BOARD OF VETERANS' APPEALS
DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON, DC 20420

IN THE APPEAL OF [redacted]
WILLIAM G. CRAWLEY

DOCKET NO. 13-27 534) DATE May 12, 2017
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On appeal from the
Department of Veterans Affairs Regional Office in St. Petersburg, Florida

THE ISSUES

1. Entitlement to service connection for mild dry eyes.

2. Entitlement to service connection for bilateral normal tension glaucoma, cataract of the right eye, and pseudophakia of the left eye.

3. Entitlement to service connection for labyrinthitis with vestibular dysfunction ("labyrinthitis").

4. Entitlement to service connection for lumbar strain with sacroiliac pain ("lumbar strain").

5. Entitlement to service connection for hypertension, to include as secondary to service-connected diabetes mellitus.

6. Entitlement to service connection for obstructive sleep apnea, to include as secondary to service-connected diabetes mellitus.

7. Entitlement to service connection for erectile dysfunction, to include as secondary to service-connected diabetes mellitus.

8. Entitlement to special monthly compensation (SMC) based on loss of use of a creative organ.

9. Entitlement to service connection for right leg arterial insufficiency, to include as secondary to service-connected diabetes mellitus.

10. Entitlement to service connection for chronic renal insufficiency, to include as secondary to service-connected diabetes mellitus.

11. Entitlement to service connection for bilateral diabetic retinopathy, to include as secondary to service-connected diabetes mellitus.

REPRESENTATION

Appellant represented by: Deanne L. Bonner, Attorney at Law

ATTORNEY FOR THE BOARD

N. Nelson, Associate Counsel

INTRODUCTION

This appeal has been advanced on the Board's docket pursuant to 38 C.F.R. § 20.900(c) (2016). 38 U.S.C.A. § 7107(a)(2) (West 2014).

The Veteran served on active duty for 20 years, including from August 1955 to August 1958; from February 1960 to February 1963; and from August 1963 to August 1977, including service in Vietnam.

These matters come before the Board of Veterans' Appeals (Board) on appeal from April 2011 and October 2012 rating decisions by the Department of Veterans Affairs (VA) Regional Office (RO) in St. Petersburg, Florida. The April 2011 rating decision denied service connection for bilateral normal tension glaucoma, mild dry eyes, cataract of the right eye, and pseudophakia of the left eye. The October 2012 rating decision denied service connection for the remaining disabilities, and denied entitlement to SMC based on loss of use of a creative organ.

The Board notes that for bilateral normal tension glaucoma, mild dry eyes, cataract of the right eye, and pseudophakia of the left eye have previously been considered as one issue. However, the Board has recharacterized the diagnoses as two separate issues.

The Board also notes that the Veteran initiated appeals of the initial ratings for tinnitus and hemorrhoids, and service connection for hyperlipidemia. However, the Veteran did not perfect these appeals; rather, in a September 2013 statement submitted with a substantive appeal (VA Form 9), he specifically limited the appeal to exclude these three issues. There is no indication that the Veteran or his representative were confused by the VA Form 9, and subsequent Supplemental Statements of the Case (SSOCs) do not list these issues. *See Evans v. Shinseki*, 25 Vet. App. 7, 15-17 (2011) (finding that VA must seek clarification from the appellant if there is a "perceived concern about how the appellant had filled out the Form 9" that leaves a question as to whether the appellant wished to continue to appeal an issue). As such, the claims for initial ratings for tinnitus and hemorrhoids and service connection for hyperlipidemia are not before the Board.

In January 2014, August 2015, and September 2016, the Board remanded the case for further development. The January 2014 remand directed the AOJ to obtain private treatment records and schedule the Veteran for VA examinations to determine the nature and etiology of any diagnosed right leg arterial insufficiency, hypertension, chronic renal insufficiency, obstructive sleep apnea, bilateral diabetic retinopathy, and erectile dysfunction. Treatment records have since been associated with the claims file and the Veteran had VA examinations in April and May 2014.

The August 2015 and September 2016 remands were to schedule the Veteran for a videoconference hearing before a Veterans Law Judge. A hearing was subsequently scheduled in November 2016; however, in November 2016, prior to the hearing, the Veteran withdraw his hearing request. *See* 38 C.F.R. § 20.704(d). The Board is therefore satisfied that there has been substantial compliance with the remands' directives and will proceed with review. *Stegall v. West*, 11 Vet. App. 268 (1998).

The issue of service connection for bilateral normal tension glaucoma, cataract of the right eye, and pseudophakia of the left eye and diabetic retinopathy is addressed in the REMAND portion of the decision below and is REMANDED to the Agency of Original Jurisdiction (AOJ).

FINDINGS OF FACT

1. The currently diagnosed mild dry eyes was not incurred in service, was not related to a service-connected disability, and is not otherwise related to service.

2. The currently diagnosed labyrinthitis with vestibular dysfunction was not incurred in service, is not related to a service-connected disability, and is not otherwise related to service.

3. The currently diagnosed lumbar strain with sacroiliac pain was not incurred in service, is not related to a service-connected disability, and is not otherwise related to service.

4. The currently diagnosed hypertension was not incurred in service, is not related to a service-connected disability, and is not otherwise related to service.

5. The currently diagnosed obstructive sleep apnea was not incurred in service, is not related to a service-connected disability, and is not otherwise related to service.

6. The currently diagnosed erectile dysfunction was not incurred in service, is not related to a service-connected disability, and is not otherwise related to service.

7. Service connection for erectile dysfunction is not in effect.

8. The evidence does not demonstrate the presence of a current right leg arterial insufficiency disability.

9. The evidence does not demonstrate the presence of a current chronic renal insufficiency disability.

CONCLUSIONS OF LAW

1. The criteria for service connection for mild dry eyes have not been met. 38 U.S.C.A. §§ 1110, 1131, 5103, 5103A, 5107 (West 2014); 38 C.F.R. §§ 3.102, 3.159, 3.303 (2016).

