Reference Determination Content

Example document — fictitious patient. A suggested draft determination prepared by the Veterans Health Centre from the matching example Diagnostic Assessment, to show how a DVA delegate could determine the claim. Names, dates, service details and clinicians are invented. It is not a decision of the Department of Veterans' Affairs.

Acute Pericarditis

Evidence

The evidence that I have considered in making this decision includes:

- Formal Claim with supporting statements;
- A Statement of your Service from the Department of Defence;
- Copies of your Service Medical Records.
- A Diagnostic Assessment by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 9 June 2025;
- A Diagnosis Form (D9287) by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 9 June 2025;
- An operation report (sternotomy and right ventricular repair) by the hospital ship, Persian Gulf, dated 21 March 2003;
- A defibrillator implantation report by the cardiologist, dated 18 August 2003;
- A respiratory medicine consultation and sputum culture by the respiratory physician, dated 12 June 2000;
- A radiation oncology treatment summary by the radiation oncologist, dated 12 May 2006;
- A rheumatology consultation by the rheumatologist, dated 7 July 2011;
- A CT chest by the radiologist, dated 4 September 2012;
- A pre-deployment medical by the medical officer, dated 16 January 2018;
- A deployed health record by the medical officer, Iraq, dated 14 March 2018;
- An echocardiogram and pericardiocentesis report by Role 3 hospital, Iraq, dated 16 March 2018;
- A cardiac MRI and cardiology consultation by the cardiologist, dated 26 March 2018;
- A pericardiocentesis and sclerotherapy report by the cardiologist, dated 14 May 2019;
- A renal biopsy report and nephrology consultation by the renal physician, dated 20 June 2019;
- A transplant operation report by the transplant surgeon, dated 11 August 2020;
- A hospital admission (echocardiogram and CT reports) by the cardiologist, dated 12 October 2021;

- An operation and histopathology reports by the cardiothoracic surgeon and pathologist, dated 16 October 2021.

Your service

I have identified that you have the following service:
Australian Defence Force service between :

14 January 1987 and 30 June 2022

Acute Pericarditis

You have stated that your condition was caused by:

- *having open heart surgery within the 20 years before the clinical onset or clinical worsening of pericarditis*
- *having a pacemaker, or defibrillator lead insertion within the 20 years before the clinical onset or clinical worsening of pericarditis*
- *having penetrating or blunt trauma to the heart within the 20 years before the clinical onset or clinical worsening of pericarditis*
- *having electrical injury affecting the heart within the 20 years before the clinical onset or clinical worsening of pericarditis*
- *undergoing a course of therapeutic radiation for cancer, where the heart was in the field of radiation, within the 20 years before the clinical onset or clinical worsening of pericarditis*
- *having a pericardial infection at the time of the clinical onset or clinical worsening of pericarditis*
- *having a systemic viral infection within the 4 weeks before the clinical onset or clinical worsening of pericarditis*
- *having tuberculosis before the clinical onset or clinical worsening of pericarditis*
- *having myocarditis at the time of the clinical onset or clinical worsening of pericarditis*
- *having one of the following systemic inflammatory diseases: (a) Addison disease with type 2 autoimmune polyglandular syndrome; (b) ankylosing spondylitis and seronegative spondyloarthropathies; (c) dermatomyositis; (d) IgG4-related disease; (e) inflammatory bowel disease; (f) mixed connective tissue disease; (g) polymyositis; (h) rheumatoid arthritis; (i) scleroderma (progressive systemic sclerosis); (j) Sjögren's syndrome; or (k) systemic lupus erythematosus; at the time of the clinical onset or clinical worsening of pericarditis*
- *having a benign or malignant cancer involving the pericardium at the time of the clinical onset or clinical worsening of pericarditis*
- *taking a drug which is associated in the individual with the development of pericarditis during drug therapy; and either: (a) the improvement of pericarditis within one month of discontinuing or tapering drug therapy; or (b) the redevelopment of pericarditis on*

rechallenge with the same drug; and where taking the drug continued for at least the 7 days before the clinical onset of pericarditis

