**Back Claim Statement and Evidence Review**

The following statement and evidence review is offered to support my contention that my current back and lower extremity problems are directly related to various service events; therefore, service connection is justified. Service connection is also justifiable on a secondary basis per service-connected bilateral ankle bursitis/osteoarthritis with instability and severely pronated bilateral flatfeet with bunions. I also believe my weight gain during service and current weight caused by my service-connected conditions, including depression, contribute to my back problems. My current weight is 178, BMI 29.2 (VA annual physical 09/09/2022).

**During service (1974-1995)**

During my time on active duty, I had the following back problem symptoms; pain, weakness, stiffness, tenderness, and radiculopathy causing pain and tingling down both of my lower extremities. Early in my army career I was taught to endure physical pain and to only complain to medical personnel when the pain reached a level indicative of a likely serious injury. As a career soldier I also taught my subordinates what I was taught: endure pain without complaint. I often told my soldiers “The army is no place for crybabies, so suck it up or get the hell out.” I rarely went to sick call of my own volition. Typically, I was ordered to report to medical personnel by my superiors; thus, my service medical records have but a few complaints documented.

Throughout my service I chose to self-treated my back and lower extremity problem symptoms with over-the-counter pain medications, heat, and rest; however, I did seek treatment on 05/05/1976 with a complaint of back pain and on 08/08/1978 with a complaint of lower extremity pain. I was prescribed Ibuprofen on both occasions. On my retirement physical exam (December 1994) report of medical history form (SF-93) “recurrent back pain” is checked. After my first several years or so of service, most of my back and lower extremity pain symptoms occurred daily. My back was always stiff in the morning.

Morning physical fitness training (PT) exacerbated my symptoms. PT was a daily requirement and involved a 2-mile run and many exercises that place stress on the back and lower extremities: the side-straddle hop, mule kick, bend and reach, high jumper, squat bender, lunger, and knee bender are typical exercises. 20-25 exercise repetitions were normal; however, often exercise reptations were excessive in the 40-50 range. Additionally, run lengths were often 3-5 miles. The long runs and excessive number of exercise repetitions caused my back and lower extremity symptoms to worsened significantly during my last few years of service; especially considering my weight gain during service. My weight at enlistment exam was 126 and on my retirement exam my weight was 174 for a 48-pound gain.

Daily marching (2 miles per day) and prolonged standing (8-10 hours daily with 4-5 hours continuously per day without rest) while performing my normal duties added to the severity level of back and lower extremity symptoms. I was involved in tactical training or real-world deployments for approximately 3-4 months a year on average with some missions lasting as long 6 months. During these periods, I was required to be in full combat gear; including M16, helmet, flak vest, web gear, ammunition, full water canteen, and combat boots. This gear was required to be worn on average of 10-12 hours per day and often for up to 18 hours per day. A backpack weighing approximately 20-30 pounds was often also worn. This heavy load of equipment kept all back and lower extremity symptoms in a nearly constant state of flare.

**Current back symptoms, functional limitations, and diagnoses**

My back and lower extremity symptoms that began in-service including pain, weakness, stiffness, tenderness, and radiculopathy causing pain and tingling down both of my lower extremities continued continuously after service to the present; these symptoms currently cause significant functional limitations. I have stopped running and all bending over exercises as both endeavors cause an exacerbation of symptoms. Even a brisk walk will exacerbate my back and lower extremity symptoms. I walk at a slow pace due to back pain and my lower extremities tire quickly limiting my walks to a duration of 15-30 minutes. I try to supplement my walking limitations with bike riding; however, due to severe lower extremity symptoms I am only able to tolerate bike riding occasionally. Sitting on any type of exercise device, including bikes, is unbearable as the seats are too hard causing back and sciatica type pain.

Standing in place for more ten minutes is intolerable, such as standing in a long checkout line after shopping. Often, I cannot bend forward or down due to back and lower extremity pain. I can only tolerate sitting in normal chairs for a few minutes before sciatica type pain becomes intolerable. At home I use a well cushioned couch, recliner, or bed for rest. Typically, my back is under stress from walking, standing, and kneeling for 2-3 hours per day; during this time, I must have frequent rest periods due to back and sciatica type pain, as well as, lower extremity weakness. By the end each day, often my back range of motion (ROM) is reduced by approximately one third.

After service I continued to self-treat my back symptoms with over-the-counter pain medications, heat, and rest. Most symptoms are mitigated to tolerable levels within a few hours of selfcare. My selfcare negates the need to seek professional medical care for my back and lower extremity symptoms; thus, I have never sought treatment specifically for these problems. I do attend my annual VA physicals and through that process I have reported my back and lower extremity problems. Currently two back related diagnoses are current per VA health records: bilateral lower extremity radiculopathy (12/12/2021) and degenerative joint disease (02/02/2015).

