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On appeal from the
Department of Veterans Affairs Regional Office in Waco, Texas

THE ISSUES

1. Entitlement to service connection for tremors.

2. Entitlement to service connection for bilateral knee degenerative joint disease.

3. Entitlement to service connection for bilateral ankle disability.

4. Entitlement to service connection for lumbar spine degenerative joint disease.

REPRESENTATION

Appellant represented by: Texas Veterans Commission

WITNESS AT HEARINGS ON APPEAL

Appellant

ATTORNEY FOR THE BOARD

Alice A. Booher, Counsel

INTRODUCTION

The veteran had active service from September 1955 to August 1959, and from October 1961 to March 1979.

Service connection is in effect for peptic ulcer disease with hiatal hernia, evaluated as 10 percent disabling.

This appeal to the Board of Veterans Appeals (the Board) is from rating actions taken by the Department of Veterans Affairs (VA) Regional Office (RO) in Waco, Texas.

During the course of the current appeal, the veteran withdrew the issue of entitlement to service connection for psoriasis. In May 2002, the veteran provided testimony before a Hearing

Officer at the RO; a transcript is of record. The veteran also provided testimony before a Veterans Law Judge via videoconferencing at the RO in January 2004, of which a transcript is also of record. He submitted additional evidence at that time which is now of record in his file.

FINDINGS OF FACT

1. Tremors were first demonstrated in service and have continued with progressive intensity to date.

2. Lay and medical evidence and opinion provides reasonable basis for associating the veteran's tremors with service, probably due to exposure to chemical aircraft cleaning agents.

3. Numerous orthopedic problems were initially manifest in service.

4. Evidence including medical opinion establishes that current chronic orthopedic disabilities including bilateral knee degenerative joint disease, ankles disability and lumbar spine degenerative joint disease are reasonably the result of service.

CONCLUSIONS OF LAW

1. Tremors were incurred in service. 38 U.S.C.A. §§ 1101, 1110, 1131, 1153, 1154, 5103, 5107 (West 1991 & Supp. 2003; 38 C.F.R. §§ 3.303, 3.304, 3.306, 3.307, 3.309 (2003).

2. Bilateral knee degenerative joint disease was incurred in service. 38 U.S.C.A. §§ 1110, 1131; 38 C.F.R. § 3.303 (2003).

3. Bilateral ankle disability was incurred in service. 38 U.S.C.A. §§ 1110, 1131; 38 C.F.R. § 3.303 (2003).

4. Lumbar spine degenerative joint disease was incurred in service. 38 U.S.C.A. §§ 1110, 1131; 38 C.F.R. § 3.303 (2003).

REASONS AND BASES FOR FINDINGS AND CONCLUSIONS

Preliminary Matters

On November 9, 2000, the President signed into law the Veterans Claims Assistance Act of 2000 (VCAA), Pub. L. No. 106-475, 114 Stat. 2096 (2000). The Act is applicable to all claims filed on or after the date of enactment, November 9, 2000, or filed before the date of enactment and not yet final as of that date. See Karnas v. Derwinski, 1 Vet. App. 308 (1991). The new law eliminates the concept of a well-

grounded claim, and redefines the obligations of the VA with respect to the duty to assist claimants in the development of their claims. First, the VA has a duty to notify the appellant and his representative, if represented, of any information and evidence needed to substantiate and complete a claim. 38 U.S.C.A. §§ 5102 and 5103 (West Supp. 2001). Second, the VA has a duty to assist the appellant in obtaining evidence necessary to substantiate the claim. 38 U.S.C.A. § 5103A (West Supp. 2002).

The VA has promulgated revised regulations to implement these changes in the law. In this case, and given the nature of the action taken by the Board herein, it can be stipulated that all aspects of the new guidelines have been satisfactorily addressed and that the veteran is in no way prejudiced by the Board's taking final action at this time without further development or other actions.

Criteria

Service connection may be granted for disability due to disease or injury incurred in or aggravated by service. See 38 U.S.C.A. §§ 1110, 1131 (West 1991 & Supp. 2003). If a chronic disability such as a neurological disorder or arthritis is manifest to a compensable degree within one year after separation from service, the disorder may be presumed to have been incurred in service. See 38 U.S.C.A. §§ 1101, 1112, 1113, 1137 (West 1991 & Supp. 2003); 38 C.F.R. §§ 3.307, 3.309 (2003).

