Neurological and Convulsive Disorders

Trainee Handout

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Objectives

* understand the various etiologies and the prevalence of neurological and convulsive disorders
* recognize those conditions most frequently claimed under the neurological system and understand how top rate neurological issues.

References

* [38 CFR 3.350 - Special monthly compensation ratings](http://vbaw.vba.va.gov/bl/21/publicat/Regs/Part3/3_350.htm)
* [38 CFR 4.120 - Evaluations by Comparison](http://vbaw.vba.va.gov/bl/21/publicat/Regs/Part4/4_120.htm)
* [38 CFR 4.121 - Identification of epilepsy](http://vbaw.vba.va.gov/bl/21/publicat/Regs/Part4/4_121.htm)
* [38 CFR 4.122 - Psychomotor epilepsy](http://vbaw.vba.va.gov/bl/21/publicat/Regs/Part4/4_122.htm)
* [38 CFR 4.123 - Neuritis, Cranial or Peripheral](http://vbaw.vba.va.gov/bl/21/publicat/Regs/Part4/4_123.htm)
* [38 CFR 4.124 (a) - Schedule of Ratings - Neurological Conditions](http://vbaw.vba.va.gov/bl/21/Publicat/Regs/Part4/4_124a.htm)
* [38 CFR 4.31 - A no-percent rating](http://vbaw.vba.va.gov/bl/21/publicat/Regs/Part4/4_31.htm)
* [M21-1, Part III, Subpart iv, 4, G - Neurological Conditions and Convulsive Disorders](https://vaww.compensation.pension.km.va.gov/system/templates/selfservice/va_ka/)

Topic 1: General Considerations

**Neurological and convulsive disorders**

Neurological and convulsive disorders can result from a variety of conditions, such as brain injury due to trauma and cerebrovascular accidents, organic diseases of the central nervous system, nutritional deficiency and diabetes.

With the increasing frequency of service connection for diabetes, Parkinson’s Disease, Multiple Sclerosis (MS), Amyotrophic Lateral Sclerosis (ALS), Traumatic Brain Injury (TBI), Cerebral Vascular accidents (CVA), and Organic diseases of the Central Nervous System recognizing and evaluating functional impairment due to neurological abnormalities has become a major concern.

The neurological system connects the central nervous system with the periphery of the body. There are 12 pairs of cranial nerves and 31 pairs of spinal nerves. Also, there are certain nerves concerned with the involuntary muscular movements of the body**.**

**Evaluation, general considerations**

***Organic diseases of the nervous system and epilepsy are included under 38 CFR 3.309(a) as subject to presumptive service connection.***

**Excerpt from M21-1, Part III. Subpart iv, 4, G**

|  |  |
| --- | --- |
| **When ...** | **Then ...** |
| considering questions of incurrence or aggravation in service | bear in mind the etiology and clinical course of each separate disease. |
| considering conditions of infectious origin | consider both the circumstances of infection and the incubation period. |
| determining aggravation for conditions such as multiple sclerosis, progressive muscular atrophy, and myasthenia gravis | be aware that increased symptomatology over a period of a few months may reflect natural progression of the disease. Base determinations on the developed medical evidence of record. |

**§4.120 Evaluations by comparison.**

Disability in this field is ordinarily to be rated in proportion to the impairment of motor, sensory or mental function. Consider especially psychotic manifestations, complete or partial loss of use of one or more extremities, speech disturbances, impairment of vision, disturbances of gait, tremors, visceral manifestations, injury to the skull, etc. In rating disability from the conditions in the preceding sentence refer to the appropriate schedule. In rating peripheral nerve injuries and their residuals, attention should be given to the site and character of the injury, the relative impairment in motor function, trophic changes, or sensory disturbances.

* Neurological conditions and convulsive disorders are to be rated in proportion to impairment of motor, sensory or mental function.
* Be cautioned against *lumping* of disabilities arising from organic disease of the central nervous system. For example**,** a single 100% evaluation under **DC 8018** for multiple sclerosis with loss of use of both lower extremities may overlook involvement of other body systems that may meet requirements for an intermediate rate under **38 CFR** **3.350(f)(3)**, or the next higher rate under **38 CFR 3.350(f)(4)**. In such a case a 100% evaluation for loss of use of both lower extremities should be assigned under **DC 8018-5110** and any involvement of other extremities, or other disabilities due to multiple sclerosis, rated separately and combined. *(SMC will be covered in more depth in a separate lesson.)*

Topic 2: Diseases of the Central Nervous System

**Organic diseases of the central nervous system**

* As indicated in paragraph 4.124a of the schedule, (with the exceptions noted) these disabilities and their residuals may be rated 10% to 100% in proportion to the degree of impairment. You are to consider psychotic manifestations, loss of use, speech disturbances, vision, etc. By the very nature of these diseases, it will be seldom that moderate to far advanced conditions will result in only disturbances of one body system. With partial loss of use of one or more extremities from neurological lesions, rate by comparison with the mild, moderate, severe, or complete paralysis of peripheral nerves.
* There must be ascertainable residuals for a compensable evaluation. If there are no residuals, a 0% evaluation is to be assigned (Paragraph 4.31 of the schedule).
* The organic diseases of the central nervous system are evaluated as shown under diagnostic codes 8000 to 8046. Every disease listed is shown here. We will *briefly* discuss some of the more important aspects of these conditions.

**8000** Encephalitis, epidemic, chronic:

Epidemic encephalitis is a disease caused by any of several viruses with symptoms of fever, malaise, sore throat, nausea, vomiting, lethargy, coma and convulsions.