2. The criteria for service connection for labyrinthitis with vestibular dysfunction have not been met. 38 U.S.C.A. §§ 1110, 1131, 5103, 5103A, 5107 (West 2014); 38 C.F.R. §§ 3.102, 3.159, 3.303 (2016).

3. The criteria for service connection for lumbar strain with sacroiliac pain have not been met. 38 U.S.C.A. §§ 1110, 1131, 5103, 5103A, 5107 (West 2014); 38 C.F.R. §§ 3.102, 3.159, 3.303 (2016).

4. The criteria for service connection for hypertension have not been met. 38 U.S.C.A. §§ 1110, 1131, 5103, 5103A, 5107 (West 2014); 38 C.F.R. §§ 3.102, 3.159, 3.303 (2016).

5. The criteria for service connection for obstructive sleep apnea have not been met. 38 U.S.C.A. §§ 1110, 1131, 5103, 5103A, 5107 (West 2014); 38 C.F.R. §§ 3.102, 3.159, 3.303 (2016).

6. The criteria for service connection for erectile dysfunction have not been met. 38 U.S.C.A. §§ 1110, 1131, 5103, 5103A, 5107 (West 2014); 38 C.F.R. §§ 3.102, 3.159, 3.303 (2016).

7. The criteria for entitlement to special monthly compensation (SMC) based on loss of use of a creative organ have not been met. 38 U.S.C.A. § 1114 (k) (West 2014); 38 C.F.R. §§ 3.102, 3.350(a) (2016).

8. The criteria for service connection for right leg arterial insufficiency have not been met. 38 U.S.C.A. §§ 1110, 1131, 5103, 5103A, 5107 (West 2014); 38 C.F.R. §§ 3.102, 3.159, 3.303 (2016).

9. The criteria for service connection for chronic renal insufficiency have not been met. 38 U.S.C.A. §§ 1110, 1131, 5103, 5103A, 5107 (West 2014); 38 C.F.R. §§ 3.102, 3.159, 3.303 (2016).

REASONS AND BASES FOR FINDINGS AND CONCLUSIONS

I. Duties to Notify and Assist

Upon receipt of a complete or substantially complete application for benefits, VA is required to notify the claimant and his or her representative, if any, of any information and any medical or lay evidence that is necessary to substantiate the claim. 38 U.S.C.A. § 5103(a); 38 C.F.R. § 3.159(b); *Quartuccio v. Principi*, 16 Vet. App. 183 (2002). VA notice letters must also include notice of a disability rating and an effective date for award of benefits if service connection is granted. *Dingess/Hartman v. Nicholson*, 19 Vet. App. 473 (2006).

Here, the RO provided notice letters to the Veteran in June 2010 and February 2012, prior to the adjudication of the claims. The letters notified the Veteran of what information and evidence must be submitted to substantiate the claims for service connection, what information and evidence must be provided by the Veteran, and what information and evidence would be obtained by VA. The

Veteran was told to inform VA of any additional information or evidence that VA should have, and was told to submit evidence to the RO in support of his claims. The letters also provided the Veteran with notice of the type of evidence necessary to establish a disability rating and effective date. The content of the letters complied with the requirements of 38 U.S.C.A. § 5103(a) and 38 C.F.R. § 3.159(b).

The record establishes that the Veteran has been afforded a meaningful opportunity to participate in the adjudication of his claims. The Board notes that there has been no allegation from the Veteran or his representative that he has been prejudiced by any of notice defects. *See Shinseki v. Sanders*, 556 U.S. 396 (2009). Thus, there is no prejudice to the Veteran in the Board's considering the claims on their merits. The Board finds that the duty to notify provisions have been fulfilled, and any defective notice is nonprejudicial to the Veteran and is harmless.

The Board further finds that all relevant evidence has been obtained with regard to the Veteran's claims, and the duty to assist requirements have been satisfied. The claims file contains the Veteran's STRs, VA and private medical treatment evidence and opinions, medical publications, and the Veteran's statements. The VA attempted to obtain the Veteran's Social Security Administration (SSA) disability records, but is unable to do so as SSA has stated that the records were destroyed. The Veteran was notified of the VA's inability to obtain those records and informed he could submit any records he had in a letter. Thus, the Board concludes that there is no outstanding evidence.

The Veteran underwent VA examinations in September 2012, April 2014, and May 2014 to obtain medical evidence regarding the nature and severity of the claimed disabilities. The Board finds the VA examinations and opinions to be adequate for adjudication purposes. The examinations were performed by medical professionals based on review of the claims file, solicitation of history and symptomatology from the Veteran, and examination of the Veteran. The examination reports are accurate and fully descriptive. Opinion is provided as the nature and etiology of any diagnosed conditions. As such, the Board finds that the Veteran has been afforded adequate examination. The Board finds that VA's duty to assist with respect to

obtaining a VA examination or opinion has been met. *See* 38 C.F.R. § 3.159(c)(4); *Barr v. Nicholson*, 21 Vet. App. 303, 312 (2007).

The Board finds that the duties to notify and assist the Veteran have been met, so no further notice or assistance to the Veteran is required to fulfill VA's duty to assist in the development of the claims.

II. Law and Regulations

Service connection will be granted for disability resulting from a disease or injury incurred in or aggravated by military service. 38 U.S.C.A. §§ 1110, 1131; 38 C.F.R. § 3.303. Service connection may also be granted for a disease first diagnosed after discharge when all of the evidence, including that pertinent to service, establishes that the disease was incurred in service. 38 C.F.R. § 3.303(d).

Service connection requires competent evidence showing (1) the existence of a present disability; (2) in-service incurrence or aggravation of a disease or injury; and (3) a causal relationship between the present disability and the disease or injury incurred or aggravated during service. *Shedden v. Principi*, 381 F.3d 1163, 1167 (Fed. Cir. 2004), *citing Hansen v. Principi*, 16 Vet. App. 110, 111 (2002); *see also Caluza v. Brown*, 7 Vet. App. 498 (1995). Service connection may be also granted on a secondary basis for a disability that is proximately due to or the result of an established service-connected disorder. *See* 38 C.F.R. § 3.310(a) (2013); *Allen v. Brown*, 7 Vet. App. 439 (1995).