Service connection may be granted for any disease diagnosed after discharge when all the evidence, including that pertinent to service, establishes that the disease was incurred in service. Presumptive periods are not intended to limit service connection to disease so diagnosed when the evidence warrants direct service connection. See 38 C.F.R. § 3.303(d).

In any event, in adjudicating a claim for service connection, VA is required to evaluate the supporting evidence in light of the places, types, and circumstances of service, as evidenced by service records, the official history of each organization in which the veteran served, the veteran's military records, and all pertinent medical and lay evidence. 38 U.S.C.A. § 1154(b); 38 C.F.R. §§ 3.303(a), 3.304; see Hayes v. Brown, 5 Vet. App. 60, 66 (1993).

For the showing of chronic disease in service, there is required a combination of manifestations sufficient to identify the disease entity and sufficient observation to establish chronicity at the time. If chronicity in service is not established, a showing of continuity of symptoms after discharge is required to support the claim. 38 C.F.R. § 3.303(b) (2003). Service connection may also be granted for any disease diagnosed after discharge when all of the

evidence establishes that the disease was incurred in service. 38 C.F.R. § 3.303(d) (2003).

Service connection connotes many factors but basically it means that the facts, shown by evidence, establish that a particular injury or disease resulting in disability was incurred coincident with service in the Armed Forces, or if preexisting such service, was aggravated therein. This may be accomplished by affirmatively showing inception or aggravation during service or through the application of statutory presumptions. Each disabling condition shown by a veteran's service records, or for which he seeks service connection must be considered on the basis of the places, types and circumstances of his service as shown by service records, the official history of each organization in which he served, his medical records and all pertinent medical and lay evidence. Determinations as to service connection will be based on review of the entire evidence of record, with due consideration to the policy of the VA to administer the law under a broad and liberal interpretation consistent with the facts in each individual case. See 38 C.F.R. § 3.303(a).

Service connection may also be granted for disability shown to be proximately due to or the result of a service-connected disorder. See 38 C.F.R. § 3.310(a) (2003). This regulation has been interpreted by the Court to allow service connection for a disorder which is caused by a service-connected disorder, or for the degree of additional disability resulting from aggravation of a nonservice-connected disorder by a service-connected disorder. See Allen v. Brown, 7 Vet. App. 439 (1995).

A veteran will be considered to have been in sound condition when examined, accepted and enrolled for service except as to defects, infirmities, or disorders noted at entrance into service, or where clear and unmistakable evidence demonstrates that an injury or disease existed prior thereto. Only such conditions as are recorded in examination reports are to be considered as noted. 38 U.S.C.A. § 1132, 1137; 38 C.F.R. § 3.304 (2003).

Under the provisions of 38 U.S.C.A. § 1153 and 38 C.F.R. § 3.306 (2003), a preexisting injury or disease will be considered to have been aggravated by service where there is an increase in disability during such service, unless there is a finding that the increase in disability is due to the natural progress of the disease. The regulation further provides that aggravation may not be conceded where the disability underwent no increase in severity during service on the basis of all the evidence of record pertaining to the manifestations of the disability prior to, during, and subsequent to service. 38 C.F.R. § 3.306(b).

Clear and unmistakable evidence is required to rebut the presumption of aggravation when the pre-service disability

underwent an increase in severity during service. 38 U.S.C.A. § 1153; 38 C.F.R. § 3.306(b). However, temporary or intermittent flare-ups of a pre-existing injury or disease are not sufficient to be considered "aggravation in service" unless the underlying condition as contrasted to symptoms, is worsened. Jensen v. Brown, 4 Vet. App. 304, 306-307 (1993), citing Hunt v. Derwinski, 1 Vet. App. 292 (1991).

A pre-existing injury or disease will be considered to be aggravated by service when there is an increase in disability during service, unless there is a specific finding that the increase was due to the natural progress of the disease. 38 C.F.R. § 3.306(a) (2003). If a disability is found to have preexisted service, then service connection may be predicated only upon a finding of aggravation during service. Paulson v. Brown, 7 Vet. App. 466, 468 (1995).

