, and social functioning.

For example, a veteran might have a 50% VA rating for Sleep Apnea but could possibly receive a 40% VA rating (lower or higher rating possible as well) for Hypertension secondary to Sleep Apnea.

VA Disability Ratings for Hypertension Explained:

How is Hypertension Rated by the VA?

Medical Research Study:

Association of obstructive sleep apnea with hypertension: A systematic review and meta-analysis

BVA Case History Example:

Hypertension Secondary to Sleep Apnea is granted

Hypertension secondary to PTSD

The clinical literature increasingly indicates that cardiovascular risk factors and cardiovascular disease (CVD) are more common among individuals with

posttraumatic stress disorder (PTSD). Depression, and other mental health symptoms, also pose a risk for CVD and/or Hypertension (high blood pressure) as comorbidities can be present.

A **study** stated that Post-traumatic stress disorder (PTSD) is a disabling condition that develops consequent to trauma exposure such as natural disasters, sexual assault, automobile accidents, and combat that independently increases risk for early incident cardiovascular disease (CVD) and cardiovascular (CV) mortality by over 50% and incident hypertension risk by over 30%.

According to the **American College of Cardiology**, PTSD may have long-term effects on heart health, based on a recent study that links PTSD to increased risk for **high blood pressure** in injured soldiers.

Published in the American Heart Association journal *Circulation*, this study explored the long-term effects of stress on blood pressure in military members. The goal was to see whether PTSD is associated with high blood pressure—a common condition that increases risk for life-threatening heart events.

The researchers found out that soldiers with PTSD were 77–85% more likely to develop high blood pressure than those without the disorder. Researchers also found that the more severe the injury, the more likely participants were to develop high blood pressure.

Can Hypertension be a secondary VA claim to PTSD?

Yes, Hypertension can be service-connected secondary to PTSD.

The **VA Ratings for Hypertension** secondary to PTSD are 10%, 20%, 40%, or 60%, depending upon the severity of your Hypertension, and how your Hypertension symptoms affect your work, life, and social functioning.

For example, a veteran may have a 30% rating for PTSD but could possibly receive a 40% VA rating (lower or higher rating possible as well) for Hypertension secondary to PTSD.

VA Disability Ratings for Hypertension Explained:

How is Hypertension Rated by the VA?

Medical Research Study:

Post-traumatic Stress Disorder and Cardiovascular Disease

BVA Case History Example:

Hypertension Secondary to PTSD is granted

Hypertension secondary to Weight Gain Obesity as Interim Link

Obesity is a term used to describe people with a body mass index (BMI) above 30, and it's a major risk factor for high blood pressure. When you're overweight or obese, your heart must work harder to pump blood through your body. But all that extra effort puts strain on your arteries. Your arteries, in turn, resist this flow of blood, causing your blood pressure to rise.

Together, obesity and hypertension **combine** to create a leading cause of cardiovascular disease.

Several interrelated mechanisms promote the development of hypertension in obesity, often contributing to end organ damage including cardiovascular disease and chronic kidney disease.

Can Hypertension be a secondary VA claim to Weight Gain Obesity as Interim Link?

Yes, Hypertension can be service-connected secondary to Weight Gain Obesity as Interim Link.

The **VA Ratings for Hypertension** secondary to Weight Gain Obesity as Interim Link are 10%, 20%, 40%, or 60%, depending upon the severity of your Hypertension, and how your Hypertension symptoms affect your work, life, and social functioning.

While a veteran can't be rated for Weight Gain Obesity, if a service connected disability such as Hypertension causes/aggravates Weight Gain Obesity, it can be used as an "Interim Link" for service connection. For example, you could possibly receive a 40% service connected VA rating for Hypertension secondary to Weight Gain Obesity as an Interim Link to another service connected condition.

VA Disability Ratings for Hypertension Explained:

How is Hypertension Rated by the VA?

Medical Research Studies:

Hypertension in Obesity and the Impact of Weight Loss

Diagnosis and management of hypertension in obesity

BVA Case History Example:

As of this writing, a BVA case history example could not be located. However, it's still possible to connect the two conditions depending upon your medical evidence and medical research.

Hypertension secondary to Kidney Disease

Renal Hypertension, also called renovascular hypertension, is elevated blood pressure caused by kidney disease. It can usually be controlled by blood pressure drugs**.**

Renal hypertension is caused by a narrowing in the arteries that deliver blood to the kidney. One or both kidneys' arteries may be narrowed. This is a condition called renal artery stenosis.

When the kidneys receive low blood flow, they act as if the low flow is due to dehydration. So, they respond by releasing hormones that stimulate the body to retain sodium and water. Blood vessels fill with additional fluid, and blood pressure goes up.

The narrowing in one or both renal arteries is most often caused by atherosclerosis, or hardening of the arteries. This is the same process that leads to many heart attacks and strokes. A less common cause of the narrowing is fibromuscular dysplasia. This is a condition in which the structure of the renal arteries develops abnormally for unclear reasons.

Can Hypertension be a secondary VA claim to Kidney Disease?

Yes, Hypertension can be service-connected secondary to Kidney Disease.

The **VA Ratings for Hypertension** secondary to Kidney Disease are 10%, 20%, 40%, or 60%, depending upon the severity of your Hypertension, and how your Hypertension symptoms affect your work, life, and social functioning.

VA Disability Ratings for Hypertension Explained:

How is Hypertension Rated by the VA?

Medical Research Studies:

Hypertension in Chronic Kidney Disease

Hypertension and kidneys: unraveling complex molecular mechanisms underlying hypertensive renal damage

BVA Case History Example:

Hypertension secondary to Kidney Disease is granted

Hypertension secondary to Diabetes

According to **Johns Hopkins Medicine**, high blood pressure is twice as likely to strike a person with diabetes than a person without diabetes. Left untreated, high blood pressure can lead to **heart disease** and **stroke**. In fact, a person with diabetes and high blood pressure is four times as likely to develop heart disease than someone who does not have either of the

conditions. About two-thirds of adults with **diabetes** have blood pressure greater than 130/80 mm Hg or use prescription medications for hypertension.

The **National Library of Medicine** stated that patients with diabetes mellitus experience increased peripheral artery resistance caused by vascular remodeling and increased body fluid volume associated with insulin resistance-induced hyperinsulinemia and hyperglycemia. Both of these mechanisms elevate systemic blood pressure.

Can Hypertension be a secondary VA claim to Diabetes?

Yes, Hypertension can be service-connected secondary to Diabetes.

The **VA Ratings for Hypertension** secondary to Diabetes are 10%, 20%, 40%, or 60%, depending upon the severity of your Hypertension, and how your Hypertension symptoms affect your work, life, and social functioning.

For example, a veteran might only have a 10% rating for Diabetes but could possibly receive a 40% VA rating (lower or higher rating possible as well) for Hypertension (high blood pressure) secondary to Diabetes.

VA Disability Ratings for Hypertension Explained:

How is Hypertension Rated by the VA?

Medical Research Study:

Diabetes and Hypertension: Is There a Common Metabolic Pathway?

BVA Case History Example:

Hypertension Secondary to Diabetes is granted

Hypertension secondary to Hyperthyroidism

An overactive thyroid, known as **Hyperthyroidism**, is a condition where the thyroid gland produces too much of the thyroid hormone. When too much of this hormone is produced, the heart is forced to work harder than usual,

which increases heart rate and raises blood pressure. Hyperthyroidism is the more common thyroid disorder that can cause hypertension.

If a thyroid disorder is the reason for high blood pressure, adjustments in diet and lifestyle won't resolve the problem and medications may not be effective. If a patient's blood pressure does not respond to conventional treatment, a doctor can perform tests to see if the thyroid is the cause.

In cases where hypertension due to a thyroid disorder is diagnosed, medications or supplemental hormones can be prescribed to control the thyroid gland and better control blood pressure.

Previous **studies** on the prevalence of hypertension in subjects with hypothyroidism have demonstrated elevated blood pressure values. Increased peripheral vascular resistance and low cardiac output has been suggested to be the possible link between hypothyroidism and diastolic hypertension.

Can Hypertension be a secondary VA claim to Hyperthyroidism?

Yes, Hypertension can be service-connected secondary to Hyperthyroidism.

The **VA Ratings for Hypertension** secondary to Hyperthyroidism are 10%, 20%, 40%, or 60%, depending upon the severity of your Hypertension, and how your Hypertension symptoms affect your work, life, and social functioning.

For example, a veteran may only have a 10% rating for a **Thyroid Condition** but could possibly receive a 40% VA rating (lower or higher rating possible as well) for Hypertension secondary to Hyperthyroidism.

VA Disability Ratings for Hypertension Explained:

How is Hypertension Rated by the VA?

Medical Research Study:

Hypothyroidism and Hypertension

BVA Case History Example:

Hypertension Secondary to Hyperthyroidism is remanded

Hypertension secondary to Lupus

Lupus can affect the cardiovascular system, which includes your heart and blood vessels. In fact, cardiovascular disease, not lupus itself, is the number one cause of death in people with systemic lupus erythematosus (SLE).

According to **Lupus Foundation of America**, people with lupus have an elevated risk for developing heart disease, which includes high blood pressure.

A new **study** compared risk of resistant hypertension (blood pressure that remains above goal despite treatment) in people with SLE and people without lupus to identify factors associated with the condition. The researchers found that resistant hypertension (RHTN) was nearly twice as prevalent in people with SLE. Factors associated with the condition were black race, lower renal function, hypercholesterolemia (high cholesterol) and increased inflammatory markers. Additionally, RHTN was associated with significantly higher mortality risk. The researchers concluded that people with lupus have higher risk of RHTN and the condition is an important comorbidity for clinicians to monitor in people with lupus because it is associated with a higher risk of death.

Can Hypertension be a secondary VA claim to Lupus?

Yes, Hypertension can be service-connected secondary to Lupus.

The **VA Ratings for Hypertension** secondary to Lupus are 10%, 20%, 40%, or 60%, depending upon the severity of your Hypertension, and how your Hypertension symptoms affect your work, life, and social functioning.

For example, a veteran may only have a 10% rating for Lupus but could possibly receive a 40% VA rating (lower or higher rating possible as well) for Hypertension secondary to Lupus.

VA Disability Ratings for Hypertension Explained:

How is Hypertension Rated by the VA?

Medical Research Study:

Increased Incidence of Resistant Hypertension in Patients With Systemic Lupus Erythematosus: A Retrospective Cohort Study

BVA Case History Example:

Hypertension Secondary to Lupus is granted

Hypertension secondary to Scleroderma

Pulmonary hypertension means high blood pressure in the lungs. This is an extremely important issue in scleroderma occurring in up to 40% of patients.

According to the **University of Michigan**, patients with limited scleroderma have the risk of developing progressive blood vessel narrowing in the lungs frequently in the absence of lung scarring and inflammation.

This complication is called pulmonary arterial hypertension (PAH). PAH is recognized by the World Health Organization (WHO) as a distinct medical syndrome that shares common tissue features of non-inflammatory blood vessel narrowing. PAH occurs in scleroderma but also in lupus, as an isolated disease called idiopathic PAH, and as a complication of liver failure, HIV infection and use of diet pills.

PAH can occur in diffuse scleroderma as well, but a more common scenario is for progressive lung scarring to lead to loss of microvasculature in the lung again leading to elevated lung blood pressure. This syndrome is recognized by the WHO as pulmonary hypertension (PH) secondary to intrinsic lung disease.

Can Hypertension be a secondary VA claim to Scleroderma?

Yes, Hypertension can be service-connected secondary to Scleroderma.

The **VA Ratings for Hypertension** secondary to Scleroderma are 10%, 20%, 40%, or 60%, depending upon the severity of your Hypertension, and how your Hypertension symptoms affect your work, life, and social functioning.

Scleroderma is a potentially serious condition that doesn't have its own Diagnostic Code (DC) for VA rating purposes. Thus, you'll need to research DCs, and symptoms most closely related to your Scleroderma. Here's a good starter for you in your research; you can keyword search **HERE** to find analogous code equivalents.

VA Disability Ratings for Hypertension Explained:

How is Hypertension Rated by the VA?

Medical Research Study:

Long-Term Outcomes in Systemic Sclerosis-Associated Pulmonary Arterial Hypertension From the Pulmonary Hypertension Assessment and Recognition of Outcomes in Scleroderma Registry (PHAROS)

BVA Case History Example:

Hypertension Secondary to Scleroderma is granted

IBS secondary to PTSD

At first glance, posttraumatic stress disorder (PTSD) and irritable bowel syndrome (IBS) may not seem to have any special connection. However, PTSD and IBS often occur together. If you have PTSD, IBS, or both, understanding how they're connected can help you seek out the most appropriate treatment, and get the VA benefits you deserve.

It's not clear why traumatic events and PTSD can lead to IBS, but it's likely that chronic stress from a traumatic event or PTSD can harm your digestive system. There's also a link to medication side effects taken to manage PTSD symptoms that can lead to IBS.

In PTSD, your body's "fight or flight" response is frequently activated, releasing a substance in the brain called *corticotropin-releasing factor* (CRF). Among other things, CRF increases mucus and water secretion in your colon and disrupts colon motility (speed of muscle contraction). It's likely, then, that high levels of CRF contribute to the development of IBS in people with PTSD.

What's more, since most of the world is affected by trauma to varying degrees without meeting full criteria for PTSD, this is something that potentially could be contributing to the prevalence of IBS.

In an article posted by the **American Gastroenterology Association**, it is stated that Patients with the irritable bowel syndrome (IBS) have been found to have high rates of psychological trauma history (44%) and **PTSD (36%)**. Individuals with PTSD have been reported to experience rates of **IBS at 35%** and nonulcer dyspepsia at 41%.

Can IBS be a secondary VA claim to PTSD?

Yes, IBS can be service-connected secondary to PTSD.

The **VA Ratings for IBS** secondary to PTSD are 0%, 10%, and 30%, depending upon the severity of your IBS, and how your IBS symptoms affect your work, life, and social functioning.

For example, a veteran have a 70% rating for PTSD but could possibly receive a 30% VA rating (lower rating possible as well) for IBS secondary to PTSD.

VA Disability Ratings for IBS Explained:

How is IBS Rated by the VA?

Medical Research Study:

Systematic review with meta-analysis: The association between post-traumatic stress disorder and irritable bowel syndrome

BVA Case History Example:

[IBS Secondary to PTSD is granted]

IBS secondary to Depression

Both physiologic and psychosocial variables appear to play important roles in the development and maintenance of IBS. Recent information suggests that the association of IBS and psychiatric disorders may be more fundamental than was previously believed and a significant amount of clinical and research data suggest the importance of the brain-gut interaction in IBS.

In a study published by the National Library of Medicine, they examined the observed high prevalence of psychiatric disorders in patients with IBS. The published literature indicates that fewer than half of individuals with IBS seek treatment for it. Of those who do, 50% to 90% have psychiatric disorders, including panic disorder, generalized anxiety disorder, social phobia, posttraumatic stress disorder, and **major depression**, while those who do not seek treatment tend to be psychologically normal.

Can IBS be a secondary VA claim to Depression?

Yes, IBS can be service-connected secondary to Depression.

The VA Ratings for IBS secondary to Depression are 0%, 10%, and 30%, depending upon the severity of your IBS, and how your IBS symptoms affect your work, life, and social functioning.

For example, a veteran may have a 50% VA rating for Depression but could possibly receive a 30% VA disability rating (lower rating of 0% or 10% for IBS is possible, too) for IBS secondary to Depression.

VA Disability Ratings for IBS Explained:

[How is IBS Rated by the VA?]

Medical Research Studies:

[A systematic review with meta-analysis of the role of anxiety and depression in irritable bowel syndrome onset]

Irritable bowel syndrome, anxiety, and depression: what are the links?

BVA Case History Example:

IBS secondary PTSD (with Depression) is granted.

IBS secondary to Anxiety

Sure, Anxiety is a mental health issue, but it can also have a powerful effect on your physical body chemistry. The stress from IBS changes your hormone production, alters your immune system, and in some cases, upsets your digestive tract.

So it comes as little surprise that anxiety has been **linked** to contributing to the development of irritable bowel syndrome (IBS), also known as "spastic colon," which is a chronic condition that causes bloating, gastrointestinal discomforts, erratic bowel movements, chronic abdominal pain, diarrhea, and constipation.

IBS is diagnosed when these symptoms are present without a medical cause, and while scientists believe that there are likely other factors that go into IBS, most agree that anxiety and stress contribute to its development.

Can IBS be a secondary VA claim to Anxiety?

Yes, IBS can be service-connected secondary to Anxiety.

The **VA Ratings for IBS** secondary to Anxiety are 0%, 10%, and 30%, depending upon the severity of your IBS, and how your IBS symptoms affect your work, life, and social functioning.

