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ORDER

1. Entitlement to service connection for a urinary disability is denied.

2. Entitlement to service connection for gastroesophageal reflux disease (GERD) is denied.

3. Entitlement to service connection for erectile dysfunction is denied.

4. Entitlement to service connection for hypertension is denied.

5. Entitlement to service connection for a prostate disability is denied.

6. Entitlement to service connection for obstructive sleep apnea (OSA) is denied.

FINDINGS OF FACT

1. The Veteran's urinary disability is not secondary to service-connected disability and is not otherwise related to an in-service event, injury, or disease.

2. The Veteran's GERD is not secondary to service-connected disability and is not otherwise related to an in-service event, injury, or disease.

3. The Veteran's erectile dysfunction is not secondary to service-connected disability and is not otherwise related to an in-service event, injury, or disease.

4. The Veteran's hypertension was not shown as chronic in service and did not manifest to a compensable degree within the applicable presumptive period; continuity of symptomatology is not established; and the disability is not secondary to service-connected disability and is not otherwise related to an in-service injury or disease.

5. The Veteran's prostate cancer was not shown as chronic in service and did not manifest to a compensable degree within the applicable presumptive period; continuity of symptomatology is not established; and a prostate disability is not secondary to service-connected disability and is not otherwise related to an in-service injury or disease.

6. The Veteran's prostate disability is not secondary to service-connected disability and is not otherwise related to an in-service event, injury, or disease.

7. The Veteran's OSA is not secondary to service-connected disability and is not otherwise related to an in-service event, injury, or disease.

CONCLUSIONS OF LAW

1. The criteria for service connection for a urinary disability are not met. 38 U.S.C. §§ 1110, 1131, 5107; 38 C.F.R. §§ 3.102, 3.303, 3.310.

2. The criteria for service connection for GERD are not met. 38 U.S.C. §§ 1110, 1131, 5107; 38 C.F.R. §§ 3.102, 3.303, 3.310.

3. The criteria for service connection for erectile dysfunction are not met. 38 U.S.C. §§ 1110, 1131, 5107; 38 C.F.R. §§ 3.102, 3.303, 3.310.

4. The criteria for service connection for hypertension are not met. 38 U.S.C. §§ 1110, 1112, 1113, 1131, 1137, 5107; 38 C.F.R. §§ 3.102, 3.303, 3.307, 3.309, 3.310.

5. The criteria for service connection for a prostate disability are not met. 38 U.S.C. §§ 1110, 1112, 1113, 1131, 1137, 5107; 38 C.F.R. §§ 3.102, 3.303, 3.307, 3.309, 3.310.

6. The criteria for service connection for OSA are not met. 38 U.S.C. §§ 1110, 1131, 5107; 38 C.F.R. §§ 3.102, 3.303, 3.310.

REASONS AND BASES FOR FINDINGS AND CONCLUSIONS

The Veteran served in the United States Marine Corps Reserves from September 1962 to September 1968 with periods of active duty for training (ACDUTRA) including an initial tour from June 1963 to December 1963.

The Board notes that the Veteran has two separate appeals streams. The appeal with respect to the issues in this decision is being processed under the Legacy Review System; and the appeal with respect to the ratings assigned for TBI/anxiety disorder and migraine headaches in the November 2021 rating decision is being processed under the Appeals Modernization Act (AMA).

Historically, with respect to the issues in this decision, the matter is originally on appeal from a March 2018 rating decision which granted service connection for hemorrhoids, tinnitus, and hearing loss and denied service connection for the issues on appeal in this decision as well as the issues of service connection for traumatic brain injury (TBI), vertigo, cysts on arms, a psychiatric disability, ocular migraine, and a right-hand finger disability.

In June 2018, the Veteran submitted his Notice of Disagreement with respect to the issues denied in the March 2018 rating decision; in April 2020, a Statement of the Case was issued; and in May 2020, the Veteran perfected his appeal.

In July 2020, the Board remanded the issues denied in the March 2018 rating decision for additional development to include providing VA examinations and obtaining etiology opinions to include whether hypertension, GERD, urinary disorder, OSA, prostate disorder, and erectile dysfunction were at least as likely as related to service including presumed exposure to contaminants in the water supply at Camp Lejeune or caused or aggravated by TBI.

In a November 2021 rating decision, service connection was established for TBI and other specified anxiety, migraine headache, vertigo, and right-hand finger disabilities. In January 2022, a Supplemental Statement of the Case was issued for the issues on appeal in this decision.

In July 2022, the Board again remanded the issues on appeal in this decision for additional development to include obtaining an additional etiology opinion which addressed the Veteran's contention was that his TBI caused his obesity and that his obesity caused or contributed to his hypertension, GERD, urinary disorder, OSA, prostate disorder, and erectile dysfunction.

