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ORDER

New and material evidence having been received, the claim for service connection for a back disability is reopened.

New and material evidence having been received, the claim for service connection for a bilateral knee disability is reopened.

New and material evidence having been received, the claim for service connection for cesarean section is reopened.

Entitlement to service connection for irritable bowel syndrome (IBS) is granted.

Entitlement to service connection for breast cancer is granted pursuant to the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act of 2022 (PACT Act).

Entitlement to special monthly compensation (SMC) based on the loss of breast issue is granted, subject to laws and regulation controlling the payment of monetary benefits.

REMANDED

Entitlement to service connection for a psychiatric disability, to include mood and depressive disorder is remanded.

Entitlement to service connection for glaucoma is remanded.

Entitlement to service connection for frost bite, fingers and toes is remanded.

Entitlement to service connection for a neck condition (claimed as stiff neck) is remanded.

Entitlement to service connection for a low back condition is remanded.

Entitlement to service connection for right knee retropatellar pain syndrome (knee condition) is remanded.

Entitlement to service connection for left knee retropatellar pain syndrome (knee condition) is remanded.

Entitlement to service connection for fatigue is remanded.

Entitlement to service connection for abdominal trauma, other than IBS, is remanded.

Entitlement to service connection for migraine headaches is remanded.

Entitlement to service connection for sinusitis is remanded.

Entitlement to service connection for frequent urination is remanded.

Entitlement to service connection for cesarean sections is remanded.

Entitlement to service connection for breast cancer on a direct basis is remanded.

Entitlement to special monthly compensation (SMC) for anatomical loss of breast tissue prior to August 10, 2022 is remanded.

Whether clear and unmistakable error (CUE) exists in a January 2004 rating decision denying entitlement to service connection for a bilateral knee disability.

Whether CUE exists in a January 2004 rating decision denying entitlement to service connection for cesarean sections.

Whether CUE exists in a January 2004 rating decision denying entitlement to service connection for a hysterectomy.

Whether CUE exists in a January 2004 rating decision denying entitlement to service connection for a back disability.

FINDINGS OF FACT

1. In a January 2004 rating decision, the Agency of Original Jurisdiction (AOJ) denied service connection for a bilateral knee condition, cesarean section, and back trouble. The Veteran did not appeal the decision nor was new and material evidence received within one year.

2. Since the last final decision in January 2004 regarding the bilateral knee condition, cesarean section, and back trouble, the claims file includes evidence which relates to unestablished facts necessary to substantiate the claims of entitlement to service connection, and, if presumed credible, raises a reasonable possibility of substantiating the claims.

3. The evidence demonstrates that the Veteran served in the Southwest Asia theater of operations after August 2, 1990, and developed irritable bowel syndrome (IBS) to a compensable degree.

4. The evidence demonstrates that the Veteran served in the Southwest Asia theater of operations after August 2, 1990, and is therefore presumed to have toxic exposure; she developed left breast cancer and underwent a double mastectomy.

CONCLUSIONS OF LAW

1. The January 2004 rating decision denying service connection for a bilateral knee condition, cesarean section, and back trouble is final. 38 U.S.C. § 7105; 38 C.F.R. §§ 3.104, 20.1103.

2. Since the last final decision in January 2004 regarding the bilateral knee condition, cesarean section, and back trouble, new and material evidence has been received to warrant reopening of the claim of service connection for a bilateral knee condition, cesarean section, and back trouble. 38 U.S.C. §§ 5107, 5108, 7104; 38 C.F.R. § 3.156.

3. The criteria for service connection for IBS have been met. 38 U.S.C. § 1117; 38 C.F.R. § 3.317.

4. The criteria for entitlement to service connection for breast cancer are met. 38 U.S.C. §§ 1110, 1131; 38 C.F.R. §§ 3.102, 3.303, 3.307, 3.309, Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act of 2022 (PACT Act).

5. The criteria for an award of SMC based on the loss of at least 25% of breast tissue have been met. 38 U.S.C. § 1114(k).

REASONS AND BASES FOR FINDINGS AND CONCLUSIONS

The Veteran served on active duty from January 1980 to June 1997.

In January 2023, VA reported that the Department of Defense (DOD) confirmed that the Veteran met the definition of a "Persian Gulf Veteran" as specified by 38 U.S.C. § 1117. DOD Gulf War Veterans Information System (GWVIS) confirmed that the Veteran served in the Southwest Asia theater of operations, as defined by 38 C.F.R. § 3.317(e)(2), for at least one day between August 2, 1990, through July 31, 1991. In addition, in a December 2022 memorandum, VA reported that DoD confirmed that the Veteran had presumptive toxic exposure based on such service, as per 38 U.S.C. § 1119.

By way of procedural background, as will be discussed below, the Veteran's service-

connection claims for a bilateral knee disability, for a back disability and for cesarean sections were denied in a January 2004 rating decision, which became final.

In a December 2013 rating decision, the agency of original jurisdiction (AOJ) addressed each of the issues listed on the first page above, to include whether CUE existed in the January 2004 rating decisions to deny service connection.

Within one year, in June 2014, the Veteran submitted a typewritten statement addressing all decisions made in the December 2013 rating decision, articulating reasons why the decisions were incorrect, and asking the AOJ for "reconsideration," to include consideration of additionally submitted evidence. Because VA's current requirement that a Notice of Disagreement be filed on a specific form prescribed by the Secretary was not in effect in June 2014, the Board will accept the June 2014 correspondence as a timely Notice of Disagreement with each of the issues denied in the December 2013 rating decisions, to include the CUE claims.

Insofar as the Veteran has asserted that the AOJ committed CUE in the December 2013 rating decision, such assertions are misplaced, as the December 2013 rating decision has not become final, by dint of this appeal.

The Board notes that in an August 2019 rating decision, the Agency of Original Jurisdiction granted entitlement to service connection for a total hysterectomy; therefore, that issue is no longer on appeal.

