

SAMPLE NEXUS LETTER:

MEDICAL OPINION

CONDITION(S) CONSIDERED

Cold Injury Residuals of the Bilateral Feet, to include Chronic Plantar Hyperkeratosis/Callus Formation and Chronic Foot Pain

CONTENTION

The Veteran contends that he sustained a cold injury to both feet during active-duty service while stationed in Europe after prolonged exposure to freezing temperatures. He reports that he was required to stand outdoors for several hours in the cold as a form of punishment and subsequently developed severe bilateral foot pain requiring medical evaluation. The Veteran reports persistent foot symptoms since that time, including chronic pain and severe callus formation requiring ongoing podiatric treatment.

THEORY OF ENTITLEMENT

Direct Service Connection

OPINION

It is at least as likely as not (50 percent probability or greater) that the Veteran's current cold injury residuals of the bilateral feet, including chronic foot pain and severe plantar hyperkeratosis/callus formation, were incurred during active military service and are the result of the documented cold exposure sustained while stationed in Europe.

RATIONALE

The claims file, service treatment records, lay statements, prior medical opinions, and podiatry records were carefully reviewed.

The Veteran's account of prolonged exposure to freezing environmental conditions while stationed in Germany is consistent with the circumstances of his service and is supported by contemporaneous service treatment records documenting medical evaluation after the cold exposure event. The records indicate that the Veteran developed significant bilateral foot pain following several hours of cold exposure.

A key factor in prior denials appears to have been a service treatment record notation indicating that the Veteran's feet were "quite warm" during examination and therefore did not demonstrate frostbite. However, this examiner finds that conclusion to be based upon an incomplete understanding of cold injury pathophysiology.

Cold injuries occur along a clinical spectrum. Frostnip represents the earliest stage of freezing cold injury and is characterized by pain, numbness, tingling, erythema, and reactive hyperemia during rewarming. During this stage, affected tissues frequently become warm, flushed, and painful as circulation returns. Tissue necrosis and deep tissue freezing are not required for a clinically significant cold injury to occur.

More advanced stages include superficial frostbite and deep frostbite, which involve actual tissue freezing, blister formation, vascular compromise, and tissue loss. Therefore, the absence of deep frostbite findings does not exclude the presence of a significant cold injury.

In this case, the Veteran's reported prolonged cold exposure, severe foot pain, and contemporaneous examination shortly thereafter are entirely consistent with frostnip, which represents a recognized form of cold injury. The notation that the feet were "quite warm" is actually consistent with the rewarming phase of frostnip and should not be interpreted as evidence that no cold injury occurred. Rather, it supports the conclusion that a cold injury had occurred but had not progressed to deeper tissue freezing.

The Veteran has subsequently developed chronic bilateral foot pain and severe plantar hyperkeratosis/callus formation involving the soles of both feet. Medical records document ongoing podiatric treatment for these conditions. Significantly, the treating podiatrist has attributed the Veteran's chronic foot pathology to his history of cold injury. This opinion is medically reasonable given the known long-term sequelae of cold injuries, which may include chronic pain, sensory abnormalities, skin changes, abnormal keratinization, hyperkeratosis, and persistent foot dysfunction.

The Veteran has consistently reported ongoing symptoms since the in-service event. His statements are internally consistent and supported by the documented cold exposure, documented in-service symptoms, and post-service podiatric findings. The continuity of symptomatology further supports a causal relationship between the in-service injury and the current condition.

DISCUSSION OF PRIOR NEGATIVE OPINIONS

This examiner respectfully disagrees with prior negative opinions that concluded a cold injury did not occur because frostbite was not diagnosed during service.

Those opinions appear to rely on the assumption that the absence of deep frostbite findings excludes the possibility of a clinically significant cold injury. This assumption is medically inaccurate because cold injury exists on a continuum ranging from frostnip to superficial and deep frostbite.

The service treatment record documenting warm feet following prolonged cold exposure was interpreted by prior examiners as evidence against a cold injury. However, warm feet during the rewarming phase are a classic feature of frostnip and early cold injury. Consequently, the same evidence relied upon to deny the claim may reasonably be interpreted as objective evidence supporting the occurrence of a cold injury.

Additionally, prior opinions do not adequately address the Veteran's documented symptoms immediately following exposure, the chronicity of symptoms thereafter, or the treating podiatrist's assessment linking the Veteran's chronic plantar pathology to the cold injury history.

For these reasons, this examiner finds the prior negative opinions less persuasive than the totality of the medical and lay evidence currently available.

CONCLUSION

The evidence supports that the Veteran sustained a documented cold injury of the bilateral feet during active military service. Although the injury did not progress to deep frostbite, the clinical findings are consistent with frostnip, which is a recognized early-stage cold injury. The Veteran subsequently developed chronic bilateral foot pain and severe plantar hyperkeratosis/callus formation requiring podiatric treatment. Given the documented in-service cold exposure, contemporaneous symptoms, continuity of symptomatology, and supportive podiatric findings, it is at least as likely as not (50 percent probability or greater) that the Veteran's current bilateral foot condition represents residuals of the cold injury sustained during active service.

SUPPORTING MEDICAL LITERATURE

Regli IB, Strapazzon G, Falla M, Oberhammer R, Brugger H. Long-Term Sequelae of Frostbite: A Scoping Review. *International Journal of Environmental Research and Public Health*. 2021;18(18):9655.

This scoping review discusses long-term residuals of frostbite and cold injury, including persistent neuropathic pain, nociceptive pain, vasospasm, cold sensitivity, and chronic tissue-related symptoms. This supports that cold injury can result in chronic residual symptoms long after the initial exposure event, even when the acute presentation does not include tissue loss or deep necrosis.

Vale TA, Symmonds M, Polydefkis M, Byrnes K, Rice ASC, Themistocleous AC, Bennett DLH. Chronic Non-Freezing Cold Injury Results in Neuropathic Pain Due to a Sensory Neuropathy. *Brain*. 2017;140(10):2557-2569.

This study explains that non-freezing cold injury can occur after sustained cold exposure without actual tissue freezing and may result in persistent sensory disturbance, numbness, paresthesias, and chronic pain of the hands and feet. This supports the medical rationale that absence of documented deep frostbite does not exclude clinically significant cold injury or later chronic foot pain.

Anand P, Privitera R, Yiangou Y, Donatien P, Birch R, Misra P. Capsaicin 8% Patch Treatment in Non-Freezing Cold Injury: Evidence for Painful Neuropathy. *Frontiers in Neurology*. 2021;12:722875.

This article notes that neuropathic pain associated with non-freezing cold injury is a significant condition in military service personnel and is associated with reduced intra-epidermal nerve fiber density, consistent with painful neuropathy. This supports that cold injury may produce chronic neurological pain symptoms even in the absence of severe frostbite or tissue loss.