Clear and unmistakable evidence (obvious or manifest) is required to rebut the presumption of aggravation where the pre-service disability underwent an increase in severity during service. This includes medical facts and principles which may be considered to determine whether the increase is due to the natural progress of the condition. Aggravation may not be conceded where the disability underwent no increase in severity during service on the basis of all the evidence of record pertaining to the manifestations of the disability prior to, during, and subsequent to service. 38 U.S.C.A. § 1153 (West 1991); 38 C.F.R. § 3.306(b) (2003); Falzone v. Brown, 8 Vet. App. 398, 402 (1995).

Notwithstanding the foregoing, congenital or developmental defects such as personality disorders are not diseases or injuries for the purposes of service connection. 38 C.F.R. § 3.303(c), 4.9 (2003); see also Winn v. Brown, 8 Vet. App. 510, 516 (1996).

However, see VAOPGCPREC 82-90 (July 18, 1990) (in which the VA Office of General Counsel held that service connection may be granted for a congenital disorder on the basis of in-service aggravation). See VAOPGCPREC 82- 90, 55 Fed. Reg. 45,711 (1990) [a reissue of General Counsel opinion 01-85 (March 5, 1985)] which in essence held that a disease considered by medical authorities to be of congenital, familial (or hereditary) origin by its very nature preexist claimants' military service. The opinion went on to hold, however, that service connection for congenital, developmental or familial diseases could be granted if manifestations of the disease in service constituted aggravation of the condition. See also Carpenter v. Brown, 8 Vet. App. 240, 245 (1995); Monroe v. Brown, 4 Vet. App. 513, 514- 15 (1993).

A veteran who served during a period of war, or a veteran who had peacetime service after December 31, 1946, is presumed to have been in sound condition except for defects, infirmities

or disorders noted when examined and accepted for service. The presumption of sound condition attaches only where there has been an induction examination in which the later complained-of disability was not detected. 38 U.S.C.A. § 1111; 38 C.F.R. § 3.304(b); Verdon v. Brown, 8 Vet. App. 529 (1996). Clear and unmistakable evidence that the disability manifested in service existed before service will rebut the presumption. 38 U.S.C.A. §§ 1111, 1137; 38 C.F.R. § 3.304(b).

With respect to medical opinions, in general, an opinion based on an inaccurate history has essentially no probative value. See Kightly v. Brown, 6 Vet. App. 200 (1994). The Board is not bound to accept medical opinions which are based on a history supplied by the veteran, where that history is unsupported or based on inaccurate factual premises. Black v. Brown, 5 Vet. App. 177 (1993); Swann v. Brown, 5 Vet. App. 229 (1993); Reonal v. Brown, 5 Vet. App. 458 (1993); Guimond v. Brown, 6 Vet. App. 69 (1993).

A speculative relationship is not enough to support a claim. See Obert v. Brown, 5 Vet. App. 30 (1993). See also Tirpak v. Derwinski, 2 Vet. App. 609, 611 (1992) (holding that a physician's statement that a service-connected disorder "may or may not" have prevented medical personnel from averting the veteran's death was not sufficient); Beausoleil v. Brown, 8 Vet. App. 459 (1996) (holding that a general and inconclusive statement about the possibility of a link was not sufficient); and Stegman v. Derwinski, 3 Vet. App. 228, 230 (1992) (holding that there was a plausible basis for the Board's decision that a disability was not incurred in service where even the medical evidence favorable to the appellant's claim did little more than suggest the possibility that the veteran's illness might have been caused by his wartime radiation exposure). Although the foregoing cases involved assessing the matter of whether medical opinions rendered claims "well-grounded" (a legal principle which was eliminated by the VCAA) the principles discussed in such cases are nevertheless applicable when weighing evidence and deciding a claim on the merits.

The Board has the responsibility to assess the credibility and weight to be given to the competent medical evidence of record. See Hayes v. Brown, 5 Vet. App. 60, 69 (1993); Wood v. Derwinski, 1 Vet. App. 190, 192-93 (1992); see also Guerrieri v. Brown, 4 Vet. App. 467, 470-71 (1993).

The veteran may provide lay evidence, including his own lay statements and those of other acquaintances. However, these lay individuals do not possess the requisite medical expertise, credentials, or training to render a medical diagnosis or a competent opinion as to causation. See Routen v. Brown, 10 Vet. App. 183, 186 (1998), aff'd, Routen v. West, 142 F.3d 1434 (Fed. Cir. 1988); YT v. Brown, 9 Vet. App. 195, 201 (1996); Espiritu v. Derwinski, 2 Vet. App. 492,

494-95 (1992).