For example, a veteran might have a 70% rating for Generalized Anxiety Disorder (GAD) but could possibly receive a 30% VA rating (lower rating possible as well at 0% or 10%) for IBS secondary to Anxiety.

VA Disability Ratings for IBS Explained:

How is IBS Rated by the VA?

Medical Research Studies:

A systematic review with meta-analysis of the role of anxiety and depression in irritable bowel syndrome onset

Irritable bowel syndrome, anxiety, and depression: what are the links?

BVA Case History Example:

IBS secondary to Anxiety is granted

IBS secondary to Medication Side Effects

Your gut is filled with good bacteria that help keep you healthy. Antibiotics can upset the balance of bacteria, which might make Irritable Bowel Syndrome (IBS) more likely in some people. They can also let a dangerous bacteria called *C. difficile* multiply in your gut, which can cause severe -- and sometimes life-threatening -- diarrhea.

According to **Dr. Stephen Wangen**, an award-winning author of two books on solving digestive disorders, a patient came to him with diarrhea and urgent bowel movements. After a very thorough investigation they discovered that they could find no explanation for her symptoms, unlike most of their patients. Knowing that there is always a logical cause for any symptom, they finally settled on her medication. They urged her to show her primary doctor the list of known side-effects, and to work with him to change medications. Sure enough, when they saw her a month later the first thing she said was, “I stopped the Metroprolol and my digestive problems are gone.”

“Sometimes it’s as simple as that. Other times, the medication has no impact, or is only a piece of the puzzle. At the **IBS Treatment Center** our job is to figure that out,” said. Dr. Wangen.

The IBS Treatment Center article cited above added that some medications are more likely to cause diarrhea than others. Some particularly problematic medications include:

- Most cholesterol lowering statin drugs, such as simvastatin, lovastatin, and Lipitor®
- Most heartburn medications including: omeprazole (Prilosec®), Nexium®, Prevacid®, pantoprazole (Protonix®), cimetidine (Tagamet®), ranitidine (Zantac®).
- Bone density medications like Fosamax®.
- Antibiotics and even NSAIDS such as ibuprofen (Advil®) and naproxen (Aleve®).
- Anything that dries you up like Allegra® or Claritin®
- Antidepressants: especially tricyclic antidepressants such as amitryptiline (Elavil®) and imipramine
- Calcium channel blockers such as such as Cardizem®, Zyrtec®, and Procardia®
- Antispasmodics: Dicyclomine® and hyoscine (Hyoscyamine®)

Can IBS be a secondary VA claim to Medication Side Effects?

Yes, IBS can be service-connected secondary to Medication Side Effects as an “Interim Link.”

The **VA Ratings for IBS** secondary to Medication Side Effects are 0 percent, 10 percent, and 30 percent, depending upon the severity of your IBS, and how your IBS symptoms affect your work, life, and social functioning.

While Medication Side Effects are not a ratable VA disability on its own, Medication Side Effects may be used as an “Interim Link” for secondary service connection. How? For example, if a veteran takes medications to manage symptoms of a service connected disability (e.g., antidepressants for PTSD) and those medications cause side effects of a (new) non service connected disability (IBS in this example), the new disability (IBS in this example) can be connected as a secondary VA claim to the service connected condition with Medication Side Effects as the Interim Link. The best example would be a veteran who is taking antidepressants to manage symptoms of PTSD, and those antidepressants have side effects that cause or aggravate IBS. Thus, while the PTSD might not necessarily “cause” the IBS, the *side effects of the medications* taken to manage PTSD symptoms

can be used as the “Interim Link” for service connecting IBS secondary to PTSD.

VA Disability Ratings for IBS Explained:

How is IBS Rated by the VA?

Medical Research Study:

THESE 6 Drugs Are Causing IBS?!

BVA Case History Example:

As of this writing, a BVA case history example could not be located. However, it’s still possible to connect the two conditions depending upon your medical evidence and medical research.

IBS secondary to Weight Gain Obesity as Interim Link

Some scientists believe that existing weight problems may contribute to the development of IBS. However, further studies are required to properly establish a causal link between obesity and IBS. Meanwhile, another **study** pointed out that IBS symptoms are aggravated in obese patients because of the problems in satiation signals in IBS patients.

According to a study of the **National Library of Medicine**, in adults, the prevalence of IBS in obese subjects varied from 11.6% to 24%, depending on the study population. Two studies did not show increased odds of IBS in obese patients; however, two other studies showed that symptoms were more severe in obese patients affected by IBS, thus showing comorbidities between the two conditions.

Can IBS be a secondary VA claim to Weight Gain Obesity as Interim Link?

Yes, IBS can be service-connected secondary to Weight Gain Obesity as Interim Link.

The **VA Ratings for IBS** secondary to Weight Gain Obesity as Interim Link are 0%, 10%, and 30%, depending upon the severity of your IBS, and how your IBS symptoms affect your work, life, and social functioning.

While a veteran can't have a VA rating for Weight Gain Obesity on its own, if a service connected disability such as PTSD or other musculoskeletal disability causes/aggravates Weight Gain Obesity, it can be used as an "Interim Link" for service connection. For example, you could possibly receive a 30% service connected VA rating for IBS secondary to Weight Gain Obesity as an Interim Link to another service connected mental or physical condition.

VA Disability Ratings for IBS Explained:

How is IBS Rated by the VA?

Medical Research Studies:

Visceral abdominal obesity is associated with an increased risk of irritable bowel syndrome

Obesity and Irritable Bowel Syndrome: A Comprehensive Review

Irritable Bowel Syndrome May Be Associated with Elevated Alanine Aminotransferase and Metabolic Syndrome

BVA Case History Example:

As of this writing, a BVA case history example could not be located. However, it's still possible to connect the two conditions depending upon your medical evidence and medical research.

Meniere's Syndrome secondary to Tinnitus

Meniere's Syndrome, aka "Meniere's Disease" is most often diagnosed and treated by an otolaryngologist (commonly called an ear, nose, and throat doctor, or ENT). However, there is no definitive test or single symptom that a doctor can use to make the diagnosis. Diagnosis is based upon your medical history and the presence of:

- Two or more episodes of vertigo lasting at least 20 minutes each
- Tinnitus
- Hearing loss
- A feeling of fullness in the ear

The **symptoms of Meniere's Disease** are caused by the buildup of fluid in the compartments of the inner ear, called the labyrinth. The labyrinth contains the organs of balance (the semicircular canals and otolithic organs) and of hearing (the cochlea). It has two sections: the bony labyrinth and the membranous labyrinth. The membranous labyrinth is filled with a fluid called endolymph that, in the balance organs, stimulates receptors as the body moves. The receptors then send signals to the brain about the body's position and movement. In the cochlea, fluid is compressed in response to sound vibrations, which stimulates sensory cells that send signals to the brain.

In Meniere's disease, the endolymph buildup in the labyrinth interferes with the normal balance and hearing signals between the inner ear and the brain.

Can Meniere's Syndrome be a secondary VA claim to Tinnitus?

Yes, Meniere's Syndrome can be service-connected secondary to Tinnitus.

The **VA Ratings for Meniere's Syndrome** secondary to Tinnitus are under DC 6205, which provides a 30% rating for hearing impairment with vertigo less than once a month, a 60% rating for vertigo attacks with staggering at least once a month, or a full 100% rating for such attacks on at least a weekly basis.

For example, a veteran may only have a 10% rating for Tinnitus but could possibly receive a 30%, 60%, or 100% VA rating for Meniere's Syndrome secondary to Tinnitus.

VA Disability Ratings for Meniere's Syndrome Explained:

How is Meniere's Disease Rated by the VA?

Medical Research Study:

Tinnitus and Meniere's disease: characteristics and prognosis in a Tinnitus clinical sample

BVA Case History Example:

Meniere's Syndrome Secondary to Tinnitus is granted

Meniere's Syndrome secondary to Hearing Loss

Meniere's Syndrome or Meniere's Disease is most often diagnosed and treated by an otolaryngologist (commonly called an ear, nose, and throat doctor, or ENT). However, there is no definitive test or single symptom that a doctor can use to make the diagnosis. Diagnosis is based upon your medical history and the presence of:

- Two or more episodes of vertigo lasting at least 20 minutes each
- Tinnitus
- Hearing loss
- A feeling of fullness in the ear

The **symptoms of Meniere's disease** are caused by the buildup of fluid in the compartments of the inner ear, called the labyrinth. The labyrinth contains the organs of balance (the semicircular canals and otolithic organs) and of hearing (the cochlea). It has two sections: the bony labyrinth and the membranous labyrinth. The membranous labyrinth is filled with a fluid called endolymph that, in the balance organs, stimulates receptors as the body moves. The receptors then send signals to the brain about the body's position and movement. In the cochlea, fluid is compressed in response to

sound vibrations, which stimulates sensory cells that send signals to the brain.

In Meniere's disease, the endolymph buildup in the labyrinth interferes with the normal balance and hearing signals between the inner ear and the brain.

Can Meniere's Syndrome be a secondary VA claim to Hearing Loss?

Yes, Meniere's Syndrome can be service-connected secondary to Hearing Loss.

The **VA Ratings for Meniere's Syndrome** secondary to Hearing Loss are under DC 6205, which provides a 30% rating for hearing impairment with vertigo less than once a month, a 60% rating for vertigo attacks with staggering at least once a month, or a full 100% rating for such attacks on at least a weekly basis.

For example, a veteran might only have a 0% rating for Hearing Loss but could possibly receive a 30%, 60%, or 100% VA rating for Meniere's Disease secondary to Hearing Loss.

VA Disability Ratings for Meniere's Syndrome Explained:

How is Meniere's Disease Rated by the VA?

Medical Research Study:

Meniere's Disease and Hearing Loss- How are They Related?

BVA Case History Example:

As of this writing, a BVA case history example could not be located. However, it's still possible to connect the two conditions depending upon your medical evidence and medical research.

Meniere's Syndrome secondary to Migraines

Like Meniere's disease, migraine (headaches) are a disorder that occurs in the brain. One popular theory is that your nervous system, **responding** to

migraine triggers, causes a spasm at the base of your brain that causes blood vessels to constrict, setting into motion a series of chemical reactions that lead to debilitating **migraine headaches**.

Some scientists believe that migraines are caused by intercepted messages between the brain and the blood vessels in the head. This bears striking resemblance to the cause of Meniere's disease, which involves intercepted sound messages between the brain and the inner ear's cochlea.

According to **MigraineStrong**, those with MD (Meniere's Disease) are twice as likely to have migraine and those with migraine are more likely to have earlier onset and bilateral hearing loss from MD. Clearly migraine is very often a common thread between vestibular migraine and Meniere's. There are no specific diagnostic tests to determine vestibular migraine or Meniere's disease. Both are currently diagnosed by excluding other disease by reviewing a patient's personal symptom history. The inability to determine pathology is really what determines diagnosis.

Can Meniere's Syndrome be a secondary VA claim to Migraines?

Yes, Meniere's Syndrome can be service-connected secondary to Migraines.

The **VA Ratings for Meniere's Syndrome** secondary to Migraines are under DC 6205, which provides a 30% rating for hearing impairment with vertigo less than once a month, a 60% rating for vertigo attacks with staggering at least once a month, or a 100% VA rating for such attacks on at least a weekly basis.

For example, a veteran might have a 30% VA rating for Migraine (Headaches) but could possibly receive a 30%, 60%, or 100% VA rating for Meniere's Syndrome secondary to Migraine (Headaches).

VA Disability Ratings for Meniere's Syndrome Explained:

How is Meniere's Syndrome Rated by the VA?

Medical Research Study:

[Meniere's Disease and Vestibular Migraine: Updates and Review of the Literature]

BVA Case History Example:

[Meniere's Syndrome secondary to Migraines is granted]

Meniere's Syndrome secondary to TBI

Post-traumatic Meniere's disease (PTMD) is Meniere's syndrome that develops after acoustic or physical trauma. The histopathologic characteristics of PTMD are identical to those of idiopathic Meniere's disease. The causes of traumatic insult that lead to PTMD include blows to the head, temporal bone fractures, previous ear operations such as stapedectomy, or acoustic trauma.

Dizziness and vertigo, (symptoms of Meniere's Syndrome) are also common symptoms following traumatic brain injury (**TBI**). Although these symptoms can resolve within a brief period, many patients' symptoms last much longer and impede the ability to return to work in full functioning.

Post-traumatic vertigo and dizziness caused by TBI can have many different causes including the following: Benign Paroxysmal Positional Vertigo (BPPV), Labyrinthine or Inner Ear Concussion, and **Post-Traumatic Meniere's Syndrome**: Post-traumatic Meniere's disease or syndrome is a vestibular injury that is a disorder of the inner ear causing episodes of vertigo (dizziness), tinnitus (noise in the ear) and hearing changes. Post-traumatic Meniere's Syndrome is caused by bleeding into the inner ear or disturbance of fluid in the ear caused by the trauma.

Can Meniere's Syndrome be a secondary VA claim to TBI?

Yes, Meniere's Syndrome can be service-connected secondary to TBI.

The VA Ratings for Meniere's Syndrome secondary to TBI are under DC 6205, which provides a **30%** rating for hearing impairment with vertigo less than once a month, a **60%** rating for vertigo attacks with staggering at least

once a month, or a **100%** rating for Meniere's Syndrome for such attacks on at least a weekly basis.

For example, a veteran may only have a 0% rating for TBI but could possibly receive a 30%, 60%, or 100% VA rating for Meniere's Syndrome secondary to TBI.

VA Disability Ratings for Meniere's Syndrome Explained:

How is Meniere's Syndrome Rated by the VA?

Medical Research Study:

Fluid dynamics vascular theory of brain and inner-ear function in traumatic brain injury: a translational hypothesis for diagnosis and treatment

BVA Case History Example:

As of this writing, a BVA case history example could not be located. However, it's still possible to connect the two conditions depending upon your medical evidence and medical research.

Migraines secondary to Tinnitus

According to the **American Migraine Foundation**, Tinnitus can be associated with multiple types of headache disorders. One headache type where Tinnitus is sometimes seen is in those with chronic migraines (headaches). Some patients report that their Tinnitus worsens only and consistently during migraine attacks. In migraine patients with cutaneous allodynia, the allodynia may occur in parallel with the development of the tinnitus.

Multiple hypotheses have been formed to explain why Tinnitus and headache may co-occur. Some researchers suggest that it could be from spontaneous abnormal neural activity. Others suggest it may be an allodynic symptom.

Findings of a National Library of Medicine study suggest a significant relationship between Tinnitus and headache laterality and symptom interaction over time and argue against a purely coincidental cooccurrence of tinnitus and headache. Both disorders may be linked by common pathophysiological mechanisms.

Can Migraine (Headaches) be a secondary VA claim to Tinnitus?

Yes, Migraines can be service-connected secondary to Tinnitus.

VA Ratings for Migraines secondary to Tinnitus are 0%, 10%, 30%, or 50%, depending upon the frequency, severity, and duration of your Migraines, and how your headache symptoms affect your work, life, and social functioning.

For example, a veteran may only have a 10% rating for Tinnitus but could possibly receive a 0%, 10%, 30%, or 50% VA rating for Migraines secondary to Tinnitus.

VA Disability Ratings for Migraines Explained:

How Are Migraines Rated by the VA?

Medical Research Study:

Tinnitus and Headache

BVA Case History Example:

Migraines Secondary to Tinnitus is Granted

Migraines secondary to Cervical Strain

According to Envista Medical Neck and Back Center, tightness in the muscles of the shoulders and neck can often lead to headaches. The tightness stimulates the nerves that travel from the neck to the head. When the nerve impulse begins to fire, the pain can move to the head, where a headache can occur. This type of disorder, a cervicogenic headache, is called that because it stems from the cervical spine (neck).

Migraine attacks arising from neck pain can also occur, although they are not as common, as noted by Dr. David Salisbury, DO. The exact processes through which a migraine arises in the head are not yet completely evident. However, the mainstream neurological understanding is that a blend of changes occur within the head's blood vessels and nerves. Neck tightness could lead to a migraine in exactly the same manner as a cervicogenic headache: it could stimulate the nerves that go to the head, but a migraine could arise instead – a likelier scenario in someone who experiences regular migraine attacks.

In addition, **Cervicogenic headache** is a term used to describe a headache which has its root cause not in the head, but rather in a *neck* issue. A cervicogenic headache is typically characterized by a dull pain that radiates from the neck to the back of the head. At times it may also spread around the side or front of your head – it's different from a migraine, although the two are often confused, and there's nothing to say that you couldn't be suffering from both types—this is fairly common.