Service Connection

Service connection may be granted for disability resulting from disease or injury incurred in, or aggravated, while performing ACDUTRA or from injury incurred or aggravated while performing INACDUTRA. 38 U.S.C. §§ 101, 106, 1131.

ACDUTRA includes full time duty performed by members of the Reserves or National Guard of any state. INACDUTRA includes duty other than full-time duty performed by a member of the Reserves or the National Guard of any state. 38 C.F.R. § 3.6 (c), (d).

The three-element test for service connection requires evidence of: (1) a current disability; (2) in-service incurrence or aggravation of a disease or injury; and (3) a causal relationship between the current disability and the in-service disease or injury. Shedden v. Principi, 381 F.3d 1163, 1166 -67 (Fed. Cir. 2004).

Certain chronic diseases will be presumed related to service, absent an intercurrent cause, if they were shown as chronic in service; or, if they manifested to a compensable degree within a presumptive period following separation from service; or, if they were noted in service (or within an applicable presumptive period) with continuity of symptomatology since service that is attributable to the chronic disease. 38 U.S.C. §§ 1101, 1112, 1113, 1137; 38 C.F.R. §§ 3.303, 3.307, 3.309. Walker v. Shinseki, 708 F.3d 1331, 1338 (Fed. Cir. 2013).

A veteran, former reservist, or member of the National Guard, who had no less than 30 days (consecutive or nonconsecutive) of service at Camp Lejeune during the period beginning on August 1, 1953 and ending on December 31, 1987, shall be presumed to have been exposed during such service to the contaminants in the water supply (trichloroethylene (TCE), perchloroethylene (PCE), benzene and vinyl chloride), unless there is affirmative evidence to establish that the individual was not exposed to contaminants in the water supply during that service. 38 C.F.R. § 3.307 (a)(7). If a Veteran served on Camp Lejeune during the time frame specified, certain diseases including kidney cancer, liver cancer, non-Hodgkin's lymphoma, adult leukemia, multiple myeloma, Parkinson's disease, aplastic anemia and other myelodysplastic syndromes, and bladder cancer shall be service connected even though there is no record of such disease during service. 38 C.F.R. § 3.309 (f).

Service connection may also be established on a secondary basis for a disability that is proximately due to or the result of a service-connected disease or injury pursuant to 38 C.F.R. § 3.310(a). Establishing service connection on a secondary basis requires evidence sufficient to show that a current disability exists and that the current disability was either caused by or aggravated by a service-connected disability. 38 C.F.R. § 3.310(a); Allen v. Brown, 7 Vet. App. 439 (1995) (en banc).

The question for the Board is whether the Veteran has a urinary disability, GERD, erectile dysfunction, hypertension, a prostate disability, or OSA that began during service or is at least as likely as not related to an in-service injury, event, or disease or proximately due to, the result of, or aggravated beyond its natural progress by a service-connected disability.

The service treatment records are absent complaints, findings or diagnoses of any urinary problems, stomach problems, erectile dysfunction, hypertension, prostate problems, and sleep problems during the Veteran's active-duty service. On the clinical examinations in May 1963, December 1963, January 1965, June 1966, and June 1967, the Veteran's genitourinary system, abdomen, and viscera, were evaluated as normal. The Veteran's blood pressure readings on the clinical examinations in May 1963, December 1963, January 1965, June 1966, and June 1967, were 128/70, 110/62, 120/74, 100/60, and 120/78, respectively. Further, on the Reports of Medical History completed by the Veteran in conjunction with his physicals in May 1963, January 1965, June 1966, and June 1967, he denied ever having frequent or painful urination, blood in urine, bed-wetting, high or low blood pressure, frequent indigestion, stomach trouble, and frequent trouble sleeping.

In addition, on VA examinations in February 2018, the Veteran reported onset of pain with urination and a weaker stream and being diagnosed as having BPH in 1980; onset of heartburn in 1978 and being diagnosed as having GERD in 1980; and onset of erectile dysfunction in 2005.

As such, there is no evidence in the Veteran's service treatment records that shows that he suffered from a urinary disability, GERD, erectile dysfunction, hypertension, a prostate disability, or OSA during service.

