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August 5, 2026

Olivia M. Bennett, Esq.
Bennett & MacAllister
417 Harbor Avenue
Fairview, Maine 04000

Re: Carl S. Reed - Independent Medical Nexus, Rating, and Employability Opinion
Date of birth: March 3, 1956

Dear Ms. Bennett:

Purpose and records reviewed. I was asked to evaluate Mr. Reed's claimed headaches, bilateral hearing loss, bilateral knee conditions, bilateral eye condition, Type 2 diabetes mellitus, hypertension, and back condition; to state whether each is at least as likely as not related to military service; to identify the highest medically supportable rating level if service connection is granted; and to address occupational effects. I reviewed the pertinent service treatment and personnel records, DD Form 214, VA treatment records, imaging, surgical and physical-therapy records, the May 10, 2022 VA Rating Decision and code sheet, appeal materials, counsel's July 27, 2026 evaluation request, and the July 27, 2026 unsigned draft affidavit prepared from counsel's communications with Mr. Reed. Duplicate copies were not treated as independent corroboration.

Opinion standard. I applied the Department of Veterans Affairs evidentiary standard of "at least as likely as not," meaning that the favorable and unfavorable medical evidence is approximately balanced or nearly equal. This standard does not require scientific certainty. I considered direct service causation, cumulative physical loading, toxic or environmental exposure, secondary causation, permanent aggravation, and manifestation within an applicable presumptive period, as relevant to each claimed condition.

Lay evidence and military treatment culture. I gave substantial weight to Mr. Reed's competent reports of observable injuries, pain, symptom persistence, altered gait, functional limitations, self-treatment, and treatment history when medically plausible and consistent with the longitudinal evidence. Published Army survey research provides contextual support: in a modern Infantry Brigade Combat Team, 49 percent of 3,202 reported injuries were not disclosed to medical personnel, commonly because of career concerns or avoidance of duty-limiting profiles. A companion analysis found that 58 percent of surveyed Soldiers acknowledged at least one unreported injury and that 81 percent used over-the-counter pain medication for self-management [1,2]. These population studies do not prove Mr. Reed's conduct or recreate his specific 1970s unit culture, but they demonstrate that self-management and delayed reporting are medically plausible. Accordingly, absence of a troop-medical-clinic record was not treated as affirmative negative evidence unless the encounter reasonably should have documented the symptom and affirmatively recorded its absence. Objective testing, specific contemporaneous denials, intervening injuries, and competing risks were weighed in context.

Qualifications. I am Robert Townsend, D.O., a physician with more than 25 years of experience in Internal Medicine. I previously performed Department of Veterans Affairs Compensation and Pension examinations as an independent physician contractor, reviewing service treatment records and longitudinal medical evidence and addressing diagnosis, causation, permanent aggravation, functional impairment, disability severity, and employability. I am also a Veteran of the United States Army, where I served as a Combat Medic. My clinical training, prior VA disability-evaluation work, and military medical experience are directly relevant to the opinions expressed in this report.

Current VA rating context. The May 10, 2022 VA Rating Decision and code sheet list the eight conditions addressed below as denied and not service connected; therefore, none has an official compensable percentage in the materials reviewed. The percentages discussed in this report are medical recommendations only and are not VA rating assignments. Several conditions cannot be rated reliably without current condition-specific testing.

Status of the lay statement. The affidavit supplied for this review was unsigned when provided. I therefore treat it as an attributed lay statement reflecting the history obtained by counsel rather than as completed sworn testimony. Its descriptions of observable symptoms, duties, self-treatment, and functional loss are medically relevant and were weighed with the longitudinal record.

Service Background and Executive Summary

Mr. Reed served honorably in the United States Army from August 14, 1974 through August 13, 1976. His DD Form 214 records service in Korea and military education as a Tactical Wire Operator Specialist; personnel records identify MOS 36K20 and assignment to HHC, 1st Brigade, 2d Infantry Division in 1976. The role is consistent with field communications work, climbing poles, carrying equipment, repeated kneeling and bending, uneven-ground activity, and hazardous-noise exposure. The supplied packet does not document transport, spraying, testing, storage, or direct handling of tactical herbicides or another identified toxic agent. His Korean service occurred after the presumptive Korean-DMZ herbicide period, although a direct exposure theory could still be reconsidered if competent evidence identifies the agent, location, and circumstances.

Executive Opinion Summary

Favorable musculoskeletal opinions. The affidavit materially strengthens the direct and cumulative-service theories for both knees and the back. Mr. Reed describes repeated carriage of heavy wire reels and communications equipment, marching and work over rough terrain, frequent climbing, kneeling, and squatting, bilateral knee pain beginning during service, and persistence after discharge. For the left knee, that history is consistent with the documented 1974 patellar injury and with chronic or remote pathology already visible when the major 2010 injury occurred. For the right knee, the new history places direct cumulative loading at least in equipoise, with later altered gait from the left knee providing an additional aggravating mechanism. The back condition is at least as likely as not permanently aggravated by the reported icy telephone-pole fall and cumulative tactical-wire duties, with the affidavit providing detailed onset, persistence, and functional continuity.