Can Migraines be a secondary VA claim to Cervical Strain (Shoulders / Neck Condition)?

Yes, Migraines can be service-connected secondary to Cervical Strain.

VA Ratings for Migraines secondary to Cervical Strain are 0%, 10%, 30%, or 50%, depending upon the frequency, severity, and duration of your Migraines, and how your headache symptoms affect your work, life, and social functioning.

For example, a veteran may only have a 10% rating for Cervical Strain but could possibly receive a 0%, 10%, 30%, or 50% VA rating for Migraines secondary to Cervical Strain.

VA Disability Ratings for Migraines Explained:

How Are Migraines Rated by the VA?

Medical Research Studies:

Can Neck Conditions Cause Headaches or Migraines?

The effects of aerobic exercise for persons with migraine and co-existing tension-type headache and neck pain. A randomized, controlled, clinical trial

BVA Case History Example:

Migraines Secondary to Cervical Strain is Granted

Migraines secondary to Gastroesophageal Reflex Disease (GERD)

Recent studies are increasingly linking GERD and Headaches, but some questions remain on why exactly this happens. Headaches or migraines are associated with a number of gastrointestinal conditions. These include: dyspepsia (indigestion), GERD, constipation, functional abdominal pain, inflammatory bowel syndrome (IBS), inflammatory bowel disorders (IBD), celiac disease and Heliobacter pylori (H. pylori) infection. Studies suggest that between 30 and 50 percent of people with chronic headaches or migraines also have GERD. Researchers are still trying to pinpoint which comes first, and whether GERD and headaches exist together, or if one causes the other.

Autonomic nervous system malfunction has been linked to both GERD and migraines and could contribute to the development of either — or both — conditions. Food allergies, medications, and even serotonin levels are also common threads between both headache and reflux, and could play a role in connection between the two.

Acid reflux and GERD occur when stomach acid bubbles up from the opening between the stomach and the esophagus. When the acid reaches the esophagus, it causes irritation or a burning sensation. In some cases, this backflow of stomach acids can even reach the eustachian tubes in your throat. They connect to your inner ear. The ear plays a large role in balance, and disruptions to the pressure in your ear —especially with stomach acid — can cause dizziness.

Research has also shown that people who regularly experience gastrointestinal symptoms — such as reflux, diarrhea, constipation and nausea — have a higher prevalence of headaches than do those who don't have gastrointestinal symptoms.

Can Migraines be a secondary VA claim to GERD?

Yes, Migraines can be service-connected secondary to GERD.

The VA Ratings for Migraines secondary to GERD are 0%, 10%, 30%, or 50%, depending upon the frequency, severity, and duration of your Migraines, and how your headache symptoms affect your work, life, and social functioning.

For example, a veteran may only have a 10% rating for GERD but could possibly receive a 0%, 10%, 30%, or 50% VA rating for Migraines secondary to GERD.

VA Disability Ratings for Migraines Explained:

How Are Migraines Rated by the VA?

Medical Research Study:

Gastroesophageal Reflux Disease and Migraine Disorders

BVA Case History Example:

As of this writing, a BVA case history example could not be located. However, it's still possible to connect the two conditions depending upon your medical evidence and medical research.

Migraines secondary to IBS

The association between migraine and functional gastrointestinal disorders has been confirmed by many clinical observations and epidemiological studies.

A **study** published in the *Polish Journal of Neurology and Neurosurgery* found that 23 to 53 percent of people with IBS experienced frequent headaches, and the authors noted that "Functional gastrointestinal disorders, such as irritable bowel syndrome (IBS), are reported in migraine patients in periods between the attacks [of migraine].

There is indeed an elevated incidence of migraine or headache among people who have IBS, and an increased incidence of IBS among people with migraine. Another **study**, published in *BMC Gastroenterology*, concluded that people with IBS were 40-80% more likely to also have migraine, fibromyalgia, or depression than people without IBS.

Can Migraines be a secondary VA claim to IBS?

Yes, Migraines can be service-connected secondary to IBS.

The **VA Ratings for Migraines** secondary to IBS are 0%, 10%, 30%, or 50%, depending upon the frequency, severity, and duration of your Migraines, and how your headache symptoms affect your work, life, and social functioning.

For example, a veteran may only have a 10% rating for IBS but could possibly receive a 0%, 10%, 30%, or 50% VA rating for Migraines secondary to IBS.

VA Disability Ratings for Migraines Explained:

How Are Migraines Rated by the VA?

Medical Research Studies:

Migraine and irritable bowel syndrome

Gut-brain Axis and migraine headache: a comprehensive review

BVA Case History Example:

As of this writing, a BVA case history example could not be located. However, it's still possible to connect the two conditions depending upon your medical evidence and medical research.

Migraines secondary to PTSD

There are several theories as to why people with PTSD are more likely to experience problems with **headaches**, but the most common involves stress. PTSD causes persistently high levels of stress due to intense feelings of fear, anxiety about surroundings, and tension in social situations. The strain of reliving the event can easily cause tension headaches, as can the physical responses of grinding teeth and clenching muscles in the neck and back.

One **study** of civilian participants showed a worrying link between migraines and PTSD. For example, over a one year timeframe, people with migraines suffered PTSD at a rate of 14.3%, while those without headache disorders only suffered a 2.1% rate of PTSD. And migraine sufferers reported a lifetime PTSD prevalence rate of 21.5%, compared to just 4.5% in people without migraines.

People with migraines were not only at risk of suffering PTSD, but they were also at increased risk of suffering major depression or generalized anxiety. In subjects with both migraines and PTSD, PTSD symptoms occurred before migraines in roughly 70% of participants.

People with migraines reported nearly twice as many traumatic stressors than those who did not suffer from headaches. Traumatic life events suffered by people with migraines included sudden injuries, death or injury of a close family member or friend, seeing someone killed or injured, and violent attacks.

Veterans can suffer from migraine headaches for a variety of reasons, including **PTSD or a traumatic brain injury (TBI)**, and these headaches can have a devastating impact on quality of life. Researchers aren't certain why people who suffer from PTSD are more likely to experience **migraines**, but

it's believed that the symptoms of PTSD contribute to high stress levels and emotional tension and pressure. This stress can be a catalyst for these headaches. It is known, however, that a veteran or any person who suffers a TBI will likely experience headache problems. And because the brain reacts to trauma through pathways that are like those in migraines, these types of headaches can be a result of a TBI. Additionally, the link between a TBI and a migraine can be PTSD.

Can Migraines be a secondary VA claim to PTSD?

Yes, Migraines can be service-connected secondary to PTSD.

The **VA Ratings for Migraines** secondary to PTSD are 0%, 10%, 30%, or 50%, depending upon the frequency, severity, and duration of your Migraines, and how your headache symptoms affect your work, life, and social functioning.

For example, a veteran may have a 70% VA disability rating for PTSD but could possibly receive a 0%, 10%, 30%, or 50% VA rating for Migraines secondary to PTSD.

VA Disability Ratings for Migraines Explained:

How Are Migraines Rated by the VA?

Medical Research Study:

Migraine and its psychiatric comorbidities

BVA Case History Example:

Migraines Secondary to PTSD is granted

Migraines secondary to Insomnia

Migraines and sleep disorders/disturbances are complex conditions that are often intertwined in a vicious cycle of one triggering the other. While lack of

sleep is a trigger for many migraineurs, migraine patients use sleep as a treatment for migraine.

Having a sleep disorder is linked to more **severe and more frequent migraines** as well. And sleep disturbances are believed to contribute to the transformation from episodic migraine (fewer than 15 migraines per month) to **chronic migraine** (15 or more migraines per month) in certain people.

Insomnia is not just the most common sleep problem in those suffering from migraines, it's also the most common one in the general population as well. This condition occurs when you have difficulty falling and/or staying asleep, leaving you feeling tired. Your sleep may also be light and of poor quality, and you may wake up much earlier than you should.

People with migraine report increased insomnia symptoms in between their migraines including poor sleep quality, difficulty falling and staying asleep, feeling tired after awakening, waking up too early, feeling sleepy during the day, and getting less sleep than normal. Additionally, many migraineurs say they're awakened from deep sleep by a migraine.

Can Migraines be a secondary VA claim to Insomnia?

Yes, Migraines can be service-connected secondary to Insomnia.

VA Ratings for Migraines secondary to Insomnia are 0%, 10%, 30%, or 50%, depending upon the frequency, severity, and duration of your Migraines, and how your headache symptoms affect your work, life, and social functioning.

For example, a veteran may only have a 10% rating for Insomnia (although Insomnia is typically an underlying symptom of a different ratable mental health condition under the law that’s probably already service connected) but could possibly receive a 0%, 10%, 30%, or 50% VA rating for Migraines secondary to Insomnia.

VA Disability Ratings for Migraines Explained:

How Are Migraines Rated by the VA?

Medical Research Studies:

Sleep, Insomnia, and Migraine

Migraine and sleep disorders: a systematic review

BVA Case History Example:

As of this writing, a BVA case history example could not be located. However, it's still possible to connect the two conditions depending upon your medical evidence and medical research.

Migraines secondary to Depression

The association of depression with migraine headaches, which affect more than 10% of Americans, is especially close, and even a causal bi-directional relationship. One **study** found that over a two-year period, a person with a history of major depression was three times more likely than average to have a first migraine attack, and a person with a history of migraine was five times more likely than average to have a first episode of depression.

This study's results indicated that stress and anxiety were higher in the migraine group than in the control group and above the clinical level. In addition, they claimed that stress is a primordial factor in the triggering and perpetuation of migraine attacks.

The biological link between migraines and depression is complex and may be related to genes, low serotonin production, or other factors. They are worth understanding more about, especially when working to manage both conditions effectively.

Scientific studies reveal that the relationship between migraine and depression is a two-way street: Having one puts you at a higher risk of the other, and worsening symptoms of one condition can also worsen the symptoms of the other, and vice versa.

Can Migraines be a secondary VA claim to Depression?

Yes, Migraines can be service-connected secondary to Depression.

VA Ratings for Migraines secondary to Depression are 0%, 10%, 30%, or 50%, depending upon the frequency, severity, and duration of your Migraines, and how your headache symptoms affect your work, life, and social functioning.

For example, a veteran might have a 70% VA rating for Depression but could possibly receive a 0%, 10%, 30%, or 50% VA disability rating for Migraines secondary to Depression.

VA Disability Ratings for Migraines Explained:

How Are Migraines Rated by the VA?

Medical Research Studies:

Anxiety and depression symptoms and migraine: a symptom-based approach research

The relationships between migraine, depression, anxiety, stress, and sleep disturbances

BVA Case History Example:

Migraines Secondary to Depression is granted

Migraines secondary to Anxiety

Many migraine sufferers find that their headaches are often associated with feelings of anxiety or depression, and wonder if the two conditions are related.

Research has shown that some people develop anxiety after living with migraine for a while, while in others the anxiety developed before the onset of migraine headaches.

Anxiety can prompt the release of adrenaline, which is a known migraine trigger. Hormonal changes in the body can also affect or trigger migraines or

anxiety disorders. **Women are more affected by hormonal changes**, but men experience this too. Both sexes are more sensitive to changes in both their physical and emotional states when suffering from anxiety, migraine, or even depression.

This is an example of a vicious cycle situation: You feel anxious so you can't get to sleep but knowing the difficulties you'll face getting through the day when you're feeling fatigued creates even more stress, further reducing your chances of getting to sleep. The resulting stress can be enough to trigger a migraine headache.

Can Migraines be a secondary VA claim to Anxiety?

Yes, Migraines can be service-connected secondary to Anxiety.

The **VA Rating Criteria for Migraines** secondary to Anxiety (Generalized Anxiety Disorder) are 0%, 10%, 30%, or 50%, depending upon the frequency, severity, and duration of your Migraines, and how your headache symptoms affect your work, life, and social functioning.

For example, a veteran may have a 70% service connected VA rating for Anxiety but could possibly receive a 0%, 10%, 30%, or 50% VA rating for Migraines secondary to Anxiety.

VA Disability Ratings for Migraines Explained:

How Are Migraines Rated by the VA?

Medical Research Studies:

Anxiety and depression symptoms and migraine: a symptom-based approach research

The relationships between migraine, depression, anxiety, stress, and sleep disturbances

BVA Case History Example:

Migraines Secondary to Anxiety is granted

Migraines secondary to Traumatic Brain Injury (TBI)

Right after a severe TBI (Traumatic Brain Injury), people may have headaches because of the surgery on their skulls or because they have small collections of blood or fluid inside the skull.

Headaches can also occur after mild to moderate injury or, in the case of severe TBI, after the initial healing has taken place. These headaches can be caused by a variety of conditions, including a change in the brain caused by the injury, neck and skull injuries that have not yet fully healed, tension and stress, or side effects from medication.

When a serious injury occurs to the head, brain and/or neck, the risk for long-term complications is significant. In particular, headaches and migraine attacks develop regularly after traumatic brain injuries (regardless of severity), with estimates of prevalence between 58-81% of patients according to **Therespecs.com**

The five types of post-TBI headache disorders are:

- **Persistent post-traumatic headache**
- **Migraine with or without aura**
- **Vestibular migraine**
- **Cluster headache**
- **Chronic tension-type headache**

Can Migraines be a secondary VA claim to TBI?

Yes, Migraines can be service-connected secondary to TBI.

VA Ratings for Migraines secondary to TBI are 0%, 10%, 30%, or 50%, depending upon the frequency, severity, and duration of your Migraines, and how your headache symptoms affect your work, life, and social functioning.

For example, a veteran may only have a 10% rating for TBI but could possibly receive a 0%, 10%, 30%, or 50% VA rating for Migraines secondary to TBI.

VA Disability Ratings for Migraines Explained:

How Are Migraines Rated by the VA?

Medical Research Studies:

Mild Traumatic Brain Injury and Post-concussion Syndrome: Treatment and Related Sequela for Persistent Symptomatic Disease

Posttraumatic Headache

BVA Case History Example:

Migraines Secondary to TBI is granted

Migraines secondary to Medication Side Effects

According to **Dr. Andrew Charles, MD**, director of Headache Research and Treatment and a professor of neurology at the David Geffen School of Medicine at the University of California Los Angeles, medication is a common problem seen by headache and non-headache doctors alike. “Any medication is on the table as a possible exacerbator of migraine…you have to always consider even something that may seem innocuous as a potential contributor,” he said as part of a presentation at the virtual 2018 **World Migraine Summit.**

While **SSRI antidepressants**, or selective serotonin reuptake inhibitors, have been shown to be effective in the treatment of depression, their role in migraine is a long, rocky road. The current medical hypothesis is that a deficiency of serotonin is somehow involved in migraine; triptans, prescription-strength migraine treatment, activate a set of serotonin receptors in the brain. One would think that SSRIs, which look to increase serotonin, would help migraine, but it is not as simple as “high serotonin is good and low serotonin is bad,” explained Dr. Charles. These drugs react differently in each patient, and may deliver the opposite effect intended, leading to migraines (or other types of headaches).

Proton Pump Inhibitors (PPIs), commonly branded as Nexium or other generics, are usually prescribed by internists or gastroenterologists for the treatment of acid reflex. According to Dr. Charles, there is some evidence that these medications get into the nervous system. He referenced an experimental study from Taiwan that showed when patients are started on a PPI, they're more likely to complain of headaches.

Nasal steroids and decongestants indicated for chronic allergies are stimulants, and some include caffeine in their chemical makeup, which has been shown to be an on-and-off migraine trigger.

Can Migraines be a secondary VA claim to Medication Side Effects?

Yes, Migraines can be service-connected secondary to Medication Side Effects as an "Interim Link" for secondary service connection.

The **VA Rating Criteria for Migraines** secondary to Medication Side Effects as an interim link for secondary service connection are 0%, 10%, 30%, or 50%, depending upon the frequency, severity, and duration of your Migraines, and how your headache symptoms affect your work, life, and social functioning.

For example, a veteran may have a 50% service connected VA rating for Depression but could possibly receive a 0%, 10%, 30%, or 50% VA rating for Migraines secondary to Medication Side Effect as an Interim Link to another service connected condition, which in this example, is Depression.

While a veteran can't have a VA rating for Medication Side Effects on its own, if a service connected disability such as Depression, PTSD, or other musculoskeletal disability causes/aggravates Migraine (Headaches) because of side effects of medications taken to manage your mental health symptoms, it can be used as an "Interim Link" for service connection.

VA Disability Ratings for Migraines Explained:

How Are Migraines Rated by the VA?

Medical Research Studies:

[List of Medicines That Can Cause Headaches]

[Can the Overuse of Medication Cause Chronic Migraines?]