As for statutory presumptions, certain chronic diseases, such as hypertension and prostate cancer, will be presumed related to service, absent an intercurrent cause, if they were shown as chronic in service; or, if they manifested to a compensable degree within a presumptive period following separation from service; or, if they were noted in service (or within an applicable presumptive period) with continuity of symptomatology since service that is attributable to the chronic disease. 38 U.S.C. §§ 1101, 1112, 1113, 1137; 38 C.F.R. §§ 3.303, 3.307, 3.309. Walker v. Shinseki, 708 F.3d 1331, 1338 (Fed. Cir. 2013). The advantage of this evidentiary presumption does not usually extend to those who claim service connection based on a period of ACDUTRA or INACDUTRA unless "veteran" status is attained during that period. Paulson v. Brown, 7 Vet. App. 466, 470 (1995).

In this case, service connection has been established for TBI in October 1963 and resulting vertigo and migraine headaches; hemorrhoids in October 1963, right hand long third finger disability from an injury in July 1963, tinnitus and hearing loss from exposure to an explosion in October 1963. As such, all of the Veteran's service-connected disabilities are from the Veteran's initial period of ACDUTRA from June 1963 to December 1963. Thus "veteran" status has been attained during the period of June 1963 to December 1963.

Hypertension and prostate cancer, however, were not shown as chronic in service, did not

manifest to a compensable degree within a presumptive period, and were not noted in service with attributable continuity of symptomatology. VA treatment records do not show that the Veteran was diagnosed with either hypertension or prostate cancer within a year of his discharge from his period of ACTDUTRA from June 1963 to December 1963.

The Board notes that on VA examination in May 2021, the Veteran reported that his hypertension began in 1968 with elevated blood pressures while in service, more than a year after his discharge from his period of ACTDUTRA from June 1963 to December 1963. In addition, the record is devoid of objective evidence of hypertension until 2017, the first post-service treatment records in the claims file; and the Veteran was diagnosed as having prostate cancer in 2022.

Also, with respect to statutory presumptions, the Veteran's service personnel records indicate that he was stationed at Camp Lejeune during service from September 9, 1963, to October 3, 1963, and from July 16, 1966, to July 30, 1966; and, therefore, exposure to contaminated water is conceded. The Veteran, however, is not claiming service connection for any of the presumptive disabilities; and prostate cancer is not one of the diseases for which service connection on a presumptive basis as due to exposure to contaminated water at Camp Lejeune is available.

Nonetheless, the United States Court of Appeals for the Federal Circuit has held that a claimant is not precluded from establishing service connection with proof of actual direct causation. Combee v. Brown, 34 F.3d 1039, 1043-44 (Fed. Cir. 1994). Thus, the Veteran may still prove service connection by way of a direct theory of entitlement.

In this case, the evidence of record persuasively weighs against finding that a medical nexus exists between a current urinary disability, GERD, erectile dysfunction, hypertension, a prostate disability, or OSA and an in-service injury, event or disease or a service-connected disability. 38 U.S.C. §§ 1110, 1131; 38 C.F.R. §§ 3.303, 3.310.

The Veteran has undergone many VA examinations, and many VA opinions have been rendered.

In February 2018, a VA examiner noted that the Veteran's file was silent for any issues pertaining to any urinary tract conditions or treatments, any treatment for a prostate condition, erectile dysfunction, hypertension, a prostate disability, or OSA and that such opined that the Veteran's erectile dysfunction, prostate disorder, urinary tract disorder, and acid reflux were less likely than not incurred in or caused by an in-service injury, event, or illness.

In September 2020, an independent medical opinion was rendered by an occupational medicine physician that the Veteran's hypertension, GERD, OSA, urinary condition, BPH, and erectile dysfunction were less likely incurred in service or caused by the Veteran's exposure to contaminated water at Camp Lejeune.

The examiner stated,

The Veteran's hypertension was due to personal risk factors including poor diet including salt intake, lack of exercise, obesity, hyperlipidemia, gender, age, drinking, high cholesterol, pre-diabetes. Thus, the Veteran's personal risk factors significantly outweigh the small environmental exposure risk posed by low level solvent exposure in the drinking water at Camp Lejeune for less than 3 and 12 months duration. Workers who developed hypertension were exposed to solvents a[t] levels one thousand times higher than the levels found in the drinking water at Camp Lejeune and for periods of three to five years duration of exposure. The Camp Lejeune cohort was exposed to solvents for 18 months and the [Agency for Toxic Substances and Disease Registry] ATSDR did not find any incidence of hypertension in the cohort of exposed service members. The Veteran was exposed for less than 3 and 12 months which was less than 20 percent of the average exposure of service members stationed at Camp Lejeune so his risk was exceedingly low and it makes it unlikely that his hypertension was due to exposure to contaminated water at Camp Lejeune. ...