Testing-dependent and exposure-dependent issues. The affidavit now supplies competent evidence that recurrent headaches began during Korea service, were often self-treated, and continued thereafter. That history supports a favorable direct-continuity opinion for a recurrent headache disorder, although a current examination remains necessary to classify the disorder and determine attack frequency and rating. It also supplies detailed bilateral hearing difficulty beginning during or after hazardous military noise exposure and continuing to worsen; the etiologic opinion is favorable, but a VA-standard audiogram is still required to establish a current regulatory disability and percentage. The eye history now supports in-service onset and continuity of dryness, irritation, and blurred vision, but a current ophthalmologic diagnosis remains necessary before linking a specific eye disease. Type 2 diabetes and hypertension are established disabilities, but the affidavit does not identify a specific herbicide agent, exposure event, location, route, or duration sufficient to support a favorable toxic-exposure nexus.

A missing contemporary test or rating measurement is a development limitation, not negative nexus evidence. Where the current disability or rating element is unconfirmed, I identify the examination needed rather than treating the missing test as proof against the claim.

1. Headaches

Current diagnosis and function. The treatment record does not contain a clinician-established migraine or other specific headache diagnosis, a defined preventive regimen, or measurements sufficient to rate prostrating attacks. The new draft affidavit, however, provides a detailed lay history of recurrent headaches beginning during service in Korea, persisting for many years, affecting daily life, and frequently being managed without formal medical care. The same statement later describes migraine headaches in association with chronic stress, anxiety, and sleep disturbance. Headache occurrence, recurrence, self-treatment, and interruption of ordinary activity are matters a layperson is competent to observe.

Clinical chronology and lay evidence. Several 2010 review-of-systems templates and the January 25, 2022 medication-refill encounter recorded no headache at those particular visits. Those are affirmative findings for the dates and purposes of those encounters, but they do not establish that an episodic headache disorder was absent before, between, or after them. Mr. Reed explains that he learned to live with the headaches and often treated them himself rather than seeking medical attention for each episode. That explanation is consistent with the episodic nature of headache disorders and with the broader self-management context discussed above. The absence of a TMC entry is therefore not, by itself, persuasive evidence against onset or continuity.

Theory and current limitation. The strongest theory is direct onset and continuity, not an unidentified toxic exposure. The affidavit places onset during Korea service in the setting of continuous noise and substantial stress and reports persistence thereafter. Loud noise and stress can provoke or worsen headaches, but the present record does not permit classification as migraine, tension-type, sinus-related, or another phenotype. The missing diagnostic classification limits rating precision, but it does not eliminate the medically coherent chronology of recurrent symptoms beginning in service.

Opinion - headaches: After considering the new lay history together with the episodic nature of headache disorders and the limited weight of symptom-free unrelated encounters, it is my medical opinion that Mr. Reed's recurrent headache disorder at least as likely as not began during active service in Korea and continued thereafter. This favorable opinion rests primarily on competent reported onset, persistence, and self-management rather than on an unverified toxic-exposure theory. A current headache examination is still required to establish the precise diagnosis and severity.

Current VA status and rating. The condition is denied and unrated. The affidavit establishes chronicity but does not quantify the number of characteristic prostrating attacks, their duration, associated features, recovery time, or economic impact. No defensible percentage can be assigned under Diagnostic Code 8100 without a current headache DBQ and a contemporaneous 3- to 6-month episode log.

Occupational effect. Mr. Reed reports that headaches affect daily life, and the draft affidavit also associates migraine symptoms with chronic stress and sleep disturbance. Recurrent attacks could impair concentration, pace, attendance, driving safety, and tolerance of noise; however, the present record does not establish attack frequency or prostrating severity well enough to quantify those restrictions.

Principal sources: Unsigned Draft Affidavit of Carl S. Reed, July 27, 2026; Oakridge VAMC review-of-systems records, 2010; Oakridge VAMC Emergency Department Note, January 25, 2022; VA Rating Decision, May 10, 2022; Bennett & MacAllister Attorney Evaluation Request Letter, July 27, 2026.

2. Bilateral Hearing Loss

Current diagnosis and function. The record documents decreased left-ear hearing after a traumatic tympanic-membrane perforation, but it does not contain a current VA-standard audiogram or Maryland CNC speech-recognition testing. The draft affidavit adds competent functional evidence of progressively worsening bilateral hearing difficulty, impaired understanding of conversation, particular difficulty in background noise or when several people speak, and frequent need to ask others to repeat themselves. General examinations describing hearing as 'grossly intact' are screening observations and cannot determine whether a frequency-specific bilateral hearing-loss disability exists.