BVA Case History Example:

[Migraines Secondary due to Medication Side Effects is granted]

Migraines secondary to Meniere's Disease

Like **Meniere's disease**, **migraines** are a disorder that occurs in the brain. According to **Migravent**, one popular theory is that your nervous system, responding to **migraine triggers**, causes a spasm at the base of your brain that causes blood vessels to constrict, setting into motion a series of chemical reactions that lead to debilitating **migraine headaches**.

Some scientists believe that migraines are caused by intercepted messages between the brain and the blood vessels in the head. This bears striking resemblance to the cause of Meniere's disease, which involves intercepted sound messages between the brain and the inner ear's cochlea.

A **study** concluded that the lifetime prevalence of migraine is increased in patients with MD when strict diagnostic criteria for both conditions are applied. The frequent occurrence of migraine symptoms during Meniere's Disease attacks suggests a pathophysiologic link between the two conditions.

As most Meniere's patients can probably attest, they are not strangers to the pain and other feelings of a migraine attack—even if they have never been diagnosed with a headache disorder and do not otherwise meet the criteria for one. A small **study** showed that at least half of people with Meniere's disease deal with migraine-like head pain; and amazingly, 95% of those same individuals dealt with other typical migraine symptoms—such as photophobia and phonophobia (light and sound sensitivity, respectively), motion sickness and brain fog.

Can Migraines be a secondary VA claim to Meniere's Disease?

Yes, Migraines can be service-connected as a secondary VA claim to Meniere's Disease.

VA Ratings for Migraines secondary to Meniere's Disease are 0%, 10%, 30%, or 50%, depending upon the frequency, severity, and duration of your Migraines, and how your Migraine (or any other type of Headache) symptoms affect your work, life, and social functioning.

For example, a veteran might have a 30% VA rating for Meniere's Disease but could possibly receive a 0%, 10%, 30%, or 50% VA rating for Migraines secondary to Meniere's Disease.

VA Disability Rating for Migraines Revealed & Explained:

How Are Migraine (Headaches) Rated by the VA?

Medical Research Study:

Migraine and Meniere's disease: Is There a Link?

BVA Case History Example:

Migraines Secondary to Meniere's Disease is granted

Migraines secondary to Fibromyalgia

Fibromyalgia (FM) and Migraines have long been connected according to a multitude of medical research. **Studies** have revealed that **more than half of fibromyalgia patients** have also met the diagnostic criteria for **migraine**, with and without aura. Furthermore, Tension Headaches, which are characterized by mild or moderate pain around the head—has also been linked to FM. **Chronic migraines** have also been shown to increase episodes of pain in people with fibromyalgia, among other symptoms such as high frequency of headache, sleep disturbances and anxiety. Greater instances of headache-related disability as well as overall severity of migraine attacks were also more pronounced in patients with both disorders.

Although the causes of either condition are not immediately clear, some researchers have suggested that the two conditions reflect issues with how the nervous system processes pain. Both disorders also disproportionately affect women, which may partially explain their mutual presence. Furthermore, light, noise, touch and/or joint stiffness can act as triggers for both fibromyalgia and migraine.

According to the **Association of Migraine Disorders**, At least half of people living with fibromyalgia report headache as a symptom. A 2005 study of 100 patients found that 63% reported severe headaches, and a 2015 study found that 55% of fibromyalgia patients met the criteria for migraine headaches.7 Migraine disease and fibromyalgia co-occur so frequently that it suggests they share common mechanisms in pathophysiology. Both conditions involve hyperalgesia (or increased sensitivity to pain and pain response). That is a double-edged sword as hyperalgesia is partly responsible for the frequency of migraine attacks, which triggers fibromyalgia flares.

People who have these conditions tend to report different pain sensitivity levels than those who live with just one of them. The widespread pain, cognitive difficulties, and fatigue involved with fibromyalgia can be amplified by migraine attacks, decreasing quality of life.

When a 2018 study focused on migraine patients and the incidence of fibromyalgia, they found that 36.2% met the diagnostic criteria for fibromyalgia. Those patients experienced more rates of depression, sleep disruption, anxiety, and overall lower quality of life than those with migraine disease alone.

Can Migraines be a secondary VA claim to Fibromyalgia (FM)?

Yes, Migraines can be service-connected secondary to Fibromyalgia (FM).

VA Ratings for Migraines secondary to Fibromyalgia are 0%, 10%, 30%, or 50%, depending upon the frequency, severity, and duration of your Migraines, and how your Migraine (or any other type of Headache) symptoms affect your work, life, and social functioning.

For example, a veteran might have a 10% VA rating for Fibromyalgia but could possibly receive a 0%, 10%, 30%, or 50% VA rating for Migraines secondary to Fibromyalgia.

VA Disability Rating for Migraines Revealed & Explained:

How Are Migraines Rated by the VA?

Medical Research Study:

Bidirectional association between migraine and fibromyalgia: retrospective cohort analyses of two populations

BVA Case History Example:

Migraines Secondary to Fibromyalgia is granted

Migraines secondary to Heart Disease

Cardiovascular disease (CVD) is the more common name that describes **conditions affecting the heart or blood vessels**. It's typically associated with a build-up of fatty deposits inside the arteries ("atherosclerosis") and presents an increased risk of blood clots in patients with CVD.

A substantial body of medical research worldwide demonstrates consistent associations between migraine headaches and **cardiovascular disease (CVD),** aka **heart disease.**

Neurology Advisor posted a range of studies that have revealed a link between migraine – especially migraine with aura – and stroke, including a case-control study showing higher rates of migraine with aura among patients with ischemic stroke vs those with no history of stroke (18.3% vs 4.4%, *P* =.0001). The increased stroke risk associated with migraine with aura was observed in women but not in male participants.

In a meta-analysis of 21 studies composed of 622,381 participants, migraine was independently associated with ischemic stroke, with a pooled adjusted odds ratio (OR) of 2.04 (95% CI, 1.72–2.43). An earlier investigation, which

surveyed US male physicians with migraine, found a relative risk of 1.84 (95% CI, 1.06-3.20) for total stroke and 2.00 (95% CI, 1.10-3.64) for ischemic stroke compared with the physicians with no migraine history.

In a large population-based cohort study published in 2018 in *BMJ*, researchers investigated the risk of various **cardiovascular disorders in 51,032 patients with migraine** compared with 510,320 individuals from the general population during a period of 19 years. Migraine was shown to be positively associated with ischemic stroke (HR, 2.26; 95% CI, 2.11-2.41), hemorrhagic stroke (HR, 1.94; 95% CI, 1.68-2.23), venous thromboembolism (HR, 1.59; 95% CI, 1.45-1.74), myocardial infarction (adjusted HR, 1.49; 95% CI, 1.36-1.64), and atrial fibrillation or atrial flutter (HR, 1.25; 95% CI, 1.16-1.36).

Additional evidence points to endothelial dysfunction, a well-defined risk factor for cardiovascular disease (CVD), as a potential mechanism underlying the connection between migraine with aura and stroke in female patients. Elevated levels of endothelial microparticles (EMPs) have been observed in women with migraine with aura and were associated with increased arterial stiffness.

Accumulating research also highlights the potential role of genetic factors in the connection between migraine and CVD, including various studies identifying higher risk of CVD events and death in migraine patients with certain single nucleotide polymorphisms. Further research is warranted to clarify these associations and their clinical implications.

Can Migraines be a secondary VA claim to Heart Disease?

Yes, Migraines can be service-connected secondary to Heart Disease.

VA Ratings for Migraines secondary to Heart Disease are 0%, 10%, 30%, or 50%, depending upon the frequency, severity, and duration of your Migraines, and how your Migraine Headaches (or any other type of Headache) symptoms affect your work, life, and social functioning.

For example, a veteran might have a 10% VA rating for Heart Disease but could possibly receive a 0%, 10%, 30%, or 50% VA rating for Migraines secondary to Fibromyalgia.

VA Disability Rating for Migraines Revealed & Explained:

How Are Migraines Rated by the VA?

Medical Research Studies:

Migraines & Cardiovascular Disease: The Missing Link

Migraines and Cardiovascular Disease

BVA Case History Example:

As of this writing, a BVA case history example could not be located. However, it's still possible to connect the two conditions depending upon your medical evidence and medical research.

Migraines secondary to Asthma

Individuals with asthma who also experience episodic or occasional migraine may be more likely to develop chronic migraine, according to a **National Headache Foundation-sponsored study**, recently published online in the journal *Headache*.

"If you have asthma along with episodic or occasional migraine, then your headaches are more likely to evolve into a more disabling form known as **chronic migraine**," said Vincent Martin, MD, professor of medicine in UC's Division of General Internal Medicine, co-director of the Headache and Facial Pain Program at the UC Neuroscience Institute and lead author in the study. Dr. Martin is Vice President of the National Headache Foundation.

Researchers from the University of Cincinnati (UC), Montefiore Headache Center, Albert Einstein College of Medicine, and Vedanta Research studied 4,500 individuals who experienced **episodic migraine** or fewer than 15 headaches per month in 2008.

The researchers analyzed data from the American Migraine Prevalence and Prevention (AMPP) Study which was undertaken during 2008 and 2009 Study participants completed written questionnaires in both years. Based on responses to the 2008 questionnaire, patients were divided into two groups—one with episodic migraine and coexisting asthma and another with episodic migraine and no asthma. They were questioned about medication usage, depression, and smoking status. The 2008 and 2009 questionnaires included questions about frequency of headaches, which enabled the authors to identify the participants who had progressed to chronic migraine.

After one year of follow-up, researchers found that new onset chronic migraine developed in 5.4 percent of participants who were also suffering from asthma, and in 2.5 percent of individuals without asthma.

“The strength of the relationship is robust,” Martin said. “Asthma was a stronger predictor of chronic migraine than depression, which other studies have found to be one of the most potent conditions associated with future development of chronic migraine.”

There are various theories as to why asthma may have a predictive role in chronic migraine development for individuals with episodic or occasional migraine. Martin said asthmatic patients are more likely to also have allergies and prior studies have shown that allergies may increase the number of headaches, particularly if the individual has **hay fever**.

Other possibilities, according to Martin, include patients with asthma who may have an **overactive parasympathetic nervous system** that predisposes them to attacks of both migraine and asthma. He said it is also possible that asthma may not directly cause chronic migraine, but that a shared environmental or genetic factor, like air pollution which has been known to trigger both asthma and migraine attacks, may play a role.

Can Migraines be a secondary VA claim to Asthma?

Yes, Migraines can be service-connected secondary to Asthma.

VA Ratings for Migraines secondary to Asthma are 0%, 10%, 30%, or 50%, depending upon the frequency, severity, and duration of your Migraines, and how your Migraine Headaches (or any other type of Headache) symptoms affect your work, life, and social functioning.

For example, a veteran might have a 30% VA rating for Asthma but could possibly receive a 0%, 10%, 30%, or 50% VA rating for Migraines secondary to Asthma.

VA Disability Rating for Migraines Revealed & Explained:

How Are Migraines Rated by the VA?

Medical Research Studies:

Bidirectional association between asthma and migraines in adults: Two longitudinal follow-up studies

BVA Case History Example:

Migraines Secondary to Asthma is granted

Plantar Fasciitis secondary to Foot Condition(s)

Plantar fasciitis is thought to develop as the result of repeated small tears in the plantar fascia that occur when your foot strikes the ground. According to the **Institute for Preventive Foot Health**, common causes of Plantar Fasciitis include the following:

- Overuse or a sudden rapid increase in physical activity. Plantar fasciitis is especially common in long-distance runners. Other types of sudden exertion, such as lifting heavy weights, can trigger the pain.
- Faulty biomechanics. **Overpronation** (flat-footedness), a high arch or an altered gait can affect the way weight is distributed when you're on your feet, thereby stressing the plantar fascia.
- Being overweight, especially if weight gain takes place rapidly.
- Poorly designed shoes. Shoes that are thin-soled, too loose, too stiff, or that lack arch support and impact absorption don't protect the feet

well. If you regularly wear shoes with high heels, the Achilles tendon can contract and shorten, causing strain on the plantar fascia.

- Arthritis. Some types of arthritis can cause inflammation in the **tendons in the bottom of the foot**, which can lead to plantar fasciitis.
- Diabetes. For reasons that are not yet clear, plantar fasciitis occurs more often in people with diabetes than in those who don't have diabetes.
- Being on the feet for extended periods. People in occupations that require a lot of walking or standing on hard surfaces often develop plantar fasciitis.

Can Plantar Fasciitis be a secondary VA claim to a Foot Condition?

Yes, Plantar Fasciitis, or severe heel pain, can be service-connected secondary to Foot Conditions.

As of 2021, the **VA Ratings for Plantar Fasciitis** now has its own **Diagnostic Code (DC) 5269** with ratings that range from 10% to 30% with a break at 20%, depending upon the severity of your Plantar Fasciitis and how your Plantar Fasciitis symptoms affect your work, life, and social functioning.

For example, a veteran may only have a 10% rating for Foot Condition but could possibly receive a 30% or VA rating (lower rating possible as well) for Plantar Fasciitis secondary to Foot Condition.

The highest possible scheduler VA disability rating for bilateral Plantar Fasciitis is now 30% (not 50% - which was the highest scheduler rating prior to February 7, 2021), which includes symptoms such as no relief from both non-surgical (orthopedic shoes or appliances) and surgical treatment.

However, if the veteran has actual loss of use of the foot, the rating is 40%.

VA Disability Ratings for Plantar Fasciitis Explained:

How is Plantar Fasciitis Rated by the VA?

Medical Research Studies:

[Diagnosis and treatment of plantar fasciitis]

BVA Case History Example:

[Plantar Fasciitis secondary to Foot Condition is granted]

Plantar Fasciitis secondary to Back Condition(s)

Plantar fasciitis is thought to develop as the result of repeated small tears in the plantar fascia that occur when your foot strikes the ground. According to the [Institute for Preventive Foot Health], causes of Plantar Fasciitis include types of sudden exertion, such as **lifting heavy weights** and also being on the feet for **extended periods**. People in occupations that require a lot of walking or standing on hard surfaces often develop plantar fasciitis.

Somatic Movement Center published that Our muscles, tendons, ligaments, and bones create a complicated pulley system throughout our body. No part of our body moves independently; movement or tension in one part of the body always affects other parts of the body.

When it comes to plantar fasciitis, tight lower back muscles—the quadratus lumborum and erector spinae group—pull the top of the pelvis and lumbar vertebrae closer together. This typically brings the pelvis into an anterior (forward) tilt. Tight hip flexors will also tilt the pelvis forward, and often play a role in plantar fasciitis.

An even amount of tension across the lower back might translate into plantar fasciitis pain being experienced equally in both feet. But many people have one side of their lower back or one hip that's tighter than the other.

Imbalanced tightness in the lower back muscles, iliopsoas, and even the obliques can result in us experiencing plantar fasciitis pain more in one foot than the other.

Can Plantar Fasciitis be a secondary VA claim to Back Condition?

Yes, Plantar Fasciitis can be service-connected secondary to Back Condition.

As of 2021, the **VA Ratings for Plantar Fasciitis** now has its own **Diagnostic Code (DC) 5269** with ratings that range from 10% to 30% with a break at 20%, depending upon the severity of your Plantar Fasciitis and how your Plantar Fasciitis symptoms affect your work, life, and social functioning.

For example, a veteran may only have a 10% rating for a Back Condition such as Lumbar Strain but could possibly receive a 30% or VA rating (lower rating possible as well) for Plantar Fasciitis secondary to Back Conditions.

The highest possible scheduler VA disability rating for bilateral Plantar Fasciitis is now 30% (not 50% - which was the highest scheduler rating prior to February 7, 2021), which includes symptoms such as no relief from both non-surgical (orthopedic shoes or appliances) and surgical treatment.

However, if the veteran has actual loss of use of the foot, the rating is 40%.

VA Disability Ratings for Plantar Fasciitis Explained:

How is Plantar Fasciitis Rated by the VA?

Medical Research Study:

Limb-length discrepancy as a cause of plantar fasciitis

Are Plantar Fasciitis and Lower Back Pain linked?

BVA Case History Example:

Plantar Fasciitis secondary to Back Condition is remanded

Plantar Fasciitis secondary to Knees, Hips, Joint Instability

It's well known in the medical community that musculoskeletal conditions can cause or aggravate other disability conditions in your body, primarily due to your body overcompensating for pain, fatigue, and weakness.

For example, if your plantar fasciitis is severe, you might change the way you walk or run to avoid pain, and in the process of doing so, can cause or

aggravate other conditions such as knee conditions, hip pain, and joint instability.

According to **SLO Motion Shoes**, weakness in the gluteus region causes instability to your trunk that leads to excessive motion which when paired with hamstring or calf tightness can lead to overuse injuries.