 As active febrile disease 100

 Rate residuals, minimum 10

**8002** (Brain, new growth of) Malignant 100

 Note: The rating in code 8002 will be continued for 2 years following cessation of surgical, chemotherapeutic or other treatment modality. At this point, if the residuals have stabilized, the rating will be made on neurological residuals according to symptomatology.

 Minimum rating 30

**8003** (Brain, new growth of) Benign, minimum 60

 Rate residuals, minimum 10

* Notice that under DC 8003 a benign growth of the brain warrants a 60% evaluation. This evaluation refers to a growth as an active process and one which has not been the subject of surgery.

**8004** Paralysis agitans:

 Minimum rating 30

* DC's 8005 - 8009 refer to disability of the brain vessels. You are cautioned that the 100% evaluation specified for six months under DC 8007-DC 8009, is not an exclusive evaluation during that period. Recall our previous discussion of "lumping" of disabilities. If special monthly compensation is payable by separate evaluation of the various disabilities resulting from a disease of the brain vessels, separate evaluation is required.

**8005** Bulbar palsy 100

**8007** Brain, vessels, embolism of.

**8008** Brain, vessels, thrombosis of.

**8009** Brain, vessels, hemorrhage from:

 Rate the vascular conditions under Codes 8007 through 8009,

 for 6 months 100

 Rate residuals, thereafter, minimum 10

**8010** Myelitis:

 Minimum rating 10

**8011** Poliomyelitis, anterior:

 As active febrile disease 100

 Rate residuals, minimum 10

**8012** Hematomyelia:

 For 6 months 100

 Rate residuals, minimum 10

**8013** Syphilis, cerebrospinal.

**8014** Syphilis, meningovascular.

**8015** Tabes dorsalis.

 Note: Rate upon the severity of convulsions, paralysis, visual impairment or psychotic involvement, etc.

**8017** Amyotrophic lateral sclerosis:

 Minimum rating 30

**8018** Multiple sclerosis:

 Minimum rating 30

**The presumptive period for multiple sclerosis is seven years as defined in 38 CFR 3.307(a)(3) and 3.309(a).**

**Excerpt from** **III.iv.4.G.5.a.**

Definition: Multiple Sclerosis - Multiple sclerosis (MS) is a slowly progressive central nervous system disease, and is characterized by

* disseminated patches of demyelination in the brain and spinal cord which cause multiple and varied neurologic symptoms and signs, and
* the occurrence of remissions and exacerbations in the symptoms.

**Evaluating a Residual MS Disability 30 Percent or More**

In cases of multiple sclerosis

* evaluate each affected system or body part separately
* show the DC for MS only once by listing it with the most severely affected function
* code involvement of other manifestations thereafter under the DC assignable for the condition on which the evaluation is based, and
* show the remaining conditions as secondary to multiple sclerosis.

***Notes:***

* This is a change from the previous requirement to evaluate MS as a single disability when the combined degree was less than 100 percent.
* If the combined evaluation for all disabilities due to MS is 20 percent or less, assign a 30-percent evaluation under 38 CFR 4.124a, DC 8018.

**Important*: Readjudicate cases previously evaluated as a single disability as they are encountered under the procedure outlined above.***

**8019** Meningitis, cerebrospinal, epidemic:

 As active febrile disease 100

 Rate residuals, minimum 10

**8020** Brain, abscess of:

 As active disease 100

 Rate residuals, minimum 10

**8021** (Spinal cord, new growths of) Malignant 100

Note: The rating in code 8021 will be continued for 2 years following cessation of surgical, chemotherapeutic or other treatment modality. At this point, if the residuals have stabilized, the rating will be made on neurological residuals according to symptomatology.

 Minimum rating 30

**8022** (Spinal cord, new growths of) Benign, minimum rating 60

 Rate residuals, minimum 10

**8023** Progressive muscular atrophy:

 Minimum rating 30

Excerpt from M21-1 Part III. Subpart iv.4.G..- Evaluating Progressive Spinal Muscular Atrophy

Progressive muscular atrophy, 38 CFR 4.124a, diagnostic code (DC) 8023, refers to progressive spinal muscular atrophy, which is a disease of the spinal cord.

Progressive muscular atrophy is subject to presumptive SC under 38 CFR 3.309(a) because it is an organic disease of the nervous system.

**8024** Syringomyelia:

 Minimum rating 30

**8025** Myasthenia gravis:

 Minimum rating 30

Note: It is required for the minimum ratings for residuals under diagnostic codes 8000-8025, that there be ascertainable residuals. Determinations as to the presence of residuals not capable of objective verification, i.e., headaches, dizziness, fatigability, must be approached on the basis of the diagnosis recorded; subjective residuals will be accepted when consistent with the disease and not more likely attributable to other disease or no disease. It is of exceptional importance that when ratings in excess of the prescribed minimum ratings are assigned, the diagnostic codes utilized as bases of evaluation be cited, in addition to the codes identifying the diagnoses.

**8045** Brain disease due to trauma:

 Purely neurological disabilities, such as hemiplegia, epileptiform seizures, facial nerve paralysis, etc., following trauma to the brain, will be rated under the diagnostic codes specifically dealing with such disabilities, with citation of a hyphenated diagnostic code (e.g., 8045–8207).

 Purely subjective complaints such as headache, dizziness, insomnia, etc., recognized as symptomatic of brain trauma, will be rated 10 percent and no more under diagnostic code 9304. This 10 percent rating will not be combined with any other rating for a disability due to brain trauma. Ratings in excess of 10 percent for brain disease due to trauma under diagnostic code 9304 are not assignable in the absence of a diagnosis of multi-infarct dementia associated with brain trauma.