The veteran's personal risk factors for Chronic Gastroesophageal Reflux Disease outweighed the Veteran's exposure risk from solvent contaminated water at Camp Lejeune. The Veteran's personal risk factors included gender, NSAID use including Motrin, drinking alcohol, poor diet and obesity. The combination of the Veteran's drinking, obesity, poor diet and medication use acted together to increase the Veterans risk of developing GERD. The ATSDR

in their Assessment of the Evidence for the Drinking Water Contaminants at Camp Lejeune and Specific Cancers and Other Diseases, Jan 13, 2017 found no evidence of an increased incidence of Chronic Gastrointestinal conditions to include GERD in the Camp Lejeune cohort. The ATSDR Morbidity Study of Former Marines, Employees, and Dependents Potentially Exposed to Contaminated Drinking Water at U.S. Marine Corps Base Camp Lejeune published in April, 2018 also noted no increase in GERD in service members exposed to contaminated water at Camp Lejeune. This makes it unlikely that these exposures contributed to the Veterans development of GERD. It is more likely that the Veteran's alcohol use, medication use, poor diet, (high in fat and caffeine), and obesity caused the development of the Veteran's GERD. ...

The Veteran's service treatment records did not have a diagnosis of a sleep disorder. On the Veteran's separation exam, the Veteran denied any problems to include sleep conditions. There was no continuity of symptoms from service to the present. The Veteran was at Camp Lejeune from 9/7/1963 to 12/18/1963. Thus, the Veteran's cumulative exposure to contaminated water supply at Camp Lejeune was 102 days. Further, a review of the medical literature does not indicate that there an association between exposure to contaminated water at Camp Lejeune and the Veteran's claimed sleep condition. The post service medical records within a year of discharge and subsequent post service records were reviewed and also do not show the veteran sought evaluation for sleep apnea. The ATSDR January 2017 Study of Morbidity of service members at Camp Lejeune noted no increased risk of OSA in the cohort of service members stationed at Camp Lejeune. The ATSDR completed a Morbidity Study of Former Marines, Employees, and Dependents Potentially Exposed to Contaminated Drinking Water at U.S. Marine Corps Base Camp Lejeune in April of 2018 and did not observe an increased incidence of sleep apnea. There have been studies in the medical literature that evaluated the effects of chlorinated solvents on development or worsening of sleep apnea and no effects were observed. A recent study conducted by Saygun et al. examined the effects of long-term low-level solvent exposure on cognitive function and found no significant difference in the exposed and control groups for cognitive function or behavioral effects. If the Veteran had a sleep condition, his personal risk factors for Sleep Apnea would outweigh any environmental risk the Veteran had due to contaminated water exposure at Camp Lejeune. The veteran has several risk factors for sleep apnea that include obesity, the Veteran's age, male sex, hypertension, and pre-diabetes. Sleep apnea is more common in middle and older age adults. OSA is two times more common in men, especially in middle age. People who are obese have four times the risk of sleep apnea. Fat deposits around the upper airway and may obstruct breathing. Thus, the Veteran's personal risk factors markedly increased the Veteran's risk of developing Obstructive Sleep Apnea and outweighed any environmental risk posed by exposure to contaminated water at Camp Lejeune. ...

The Veteran has prostate problems that likely increased his personal risk of Incontinence. In addition, changes as we age reduce how much your bladder can hold and increase the chances of involuntary urine release. The Veteran is 76 years old so he is at increased risk of incontinence due to his age. In addition, the Veteran is obese which increases pressure on the bladder and surrounding muscles, which weakens them and allows urine to leak out when you cough or sneeze. Diabetes may increase the risk of incontinence and the Veteran has pre-diabetes so he is at some increased risk of incontinence. Further, the Veteran has an enlarged prostate which increases his risk of incontinence especially in older men due to benign prostatic hyperplasia. The Veteran's personal risk factors outweighed the Veteran's environmental risk due to chlorinated solvent exposure at Camp Lejeune for 102 days. The ATSDR January 2017 Study of Morbidity of service members at Camp Lejeune noted no increased risk of Incontinence in the cohort of service members stationed at Camp Lejeune. The ATSDR completed a Morbidity Study of Former Marines, Employees, and Dependents Potentially Exposed to Contaminated Drinking Water at U.S. Marine Corps Base Camp Lejeune in April of 2018 and did not observe an increased incidence of Incontinence in Marines stationed at Camp Lejeune. ...