Applications to Reopen Previously Denied Claims

If a claim of entitlement to service connection has previously been denied and that decision became final, the claim can be reopened and reconsidered only if new and material evidence is presented with respect to that claim. 38 U.S.C. § 5108. New evidence means existing evidence not previously submitted to agency decision-makers. Material evidence means existing evidence that, by itself or when considered with previous evidence of record, relates to an unestablished fact necessary to substantiate the claim. New and material evidence can be neither cumulative nor redundant of the evidence of record at the time of the last prior final denial of the claim sought to be reopened and must raise a reasonable possibility of substantiating the claim. 38 C.F.R. § 3.156(a).

The evidence VA is required to review for newness and materiality is that which has been submitted by the claimant since the last final disallowance of the claim on any basis. See Evans v. Brown, 9 Vet. App. 273 (1996). The prior evidence of record is important in determining newness and materiality for the purposes of deciding whether to reopen a claim. Id. For the purpose of determining whether a case should be reopened, the credibility of the evidence added to the record is to be presumed. Justus v. Principi, 3 Vet. App. 510, 513 (1992).

The threshold for determining whether new and material evidence raises a reasonable possibility of substantiating a claim is low. See Shade v. Shinseki, 24 Vet. App. 110, 117 (2010). Furthermore, in determining whether this low threshold is met, the VA should not limit its consideration to whether the newly submitted evidence relates specifically to the reason why the claim was last denied, but instead should ask whether the evidence could reasonably substantiate the claim were the claim to be reopened, to include activating the Secretary's duty to assist. Shade, 24 Vet. App. at 118.

New and material evidence having been received, the claims of entitlement to service connection for bilateral knee condition, cesarean section, and back trouble are reopened.

In a January 2004 rating decision, the AOJ denied entitlement to service connection for a bilateral knee condition, cesarean section, and back trouble finding that current chronic bilateral knee and back disabilities were not shown. Also, there was no permanent residual or chronic disability subject to service connection regarding the Veteran's in-service cesarean sections.

The Veteran did not file a Notice of Disagreement with the January 2004 rating decisions and no new and material evidence was received within the appeal period. Therefore, the decision is final.

In January 2013, the Veteran filed a new claim seeking to reopen the underlying claims for right and left knee conditions, residuals of a cesarean section, and back trouble.

Since the last final decision, in February 2022, the Veteran's representative reported that the Veteran suffered from complications of the in-service cesarean section, including lower abdominal scars and gynecological complications.

Treatment records also show treatment for knee pain, and the April 2019 VA examinations included such diagnoses as lumbosacral strain as well as right and left knee retropatellar pain. The Veteran reported that during service she began to experience pain behind both knees during running exercises. She stated that she was seen by medical staff at that time and placed on profile along with pain medication. She claimed that she continued to experience pain to the back of her knee. She also reported that since the in-service fall from a tree, she continued to have periodic lower back pain

This evidence is new as it was not before adjudicators at the time of the prior final decision in January 2004; it is also material as it supports elements of service connection missing at the time of the prior decision. Accordingly, the claims for service connection for a bilateral knee condition, cesarean section, and back trouble are reopened.

Service Connection – IBS

As noted above, the Department of Defense has confirmed that the Veteran had service in Southwest Asia, and is a Persian Gulf Veteran as defined by statute. Under 38 C.F.R. § 3.317, functional gastrointestinal disorders, to specifically include IBS, are presumed to be service connected for Persian Gulf Veterans if manifested to a compensable degree after service. See 38 C.F.R. § 3.317(a)(2)(3). Here, a November 2014 VA examiner confirmed the presence of IBS manifesting in alternating constipation and diarrhea and weight loss, and requiring continuous medication. Given the Veteran's verified Persian Gulf service and post-service IBS diagnosis, service-connection for IBS is presumed under the law. The benefit sought on appeal is granted.

Service Connection – Breast Cancer

On August 10, 2022, the President signed into law the Honoring Our Promise to Address Comprehensive Toxics (PACT) Act of 2022. Among other things, defined which veterans may be presumed to have been exposed to burn pits and other toxins, and identified disabilities that may be presumed to be related to such exposures.

Here, the DoD has confirmed the Veteran's toxic exposure, to include burn pits, as identified under the provisions of 38 U.S.C. § 1119 by dint of her service in the Persian Gulf after August 2, 1990. See the December 3, 2022 VA Memorandum. Under 38 U.S.C. § 1120, reproductive cancers of any type are presumed to be related to such exposure. The Secretary has identified breast cancer as a type of reproductive cancer for the purposes of this presumption. VBA Letter 20-22-10, Processing Claims Involving the PACT Act, 87 Fed. Reg. 78,543 (Dec. 22, 2022).

The Veteran was diagnosed with left breast cancer in 2012. Accordingly, service-connection for breast cancer is presumed.

The Board will address whether service connection may be granted on a direct basis in the Remand section below.

Special Monthly Compensation (SMC) – Loss of Breast Tissue

SMC at the (k) rate is payable for each anatomical loss or loss of use of one hand, one foot, both buttocks, one or more creative organs, blindness of one eye having only light perception, deafness of both ears, having absence of air and bone conduction, complete organic aphonia with constant inability to communicate by speech or, in the case of a woman veteran, loss of 25% or more of tissue from a single breast or both breasts in combination, or following receipt of radiation treatment of breast tissue. 38 U.S.C. § 1114(k), 38 C.F.R. § 3.350(a).

Here, the Veteran underwent a double mastectomy following her breast cancer diagnosis. Accordingly, SMC based on loss of 25% or more of breast tissue is warranted under 38 U.S.C.

§ 1114(k), subject to laws and regulations controlling the payment of monetary benefits.

As a more favorable effective date for this SMC award may be available if service-connection for breast cancer can be established on a direct basis, the question of whether SMC can be awarded prior to the effectuation of the PACT Act, i.e., prior to August 10, 2022, also remains on appeal and is discussed in the Remand section below.

REASONS FOR REMAND

Entitlement to service connection for a psychiatric disability, to include mood and depressive disorder, glaucoma and residuals of frost bite in fingers and toes is remanded.