Clinical chronology and service exposure. The DD Form 214 identifies Tactical Wire Operator Specialist duties, and VA expressly conceded a possibility of hazardous military noise exposure. Mr. Reed now describes regular exposure to military equipment, vehicles, communications equipment, weapons fire, and other high noise without consistently available hearing protection. He recalls hearing difficulty during and after service with progressive worsening. Entrance and separation audiograms remained within conventionally normal limits, but those historical forms do not exclude later-recognized high-frequency sensorineural injury. In January 2011, a Oakridge VA clinician documented a traumatic left tympanic-membrane perforation and decreased left-ear hearing, creating a potential additional conductive or mixed component limited primarily to the left ear.

Theory, mechanism, and competing causes. Repeated hazardous noise can cause bilateral sensorineural injury and difficulty with speech understanding, especially in background noise. A traumatic tympanic-membrane perforation generally produces a unilateral conductive or mixed deficit. The later left-ear trauma is therefore a competing cause for an additional left conductive component, but it would not adequately explain the reported bilateral onset and progressive bilateral communication difficulty. Current air- and bone-conduction thresholds,

tympanometry, and speech recognition are needed to separate the mechanisms and determine whether VA's regulatory criteria are met.

Opinion - bilateral hearing loss: It is my medical opinion that Mr. Reed's reported progressive bilateral hearing impairment is at least as likely as not related in material part to repeated hazardous military noise exposure as a Tactical Wire Operator Specialist. This etiologic conclusion is supported by the conceded noise environment, his competent report of onset and progressive communication difficulty, and a mechanism distinct from the later unilateral tympanic-membrane trauma. A current VA-standard audiogram is required to confirm a regulatory hearing-loss disability and to identify any additional left conductive or mixed component.

Current VA status and rating. The condition is denied and unrated. No percentage should be assigned from an outdated or absent audiogram. A VA-standard audiogram, Maryland CNC testing, otoscopy, tympanometry, and differentiation of conductive versus sensorineural components are required under 38 C.F.R. §§ 3.385 and 4.85.

Occupational effect. Mr. Reed reports difficulty understanding ordinary conversation, especially in background noise or with multiple speakers, and frequent need for repetition. Those limitations would impair telephone communication, group interaction, localization, and recognition of warning signals, particularly in commercial driving, field work, and other safety-sensitive settings. Updated testing is necessary to quantify severity and determine whether amplification is indicated.

Principal sources: DD Form 214; Unsigned Draft Affidavit of Carl S. Reed, July 27, 2026; Oakridge VA South Clinic Primary Care Note, January 12, 2011; VA Rating Decision, May 10, 2022.

3. Left Knee Condition

Current diagnosis and function. Mr. Reed has substantial chronic left-knee disability after patellar fracture, chronic patellar-tendon disruption, surgical repair, persistent patella alta, degenerative changes, weakness, painful limited extension, gait impairment, cane use, locking, popping, and fall risk. The draft affidavit adds a history of knee soreness and pain during service, persistence after discharge, progressive weakness and limited motion, and difficulty standing, walking, climbing stairs, kneeling, and squatting.

Service chronology and evidentiary weight. A September 7, 1974 service record documents a direct blow to the left patella, tenderness, and an assessment of left-knee contusion. Mr. Reed now explains that his Tactical Wire Operator duties also required prolonged marching, climbing, kneeling, squatting, and carriage of heavy wire reels, communications equipment, and field gear over rough terrain. He reports that the left knee remained sore and painful, that he continued performing because that was expected, and that the pain never completely resolved after service. The label 'contusion' does not establish that the patellofemoral surface, inferior patellar pole, or extensor mechanism was structurally normal, particularly because no contemporaneous imaging was obtained. The absence of repeated TMC visits does not medically prove resolution.

Post-service event and objective evidence of pre-existing pathology. In August 2010, Mr. Reed struck the left knee while climbing from a pickup truck and sustained a major superimposed injury. Importantly, the CT did not describe a purely normal knee with a simple new fracture. It documented a well-marginated inferior patellar fragment, degenerative patellar change, and an impression that the findings could represent a remote fracture with acute tendon disruption or an acute fracture through areas of osteophyte formation. Subsequent radiographs described marked degenerative change, and the operative course was characterized as repair of a chronic patellar tendon. These findings do not date the earlier structural pathology with certainty, but they objectively show that chronic patellofemoral/extensor-mechanism disease existed at the time of the 2010 event.

Causal-chain analysis. A direct patellar blow can initiate chondral injury, patellofemoral degeneration, inferior-pole pathology, and extensor-mechanism vulnerability. Repeated kneeling, climbing, load carriage, and uneven-ground work add cumulative stress. The 2010 trauma was unquestionably a major superimposed event and explains much of the later surgical burden; however, the documented service injury, the newly supplied continuity history, and the objective evidence of chronic or remote pathology prevent a medically sound conclusion that the 2010 event was the sole cause. The most coherent interpretation is service-related patellofemoral and extensor-mechanism vulnerability followed by substantial superimposed post-service injury.