Several alternative paths to service connection exist for certain chronic diseases identified in 38 C.F.R. §3.309 (a), such as hypertension. *See* Dorland's Illustrated Medical Dictionary 531 (30th ed. 2003) (defining degenerative joint disease as osteoarthritis). Service connection may be awarded if a chronic disease manifests itself and is identified as such in service, or within the presumptive period under 38 C.F.R. § 3.307, and the Veteran presently has the same condition, unless the condition is clearly attributable to intercurrent causes. 38 U.S.C.A. § 1112; 38 C.F.R. §§ 3.307, 3.309; *see Walker v. Shinseki*, 708 F.3d 1331, 1336 (Fed. Cir. 2013) (finding that "§3.303(b) is constrained by §3.309(a), regardless of the point in

time when a Veteran's chronic disease is either shown or noted, in that the regulation is only available to establish service connection for the specific chronic diseases listed n §3.309(a)."). If, however, a chronic disease is noted during service but is either not chronic or the diagnosis could be questioned, then a showing of continuity of related symptomatology after discharge is required in order to grant service connection. 38 C.F.R. §§ 3.303 (b); *Walker*, 708 F.3d at 1336.

The Board will assess both medical and lay evidence. The evaluation of evidence generally involves a three-step inquiry. First, the Board must determine whether the evidence comes from a competent source. Second, the Board must then determine if the evidence is credible, or worthy of belief. *See Barr v. Nicholson*, 21 Vet. App. 303, 308 (2007). Third, the Board must weigh the probative value of the proffered evidence in light of the entirety of the record.

Competent medical evidence is evidence provided by a person who is qualified through education, training, or experience to offer medical diagnoses, statements, or opinions. Competent medical evidence may include statements conveying sound medical principles found in medical treatises, and may also include statements from authoritative writings, such as medical and scientific articles and research reports or analyses. 38 C.F.R. § 3.159(a)(1).

Competent lay evidence means any evidence not requiring that the proponent have specialized education, training, or experience. Lay evidence is competent if it is provided by a person who has knowledge of facts or circumstances and conveys matters that can be observed and described by a lay person. *See Layno v. Brown*, 6 Vet. App. 465, 469 (1994). A layperson is not generally capable of opining on matters requiring medical knowledge. *See* 38 C.F.R. § 3.159(a)(2); *Jandreau v. Nicholson*, 492 F.3d 1372, 1376-77 (Fed. Cir. 2007).

In weighing credibility, VA may consider interest, bias, inconsistent statements, bad character, internal inconsistency, facial plausibility, self-interest, consistency with other evidence of record, malingering, desire for monetary gain, and demeanor of the witness. *See generally Caluza v. Brown*, 7 Vet. App. 498 (1995). The Board may weigh the absence of contemporaneous medical evidence against the lay

evidence in determining credibility, but the Board cannot determine that lay evidence lacks credibility merely because it is unaccompanied by contemporaneous medical evidence. *See Buchanan v. Nicholson*, 451 F.3d 1331, 1335 (Fed. Cir. 2006); *but see Maxson v. Gober*, 230 F.3d 1330 (Fed. Cir. 2000) (evidence of a prolonged period without medical complaint after service can be considered along with other factors in the analysis of a service connection claim).

When there is an approximate balance of positive and negative evidence regarding any issue material to the determination of a matter, the Secretary shall give the benefit of the doubt to the claimant. 38 U.S.C.A. § 7105; 38 C.F.R. §§ 3.102, 4.3. When a claimant seeks benefits and the evidence is in relative equipoise, the claimant prevails. *See Gilbert v. Derwinski*, 1 Vet. App. 49, 53-54 (1990). The preponderance of the evidence must be against the claim for benefits to be denied. *See Alemany v. Brown*, 9 Vet. App. 518 (1996).

III. Mild Dry Eyes, Labyrinthitis, and Lumbar Strain Claims

The Veteran contends that service connection is warranted for mild dry eyes; labyrinthitis with vestibular dysfunction ("labyrinthitis"); and lumbar strain with sacroiliac pain ("lumbar strain").

STRs indicate that in an August 1955 enlistment report of medical history, the Veteran denied having eye or ear trouble, and denied having swollen or painful joints, or a bone, joint, or other deformity. In an enlistment examination the same day, his eyes, ears and ear drums, and spine were all found to be clinically normal. His vision was 20/20 in both eyes. In an August 1958 separation examination, the Veteran's eyes, ears and ear drums, and spine were all found to be clinically normal. His vision was 20/20 in both eyes.

A January 1960 reenlistment examination indicates that the Veteran's eyes, ears and ear drums, and spine were all found to be clinically normal. His vision was 20/20 in both eyes. He denied having eye or ear trouble, and indicated that he was "in good health." In September 1960, the Veteran was seen for eye trouble. He was found to have a conjunctival hemorrhage of the right eye. In December 1961, the Veteran

was issued glasses to correct his distance vision. The treating officer did not note any glaucoma, dry eye, cataract, or pseudophakia. A November 1962 separation examination notes that the Veteran's eyes, ears and ear drums, and spine were all found to be clinically normal. His vision was 20/40 bilaterally uncorrected, and corrected to 20/20 bilaterally.

An August 1963 reenlistment examination indicates that the Veteran's eyes, ears and ear drums, and spine were all found to be clinically normal. His vision was 20/30. In an August 1967 examination for flying, the Veteran was noted to be color blind. In September 1969 and May 1973 periodic examinations, the Veteran's eyes, ears and ear drums, and spine were all found to be clinically normal. A May 1972 treatment record notes, "labyrinthitis: seems resolved." A November 1975 treatment record notes that the Veteran injured his back. The treatment record indicates that the lumbar spine had less range of motion in flexion, but the Veteran's sensation was intact, strength was good, and a straight leg test was negative bilaterally. There was no diagnosis, and the Veteran was advised to rest for the day. In June 1977, the Veteran reported having pain and stiffness in the low back, at approximately the L5 area. He had pain walking and in his right leg. In July 1977, the Veteran's back was noted to show "much improvement"; however, range of motion was still reduced and he had tenderness over the paraspinal muscles. In a June 1977 service separation examination, the Veteran's eyes, ears and ear drums, and spine were all found to be clinically normal.