**8046** Cerebral arteriosclerosis:

 Purely neurological disabilities, such as hemiplegia, cranial nerve paralysis, etc., due to cerebral arteriosclerosis will be rated under the diagnostic codes dealing with such specific disabilities, with citation of a hyphenated diagnostic code (e.g., 8046-8207).

 Purely subjective complaints such as headache, dizziness, tinnitus, insomnia and irritability, recognized as symptomatic of a properly diagnosed cerebral arteriosclerosis, will be rated 10 percent and no more under diagnostic code 9305. This 10 percent rating will not be combined with any other rating for a disability due to cerebral or generalized arteriosclerosis. Ratings in excess of 10 percent for cerebral arteriosclerosis under diagnostic code 9305 are not assignable in the absence of a diagnosis of multi-infarct dementia with cerebral arteriosclerosis.

 Note: The ratings under code 8046 apply only when the diagnosis of cerebral arteriosclerosis is substantiated by the entire clinical picture and not solely on findings of retinal arteriosclerosis.

**Miscellaneous diseases (DC 8100-8108*)***

* These codes cover diseases of a neurological nature not listed elsewhere.

**8100** Migraine:

Migraines are characterized by paroxysmal attacks of headache often preceded by psychologic or visual disturbances and sometimes followed by drowsiness.

 With very frequent completely prostrating and prolonged attacks

 productive of severe economic inadaptability 50

 With characteristic prostrating attacks occurring on an average once

 a month over last several months................................................ 30

 With characteristic prostrating attacks averaging one in 2 months over last

 several months 10

 With less frequent attacks 0

**8103** Tic, convulsive:

 Severe……………… 30

 Moderate………………………. ………………………………………………10

 Mild……………………………………………………………………………...…. 0

 Note: Depending upon frequency, severity, muscle groups involved.

**8104** Paramyoclonus multiplex (convulsive state, myoclonic type):

 Rate as tic; convulsive; severe cases ………………..60

**8105** Chorea, Sydenham’s:

Sydenham's chorea is a disease characterized by involuntary, irregular movements, incoordination of voluntary movements, mild muscle weakness and emotional disturbances.

 Pronounced, progressive grave types 100

 Severe……… 80

 Moderately severe 50

 Moderate… 30

 Mild…….. 10

Note: Consider rheumatic etiology and complications.

**8106** Chorea, Huntington’s.

Rate as Sydenham’s chorea. This, though a familial disease, has its onset in late adult life, and is considered a ratable disability.

* Attention is called to the note following DC 8105 (chorea, Sydenham's). With this disease you should consider rheumatic etiology. If rheumatic in origin there may be additional disabilities warranting service connection and evaluation. (Refer to the Cardiovascular training material for the various complications of rheumatic fever (DC 7000). Also note that even though Huntington's Chorea is a familial disease, it is a ratable disability under DC 8106.

**8107** Athetosis, acquired.

 Rate as chorea.

**8108** Narcolepsy.

 Rate as for epilepsy, petit mal.

Narcolepsy is a chronic, clinical syndrome characterized by recurrent episodes of uncontrollable desire to sleep. The sleep is similar to normal sleep, but may occur at inappropriate times and the attacks may occur once or several times each day lasting minutes to hours.

**THE CRANIAL NERVES**



**§4.123 Neuritis, cranial or peripheral.**

Neuritis, cranial or peripheral, characterized by loss of reflexes, muscle atrophy, sensory disturbances, and constant pain, at times excruciating, is to be rated on the scale provided for injury of the nerve involved, with a maximum equal to severe, incomplete, paralysis. See nerve involved for diagnostic code number and rating.

The maximum rating which may be assigned for neuritis not characterized by organic changes referred to in this section will be that for moderate, or with sciatic nerve involvement, for moderately severe, incomplete paralysis.

**§4.124 Neuralgia, cranial or peripheral.**

Neuralgia, cranial or peripheral, characterized usually by a dull and intermittent pain, of typical distribution so as to identify the nerve, is to be rated on the same scale, with a maximum equal to moderate incomplete paralysis. See nerve involved for diagnostic code number and rating. Tic douloureux, or trifacial neuralgia, may be rated up to complete paralysis of the affected nerve.

* Following each cranial nerve listed there is a note indicating the evaluation, dependent upon the degree of interference with the function of the nerve involved. For example, the seventh cranial nerve (DC 8207) is the facial nerve and its function is that of motor, secretion, vasomotion, etc. Evaluation will be dependent upon the loss of innervation (loss of nerve stimulus) of the facial muscles.
* Following the nerve specified there are three diagnostic codes pertaining to that nerve. Rating of the nerve may be on the basis of paralysis (either complete or incomplete), neuritis; or neuralgia. Neuritis of a nerve is inflammation attended by pain and tenderness of the nerve, anesthesia, disturbances of sensation and may result in paralysis, wasting and disappearance of the reflexes associated with the nerve involved. Neuralgia is paroxysmal pain extending along the course of the nerve.
* In rating, use the diagnostic code that best reflects the nature of the disability-- paralysis, neuralgia or neuritis of the nerve.
* The note following DC 8405 concerning tic douloureux states this condition may be rated in accordance with severity, up to complete paralysis.
* Disability from lesions of peripheral portions of first, second, third, fourth, sixth, and eighth nerves will be rated under the Organs of Special Sense. The ratings for the cranial nerves are for unilateral involvement; when bilateral, combine but without the bilateral factor.

 **Fifth (trigeminal) cranial nerve**

**8205** Paralysis of:

 Complete 50

 Incomplete, severe 30

 Incomplete, moderate 10

 Note: Dependent upon relative degree of sensory manifestation or motor loss.