Opinion - left knee condition: After considering the documented September 1974 patellar injury, the cumulative physical demands described in the draft affidavit, the reported persistence of left-knee pain after discharge, and the chronic or remote pathology documented in 2010, it is my medical opinion that the current left patellofemoral and extensor-mechanism disorder is at least as likely as not related in material part to active service. The 2010 fracture and tendon disruption were major superimposed aggravating events, but they do not medically erase the pre-existing service-related component, which cannot be reliably separated from the present residual disability.

Current VA status and rating. The condition is denied and unrated. A January 2011 clinician wrote that Mr. Reed could actively extend the knee "about 30 degree only," with persistent limp and cane use. That language documents severe extensor dysfunction, but it is not a sufficiently precise goniometric measurement to assign a percentage under Diagnostic Code 5261. The existing record supports at least a 10 percent medical estimate for painful degenerative motion if service connection is granted, but any higher limitation-of-extension rating requires a current knee DBQ with measured active and passive extension, repeated-use and flare estimates, and clarification of extensor lag. A separate rating for recurrent patellar instability or other residuals should be considered only if current objective findings and prescribed assistive-device use satisfy the applicable criteria.

Occupational effect. The left knee materially limits prolonged standing and walking, stairs, climbing, kneeling, squatting, uneven terrain, rapid directional change, repeated pedal use, and safe commercial driving. The extension deficit, cane use, and history of falls create a significant safety restriction for physical and mobile work.

Principal sources: U.S. Army Chronological Record of Medical Care, September 7, 1974; Unsigned Draft Affidavit of Carl S. Reed, July 27, 2026; Oakridge VAMC CT Lower Extremity, August 2010; Oakridge VAMC Orthopedic History and Physical, October 29, 2010; Oakridge VAMC preoperative, surgical, and postoperative records, November 2-3, 2010; Oakridge VA South Clinic Primary Care Note, January 12, 2011; Oakridge VAMC bilateral-knee radiographs, March 11, 2022; Army injury-reporting studies [1,2].

4. Right Knee Condition

Current diagnosis and function. The record establishes chronic right-knee pain and popping. March 2022 radiographs showed mild medial-compartment narrowing, patellofemoral spurring, and calcific patellar-tendon tendinopathy without fracture or dislocation. The draft affidavit adds reports of bilateral knee soreness and pain during service, persistence after discharge, progressive weakness and popping, limited motion, and difficulty with standing, walking, stairs, kneeling, and squatting.

Clinical chronology and theory. There is no documented discrete right-knee injury during service, but Mr. Reed describes repeated heavy load carriage, marching, climbing, kneeling, squatting, and rough-terrain work that affected both knees. He reports bilateral pain during service and incomplete resolution after discharge. Those activities provide a plausible cumulative mechanical pathway to the later patellofemoral and tendon findings. Chronic left-knee extension loss, limp, and cane-dependent gait later supplied an additional secondary aggravating mechanism through asymmetric stance and compensatory loading.

Competing causes and incremental worsening. Age, obesity, and post-service occupational loading remain contributors and likely account for part of the degenerative risk. They do not fully explain the specific history of bilateral knee pain beginning under sustained military loading or the added asymmetric load imposed by chronic left-knee dysfunction. The current pathology is mild, and the lack of early post-service imaging limits certainty, but the favorable lay continuity and compatible mechanics place direct cumulative contribution at least in equipoise. Altered gait provides an additional permanent-aggravation pathway.

Opinion - right knee condition: It is my medical opinion that Mr. Reed's current right-knee degenerative and patellar-tendon disorder is at least as likely as not related in material part to cumulative load carriage, marching, kneeling, squatting, climbing, and rough-terrain duties during active service, based on his competent report of bilateral onset and persistence and the compatible later pathology. In addition, if the left-knee disorder is accepted as service related, chronic altered gait and compensatory loading at least as likely as not permanently aggravated the right knee beyond ordinary progression.

Current VA status and rating. The condition is denied and unrated. If service connection is granted on a direct or secondary basis, the documented painful degenerative disability most nearly supports a 10 percent medical estimate pending a current knee DBQ. A higher evaluation would require measured limitation of flexion or extension, recurrent instability, meniscal pathology, flare-related loss, or other qualifying findings not established by the present record.

Occupational effect. Right-knee pain adds to limits on prolonged standing, walking, stairs, kneeling, squatting, and repetitive pedal use, but the left knee is the dominant lower-extremity restriction.

Principal sources: Unsigned Draft Affidavit of Carl S. Reed, July 27, 2026; Oakridge VAMC Primary Care Note and bilateral-knee radiographs, March 11, 2022; VA Rating Decision, May 10, 2022; left-knee gait and rehabilitation records, 2010-2011.