- *having smallpox vaccine within the 4 weeks before the clinical onset or clinical worsening of pericarditis*
- *having asbestosis or asbestos related pleural plaques before the clinical onset or clinical worsening of pericarditis*
- *inhaling respirable asbestos fibres in an enclosed space at the time material containing asbestos was being applied, removed, cut, drilled, dislodged or disturbed: (a) for a cumulative period of at least 1,000 hours before the clinical onset of pericarditis; and (b) where the first inhalation of asbestos fibres commenced at least 5 years before the clinical onset of pericarditis*
- *inhaling respirable asbestos fibres in an open environment at the time material containing asbestos was being applied, removed, cut, drilled, dislodged or disturbed: (a) for a cumulative period of at least 3,000 hours before the clinical onset of pericarditis; and (b) where the first inhalation of asbestos fibres commenced at least 5 years before the clinical onset of pericarditis*
- *having a cardiac ablation procedure to treat cardiac dysrhythmia within the 4 weeks before the clinical onset or clinical worsening of pericarditis*
- *having sclerosants such as talc, and tetracyclines directly introduced into the pericardial sac before the clinical onset or clinical worsening of pericarditis*
- *having a peptic ulcer that erodes the pericardium at the time of the clinical onset or clinical worsening of pericarditis*
- *having an infection of the structures contiguous with the pericardium at the time of the clinical onset or clinical worsening of pericarditis*
- *having acute rheumatic fever at the time of the clinical onset or clinical worsening of pericarditis*
- *having one of the following vasculitides: (a) Behcet's disease; (b) eosinophilic granulomatosis with polyangiitis (Churg Straus syndrome); (c) giant cell (temporal) arteritis; (d) granulomatosis with polyangiitis (Wegener's granulomatosis); (e) microscopic polyangiitis; (f) polyarteritis nodosa; or (g) Takayasu's arteritis; at the time of the clinical onset or clinical worsening of pericarditis*
- *having a heart transplant, lung transplant, kidney transplant or haematopoietic cell transplant before the clinical onset or clinical worsening of pericarditis*
- *having a myocardial infarction within the 4 weeks before the clinical onset or clinical worsening of pericarditis*
- *having a dissection of the ascending aorta at the time of the clinical onset or clinical worsening of pericarditis*
- *having a pulmonary infarction at the time of the clinical onset or clinical worsening of pericarditis*
- *having pancreatitis at the time of the clinical onset or clinical worsening of pericarditis*

- *having a malignant neoplasm with a paraneoplastic pericarditis at the time of the clinical onset or clinical worsening of pericarditis*
- *having sarcoidosis or amyloidosis at the time of the clinical onset or clinical worsening of pericarditis*
- *having acute or chronic renal failure at the time of the clinical onset or clinical worsening of pericarditis*
- *having diabetic ketoacidosis at the time of the clinical onset or clinical worsening of pericarditis*
- *taking a drug from the specified list at the time of the clinical onset or clinical worsening of pericarditis*
- *having a COVID-19 vaccine within the 4 weeks before the clinical onset or clinical worsening of pericarditis*

Diagnosis: Acute Pericarditis

Basis of diagnosis: The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 9 June 2025, and is supported by a deployed health record by the medical officer, Iraq, dated 14 March 2018.

I am satisfied this is the appropriate diagnosis.
In determining your claim for this condition, I have applied the SOP:

Statement of Principles concerning Pericarditis (Reasonable Hypothesis) (No. 90 of 2023)

which sets out the factors that can connect the condition with service.

I am satisfied that you have met the following factor:

- *having open heart surgery within the 20 years before the clinical onset or clinical worsening of pericarditis*
- *having a pacemaker, or defibrillator lead insertion within the 20 years before the clinical onset or clinical worsening of pericarditis*
- *having penetrating or blunt trauma to the heart within the 20 years before the clinical onset or clinical worsening of pericarditis*
- *having electrical injury affecting the heart within the 20 years before the clinical onset or clinical worsening of pericarditis*
- *undergoing a course of therapeutic radiation for cancer, where the heart was in the field of radiation, within the 20 years before the clinical onset or clinical worsening of pericarditis*
- *having a pericardial infection at the time of the clinical onset or clinical worsening of pericarditis*
- *having a systemic viral infection within the 4 weeks before the clinical onset or clinical worsening of pericarditis*
- *having tuberculosis before the clinical onset or clinical worsening of pericarditis*