A September 1984 reserve service eye examination did not reveal any glaucoma, or dry eyes.

Mild Dry Eyes

In an October 2010 VA diabetes examination, the Veteran was found to have mild dry eyes. The examining optometrist, Dr. A.W., opined that dry eyes were not caused by or a result of diabetes, and that dry eyes was not the same eye condition noted during service. He indicated that his opinion was based on a medical literature review, medical records review, and his clinical experience.

The Veteran submitted a December 2011 medical opinion from G.U., ARNP, MN, which did not include a diagnosis of dry eyes.

A September 2012 VA examination again provided a diagnosis of dry eyes, but no opinion on the etiology of the diagnosis was provided.

Labyrinthitis

Post-service private treatment records from Dr. G.S. indicate that in an April 2010 oculomotor study, the Veteran was diagnosed with mild central vestibular dysfunction.

In a September 2012 VA ear examination, the Veteran reported that he experienced episodes of dizziness that occurred weekly and last 2-3 minutes. The diagnosis was mild central vestibular dysfunction. The VA examiner opined that the Veteran's current condition is less likely than not caused by or related to the episode of labyrinthitis in service. The rationale was that "labyrinthitis is an inflammation of the inner ear while a central vestibular disorder is a disturbance of the central vestibular pathways in the brain. The two conditions are different." The examiner also noted that after the Veteran's labyrinthitis during service in 1972, there were no further complaints of vertigo or dizziness for more than 35 years, until approximately April 2010 when the Veteran complained of dizziness and was diagnosed with mild central vestibular dysfunction.

Lumbar Strain

In private treatment records from Dr. G.S., the Veteran was found in April 2011 to have mild levoscoliosis and mild multilevel degenerative changes without acute change of the thoracolumbar spine.

In a September 2012 VA back examination, the Veteran was diagnosed with a low back strain without any finding of arthritis. The VA examiner opined that the Veteran's current condition was less likely than not caused by or related to the back injury in service. The rationale was that there were no other complaints of back

problems in service or in close proximity after his release from active duty, and no degenerative spine changes recorded in service.

Analysis

The Board finds that there is no basis on which to award service connection for mild dry eyes, labyrinthitis, or lumbar strain. The Veteran has made general assertions that the dry eyes, labyrinthitis, and lumbar strain are related to service. The Board does not doubt the Veteran's sincerity, but cannot rely on his general assertions regarding the medical origins of the diagnoses because he is not shown to possess the type of medical expertise that would be necessary to opine regarding the etiology of eye conditions, labyrinthitis, or lumbar strains. *See Kahana v. Shinseki*, 24 Vet. App. 428, 435 (2011). Although lay persons are competent to provide opinions on some medical issues, as to the specific issue in this case, opinions as to the etiology and onset of dry eyes, labyrinthitis, and lumbar strain falls outside the realm of common knowledge of a lay person. *See Jandreau*, 492 F.3d at 1377 n.4 (lay persons not competent to diagnose cancer). The Veteran does not have the medical expertise and training to provide a medical opinion as to the cause of his dry eyes, labyrinthitis, or lumbar strain. An opinion of etiology requires medical knowledge of the complexities of the eyes, ears, and lumbar spine, and involves objective clinical testing that the Veteran does not have the training to perform. Accordingly, the Board does not find the Veteran's general assertions to be probative with regard to establishing the etiology of his dry eyes, labyrinthitis, or lumbar strain.

The Board finds the VA examiner's opinions to be competent and credible, and as such, entitled to great probative weight. *See Gabrielson v. Brown*, 7 Vet. App. 36, 39-40 (1994). The examination opinions were based on a review of the Veteran's claims file, solicitation of history and symptomatology from the Veteran, and physical examination of the Veteran. The medical opinion addendums were rendered after detailed review of the claims file and further discussion with the Veteran regarding his medical history. The examiners stated the rationales on which the opinions were based. Moreover, there is no competent and credible medical opinion to contradict the conclusions of the VA examiners. As such, there

is no competent medical evidence to establish a nexus between the dry eyes, labyrinthitis, or lumbar strain and any event, illness, or injury in service.

For the reasons and bases discussed above, the Board finds that a preponderance of the lay and medical evidence that is of record weighs against the claims for service connection for dry eyes, labyrinthitis, and lumbar strain, and the claims must be denied. Because the preponderance of the evidence is against the claims, the benefit of the doubt doctrine is not for application. *See* 38 U.S.C.A. § 5107; 38 C.F.R. § 3.102.

IV. Hypertension, Obstructive Sleep Apnea, and Erectile Dysfunction (to Include SMC) Claims

The Veteran contends that service connection is warranted for hypertension, obstructive sleep apnea, and erectile dysfunction (to include entitlement to SMC based on loss of use of a creative organ) as secondary to (or aggravated by) his service-connected diabetes mellitus. He does not contend that any of these claimed conditions had their onset in service.

An October 2010 VA diabetes examination noted that the Veteran's hypertension was essential hypertension and "not likely caused by diabetes mellitus in light of normal urinary microalbumin."