Regarding the psychiatric disability, in a February 2022 informal hearing presentation, the Veteran's representative indicated that the Veteran had a longstanding history of depression symptomatology since her time in the Army and that she was diagnosed with depression shortly after her service.

Service treatment records show that the Veteran was referred to a mental status evaluation in October 1989 with no identified psychiatric disorder. Post-service treatment records reflect a diagnosis of depression in April 2001.

Regarding glaucoma, in a February 2022 informal hearing presentation, the Veteran's representative reported that the Veteran's glaucoma began developing during service and not in the four years between her getting out and when it was mentioned in 2001.

Service treatment records show that in March 1980, the Veteran's left eye was red due to viral conjunctivitis. In July 1983, she had complaints of epiphora and pruritis of the eyes. She also had a bump in the right eye. Her left eye was irritated in July 1993.

Post-service, an October 1999 treatment record from Tricare included an eye examination that showed that glaucoma was suspected with a high probability. An April 2001 record included a diagnosis of glaucoma.

Regarding residuals of frostbite, in a February 2022 informal hearing presentation, the Veteran's representative reported that the Veteran developed frostbite in her fingers and toes due to cold weather exposure during her service. She still continued to experience residuals of her frostbite and developed a painful left antecubital lump. She experienced intermittent numbness/tingling in her fingers and was diagnosed with hypesthesia in March 2010.

Service treatment records documented swollen fingers with a fever in January 1982. She had equal swelling in her feet by at the end of the day that was resolved with elevation in January 1994.

Post-service, March 2010 private treatment records noted complaints of tenderness and occasional numbness in the hand that impacted the distribution of the median nerve and the 1st through 3rd digits. The impression was that she had a lipomatous mass with sensation of numbness and possible nerve compression. She underwent an excision of left arm (antecubital) lipoma.

The Veteran has not been afforded VA examinations addressing the nature and etiology of a psychiatric disorder, residuals of frostbite, and glaucoma. VA is obliged to provide an examination when the record contains competent evidence that the claimant has a current disability or signs and symptoms of a current disability, the record indicates that the disability or signs and symptoms of disability may be associated with active service; and the record does not contain sufficient information to make a decision on the claim. 38 U.S.C. § 5103A(d); McLendon v. Nicholson, 20 Vet. App. 79 (2006). Therefore, necessary examinations should be scheduled on remand.

Entitlement to service connection for right and left knee retropatellar pain syndrome, a low back condition, and a neck condition is remanded.

Regarding a bilateral knee condition, the Veteran contends that her bilateral knee condition is related to service. At an April 2019 VA examination, the Veteran reported that during service she began to experience pain behind both knees during running exercises. She stated

that she was seen by medical staff at that time and placed on profile along with pain medication. She claimed that she continued to experience pain to the back of her knee.

Service treatment records show that the Veteran underwent x-rays in March 1982 to rule out a right knee fracture after she injured her right knee when she fell over a tree while participating in war games. There was an apparent soft tissue density adjacent to the medial aspect of the distal third of the femur most likely representing an artifact. A January 1995 radiologic report noted that the Veteran was seen to rule out Baker's cyst. No evidence of mass lesions was shown within the popliteal fossa. In March 1997, the Veteran had complaints of bilateral knee pain for one month duration. She reported sharp pain wile going up the stairs and her knees occasionally "give out". She was given a provisional diagnosis of retropatellar pain syndrome.

The Veteran was diagnosed with right and left knee retropatellar pain during and April 2019 VA examination. The VA examiner opined that the Veteran's current right and left knee conditions were less likely than not incurred in or caused by service. The examiner stated the during service, the Veteran's right and left knee retropatellar pain syndrome was acute only. According to Veteran's records she was referred to physical therapy after complaints of bilateral knee pain. There, however, were no other complaints and or treatment for a knee condition during the rest of her career. Additionally, there were no complaints of a knee condition noted on separation examination. The examiner added that chronicity of care or a nexus could not be established.

Regarding a neck condition, the Veteran and her representative reported that the Veteran's neck pain began during service. She reported that she frequently woke up with a stiff neck and was only treated with ice and heat. She reported that she experienced pain in her neck and shoulder area ever since. She indicated that her current symptoms were the same as those she experienced in service. See February 2022 Third Party Correspondence.

Service treatment records dated in March 1981 show complaints of a stiff sore neck due to sleeping. She was treated with analgesic balm and aspirin. She was seen again in April 1981 for complaints of a stiff neck for two weeks.

Post-service, she was diagnosed with cervical strain status post motor vehicle accident in October 2011. See treatment records from Tuomey Healthcare System.

During an April 2019 VA examination, the Veteran was diagnosed with neck strain. The VA examiner opined that the Veteran's current neck condition was less likely than not related to service. The examiner reasoned that there was no evidence in records supporting a chronic condition of "stiff neck." The examiner added that although it appeared that Veteran may be experiencing a current cervical strain, it had been 21 years since her separation from service, which would make this condition less likely than not caused by her time in service.

Regarding a low back condition, the Veteran contends that her back condition is related to service and that she continues to have periodic lower back pain since she fell out of a tree in service. See April 2019 VA examination.

Service treatment records show that in March 1982, she fell over a tree while participating in war games. In July 1989, she had complaints of low back pain from a spinal tap approximately one month prior. She underwent spinal anesthesia approximately 15 months prior. She was diagnosed with mechanical low back pain. In December 1991, she had low back pain. In April 1996, she had complaints of low back pain with pregnancy.

On April 2019 VA examination, the Veteran was diagnosed with lumbosacral strain. The examiner opined that the lumbosacral strain was less likely than not related to service. The examiner reasoned that the condition during service was acute only. The examiner stated that there was no subsequent records or documentation on separation examination of a lower back condition. There was no evidence of chronicity of care. A nexus was not established.

The Board finds that the examiner's April 2019 opinions were not adequately explained. The opinions were primarily based upon the lack of continued treatment and lack of contemporaneous treatment records. The mere fact that medical records do not establish chronicity after service is not, in and of itself, a sufficient basis on which to rest a medical conclusion. The examiner did not appear to consider the Veteran's lay statements regarding in-service onset and post-service symptomology.