The Board has an obligation to seek additional medical evidence. See 38 U.S.C.A. § 7109(a) (West 1991); 38 C.F.R. § 20.901(a) (2003); see also Colvin v. Derwinski, 1 Vet. App. 171, 175 (1991) ("If the medical evidence of record is insufficient, or, in the opinion of the [Board], of doubtful weight or credibility, the [Board] is always free to supplement the record by seeking an advisory opinion, ordering a medical examination or [quoting] recognized treatises").

The Court has recognized that the Board is not compelled to accept medical opinions; rather, if the Board reaches a contrary conclusion, it must state its reasons and bases and be able to point to a medical opinion other than the Board's own, unsubstantiated opinion. Colvin, 1 Vet. App. at 175.

It is incumbent upon the Board to weigh doctors' opinions so as to determine their relative weight, and the Board may favor the opinion of one competent medical expert over that of another so long as an adequate statement of reasons and bases is provided. See Owens v. Brown, 7 Vet. App. 429, 433 (1995).

When all the evidence is assembled, VA is responsible for determining whether the evidence supports the claim or is in relative equipoise, with the veteran prevailing in either event, or whether a preponderance of the evidence is against the claim, in which case, the claim is denied. Gilbert v. Derwinski, 1 Vet. App. 49 (1990).

Factual Background

There are no service medical records available from the veteran's initial period of service, and the records available from his second period of service are limited. His service documents reflect that he was involved throughout service in a variety of aircraft and electronics warfare technician positions.

Available service records reflect that in October 1961, X-rays of his left ankle showed a 6 x 12 mm. circumscribed bone density lying anterior to the talo-tibial joint. The talus and tibia in that area were both somewhat irregular and this was felt to represent an old avulsion fracture.

In November 1961, the veteran was seen in the emergency room after having complained of pain and swelling in his left foot and ankle of a recurrent nature since an injury in 1956. X-rays had not been fully reported but it was noted that an old chip was shown. Hot packs were instituted and the left foot was to be elevated to be followed by massage. The veteran was soaking his foot at home. A series of four notations were made in December 1961 reflecting that the veteran was

treated for symptoms including limitation of motions and pain after having twisted his left ankle.

He was sent to the orthopedic clinic in December 1961 and January 1962, at which latter occasion, the notation was made that he was to return in 3 weeks to be admitted for surgery, and his profile limitation was to be continued into late February. A notation was made later in January 1962 that he was to be admitted for surgery on February 27, 1962, and on the day before that admission, his profile change was continued for another 6 weeks at L-3, with no marching or prolonged standing. In May 1962, that limited profile was continued by the orthopedic clinic at L-3 for another 2 months with no marching or prolonged standing. No further records are available from any of that extended period of care.

In September 1963, he was seen in the emergency room after having lacerated his right hand. He was seen several days later after the area became very red and tender; hot soaks were prescribed.

The veteran underwent an occupational health physical examination in June 1963. The examination form was noted that he was in aircraft repair and had been in work for a year as a flight line mechanic during which time he was specifically exposed to Trichlorine and other chemicals.

In March 1965, the veteran was seem at the orthopedic clinic with aching in his calf. There were heel cord contractions and he lacked full range of motion in the right ankle with his knee extended. There was also marked hamstring tightness. Various exercises were recommended.

Also in September 1966, the veteran complained that his right shoulder hurt on the anterior surface when he moved. There had been no specific trauma. The symptoms had existed for a day and were particularly present when he raised his arm upward. Examination showed tenderness in the anterior biceps and when the arm was rotated and abducted. Impression was anterior bursitis or bicipital tendonitis. It was recommended that he use heat, rest and take Indocin.

Clinical records from service show that in September 1966, the veteran also complained of recurrent ankle problems, after a long history of similar problems. He had injured his left ankle and now, when walking, there was pain on the medial aspect, and sharp pain in the sub-maleolar area. He was able to put weight on the ankle as long as he did not flex past a certain point. Range of motion was felt to be all right but the heel cord was not tight and there was tenderness in the anterior maleolus.

Left ankle X-rays were taken in September 1966 after the veteran complained that he had pain in cold, damp weather.

