WALTER REED NATIONAL MILITARY MEDICAL CENTER
MEDICAL BOARDS SECTION/PATIENT ADMINISTRATION
REPORT OF MEDICAL EVALUATION BOARD

This consolidated NARSUM incorporates specialty consults and VA C&P Examination findings, obviating the need for specialty addenda, and is an Administrative Document *not* to be used as source documentation for medical decisions.

NAME: Little, Michael Joseph
SSN/DOB: /
STATUS: USNR/ E-5 /ABH2
DATE: 14 October 2015

IDENTIFICATION: ABH2 Little is a 32 year old Sailor, right hand dominant, with MOS Rate/NEC ABH2/9 ODO with 5 years of active military service and reserve satisfactory years of 7 years/10 months (ADSD/ADBD 22 Jan 2003). He is cross assigned to Naval Support Activity Souda Bay, Greece. He is referred to the IDES due to PTSD.

HISTORY OF PRESENT ILLNESS:

Per VA Worksheets and AHLTA notes and consultations, the following diagnoses are retained as not meeting retention standards:

Diagnosis 1: Posttraumatic Stress Disorder (PTSD); does not meet retention standards in accordance with SECNAVINST 1850.4E Enclosure 8013d. This condition did not exist prior to his entrance into military service.

Diagnosis 2: Unspecified Depressive Disorder; does not meet retention standards in accordance with SECNAVINST 1850.4E Enclosure 8013d. This condition did not exist prior to his entrance into military service.

The VA DBQ for PSYCH PTSD Review Exam dated 29SEP2015 diagnosed the SM with PTSD and Unspecified Depressive Disorder. According to a DVA Rating Decision dated 09APR2014 the SM has been granted Service Connection for post-traumatic stress disorder and unspecified depressive disorder with an evaluation of 70 percent effective March 8, 2013.

ABH2 Little has multiple deployments: 2005-06- West Pac (QIF /OEF), 2008-09 Iraq, and 2009-10 Afghanistan. His deployment in 2008 May was to Camp Bucca in Iraq where he served as a call guard and section leader and SGT of the guard. He reports experiencing moral injury, physical and mental abuse and feared for his life on a daily basis. On his second deployment to Afghanistan 9/ 2009-he was commended to take on this deployment based on his exemplary service while in Iraq. He witnessed riots and was exposed to violence, he feared for life on a daily basis during this deployment. The most difficult experience he recalls is witnessing a female Navy service member attacked by a detainee. This same detainee ended up giving up vital intelligence information which in effect resulted in him getting rewarded by this SM-he still feels guilty for letting down his fellow Seaman and was 'shunned' by other seaman who were not aware of the intelligence info given.
An AHLTA note dated 07JUN2015 reported that ABH2 Little stated he has been suffering with symptoms of PTSD and depression since returning from deployment to Iraq in 2008 and that the symptoms were only compounded after his second deployment to Afghanistan in 2010. He reported hypervigilance, such that he reported feeling watchful and easily startled, particularly by loud noises. SM reported that certain situations would trigger intrusive reminders about his deployments, such as specific smells (feces), hearing people speaking Arabic. He was so terrified of re-living the experience of having feces thrown on him, that he fears having a baby because the mere thought of changing a diaper and seeing feces scares him. SM reported that he avoided reminders of his traumatic experience, particularly crowded places. He had repetitive nightmares about his deployment experiences involving the detainees who regularly threw feces at him and gave him scary looks, he felt threatened at all times. He reports having worked with a lot of