5. Bilateral Eye Condition

Current diagnosis and function. The packet does not clearly establish a current bilateral ophthalmologic diagnosis. The draft affidavit now documents chronic dry, gritty, irritated eyes and intermittent blurred vision that interferes with reading, driving, and other daily activities, as well as post-service eye surgery. These symptoms are competent lay observations, but they do not identify whether the current disorder is dry-eye disease, cataract residuals, refractive error, retinal disease, glaucoma, or another condition.

Service chronology and lay evidence. Entrance and separation examinations generally recorded normal eyes and visual acuity, although an August 1974 optometry entry is difficult to interpret consistently. Mr. Reed now reports that dust, dirt, wind, sunlight, and field conditions caused recurrent irritation and that dryness, discomfort, and visual changes began during service and continued thereafter. He also explains that he often continued working rather than repeatedly seeking care. This new history materially supports onset and continuity of ocular-surface and visual symptoms, but it does not by itself establish the disease responsible for them.

Limitations. The conflicting laterality of surgery and absence of best-corrected acuity, slit-lamp findings, retinal examination, visual fields, and operative records prevent a reliable causal or rating analysis. The lack of TMC treatment is not itself negative evidence; the decisive limitation is the missing diagnosis and missing ophthalmologic data.

Opinion - bilateral eye condition: The draft affidavit materially strengthens the evidence that chronic ocular irritation, dryness, and intermittent blurred vision began during service and persisted thereafter. I cannot yet render a reliable nexus opinion for a specific bilateral eye disease because the current diagnosis and the nature and laterality of the 1979 surgery remain unclear. A comprehensive ophthalmology examination is required to determine whether the present pathology is medically consistent with the reported service onset and environmental exposures. The claim is diagnosis-dependent, not disproved.

Current VA status and rating. The condition is denied and unrated. No percentage can be assigned without a current ophthalmologic diagnosis, best-corrected distance and near acuity, visual-field testing, and identification of any aphakia, pseudophakia, retinal disease, or other residual.

Occupational effect. No reliable visual restriction can be assigned from the current packet. Any commercial-driving impact depends on corrected acuity, fields, glare, depth perception, and the eye actually affected.

Principal sources: U.S. Army entrance and separation examinations; August 1974 optometry record; Unsigned Draft Affidavit of Carl S. Reed, July 27, 2026; Oakridge VAMC Emergency Department Note, January 25, 2022; VA Rating Decision, May 10, 2022; counsel request, July 27, 2026.

6. Type 2 Diabetes Mellitus (Previously Claimed as Borderline Diabetes)

Current diagnosis and function. Type 2 diabetes mellitus is currently established. Earlier records documented impaired fasting glucose. On January 25, 2022, glucose was 285 mg/dL and metformin 1000 mg twice daily was refilled with dietary counseling. The January 18, 2023 VA visit lists Type 2 diabetes mellitus, continued metformin, diabetic supplies, and discontinuation of insulin glargine.

Service and exposure theory. The record does not show diabetes during service or for decades thereafter. The draft affidavit confirms Mr. Reed's sincere belief that he was exposed to herbicides in Korea and that the disease progressed from impaired glucose to Type 2 diabetes requiring Metformin and monitoring. It does not identify the herbicide, location, unit activity, route, duration, spraying, storage, transport, or direct handling. His Korean service occurred in 1975-1976, after the recognized presumptive Korean-DMZ herbicide period. The affidavit therefore strengthens diagnosis and treatment history but does not verify the exposure event needed for a presumptive or direct toxic-exposure nexus.

Competing causes. The record documents obesity and a strong family history of diabetes in his mother and sister. Those factors, together with the decades-long latency and initially normal A1c in 2010-2011, provide a substantially stronger medical explanation than an unspecified exposure.

Opinion - Type 2 diabetes mellitus: It is my medical opinion that the current record does not support a service nexus for Type 2 diabetes mellitus. This conclusion does not rest on the absence of TMC treatment; diabetes was not shown until decades later, the packet does not verify a qualifying or direct toxic exposure, and obesity plus a strong family history provide a substantially more persuasive causal pathway. A favorable exposure-based opinion should be reconsidered if competent evidence verifies the agent and circumstances.

Current VA status and rating. The condition is denied and unrated. If service connection is granted, the current treatment pattern most nearly approximates 20 percent under Diagnostic Code 7913 because an oral hypoglycemic agent is required; confirmation of a prescribed restricted diet should be obtained. The record does not establish regulation of activities, recurrent ketoacidosis, or hypoglycemic hospitalizations for a higher level.

Occupational effect. Diabetes requires medication adherence, dietary management, monitoring, and access to routine care. On the present record it does not independently preclude sedentary or light work, but unstable glucose or treatment escalation could affect safety-sensitive driving and attendance.

Principal sources: Oakridge VAMC primary-care records, 2010-2011; Emergency Department note, January 25, 2022; VA visit summary, January 18, 2023; VA Rating Decision, May 10, 2022.