**8305** Neuritis.

**8405** Neuralgia.

 Note: Tic douloureux may be rated in accordance with severity, up to complete paralysis.

 **Seventh (facial) cranial nerve**

**8207** Paralysis of:

 Complete 30

 Incomplete, severe 20

 Incomplete, moderate 10

 Note: Dependent upon relative loss of innervation of facial muscles.

**8307** Neuritis.

**8407** Neuralgia.

 **Ninth (glossopharyngeal) cranial nerve**

**8209** Paralysis of:

 Complete 30

 Incomplete, severe 20

 Incomplete, moderate 10

Note: Dependent upon relative loss of ordinary sensation in mucous membrane of the pharynx, fauces, and tonsils.

**8309** Neuritis.

**8409** Neuralgia.

 **Tenth (pneumogastric, vagus) cranial nerve**

**8210** Paralysis of:

 Complete 50

 Incomplete, severe 30

 Incomplete, moderate 10

Note: Dependent upon extent of sensory and motor loss to organs of voice, respiration, pharynx, stomach and heart.

**8310** Neuritis.

**8410** Neuralgia.

 **Eleventh (spinal accessory, external branch) cranial nerve**

**8211** Paralysis of:

 Complete 30

 Incomplete, severe 20

 Incomplete, moderate 10

Note: Dependent upon loss of motor function of sternomastoid and trapezius muscles.

**8311** Neuritis.

**8411** Neuralgia.

 **Twelfth (hypoglossal) cranial nerve**

**8212** Paralysis of:

 Complete…………. 50

 Incomplete, severe 30

 Incomplete, moderate 10

Note: Dependent upon loss of motor function of tongue.

**8312** Neuritis.

**8412** Neuralgia.

**DISEASES OF THE PERIPHERAL NERVES (DC 8510-8730)**

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* The schedule follows the same format for these diseases as that for diseases of the cranial nerves. That is, the nerves are listed followed by diagnostic codes for paralysis, neuritis and neuralgia for that particular nerve.

The term “incomplete paralysis” with this and other peripheral nerve injuries indicates a degree of lost or impaired function substantially less than the type pictured for complete paralysis given with each nerve, whether due to varied level of the nerve lesion or to partial regeneration. When the involvement is wholly sensory, the rating should be for the mild, or at most, the moderate degree. The following ratings for the peripheral nerves are for unilateral involvement; when bilateral, combine with application of the bilateral factor. A muscle injury rating will not be combined with a peripheral nerve paralysis rating of the same body part, unless the injuries affect entirely different functions.

**Upper radicular group (fifth and sixth cervicals** *Major Minor*

**8510** Paralysis of:

 Complete; all shoulder and elbow movements lost or severely

 affected, hand and wrist movements not affected 70 60

 Incomplete:

 Severe 50 40

 Moderate 40 30

 Mild 20 20

**8610** Neuritis

**8710** Neuralgia

 **Middle radicular group**

**8511** Paralysis of:

 Complete; adduction, abduction, and rotation of arm, flexion of

 elbow, and extension of wrist lost or severely affected 70 60

 Incomplete:

 Severe 50 40

 Moderate 40 30

 Mild 20 20

**8611** Neuritis

**8711** Neuralgia

 **Lower radicular group**

**8512** Paralysis of

 Complete; all intrinsic muscles of hand, and some or all of

 flexors of wrist and fingers, paralyzed (substantial loss of use

 of hand) 70 60

 Incomplete:

 Severe…………………………………………………………………………50……...40

 Moderate………….……………………………………………… …………..40 ……...30

Mild……… 20 20

**8612** Neuritis

**8712** Neuralgia

 **All radicular groups**

**8513** Paralysis of:

 Complete ……………………………………………………………….. 90 ………80

 Incomplete:

 Severe ..70 60

 Moderate 40 30

 Mild 20 20

**8613** Neuritis

**8713** Neuralgia

 **The musculospiral nerve (radial nerve)**

**8514** Paralysis of:

 Complete; drop of hand and fingers, wrist and fingers perpetually

 flexed, the thumb adducted falling within the line of the outer

 border of the index finger; can not extend hand at wrist, extend

 proximal phalanges of fingers, extend thumb, or make lateral

 movement of wrist; supination of hand, extension and flexion

 of elbow weakened, the loss of synergic motion of extensors

 impairs the hand grip seriously; total paralysis of the triceps

 occurs only as the greatest rarity 70 60

 Incomplete:

 Severe 50 40

 Moderate 30 20

 Mild 20 20

**8614** Neuritis

**8714** Neuralgia

Note: Lesions involving only “dissociation of extensor communis digitorum” and “paralysis below the extensor communis digitorum,” will not exceed the moderate rating under code 8514.

 **The median nerve**

**8515** Paralysis of:

 Complete; the hand inclined to the ulnar side, the index and middle

 fingers more extended than normally, considerable atrophy of the

 muscles of the thenar eminence, the thumb in the plane of the hand

 (ape hand); pronation incomplete and defective, absence of flexion

 of index finger and feeble flexion of middle finger, cannot make a fist,

 index and middle fingers remain extended; cannot flex distal phalanx

 of thumb, defective opposition and abduction of the thumb at right

 angles to palm; flexion of wrist weakened; pain with trophic

 disturbances 70 60

 Incomplete:

 Severe 50 40

 Moderate 30 20

 Mild 10 10

**8615** Neuritis

**8715** Neuralgia

 **The ulnar nerve**

**8516** Paralysis of:

 Complete; the “griffin claw” deformity, due to flexor contraction of

 ring and little fingers, atrophy very marked in dorsal interspace

 and thenar and hypothenar eminences; loss of extension of ring

 and little fingers, cannot spread the fingers (or reverse), cannot

 adduct the thumb; flexion of wrist weakened 60 50

 Incomplete:

 Severe 40 30

 Moderate 30 20

 Mild 10 10

**8616** Neuritis

**8716** Neuralgia

 **Musculocutaneous nerve**

**8517** Paralysis of:

 Complete; weakness but not loss of flexion of elbow and

 supination of forearm 30 20

 Incomplete:

 Severe 20 20

 Moderate 10 10

 Mild 0 0

**8617** Neuritis

**8717** Neuralgia

 **Circumflex nerve**

**8518** Paralysis of:

 Complete; abduction of arm is impossible, outward rotation is

 weakened; muscles supplied are deltoid and teres minor 50 40

 Incomplete:

 Severe 30 20

 Moderate 10 10

 Mild 0 0

**8618** Neuritis

**8718** Neuralgia

 **Long thoracic nerve**

**8519** Paralysis of:

 Complete; inability to raise arm above shoulder level, winged

 scapula deformity 30 20

 Incomplete:

 Severe 20 20

 Moderate 10 10

 Mild 0 0

Note: Not to be combined with lost motion above shoulder level.

**8619** Neuritis

**8719** Neuralgia

Note: Combined nerve injuries should be rated by reference to the major involvement, or if sufficient in extent, consider radicular group ratings.

 **Sciatic nerve**

**8520** Paralysis of:

 Complete; the foot dangles and drops, no active movement possible

 of muscles below the knee, flexion of knee weakened or (very

 rarely) lost 80

 Incomplete:

 Severe, with marked muscular atrophy 60

 Moderately severe 40

 Moderate 20

 Mild 10

**8620** Neuritis.

**8720** Neuralgia.

 **External popliteal nerve (common peroneal)**

**8521** Paralysis of:

 Complete; foot drop and slight droop of first phalanges of all toes,

 cannot dorsiflex the foot, extension (dorsal flexion) of proximal

 phalanges of toes lost; abduction of foot lost, adduction weakened;

 anesthesia covers entire dorsum of foot and toes 40

 Incomplete:

 Severe 30

 Moderate 20

 Mild 10

**8621** Neuritis

**8721** Neuralgia.

 **Musculocutaneous nerve (superficial peroneal)**

**8522** Paralysis of:

 Complete; eversion of foot weakened 30

 Incomplete:

 Severe 20

 Moderate 10

 Mild 0

**8622** Neuritis.

**8722** Neuralgia.

 **Anterior tibial nerve (deep peroneal)**

**8523** Paralysis of:

 Complete; dorsal flexion of foot lost 30

 Incomplete:

 Severe 20

 Moderate 10

 Mild 0

**8623** Neuritis.

**8723** Neuralgia.

 **Internal popliteal nerve (tibial)**

**8524** Paralysis of:

 Complete; plantar flexion lost, frank adduction of foot impossible,

 flexion and separation of toes abolished; no muscle in sole can

 move; in lesions of the nerve high in popliteal fossa, plantar flexion

 of foot is lost 40

 Incomplete:

 Severe 30 Moderate 20 Mild 10

**8624** Neuritis.

**8724** Neuralgia

 **Posterior tibial nerve**

**8525** Paralysis of:

 Complete; paralysis of all muscles of sole of foot, frequently with painful

 paralysis of a causalgic nature; toes cannot be flexed; adduction

 is weakened; plantar flexion is impaired 30

 Incomplete:

 Severe 20

 Moderate 10

 Mild 10

**8625** Neuritis.

**8725** Neuralgia.

 **Anterior crural nerve (femoral)**

**8526** Paralysis of:

 Complete; paralysis of quadriceps extensor muscles 40

 Incomplete:

 Severe 30

 Moderate 20

 Mild 10

**8626** Neuritis.

**8726** Neuralgia.

 **Internal saphenous nerve**

**8527** Paralysis of:

 Severe to complete 10

 Mild to moderate 0

**8627** Neuritis.

**8727** Neuralgia.

 **Obturator nerve**

**8528** Paralysis of:

 Severe to complete 10

 Mild or moderate 0

**8628** Neuritis.

**8728** Neuralgia.

 **External cutaneous nerve of thigh**

**8529** Paralysis of:

 Severe to complete 10

 Mild or moderate 0

**8629** Neuritis.

**8729** Neuralgia.

 **Ilio-inguinal nerve**

**8530** Paralysis of:

 Severe to complete 10

 Mild or moderate 0

**8630** Neuritis.

**8730** Neuralgia.

**8540** Soft-tissue sarcoma (of neurogenic origin) 100

Note: The 100 percent rating will be continued for 6 months following the cessation of surgical, X-ray, antineoplastic chemotherapy or other therapeutic procedure. At this point, if there has been no local recurrence or metastases, the rating will be made on residuals.

**EPILEPSIES (DC 8910-8914)**

Identification of epilepsy is discussed in paragraph 4.121 of the schedule.

**§4.121 Identification of epilepsy.**

 When there is doubt as to the true nature of epileptiform attacks, neurological observation in a hospital adequate to make such a study is necessary. To warrant a rating for epilepsy, the seizures must be witnessed or verified at some time by a physician. As to frequency, competent, consistent lay testimony emphasizing convulsive and immediate post-convulsive characteristics may be accepted. The frequency of seizures should be ascertained under the ordinary conditions of life (while not hospitalized).

**M21-1, Part III.Subpart iv.4.G.**

Seizures must be witnessed or verified by a physician to warrant service connection for epilepsy. Verification may be by an electroencephalogram (EEG), which measures electrical activity in the brain.