**Flare ups**

Currently 1-2 days per week every week I experience back and lower extremity symptom flare-ups to varying degrees. Flare-ups are brought on by activity. Typically, my ROM is reduced by half; however, occasionally ROM is reduced by ¾ and at times ROM reduced completely; in other words, I cannot bend forward at all. On these occasions, my mobility is severely or completely limited due to pain. During a typical flare-up standing in place for more than a couple of minutes is not possible and walking is limited to movements within my home (approximately 20 feet) such as going to the bathroom or answering the doorbell. On extreme flare-ups (typically once every two months), I am restricted to my recliner with no possibility of weight bearing and require assistance to move such as going to the restroom. Sometimes crutch use is possible. Radiculopathy also often flares at least twice monthly severely limiting my mobility and ability to sit or stand; often, I am forced to lay on my side. During radiculopathy flare ups the pain to one or both legs is 8-10 on the 10 scale.

**Diagnostics and assistive devices**

The following MRIs, X-rays, and prescribed assistive devices are relevant to my back claim; hence, I ask they be given due consideration:

1. Back MRI results dated September 5, 2021.
2. Back X-ray results dated August 25, 2021.
3. Crutches prescribed August 25, 2021.

**Published Considerations**

I believe the following manuals, studies, journal articles, and other treatise are relevant to my back claim; hence, I ask they be given due consideration:

1. **Journal Article: Incidence of Physician-Diagnosed Osteoarthritis Among Active-Duty United States Military Service Members**

The article concludes “Rates of osteoarthritis were **significantly higher** in military populations than in comparable age groups in the general population” and states “Studies also suggest that physical activity involving **repetitive joint** loading may be associated with the occurrence of osteoarthritis” (page 2974). PT, workday duties, and tactical environment duties placed extreme repetitive stress on my feet, ankles, and back.

1. **Journal Article: Flat foot and spinal degeneration: Evidence from nationwide population-based cohort study**

This study concluded “that that people at all age groups diagnosed with flat foot having a modest risk of developing spinal degeneration.” I have flatfeet and DJD.

1. **Journal Article: A systematic review: The effects of podiatrical deviations on nonspecific chronic low back pain**

This review concluded “it can be inferred from this review that deviations in the ankle and foot have an impact on the lower back and are a potential cause for chronic LBP.” I have both flatfeet and ankle problems.

1. **CDC Article: Physical Activity for a Healthy Weight**

The article states “To maintain your weight: Work your way up to 150 minutes of **moderate**-intensity aerobic activity, 75 minutes of **vigorous**-intensity aerobic activity, or an equivalent mix of the two each week. Strong scientific evidence shows that physical activity can help you maintain your weight over time.” In my case, vigorous-intensity aerobic activities are completely out of the question: even routine moderate-intensity aerobic activity like brisk walking and bike riding would cause my feet and ankle conditions to flare resulting in unnecessary pain and functional limitations.

I always exercise within my known limitations; however, I cannot exercise enough to maintain my weight at recommended levels. Due to my limited exercise capacity, I do my best to control my diet. I limit my calorie intake to 1800 per day. This pretty much maintains my current weight; however, continuously limiting my calories does have an adverse impact on my mental health. I have tried reducing my calorie intake to 1500 per day to lose weight; however, I eventually become extremely depressed. Limiting my calorie intake to 1800 per day is a balance between my physical and mental health that for the most part works for me.

1. **Diagnostic and Statistical Manual of Mental Disorders (DSM–5)**

I am service connected for Major Depressive Disorder (MDD). DSM-5 notes weight gain as part of the diagnostic criteria: “Significant weight loss when not dieting or **weight** **gain** (e.g., a change of more than 5% of bodyweight in a month), or decrease or **increase in** **appetite** nearly every day.” Weight gain due to increased appetite is absolutely one of the defining characteristics of my MDD. It is a constant battle to control my food cravings especially considering that eating absolutely lessens my depressive symptoms at least momentarily.

Not being able to eat the things I like most due to high calorie content is a factor that always weighs heavily on my mind; however, as noted above I have found a balance between my physical and mental health in relation to weight. I want to make it clear that maintaining this balance is a constant struggle resulting in weight fluctuations. Also, there are times where my depressive symptoms are so severe that I am unable to exercise; during these times, I find it difficult to accomplish anything and I am often suicidal. My weight fluctuations are directly related to the severity level fluctuations of my depression.

**I CERTIFY THAT the statements on this document are true and correct to the best of my knowledge and belief.**

**Sign: Date:**