Entitlement to service connection for fatigue, sinusitis, migraine headaches, and abdominal trauma other than IBS, is remanded.

The Veteran contends that she has fatigue, sinusitis, migraine headaches, and abdominal trauma that are related to service. The Board notes that it has granted entitlement to service connection for IBS in this decision. However, it is possible the Veteran has other abdominal trauma or distress disabilities present other than IBS, given the medical assessments of record. As such the issue of entitlement to service connection for an abdominal trauma disability other than IBS remains on appeal.

As noted above, in January 2023, the Department of Defense (DOD) confirmed that the Veteran met the definition of a "Persian Gulf Veteran" as specified by 38 U.S.C. § 1117. DOD Gulf War Veterans Information System (GWVIS) confirmed that the Veteran served in the Southwest Asia theater of operations, as defined by 38 C.F.R. § 3.317(e)(2), for at least one day between August 2, 1990, through July 31, 1991. The Veteran is also presumed to have been exposed to particulate matter and burn pits.

On review of the record the Veteran's service treatment records reflect treatment for symptoms of sinus congestion, headaches, as well as abdominal issues.

More specifically, an October 1979 report of medical history indicated that the Veteran has had headaches. An accompanying report of medical examination did not document any current headache. In January 1980 and April 1981, she had complaints of headache and also felt run down in April 1981. An undated record noted complaints of stomach pain with headaches for one week. She had lower abdominal pain in July 1980. Another record noted complaints of a urinary tract infection for three months. She felt run down in April 1982. In August 1982, she was assessed with irritable bowel and treated with stool softeners. In March 1983, she had complaints of pain in the lower stomach and had diarrhea and nausea for a month. She was assessed with inhalant allergies in July 1983 due to increased sneezing and rhinorrhea for weeks. She had right lower quadrant pain in August 1983. She was seen in the emergency department for complaints of abdominal pain and headaches for three weeks in September 1984. The diagnosis was chronic abdominal pain of an unknown etiology. Another September 1984 record noted that she had abdominal pain, hard bowel movements, then diarrhea for three days. She experienced abdominal trauma and pain after falling on her skis four days ago.

She was assessed with an upper respiratory infection; rule out bronchitis in June 1986. In February 1987, she had nausea and abdominal cramping. In 1987, she had complaints of vomiting and headaches and was diagnosed with viral syndrome. Subsequently in April 1987, she had resolved viral syndrome. She underwent a repeat low transverse cesarean section in April 1988. In May 1988, she had complaints of headache, stuffed sinuses, and frequent diarrhea and was diagnosed with gastroenteritis. In September 1988, she was seen for soft stools, an upset stomach, nasal congestion, and a headache and was diagnosed with viral syndrome. She sought treatment for a stomachache and diarrhea and was diagnosed with gastroenteritis in April 1989. Subsequently, in May 1989, she complained of nausea, vomiting, diarrhea, headache, and sinus congestion for two days and was diagnosed with gastroenteritis. A September 1989 report of medical history indicated that the Veteran had headaches for four days and a cough. In July 1990, she had abdominal pain and was diagnosed with gastritis versus viral gastroenteritis. She was treated for abdominal pain and diarrhea and assessed with pre-ulcerative colitis in December 1991. She was seen later in December for a stomachache and nausea. In August 1992, she was seen for increased fatigue. She had complaints of migraine headaches in November 1995. In December 1995, the Veteran had complaints of headaches, which went away at night. A history of fibroids was noted in the record. She had mild abdominal cramping and was currently pregnant.

Regarding fatigue, in a February 2022 informal hearing presentation, the representative reported that the Veteran experienced whole body fatigue that dated back to when she was in service and that complaints of fatigue were documented in her service treatment records. The representative noted that the Veteran repeatedly sought help for her "undiagnosed" fatigue, but never received an official diagnosis of chronic fatigue syndrome. She required continuous medication to control her symptoms and took Tamoxifen to manage her general fatigue. Also, her breast cancer treatment and IBS made her fatigue worse.

During the January 2015 VA examination, the examiner opined that it was less likely than not that the Veteran's current condition fit the criteria for a diagnosis of chronic fatigue

syndrome nor was their evidence in the record of such a diagnosis. Therefore, there was no diagnosis for service connection.

The Board finds the January 2015 VA opinion inadequate. The examiner relied solely on the determination that the Veteran did not meet the criteria for chronic fatigue syndrome. Therefore, a new VA opinion necessary. The examiner should also address the relationship between her symptoms and an undiagnosed illness or a medically unexplained chronic multisymptom illness, particularly as it would present as a result of service in the Gulf War.

Regarding stomach trauma, in a February 2022 informal hearing presentation, the representative reported that the Veteran was treated for abdominal complaints in service. She developed irritable bowel syndrome due to stomach issues and abdominal trauma during service. She was given stool softeners during service and received continuous treatment ever since. In July 2001, she suffered an abdominal wall hernia containing the bowel, and subsequently treated for nondistended bowel loop. A 2005 examiner diagnosed her with ileus. The representative reported that the Veteran's bowel could not contract normally to remove waste from her body, which caused abdominal pain that could only be relieved by bowel movements, passing gas, or belching.

Post-service treatment records from Tuomey Healthcare System show treatment for abdominal pain diagnosed as ileus in June and August 2005. A March 2010 record noted a history of an abdominoplasty.

At the November 2014 VA examinations, the examiner found that the Veteran did not have and never had any stomach or duodenum conditions. The examiner opined that the Veteran's growling stomach was not at least as likely as not incurred in or caused by service. The examiner reasoned that research of the medical literature, medical history, and VBMS did not demonstrate evidence of connection of the stomach growling and bowel symptoms to the trauma incurred in service.

Regarding headaches, in a February 2022 informal hearing presentation, the Veteran's representative indicated that the Veteran's headaches were related to her glaucoma. The representative also reported that the Veteran's migraines resulted from noise trauma from service. The Veteran indicated that that she has experienced migraines ever since service and repeatedly sought treatment for her head pain. The Veteran suggested that her migraine headaches began in or were aggravated by service.