A physician does not have to witness an actual seizure before a diagnosis of epilepsy can be accepted for rating purposes. Verification by a physician based upon factors other than observing an actual seizure is sufficient.

***Reference***: For more information on

* identifying epilepsy, see 38 CFR 4.121, and
* psychomotor epilepsy, see 38 CFR 4.122.

Psychomotor epilepsy, DC 8914, is discussed in Section 4.122 of the rating schedule.

**§4.122 Psychomotor epilepsy.**

 The term psychomotor epilepsy refers to a condition that is characterized by seizures and not uncommonly by a chronic psychiatric disturbance as well.

1. Psychomotor seizures consist of episodic alterations in conscious control that

 may be associated with automatic states, generalized convulsions, random motor movements (chewing, lip smacking, fumbling), hallucinatory phenomena (involving taste, smell, sound, vision), perceptual illusions (deja vu, feelings of loneliness, strangeness, macropsia, micropsia, dreamy states), alterations in thinking (not open to reason), alterations in memory, abnormalities of mood or affect (fear, alarm, terror, anger, dread, well-being), and autonomic disturbances (sweating, pallor, flushing of the face, visceral phenomena such as nausea, vomiting, defecation, a rising feeling of warmth in the abdomen). Automatic states or automatisms are characterized by episodes of irrational, irrelevant, disjointed, unconventional, asocial, purposeless though seemingly coordinated and purposeful, confused or inappropriate activity of one to several minutes (or, infrequently, hours) duration with subsequent amnesia for the seizure. Examples: A person of high social standing remained seated, muttered angrily, and rubbed the arms of his chair while the National Anthem was being played; an apparently normal person suddenly disrobed in public; a man traded an expensive automobile for an antiquated automobile in poor

mechanical condition and after regaining conscious control, discovered that he had signed an agreement to pay an additional sum of money in the trade. The seizure manifestations of psychomotor epilepsy vary from patient to patient and in the same patient from seizure to seizure.

 (b) A chronic mental disorder is not uncommon as an interseizure manifestation of psychomotor epilepsy and may include psychiatric disturbances extending from minimal anxiety to severe personality disorder (as distinguished from developmental) or almost complete personality disintegration (psychosis). The manifestations of a chronic mental disorder associated with psychomotor epilepsy, like those of the seizures, are protean in character.

* Evaluations are based on the frequency and type of seizures. Please note that a 10% evaluation is now warranted based on a confirmed diagnosis of epilepsy with a history of seizures.
* The notes following the general rating formula must be complied with. As stated, when continuous medication is required for control of epilepsy, a minimum evaluation of 10% not to be combined with any other rating for epilepsy is to be assigned. Also, in the presence of major and minor seizures rate the predominate type. There is to be no distinction between diurnal and nocturnal major seizures.

**8910** Epilepsy, grand mal.

 Rate under the general rating formula for major seizures.

**8911** Epilepsy, petit mal.

 Rate under the general rating formula for minor seizures.

Note (1): A major seizure is characterized by the generalized tonic-clonic convulsion with unconsciousness.

 Note (2): A minor seizure consists of a brief interruption in consciousness or conscious control associated with staring or rhythmic blinking of the eyes or nodding of the head (“pure” petit mal), or sudden jerking movements of the arms, trunk, or head (myoclonic type) or sudden loss of postural control (akinetic type).

 General Rating Formula for Major and Minor Epileptic Seizures:

 Averaging at least 1 major seizure per month over the last year 100

 Averaging at least 1 major seizure in 3 months over the last year;

 or more than 10 minor seizures weekly 80

 Averaging at least 1 major seizure in 4 months over the last year;

 or 9-10 minor seizures per week 60

 At least 1 major seizure in the last 6 months or 2 in the last year;

 or averaging at least 5 to 8 minor seizures weekly 40

 At least 1 major seizure in the last 2 years; or at least 2 minor seizures

 in the last 6 months 20

 A confirmed diagnosis of epilepsy with a history of seizures 10

Note (1): When continuous medication is shown necessary for the control of epilepsy, the minimum evaluation will be 10 percent. This rating will not be combined with any other rating for epilepsy.

 Note (2): In the presence of major and minor seizures, rate the predominating type.

 Note (3): There will be no distinction between diurnal and nocturnal major seizures.

**8912** Epilepsy, Jacksonian and focal motor or sensory.

**8913** Epilepsy, diencephalic.

Rate as minor seizures, except in the presence of major and minor seizures, rate the predominating type.

**8914** Epilepsy, psychomotor.

 Major seizures:

 Psychomotor seizures will be rated as major seizures under the general

 rating formula when characterized by automatic states and/or

 generalized convulsions with unconsciousness.

 Minor seizures:

 Psychomotor seizures will be rated as minor seizures under the general

rating formula when characterized by brief transient episodes of random motor movements, hallucinations, perceptual illusions, abnormalities of thinking, memory or mood or autonomic disturbances.

*Mental Disorders in Epilepsies*: A nonpsychotic organic brain syndrome will be rated separately under the appropriate diagnostic code (e.g., 9304 or 9307). In the absence of a diagnosis of non-psychotic organic psychiatric disturbance (psychotic, psychoneurotic or personality disorder) if diagnosed and shown to be secondary to or directly associated with epilepsy will be rated separately. The psychotic or psychoneurotic disorder will be rated under the appropriate diagnostic code. The personality disorder will be rated as a dementia (e.g., diagnostic code 9304 or 9307).