- *having myocarditis at the time of the clinical onset or clinical worsening of pericarditis*
- *having one of the following systemic inflammatory diseases: (a) Addison disease with type 2 autoimmune polyglandular syndrome; (b) ankylosing spondylitis and seronegative spondyloarthropathies; (c) dermatomyositis; (d) IgG4-related disease; (e) inflammatory bowel disease; (f) mixed connective tissue disease; (g) polymyositis; (h) rheumatoid arthritis; (i) scleroderma (progressive systemic sclerosis); (j) Sjögren's syndrome; or (k) systemic lupus erythematosus; at the time of the clinical onset or clinical worsening of pericarditis*
- *having a benign or malignant cancer involving the pericardium at the time of the clinical onset or clinical worsening of pericarditis*
- *taking a drug which is associated in the individual with the development of pericarditis during drug therapy; and either: (a) the improvement of pericarditis within one month of discontinuing or tapering drug therapy; or (b) the redevelopment of pericarditis on rechallenge with the same drug; and where taking the drug continued for at least the 7 days before the clinical onset of pericarditis*
- *having smallpox vaccine within the 4 weeks before the clinical onset or clinical worsening of pericarditis*
- *having asbestosis or asbestos related pleural plaques before the clinical onset or clinical worsening of pericarditis*
- *inhaling respirable asbestos fibres in an enclosed space at the time material containing asbestos was being applied, removed, cut, drilled, dislodged or disturbed: (a) for a cumulative period of at least 1,000 hours before the clinical onset of pericarditis; and (b) where the first inhalation of asbestos fibres commenced at least 5 years before the clinical onset of pericarditis*
- *inhaling respirable asbestos fibres in an open environment at the time material containing asbestos was being applied, removed, cut, drilled, dislodged or disturbed: (a) for a cumulative period of at least 3,000 hours before the clinical onset of pericarditis; and (b) where the first inhalation of asbestos fibres commenced at least 5 years before the clinical onset of pericarditis*
- *having a cardiac ablation procedure to treat cardiac dysrhythmia within the 4 weeks before the clinical onset or clinical worsening of pericarditis*
- *having sclerosants such as talc, and tetracyclines directly introduced into the pericardial sac before the clinical onset or clinical worsening of pericarditis*
- *having a peptic ulcer that erodes the pericardium at the time of the clinical onset or clinical worsening of pericarditis*
- *having an infection of the structures contiguous with the pericardium at the time of the clinical onset or clinical worsening of pericarditis*
- *having acute rheumatic fever at the time of the clinical onset or clinical worsening of pericarditis*
- *having one of the following vasculitides: (a) Behcet's disease; (b) eosinophilic granulomatosis with polyangiitis (Churg Straus syndrome); (c) giant cell (temporal)*

arteritis; (d) granulomatosis with polyangiitis (Wegener's granulomatosis); (e) microscopic polyangiitis; (f) polyarteritis nodosa; or (g) Takayasu's arteritis; at the time of the clinical onset or clinical worsening of pericarditis

- *having a heart transplant, lung transplant, kidney transplant or haematopoietic cell transplant before the clinical onset or clinical worsening of pericarditis*
- *having a myocardial infarction within the 4 weeks before the clinical onset or clinical worsening of pericarditis*
- *having a dissection of the ascending aorta at the time of the clinical onset or clinical worsening of pericarditis*
- *having a pulmonary infarction at the time of the clinical onset or clinical worsening of pericarditis*
- *having pancreatitis at the time of the clinical onset or clinical worsening of pericarditis*
- *having a malignant neoplasm with a paraneoplastic pericarditis at the time of the clinical onset or clinical worsening of pericarditis*
- *having sarcoidosis or amyloidosis at the time of the clinical onset or clinical worsening of pericarditis*
- *having acute or chronic renal failure at the time of the clinical onset or clinical worsening of pericarditis*
- *having diabetic ketoacidosis at the time of the clinical onset or clinical worsening of pericarditis*
- *taking a drug from the specified list at the time of the clinical onset or clinical worsening of pericarditis*
- *having a COVID-19 vaccine within the 4 weeks before the clinical onset or clinical worsening of pericarditis*

I have noted your contention as to the cause of this condition. The available evidence indicates, I have noted your contention to the cause of your condition. Your service medical records indicate that you presented to the health facility with sharp central chest pain radiating to the trapezius ridges, worse on lying flat, coughing and deep breathing and relieved by sitting forward, with fever, breathlessness on exertion, palpitations and fatigue on 14 March 2018.