There was calcification present in what were felt to be presumably ligamentous structures. There was also slight asymmetry in the ankle mortise and prominent calcification extending toward the medial aspect of the anterior portion of the ankle joint. It was felt that the degree of calcification anteriorly was significant and probably represented residuals of old trauma, and if progressive, would probably lead to ankylosis of the mortise.

On orthopedic examination in September 1966, there was noted calcification in the left ankle felt to be due to old trauma. The orthopedic review was undertaken to analyze the radiologist's suggestions of possible damage. The examiner noted crepitus when the veteran walked in a certain way. He had a history of two episodes of jumping from trucks, once in 1956 in the Navy, and later in the Air Force, and both had been with resultant pain in the ankle. Examination showed free range of motion with mild crepitus of a diffuse nature without effusion of pain on range of motion. X-rays were noted to confirm the clarifications in the anterior capsule of the left ankle and a loose body was to be ruled out. The recommendation was for him to wait for 2 weeks and then have the left ankle X-rayed again. It was felt that he might also need surgical removal of the loose body.

On a subsequent orthopedic visit in November 1966, the symptoms were noted to have decreased somewhat and there was no effusion. X-ray films showed no further changes. He was to be observed and return in 2 months. Apparently another X-ray dated in November 1966 indicated that the veteran had had trauma to the left ankle. X-rays were compared to those of September 1966, and calcifications anterior to the ankle mortise was again noted and appeared unchanged.

The veteran as seen in July 1967 at the hospital with a history of prior complaints of ankle problems which had exacerbated. This was felt to be an old problem which had been aggravated. He also had pain in the right shoulder when doing push-ups or sit-ups. Examination showed anterior tenderness in the shoulder girdle with pain on pushing and scratching his back. The impression was that he was experiencing tendonitis. An X-ray report dated in July 1967 indicated that he had probable calcific tendonitis in the right shoulder. Butazolydin was prescribed and he was given an 80 day excuse for not doing certain activities for the diagnosed right shoulder tendonitis.

In October 1967 he was seen at the orthopedic clinic for persistent right shoulder complaints. Examination was within normal limits and he was to return in a month for new X-rays with continued profile limitation in the interim.

In January 1974, the veteran complained of tenderness in the right side of his neck for 2 days. It was thought that there was a sign of folliculitis for which soaks were prescribed

but no other orthopedic problem was shown at that time.

In March 1974, the veteran was seen for joint pain in his left shoulder and left hip for the past year. Examination of the shoulder showed good range of motion. He said that there had been a feeling that the arm was going to sleep, and that this had existed for about a year.

On his retirement examination in March 1979, the veteran was noted to have a history of painful ankles without specific trauma. He had been advised to have a fusion of the one ankle in the 1960's. He also said he had a history of leg cramping when in bed at night. He specifically checked that he had a history pf painful joints, leg cramps, and arthritis, rheumatism or bursitis.

On VA examination in December 1999, the veteran said he had a history of exposure to certain solvents in service since which time he had developed nerve problems. He also had complaints of pain in his ankles, knees and lower back. The back had been a problem for many years and was aggravated by bending over for long periods of time, lifting, standing or walking. The pain was localized to the lower back. He had some limitations of motion. His knees had bothered him since the mid-1970's and included pain and swelling when sitting for long periods of time, and periodic episodes of a feeling like a needle was sticking him in his legs. Examination showed range of motion of both knees from 5 degrees of flexion contracture further to 110 degrees with some minimal grating of the soft tissues as they were felt to move in and out of the joints but no specific chondromalacia. His feet had started bothering him in 1962 and the ankles began soon thereafter. He was put on crutches at times and advised to fuse the ankles which he had declined to do. He had a giving way of the ankles with pain, some swelling and a tendency of the ankles to turn easily. There was limitation of bilateral ankle motion with slight varus of ankle and foot, increased when he went on tiptoes.

X-rays of both knees showed narrowing of the right medial joint compartment without reactive bone changes. There was a probable loose body anteriorly and questionable loose body in the left knee. Both ankles showed talo-tibial joint space asymmetry with widening of the joint spaces laterally. There was a small bone density in proximity to the left medial malleolus which was felt to be the result of remote trauma versus ununited ossification in the center. There were talar beaks, more prominent on the left, soft tissue swelling and bilateral plantar spurs. Back X-rays showed anterior compression of T-12 with degenerative changes at T-12/L-1 and slight dextroscoliosis.

