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.

Bilateral Shoulder - Pain

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 30 April 2025;
- A Diagnosis Form (D9287) by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 30 April 2025;
- A trauma admission and X-ray reports by Role 3 hospital, Middle East Area of Operations, dated 12 May 2007;
- An operation report by the orthopaedic surgeon, dated 30 May 2007;
- A nerve conduction study report by the neurologist, dated 18 September 2007;
- An operation report right shoulder by the orthopaedic surgeon, dated 14 February 2008;
- A rheumatology consultation and shoulder ultrasound by the rheumatologist and radiologist, dated 3 November 2008;
- An operation report left shoulder by the orthopaedic surgeon, dated 18 August 2009;
- A renal medicine consultation by the nephrologist, dated 15 February 2010;
- An endocrinology and lipid assessment by the endocrinologist, dated 22 June 2015;
- A histopathology report by the pathologist, dated 22 September 2015;
- A pre-deployment medical examination by the medical officer, RAAF base health centre, dated 10 January 2018;
- A deployed prescribing record by the medical officer, Middle East Region, dated 20 May 2018;
- A role 2 consultation (ultrasound and microbiology) by the medical officer and pathologist, Middle East Region, dated 12 July 2018;
- A role 2 consultation by the medical officer, Middle East Region, dated 10 September 2018;
- An MRI both shoulders report by the radiologist, dated 5 October 2018;
- An orthopaedic consultation by the orthopaedic surgeon, dated 14 May 2019;

- An MRI right shoulder report by the radiologist, dated 3 June 2019.

Your service

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

20 January 1993 and 15 December 2019

Bilateral Shoulder - Pain

You have stated that your condition was caused by:

- *having an injury to the affected shoulder within the 3 months before the clinical onset of rotator cuff syndrome*
- *undergoing a surgical procedure involving the affected shoulder joint before the clinical onset of rotator cuff syndrome*
- *performing any combination of: (a) repetitive or sustained activities of the affected shoulder when the shoulder on the affected side is abducted or flexed by at least 60 degrees; or (b) forceful activities with the affected upper limb; for at least 80 hours within a period of 120 consecutive days before the clinical onset of rotator cuff syndrome, and where the repetitive or sustained or forceful activities have not ceased more than 30 days before the clinical onset of rotator cuff syndrome*
- *performing repetitive or sustained activities of the affected shoulder when the shoulder on the affected side is abducted or flexed by at least 60 degrees for at least 2,000 hours within the 10 years before the clinical onset of rotator cuff syndrome*
- *lifting or carrying loads of at least 20 kilograms using the upper limb of the affected side for at least 200 hours within the 10 years before the clinical onset of rotator cuff syndrome*
- *using a hand-held, vibrating, percussive, heavy industrial tool with the affected upper limb, for at least 2,000 hours within the 10 years before the clinical onset of rotator cuff syndrome*
- *having dialysis-related amyloidosis before the clinical onset of rotator cuff syndrome*
- *regularly using the upper limbs for weight-bearing for a continuous period of at least the 1 year before the clinical onset of rotator cuff syndrome*
- *having anatomical narrowing of the subacromial space on the affected side at the time of the clinical onset of rotator cuff syndrome*
- *having joint instability of the affected shoulder, or dislocation or subluxation of the affected shoulder joint before the clinical onset of rotator cuff syndrome*
- *having an infection of the subacromial bursa or subdeltoid bursa of the affected shoulder at the time of the clinical onset of rotator cuff syndrome*
- *having an autoimmune disease from the specified list of autoimmune diseases, involving the shoulder joint or associated bursae of the affected side, before the clinical onset of rotator cuff syndrome*

- *having gout involving the affected shoulder at the time of the clinical onset of rotator cuff syndrome*
- *having acquired scapular dyskinesis of the affected side at the time of the clinical onset of rotator cuff syndrome*
- *having smoked at least 20 pack-years of tobacco products before the clinical onset of rotator cuff syndrome*
- *having diabetes mellitus before the clinical onset of rotator cuff syndrome*
- *having dyslipidaemia before the clinical onset of rotator cuff syndrome*
- *taking a glucocorticoid drug as specified before the clinical onset of rotator cuff syndrome*
- *taking a fluoroquinolone antibiotic within the 60 days before the clinical onset of rotator cuff syndrome*
- *taking an aromatase inhibitor for at least 4 weeks within the 2 years before the clinical onset of rotator cuff syndrome*