Post-service treatment records document complaints of a headache in October 2000. Records from Tricare Prime identified headaches in the active list of problems dated in February 2010. Another private record documented a headache with cervical pain status post motor vehicle accident in October 2011.

During her October 2014 VA examination, the Veteran reported that during her active duty she frequently observed a headache with gastrointestinal issues. The examiner determined that the Veteran's current headache would qualify as migraine without aura, but there is no way to say if her current headache is the same as her headaches while on active duty.

During an April 2019 VA examination, the Veteran reported that she experienced headaches that she describes as migraines several times a week. She attributed her headaches to her glaucoma. The VA examiner opined that the Veteran's claimed condition was less likely than not incurred in or caused by service. The examiner reasoned that the Veteran's symptoms were subjective only and there was no objective evidence of a chronic headache condition. A nexus had not been established.

Regarding sinusitis, in a February 2022 informal hearing presentation, the representative reported that the Veteran's sinusitis began in 1980 when she experienced nasal congestion, headaches, sneezing, and a runny nose. The representative indicated that the Veteran's upper respiratory infection diagnosed in 1988 was sinusitis. The Veteran has had the same symptoms that she experienced in service.

Post-service treatment records show treatment for sinus fullness, upper respiratory infection, allergic rhinitis in April 2001, February 2009 and 2010, and March 2010.

On April 2019 VA examination, the Veteran reported that she was treated in service for nasal congestion and continued to have these symptoms throughout her career. She continues to experience occasional nasal congestion, runny nose, headache, and sneezing. The examiner found that the Veteran has never been diagnosed with a sinus, nose, throat, larynx, or pharynx condition. The examiner opined that the Veteran's claimed condition was less likely than not incurred in or caused by service. The examiner reasoned that there was no objective evidence of a chronic condition and there was no diagnosis or treatment for sinusitis while in service. A nexus had not been established.

Here, the April 2019 VA examiner did not appear to consider the multiple in-service treatment for headaches, stomach and gastrointestinal issues, viral syndromes, upper respiratory infections, stuffed sinuses, congestion, sneezing and rhinorrhea as well as the Veteran's contentions of experiencing the same symptoms that she experienced in service. The examiner should also address the relationship between her symptoms and an undiagnosed illness or a medically unexplained chronic multisymptom illness, particularly as it would present as a result of service in the Gulf War. Therefore, new opinions are necessary.

The Board recognizes that for certain disabilities such as rhinitis and sinusitis, confirmation of the presence of the disability may be enough to award service connection on a presumptive basis under recently amended and added statutes and regulations governing VA's benefits. Nevertheless, even if on remand such disabilities are confirmed, favorable medical opinions directly attributing such disabilities to service may serve to allow for a service-connection award on a basis that pre-dates the enactment of the more favorable presumptions.

Entitlement to service connection for frequent urination is remanded.

In a February 2022 informal hearing presentation, the representative claimed that the Veteran's frequent urination was a complication of her symptomatic fibroids that manifested during service and resulted in a total hysterectomy. The representative indicated that the Veteran's fibroids became bigger and compressed her bladder resulting in frequent urination. Her voiding dysfunction/urinary incontinence was a side effect of her service-connected hysterectomy.

In July 1980, a service treatment record noted complaints of a urinary tract infection for three months. In May 1981 she had complaints of vaginal pruritis. She was seen in the emergency room for a "bladder infection". The diagnosis was endometriosis/cervicitis. She was seen again for a vaginal infection in September 1981. In March 1983, she had frequent urination. In July 1983, a right ovarian mass was found and diagnosed as probably ovarian cyst. In May 1985, she underwent a low transverse primary cesarean section. In May 1987, she was treated for a vaginal yeast infection with lower pelvic pain. She underwent a repeat low transverse cesarean section in April 1988. She had complaints of increased urination in December 1991. In August 1992, she was seen for a vaginal infection. In December 1995, a history of fibroids was noted in the record. She had mild abdominal cramping and was currently pregnant. In June 1996, she underwent a repeat low transverse cesarean section and bilateral tubal ligation. A February 1997 retirement report of medical history noted that she underwent three cesarean sections from having children in 1985, 1987, and 1996. The examiner noted that the Veteran reported increased cramping and clots during menstrual cycles. She had a history of fibroids. An accompanying retirement report of medical examination noted that the cesarean scar above her lower abdomen was well-healed. A history of fibroids was noted.

On November 2014 VA examination, the Veteran was diagnosed with incontinence and the cause of the urinary incontinence was not identified. The examiner opined that the condition was not at least as likely as not incurred in or caused by service. Review of the medical literature and veteran's medial history do not provide a connection of the Veteran's service to current condition. The examiner did not appear to consider the Veteran's in-service complaints and treatment for frequent urination, bladder infection, and urinary tract infections. The examiner also did not consider the Veteran's contentions indicating that her incontinence was related to her uterine fibroids in-service and/or secondary to her service-connected total hysterectomy. In April 2022, the Veteran submitted articles regarding urinary incontinence after a total hysterectomy. Therefore, a new VA opinion is necessary.

Entitlement to service connection for cesarean sections is remanded.

Here, while an April 2019 examiner opined that the Veteran's cesarean sections were incurred in service, the Board notes that it is not in dispute that the Veteran underwent three in-service cesarean sections in 1985, 1988, and 1996. However, the current residuals or complications of the in-service cesarean sections remain unclear. At the time of examination, the examiner noted that the Veteran reported no residual symptoms. The examiner added that there was no visible cesarean section scar as Veteran had a tummy tuck. It does not appear that the Veteran considered the Veteran's contentions of having complications of her in-service cesarean sections such as cut nerves, abdominal scars, and gynecological complications. See February 2022 informal hearing presentation. Therefore, a new opinion is necessary.

Entitlement to service connection for left breast cancer on a direct basis is remanded.