7. Hypertension

Current diagnosis and function. Essential hypertension is well established and requires continuous medication. In October 2010, readings included approximately 157/87 to 160/88, and chlorthalidone was initiated. In January 2011, therapy was changed to lisinopril and hydrochlorothiazide. Later records continued lisinopril and hydrochlorothiazide, with controlled readings such as 137/85 in March 2022 and 127/75 in January 2023.

Service and exposure theory. The record does not show hypertension during service or within one year of discharge. The draft affidavit confirms chronic medication dependence and Mr. Reed's belief that herbicide exposure in Korea contributed to the disease. It does not identify a specific agent, exposure event, location, route, or duration. Although hypertension is an herbicide-associated presumptive condition when qualifying exposure is established, the diagnosis and medication history cannot substitute for verification of the exposure itself.

Competing causes and treatment effect. The record documents obesity, substantial tobacco exposure, and family history of hypertension and premature cardiovascular disease. These are strong conventional risk factors. Controlled readings reflect treatment benefit and do not negate the diagnosis, but the available history does not show a predominant diastolic pattern of 100 mm Hg or more.

Opinion - hypertension: It is my medical opinion that the current record does not support a service nexus for hypertension. This conclusion does not rest on silence in the service treatment record; rather, the disease became established decades after service, no qualifying or direct toxic exposure is verified, and obesity, tobacco exposure, and family cardiovascular risk provide stronger conventional causes. A favorable exposure-based opinion should be reconsidered if competent evidence verifies the agent and circumstances.

Current VA status and rating. The condition is denied and unrated. The present record supports a noncompensable level under Diagnostic Code 7101. A 10 percent recommendation would require a history of diastolic pressure predominantly 100 or more requiring continuous medication, or current predominant systolic/diastolic thresholds; that pattern is not established by the available readings.

Occupational effect. Controlled hypertension primarily requires medication adherence and monitoring. It does not independently prevent physical or sedentary work, though medication interruption or severe excursions would create safety concerns.

Principal sources: Oakridge VAMC initial primary-care records, October 2010; primary-care note, January 12, 2011; Emergency Department note, January 25, 2022; VA visit summary, January 18, 2023.

8. Back Condition - Preexisting Lower Thoracic Scoliosis with Current Lumbar Degenerative Pathology

Current diagnosis and function. The record establishes chronic low-back pain with objective mild convex-left lumbar scoliosis, multilevel degenerative vertebral spurring, and mild L5-on-S1 anterolisthesis. The draft affidavit reports daily pain affecting standing, walking, bending, lifting, prolonged sitting, morning mobility, and routine tasks. It also confirms continued VA treatment, physical therapy, home exercise, and cane use as needed.

Entrance finding and service history. Mild lower thoracic scoliosis was noted at the August 14, 1974 entrance examination, establishing a preexisting curvature in the lower thoracic region without reported disabling symptoms before service. Mr. Reed now gives a more detailed account of climbing telephone poles in Korea while carrying heavy gear, losing his grip in icy conditions, sliding down the pole, and landing hard on the ground. He reports that back pain began before discharge, that he continued performing because that was expected, and that the pain never resolved. He also describes repeated lifting, climbing, equipment carriage, and long-distance load bearing. The current imaging describes lumbar, rather than lower-thoracic, scoliosis with lumbar spurring and L5-S1 anterolisthesis; those findings are not treated as anatomically identical to the entrance curvature.

Mechanism and causal-chain analysis. A forceful axial landing can injure paraspinal tissues, facets, discs, and stabilizing structures throughout the thoracolumbar kinetic chain. A preexisting lower-thoracic curvature can alter trunk balance and load distribution, increasing susceptibility to persistent mechanical pain and compensatory loading of the lumbar segments. Repeated climbing, equipment carriage, bending, and uneven-ground work can further aggravate those mechanics. My opinion does not depend on treating the present lumbar scoliosis as the same anatomical finding recorded at entrance. It rests on permanent aggravation of the preexisting thoracic curvature and overall thoracolumbar mechanical function, with a direct mechanical contribution from the reported fall and cumulative duties to the later lumbar pain and degenerative pathology. The precise baseline and degree of additional worsening cannot be quantified because serial service-era imaging and range-of-motion measurements are unavailable.

Contrary evidence and competing causes. The absence of an acute TMC entry does not establish that the reported fall or subsequent pain did not occur. The draft affidavit now personally explains that Mr. Reed continued working despite pain because that was expected, while the Army research provides broader context that self-management and delayed reporting occur in military populations [1,2]. A 2010 review-of-systems template recorded no back pain at that visit, and age, obesity, and post-service occupational loading are competing contributors. Those factors reduce precision but do not identify a stronger discrete post-service back trauma. The specific mechanism was later reported to a treating clinician and is now described consistently in the draft affidavit.