*Epilepsy and Unemployability*:

1. Rating specialists must bear in mind that the epileptic, although his or her seizures are controlled, may find employment and rehabilitation difficult of attainment due to employer reluctance to the hiring of the epileptic.
2. Where a case is encountered with a definite history of unemployment, full and complete development should be undertaken to ascertain whether the epilepsy is the determining factor in his or her inability to obtain employment.
3. The assent of the claimant should first be obtained for permission to conduct this economic and social survey. The purpose of this survey is to secure all the relevant facts and data necessary to permit of a true judgment as to the reason for his or her unemployment and should include information as to:

 (a) Education;

 (b) Occupations prior and subsequent to service;

 (c) Places of employment and reasons for termination;

 (d) Wages received;

 (e) Number of seizures.

1. Upon completion of this survey and current examination, the case should have rating board consideration. Where in the judgment of the rating board the veteran’s unemployability is due to epilepsy and jurisdiction is not vested in that body by reason of schedular evaluations, the case should be submitted to the Director, Compensation and Pension Service.

Attachment A: : Cranial Nerves - I through XII

**I. OLFACTORY NERVE**

A. Smell*.*

**II. OPTIC NERVE**

A. Sight*.*

**III. OCULOMOTOR NERVE**

 A. Upward, inward and downward movement of eyeball.

 B. Contraction of pupil and accommodation.

 C. Muscle sensibility.

**IV. TROCHLEAR NERVE**

 A. Upward movement of eyeball.

 B. Muscle sensibilit*y.*

**V. TRIGEMINAL NERVE**

 A. Sensation of skin and mucous membranes of head and face.

 B. Mastication.

 C. Muscle sensibility.

**VI. ABDUCENS NERVE**

 A. Outward movement of eyeball.

 B. Muscle sensibility.

**VII. FACIAL NERVE**

 A. Facial expression.

 B. Glandular secretions of nasal mucosa, submaxillary and sublingual glands.

 C. Taste - Anterior part of tongue.

 D. Visceral sensibility (Soft palate and tongue).

 E. Cutaneous sensibility to external ear and mastoid area.

**VIII. ACOUSTIC NERVE**

 A. Hearing.

 B. Equilibrium.

**IX. GLOSSOPHARYNGEAL NERVE**

A. Taste--post tongue

 B. Visceral sensibility to middle ear, pharynx, tongue and carotid sinus.

 C. Glandular secretion, parotid gland.

 D. Swallowing.

 E. Phonation.

**X. VAGUS NERVE**

 A. Involuntary muscle control of heart, respiration, esophagus, stomach, muscles and glands of intestinal tract down to transverse colon.

 B. Swallowing.

 C. Phonation.

 D. Visceral sensation to organs in the throat, chest abdomen.

 E. Taste - complete tongue and epiglottis.

 F. Cutaneous sensibility to external ear and meatus.

**XI. ACCESSORY NERVE**

 A. Swallowing

 B. Phonation

 C. Movement of the head and shoulders.

**XII. HYPOGLOSSAL NERVE**

1. Movement of the tongue.

Attachment B: Cranial Nerves - How to evaluate and associated symptoms

 

Practical Exercise

Directions:

Reveiew the scenarios and choose the answer that is the most appropriate.

Circle the answer that is most appropriate.

1. Following their acute manifestations, organic diseases of the central nervous system (CNS) are as a rule rated on residuals. The veteran while on active duty had a brain abscess requiring aspiration. He had no apparent residuals affecting the nervous system when examined following discharge.

 a. In the absence of residuals, a noncompensable evaluation should be assigned.

 b. At least a 10 percent evaluation must be assigned due to residuals from a craniotomy.

 c. Brain abscesses are considered a congenital disease and service connection is not warranted.

2. Service connection was established for migraine. A claim for increase is received with a statement from veteran's physician stating that during the past year , the frequency of prostrating attacks has increased to one every month over the past year, requiring increased medication. On VA examination veteran had an attack and physician reports increase in attacks but fails to note frequency. Current evaluation is 10 percent.

 a. Rating action should be taken to continue the 10 percent evaluation.

 b. A 30 percent evaluation should be assigned.

 c. A 50 percent evaluation should be assigned and development should be taken to determine whether veteran has lost time from employment as a result of his migraine.

3. Service connection was established for narcolepsy. The veteran states he falls asleep once or twice a day averaging 9-10 episodes a week. Which of the following percentages should be assigned?

 a. 20 percent.

 b. 40 percent.

 c. 60 percent.

4. During his nineteenth year of military service, the veteran began manifesting personality changes that progressed to motor difficulties in walking, swallowing, etc. The disorder was diagnosed as Huntington's chorea, and the veteran was separated on permanent disability. At time of VA examination, dementia was demonstrated.

 a. Service connection should be disallowed, as the disorder is considered hereditary. Pension may be considered.

 b. Service connection should be allowed as the rating schedule provides for service connection. A 100 percent evaluation is assignable under DC 8106-8105. This includes the severe dementia and the ambulation difficulty.

1. Service connection can be granted and separate evaluations assigned for both mental and physical components.

5. VAE notes trigeminal neuralgia or Tic Douloureux producing severe lancinating pain. The veteran, in receipt of service-connected benefits, has claimed an increase indicating that he has many lost weeks of employment due to it.

 a. A 50 percent evaluation should be assigned.

 b. A 30 percent evaluation is warranted.

 c. A 10 percent evaluation should be assigned since paralysis is not shown.