The gluteus medius and gluteus minimus muscles control the side to side movement of the body by countering the weight of your center of mass. If the gluteus muscles are weak they won't be able to counter the force of your center of mass. Without this stability the body will excessively sway from side to side stressing joints and soft tissue.

Although the unbalanced gait caused by a weak gluteus medius and minimus can have harmful effects, anterior pelvic tilt caused by an unbalanced midsection can be root of your plantar fasciitis. An anterior pelvic tilt is caused by a combination of tight back extensors, weak glutes and hamstrings, weak abdominals, and tight hip flexors all commonly caused by prolonged sitting which activates certain muscle groups and rests others. This anterior pelvic tilt leads to your body weight being shifted forward causing higher stress on the achilles tendon and the plantar fascia and making it hard to fully rest these areas enough for proper healing to occur.

Furthermore, not only does a muscular imbalance cause a shift of weight but it also causes a skeletal misalignment down the kinetic chain. Weak glutes and tight hip flexors lead to an internal rotation of the femur, causes a valgus position of the knee, tibial internal rotation, and ultimately excessive pronation which loads the plantar fascia.

Can Plantar Fasciitis be a secondary VA claim to Knees, Hips, Joint Instability?

Yes, Plantar Fasciitis can be service-connected secondary to Knees, Hips, Joint Instability conditions.

As of 2021, the **VA Ratings for Plantar Fasciitis** now has its own **Diagnostic Code (DC) 5269** with ratings that range from 10% to 30% with

a break at 20%, depending upon the severity of your Plantar Fasciitis and how your Plantar Fasciitis symptoms affect your work, life, and social functioning.

For example, a veteran may only have a 10% rating for a Back Condition such as Lumbar Strain but could possibly receive a 30% or VA rating (lower rating possible as well) for Plantar Fasciitis secondary to Back Conditions.

The highest possible scheduler VA disability rating for bilateral Plantar Fasciitis is now 30% (not 50% - which was the highest scheduler rating prior to February 7, 2021), which includes symptoms such as no relief from both non-surgical (orthopedic shoes or appliances) and surgical treatment.

However, if the veteran has actual loss of use of the foot, the rating is 40%.

VA Disability Ratings for Plantar Fasciitis Explained:

How is Plantar Fasciitis Rated by the VA?

Medical Research Studies:

The effects of hip strengthening exercises in a patient with plantar fasciitis: A case report

A prospective study of the muscle strength and reaction time of the quadriceps, hamstring, and gastrocnemius muscles in patients with plantar fasciitis

BVA Case History Example:

Plantar Fasciitis secondary to Knees, Hips, Joint Instability is granted

Plantar Fasciitis secondary to Weight Gain Obesity as Interim Link

Significant medical research points to the prevalence of plantar fasciitis in patients who are overweight or obese—meaning a patient has a Body Mass Index (BMI) of 25 or more (overweight), and 30 or more (obese).

Plantar fasciitis is thought to develop as the result of repeated small tears in the plantar fascia that occur when your foot strikes the ground. According to the **Institute for Preventive Foot Health**, common causes of Plantar Fasciitis that may be linked to obesity include the following:

- Being **overweight**, especially if weight gain takes place rapidly.
- **Diabetes**. For reasons that are not yet clear, plantar fasciitis occurs more often in people with diabetes than in those who don't have diabetes.

HealthPrep also published a study that individuals who are overweight or obese are at a higher risk of developing problems with their feet. This is because of the extra weight and stress it puts on their muscles and tissues. While most cases of plantar fasciitis heal within a few weeks, patients who are obese are more likely to experience chronic plantar pain. The problem can easily become a long-lasting issue that dramatically reduces an individual's ability to walk for an extended period.

Furthermore, heel pain is often cited as a big reason for an overweight individual's inability to lose weight through exercise. It's difficult to engage in most cardiovascular activities when the pain in the foot is strong and chronic, though swimming and cycling are great alternatives in such cases.

A **study** also concluded that tendinitis, **plantar fasciitis**, and osteoarthritis usually are secondary to overuse and increased stress on the soft tissues and joints, which may be directly related to increased weight on these structures.

Can Plantar Fasciitis be a secondary VA claim to Weight Gain Obesity as Interim Link?

Yes, Plantar Fasciitis can be service-connected secondary to Weight Gain Obesity as Interim Link.

The **VA Ratings for Plantar Fasciitis** has its own **Diagnostic Code (DC) 5269** with ratings that range from 10% to 30% with a break at 20%,

depending upon the severity of your Plantar Fasciitis and how your Plantar Fasciitis symptoms affect your work, life, and social functioning.

For example, a veteran may only have a 10% rating for Foot Condition but could possibly receive a 30% or VA rating (lower or higher rating possible as well) for Plantar Fasciitis secondary to Foot Condition.

The highest possible scheduler VA disability rating for bilateral Plantar Fasciitis is now 30% (not 50%), which includes symptoms such as no relief from both non-surgical (orthopedic shoes or appliances) and surgical treatment.

However, if the veteran has actual loss of use of the foot, the rating is 40%.

While a veteran can't have a VA rating for Weight Gain Obesity on its own, if a service connected disability such as a mental or physical disability causes/aggravates Weight Gain Obesity, it can be used as an "Interim Link" for service connection. For example, you could possibly receive a 10% service connected VA rating for Plantar Fasciitis secondary to Weight Gain Obesity as an Interim Link to another service connected mental or physical condition, such as back pain, hip pain, or depression and anxiety.

VA Disability Ratings for Migraines Explained:

How is Plantar Fasciitis Rated by the VA?

Medical Research Studies:

The effects of obesity on orthopedic foot and ankle pathology

Obesity-Related Foot Pain: Diagnosis and Surgical Planning

BVA Case History Example:

Plantar Fasciitis secondary to Weight Gain Obesity as Interim Link is remanded

Radiculopathy secondary to Back Pain

Pain in the back can be continuous or intermittent and range from mild to severe. Lower back pain is most common and often affects the lumbar vertebrae.

Upper and middle back pain includes the area from the base of the neck to the bottom of the rib cage. This is the largest part of the back and often affects the thoracic vertebrae.

According to **Medical News Today**, various forms of Radiculopathy can be caused by a variety of conditions or injuries, including:

- herniated disc, when a disc protrudes, compressing the nerve root
- sciatica
- degenerative disc disease
- bone spurs
- tumors of the spine
- osteoarthritis or spinal arthritis
- spinal stenosis, a painful condition when the spinal canal narrows
- compression fractures
- spondylolisthesis, when a vertebra moves and rests on the vertebra below
- scoliosis caused by an abnormal curve in the spine
- diabetes, caused by altered nerve blood flow
- cauda equine syndrome, an uncommon but serious condition when nerve root compression affects the pelvic organs and lower extremities

Additional risk factors for developing radiculopathy include:

- aging
- being overweight
- poor posture
- improper lifting techniques
- repetitive motions
- a family history of degenerative bone conditions

Can Radiculopathy be a secondary VA claim to Back Pain?

Yes, **Radiculopathy** can be service-connected secondary to **Back Pain,** or any other service connected back condition.

Depending upon the severity of your Radiculopathy, and how your Radiculopathy symptoms affect your work, life, and social functioning, the **VA Ratings for Radiculopathy** secondary to Back Pain typically range from 0% to 70%.

However, a **VA rating for Sciatica** can range from 10% to 80%, depending upon the severity of symptoms.

The highest possible VA disability rating for Radiculopathy, across all radicular groups, with complete paralysis, is 90%.

For example, a veteran may only have a 10% rating for a Back Condition but could possibly receive 20% VA rating (lower or higher rating possible as well) for Radiculopathy secondary to Back Pain.

We've seen veterans get up to four types of Radiculopathy service connected to a single back / spine condition, with each type of Radiculopathy rated at 20% on its own, thus Radiculopathy of the limbs was rated at 20%, four times each, secondary to a back condition.

VA Disability Ratings for Radiculopathy Explained:

How is Radiculopathy Rated by the VA?

Medical Research Studies:

Low back pain, Radiculopathy

Efficacy of the lumbar stabilization and thoracic mobilization exercise program on pain intensity and functional disability reduction in chronic low back pain patients with lumbar radiculopathy: A randomized controlled trial

BVA Case History Example:

Radiculopathy Secondary to Back Pain is granted

Radiculopathy secondary to Lumbosacral or Cervical Strain

Abstract of a study stated that **Lumbosacral Radiculopathy** is a term used to describe a pain syndrome caused by compression or irritation of nerve roots in the lower back.

It can be caused by lumbar disc herniation, degeneration of the spinal vertebra, and narrowing of the foramen from which the nerves exit the spinal canal. Symptoms include low back pain that radiates into the lower extremities in a dermatomal pattern.

According to Medical News Today, various forms of Radiculopathy can be caused by a variety of conditions or injuries, including:

- herniated disc, when a disc protrudes, compressing the nerve root
- sciatica
- degenerative disc disease
- bone spurs
- tumors of the spine
- osteoarthritis or spinal arthritis
- spinal stenosis, a painful condition when the spinal canal narrows
- compression fractures
- spondylolisthesis, when a vertebra moves and rests on the vertebra below
- scoliosis caused by an abnormal curve in the spine
- diabetes, caused by altered nerve blood flow
- cauda equine syndrome, an uncommon but serious condition when nerve root compression affects the pelvic organs and lower extremities

Additional risk factors for developing radiculopathy include:

- aging
- being overweight
- poor posture
- improper lifting techniques

- repetitive motions
- a family history of degenerative bone conditions

Can Radiculopathy be a secondary VA claim to Lumbosacral or Cervical Strain?

Yes, **Radiculopathy** can be service-connected secondary to Lumbosacral or Cervical Strain.

Depending upon the severity of your Radiculopathy, and how your Radiculopathy symptoms affect your work, life, and social functioning, the **VA Ratings for Radiculopathy** secondary to Lumbosacral or Cervical Strain typically range from 0% to 70%.

However, a **VA rating for Sciatica** can range from 10% to 80%, depending upon the severity of symptoms.

The highest possible VA disability rating for Radiculopathy, across all radicular groups, with complete paralysis, is 90%.

For example, a veteran may only have a 10% rating for Lumbosacral or Cervical Strain but could possibly receive a 20% VA rating (lower or higher rating possible as well) for Radiculopathy secondary to Lumbosacral or Cervical Strain.

We've seen veterans get up to four types of Radiculopathy service connected to a single neck / back / spine condition, with each type of Radiculopathy rated at 20% on its own, thus Radiculopathy of the upper and lower limbs was rated at 20%, four times each, secondary to a back condition.

VA Disability Ratings for Radiculopathy Explained:

How is Radiculopathy Rated by the VA?

Medical Research Studies:

Lumbosacral Radiculopathy

Efficacy of the lumbar stabilization and thoracic mobilization exercise program on pain intensity and functional disability reduction in chronic low back pain patients with lumbar radiculopathy: A randomized controlled trial

BVA Case History Example:

Radiculopathy Secondary to Lumbosacral or Cervical Strain is granted

Radiculopathy secondary to Spinal Stenosis

Patients who place excessive or repetitive pressure on the **spine** are at risk for developing **radiculopathy**, especially for those with jobs involve intense manual labor, those who play contact sports, and members of the military to include veterans. In addition, patients with a family history of radiculopathy or other spine conditions may be predisposed to the condition.

Spine Universe published that Spinal Stenosis in your neck can cause cervical radiculopathy—symptoms may include pain accompanied by tingling sensations, numbness and/or weakness. These symptoms may radiate downward from your neck into one or both shoulders, arms and/or hands. The pain caused by cervical spinal stenosis may be described as acute, episodic, occasional, or it may become chronic; it's intensity can vary from mild to severe.

According to **Medical News Today**, various forms of Radiculopathy can be caused or aggravated by a variety of conditions or injuries, including:

- herniated disc, when a disc protrudes, compressing the nerve root
- sciatica
- degenerative disc disease
- bone spurs
- tumors of the spine
- osteoarthritis or spinal arthritis
- spinal stenosis, a painful condition when the spinal canal narrows
- compression fractures

- spondylolisthesis, when a vertebra moves and rests on the vertebra below
- scoliosis caused by an abnormal curve in the spine
- diabetes, caused by altered nerve blood flow
- cauda equine syndrome, an uncommon but serious condition when nerve root compression affects the pelvic organs and lower extremities

Additional risk factors for developing radiculopathy include:

- aging
- being overweight
- poor posture
- improper lifting techniques
- repetitive motions
- a family history of degenerative bone conditions

Can Radiculopathy be a secondary VA claim to Spinal Stenosis?

Yes, **Radiculopathy** can be service-connected secondary to Spinal Stenosis.

Depending upon the severity of your Radiculopathy, and how your Radiculopathy symptoms affect your work, life, and social functioning, the **VA Ratings for Radiculopathy** secondary to Spinal Stenosis typically range from 0% to 70%.

However, a **VA rating for Sciatica** can range from 10% to 80%, depending upon the severity of symptoms.

The highest possible VA disability rating for Radiculopathy, across all radicular groups, with complete paralysis, is 90%.

For example, a veteran may only have a 20% VA rating for Spinal Stenosis but could possibly receive a 20% VA rating (lower or higher rating possible as well) for Radiculopathy secondary to Spinal Stenosis.

We've seen veterans get up to four types of Radiculopathy service connected to a single neck / back / spine condition, with each type of

Radiculopathy rated at 20% on its own, thus Radiculopathy of the upper and lower limbs was rated at 20%, four times each, secondary to a back condition.

VA Disability Ratings for Radiculopathy Explained:

How is Radiculopathy Rated by the VA?

Medical Research Studies:

Efficacy of gabapentin for radiculopathy caused by lumbar spinal stenosis and lumbar disk hernia

Epidural Injections for Lumbar Radiculopathy and Spinal Stenosis: A Comparative Systematic Review and Meta-Analysis

Radicular Pain Syndromes: Cervical, Lumbar, and Spinal Stenosis

BVA Case History Example:

Radiculopathy Secondary to Spinal Stenosis is granted

Radiculopathy secondary to Spondylolisthesis

Lumbar radiculopathy may occur when the spinal nerve roots are irritated or compressed by one of many conditions, including lumbar disc herniation, spinal stenosis, osteophyte formation, spondylolithesis, foraminal stenosis, or other degenerative disorders.

Degenerative lumbar **spondylolisthesis** is one of the most common causes of low back pain and is defined as displacement of one vertebra over subjacent vertebra, associated with degenerative changes, without an associated disruption or defect in the vertebral ring. Understanding natural history of degenerative spondylolisthesis is important to tailor an individualized management plan for each patient.

A trial of conservative therapy may be considered for patients with low-grade spondylolisthesis presenting with **radiculopathy** and/or pseudoclaudication.

These options may include physical therapy, epidural steroid injection, and pain medications. If unresolved, surgical options may include decompression alone or decompression and fusion.

Can Radiculopathy be a secondary VA claim to Spondylolisthesis?

Yes, various forms of **Radiculopathy** can be service-connected as a secondary VA claim to **Spondylolisthesis**.

Depending upon the severity of your Radiculopathy, and how your Radiculopathy symptoms affect your work, life, and social functioning, the **VA Ratings for Radiculopathy** secondary to Spondylolisthesis typically range from 0% to 70%.

However, a **VA rating for Sciatica** can range from 10% to 80%, depending upon the severity of symptoms.

The highest possible VA disability rating for Radiculopathy, across all radicular groups, with complete paralysis, is 90%.

For example, a veteran may have a 40% VA rating for Spondylolisthesis but could possibly receive a 20% VA rating (lower or higher rating possible as well) for Radiculopathy secondary to Spondylolisthesis.

We've seen veterans get up to four types of Radiculopathy service connected to a single neck / back / spine condition, with each type of Radiculopathy rated at 20% on its own, thus Radiculopathy of the upper and lower limbs was rated at 20%, four times each, secondary to a back condition.

VA Disability Ratings for Radiculopathy Explained:

How is Radiculopathy Rated by the VA?

Medical Research Studies:

Successful Endoscopic Surgery for L5 Radiculopathy Caused by Far Lateral Disc Herniation at L5-S1 and L5 Isthmic Grade 2 Spondylolisthesis in a Professional Baseball Player

Degenerative Lumbar Spondylolisthesis: Definition, Natural History, Conservative Management, and Surgical Treatment

BVA Case History Example:

Radiculopathy Secondary to Spondylolisthesis is granted

Radiculopathy secondary to Ankylosing Spondylitis

Ankylosing spondylitis (AS) is a long-term disease that affects the joints near the center of the body, especially the spine and sacroiliac joints. The sacroiliac joints are located at the lowest end of the spine where the sacrum meets the iliac bone in the pelvis. AS can lead to eventual fusion of the spine. Peripheral joints away from the spine, such as the hips and knees, may also be involved.