Opinion - back condition: After weighing the documented preexisting lower-thoracic scoliosis, the detailed and consistent report of an icy telephone-pole fall with hard ground impact, the cumulative mechanical demands of climbing and field communications work, the reported persistence of pain from service onward, the absence of a stronger intervening back trauma, and the current compatible lumbar pathology, it is my medical opinion that active service at least as likely as not permanently aggravated the preexisting lower-thoracic scoliosis and overall thoracolumbar mechanical condition beyond natural progression. The same fall and cumulative duties at least as likely as not materially contributed to the later chronic lumbar pain and degenerative loading pattern.

Current VA status and rating. The condition is denied and unrated. The current medically demonstrated picture most nearly approximates 10 percent under the General Rating Formula for the Spine because chronic painful motion and objective degenerative pathology are established. The record does not document thoracolumbar flexion, combined range of motion, guarding, muscle spasm, abnormal gait attributable to the spine, or flare-related additional loss required to support 20 percent or higher. A current thoracolumbar DBQ is necessary.

Occupational effect. The back condition limits heavy lifting, repetitive bending and twisting, climbing, uneven terrain, prolonged standing and walking, and fixed sitting without position changes. It would interfere with truck driving through vibration exposure, prolonged sitting, ingress/egress, load handling, and emergency maneuvers. The favorable back condition alone does not establish inability to perform all sedentary work with ergonomic seating, position changes, limited lifting, and ready access to breaks.

Principal sources: U.S. Army Report of Medical Examination, August 14, 1974; DD Form 214 and service personnel records; Unsigned Draft Affidavit of Carl S. Reed, July 27, 2026; Oakridge VAMC Primary Care Note and lumbar-spine radiographs, March 11, 2022; Oakridge VAMC Physical Therapy Evaluation, May 5, 2022; VA Rating Decision, May 10, 2022; Army injury-reporting studies [1,2].

Scope Note - Psychiatric Symptoms

The draft affidavit also describes grief, dangerous unexploded-ordnance duties near North Korea, fear, sleep disturbance, chronic stress, anxiety, and migraine symptoms, and requests a psychiatric examination. Counsel's evaluation request did not ask for a PTSD or other psychiatric nexus opinion, and the record reviewed does not establish a current DSM diagnosis. I therefore do not render a psychiatric nexus or rating opinion in this report. The statement supports referral for a comprehensive mental-health evaluation if counsel wishes to pursue that claim.

Combined Functional and Employability Opinion

Physical work. The combined back and bilateral-knee pathology materially restricts prolonged standing and walking, lifting, climbing, bending, kneeling, squatting, balance on uneven terrain, rapid response, repeated pedal operation, and safe movement without a cane. The left-knee extension deficit and fall history are the dominant safety limitations. These restrictions are incompatible with sustained heavy or medium physical work and materially compromise prior truck-driving duties that require prolonged sitting, vibration tolerance, repeated entry and exit, cargo handling, and safe emergency braking.

Sedentary work. Sedentary work would require an ergonomic workstation, freedom to alternate sitting and standing, limited walking between work areas, no climbing or kneeling, lifting generally limited to light loads, and allowance for treatment and symptom-related breaks. The reported hearing impairment would add communication and warning-signal restrictions, especially in background noise. Recurrent headaches could reduce concentration, pace, and attendance, but their frequency and prostrating severity are not yet quantified. Diabetes and hypertension require adherence and monitoring but do not independently preclude sedentary work on the current record.

Opinion - employability: Considering the back and bilateral-knee conditions together, Mr. Reed is medically unsuited for his prior truck-driving and physically demanding work. The combination of left-knee extensor loss, cane dependence, fall risk, right-knee aggravation, and chronic back pain materially compromises prolonged sitting, repeated vehicle entry and exit, emergency braking, load handling, climbing, and sustained standing or walking. The present record is insufficient to conclude that every form of substantially gainful sedentary employment is precluded; that determination requires a complete work and education history, current functional examinations, and vocational analysis.

Final Conclusions

- Back condition: favorable. The detailed affidavit history strengthens the conclusion that the icy telephone-pole fall and cumulative tactical-wire duties permanently aggravated the documented preexisting lower-thoracic scoliosis and overall thoracolumbar mechanical condition and materially contributed to later lumbar pain and degenerative loading. A 10 percent medical estimate is supportable pending a current DBQ.
- Left knee: favorable. The documented 1974 patellar injury, the affidavit history of continued service pain and cumulative loading, and the 2010 evidence of chronic or remote pathology place service contribution at least in equipoise despite the major superimposed 2010 trauma. At least a 10 percent painful-motion estimate is supportable pending a current DBQ. Right knee: favorable on cumulative direct contribution, with an additional secondary-aggravation pathway. The affidavit supplies competent bilateral onset and continuity under sustained load carriage and field duties; chronic altered gait from the left knee later added compensatory loading. A 10 percent estimate is supportable pending a current DBQ.
- Bilateral hearing loss: etiologically favorable but regulatory status testing-dependent. The conceded noise environment and affidavit history of bilateral onset, progressive difficulty, background-noise impairment, and need for repetition support a military-noise contribution. A VA-standard audiogram, Maryland CNC testing, and differentiation of the later left conductive component are required before assigning a percentage.
- Headaches: favorable on direct onset and continuity. The affidavit supplies competent evidence of recurrent headaches beginning during Korea service, persistent self-management, and ongoing daily-life effects. A current examination and episode log remain necessary for diagnosis and rating. Bilateral eye condition: diagnosis-dependent and unresolved. The affidavit strengthens onset and continuity of dry, irritated eyes and blurred vision, but a specific current disorder and the nature and laterality of the 1979 surgery must be established before a disease-specific nexus or rating opinion can be completed.
- Type 2 diabetes mellitus and hypertension: current diagnoses are established, but a favorable toxic-exposure nexus is not supportable without competent evidence identifying an actual qualifying or direct exposure. The conclusions do not rely on lack of TMC records.
- Employability: the favorable back and bilateral-knee opinions substantially impair and likely preclude prior truck-driving and physical work. The evidence does not yet establish inability to perform every accommodated sedentary occupation without vocational assessment.