The Veteran submitted a December 2011 medical opinion from G.U., ARNP, MN. G.U. opined that it was at least as likely as not that the Veteran's diabetes aggravated his hypertension, sleep apnea, and erectile dysfunction. G.U. noted that "there is a plethora of statistically significant data within the medical literature that is documented in scientific studies that note that these conditions can be aggravated by diabetes mellitus type II." With regard to hypertension, G.U. noted that it could be aggravated by the hastening of the deposits of fatty substances in the vessels, narrowing them and causing a diminished blood flow capability, which caused an increased blood pressure. The narrowing is particularly evidence in organs that have smaller contributor arteries, including the penis, which was way diabetics frequently developed conditions such as erectile dysfunction. In addition, insulin

resistance could cause metabolic syndrome to develop, which would lead to difficulty with weight management, which could cause obstructive sleep apnea due to the accumulation of fatty tissue and enlargement of neck girth. G.U. noted that, specific to the Veteran, he was diagnosed with diabetes mellitus in 2008, which "has notably been difficult to control on oral hypoglycemics." Around that same time, the Veteran's weight began to be poorly controlled and an additional medication for hypertension had to be added to attempt control due to his weight. G.U. indicated that the Veteran had been diagnosed with sleep apnea in 2003, and notably, shortly after his diabetes diagnosis, his CPAP treatment had to be increased. She also noted that the veteran began having erectile difficulties around 2008, concurrently with his diabetes diagnosis. Thus the Veteran's "pre-existing or concurrently diagnosed medical conditions of hypertension, obstructive sleep apnea, . . . and erectile dysfunction all worsened and became difficult to control and medically manage, objectively, necessitating more aggressive medical management with added medications or increased dosages as above, around the time of his diabetes diagnosis or soon afterwards, due to aggravation."

In January 2012, the Veteran submitted three medical news articles suggesting a link between obstructive sleep apnea and diabetes, erectile dysfunction and diabetes, and glaucoma and diabetes. The sleep apnea article indicated that a majority of patients with type 2 diabetes also have obstructive sleep apnea, and that clinicians needed to address the risk of obstructive sleep apnea in patients with type 2 diabetes, and conversely, evaluate the presence of type 2 diabetes in patients with obstructive sleep apnea. The erectile dysfunction article indicated that sexual dysfunction was a well-recognized consequence of diabetes mellitus in men. The glaucoma article indicated that diabetes type 2 was associated with an increased risk of glaucoma, but the link between diabetes and glaucoma had not been proven conclusively.

A September 2012 VA examiner opined that the Veteran's hypertension, sleep apnea, and erectile dysfunction were not caused or aggravated by diabetes. With regard to hypertension, the examiner specified that the Veteran's hypertension had its onset many years prior to diabetes, and that there was no objective data to support aggravation of the hypertension by diabetes. With regard to sleep apnea,

the examiner specified that there was on objective data to support the Veteran's claim that his obstructive sleep apnea was caused by or aggravated by his diabetes. The examiner noted that obstructive sleep apnea was characterized by recurrent episodes of upper airway collapse and obstruction during sleep, and that it was a common disease most often seen in males who are 18-60 years old with a normal physical examination except for obesity, and often but not always, a crowded oropharyngeal airway. With regard to erectile dysfunction, the examiner indicated that the Veteran's erectile dysfunction began many years prior to his diabetes, and there was no objective data to support aggravation by diabetes.

In May 2014, the Veteran had another series of VA examinations for his claimed disabilities. The examining physician indicated that she did not agree with G.U.'s assertion that the Veteran had poorly-controlled diabetes mellitus, which was the basis for G.U. attributing the diabetes as the cause or aggravation for the hypertension, sleep apnea, and erectile dysfunction. The examiner indicated that she had over 25 years of experience as an internal medicine physician and that despite more than five hours medical treatment record review, two hours of face-to-face contact with the Veteran, and the time spent writing the examination report, she could not support the G.U.'s assertion that the Veteran's diabetes was poorly controlled. She noted that multiple treatment records since February 2008 (the date of diagnosis of diabetes) showed the Veteran's HgbA1C had remained at 6.5 percent or less, which was indicative of excellent glycemic control (near normal range). The examiner noted that the discrepancies could be in part related to the challenges of reading private physicians' handwriting. The examiner opined that the Veteran's hypertension, which was diagnosed at least nine years prior to diabetes, was not caused or aggravated by diabetes. The rationale was that the medical treatment evidence showed that the Veteran's level of blood pressure control did not correlate with his diabetes, and there was no objective data to support aggravation. The examiner further opined that sleep apnea, which had its onset years prior to the diabetes, was not caused or aggravated by diabetes. While noting that the Veteran's private physician increased the oxygen flow rate utilized with the nocturnal CPAP in February 2008, the VA examiner opined that "there is nothing to substantiate that this adjustment was made due to the Veteran's early, developing diabetes mellitus." The examiner acknowledged the medical research

article submitted by the Veteran, but asserted that the article actually provides evidence in support of sleep apnea as a potential cause of diabetes. Finally, the examiner opined that the Veteran's erectile dysfunction was less likely than not caused or aggravated by his diabetes, noting that erectile dysfunction had its onset prior to diabetes. The examiner opined that the "Veteran's ED is most likely caused by his non-service connected conditions to include longstanding hypertension (well documented as not ideally controlled), hyperlipidemia, advancing age, obesity, sedentary lifestyle and BPH with Lower Tract Symptoms (LUTS) - rather than his well-controlled DM." The examiner noted that while medical literature supported diabetes as a potential cause of erectile dysfunction, the preponderance of the evidence did not substantiate diabetes as the cause of the erectile dysfunction in this Veteran's case. The examiner further noted that there was no objective evidence of aggravation, as the erectile dysfunction had its onset year prior to the diabetes mellitus, was not responsive to medications, and has persisted.

The Board finds that service connection is not warranted for the currently diagnosed hypertension, obstructive sleep apnea, or erectile dysfunction, as either directly related to service or to service-connected diabetes. The Veteran has made general assertions that the hypertension, obstructive sleep apnea, and erectile dysfunction are related to service. As discussed above, the Board does not doubt the Veteran's sincerity, but cannot rely on his general assertions regarding the medical origins of the diagnoses because he is not shown to possess the type of medical expertise that would be necessary to opine regarding the etiology of hypertension, obstructive sleep apnea, or erectile dysfunction. *See Kahana v. Shinseki*, 24 Vet. App. 428, 435 (2011).