6. The veteran served from January 14, 1996 to January 13, 2006. He had an attack of Bell's Palsy (approximately March 2005) while in service. Six months later (September 2005) the facial nerves continue to be affected. The left side of the face has no expression, the left lower eyelid droops, tears roll down the face from the affected eye. He is unable to close the left eye and there is diminished sensation on the affected side. The discharge examination showed that these residuals continued at the time of discharge from service. The veteran filed his claim for service connection on March 12, 2006.

 a. A 10 percent evaluation should be assigned under DC 8207.

 b. A 20 percent evaluation should be assigned under DC 8207.

 c. A 30 percent should be assigned and consideration given to an additional 10 percent for the left eye that cannot be closed.

7. During a partial thyroidectomy for an adenoma while in service, the veteran's recurrent laryngeal nerve was severed leaving her with bilateral vocal cord paralysis.

 a. A 50 percent evaluation should be assigned for complete paralysis of the tenth cranial nerve.

 b. Since the veteran has complete paralysis of both vocal cords, the two 50 percents should be combined and an 80 percent evaluation assigned, including bilateral factor.

 c. The veteran has complete aphonia and is entitled to a 100 percent evaluation under DC 6519. In addition, she is entitled to SMC under 38 U.S.C. § 314(k).

8. Neuritis of either the cranial or peripheral nerves will always have a higher evaluation than a neuralgia of that nerve.

 a. True

 b. False

 c. True, but only if organic changes are present.

10. The veteran suffered a through and through gunshot wound to the upper right arm, with no bone involvement. Muscle group VI (DC 5306) was involved. However, the ulnar and median nerves were damaged leaving the veteran with the inability to grasp objects. The damage is to the major extremity.

 a. A 50 percent evaluation should be assigned under DC 8512. This together with muscle damage to the arm evaluated at 30 percent under DC 5306, will give a combined evaluation of 70 percent.

 b. A 70 percent evaluation should be assigned under DC 8512. This together with a 10 percent evaluation under DC 5306 for muscle damage will give a combined evaluation of 70 percent with SMC (k) .

 c. The muscle groups involved are to be rated without combining with nerve injuries at the same location; otherwise, it would constitute pyramiding.

11. The veteran was involved in a serious auto accident in which he damaged his spine. The residuals consist of damage to the intervertebral discs at the L4-5, S1, level. The sciatic nerve is involved requiring the veteran to wear a brace on the right lower extremity due to complete foot drop.

 a. A 60 percent evaluation should be assigned.

 b. An 80 percent evaluation should be assigned.

 c. An 80 percent evaluation should be assigned based on complete paralysis with entitlement to loss of use under 38 U.S.C. §1114(k). Limitation of motion of the spine will be rated separately.

12. The veteran fell from a truck while on active duty for training. He injured his right (major) shoulder with the shock transmitted to the roots of the brachial plexus. Although no bones were broken, traumatic arthritis of the shoulder joint developed. A VA examination showed that the veteran had abduction and flexion of the right arm to 130 degrees with pain on motion (110 degrees with DeLuca factor). In addition, he had loss of sensation in the right upper extremity, with decreased grip strength and he reports intermittent pain while at rest.

 a. Assign a 10 percent evaluation for the traumatic arthritis under DC 5010- DC 5200.

 b. Assign a 40 percent evaluation under DC 8613 for the loss of sensation and reduced grip strength..

 c. Assign both a 10 evaluation under DC 5201-5010 for arthritis and a 40 percent evaluation under DC 8613, which will combine to 50 percent, a greater evaluation.

13. The veteran has documented frequency for major seizures of at least one in the last two years and minor seizures of six weekly.

 a. A 20 percent evaluation should be assigned.

 b. A 40 percent evaluation should be assigned.

 c. Before taking any rating action, the veteran should be asked whether he takes his medication. If he does not, the prior evaluation of 10 percent should be continued.

14. On review examination for seizures, veteran indicates she now has episodes of uncontrolled movements of her arms without unconsciousness. Frequency is once every two weeks. She is in receipt of service-connected benefits for psychomotor epilepsy evaluated at 40 percent for the past seven years rated under major seizures.

 a. A reduction in evaluation is warranted to 20 percent.

 b. A reduction to 10 percent should be made since major seizures are no longer occurring.

 c. The 40 percent should be allowed to continue with reexamination in two years to determine whether there has been sustained improvement.

15. Veteran's service-connected minor seizures have been rated 60 percent for three years. Treatment records indicate that during prolonged hospitalization for a fracture of the hip, the frequency of his seizures declined.

 a. Reduce based on decreased frequency during hospitalization.

 b. Grant SC for fracture of the hip due to minor seizures.

 c. Continue the 60 percent evaluation and consider examination in two years to determine if there has been sustained improvement.

16. Veteran claims service connection for seizures that began six months after service, for which he is currently on medication. Statement from his private physician verified veteran's claim as to first manifestation, indicating no known incurrent causes of seizures since discharge from service.

 a. Service connection can be granted.

 b. Further development is required.

 c. Service connection must be denied.

17. Service connection has been established for grand mal seizures evaluated 20 percent disabling. A claim for increase is received. Private treatment records show that the veteran’s physician increased his medication because the veteran had visited twice in the past twelve months reporting seizures involving unconsciousness. A VA examination shows the veteran reported having had one to two episodes of convulsion with unconsciousness in the past year. You should…

 a. Confirm and continue the 20 percent based on the VA examination.

 b. Increase to 60 percent based on frequency of seizures and increased medication.

c. Increase to 40 percent based on consideration of private treatment records and VA examination results.

18. Veteran is seen on two-year review examination for service-connected seizure disorder. The examination also shows the presence of a psychosis not previously diagnosed, but no details are given by physician.

a. Service connection should not be considered for the psychosis as related to the epilepsy.

 b. In the absence of a specific claim, only the epilepsy should be rated.

c. The examiner should be requested to state whether there is a relationship between the two disorders.