death row detainees as well. He recalls witnessing several fights between the detainees and he would frequently have to break these fights up. When he returned from his deployment in 2010, he lost 10 shipmates to suicide. He recalls being contacted by the 8th victim before the suicide but he did not pick up. When this happened again one year later after a female shipmate called him before she took her life but he did not answer. This led him to become suicidal himself. He asked for help, but rather was told to go home and was informed later that he was being discharged for admin purposes. He fought the charges and returned into the navy reserve.
He has undergone several medication trials while under treatment in the VA: Zoloft in 2010 for nightmares, depressive symptoms, but switched to Seroquel, Trazodone, Propranolol and Ambien. In 2011 he became suicidal after hearing that his female friend committed suicide, went to his command suicidal but was told to go home. He received care at the VA and symptoms were reduced with both medication and therapy. His symptoms stabilized and he was about to get promoted to first class, "life was good, I was in shape, I was recognized as a top advocate on Capitol Hill." However, in Sept of 2014, he witnessed a couple get run over by a speeding taxi. He recalls their bodies lay across the street-it was at point that his symptoms re-emerged and he felt the need to seek out treatment at WRNMMC. He was diagnosed with PTSD and started on Prazosin to address his nightmares. He was also referred for individual therapy. An AHLTA note by his therapist dated 09JUN2015 noted the SM talked at length and in detail about multiple traumatic events, including threats to his life and safety, that occurred during an extended deployment (beginning MAY 2008) to Iraq and then Afghanistan (beginning SEP 2009) during which he worked in Detainee Operations, first as a cell guard and then eventually as section leader and SGT of the guard/head guard. He was administered the PCL-M (PTSD Checklist, Military Version, scored 1 through 5 per item). He received a score of 84, almost the maximum score possible, consistent with a diagnosis of PTSD and indicative of a severe PTSD clinical picture. The latest AHLTA note by his therapist dated 01SEP2015 reported that he presented with PTSD, depression, anxiety symptoms, that have not responded to initial SSRI medications and psychotherapy. He has improved slightly but wishes to pursue alternative strategies such as ganglion block. He was to continue weekly therapy and was going to be referred for a stellate ganglion block and possibly referral to the intensive outpatient program (IOP). He currently takes no psychotropic medications, preferring to focus on treatment with individual therapy. His psychotherapy has included the use of Accelerated Resolution Therapy (with modifications as needed), CBT and supportive therapy for depression.
Despite intensive multi-modal therapies his PTSD and depression prevent him from performing the requirements of his rank and Service. These conditions do not meet retention standards IAW SECNAVINST 8450.4E.

Limitations and prognosis: His prognosis is guarded. His psychiatric conditions may stabilize and improve with ongoing psychotherapy and the use of psychotropic medications. Although his non-medical assessment (NAM) recommended retaining him in the Navy Reserve, because of the chronic recurrent nature of his symptoms, it is unlikely that the SM will improve sufficiently in the next 5 years to meet retention standards. It is almost certain that his PTSD and depression would worsen if exposed to the unique stressors of the military environment.

DISCUSSION: An AHLTA note dated 03JUN2015 documented that he was seen by DVBIC for a diagnostic evaluation for a mild TBI/concussion. He described several events that could possibly cause a TBI, including NOV 2005 fall from a prop wash on the flight deck, as assault with injury to his shoulder in 2010 in Afghanistan, and some explosions outside of his building in Afghanistan in 2010. The examiner felt he did not meet VA/DoD criteria for mTBI/concussion for these incidents. There was no other reported history of concussion. He was provided education that he did not have loss of consciousness (LOC), posttraumatic amnesia (PTA), or alteration of consciousness (AOC) and therefore did not meet criteria for mTBI. As he reported symptoms consistent with post-traumatic stress, and was being seen in Psychiatry they discussed that he has not tried cognitive processing therapy (CPT), but had completed prolonged exposure without reported success. It was recommended that he speak with his psychiatrist about psychologist follow-up with CPT. The evaluator noted that PO2 Little works for the Association of the USN filing claims for veterans and reported some lobbying on Capitol Hill.

CONDITIONS MEETING RETENTION STANDARDS:

1. **Migraine including migraine variants**: SM has been rated as service connected for migraines at 30% by the VA. He was initially diagnosed with migraine in 2010. SM reported progressively worsening in frequency and severity and reported that it is affecting his quality of life. He reported that headaches occur 4-5 times per week, sometimes lasting for days. Has prostrating attacks once a month. Pain is located bifrontal and sometimes bioccipital which radiates to the shoulders and neck. Headaches were described as with aura (tension/jaw pain and numbness), and associated with photophobia. Headaches were severe during PTSD flares. SM is currently treated with Propranolol for prophylactic medication and Rizatriptan MLT 10 mg TBSL as abortive medication. Only one recent entry in AHLTA Neurology note (14 Sept 2015) for refill of medication (Rizatriptan) and no mention about his headaches. A Letter of Recommendation dated 26 May 2015 from John Totushek (Vice Admiral, U.S. Navy Retired, President of Association of the United States Navy) stated that "ABH2 Little is currently employed by Association of the United States Navy (AUSN) as Director of Military and Veterans Benefits. He is the direct liaison with the members when they need assistance with Department of the Navy or the Department of Veterans Affairs. He also brings experience from the American Legion and New York State Senate, where he served as a Veteran Service Officer and Veteran Legislative Analyst. In this capacity, he is performing well above his pay grade and continues to provide exceptional support to a demanding mission that supports our mission and vision at AUSN." His NMA recommended the SM be retained in his Drilling Status. His migraine headache does not impact satisfactory performance of duty.
2. **Chronic lumbar strain**: SM reported intermittent low back pain for 2 years. This occurs 2 times a month related to activity such as walking all day. Pain is located at upper lumbar and non-radiating. No history of injuries/ trauma/ surgeries. SM attributed this to wearing heavy body armor in the Navy. X-ray L-spine (5/2014) showed lumbar spine alignment, vertebral heights and disc spaces are preserved. No evidence of acute fracture, subluxation or dislocation. No significant facet joint arthropathy. There were mild sclerotic changes along the left SI joint. This was managed with rest prn. C&P Medical SHA (29 Sept 2015) demonstrated normal thoracolumbar spine ROM: forward flexion 0-90°, extension 0-30°, bilateral lateral flexion 0-30°, bilateral lateral rotation 0-30°, there was no evidence of painful motion, weight bearing or tenderness on deep palpation of the joints. There was no additional loss of function and ROM after 3 repetitions. Normal muscle strength, no muscle atrophy, normal reflex exam, normal sensory exam, negative straight leg raising, and no radiculopathy of bilateral lower extremities. Exam at VA this date was normal. This condition does not preclude satisfactory performance of duty.
3. **Normal hearing, both ears**: C&P Audio exam (29 Sept 2015) revealed pure tone threshold average of 11 dB in the right ear and 18 dB in the left ear. Speech discrimination score was 100% in both ears. This is not duty limiting.
4. **Tinnitus**: Onset of tinnitus was 5 years ago. It is fluctuating constant high pitched ringing sound in both ears. This was aggravated with stress or when he gets worked up. This affects his focusing on task at hand especially in the absence of background noise. This condition did not preclude satisfactory performance of duty.