Another VA examiner described the veteran's history of intention tremor of a mild nature. This was described as a familial tremor of both hands.

The veteran has submitted extensive testimony as well as independent treatise and print media materials relating to the hazards of exposure to certain organic chemicals to which he was allegedly continuously exposed in service including trichloroethylene (TCE) and tetrachloroethlyene, ethylene trichloride or Triclene (PCE).

A statement is of record from a neurological specialist, SH, M.D., dated in February 2002, to the effect that he had first seen the veteran in 1997 for a tremor for which he was given treatment which was not entirely productive. He had since been seen more recently with some deterioration in the tremor. The veteran had given the physician a history of significant exposure in service in the 1960's to trichloroethylene which he felt might have had a bearing on the cause of the tremor. The physician stated with regard to a possible relationship between the inservice chemical exposure and tremors, "this was a possibility" but typically one could expect a tremor not to be progressive if it were related to a toxic exposure.

A VA examiner noted in January 2003 that the veteran claimed that his upper extremities tremor was due to exposure to trichloroethylene in service. **The physician partially but incompletely quoted from Dr. SH's report cited above. He further noted that the veteran had a constant tremor even awakening him sometimes at night. He tremor was aggravated by any activity requiring hand function such as drinking a cup of coffee, cutting up food or eating with a fork. Examination showed intention tremor of both upper extremities with past-pointing on finger to nose testing. The veteran also appeared to have some hyperactive ankle reflexes with unsustained clonus. It was opined that while the veteran thought the tremor was related to inservice exposure, it was thought this was unlikely. The examiner also stated that he did not find that neurological disease was listed as one of the possible toxic effects of those chemicals to which the veteran was purportedly exposed in service.**

A statement is of record from GWL, dated in January 2004. Mr. L indicated that he had retired from the Federal Aviation Administration (FAA) in 1997 after serving for 36+ years,. He had been a manager when the veteran had been hired for work with the FAA immediately on separation from service in mid-August 1979. During the initial interview with the veteran, one of his

(f)irst observations was that his hands trembled. I asked him about this and he stated that the trembling was from using chemical while serving in the military. I did not think it would interfere with his work and it did not initially. He performed very satisfactorily in duties

he was assigned while working under my supervision; however, some of his supervisors for positions he held later in his career would call me and ask if (the veteran) might be suffering from a nervous breakdown or mental stress. I always told them that (the veteran's) trembling was caused by his experience in the military, and not to worry about it. I do believe that (the veteran's) career progression was hampered by his trembling hands and the perception by others that he was undergoing a mental breakdown or suffering from mental stress.

A statement is of record from an orthopedic surgeon, RCS, M.D., who examined the veteran in January 2004. The veteran was complaining of back pain, right knee and right ankle pain. He said that his military career had involved jumping out of the back of B-52s at a height of approximately 15 feet. He now continued to have ongoing pain in the low back, right ankle and right knee, which he rated at 4-5 out of a possible 10, and which got worse towards the end of the day or after walking up and down stairs. The physician said that he had bilateral knee braces which gave some help. He also had a history of carrying heavy objects and had had a left humerus break; he had been discharged from service in 1979. On examination, it was noted that he had had a knee arthroscopy in June 2002 at which time he had been shown to have advanced arthritis in the patellofemoral joint, medial femoral tibial condyle.

X-rays showed degenerative changes of the lumbar spine, as well as knee medial joint line narrowing bilaterally. The diagnoses were degenerative disc disease; bilateral osteoarthritis of the knees; and right ankle strain. The physician stated that

The patient and I discussed his role in work when in the U.S. Air Force and it is medically probable that his type of work (disability) more likely than not could have manifested while he was serving active duty, especially his back and knees.

The veteran submitted a statement from a neurological specialist, MDS, M.D., dated in January 2004. Dr. S stated that he had been asked to opine about whether the veteran's neurological symptoms were a result of trichloroethylene exposure in service. He stated that

(The veteran) said that his tremor first appeared in 1964 while he was exposed to trichloroethylene at his occupation as an

electronic technician. He said he was forced into retirement in 1997 as a result of his tremor. He has visited neurologists and has been prescribed numerous medications for treatment including Inderal, Mysoline, Trazodone, BuSpar and Topomax. He found that they were effective but they produced side effects of anxiety and impaired thinking so he abandoned treatment.