The VA examiners all opined that the hypertension, obstructive sleep apnea, and erectile dysfunction conditions had their onset prior to the Veteran's diagnosis of diabetes, and that there is no medical evidence to support that diabetes aggravated the conditions. The VA examinations are highly probative medical evidence, particularly the May 2014 VA examiner's opinions. The opinions were rendered after reviewing the Veteran's claims file, which included VA medical records and private medical records; soliciting a medical history from the Veteran; and conducting a physical examination of the Veteran. *See Prejean v. West*, 13 Vet.

App. 444 (2000) (factors for assessing the probative value of a medical opinion include the examiner's access to the claims folder and the Veteran's history, and the thoroughness and detail of the opinion). The examiners provided rationales for their opinions; the May 2014 examiner in particular provided detailed medical treatment records on which her opinions were based, and discussed G.U.'s opinions and the medical news articles that the Veteran submitted.

Moreover, the Board finds that the VA examinations are more probative than the opinion by G.U. The Board does not question G.U.'s clinical experience or training; however, her opinions are outweighed by the May 2014 VA examiner's opinions, given the doctor's greater expertise and higher medical education. In addition, although G.U. indicated that her opinions were not speculative, they are nonetheless still speculative and therefore of little probative value. She provided background information on hypertension, sleep apnea, and erectile dysfunction, but failed to specifically link any of those general statements to the Veteran's specific situation. For instance, G.U. noted that that Veteran's CPAP treatment was increased around the time that he was diagnosed with diabetes, but did not explain how or why she thought the increased CPAP treatment was related to the diabetes. She also indicated that the Veteran's weight increased around the same time he was diagnosed with diabetes, which led to an increase in hypertension medication, but it is not clear that the weight gain was due to diabetes (or that the diabetes was not due to the weight gain). *See* 38 C.F.R. § 3.102 (decisions of service connection are not to be based on pure speculation or remote possibility); *Obert v. Brown*, 5 Vet. App. 30 (1993) (medical opinion expressed in terms of "may" also implies "may or may not" and is too speculative to establish medical nexus); *Stegman v. Derwinski*, 3 Vet. App. 228, 230 (1992) (holding that evidence favorable to the veteran's claim that does little more than suggest a possibility that his illnesses might have been caused by service radiation exposure is insufficient to establish service connection). As such, the Board accords the opinion of G.U. low probative weight, and finds it to be outweighed by more specific medical opinion evidence pertaining to this Veteran.

For the reasons and bases discussed above, the Board finds that a preponderance of the lay and medical evidence that is of record weighs against the claims for service

connection for hypertension, obstructive sleep apnea, and erectile dysfunction (to include entitlement to SMC based on loss of use of a creative organ), and the claims must be denied. Because the preponderance of the evidence is against the claims, the benefit of the doubt doctrine is not for application. *See* 38 U.S.C.A. § 5107; 38 C.F.R. § 3.102.

V. Right Leg Arterial Insufficiency and Chronic Renal Insufficiency Claims

The Veteran contends that service connection is warranted right leg arterial insufficiency and chronic renal insufficiency as secondary to (or aggravated by) his service-connected diabetes mellitus. He does not contend that any of these claimed conditions had their onset in service.

Regarding the claimed renal condition, the September 2012 VA examination for diabetes included laboratory results which did not show any objective evidence of chronic renal insufficiency. The May 2014 VA examination further determined that the Veteran did not have a current diagnosis of chronic renal insufficiency; nor had he had such a diagnosis at any time since January 2012.

Regarding the claimed right leg arterial condition, the September 2012 VA examination did not reveal evidence of right leg arterial insufficiency in relation to diabetes. A May 2014 VA examination determined that the Veteran did not have a current diagnosis of right leg arterial insufficiency; nor has he had such a diagnosis at any time since January 2012. Upon examination, the Veteran denied a lower extremity arterial insufficiency condition, and stated that he has been told that his "circulation is good." The examiner further noted that the Veteran's complaints of "circulation problems" in a January 2012 statement were not consistent with the physical examination, or with the other medical treatment evidence of record. Furthermore, an April 2011 private examination with an abnormal finding relating to the leg "appears to have been calculated utilizing an isolated low value for the anterior tibial artery. This more sensitive calculation can be useful from a prognostic/preventative standpoint, but it is not the standard calculation utilized diagnostically."

Congress has specifically limited entitlement to service-connection for disease or injury to cases where such incidents have resulted in disability. *See* 38 U.S.C.A. § 1110. In this case, where the evidence shows no current disabilities (*see* 38 C.F.R. § 3.385) upon which to predicate a grant of service connection at any time during the claim period, there can be no valid claim for that benefit. *See Gilpin v. West*, 155 F.3d 1353 (Fed. Cir. 1998); *Brammer v. Derwinski*, 3 Vet. App. 223, 225 (1992). Although the February 2011 private treatment note assessed "very min background diabetic retinopathy," the more recent eye examination in April 2014 found no diabetic retinopathy. Thus, the Board finds that the evidence weighs against a finding of diabetic retinopathy at any time during the appeal period.

For the reasons and bases discussed above, the Board finds that a preponderance of the lay and medical evidence that is of record weighs against the claims for service connection for right leg arterial insufficiency and chronic renal insufficiency and the claims must be denied. Because the preponderance of the evidence is against the claims, the benefit of the doubt doctrine is not for application. *See* 38 U.S.C.A. § 5107; 38 C.F.R. § 3.102.

ORDER

Service connection for mild dry eyes is denied.

Service connection for labyrinthitis with vestibular dysfunction is denied.

Service connection for lumbar strain with sacroiliac pain is denied.

Service connection for hypertension is denied.

Service connection for obstructive sleep apnea is denied.

Service connection for erectile dysfunction is denied.

Entitlement to special monthly compensation (SMC) based on loss of use of a creative organ is denied.

Service connection for right leg arterial insufficiency is denied.

Service connection for chronic renal insufficiency is denied.

REMAND

The Board finds that remand for further medical opinion is necessary on the claim for bilateral normal tension glaucoma, cataract of the right eye, and pseudophakia of the left eye and diabetic retinopathy.