The Veteran's prostatic hypertrophy is less likely than not caused by or a result of the Veteran's exposure to contaminated water at Camp Lejeune. The Veteran was stationed at Camp Lejeune for 102 days and this extremely low-level environmental risk due to solvent contaminated water at Camp Lejeune was outweighed by the Veteran's personal risk factors for BPH. The ATSDR in their January 2017 report, noted that TCE and PCE were present in the drinking water during the time the Veteran was stationed at Camp Lejeune. The levels of TCE in the drinking water at Camp Lejeune was 10 PPB which was twice what the EPA considers to be the safe MCL for TCE of 5 PPB. The medical literature notes an increased risk in workers who were chronically exposed to very high levels of TCE and PCE for many years. A newly

published ASTDR Report in April 2018 noted that PCE and TCE exposure in the drinking water at Camp Lejeune increased the risk of BPH for personnel who were stationed there for two years or longer. The Veteran was stationed at Camp Lejeune 102 days which is one tenth of the average duration service members were stationed at Camp Lejeune. The average veteran who was stationed at Camp Lejeune who developed prostate problems were stationed there for an average of 22 months. Thus, the Veteran's environmental risk due to exposure to contaminated water at Camp Lejeune was far less than the average service member stationed there. Further, there are no medical studies that show Veterans with 102 days duration of exposure at Camp Lejeune developed BPH. As a result, the Veterans risk of developing BPH was elevated due to his personal risk factors that include obesity, age, gender, pre-diabetes, and family history and these risk when considered together outweigh the Veteran's environmental risk of developing BPH. In summary, the Veteran's BPH was less likely than not caused by or aggravated by the Veteran's exposure to contaminated water at Camp Lejeune. The Veteran's BPH risk due to his personal risk factors that include obesity, age, gender, pre-diabetes, and family history outweighed his environmental exposure risk due to 102 days exposures at Camp Lejeune. ...

It is less likely than not that the Veteran's ED was caused by or was related to exposure to contaminated water at Camp Lejeune. The Veteran was exposed to environmental chemicals in the water at Camp Lejeune for less than 3 and 12 months. ATSDR did not find an association between exposures to solvents including TCE, benzene, vinyl chloride and PCE and an increased risk of erectile dysfunction nor is erectile dysfunction on the list of presumption condition established by Congress and the VA. It is more likely than not that the Veteran's BPH, Hypertension and treatment for hypertension with blood pressure medications and antidepressant medications caused the Veteran's Erectile Dysfunction. Hypertension and medications to treat hypertension both play a role in causing ED. High blood pressure keeps the arteries that carry blood into the penis from dilating the way they're supposed to because there is a disturbance of endothelium-derived factors that can lead to an increase in vascular smooth muscle (VSM) contraction. It also makes the smooth muscle in the penis lose its ability to relax. As a result, not enough blood flows into the penis to make it erect. Blood pressure can also damage your arteries by causing them to become thicker. This can restrict blood flow to your penis, which may then cause erectile dysfunction. Hypertension can lead to erectile dysfunction as a consequence of anti-hypertensive treatment as well. Beta-blockers dampen the response to nerve impulses that lead to an erection. They also make it more difficult for the arteries in the penis to widen and let in blood. What's more, they can make you feel sedated and depressed which may play a part in limiting sexual arousal. Further, the Veteran's Obstructive Sleep Apnea may have aggravated the Veteran's hypertension which further contributed to the Veterans Erectile Dysfunction. ...

The Veteran underwent VA examinations in May 2021. In October 2021, the VA examiner who conducted the May 2021 examinations opined that a urinary disorder, GERD, erectile dysfunction, hypertension, a prostate condition, and OSA were less likely than not incurred in or caused by an in-service injury, event, or illness; proximately due to or the result of TBI; or aggravated beyond its natural progression by TBI.

The examiner noted that she was unable to find medical records showing treatment for a urinary condition, GERD, a prostate condition, and snoring or difficulty sleeping while in service; and she was unable to find medical records showing erectile dysfunction or elevated blood pressures while in service or shortly after service.

The examiner noted that urinary frequency may be linked to bladder infection/disease/irritation, conditions/drugs/beverages that cause increase in urine production, changes in the muscles/nerves/tissues affecting bladder function, and certain cancer treatments.

The examiner noted that conditions that can increase a risk of GERD include obesity, bulging of the top of the stomach up into the diaphragm (hiatal hernia), connective tissue disorders such as scleroderma, delayed stomach emptying; factors that can aggravate acid reflux include smoking, eating large meals or eating late at night, eating certain foods (triggers) such as fatty or fried foods, drinking certain beverages such as alcohol or coffee, and taking certain medications such as aspirin; that common causes of erectile dysfunction include heart disease, clogged blood vessels (atherosclerosis), high cholesterol, high blood pressure, diabetes, obesity, metabolic syndrome (a condition involving increased blood pressure, high insulin levels, body fat around the waist, and high cholesterol), Parkinson's

disease, multiple sclerosis, certain prescription medications, tobacco use, Peyronie's disease (development of scar tissue inside the penis), alcoholism and other forms of substance abuse, sleep disorders, treatments for prostate cancer or enlarged prostate, surgeries or injuries that affect the pelvic area or spinal cord, and low testosterone.