He finds the tremor noticeable and somewhat embarrassing. He reports difficult manipulating cups and utensils.

My examination was remarkable for a coarse static tremor that is also present with movement.

With respect to causation, it is probably as likely as not that the tremor disorder manifested while on active duty. There is no family history so it is unlikely to be a familiar tremor. I find no other neurologic condition to explain the tremor.

The veteran has submitted numerous affidavits, all of which are of record. One affiant, HEI, indicated that he had known the veteran since 1968 when they were stationed together in service in Nebraska; that they had worked together on a special project in and since service with the FAA. The affiant reported that during that entire time the veteran had exhibited an involuntary tremor of his hands and some involuntary movement of his head. He indicated that he had last seen him in 2000 when his tremor seemed to have deteriorated.

Another affiant, CS, stated that he had known the veteran all of his life. When he saw him in the mid 1960's, he noted that the veteran's hands trembled a little, and when asked, he said that he then did not know the cause. As years progressed, the problem became worse. Since then, the veteran had told him that the cause was apparently associated with the use of solvents utilized to wash equipment in service. He further described extensive studies showing the exposure to various solvents and chemicals to cause neurological problems.

Another affiant, DH, reported that he met the veteran, his co-worker, in August 1979 when he reported to the FAA for work right after service. He had himself reported there two months before. He noticed that the veteran's hands trembled and sometimes his head would shake, but not often. When he met him again some 15 years later at a FAA Office, he noticed

that the shaking had become worse, and this had continued subsequently to deteriorate.

A statement is also of record from the veteran's wife of 45 years who indicated that she met him in March 1958 and married him in August of that year, at which time he did not shake or tremble. When he was discharged from the Navy in 1959, he did not have tremors and did not develop them in the time prior to returning to active duty in the Air Force. In 1964-1965, she stated that he started to shake at a time when he spent a lot of time sleeping in his shop due to the Cuban Crisis, and then went to Guam for deploying B-52's for bombing. At that time he was usually riding in the back of the aircraft repairing systems. She said that six or seven years ago they found out that this was caused by exposure to TCE. She further stated that his tremor started after working as a ECM repairman in the Air Force. She also indicated that none of their sons, now in their 40's, display such tremor.

Analysis

From the outset, the Board would note that the veteran's testimony, and the extensive and articulate documentation he has submitted from various sources and individuals is entirely credible and has been very helpful to the equitable resolution of his case.

The veteran has testified that he was reluctant to see physicians in service for his various problems. That is entirely understandable; and indeed, although he had an extensive overall period of active duty, his service records with regard to any complaints are limited. Nonetheless, there is an entirely adequate evidentiary foundation for addressing all of the issues herein concerned. Not only are there VA and private clinical opinions in the file, but the veteran has sought out and has submitted credible lay affidavits to sustain the other pertinent factors in this case, from family, friends and associates in and since service.

The RO has primarily addressed the issue relating to tremors on the basis that his disability is familial and as such, not subject to service connection. The fact that they might be familial in nature would not necessarily result in a denial of his claim, as noted in above cited regulatory criteria. Nonetheless, in that regard, since the Board is not persuaded that his tremors are in fact of a familial nature, it is unnecessary to assess the issue on that basis. However, it should be noted that the singular medical opinion of record to that effect is not otherwise substantiated by independent evidence or documentation; and furthermore, collaborative evidence does not reflect that tremors were shown prior to service or that anyone else in the veteran's family has such problems.

On the other hand, the veteran was clearly exposed in service, on a recurrent and extended basis, to certain solvents, specifically trichloroethylene (TCE) and tetrachloroethlyene, ethylene trichloride or Triclene (PCE); the potential secondary neurological impacts of which are clearly and unequivocally set-forth in treatise and other medical information of record. It appears that the veteran's hand tremors began in service, and were clearly present at the time of his separation from service and/or at the time of his FAA job interview concurrent therewith. There is sound medical opinion to the effect that his exposure in service to the various solvents is the probable cause of his tremors, and the Board is not in a position to disregard that learned opinion. Service connection is warranted for the veteran's tremors as a result of service.