The same examiner performed VA eye examinations in October 2010 and April 2014. The examining optometrist, Dr. A.W., reached different conclusions in the two examinations and did not explain why or how his conclusions changed. In the October 2010 examination, he stated that he could not opine without resort to mere speculation whether the Veteran's glaucoma was related to the eye conditions noted during service, and that he could not determine whether the Veteran's cataracts and pseudophakia were related to his diabetes or aging. However, in April 2014, Dr. A.W. opined that the glaucoma and cataracts were consistent with aging. He did not specify the information or treatment records he used to determine that the glaucoma was not related to the in-service eye complaints, or the information or treatment records he used to determine that the cataracts and pseudophakia were caused by aging and not diabetes. Thus, the Board finds that clarification is necessary.

Regarding diabetic retinopathy, an October 2010 VA diabetes examination did not reveal the presence of diabetic retinopathy. A February 2011 private treatment note assessed "very min background diabetic retinopathy." A February 2011 private treatment note from Columbia Eye Associates the fundus examination noted "very min background diabetic retinopathy." A December 2011 medical opinion from G.U. provided a diagnosis of diabetic retinopathy. An April 2014 VA eye examiner

opined that the Veteran did not have diabetic retinopathy but did not reconcile this with the treatment records that include such a diagnosis. Accordingly, further examination is necessary.

Accordingly, the case is REMANDED for the following action:

(Please note, this appeal has been advanced on the Board's docket pursuant to 38 C.F.R. § 20.900(c). Expedited handling is requested.)

1. Contact the VA examiner who conducted the October 2010 and April 2014 VA eye examinations (or a suitable replacement) and ask the examiner to review the record and prepare an addendum to the medical opinions.

The examiner should then answer the following:

a) Clarify whether the Veteran has diabetic retinopathy. The examiner must discuss the private records noting minimum background diabetic retinopathy.

b) Whether it is at least as likely as not (50 percent or greater probability) that any current glaucoma, cataracts, and/or pseudophakia is related to incident, injury, or event in active service, to include a September 1960 in-service treatment record indicating that the Veteran was seen for a conjunctival hemorrhage of the right eye.

c) Whether it is at least as likely as not (50 percent or greater probability) that any current glaucoma, cataracts, and/or pseudophakia are causally related to and/or increased in severity by the service-connected diabetes mellitus.

> A thorough rationale should be provided for all opinions expressed. If any requested medical opinion cannot be given, the examiner should state the reason(s) why.
>
> 2. After completing all indicated development, and any additional development deemed necessary, readjudicate the claim in light of all the evidence of record. If any benefit sought on appeal remains denied, then a fully responsive supplemental statement of the case should be furnished to the Veteran and his representative and they should be afforded a reasonable opportunity for response.

The appellant has the right to submit additional evidence and argument on the matter or matters the Board has remanded. *Kutscherousky v. West*, 12 Vet. App. 369 (1999).

This claim must be afforded expeditious treatment. The law requires that all claims that are remanded by the Board of Veterans' Appeals or by the United States Court of Appeals for Veterans Claims for additional development or other appropriate action must be handled in an expeditious manner. *See* 38 U.S.C.A. §§ 5109B, 7112 (West 2014).

H. SEESEL
Veterans Law Judge, Board of Veterans' Appeals

Department of Veterans Affairs

YOUR RIGHTS TO APPEAL OUR DECISION

The attached decision by the Board of Veterans' Appeals (Board) is the final decision for all issues addressed in the "Order" section of the decision. The Board may also choose to remand an issue or issues to the local VA office for additional development. If the Board did this in your case, then a "Remand" section follows the "Order." However, you cannot appeal an issue remanded to the local VA office because a remand is not a final decision. *The advice below on how to appeal a claim applies only to issues that were allowed, denied, or dismissed in the "Order."*

If you are satisfied with the outcome of your appeal, you do not need to do anything. Your local VA office will implement the Board's decision. However, if you are not satisfied with the Board's decision on any or all of the issues allowed, denied, or dismissed, you have the following options, which are listed in no particular order of importance:

- Appeal to the United States Court of Appeals for Veterans Claims (Court)
- File with the Board a motion for reconsideration of this decision
- File with the Board a motion to vacate this decision
- File with the Board a motion for revision of this decision based on clear and unmistakable error.

Although it would not affect this BVA decision, you may choose to also:

- Reopen your claim at the local VA office by submitting new and material evidence.

There is *no* time limit for filing a motion for reconsideration, a motion to vacate, or a motion for revision based on clear and unmistakable error with the Board, or a claim to reopen at the local VA office. Please note that if you file a Notice of Appeal with the Court and a motion with the Board at the same time, this may delay your appeal at the Court because of jurisdictional conflicts. If you file a Notice of Appeal with the Court ***before*** you file a motion with the Board, the Board will not be able to consider your motion without the Court's permission or until your appeal at the Court is resolved.

How long do I have to start my appeal to the court? You have **120 days** from the date this decision was mailed to you (as shown on the first page of this decision) to file a Notice of Appeal with the Court. If you also want to file a motion for reconsideration or a motion to vacate, you will still have time to appeal to the court. *As long as you file your motion(s) with the Board within 120 days of the date this decision was mailed to you,* you will have another 120 days from the date the Board decides the motion for reconsideration or the motion to vacate to appeal to the Court. You should know that even if you have a representative, as discussed below, *it is your responsibility to make sure that your appeal to the Court is filed on time*. Please note that the 120-day time limit to file a Notice of Appeal with the Court does not include a period of active duty. If your active military service materially affects your ability to file a Notice of Appeal (e.g., due to a combat deployment), you may also be entitled to an additional 90 days after active duty service terminates before the 120-day appeal period (or remainder of the appeal period) begins to run.