AS also frequently involves inflammation at the points where the ligaments and tendons insert into the bones. As it progressively affects the spine, it can cause rigidity of the spine and loss of flexibility. It may also cause pain and stiffness in the hips, knees, and occasionally the small joints of the feet. Inflammation of the connective tissue of the undersurface of the foot (plantar fasciitis) may also occur. Chest wall cartilage inflammation can cause chest pain and tenderness.

According to emedicinehealth, neurological complications of Ankylosing Spondylitis include C1-C2 subluxation (partial displacement of the first and second cervical vertebrae), a tendency for spinal fractures with minor trauma, spinal stenosis (narrowing) in the cervical (neck) or lumbar (low back) regions, chronic inflammatory cauda equina (compression of the low back nerve roots that causes paralysis and cuts off sensation to the legs), and **radiculopathy** (shooting pain caused by pressure on the nerves) secondary to fracture or compression of the nerve roots.

Can Radiculopathy be a connected as a secondary VA claim to Ankylosing Spondylitis for secondary service connection?

Yes, **Radiculopathy** can be service-connected secondary to Ankylosing Spondylitis.

Depending upon the severity of your Radiculopathy, and how your Radiculopathy symptoms affect your work, life, and social functioning, the **VA Ratings for Radiculopathy** secondary to Ankylosing Spondylitis typically range from 0% to 70%.

However, a **VA rating for Sciatica** can range from 10% to 80%, depending upon the severity of symptoms.

The highest possible VA disability rating for Radiculopathy, across all radicular groups, with complete paralysis, is 90%.

For example, a veteran may have a 10% VA rating for Ankylosing Spondylitis but could possibly receive a 20% VA rating (lower or higher rating possible as well) for Radiculopathy secondary to Ankylosing Spondylitis.

We've seen veterans get up to four types of Radiculopathy service connected to a single neck / back / spine condition, with each type of Radiculopathy rated at 20% on its own, thus Radiculopathy of the upper and lower limbs was rated at 20%, four times each, secondary to a back condition.

VA Disability Ratings for Radiculopathy Explained:

How is Radiculopathy Rated by the VA?

Medical Research Studies:

Lumbar radiculopathy in ankylosing spondylitis with dural ectasia

Radiculopathy as a complication of ankylosing spondylitis

BVA Case History Example:

Radiculopathy/Sciatica Secondary to Ankylosing Spondylitis is granted

Radiculopathy secondary to Spinal Fusion

According to **Orange County Orthopedic And Concussion Group,** patients who undergo **spinal fusion** surgery may experience **lumbar radiculopathy** some time afterwards.

The surgery may have been successful, but the patient may develop conditions unrelated to the surgery, such as lumbar radiculopathy.

Radiculopathy is a term used to describe the symptoms produced by the pinching of a nerve root in the spinal column. Lumbar radiculopathy occurs in the lower back and is **also referred to as Sciatica**.

The condition may be caused by:

- Bulging or herniated discs
- Bone spurs, or areas of extra bone growth that may be caused by inflammation from osteoarthritis, trauma, or other degenerative conditions
- Thickening of the spinal ligaments
- Spinal infections
- Cancerous and noncancerous growths in the **spine**

Spinal fusion for sciatica is the most drastic and damaging surgical treatment option possible for patients whose pain has not responded to a host of more conservative therapy options. Spinal fusion surgery is one of the time-honored mainstays of the back pain industry but remains a hotly controversial procedure to this day.

Can Radiculopathy be a secondary VA claim to Spinal Fusion?

Yes, **Radiculopathy** can be service-connected secondary to Spinal Fusion.

Depending upon the severity of your Radiculopathy, and how your Radiculopathy symptoms affect your work, life, and social functioning, the **VA Ratings for Radiculopathy** secondary to Spinal Fusion typically range from 0% to 70%; however, with complete paralysis due to spinal fusion, the rating could go as high as 90%.

However, a **VA rating for Sciatica** can range from 10% to 80%, depending upon the severity of symptoms.

The highest possible VA disability rating for Radiculopathy, across all radicular groups, with complete paralysis, is 90%.

For example, a veteran may have a 10% VA rating for Spinal Fusion but could possibly receive a 20% VA rating (lower or higher rating possible as well) for Radiculopathy secondary to Spinal Fusion.

We've seen veterans get up to four types of Radiculopathy service connected to a single neck / back / spine condition, with each type of Radiculopathy rated at 20% on its own, thus Radiculopathy of the upper and lower limbs was rated at 20%, four times each, secondary to a back condition.

VA Disability Ratings for Radiculopathy Explained:

How is Radiculopathy Rated by the VA?

Medical Research Studies:

Curve Characteristics and Response of Sciatic and Olisthesis Scoliosis Following L5/S1 Transforaminal Lumbar Interbody Fusion in Adolescent Lumbar Spondylolisthesis

A Case of Severe Low Back Pain after Spinal Fusion

BVA Case History Example:

Radiculopathy/Sciatica Secondary to Spinal Fusion is granted

Radiculopathy secondary to Vertebral Fracture or Dislocation

Radiculopathy is typically **caused** by changes in the tissues surrounding the nerve roots. These tissues include bones of the spinal vertebrae, tendons and intervertebral discs.

When these tissues shift or change in size, they may narrow the spaces where the nerve roots travel inside the spine or exit the spine; these openings are called foramina. The narrowing of foramina is known as foraminal stenosis, which is very similar to **spinal stenosis** that affects the spinal cord.

Sometimes, radiculopathy can be accompanied by **myelopathy** — **compression** of the spinal cord itself. Herniated or bulging discs can sometimes press on the spinal cord and on the nerve roots. When the spinal cord is **involved,** the symptoms can be more severe, including poor coordination, trouble walking and paralysis.

SDG Accident Injury Lawyers, PA stated in their **article** that the most common types of injuries and complaints from a car accident involve the neck and back. Sometimes injuries to the spine are severe enough to damage the nerves and create symptoms of radiculopathy.

According to **Spine Health**, potential causes of cervical radiculopathy includes Fracture. If part of a vertebra becomes fractured, the resulting instability or foraminal narrowing in the cervical spine may impinge a nerve root. Such a fracture could be caused by an injury or cervical **spondylolisthesis** (where one vertebra slips in front of another).

Can Radiculopathy be a secondary VA claim to Vertebral Fracture or Dislocation?

Yes, **Radiculopathy** can be service-connected secondary to Vertebral Fracture or Dislocation.

Depending upon the severity of your Radiculopathy, and how your Radiculopathy symptoms affect your work, life, and social functioning, the **VA Ratings for Radiculopathy** secondary to Vertebral Fracture or Dislocation typically range from 0% to 70%.

However, a **VA rating for Sciatica** can range from 10% to 80%, depending upon the severity of symptoms.

The highest possible VA disability rating for Radiculopathy, across all radicular groups, with complete paralysis, is 90%.

For example, a veteran may have a 10% VA rating for Vertebral Fracture or Dislocation but could possibly receive a 20% VA rating (lower or higher rating possible as well) for Radiculopathy secondary to Vertebral Fracture or Dislocation.

We've seen veterans get up to four types of Radiculopathy service connected to a single neck / back / spine condition, with each type of Radiculopathy rated at 20% on its own, thus Radiculopathy of the upper and lower limbs was rated at 20%, four times each, secondary to a back condition.

VA Disability Ratings for Radiculopathy Explained:

How is Radiculopathy Rated by the VA?

Medical Research Studies:

Radiculopathy caused by osteoporotic vertebral fractures in the lumbar spine

Treatment of lower lumbar radiculopathy caused by osteoporotic compression fracture: the role of vertebroplasty

BVA Case History Example:

Radiculopathy secondary to Vertebral Fracture or Dislocation is granted

Restless Leg Syndrome secondary to Back Condition

Comprehensive Pain Management Center has been able to show a link between **chronic back pain and restless legs**. What is known for sure is that both restless leg syndrome and back pain make it hard to function properly in your daily lifestyle. Similarities in pathophysiologic mechanisms between **RLS symptoms and the chronic back symptoms** presented by

the patients led the authors to link the two conditions. While they acknowledged that more research is needed to test whether these two cases can be repeated large scale, the authors went as far as naming the back condition “restless back,” and suggested that it may be able to be treated effectively with dopaminergic medications.

A **report** posted in the Journal of Neurology, Neurosurgery and Psychiatry concluded that their report suggests that **restless legs syndrome** may occur secondary to **spinal cord** lesions due to different causative diseases including **multiple sclerosis, spinal cord injury, and cervical spondylotic myelopathy**. Like idiopathic restless legs syndrome and other secondary forms, restless legs syndrome due to myelopathy may respond well to dopaminergic drugs.

Can Restless Leg Syndrome be a secondary VA claim to Back Condition?

Yes, Restless Leg Syndrome can be service-connected secondary to Back Condition.

There is no separate Diagnostic Code (DC) for Restless Leg Syndrome, however, it’s usually rated analogous to DC 8620, Neuritis, although other codes can be applied depending upon your symptoms.

The **VA Ratings for Restless Leg Syndrome** secondary to Back Condition are typically 10%, 20%, 40%, or 60%, depending upon the severity of your Restless Leg Syndrome, and how your Restless Leg Syndrome symptoms affect your work, life, and social functioning.

For example, a veteran may only have a 10% rating for a Back Condition but could possibly receive a 10%, 20%, 40% or 60% VA rating for Restless Leg Syndrome secondary to Back Condition.

VA Disability Ratings for Restless Leg Syndrome Explained:

How is Restless Leg Syndrome Rated by the VA?

Medical Research Studies:

Restless leg syndrome in patients with spinal cord injury

Demographic and clinical characteristics of patients with restless legs syndrome in spine clinic

BVA Case History Example:

Restless Leg Syndrome Secondary to Back Condition is granted

Restless Leg Syndrome secondary to Neck Condition

Restless leg syndrome is a condition that makes the legs feel tingling when they are at rest and creates an overwhelming sensation to move them. Studies have shown that individuals with **Multiple Sclerosis** are three times more likely to experience **restless leg syndrome (RLS)** compared to the general population. **Cervical cord damage** *(cervical=pertaining to a neck in medical terms)* plays a large role in the development of **RLS** and can occur more in those with **multiple sclerosis**.

Multiple sclerosis symptoms can be difficult to determine the original cause. When the upper neck is misaligned, it affects the way the brain is working. These brain changes can mimic many of the symptoms associated with multiple sclerosis. A **study** published in 2005 revealed that 100% of the patients with multiple sclerosis had a history of upper cervical injuries, although the injuries could be months or years old.

A study published by National Library of Medicine estimated the prevalence of restless legs syndrome (RLS) in multiple sclerosis (MS) patients and compared the extent of brain and cervical cord damage between patients with and without RLS using conventional and diffusion tensor magnetic resonance imaging (MRI). It stated that higher disability and **cervical cord damage** represent a significant risk factor for **RLS** in MS patients.

Can Restless Leg Syndrome be a secondary VA claim to Neck Condition?

Yes, Restless Leg Syndrome can be service-connected secondary to Neck Condition.

There is no separate Diagnostic Code (DC) for Restless Leg Syndrome, however, it's usually rated analogous to DC 8620, Neuritis, although other codes can be applied depending upon your symptoms.

The **VA Ratings for Restless Leg Syndrome** secondary to Neck Condition are typically 10%, 20%, 40%, or 60%, depending upon the severity of your Restless Leg Syndrome, and how your Restless Leg Syndrome symptoms affect your work, life, and social functioning.

For example, a veteran may only have a 10% rating for a Back Condition but could possibly receive a 10%, 20%, 40% or 60% VA rating for Restless Leg Syndrome secondary to Neck Condition.

VA Disability Ratings for Restless Leg Syndrome Explained:

How is Restless Leg Syndrome Rated by the VA?

Medical Research Studies:

Pramipexole Responsive Neck Numbness: The Therapeutic Role of Dopamine Agonists in the Spinal Cord Indicating to a Common Spinal Pathophysiology with Restless Leg Syndrome (RLS)?

Restless legs syndrome is a common finding in multiple sclerosis and correlates with cervical cord damage

BVA Case History Example:

As of this writing, a BVA case history example could not be located. However, it's still possible to connect the two conditions depending upon your medical evidence and medical research.

Sleep Apnea Secondary to PTSD

Post-traumatic stress disorder (PTSD) is related to a wide range of medical problems, with a majority of neurological, psychological, cardiovascular, respiratory, gastrointestinal disorders, diabetes, as well as **sleep disorders**.

Many veterans attempt to **connect Sleep Apnea Secondary to PTSD**.

The problem with this secondary linkage approach between Obstructive Sleep Apnea (OSA) and PTSD is that the medical research is questionable at best, and thus, we expect more VA denials than approvals.

Special Note: We can't find ANYTHING, ANYWHERE, that says "PTSD causes Sleep Apnea…"

PTSD does NOT cause Sleep Apnea, however, PTSD and side effects of medications taken to manage PTSD symptoms can aggravate obesity (weight gain), leading to the development of Obstructive Sleep Apnea (OSA) in Veterans, hence Sleep Apnea Secondary to PTSD can be granted.

According to Sleep Foundation, veterans are up to **three times more likely** to have PTSD. Men, who represent a larger percentage of the veteran population, are also more likely to have sleep apnea. According to one study, **69% of Vietnam veterans** with PTSD also had sleep-disordered breathing.

Among the general population, the risk for sleep apnea increases with age. However, young veterans with PTSD may have an outsized risk for their age group. One study found that 69% of young **Iraq and Afghanistan war veterans** screened positive for OSA.

Can Sleep Apnea be a secondary VA claim to PTSD?

Yes, Sleep Apnea can be service-connected secondary to PTSD.

The **VA Ratings for Sleep Apnea** secondary to PTSD are 0%, 30%, 50%, or 100%, depending upon the severity of your Sleep Apnea, and how your Sleep Apnea symptoms affect your work, life, and social functioning.

For example, a veteran may have a 70% rating for PTSD but could possibly receive a 50% VA rating (lower or higher rating possible as well) for Sleep Apnea secondary to PTSD.

VA Disability Ratings for Sleep Apnea Explained:

How is Sleep Apnea Rated by the VA?

Medical Research Studies:

Sleep disturbance in adults with posttraumatic stress disorder: a review

Sleep disturbances in veterans with chronic war-induced PTSD

BVA Case History Example:

Sleep Apnea secondary to PTSD is granted

Sleep Apnea Secondary to Sinusitis

Obstructive sleep apnea is a sleep disorder, while sinusitis is a temporary inflammation of the sinus due to infection. With sinusitis, the nasal passages close off and block the airways when the individual is sleeping.

In a few research studies, obstructive sleep apnea has been shown associated with chronic rhino-sinusitis (CRS) or chronic sinusitis. A research study published in the **Journal of Otolaryngology-ENT Research** showed that chronic rhino-sinusitis is a risk factor to develop or further increase the existing snoring and obstructive sleep apnea (OSA). In another research study conducted in **Taiwan**, up to 64.7% of patients with CRS were diagnosed with OSA (Obstructive Sleep Apnea).

Because the symptoms of sinusitis make it more difficult to breathe while sleeping, someone diagnosed with chronic sinusitis who does not properly treat it is **more prone** to developing sleep apnea.

Sleep apnea is a sleep disorder, while sinusitis is a temporary infection. Sinusitis will eventually go away or can be treated with antibiotics and once you have addressed the sinusitis, you won't suffer from breathing problems at night caused by an infection. However, **chronic sinusitis** does increase your risk of sleep apnea caused by **nasal congestion**. Sleep apnea cannot be treated with medication and will not simply clear up on its own.

Can Sleep Apnea be a secondary VA claim to Sinusitis?

Yes, Sleep Apnea can be service-connected secondary to Sinusitis.

The **VA Ratings for Sleep Apnea** secondary to Sinusitis are 0%, 30%, 50%, or 100%, depending upon the severity of your Sleep Apnea, and how your Sleep Apnea symptoms affect your work, life, and social functioning.

For example, a veteran may only have a 10% rating for Sinusitis but could possibly receive a 30% or 50% VA rating (lower or higher rating possible as well) for Sleep Apnea secondary to Sinusitis.

VA Disability Ratings for Sleep Apnea Explained:

How is Sleep Apnea Rated by the VA?

Medical Research Study:

The linkage of allergic rhinitis and obstructive sleep apnea

BVA Case History Example:

Sleep Apnea secondary to Sinusitis is granted

Sleep Apnea Secondary to Rhinitis

The nose and pharynx begin the upper airway system and represent a continuum. This is the biologic basis for the mutual influences of rhinitis and obstructive sleep apnea (OSA).