Diagnosis: Pain

Basis of diagnosis: The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 30 April 2025, and is supported by a role 2 consultation (ultrasound and microbiology) by the medical officer and pathologist, Middle East Region, dated 12 July 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 Rotator Cuff Syndrome (Reasonable Hypothesis) (No. 109 of 2022)

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

I am satisfied that you have met the following factor:

- *having an injury to the affected shoulder within the 3 months before the clinical onset of rotator cuff syndrome*
- *undergoing a surgical procedure involving the affected shoulder joint before the clinical onset of rotator cuff syndrome*
- *performing any combination of: (a) repetitive or sustained activities of the affected shoulder when the shoulder on the affected side is abducted or flexed by at least 60 degrees; or (b) forceful activities with the affected upper limb; for at least 80 hours within a period of 120 consecutive days before the clinical onset of rotator cuff syndrome, and where the repetitive or sustained or forceful activities have not ceased more than 30 days before the clinical onset of rotator cuff syndrome*
- *performing repetitive or sustained activities of the affected shoulder when the shoulder on the affected side is abducted or flexed by at least 60 degrees for at least 2,000 hours within the 10 years before the clinical onset of rotator cuff syndrome*

- *lifting or carrying loads of at least 20 kilograms using the upper limb of the affected side for at least 200 hours within the 10 years before the clinical onset of rotator cuff syndrome*
- *using a hand-held, vibrating, percussive, heavy industrial tool with the affected upper limb, for at least 2,000 hours within the 10 years before the clinical onset of rotator cuff syndrome*
- *having dialysis-related amyloidosis before the clinical onset of rotator cuff syndrome*
- *regularly using the upper limbs for weight-bearing for a continuous period of at least the 1 year before the clinical onset of rotator cuff syndrome*
- *having anatomical narrowing of the subacromial space on the affected side at the time of the clinical onset of rotator cuff syndrome*
- *having joint instability of the affected shoulder, or dislocation or subluxation of the affected shoulder joint before the clinical onset of rotator cuff syndrome*
- *having an infection of the subacromial bursa or subdeltoid bursa of the affected shoulder at the time of the clinical onset of rotator cuff syndrome*
- *having an autoimmune disease from the specified list of autoimmune diseases, involving the shoulder joint or associated bursae of the affected side, before the clinical onset of rotator cuff syndrome*
- *having gout involving the affected shoulder at the time of the clinical onset of rotator cuff syndrome*
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- *having smoked at least 20 pack-years of tobacco products before the clinical onset of rotator cuff syndrome*
- *having diabetes mellitus before the clinical onset of rotator cuff syndrome*
- *having dyslipidaemia before the clinical onset of rotator cuff syndrome*
- *taking a glucocorticoid drug as specified before the clinical onset of rotator cuff syndrome*
- *taking a fluoroquinolone antibiotic within the 60 days before the clinical onset of rotator cuff syndrome*
- *taking an aromatase inhibitor for at least 4 weeks within the 2 years before the clinical onset of rotator cuff syndrome*

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 aching pain over the outer aspect of both shoulders, worse on reaching overhead and at night when lying on either side, with weakness lifting your arms and a painful catch between 60 and 120 degrees of elevation on 12 July 2018.

The diagnosis was made clinically on 12 July 2018 at a role 2 facility, where a medical officer found a painful arc, positive Hawkins, Neer and empty can tests and weakness of elevation in both shoulders, and was confirmed the same day on ultrasound, which showed bilateral

supraspinatus tendinopathy with partial-thickness tears and bursal effusions. Aspiration of both bursae confirmed concurrent Staphylococcus aureus infection and urate crystals.

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

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 10 July 2018.

Bilateral Shoulder - Pain (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 30 April 2025;
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- An MRI both shoulders report by the radiologist, dated 5 October 2018;
- An orthopaedic consultation by the orthopaedic surgeon, dated 14 May 2019;
- An MRI right shoulder report by the radiologist, dated 3 June 2019.