The examiner noted that hypertension had many risk factors including age, race, family history, being overweight or obese, not being physically active, using tobacco, too much salt and too little potassium in one's diet, drinking too much alcohol, and stress.

The examiner noted that risk factors for prostate gland enlargement include aging, family history of BPH, diabetes, heart disease, use of beta blockers, and obesity.

The examiner noted that OSA occurs when the soft tissues in the back of the throat relax and cover the airway; that factors that increase the risk of OSA include excess weight, neck circumference, a narrowed airway, being male, being older, family history of OSA, use of alcohol, smoking, nasal congestion, congestive heart failure, high blood pressure, type 2 diabetes, Parkinson's disease, prior stroke, chronic lung diseases; and that TBI can cause of worsen central sleep apnea but that the Veteran had been diagnosed as having obstructive sleep apnea.

In December 2021, a VA examiner reviewed the record and opined that hypertension, OSA, and erectile dysfunction were less likely than not proximately due or aggravated beyond its natural progression by TBI and other specified anxiety disorder.

The examiner noted that the Veteran's hypertension was essential hypertension which, by definition, indicates that the exact cause is unknown and could likely be related to age/aging/alcohol, obesity, dietary indiscretions. The examiner also noted that anxiety does increase a transient increase in blood pressure as in "flight-fright" scenario but that sustained arterial hypertension is not caused by anxiety. The examiner noted that a variety of other proximate causes, e.g., BPH and the use of finasteride, in addition to aging and a variety of co-morbidities alone or in combination may be causing his erectile dysfunction.

The examiner noted that diagnostic work-up for erectile dysfunction as outlined in peer reviewed medical journals is to evaluate hormonal, vascular, post-surgical, toxic and drug etiologies (to name a few) prior to ruling in any cause for a person's erectile dysfunction. The examiner noted that there is insufficient evidence to rule in that the Veteran's erectile dysfunction was at least as likely as not related to any of his service-connected conditions in the absence of evaluation of other hormonal, toxic, drug, and other etiologies such as aging, alcohol, co-morbidities and obesity alone or in combination.

The examiner noted that OSA is characterized by recurrent collapse of the pharyngeal airway during sleep resulting in substantially reduced or complete cessation of airflow despite ongoing breathing efforts; that TBI and other specified anxiety disorder cannot do that as it is considered a biomechanical condition. The examiner noted that many conditions have known association with OSA including TBI and other specified anxiety disorder but that association means that the conditions coexist and not that one causes the other. The examiner noted that the primary risk factors for OSA are age (increasing from young adulthood), gender (male), obesity (the strongest risk factor), family history, and craniofacial abnormalities; alcohol, and smoking are also well-known risk factors. The examiner noted that the Veteran is a male, 77 years old, and obese, the proximate factors for sleep apnea.

Thus, the February 2018 VA examiner opined that a urinary disability, GERD, erectile dysfunction, hypertension, a prostate disability, and OSA were not incurred or aggravated by a period of ACDUTRA. In addition, the September 2020 VA examiner opined that a urinary disability, GERD, erectile dysfunction, hypertension, a prostate disability, and OSA were not due to the Veteran's exposure to contaminated water while stationed at Camp LeJeune. Further, the October 2021 and December 2021 VA examiners opined that a urinary disability, GERD, erectile dysfunction, hypertension, a prostate disability, and OSA were not due to or aggravated beyond its natural progression by TBI and other specified anxiety disorder.

The Board acknowledges that the occupational medicine physician who rendered the September 2020 independent medical opinion noted that the Veteran's erectile dysfunction was more likely than not due to BPH, hypertension, treatment for hypertension with blood pressure medications, and antidepressant medications. The Board notes that although the Veteran has

been diagnosed as having other specified anxiety disorder with depressive features, the record is absent any psychiatric treatment including antidepressants. At the November 2020 VA mental disorders examination, the Veteran reported that a doctor prescribed valium many years ago and that he took it if he got "real nervous." There is no indication in the record, however, that the Veteran has been prescribed any antidepressant.

In its July 2020 Remand, the Board specifically directed that the Veteran be requested to identify the names, addresses, and approximate dates of treatment for all VA and non-VA health providers who had treated him for his disabilities. In a July 2020 letter, the Veteran was specifically asked to identify and authorize VA to obtain treatment records from any private medical sources identified. The Veteran did not identify any private medical treatment. To the extent that information may have been gained to the Veteran's benefit from any private treatment records, VA made sufficient efforts to have the Veteran identify them. The duty to assist is a two-way street, and the Veteran is responsible to assist VA in developing his claims. See Wood v. Derwinski, 1 Vet. App. 190 (1991).