While service connection for breast cancer has been presumed under the PACT Act, additional benefit may be available if service connection can alternatively be established on a direct basis. As such, the issue remains on appeal to address direct service connection.

In a February 2022 informal hearing presentation, the Veteran's representative noted that the Veteran had a nontender left breast nodule at the time of her December 1994 examination. The representative indicated that this turned into the Veteran's breast cancer. She was diagnosed with fibrocystic breast disease and atypical ductal hyperplasia and underwent a lumpectomy for her non-movable breast lump in 2009. In October 2011, there was increased density in the lump in her left breast. She underwent breast mammograms and ultrasound and was diagnosed with breast cancer in 2012. She underwent a double mastectomy that left her with residuals and scarring. She had breast reconstructive surgery in 2013. Following surgery, she had decreased range of motion in her left arm, continuous torso swelling, and pain/swelling in her axillary region. The representative reported that although Veteran was not diagnosed with breast cancer until years after her service, she experienced symptoms from service until the present.

Service treatment records revealed fibrocystic left breast tissue in December 1994. In August 1996, a mammogram showed no radiographic evidence or malignancy at the time.

On July 2014 VA examination, the examiner reported a history of the Veteran being diagnosed with cystic fibrocystic disease in November 2007, atypical ductal hypotrophy in February 2008, left breast cancer February 2012, and left arm range of motion swelling/pain in axillary region likely due to reconstruction and had follow up with plastic surgery. However, no opinion was provided regarding whether or not the claimed condition was either incurred in or caused by service.

On April 2019 VA examination, the Veteran was diagnosed with breast cancer of the left breast status post mastectomy. The examiner opined that the condition was not at least as likely as not incurred in or caused by service. The examiner reasoned that there was no evidence of a diagnosis of breast cancer while in service. The examiner acknowledged that the Veteran was diagnosed with fibrocystic tissue in the left breast in December 1994. Subsequent mammograms in 2007 and 2008 after service did not indicate a malignant condition as well. The Veteran was not diagnosed with left breast cancer with subsequent mastectomy until 2012, which was 15 years after separation from service. Therefore, a nexus had not been established. The Board finds that the examiner's April 2019 opinion was not adequately explained. The examiner's opinion was primarily based upon the lack of a diagnosis of breast cancer in service and for many years thereafter. The mere fact that medical records do not establish a diagnosis in service is not, in and of itself, a sufficient basis on which to rest a medical conclusion. The examiner did not appear to consider the Veteran's lay statements regarding in-service onset and post-service symptomology. The Veteran indicated that the lump found in her left breast in 1994, fibrocystic left breast tissue, is related to her left breast cancer. She reported that there was no intervention or biopsies at the time, and she was diagnosed with left breast cancer in 2012 with a subsequent mastectomy. She reported that she had a lumpectomy of the left breast prior to the mastectomy. Therefore, a new VA opinion is necessary that considers the Veteran's contentions.

Entitlement to SMC for anatomical loss of breast tissue prior to August 10, 2022 is remanded.

Because entitlement to SMC for loss of breast tissue, due to breast cancer, prior to August

10, 2022 is dependent upon a decision on the issue of entitlement to service connection for breast cancer on a direct basis, the claims are inextricably intertwined. Thus, consideration of the SMC claim must be deferred pending completion of the additional development being directed concerning the underlying claim for service connection for breast cancer on a direct basis.

Whether clear and unmistakable error (CUE) exists in a January 2004 rating decision denying entitlement to service connection for a bilateral knee disability.

Whether CUE exists in a January 2004 rating decision denying entitlement to service connection for cesarean sections.

Whether CUE exists in a January 2004 rating decision denying entitlement to service connection for a hysterectomy.

Whether CUE exists in a January 2004 rating decision denying entitlement to service connection for a back disability.

As discussed above, in a December 2013 rating decision, the AOJ denied the Veteran's requests to revise the January 2004 rating decision's denials of entitlement to service connection for a bilateral knee disability, cesarean sections, a hysterectomy and a back disability, based on CUE. The Veteran filed a timely Notice of Disagreement with the December 2013 rating decision in June 2014. To date, the AOJ has yet to issue a Statement of the Case addressing these CUE allegations. Although an April 2019 Statement of the Case referenced the Veteran's assertion of error in its discussion of the Veteran's service-connection claims for the knees, back and cesarean sections, it did not appear to actually adjudicate the matter of whether CUE existed in January 2004, focusing largely on additional development that did and did not occur after the January 2004 rating decision, and whether the evidence currently supports a finding of a service-connection award. Such are separate issues, and the Board finds that the CUE claims must be squarely adjudicated by the AOJ before they are ripe for Board review. See 38 U.S.C. § 7104; 38 C.F.R. §§ 19.26, 19.29; Manlincon v. West, 12 Vet. App. 238, 240-41 (1999). Thus, these issues are remanded for the AOJ to issue a Statement of the Case (SOC).

The matters are REMANDED for the following action:

1. Obtain, and associate with the claims file, the Veteran's complete service personnel file.

2. Obtain any outstanding records of pertinent medical treatment from VA or private health care providers. With the Veteran's assistance, obtain copies of any pertinent records and add them to the claims file.

3. Schedule the Veteran for an appropriate examination to ascertain the nature and etiology of any psychiatric disability, to include mood and depressive disorder. The examiner should review the entire claims file, to include a copy of this Remand, and the opinion should include discussion of the Veteran's documented history and assertions. The examiner should provide responses to the following:

a) Please identify all of the Veteran's current psychiatric disorders, including mood or depressive disorder.

b) For each identified psychiatric disorder, including mood or depressive disorder opine whether it is at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) had onset in service, or is otherwise related to an in-service injury, event, or disease.

The examiner should consider that the Veteran was referred to a mental status examination while in service.

Also, the examiner should specifically address the Veteran's contentions indicating that she has had longstanding psychiatric symptoms since her time in the Army.

The examiner should set forth all examination findings, along with complete rationale for the conclusions reached, in a printed report. Complete rationale should include an

explanation of the evidence used in support of the conclusion, as well as an explanation as to why such evidence supports the conclusion.