The diagnosis was made on 14 March 2018 by a medical officer on warlike service in Iraq on typical pericardial chest pain, a pericardial friction rub, and widespread ST elevation with PR depression, and was confirmed on 16 March 2018 by echocardiography showing a new pericardial effusion and by pericardiocentesis, with Coxsackievirus B3 detected on PCR. Cardiac MRI on 26 March 2018 showed pericardial enhancement and myocarditis. This meets the Statement of Principles definition of pericarditis as inflammation of the pericardium, including acute pericarditis.

This has then led to further investigations and the diagnosis of your condition of *Acute Pericarditis*. I have accepted your condition of *Acute Pericarditis*.

Having considered your service records and the available medical evidence, I am satisfied the SOP is met and that this condition is related to your wartime service.

I have therefore accepted that this condition is related to your service with effect from 14 March 2018.

Acute Pericarditis (Worsening)

Evidence

The evidence that I have considered in making this decision includes:

- Formal Claim with supporting statements;
- A Statement of your Service from the Department of Defence;
- Copies of your Service Medical Records.
- A Diagnostic Assessment by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 9 June 2025;
- A Diagnosis Form (D9287) by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 9 June 2025;
- An operation report (sternotomy and right ventricular repair) by the hospital ship, Persian Gulf, dated 21 March 2003;
- A defibrillator implantation report by the cardiologist, dated 18 August 2003;
- A respiratory medicine consultation and sputum culture by the respiratory physician, dated 12 June 2000;
- A radiation oncology treatment summary by the radiation oncologist, dated 12 May 2006;
- A rheumatology consultation by the rheumatologist, dated 7 July 2011;
- A CT chest by the radiologist, dated 4 September 2012;
- A pre-deployment medical by the medical officer, dated 16 January 2018;
- A deployed health record by the medical officer, Iraq, dated 14 March 2018;
- An echocardiogram and pericardiocentesis report by Role 3 hospital, Iraq, dated 16 March 2018;
- A cardiac MRI and cardiology consultation by the cardiologist, dated 26 March 2018;
- A pericardiocentesis and sclerotherapy report by the cardiologist, dated 14 May 2019;
- A renal biopsy report and nephrology consultation by the renal physician, dated 20 June 2019;
- A transplant operation report by the transplant surgeon, dated 11 August 2020;
- A hospital admission (echocardiogram and CT reports) by the cardiologist, dated 12 October 2021;
- An operation and histopathology reports by the cardiothoracic surgeon and pathologist, dated 16 October 2021.

Your service

I have identified that you have the following service:
Australian Defence Force service between :

14 January 1987 and 30 June 2022

Acute Pericarditis (Worsening)

You have stated that the worsening of your condition was caused by:

- *having open heart surgery within the 20 years before the clinical onset or clinical worsening of pericarditis*
- *having a pacemaker, or defibrillator lead insertion within the 20 years before the clinical onset or clinical worsening of pericarditis*
- *having penetrating or blunt trauma to the heart within the 20 years before the clinical onset or clinical worsening of pericarditis*
- *having electrical injury affecting the heart within the 20 years before the clinical onset or clinical worsening of pericarditis*
- *undergoing a course of therapeutic radiation for cancer, where the heart was in the field of radiation, within the 20 years before the clinical onset or clinical worsening of pericarditis*
- *having a pericardial infection at the time of the clinical onset or clinical worsening of pericarditis*
- *having a systemic viral infection within the 4 weeks before the clinical onset or clinical worsening of pericarditis*
- *having tuberculosis before the clinical onset or clinical worsening of pericarditis*
- *having myocarditis at the time of the clinical onset or clinical worsening of pericarditis*
- *having one of the following systemic inflammatory diseases: (a) Addison disease with type 2 autoimmune polyglandular syndrome; (b) ankylosing spondylitis and seronegative spondyloarthropathies; (c) dermatomyositis; (d) IgG4-related disease; (e) inflammatory bowel disease; (f) mixed connective tissue disease; (g) polymyositis; (h) rheumatoid arthritis; (i) scleroderma (progressive systemic sclerosis); (j) Sjögren's syndrome; or (k) systemic lupus erythematosus; at the time of the clinical onset or clinical worsening of pericarditis*
- *having a benign or malignant cancer involving the pericardium at the time of the clinical onset or clinical worsening of pericarditis*
- *having smallpox vaccine within the 4 weeks before the clinical onset or clinical worsening of pericarditis*
- *having asbestosis or asbestos related pleural plaques before the clinical onset or clinical worsening of pericarditis*
- *having a cardiac ablation procedure to treat cardiac dysrhythmia within the 4 weeks before the clinical onset or clinical worsening of pericarditis*
- *having sclerosants such as talc, and tetracyclines directly introduced into the pericardial sac before the clinical onset or clinical worsening of pericarditis*
- *having a peptic ulcer that erodes the pericardium at the time of the clinical onset or clinical worsening of pericarditis*
- *having an infection of the structures contiguous with the pericardium at the time of the clinical onset or clinical worsening of pericarditis*