Thus, the Board cannot conclude that that Veteran's erectile dysfunction is proximately due to anti-depressants taken for service-connected psychiatric disability, specifically, other specified anxiety disorder with depressive features.

In a February 2022 letter, the Veteran's attorney raised a theory of entitlement for service connection for a urinary condition, GERD, erectile dysfunction, hypertension, a prostate condition, and OSA, as due to TBI with obesity being an intermediate step.

VA's Office of General Counsel issued a precedential opinion in January 2017 that concluded that obesity per se is not a disease or injury for purposes of 38 U.S.C. §§ 1110 and 1131; and, therefore, may not be service connected on a direct basis. Similarly, obesity is not a "disability" for the purposes of secondary service connection under 38 C.F.R. § 3.310. However, VA's Office of General Counsel recognized that obesity may act as an "intermediate step" between a service-connected disability and a current disability that may be service-connected on a secondary basis. See VAOPGCPREC 1-2017 (January 6, 2017) (noting that the this "intermediate step" under 38 C.F.R. § 3.310 (a) equates to an inquiry into proximate cause requiring a 3-step analysis, namely of (1) whether the service-connected disability caused the Veteran to become obese; (2) if so, whether the obesity as a result of the service-connected disability was a substantial factor in causing the current disability; and (3) whether the current disability would not have occurred but for obesity caused by the service-connected disability.)

In August 2022, VA obtained a medical opinion that the Veteran's TBI was so mild that it was not at least as likely as not the cause of the Veteran's obesity, hypertension, GERD, urinary disorder, OSA, prostate disorders, and erectile dysfunction.

Specifically, the examiner stated,

Based on cumulative evidence, there is clear and unmistakable evidence that given the nature, extent, imaging, timing & onset of symptoms, and clinical findings, the Veteran's (now service connected) TBI was mild. 'Mild traumatic brain injury is defined as a traumatically-induced physiological disruption of brain function...". It is clear from imaging that there are no TBI related structural abnormalities. Therefore, it is not at least as likely as not that a condition so mild could cause all the aforementioned claimed conditions (Obesity, urinary problems, GERD, ED, hypertension, prostate disorders, and sleep apnea) or implicated for causation of these conditions, in the absence of plausible causality, based upon objective facts, and when there are other well known, well documented, peer-reviewed, established, proximate causative factors (respectively for each claimed condition). To conclude, there is no medical evidence or no available medical evidence, and it is not at least as likely as not that the claimed conditions are causally related to mild TBI from 1963. Treating providers (most credible source of accurate information) do not even mention TBI.

The examiner noted that similar history and clinical findings were noted by several providers that the Veteran had seen over the years and that no TBI residuals specifically for GERD, hypertension, erectile dysfunction, urinary symptoms, sleep apnea noted by neurologists, otolaryngologists, primary care providers, urologists and others. The examiner also noted that MR angiography brain demonstrated only absent flow related signal contrast enhancement involving the right A1 likely representing congenital anatomical

variant; that no evidence of Circle of Willis or vertebrobasilar artery aneurysm were noted; and that there were no other structural abnormalities. The examiner further noted that based on several neurological evaluations, imaging findings, and the absence of TBI-related abnormal signs as well as the presence of objective, reproducible, organ/system-specific local abnormal findings confirmed by a variety of imaging and visual diagnostic procedures, he concluded that there was no central nervous system involvement or TBI residuals for the claimed conditions.

Thus, the August 2022 VA examiner found that obesity, or any of the other disabilities on appeal, were not a result of the service connected TBI.

The Board notes that the Veteran's attorney argues that VA has relied on an inadequate examination as the examiner concluded that the Veteran's TBI was mild. The attorney argues that by unilaterally determining that the Veteran's TBI was "mild," contrary to the 40 percent rating assigned, the examiner excused himself from analyzing whether the TBI could cause or aggravate his obesity, hypertension, GERD, urinary disorder, OSA, prostate disorder, and erectile dysfunction.

The Board understands that the August 2020 VA examiner was assessing the Veteran's TBI during service in 1963 and not the current residuals of TBI. The examiner specifically noted, "Mild traumatic brain injury is defined as a traumatically-induced physiological disruption of brain function...".