MEDICATIONS: (List)

Active Medications	Status	Sig	Refills Left	Last Filled
METHOCARBAMOL, 500 MG, TABLET, ORAL	Active	TAKE 3 TABLETS BY MOUTH FOUR TIMES A DAY AS NEEDED #0 RF0	NR	07 Sep 2015
Propranolol Hydrochloride 60mg, Extended release capsule, Oral	Active	TAKE 1 CAPSULE BY MOUTH AT BEDTIME TO PREVENT MIGRAINE HEADACHES. #0 RF3	3 of 3	31 Aug 2015
ZOLMITRIPTAN, 5 MG, TAB RAPDIS, ORAL	Active	DISSOLVE 1 TABLET UNDER TONGUE AT ONSET OF MIGRAINE MAY REPEAT IN 2 HOURS IF UNRESOLVED #0 RF5	5 of 5	31 Aug 2015
ROSUVASTATIN CALCIUM, 40 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY #0 RF3	3 of 3	20 Aug 2015
PRAZOSIN HCL, 1 MG, CAPSULE, ORAL	Active	TAKE ONE CAPSULE BY MOUTH EVERY NIGHT #0 RF3	3 of 3	18 May 2015

DIVALPROEX SODIUM, 500 MG, TAB ER 24H, ORAL	Active	TAKE THREE TABLET BY MOUTH EVERY DAY FOR MIGRAINES #0 RF3	2 of 3	27 Feb 2015
MAGNESIUM OXIDE, 400 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH AT BEDTIME FOR NUTRITIONAL SUPPLEMENT #0 RF3	2 of 3	27 Feb 2015
Ketorolac Tromethamine 30mg/mL, Solution, Injection	Active	INJECT 60MG INTRAMUSCULAR EVERY 7 DAYS AS NEEDED FOR PAIN OR INFLAMMATION #0 RF2	0 of 2	19 Dec 2014

PAST PSYCHIATRIC HISTORY: As above
PAST MEDICAL HISTORY: As above
ALLERGIES: NKDA
FAMILY HISTORY: Noncontributory
SOCIAL HISTORY: Noncontributory
REVIEW OF SYSTEMS: As above, otherwise noncontributory

DIAGNOSES:
1. **Posttraumatic Stress Disorder (PTSD)**
2. **Unspecified Depressive Disorder**

RECOMMENDATIONS:

The Medical Evaluation Board recommends that the Sailor's case be referred to the Central Physical Evaluation Board for the above diagnoses. The conditions did not exist prior to entry into the service. This Service member has received maximum benefit of military medical treatment.

At the present time this Service member is considered fully competent to be discharged to his own custody, does not constitute a danger to self or others, and is not likely to become a public charge. In accordance with the provisions of 37 USC §§ 601-604 and NAVMED P-117 (Manual of the Medical Department) Chapter 18, the Service member is mentally capable of handling his own financial affairs.
There are no known disciplinary actions, investigations, or processing actions for administrative discharge.

FP, Medical Board Division
WRNMMC

Psychiatrist, Medical Board Division
WRNMMC