According to a study posted by the **National Library of Medicine**, Rhinitis can be divided into allergic and non-allergic rhinitis. Rhinitis, particularly

allergic rhinitis, has been shown to be associated with **obstructive sleep apnea**; a condition characterized by repetitive upper airway obstruction during sleep.

Allergic rhinitis **increases the risk of developing obstructive sleep apnea** by two major mechanisms: 1) increase in airway resistance due to higher nasal resistance and 2) reduction in pharyngeal diameter from mouth breathing that moves the mandible inferiorly. Other inflammatory mediators including histamine, CysLTs, IL 1β and IL-4 found in high levels in allergic rhinitis, have also been shown to worsen sleep quality in obstructive sleep apnea. Prior studies have shown that treatment of allergic rhinitis, particularly when intranasal steroid are used, improved obstructive sleep apnea.

Can Sleep Apnea be a secondary VA claim to Rhinitis?

Yes, Sleep Apnea can be service-connected secondary to Rhinitis.

The **VA Ratings for Sleep Apnea** secondary to Rhinitis are 0%, 30%, 50%, or 100%, depending upon the severity of your Sleep Apnea, and how your Sleep Apnea symptoms affect your work, life, and social functioning.

For example, a veteran may only have a 10% rating for Rhinitis but could possibly receive a 30% or 50% VA rating (lower or higher rating possible as well) for Sleep Apnea secondary to Rhinitis.

VA Disability Ratings for Sleep Apnea Explained:

How is Sleep Apnea Rated by the VA?

Medical Research Study:

The linkage of allergic rhinitis and obstructive sleep apnea

Association between allergic and nonallergic rhinitis and obstructive sleep apnea

BVA Case History Example:

Sleep Apnea secondary to Rhinitis is granted

Sleep Apnea Secondary to Deviated Septum

A deviated septum is a common issue that can affect your health and your sleep. People with deviated septum may wake frequently because they are unable to breathe well at night. In some cases, a deviated septum may either cause or worsen symptoms of sleep apnea.

“A deviated septum can cause obstructive sleep apnea due to a blockage or narrowing in the airways,” Jenna Liphart Roads, Ph.D and R.N., tells **WebMD** Connect to Care.

The most **common type of sleep apnea** is obstructive sleep apnea. This happens when the upper airway partially collapses into itself during sleep, resulting in multiple breathing stoppages throughout the night.

The **septum** is the bone and cartilage that divides the nose in half. Damage to the septum, such as from a blow to the face, can push the septum off-center and create nasal passages that are uneven in size. This is known as a **deviated septum**, which can also be an inherited genetic characteristic.

People with a deviated septum may also breathe through their mouths at night to get more air. “Mouth breathing can contribute to sleep apnea,” K. L. Ong, MBBS, a doctor in Singapore, tells WebMD Connect to Care.

Can Sleep Apnea be a secondary VA claim to Deviated Septum?

Yes, Sleep Apnea can be service-connected secondary to Deviated Septum.

The **VA Ratings for Sleep Apnea** secondary to Deviated Septum are 0%, 30%, 50%, or 100%, depending upon the severity of your Sleep Apnea, and how your Sleep Apnea symptoms affect your work, life, and social functioning.

For example, a veteran may only have a 10% rating for Deviated Septum but could possibly receive a 30% or 50% VA rating (lower or higher rating possible as well) for Sleep Apnea secondary to Deviated Septum.

VA Disability Ratings for Sleep Apnea Explained:

How is Sleep Apnea Rated by the VA?

Medical Research Study:

Sleep apnea syndrome treated by repair of deviated nasal septum

BVA Case History Example:

Sleep Apnea secondary to Deviated Septum is granted

Sleep Apnea Secondary to Asthma

Obstructive sleep apnea (OSA) and asthma are highly prevalent chronic respiratory disorders. Beyond their frequent coexistence arising from their high prevalence and shared risk factors, these disorders feature a reciprocal interaction whereby each disease impacts the severity of the other. Emerging evidence implicates airway and systemic inflammation, neuroimmune interactions, and effects of asthma-controlling medications (corticosteroids) as factors that predispose patients with asthma to OSA.

According to a study posted by the **National Library of Medicine**, The incidence of OSA syndrome among the patients with asthma is higher than in the general population, especially in the patients with nocturnal symptoms persisting despite treatment, in patients frequently admitted to hospital because of the exacerbations of asthma, and in obese patients.

The common abnormalities possibly linking asthma and OSA syndrome include obesity, gastro-esophageal reflux, nasal obstruction, and inflammation. In some patients with asthma, it would be advised to search for OSA syndrome, as obstructive sleep apneas and hypopneas may influence asthma exacerbations. Especially, OSA should be suspected in the asthma patients with the signs of ventilatory disturbances during sleep.

Can Sleep Apnea be a secondary VA claim to Asthma?

Yes, Sleep Apnea can be service-connected secondary to Asthma.

The **VA Ratings for Sleep Apnea** secondary to Asthma are 0%, 30%, 50%, or 100%, depending upon the severity of your Sleep Apnea, and how your Sleep Apnea symptoms affect your work, life, and social functioning.

For example, a veteran might have a 30% rating for Asthma but could possibly receive a 30% or 50% VA rating (lower or higher rating possible as well) for Sleep Apnea secondary to Asthma.

VA Disability Ratings for Sleep Apnea Explained:

How is Sleep Apnea Rated by the VA?

Medical Research Studies:

Asthma and obstructive sleep apnea: More than an association!

Coexistence of asthma and obstructive sleep apnea syndrome - review of the literature

BVA Case History Example:

Sleep Apnea secondary to Asthma is granted

Sleep Apnea Secondary to Weight Gain Obesity as Interim Link

Obstructive sleep apnea is a common disorder and affects approximately 4% of middle-aged men and 2% of middle-aged women. Obstructive sleep apnea is clearly associated with obesity, with more than 50% of patients having a body mass index>30 kg/m2 according to **National Library of Medicine**.

Obesity is a main risk factor for sleep apnea syndrome (SAS). The prevalence of SAS is especially high in massive obesity and in visceral obesity. The mechanisms of obstructive apneas in obesity are poorly known, but an increase in upper airway collapsibility probably plays an important role. Several cardiorespiratory complications of SAS, especially systemic

arterial hypertension, diurnal alveolar hypoventilation and pulmonary arterial hypertension are more frequent and more severe in obese patients.

A **study** posted online says that one of the main components contributing to sleep apnea is **obesity**; as well as **diabetes mellitus type 2** (T2DM), **hypercholesterolemia**, and **hypertension**. The major preventable risk factors to decrease obesity are the awareness of lifestyle modification (eating behaviors, smoking, drinking alcohol, etc.) and understanding the importance of exercise. If these lifestyle modifications are widely applied, then not only will the consequences of obesity and sleep apnea be reduced, but also the incidence of **cardiovascular disease** will decrease greatly. Public awareness of the importance of weight loss by lifestyle modification or bariatric surgery to improve the quality of life is needed. These preventive actions, screening measures, and treatment strategies for obesity and OSA can significantly reduce the incidence of obesity, as well as OSA and the related comorbidities such as cardiovascular disease, atherosclerosis, and depression.

Can Sleep Apnea be a secondary VA claim to Weight Gain Obesity as Interim Link?

Yes, Sleep Apnea can be service-connected secondary to Weight Gain Obesity as Interim Link.

The **VA Ratings for Sleep Apnea** secondary to Weight Gain Obesity as Interim Link are 0%, 30%, 50%, or 100%, depending upon the severity of your Sleep Apnea, and how your Sleep Apnea symptoms affect your work, life, and social functioning.

While a veteran can't have a VA rating for Weight Gain Obesity on its own, if a service connected disability such as a mental or physical disability causes/aggravates Weight Gain Obesity, it can be used as an "Interim Link" for service connection. For example, you could possibly receive a 50% service connected VA rating for Sleep Apnea secondary to Weight Gain Obesity as an Interim Link to another service connected mental or physical condition, such as back pain, hip pain, or depression and anxiety.

VA Disability Ratings for Sleep Apnea Explained:

How is Sleep Apnea Rated by the VA?

Medical Research Study:

Sleep apnea syndrome and obesity

Obesity and hormonal factors in sleep and sleep apnea

BVA Case History Example:

Sleep Apnea secondary to Weight Gain Obesity as Interim Link is granted

Sleep Apnea Secondary to GERD

Obstructive sleep apnea hypopnea syndrome (OSAHS) means apnea and hypopnea caused by partial or complete obstruction of upper airway collapse during sleep. Gastroesophageal reflux disease (GERD) is believed to be associated with various manifestations in the otorhinolaryngology and has been found to be an additional risk factor for OSAHS. The significant correlation between obstructive sleep apnea hypopnea syndrome and gastroesophageal reflux disease has been concluded in a **study** posted online by National Library of Medicine.

Normal physiological adaptations of the aerodigestive system to sleep prolong and **intensify** nocturnal reflux events. This occurrence leads to sleep disruption, as well as to esophageal, laryngeal, and laryngopharyngeal reflux.

Can Sleep Apnea be a secondary VA claim to GERD?

Yes, Sleep Apnea can be service-connected secondary to GERD.

The **VA Ratings for Sleep Apnea** secondary to GERD are 0%, 30%, 50%, or 100%, depending upon the severity of your Sleep Apnea, and how your Sleep Apnea symptoms affect your work, life, and social functioning.

For example, a veteran may only have a 10% rating for GERD but could possibly receive a 30% or 50% VA rating (lower or higher rating possible as well) for Sleep Apnea secondary to GERD.

By law, there are three evidentiary elements that must be satisfied for **sleep apnea secondary to GERD** to prove secondary service connection:

1. A medical diagnosis of sleep apnea confirmed by a sleep study in VA medical records or private records (unless you did this already on active duty and it's in your service treatment records)
2. Evidence of a service-connected primary disability, which in this case would be Gastroesophageal Reflux Disease (GERD), *AND*
3. Medical Nexus evidence establishing a connection between the service-connected disability and the current disability

VA Disability Ratings for Sleep Apnea Explained:

How is Sleep Apnea Rated by the VA?

Medical Research Study:

The relationship between obstructive sleep apnea hypopnea syndrome and gastroesophageal reflux disease: a meta-analysis

Sleep and Nocturnal Gastroesophageal Reflux: An Update

BVA Case History Example:

Sleep Apnea secondary to GERD is granted

Somatic Symptom Disorder secondary to Tinnitus

Somatic Symptom Disorder (DSM-5), a mental disorder previously called Chronic Pain Syndrome under DSM-4, is described by The Mayo Clinic as an "extreme focus on physical symptoms, such as pain or fatigue or Tinnitus that causes major emotional distress and problems functioning."

While Tinnitus is often quite subjective in nature, if a veteran has an extreme focus on the physical symptoms of his/her constant ringing in the ears, it can cause significant occupational and social impairment.

Pathophysiological mechanisms are often unknown in patients suffering from "idiopathic" tinnitus, and the presence of other unexplained physical symptoms such as those seen in **somatoform disorders** can be assumed. This study investigates how often tinnitus exists in general medical out-patients with and without somatoform disorders. In an international **study** initiated by the World Health Organization (WHO), 1275 patients from 12 participating centers located in 11 different countries were examined by means of the WHO Somatoform Disorders Schedule. The overall prevalence of unexplained tinnitus was 11%; however, tinnitus was clearly more frequent among patients with somatization disorder (42%) or hypochondriacal disorder (27%). It was also more frequent than a great number of other symptoms considered to be typical of somatoform disorders. Tinnitus was also related to depression, anxiety, and to symptoms indicating autonomic arousal.

Can Somatic Symptom Disorder be a secondary VA claim to Tinnitus?

Yes Somatic Symptom Disorder can be service-connected secondary to Tinnitus

The **VA Ratings for Somatic Symptom Disorder** secondary to Tinnitus are 0%, 10%, 30%, 50%, 70% or 100%, depending upon the severity of your Somatic Symptom Disorder, and how your Somatic Symptom Disorder symptoms affect your work, life, and social functioning.

For example, a veteran may only have a 10% rating for Tinnitus but could possibly receive a 30% or 700% VA rating (lower or higher rating possible as well) for Somatic Symptom Disorder secondary to Tinnitus.

VA Disability Ratings for Somatic Symptom Disorder Explained:

How is Somatic Symptom Disorder Rated by the VA?

Medical Research Study:

Association between tinnitus and somatoform disorders

The 'multiplex model' of somatic symptoms: application to tinnitus among traumatized Cambodian refugees

BVA Case History Example:

As of this writing, a BVA case history example could not be located. However, it's still possible to connect the two conditions depending upon your medical evidence and medical research.

Somatic Symptom Disorder secondary to Back Condition

Back pain is frequently found in patients with somatoform disorders, particularly in somatization and somatoform pain disorders. About 10 % to 20 % of patients suffering from back pain can be diagnosed with somatoform pain disorders. Additionally, up to 50 % of back pain patients suffer from other psychiatric disorders like major depression or anxiety disorders.

A **study** posted online by National Library of Medicine concluded that the associations among depression, somatization, and LBP (low back pain) are consistent with the findings of their previous studies. These associations, coupled with the findings that MZDI (Depression was self-reported and measured with the Modified Zung Depression Index) and MSPQ (Somatization was measured with the Modified Somatic Perception Questionnaire) scores are correlated with somatic dysfunction, and may have important implications for the use of osteopathic manual treatment in patients with chronic LBP.

Another **study** also concluded that psychological distress such as anxiety, depression, and somatization were more prevalent in LBP patients compared to patients without LBP.

Can Somatic Symptom Disorder be a secondary VA claim to Back Condition?

Yes, Somatic Symptom Disorder can be service-connected secondary to Back Condition

The **VA Ratings for Somatic Symptom Disorder** secondary to Back Condition are 0%, 10%, 30%, 50%, 70% or 100%, depending upon the severity of your Somatic Symptom Disorder, and how your Somatic Symptom Disorder symptoms affect your work, life, and social functioning.

For example, a veteran may only have a 10% rating for Back Condition but could possibly receive a 30% or 700% VA rating (lower or higher rating possible as well) for Somatic Symptom Disorder secondary to Back Condition.

VA Disability Ratings for Somatic Symptom Disorder Explained:

How is Somatic Symptom Disorder Rated by the VA?

Medical Research Study:

Depression, somatization, and somatic dysfunction in patients with nonspecific chronic low back pain: results from the OSTEOPATHIC Trial

Psychological factors: anxiety, depression, and somatization symptoms in low back pain patients

BVA Case History Example:

Somatic Symptom Disorder Secondary to Back Condition is granted

Somatic Symptom Disorder secondary to Neck Condition

Somatic symptom disorder is sometimes diagnosed when accident victims suffer chronic pain coupled with excessive anxiety about their physical condition. Somatic symptom disorder is a psychological condition where a person focuses on their physical symptoms, such as pain or fatigue in parts of his body which includes the neck or cervical spine.

In the Otorhinolaryngology *(otolaryngology, otolaryngology – head and neck surgery (ORL–H&N or OHNS), or ear, nose, and throat (ENT), is a surgical subspecialty within medicine that deals with the surgical and medical management of conditions of the head and neck)* Department, patients exhibiting somatic symptoms without a medical cause are frequently neglected and left untreated. A **study** published by National Library of Medicine aimed to characterize the psychosomatic features of outpatients with somatic symptom disorder (SSD) to better identify patients needing treatment. **Their** findings demonstrated that SSD patients are not rare in otorhinolaryngology clinics and that their quality of living is significantly affected by SSD.

Can Somatic Symptom Disorder be a secondary VA claim to Neck Condition?

Yes, Somatic Symptom Disorder can be service-connected secondary to Neck Condition

The **VA Ratings for Somatic Symptom Disorder** secondary to Neck Condition are 0%, 10%, 30%, 50%, 70% or 100%, depending upon the severity of your Somatic Symptom Disorder, and how your Somatic Symptom Disorder symptoms affect your work, life, and social functioning.

For example, a veteran may only have a 10% rating for Neck Condition but could possibly receive a 30% or 70% VA rating (lower or higher rating possible as well) for Somatic Symptom Disorder secondary to Neck Condition.

VA Disability Ratings for Somatic Symptom Disorder Explained:

How is Somatic Symptom Disorder Rated by the VA?

Medical Research Study:

Clinical and psychobehavioral features of outpatients with somatic symptom disorder in otorhinolaryngology clinics

BVA Case History Example:

[Somatic Symptom Disorder Secondary to Neck Condition is granted]

Vertigo secondary to Tinnitus

Both tinnitus and vertigo are symptoms often involving ear problems and issues with the brain or nerve pathway.