4. Schedule the Veteran for an appropriate examination to ascertain the nature and etiology of glaucoma. The examiner should review the entire claims file, to include a copy of this Remand, and the opinion should include discussion of the Veteran's documented history and assertions.

The examiner should opine whether glaucoma is at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) had onset in service, or is otherwise related to an in-service injury, event, or disease, to specifically include exposure to burn pits and other toxins during service in Southwest Asia.

The examiner should consider in-service treatment records dated in March 1980 in which her left eye was red due to viral conjunctivitis. In July 1983, she had complaints of epiphora and pruritis of the eyes. She also had a bump in the right eye. Her left eye was irritated in July 1993.

The examiner should specifically address the Veteran's contentions indicating that her glaucoma began developing during service and was diagnosed shortly thereafter. Also, an October 1999 treatment record found that there was a high probability of glaucoma.

The examiner should set forth all examination findings, along with complete rationale for the conclusions reached, in a printed report. Complete rationale should include an explanation of the evidence used in support of the conclusion, as well as an explanation as to why such evidence supports the conclusion.

5. Schedule the Veteran for an appropriate examination to ascertain the nature and etiology of residuals of frostbite of the fingers and toes. The examiner should review the entire claims file, to include a copy of this Remand, and the opinion should include discussion of the Veteran's documented history and assertions. The examiner should provide responses to the following:

a) Please identify all of the Veteran's current residuals of frostbite of the fingers and toes, if any. Address the Veteran's contentions indicating that the left arm (antecubital) lipoma is a residual of frostbite.

b) For each identified residual of frostbite and left arm (antecubital) lipoma status post excision opine whether it is at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) had onset in service, or is otherwise related to an in-service injury, event, or disease.

The examiner should consider in-service treatment for swollen fingers and feet in January 1982 and 1994 as well as post-service treatment records documenting tenderness and occasional numbness in the hand requiring excision of left arm (antecubital) lipoma

Also, the examiner should specifically address the Veteran's contentions that she developed frostbite in her fingers and toes due to cold weather exposure while in service and continued to experience intermittent numbness/tingling in her fingers. The examiner should note that the Veteran is competent to report being exposed to cold weather in service as it occurred, and is also competent to report the symptoms she experienced. Thus, acknowledging the lack of contemporaneous medical documentation, on its own, is not a valid basis for a negative nexus opinion. That stated, if there is a medical reason that supports or calls into question the Veteran's report of symptom history, this should be explained. For example, is the current nature of the Veteran's disability medically consistent with cold weather exposure and frostbite described by the Veteran as occurring in service? Why or why not?

The examiner should set forth all examination findings, along with complete rationale for the conclusions reached, in a printed report. Complete rationale should include an explanation of the evidence used in support of the conclusion, as well as an explanation as to why such evidence supports the conclusion.

6. Schedule the Veteran for an appropriate examination to ascertain the nature and etiology of her bilateral knee, neck, and low back conditions. The examiner should review the entire

claims file, to include a copy of this Remand, and the opinion should include discussion of the Veteran's documented history and assertions. The examiner should provide responses to the following:

a) Please identify all of the Veteran's current bilateral knee, back, and neck conditions. The examiner should consider that the Veteran has been diagnosed with bilateral knee retropatellar pain as well as cervical and lumbosacral strain.

b) For each identified bilateral knee, cervical, and back condition, opine whether it is at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) had onset in service, or is otherwise related to an in-service injury, event, or disease.

The examiner should consider in-service treatment records that document complaints of a stiff sore neck due to sleeping in March 1981. She was treated with analgesic balm and aspirin. She was seen again in April 1981 for complaints of a stiff neck for two weeks. She fell over a tree in March 1982 and underwent treatment for her knee at the same time as well as in January 1995 and May 1997. She also had back complaints in July 1989, December 1991, and April 1996 as explained in further detail in the Remand discussion above. The examiner should consider the intercurrent motor vehicle accident in 2011 in which the Veteran injured her neck.

Also, the examiner should specifically address the Veteran's contentions that while in service, she woke up with a stiff neck and was treated with ice. She also indicated that she injured her back and began to have pain behind both knees during running exercises in service and continued to have an occasional stiff neck after a night's rest, periodic low back pain, and pain to the back of the knee since service. The examiner should note that the Veteran is competent to report a stiff neck after sleeping, hurting her back in service, and experiencing pain behind both knees during running exercises as it occurred, and is also competent to report the symptoms she experienced.

If there is a medical reason that supports or calls into question the Veteran's report of symptom history, this should be explained. For example, is the current nature of the Veteran's disabilities medically consistent with incidents described by the Veteran as occurring in service? Why or why not?

The examiner should set forth all examination findings, along with complete rationale for the conclusions reached, in a printed report. Complete rationale should include an explanation of the evidence used in support of the conclusion, as well as an explanation as to why such evidence supports the conclusion.

7. Schedule the Veteran for an appropriate VA Gulf War medical examination for the Veteran's symptoms of headaches, sinusitis/rhinitis/respiratory issues abdominal pain/trauma other than IBS, and fatigue, to include as to do an undiagnosed illness or a diagnosable chronic multi-symptom illness. The examiner should review the entire claims file, to include a copy of this Remand, and the opinion should include discussion of the Veteran's documented history and assertions.

The examiner is asked to provide a response to the following:

a) Whether the symptoms are due to:

i. an undiagnosed illness; or

ii. medically unexplained chronic multisystem illness; or

iii. diagnosable chronic multi-symptom illness with a partially explained etiology; or

iv. is a disease with a clear and specific etiology and diagnosis.

b) If the examiner determines that the symptom(s) is/are manifestations of either a diagnosable chronic multi-symptom illness with a partially explained etiology or with a clear and specific etiology and diagnosis, then the examiner should opine whether it is at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) that such was incurred in or is otherwise related to the Veteran's active

service, including in-service treatment on multiple occasions as summarized in the Remand discussion above, and/or exposure to burn pits and other toxins.