- *having acute rheumatic fever at the time of the clinical onset or clinical worsening of pericarditis*
- *having one of the following vasculitides: (a) Behcet's disease; (b) eosinophilic granulomatosis with polyangiitis (Churg Straus syndrome); (c) giant cell (temporal) arteritis; (d) granulomatosis with polyangiitis (Wegener's granulomatosis); (e) microscopic polyangiitis; (f) polyarteritis nodosa; or (g) Takayasu's arteritis; at the time of the clinical onset or clinical worsening of pericarditis*
- *having a heart transplant, lung transplant, kidney transplant or haematopoietic cell transplant before the clinical onset or clinical worsening of pericarditis*
- *having a myocardial infarction within the 4 weeks before the clinical onset or clinical worsening of pericarditis*
- *having a dissection of the ascending aorta at the time of the clinical onset or clinical worsening of pericarditis*
- *having a pulmonary infarction at the time of the clinical onset or clinical worsening of pericarditis*
- *having pancreatitis at the time of the clinical onset or clinical worsening of pericarditis*
- *having a malignant neoplasm with a paraneoplastic pericarditis at the time of the clinical onset or clinical worsening of pericarditis*
- *having sarcoidosis or amyloidosis at the time of the clinical onset or clinical worsening of pericarditis*
- *having acute or chronic renal failure at the time of the clinical onset or clinical worsening of pericarditis*
- *taking a drug from the specified list at the time of the clinical onset or clinical worsening of pericarditis*
- *having a COVID-19 mRNA vaccine within the 4 weeks before the clinical onset or clinical worsening of pericarditis*
- *inability to obtain appropriate clinical management for pericarditis before the clinical worsening of pericarditis*

Diagnosis: Acute Pericarditis (Worsening)

Basis of diagnosis: The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 9 June 2025, and is supported by a deployed health record by the medical officer, Iraq, dated 14 March 2018.

I am satisfied this is the appropriate diagnosis.
In determining your claim for this condition, I have applied the SOP:

Statement of Principles concerning Pericarditis (Balance of Probabilities) (No. 91 of 2023)

which sets out the factors that can connect the condition with service.

I am satisfied that you have met the following factor:

- *having open heart surgery within the 20 years before the clinical onset or clinical worsening of pericarditis*
- *having a pacemaker, or defibrillator lead insertion within the 20 years before the clinical onset or clinical worsening of pericarditis*
- *having penetrating or blunt trauma to the heart within the 20 years before the clinical onset or clinical worsening of pericarditis*
- *having electrical injury affecting the heart within the 20 years before the clinical onset or clinical worsening of pericarditis*
- *undergoing a course of therapeutic radiation for cancer, where the heart was in the field of radiation, within the 20 years before the clinical onset or clinical worsening of pericarditis*
- *having a pericardial infection at the time of the clinical onset or clinical worsening of pericarditis*
- *having a systemic viral infection within the 4 weeks before the clinical onset or clinical worsening of pericarditis*
- *having tuberculosis before the clinical onset or clinical worsening of pericarditis*
- *having myocarditis at the time of the clinical onset or clinical worsening of pericarditis*
- *having one of the following systemic inflammatory diseases: (a) Addison disease with type 2 autoimmune polyglandular syndrome; (b) ankylosing spondylitis and seronegative spondyloarthropathies; (c) dermatomyositis; (d) IgG4-related disease; (e) inflammatory bowel disease; (f) mixed connective tissue disease; (g) polymyositis; (h) rheumatoid arthritis; (i) scleroderma (progressive systemic sclerosis); (j) Sjögren's syndrome; or (k) systemic lupus erythematosus; at the time of the clinical onset or clinical worsening of pericarditis*
- *having a benign or malignant cancer involving the pericardium at the time of the clinical onset or clinical worsening of pericarditis*
- *having smallpox vaccine within the 4 weeks before the clinical onset or clinical worsening of pericarditis*
- *having asbestosis or asbestos related pleural plaques before the clinical onset or clinical worsening of pericarditis*
- *having a cardiac ablation procedure to treat cardiac dysrhythmia within the 4 weeks before the clinical onset or clinical worsening of pericarditis*
- *having sclerosants such as talc, and tetracyclines directly introduced into the pericardial sac before the clinical onset or clinical worsening of pericarditis*
- *having a peptic ulcer that erodes the pericardium at the time of the clinical onset or clinical worsening of pericarditis*
- *having an infection of the structures contiguous with the pericardium at the time of the clinical onset or clinical worsening of pericarditis*
- *having acute rheumatic fever at the time of the clinical onset or clinical worsening of pericarditis*