Meniere's disease, vertigo and tinnitus are three conditions that are very closely related. While not all tinnitus sufferers experience vertigo, nearly everyone with Meniere's disease experiences severe vertigo, tinnitus, hearing loss and a feeling of fullness in the ears.

According to the **House of Hearing**, both tinnitus and vertigo are symptoms often involving ear problems and issues with the brain or nerve pathway. Because of this, they are commonly associated with one another to the extent that treating tinnitus will often resolve issues of vertigo.

Tinnitus and vertigo are both diseases of the inner ear and, sometimes, the brain. Tinnitus is often an inner ear issue, and this can cause balance issues. Not all people who suffer from tinnitus also suffer from vertigo, but some do. Conversely, vertigo can be the cause of balance and ear problems.

Tinnitus may also become very loud before vertigo sets in, and this can give the sense that you are spinning.

Keep in mind that nearly everyone with Meniere's disease will suffer from both tinnitus and vertigo. Indeed, tinnitus often accompanies dysfunction of the vestibular system, and some vestibular disorders associated with tinnitus include Meniere's disease.

In a study posted online by National Library of Medicine, the diagnosis of definite Menière's disease is based on clinical criteria and requires the observation of an **episodic vertigo syndrome** associated with low- to medium-frequency sensorineural hearing loss and fluctuating aural symptoms (hearing, **tinnitus** and/or fullness) in the affected ear. Duration of vertigo episodes is limited to a period between 20 minutes and 12 hours. Probable Menière's disease is a broader concept defined by episodic

vestibular symptoms (vertigo or dizziness) associated with fluctuating aural symptoms occurring in a period from 20 minutes to 24 hours.

Can Vertigo be a secondary VA claim to Tinnitus?

Yes, Vertigo can be service-connected secondary to Tinnitus.

According to the **Veterans Law Office**, the severity of vertigo can range from relatively mild to completely debilitating depending on what condition is causing the vertigo. Under the VA's disability rating system, both conditions causing vertigo and vertigo itself are subject to a VA schedular disability rating. Under **38 CFR § 4.87**, vertigo (i.e. peripheral vestibular disorders) and Meniere's disease are rated as follows:

Diagnostic Code 6204 Peripheral vestibular disorders:

- 30% rating – Dizziness and occasional staggering
- 10% rating – Occasional dizziness

Note: Objective findings supporting the diagnosis of vestibular disequilibrium are required before a compensable evaluation can be assigned under this code. Hearing impairment or suppuration shall be separately rated and combined.

Diagnostic Code 6205 Meniere's syndrome (endolymphatic hydrops):

- 100% rating – Hearing impairment with attacks of vertigo and cerebellar gait occurring more than once weekly, with or without tinnitus
- 60% rating– Hearing impairment with attacks of vertigo and cerebellar gait occurring from one to four times a month, with or without tinnitus
- 30% rating – Hearing impairment with vertigo less than once a month, with or without tinnitus

For example, a veteran may only have a 10% rating for Tinnitus but could possibly receive a 30% (lower or higher rating possible as well) for Vertigo secondary to Tinnitus.

VA Disability Ratings for Vertigo Explained:

How is Vertigo Rated by the VA?

Medical Research Studies:

Diagnostic criteria for Meniere's disease

Benign paroxysmal positional vertigo and tinnitus

Tinnitus and Meniere's disease: characteristics and prognosis in a tinnitus clinic sample

BVA Case History Example:

Vertigo secondary to Tinnitus is granted

Vertigo secondary to Migraines

According to a **study** posted online by National Library of Medicine, **Vestibular migraine** (VM) designates recurrent attacks of **vertigo** that are caused by **migraine**. VM presents with attacks of spontaneous or positional vertigo, lasting seconds to days, accompanied by migrainous symptoms. Because headache is often absent during acute attacks, other migrainous features have to be identified by thorough history taking. In contrast, vestibular testing serves mainly for the exclusion of other diagnoses. Treatment is targeted at the underlying migraine.

Another study suggests that **Vestibular Vertigo** is most often caused by benign paroxysmal positional vertigo (BPPV), **Meniere's disease**, vestibular neuritis, **vestibular migraine** or stroke. Features, diagnosis, and treatment of vestibular vertigo in patients with these diseases are discussed. The authors analyze common diagnostic errors based on the data of 700 outpatients (205 men and 495 women, aged 25-88 years, mean age 55 years). It is noted that the cause of vertigo is often misdiagnosed with vertebral-basilar insufficiency, discirculatory encephalopathy, cervical spine pathology; at the same time, BPPV, Meniere's disease, vestibular neuritis or vestibular migraine is diagnosed less often. This fact reflects the lack of

awareness of physicians about these diseases. BPPV, Meniere's disease and migraine are effectively treated and therefore their diagnosis and adequate treatment are of great importance.

Can Vertigo be a secondary VA claim to Migraines?

Yes, Vertigo can be service-connected secondary to Migraines.

According to the **Veterans Law Office**, the severity of vertigo can range from relatively mild to completely debilitating depending on what condition is causing the vertigo. Under the VA's disability rating system, both conditions causing vertigo and vertigo itself are subject to a VA schedular disability rating. Under **38 CFR § 4.87**, vertigo (i.e. peripheral vestibular disorders) and Meniere's disease are rated as follows:

Diagnostic Code 6204 Peripheral vestibular disorders:

- 30% rating – Dizziness and occasional staggering
- 10% rating – Occasional dizziness

Note: Objective findings supporting the diagnosis of vestibular disequilibrium are required before a compensable evaluation can be assigned under this code. Hearing impairment or suppuration shall be separately rated and combined.

Diagnostic Code 6205 Meniere's syndrome (endolymphatic hydrops):

- 100% rating – Hearing impairment with attacks of vertigo and cerebellar gait occurring more than once weekly, with or without tinnitus
- 60% rating– Hearing impairment with attacks of vertigo and cerebellar gait occurring from one to four times a month, with or without tinnitus
- 30% rating – Hearing impairment with vertigo less than once a month, with or without tinnitus

For example, a veteran may only have a 10% rating for Migraines but could possibly receive a 30% (lower or higher rating possible as well) for Vertigo secondary to Migraines.

VA Disability Ratings for Vertigo Explained:

How is Vertigo Rated by the VA?

Medical Research Study:

Vestibular migraine

Vestibular vertigo

BVA Case History Example:

Vertigo secondary to Migraines is granted

Vertigo secondary to Medication Side Effects

Vertigo can either result from a problem with our inner ear, the nerve between the inner ear and the brainstem, or the brain itself. However, medications like antihistamines, benzodiazepines, or anticholinergics can suppress the vestibular system and may do so in a way that causes dizziness or imbalance according to **verywellhealth**. The antibiotics known as aminoglycosides, such as gentamicin or tobramycin, can have a toxic effect on the inner ear, leading to permanent vertigo. Other drugs that can be toxic to the vestibular system include quinine, certain chemotherapies, salicylates like aspirin, and loop diuretics like furosemide.

Sometimes, a drug takes time to damage the vestibular system, as is the case for aminoglycosides—so it may be a while before the symptom of dizziness is experienced.

In addition, dizziness that always follows the taking of a medication is certainly suspicious, but constant dizziness may also be caused by drugs. For example, if the concentration of a drug in the blood remains fairly constant between doses, there may not be much fluctuation in side effects.

In general, it's best to be mindful of the potential side effects of medications and to discuss the proper management of those drugs with your healthcare provider.

Some medicines that cause vertigo are also ototoxic (eg, aminoglycosides, anti-inflammatory medicines, phosphodiesterase type-5 inhibitors, furosemide). When a patient who is taking a medicine known to be ototoxic presents with vertigo, dose reduction or discontinuation of the medicine may need to be considered to prevent irreversible hearing loss.

Can Vertigo be a secondary VA claim to Medication Side Effects?

Yes, Vertigo can be service-connected secondary to Medication Side Effects as an interim link.

While a veteran can't be rated separately for Medication Side Effects, if a service connected disability causes/aggravates another disability, such as Vertigo (and medications taken to manage it), it can be used as an "Interim Link" for service connection, if the side effects of medication taken to manage symptoms lead to the new disability condition.

VA Disability Ratings for Vertigo Explained:

How is Vertigo Rated by the VA?

Medical Research Study:

Drugs inducing hearing loss, tinnitus, dizziness and vertigo: an updated guide

Vertigo/dizziness as a Drugs' adverse reaction

BVA Case History Example:

Vertigo secondary to Medication Side Effects is granted

Vertigo secondary to Head or Neck Conditions

As defined by VertigoTreatment.org, Cervical vertigo is *vertigo caused by neck postures* irrespective of the orientation of the head to gravity. Cervical vertigo can also be simply defined as vertigo due to neck disorders.

The etiology of cervicogenic vertigo can be traced to pathophysiological changes in the inner ear, head or neck region. A relatively new classification in medical literature, diagnosis of cervicogenic dizziness frequently leaves patients wondering how the neck can possibly cause dizziness—which is easily explained:

Anatomically-speaking, neck muscles and joints contain tiny receptors whose job it is to continuously send signals to the brain, eyes, and inner ear (the “vestibular” apparatus) about head orientation: specifically, where the head is in relationship to the rest of the body.

The vestibular apparatus (part of a larger system responsible for controlling eye movement, muscle coordination, and general balance) relies on the eyes and mechanisms of the inner ears to inform the vestibular system as to the relative position of the head to one's surroundings.

Should any aspect of this system malfunction, inaccurate information is sent to the brain, causing sensory confusion; the physiological condition we refer to as “dizziness” or “light-headedness.”

Thus, if the neck (which is directly involved with this regulatory system) is experiencing stiffness or limited range-of-motion, the information it relays to the brain will be less than accurate. Sometimes likened to carpenter's bubble level, if the orientation between the eyes, ears, and brain are not aligned, the information conveyed to the brain will not be a true reading of physical orientation. Thus, neck-rooted “cervicogenic” dizziness results--indicating something askew.

Vascular compression of the vertebral arteries in the neck by the vertebrae and other structures (Sakaguchi and Kitagawa et al. 2003), especially, compression due to incongruity of the origin of the vertebral artery, an inconsistent course between the fascicles of either longus coli and bands of deep cervical fascia (Bogduk, 1986) have been shown to be associated with obstruction of blood flow while turning the neck.

Spasm of the vertebral arteries can occur due to their close association with the sympathetic trunk (Bogduk, 1986).

Cervical cord compression caused due to interaction of the ascending or descending tracts in the spinal cord with the cerebellum, vestibular nucleus or vestibulospinal projections is one of the chief reasons for cervical vertigo (Benito-Leon, 1996 and Brandt 1996).

Vertebral arteries can also be damaged at the points in the upper cervical spine region, due to stressful stretching such as weight lifting that causes the vertebral artery to rupture.

UpperCervical Awareness.com made a list of Disorders That Cause Vertigo:

- Migraine associated vertigo

A migraine with vestibular symptoms can cause throbbing head pain, nausea, vomiting, sensitivity to sound and light, and vertigo.

- Benign paroxysmal positional vertigo or BPPV

It occurs when you move your head in certain positions, such as rolling over in bed. It has to do with displaced crystals within the inner ear.

- Labyrinthitis

It is an irritation and swelling of the inner ear, causing dizziness, vertigo, and hearing loss.

- Cholesteatoma

It is a type of skin cyst positioned in the middle ear and mastoid bone in the skull.

- Acoustic neuroma

A benign tumor grows on the balance nerves

- Vestibular neuritis

An infection of the inner ear causes inflammation in the nerves or the inner ear itself

- Meniere's disease

This condition is known for causing severe vertigo, fluctuating hearing loss, tinnitus, and a sensation of congestion or fullness in the affected ear

Rare Reasons Behind Vertigo

- Cervical vertigo

Particular head movements lead to dizziness and vertigo caused by abnormalities in the neck muscles and bones

- Cerebrovascular accident or stroke

Vertigo is seldom the single symptom of a stroke.

- Perilymphatic fistula

An abnormal link between the inner ear and middle ear enables the leakage of the fluid in the inner ear

- Otosclerosis

Change in the dense bone that houses the inner ear causes alterations to internal ear function.

- Superior semicircular canal dehiscence

The lack of bone over the topmost portion of the inner ear balance canals

- Vertebrobasilar insufficiency

Diminished blood flow in the major blood vessels that move to the lower area of the brain causes vertigo

- Chiari malformation

An anatomic abnormality that exists at the base of the skull and triggers vertigo

Can Vertigo be a secondary VA claim to Head or Neck Conditions?

Yes, Vertigo can be service-connected secondary to Head or Neck Conditions.

According to the **Veterans Law Office**, the severity of vertigo can range from relatively mild to completely debilitating depending on what condition is causing the vertigo. Under the VA's disability rating system, both conditions causing vertigo and vertigo itself are subject to a VA schedular disability rating. Under **38 CFR § 4.87**, vertigo (i.e. peripheral vestibular disorders) and Meniere's disease are rated as follows:

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Diagnostic Code 6205 Meniere's syndrome (endolymphatic hydrops):

- 100% rating – Hearing impairment with attacks of vertigo and cerebellar gait occurring more than once weekly, with or without tinnitus
- 60% rating– Hearing impairment with attacks of vertigo and cerebellar gait occurring from one to four times a month, with or without tinnitus
- 30% rating – Hearing impairment with vertigo less than once a month, with or without tinnitus

For example, a veteran may only have a 10% rating for Head or Neck Conditions but could possibly receive a 30% (lower or higher rating possible as well) for Vertigo secondary to Head or Neck Conditions.

VA Disability Ratings for Vertigo Explained:

How is Vertigo Rated by the VA?

Medical Research Studies:

Cervicogenic causes of vertigo

Clinical characteristics of cervicogenic-related dizziness and vertigo

BVA Case History Example:

Vertigo secondary to Head or Neck Conditions is granted

Vertigo secondary to TBI

A traumatic brain injury (TBI) can cause post-traumatic vertigo resulting from damage to the sensory organs inside the inner ear due. The inner ear contains sensory organs for both hearing and balance. Vestibular dysfunction, or post-traumatic vertigo, occurs due to damage to this area.

A study posted online by the National Library of Medicine stated that TBI is the most common cause of disability in under-40-year-olds. Vestibular features of dizziness (illusory self-motion) or **imbalance** which affects 50% of TBI patients at 5 years, increases unemployment threefold in TBI survivors. Unfortunately, vestibular diagnoses are cryptogenic in 25% of chronic TBI cases, impeding therapy. The study hypothesized that chronic adaptive brain mechanisms uncouple vestibular symptoms from signs. This predicts a masking of vestibular diagnoses chronically but not acutely. Hence, defining the spectrum of vestibular diagnoses in acute TBI should clarify vestibular diagnoses in chronic TBI. There are, however, no relevant acute TBI data. Of 111 Major Trauma Ward adult admissions screened (median 38-years-old), 96 patients (87%) had subjective dizziness (illusory self-motion) and/or objective imbalance were referred to the senior author (BMS). Symptoms included: feeling unbalanced (58%), headache (50%) and dizziness (40%). In the 47 cases assessed by BMS, gait ataxia was the commonest sign (62%) with half of these cases denying imbalance when asked. Diagnoses included BPPV (38%), acute peripheral unilateral vestibular loss (19%), and migraine phenotype headache (34%), another potential source of vestibular symptoms. In acute TBI, vestibular signs are common, with gait ataxia being the most frequent one.

Another **study** stated that the most frequent peripheral vestibular disorder in acute TBI is **benign paroxysmal positional vertigo (BPPV)**, affecting approximately half of acute cases.

Can Vertigo be a secondary VA claim to TBI?

Yes, Vertigo can be service-connected secondary to TBI.

According to the **Veterans Law Office**, the severity of vertigo can range from relatively mild to completely debilitating depending on what condition is causing the vertigo. Under the VA's disability rating system, both conditions causing vertigo and vertigo itself are subject to a VA schedular disability rating. Under **38 CFR § 4.87**, vertigo (i.e. peripheral vestibular disorders) and Meniere's disease are rated as follows:

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- 60% rating– Hearing impairment with attacks of vertigo and cerebellar gait occurring from one to four times a month, with or without tinnitus
- 30% rating – Hearing impairment with vertigo less than once a month, with or without tinnitus

For example, a veteran may only have a 10% rating for TBI but could possibly receive a 30% (lower or higher rating possible as well) for Vertigo secondary to TBI.

VA Disability Ratings for Vertigo Explained:

How is Vertigo Rated by the VA?

Medical Research Studies:

Vestibular dysfunction in acute traumatic brain injury

The assessment of balance and dizziness in the TBI patient

A mixed methods randomised feasibility trial investigating the management of benign paroxysmal positional vertigo in acute traumatic brain injury

BVA Case History Example:

Vertigo secondary to Head or TBI is granted