For clarity, if the Veteran has an abdominal disability separate and apart from IBS, this should be made clear (as IBS is already considered a service-connected disability). Does the Veteran have an abdominal disability that is caused or aggravated by the Veteran's service-connected IBS?

Does the Veteran have a fatigue disability that is caused or aggravated by service-connected IBS and/or breast cancer and its treatments?

In providing a response, The examiner is requested to consider the Veteran's lay statements, including:

" The Veteran's assertion that she was treated for abdominal complaints in service, and developed abdominal trauma during service. She was given stool softeners during service and received continuous treatment ever since.

" The Veteran's assertion that was treated in service for nasal congestion and continued to have these symptoms throughout her career. She continued to experience occasional nasal congestion, runny nose, headache, and sneezing.

" The Veteran's assertion that she experienced whole body fatigue that dated back to when she was in service and that complaints of fatigue were documented in her service treatment records. She repeatedly sought help for her "undiagnosed" fatigue, but never received an official diagnosis of chronic fatigue syndrome. She required continuous medication to control her symptoms and took Tamoxifen to manage her general fatigue. Also, her breast cancer treatment and IBS made her fatigue worse.

" The Veteran's assertion that she went to sick call in service and has experienced migraines ever since service and has sought treatment for her head pain. She also suggested that her headaches were related to her noise trauma in service, and/or her glaucoma and gastrointestinal issues. She alleges that her migraine headaches began in or were aggravated by service.

If there is any medical reason to accept or reject the proposition that the Veteran's reported injury and symptoms in service and thereafter represented the onset of her current disability, this should be noted. Stated another way, do the Veteran's reports about her symptoms align with how the currently diagnosed disability is known to develop or are the Veteran's reports generally inconsistent with medical knowledge or implausible.

A rationale must be provided for all opinions.

8. Schedule an examination with an appropriate clinician regarding the Veteran's claimed frequent urination. The examiner should review the entire claims file, to include a copy of this Remand, and the opinion should include discussion of the Veteran's documented history and assertions. The examiner should provide responses to the following:

a) Identify all of the Veteran's disabilities related to frequent urination.

b) For each disability identified, opine whether it is at least as likely as not (i.e., likelihood is at least approximately balanced or nearly equal, if not higher) that it had onset in, or is otherwise related to service, to include in-service exposure to burn pits and other toxins.

c) For each disability identified, opine whether it is at least as likely as not (i.e., likelihood is at least approximately balanced or nearly equal, if not higher) that it is either i) caused, or ii) aggravated by the Veteran's service-connected hysterectomy.

In doing so, the examiner should also address the Veteran's documented in-service treatment outlined in further detail in the Remand discussion above as well as the article submitted in April 2022 regarding urinary incontinence after a total hysterectomy.

The examiner should also specifically address the Veteran's concern that while in service, her frequent urination/incontinence was related to her symptomatic fibroids that manifested

during service and service-connected hysterectomy.

The examiner should set forth all examination findings, along with complete rationale for the conclusions reached, in a printed report. Complete rationale should include an explanation of the evidence used in support of the conclusion, as well as an explanation as to why such evidence supports the conclusion.

9. Schedule the Veteran for an appropriate examination to ascertain the nature and etiology of the Veteran's residuals of the Veteran's cesarean sections. The examiner should review the entire claims file, to include a copy of this Remand, and the opinion should include discussion of the Veteran's documented history and assertions. The examiner should provide responses to the following:

a) Identify all current residuals of the Veteran's three in-service cesarean sections in 1985, 1988, and 1996. The examiner should consider the Veteran's allegations of cut nerves, abdominal scarring, gynecological complications as a result of her in-service cesarean sections.

b) For each identified residual, the examiner should opine whether it at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) had onset in service, or is otherwise related to an in-service injury, event, or disease, including the Veteran's in-service cesarean sections in 1985, 1988, and 1996.

The examiner should consider service treatment records, post service treatment records, and the Veteran's contentions indicating that she currently has complications from her three in-service cesarean sections, including cut nerves, abdominal scars, and gynecological complications.

The examiner should set forth all examination findings, along with complete rationale for the conclusions reached, in a printed report. Complete rationale should include an explanation of the evidence used in support of the conclusion, as well as an explanation as to why such evidence supports the conclusion.

10. Schedule the Veteran for an appropriate examination to ascertain the nature and etiology of the Veteran's left breast cancer. The examiner should review the entire claims file, to include a copy of this Remand, and the opinion should include discussion of the Veteran's documented history and assertions. The examiner should provide responses to the following:

a) Identify all current residuals of the Veteran's left breast cancer status post mastectomy. The examiner should consider the Veteran's allegations of scarring, decreased range of motion in her left arm, continuous torso swelling, and pain/swelling in her axillary region.

b) The examiner should opine whether the Veteran's left breast cancer status post mastectomy and residuals thereof at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) had onset in service, or is otherwise related to an in-service injury, event, or disease.

The examiner should consider in-service treatment records dated in December 1994 documenting a lump identified as fibrocystic left breast tissue.

The examiner should specifically address the Veteran's contentions indicating that the fibrocystic left breast tissue identified in December 1994 developed into her left breast cancer.

The examiner should set forth all examination findings, along with complete rationale for the conclusions reached, in a printed report. Complete rationale should include an explanation of the evidence used in support of the conclusion, as well as an explanation as to why such evidence supports the conclusion.

11. Readjudicate the issues of whether CUE exists in the January 2004 rating decision denying entitlement to service connection for a bilateral knee disability, a spine disability, a hysterectomy and cesarean sections. If any issue remains denied, send the Veteran a Statement of the Case (SOC), and notify the Veteran of her options for appeal.

12. Then readjudicate the remaining issues on appeal.

V. Chiappetta

Veterans Law Judge

Board of Veterans' Appeals

Attorney for the Board L. Crohe, Counsel

The Board's decision in this case is binding only with respect to the instant matter decided. This decision is not precedential and does not establish VA policies or interpretations of general applicability. 38 C.F.R. § 20.1303.