As for his orthopedic problems involving various designated joints, the service records show recurrent problems with various joints in service. Medical opinion, as cited above, has associated those orthopedic problems with having been first demonstrated in and/or as being otherwise due to service. The Board finds that opinion to be credible and is not in a position to argue to the contrary.

With resolution of doubt in his favor, service connection for bilateral knee degenerative joint disease, bilateral ankle disability and lumbar spine degenerative joint disease is reasonably warranted.

ORDER

Service connection for tremors is granted.

Service connection for bilateral knee degenerative joint disease is granted.

Service connection for bilateral ankle disability is granted.

Service connection for lumbar spine degenerative joint disease is granted.

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JEFF MARTIN
Veterans Law Judge, Board of Veterans' Appeals

Department of Veterans Affairs

YOUR RIGHTS TO APPEAL OUR DECISION

The attached decision by the Board of Veterans' Appeals (BVA or Board) is the final decision for all issues addressed in the "Order" section of the

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

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

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

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

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

There is no time limit for filing a motion for reconsideration, a motion to vacate, or a motion for revision based on clear and unmistakable error with the Board, or a claim to reopen at the local VA office. None of these things is mutually exclusive - you can do all five things at the same time if you wish. However, if you file a Notice of Appeal with the Court and a motion with the Board at the same time, this may delay your case because of jurisdictional conflicts. If you file a Notice of Appeal with the Court before you file a motion with the BVA, the BVA will not be able to consider your motion without the Court's permission.

How long do I have to start my appeal to the Court? You have 120 days from the date this decision was mailed to you (as shown on the first page of this decision) to file a Notice of Appeal with the United States Court of Appeals for Veterans Claims. If you also want to file a motion for reconsideration or a motion to vacate, you will still have time to appeal to the Court. As long as you file your motion(s) with the Board within 120 days of the date this decision was mailed to you, you will then have another 120 days from the date the BVA decides the motion for reconsideration or the motion to vacate to appeal to the Court. You should know that even if you have a representative, as discussed below, it is your responsibility to make sure that your appeal to Court is filed on time.

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

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

You can get information about the Notice of Appeal, the procedure for filing a Notice of Appeal, the filing fee (or a motion to waive the filing fee if payment would cause financial hardship), and other matters covered by the Court's rules directly from the Court. You can also get this information from the Court's web site on the Internet at

www.vetapp.uscourts.gov, and you can download forms directly from that website. The Court's facsimile number is (202) 501-5848.

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

How do I file a motion for reconsideration? You can file a motion asking the BVA to reconsider any part of this decision by writing a letter to the BVA stating why you believe that the BVA committed an obvious error of fact or law in this decision, or stating that new and material military service records have been discovered that apply to your appeal. If the BVA has decided more than one issue, be sure to tell us which issue(s) you want reconsidered. Send your letter to:
Director, Management and Administration (014)
Board of Veterans' Appeals
810 Vermont Avenue, NW
Washington, DC 20420

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

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

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

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

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

If you want someone to represent you before the Court, rather than before VA, then you can get information on how to do so by writing directly to the Court. Upon request, the Court will provide you with a state-by-state listing of persons admitted to practice before the Court who have indicated their availability to represent appellants. This information is also provided on the Court's website at www.vetapp.uscourts.gov.

Do I have to pay an attorney or agent to represent me? Except for a claim involving a home or small business VA loan under Chapter 37 of title 38, United States Code, attorneys or agents cannot charge you a fee or accept payment for services they provide before the date BVA makes a final decision on your appeal. If you hire an attorney or accredited agent within 1 year of a final BVA decision, then the attorney or agent is allowed to charge you a fee for representing you before VA in most situations. An attorney can also charge you for representing you before the Court. VA cannot pay fees of attorneys or agents.

Fee for VA home and small business loan cases: An attorney or agent may charge you a reasonable fee for services involving a VA home loan or small business loan. For more information, read section 5904, title 38, United States Code.

In all cases, a copy of any fee agreement between you and an attorney or accredited agent must be sent to:

Office of the Senior Deputy Vice Chairman (012)
Board of Veterans' Appeals
810 Vermont Avenue, NW
Washington, DC 20420

The Board may decide, on its own, to review a fee agreement for reasonableness, or you or your attorney or agent can file a motion asking the Board to do so. Send such a motion to the address above for the Office of the Senior Deputy Vice Chairman at the Board.