Medical Literature References

[1] Smith L, Westrick R, Sauers S, Cooper A, Scofield D, Claro PJ, Warr B. Underreporting of Musculoskeletal Injuries in the US Army: Findings From an Infantry Brigade Combat Team Survey Study. Sports Health. 2016;8(6):507-513. doi:10.1177/1941738116670873. PMID:27789871. PMCID:PMC5089359.

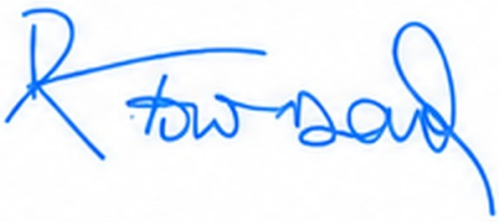
[2] Sauers SE, Smith LB, Scofield DE, Cooper A, Warr BJ. Self-Management of Unreported Musculoskeletal Injuries in a U.S. Army Brigade. Military Medicine. 2016;181(9):1075-1080. doi:10.7205/MILMED-D-15-00233. PMID:27612356.

These studies are used only as contextual evidence that injury underreporting and self-management occur in Army populations. They do not establish Mr. Reed's individual behavior, the culture of his specific 1970s unit, or the medical nexus of any claimed condition without case-specific evidence.

Source Record Trace

1. Bennett & MacAllister Attorney Evaluation Request Letter regarding Carl S. Reed, July 27, 2026.
2. Unsigned Draft Affidavit of Carl S. Reed, transmitted with counsel letter dated July 27, 2026; lay history regarding headaches, hearing difficulty, military duties, bilateral knee symptoms, ocular symptoms, diabetes, hypertension, back injury and continuity, and psychiatric symptoms.
3. DD Form 214, Report of Separation from Active Duty, service from August 14, 1974 through August 13, 1976; Korea service and Tactical Wire Operator Specialist military education.
4. U.S. Army Standard Form 88, Report of Medical Examination, and Standard Form 93, Report of Medical History, August 14, 1974; mild lower-thoracic scoliosis, entrance visual acuity, and baseline audiometry.
5. U.S. Army Chronological Record of Medical Care, September 7, 1974; direct blow to the left patella, tenderness, and assessment of left-knee contusion.
6. U.S. Army separation Report of Medical Examination, 1976; bilateral visual acuity and separation audiometry.
7. U.S. Army personnel records, assignment documents, and orders; MOS 36K20 and HHC, 1st Brigade, 2d Infantry Division assignment.
8. Oakridge VAMC CT Lower Extremity, August 2010; well-marginated inferior patellar fragment, degenerative patellar change, remote-fracture versus osteophyte-fracture differential, and acute tendon disruption.
9. Oakridge VAMC Orthopedic History and Physical, October 29, 2010; pickup-truck injury, inability to extend the knee, cane use, weakness, and falls.
10. Oakridge VAMC preoperative, surgical, and postoperative records, November 2-3, 2010; repair described as a chronic left patellar-tendon repair.
11. Oakridge VA South Clinic Primary Care Note, January 12, 2011; cane use, limp, limited active extension described as "about 30 degree only," traumatic left tympanic-membrane perforation, and decreased left hearing.
12. Oakridge VAMC Emergency Department Note, January 25, 2022; glucose 285 mg/dL, medication refill, and absence of headache at that encounter.
13. Oakridge VAMC Primary Care Note, March 11, 2022; reported Korea telephone-pole fall, chronic low-back pain, bilateral-knee symptoms, locking and popping, and cane use.
14. Oakridge VAMC lumbar-spine and bilateral-knee radiology reports, March 11, 2022.
15. Oakridge VAMC Physical Therapy Evaluation, May 5, 2022.
16. VA Rating Decision and code sheet, May 10, 2022.
17. Oakridge VAMC After Visit Summary, January 18, 2023.

Respectfully Submitted,



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Date signed: August 5, 2026