At the VA TBI examination in February 2018, the Veteran described the following history,

Veteran reported two concussive events during his service time. The first occurred in June 1963 while in training at P[a]rris [I]sland. He stated that was going through an obstacle course that included live fire which he got too close too. He was exposed to a nearby blast that lifted him off his feet and landed on his stomach striking his head and face on the ground. He stated he did not recall any residual symptoms as he was more concerned about getting out quickly. When he completed the course, he was amped up on adrenalin however, the drill sergeant noticed that he was bleeding from his nose and ear and was immediately sent to sick call. He does not recall any head pain following that evening or following days. The second event occurred in October 1963 while still at P[a]rris Island, he was going into the headquarters building which had designated "In" and "Out" doors that were large and heavy. He reported that as he approached the "In" door, an officer pushed the door open very quickly and with good force from inside the building, which struck the veteran in the head. He does not recall any details of the event until he came to in sick call. He had a laceration above his right eyebrow which he was given stitches for.

The examiner, a neurologist, stated,

Blows to the head and/or face such as those described by the veteran, are a common cause or trigger for patients to experience reoccurring chronic headaches and cognitive difficulty, as well as occasionally trigger neurobehavioral effects. However, veteran's description of symptoms including timing of when symptoms occurred, are not consistent with post traumatic diagnosis. Memory and neurobehavioral symptoms may be more closely related to age. It is unknown if veteran suffers from a mental health condition, however he did notate that he has occasional depression and anxiety. Therefore, it is impossible to determine which if any neurobehavioral symptoms are related to TBI vs. those caused by a possible mental health disorder without speculation.

At the VA TBI examination in November 2020, the Veteran described the following history,

On Oct 31, 1963 while stationed at Camp Lejeune, claimant was hit by a large heavy door. He lost consciousness for unknown period of time. The next thing he remembers is being in sick bay with his ear being sewn up. He experienced confusion upon awakening with trouble focusing. Claimant also recalls having a headache. His ear wound got infected.

Claimant was climbing through a live fire training course at Camp Geiger around Sept 1963. He got close to a bomb pit when an explosion went off. Claimant denies frank LOC [loss of consciousness]. He was bleeding from his nose. This training exercise blast injury was associated with confusion and he felt pain in his face.

These accounts are internally inconsistent; they are also inconsistent with the

contemporaneous medical evidence. Although there is evidence of a right eyebrow wound with three visits to the dispensary on October 31, November 1, and November 4, 1963, for sutures, treatment for a superficial infection, and suture removal, respectively, there is no evidence of any loss of consciousness. On Report of Medical Examination on December 10, 1963, just over one month from the Veteran's right eyebrow wound, the Veteran's head, face, and neurologic health were evaluated as normal. On the Reports of Medical History completed by the Veteran in conjunction with his physicals in January 1965, June 1966, and June 1967, he denied ever having frequent or severe headache and dizziness or fainting spells. He also denied being treated by clinics, physicians, healers, or other practitioners within the prior five years except for nervous stomach in October 1964.

As such, the Board finds that the August 2022 VA examiner's determination that the Veteran's TBI was mild is not contrary to the evidence of record.

The Board, therefore, concludes that, although the Veteran has current diagnoses of a current urinary disability, GERD, erectile dysfunction, hypertension, prostate cancer and BPH, and OSA, the evidence of record persuasively weighs against finding that the Veteran's disorders began during service, are otherwise related to his active duty service including exposure to contaminated water while stationed at Camp Lejeune, or are proximately due to or the result of, or aggravated beyond its natural progression by service-connected disability. 38 U.S.C. §§ 1110, 1131; Allen v. Brown, 7 Vet. App. 439 (1995) (en banc); 38 C.F.R. § 3.310(a).

Although the Veteran believes that his urinary disability, GERD, erectile dysfunction, hypertension, prostate disability including cancer, BPH, and OSA are related to his period of ACTDUTRA or service-connected disability, he is not competent to provide a nexus opinion regarding this issue. The issue is medically complex, requires specialized medical knowledge, and is outside the competence of the Veteran in this case because the record does not show that he has the skills or medical training to make such a determination. Jandreau v. Nicholson, 492 F.3d 1372, 1377 n.4 (Fed. Cir. 2007); see also Kahana v. Shinseki, 24. Vet. App. 428 (2011).

Consequently, the Board gives more probative weight to the medical evidence.

For the above reasons, the evidence is neither evenly balanced nor approximately so with regard to whether service connection is warranted for a urinary disability, GERD, erectile dysfunction, hypertension, prostate disability, BPH, and OSA. Rather, the evidence persuasively weighs against the claims. The benefit of the doubt doctrine, see 38 U.S.C. § 5107(b), is therefore not for application as to this claim. Lynch v. McDonough, 21 F.4th 776 (Fed. Cir. 2021) (en banc) (only when the evidence persuasively favors one side or another is the benefit of the doubt doctrine not for application).

John R. Doolittle, II

Veterans Law Judge

Board of Veterans' Appeals

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