How do I appeal to the United States Court of Appeals for Veterans Claims? Send your Notice of Appeal to the Court at:

Clerk, U.S. Court of Appeals for Veterans Claims
625 Indiana Avenue, NW, Suite 900
Washington, DC 20004-2950

You can get information about the Notice of Appeal, the procedure for filing a Notice of Appeal, the filing fee (or a motion to waive the filing fee if payment would cause financial hardship), and other matters covered by the Court's rules directly from the Court. You can also get this information from the Court's website on the Internet at: http://www.uscourts.cavc.gov, and you can download forms directly from that website. The Court's facsimile number is (202) 501-5848.

To ensure full protection of your right of appeal to the Court, you must file your Notice of Appeal **with the Court**, not with the Board, or any other VA office.

How do I file a motion for reconsideration? You can file a motion asking the Board to reconsider any part of this decision by writing a letter to the Board clearly explaining why you believe that the Board committed an obvious error of fact or law, or stating that new and material military service records have been discovered that apply to your appeal. It is important that your letter be as specific as possible. A general statement of dissatisfaction with the Board decision or some other aspect of the VA claims adjudication process will not suffice. If the Board has decided more than one issue, be sure to tell us which issue(s) you want reconsidered. Issues not clearly identified will not be considered. Send your letter to:

Litigation Support Branch
Board of Veterans' Appeals
P.O. Box 27063
Washington, DC 20038

Remember, the Board places no time limit on filing a motion for reconsideration, and you can do this at any time. However, if you also plan to appeal this decision to the Court, you must file your motion within 120 days from the date of this decision.

How do I file a motion to vacate? You can file a motion asking the Board to vacate any part of this decision by writing a letter to the Board stating why you believe you were denied due process of law during your appeal. *See* 38 C.F.R. 20.904. For example, you were denied your right to representation through action or inaction by VA personnel, you were not provided a Statement of the Case or Supplemental Statement of the Case, or you did not get a personal hearing that you requested. You can also file a motion to vacate any part of this decision on the basis that the Board allowed benefits based on false or fraudulent evidence. Send this motion to the address on the previous page for the Litigation Support Branch, at the Board. Remember, the Board places no time limit on filing a motion to vacate, and you can do this at any time. However, if you also plan to appeal this decision to the Court, you must file your motion within 120 days from the date of this decision.

How do I file a motion to revise the Board's decision on the basis of clear and unmistakable error? You can file a motion asking that the Board revise this decision if you believe that the decision is based on "clear and unmistakable error" (CUE). Send this motion to the address on the previous page for the Litigation Support Branch, at the Board. You should be careful when preparing such a motion because it must meet specific requirements, and the Board will not review a final decision on this basis more than once. You should carefully review the Board's Rules of Practice on CUE, 38 C.F.R. 20.1400-20.1411, and *seek help from a qualified representative before filing such a motion.* See discussion on representation below. Remember, the Board places no time limit on filing a CUE review motion, and you can do this at any time.

How do I reopen my claim? You can ask your local VA office to reopen your claim by simply sending them a statement indicating that you want to reopen your claim. However, to be successful in reopening your claim, you must submit new and material evidence to that office. *See* 38 C.F.R. 3.156(a).

Can someone represent me in my appeal? Yes. You can always represent yourself in any claim before VA, including the Board, but you can also appoint someone to represent you. An accredited representative of a recognized service organization may represent you free of charge. VA approves these organizations to help veterans, service members, and dependents prepare their claims and present them to VA. An accredited representative works for the service organization and knows how to prepare and present claims. You can find a listing of these organizations on the Internet at: http://www.va.gov/vso/. You can also choose to be represented by a private attorney or by an "agent." (An agent is a person who is not a lawyer, but is specially accredited by VA.)

If you want someone to represent you before the Court, rather than before the VA, you can get information on how to do so at the Court's website at: http://www.uscourts.cavc.gov. The Court's website provides a state-by-state listing of persons admitted to practice before the Court who have indicated their availability to the represent appellants. You may also request this information by writing directly to the Court. Information about free representation through the Veterans Consortium Pro Bono Program is also available at the Court's website, or at: http://www.vetsprobono.org, mail@vetsprobono.org, or (855) 446-9678.

Do I have to pay an attorney or agent to represent me? An attorney or agent may charge a fee to represent you after a notice of disagreement has been filed with respect to your case, provided that the notice of disagreement was filed on or after June 20, 2007. *See* 38 U.S.C. 5904; 38 C.F.R. 14.636. If the notice of disagreement was filed before June 20, 2007, an attorney or accredited agent may charge fees for services, but only after the Board first issues a final decision in the case, and only if the agent or attorney is hired within one year of the Board's decision. *See* 38 C.F.R. 14.636(c)(2).

The notice of disagreement limitation does not apply to fees charged, allowed, or paid for services provided with respect to proceedings before a court. VA cannot pay the fees of your attorney or agent, with the exception of payment of fees out of past-due benefits awarded to you on the basis of your claim when provided for in a fee agreement.

Fee for VA home and small business loan cases: An attorney or agent may charge you a reasonable fee for services involving a VA home loan or small business loan. *See* 38 U.S.C. 5904; 38 C.F.R. 14.636(d).

Filing of Fee Agreements: If you hire an attorney or agent to represent you, a copy of any fee agreement must be sent to VA. The fee agreement must clearly specify if VA is to pay the attorney or agent directly out of past-due benefits. See 38 C.F.R. 14.636(g)(2). If the fee agreement provides for the direct payment of fees out of past-due benefits, a copy of the direct-pay fee agreement must be filed with the agency of original jurisdiction within 30 days of its execution. A copy of any fee agreement that is not a direct-pay fee agreement must be filed with the Office of the General Counsel within 30 days of its execution by mailing the copy to the following address: Office of the General Counsel (022D), Department of Veterans Affairs, 810 Vermont Avenue, NW, Washington, DC 20420. See 38 C.F.R. 14.636(g)(3).

The Office of the General Counsel may decide, on its own, to review a fee agreement or expenses charged by your agent or attorney for reasonableness. You can also file a motion requesting such review to the address above for the Office of the General Counsel. See 38 C.F.R. 14.636(i); 14.637(d).