- *having one of the following vasculitides: (a) Behcet's disease; (b) eosinophilic granulomatosis with polyangiitis (Churg Straus syndrome); (c) giant cell (temporal) arteritis; (d) granulomatosis with polyangiitis (Wegener's granulomatosis); (e) microscopic polyangiitis; (f) polyarteritis nodosa; or (g) Takayasu's arteritis; at the time of the clinical onset or clinical worsening of pericarditis*
- *having a heart transplant, lung transplant, kidney transplant or haematopoietic cell transplant before the clinical onset or clinical worsening of pericarditis*
- *having a myocardial infarction within the 4 weeks before the clinical onset or clinical worsening of pericarditis*
- *having a dissection of the ascending aorta at the time of the clinical onset or clinical worsening of pericarditis*
- *having a pulmonary infarction at the time of the clinical onset or clinical worsening of pericarditis*
- *having pancreatitis at the time of the clinical onset or clinical worsening of pericarditis*
- *having a malignant neoplasm with a paraneoplastic pericarditis at the time of the clinical onset or clinical worsening of pericarditis*
- *having sarcoidosis or amyloidosis at the time of the clinical onset or clinical worsening of pericarditis*
- *having acute or chronic renal failure at the time of the clinical onset or clinical worsening of pericarditis*
- *taking a drug from the specified list at the time of the clinical onset or clinical worsening of pericarditis*
- *having a COVID-19 mRNA vaccine within the 4 weeks before the clinical onset or clinical worsening of pericarditis*
- *inability to obtain appropriate clinical management for pericarditis before the clinical worsening of pericarditis*

I have noted your contention as to the cause of this condition. The available evidence indicates, I have noted your contention to the cause of your condition. Your service medical records indicate that you presented to the health facility with sharp central chest pain radiating to the trapezius ridges, worse on lying flat, coughing and deep breathing and relieved by sitting forward, with fever, breathlessness on exertion, palpitations and fatigue on 14 March 2018.

The diagnosis was made on 14 March 2018 by a medical officer on warlike service in Iraq on typical pericardial chest pain, a pericardial friction rub, and widespread ST elevation with PR depression, and was confirmed on 16 March 2018 by echocardiography showing a new pericardial effusion and by pericardiocentesis, with Coxsackievirus B3 detected on PCR. Cardiac MRI on 26 March 2018 showed pericardial enhancement and myocarditis. This meets the Statement of Principles definition of pericarditis as inflammation of the pericardium, including acute pericarditis.

After the condition arose, it was worsened during your service. On 21 March 2003, during warlike service in the Persian Gulf, a metal fragment from an arc flash explosion in a switchboard room penetrated your chest and lacerated the right ventricle. A cardiologist inserted an implantable cardioverter-defibrillator with a right ventricular lead on 18 August 2003 for ventricular tachycardia arising from the right ventricular scar. The fragment wound of 21 March 2003 was a penetrating injury to the heart, with laceration of the right ventricle, and you were also thrown against a bulkhead with a sternal fracture and myocardial contusion. In the same explosion of 21 March 2003 you received a 440 volt shock across the chest from the switchboard and had ventricular fibrillation, terminated by defibrillation. You were treated for Hodgkin lymphoma of the mediastinum with chemotherapy and mediastinal radiotherapy of 30 Gy from 03 April to 12 May 2006. Pericardiocentesis at the role 3 hospital on 16 March 2018 drained 420 mL of fluid, and PCR of the fluid detected Coxsackievirus B3. From 20 February 2018 you had a febrile illness with myalgia, sore throat and diarrhoea, with Coxsackievirus B3 later confirmed on serology. You were diagnosed with pulmonary tuberculosis on 12 June 2000, with a positive sputum culture, and completed six months of treatment in December 2000. At onset troponin I was raised at 2 850 ng/L, and cardiac MRI on 26 March 2018 showed subepicardial late gadolinium enhancement of the lateral wall with myocardial oedema, confirming myocarditis present at the onset on 14 March 2018. Ankylosing spondylitis was diagnosed by a rheumatologist on 7 July 2011 on inflammatory back pain, HLA-B27 positivity and sacroiliitis on MRI. Cardiac MRI on 26 March 2018 showed a 2.4 cm benign pericardial lipoma adjacent to the right atrioventricular groove, which was present at the onset on 14 March 2018 and was resected at surgery in October 2021. You received smallpox vaccine on 22 February 2018, required for your coalition headquarters appointment, within the 4 weeks before the onset on 14 March 2018. CT chest on 4 September 2012 showed calcified bilateral pleural plaques, confirmed by a respiratory physician as asbestos related, before the onset on 14 March 2018. On 28 September 2021 you underwent catheter ablation of the cavotricuspid isthmus for typical atrial flutter that had developed after the 2018 myopericarditis. For a recurrent pericardial effusion you underwent pericardiocentesis with intrapericardial instillation of tetracycline as a sclerosant on 14 May 2019. Gastroscopy and CT during the admission of 12 October 2021 showed a deep gastric ulcer in a large hiatus hernia eroding through to the pericardium, with pericardial gas. A left pleural empyema was drained on 13 October 2021, with pus growing Streptococcus anginosus, adjacent to the pericardium. After a streptococcal pharyngitis on 1 September 2021, an infectious diseases physician diagnosed acute rheumatic fever on 11 October 2021 using the Jones criteria: migratory polyarthritis, fever, a raised ASOT of 1 200 IU/mL and a prolonged PR interval. Granulomatosis with polyangiitis was diagnosed on 20 June 2019 on PR3-ANCA positivity and a renal biopsy showing pauci-immune crescentic glomerulonephritis. Renal failure from granulomatosis with polyangiitis was treated with a deceased donor kidney transplant on 11 August 2020. A non-ST elevation myocardial infarction was confirmed on 16 September 2021, with a troponin rise and a stenosis of the left anterior descending artery attributed to radiation-related coronary disease. CT aortography on 14 October 2021 showed a limited dissection of the ascending aorta, repaired surgically on 16 October 2021. CT pulmonary angiography on 12 October 2021 showed a right lower lobe pulmonary embolus with a wedge-shaped pulmonary infarct. Acute pancreatitis was diagnosed on 12 October 2021 with epigastric

pain, a lipase of 1 480 U/L and pancreatic oedema on CT, attributed to azathioprine. Post-transplant lymphoproliferative disorder, a diffuse large B-cell lymphoma of the mediastinal nodes, was diagnosed on node biopsy on 5 October 2021. AA amyloidosis secondary to long-standing ankylosing spondylitis was confirmed on abdominal fat pad biopsy on 18 May 2021, with Congo red staining and apple-green birefringence. At the worsening on 12 October 2021 the transplanted kidney had an acute kidney injury, with creatinine rising from 120 to 380 micromol/L, which the renal physician recorded as acute renal failure. You were taking hydralazine 25 mg three times a day from 8 June 2021 for post-transplant hypertension, and was taking it at the worsening on 12 October 2021. You received your second dose of a COVID-19 mRNA vaccine on 20 September 2021, within the 4 weeks before the worsening on 12 October 2021. At onset on warlike service in Iraq in March 2018 no echocardiography or colchicine was available at the forward headquarters.

This has then led to further investigations and the diagnosis of your condition of *Acute Pericarditis (Worsening)*. I have accepted your condition of *Acute Pericarditis (Worsening)*.

Having considered your service records and the available medical evidence, I am satisfied the SOP is met and that the worsening of this condition is related to your peacetime service.

I have therefore accepted that the worsening of this condition is related to your service with effect from 12 October 2021.

Example document — fictitious patient. A suggested draft determination prepared by the Veterans Health Centre from the matching example Diagnostic Assessment, to show how a DVA delegate could determine the claim. Names, dates, service details and clinicians are invented. It is not a decision of the Department of Veterans' Affairs.