Your service

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

20 January 1993 and 15 December 2019

Bilateral Shoulder - Pain (Worsening)

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

- *having an injury to the affected shoulder within the 3 months before the clinical worsening of rotator cuff syndrome*
- *undergoing a surgical procedure involving the affected shoulder joint before the clinical worsening of rotator cuff syndrome*
- *performing any combination of: (a) repetitive or sustained activities of the affected shoulder when the shoulder on the affected side is abducted or flexed by at least 60 degrees; or (b) forceful activities with the affected upper limb; for at least 80 hours within a period of 120 consecutive days before the clinical worsening of rotator cuff syndrome, and where the repetitive or sustained or forceful activities have not ceased more than 30 days before the clinical worsening of rotator cuff syndrome*
- *performing repetitive or sustained activities of the affected shoulder when the shoulder on the affected side is abducted or flexed by at least 60 degrees for at least 2,000 hours within the 10 years before the clinical worsening of rotator cuff syndrome*
- *lifting or carrying loads of at least 20 kilograms using the upper limb of the affected side for at least 200 hours within the 10 years before the clinical worsening of rotator cuff syndrome*
- *using a hand-held, vibrating, percussive, heavy industrial tool with the affected upper limb, for at least 2,000 hours within the 10 years before the clinical worsening of rotator cuff syndrome*
- *having dialysis-related amyloidosis before the clinical worsening of rotator cuff syndrome*
- *regularly using the upper limbs for weight-bearing for a continuous period of at least the 1 year before the clinical worsening of rotator cuff syndrome*
- *having anatomical narrowing of the subacromial space on the affected side at the time of the clinical worsening of rotator cuff syndrome*
- *having joint instability of the affected shoulder, or dislocation or subluxation of the affected shoulder joint before the clinical worsening of rotator cuff syndrome*
- *having an infection of the subacromial bursa or subdeltoid bursa of the affected shoulder at the time of the clinical worsening of rotator cuff syndrome*
- *having an autoimmune disease from the specified list of autoimmune diseases, involving the shoulder joint or associated bursae of the affected side, before the clinical worsening of rotator cuff syndrome*
- *having gout involving the affected shoulder at the time of the clinical worsening of rotator cuff syndrome*
- *having acquired scapular dyskinesis of the affected side at the time of the clinical worsening of rotator cuff syndrome*
- *having smoked at least 20 pack-years of tobacco products before the clinical worsening of rotator cuff syndrome*

- *having diabetes mellitus before the clinical worsening of rotator cuff syndrome*
- *having dyslipidaemia before the clinical worsening of rotator cuff syndrome*
- *taking a glucocorticoid drug as specified before the clinical worsening of rotator cuff syndrome*
- *taking a fluoroquinolone antibiotic within the 60 days before the clinical worsening of rotator cuff syndrome*
- *taking an aromatase inhibitor for at least 4 weeks within the 2 years before the clinical worsening of rotator cuff syndrome*
- *inability to obtain appropriate clinical management for rotator cuff syndrome*

Diagnosis: Pain (Worsening)

Basis of diagnosis: The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 30 April 2025, and is supported by a role 2 consultation (ultrasound and microbiology) by the medical officer and pathologist, Middle East Region, dated 12 July 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 Rotator Cuff Syndrome (Reasonable Hypothesis) (No. 109 of 2022)

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

I am satisfied that you have met the following factor:

- *having an injury to the affected shoulder within the 3 months before the clinical worsening of rotator cuff syndrome*
- *undergoing a surgical procedure involving the affected shoulder joint before the clinical worsening of rotator cuff syndrome*
- *performing any combination of: (a) repetitive or sustained activities of the affected shoulder when the shoulder on the affected side is abducted or flexed by at least 60 degrees; or (b) forceful activities with the affected upper limb; for at least 80 hours within a period of 120 consecutive days before the clinical worsening of rotator cuff syndrome, and where the repetitive or sustained or forceful activities have not ceased more than 30 days before the clinical worsening of rotator cuff syndrome*
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syndrome

- *having dialysis-related amyloidosis before the clinical worsening of rotator cuff syndrome*
- *regularly using the upper limbs for weight-bearing for a continuous period of at least the 1 year before the clinical worsening of rotator cuff syndrome*
- *having anatomical narrowing of the subacromial space on the affected side at the time of the clinical worsening of rotator cuff syndrome*
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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 aching pain over the outer aspect of both shoulders, worse on reaching overhead and at night when lying on either side, with weakness lifting your arms and a painful catch between 60 and 120 degrees of elevation on 12 July 2018.

The diagnosis was made clinically on 12 July 2018 at a role 2 facility, where a medical officer found a painful arc, positive Hawkins, Neer and empty can tests and weakness of elevation in both shoulders, and was confirmed the same day on ultrasound, which showed bilateral supraspinatus tendinopathy with partial-thickness tears and bursal effusions. Aspiration of both bursae confirmed concurrent Staphylococcus aureus infection and urate crystals.

After the condition arose, it was worsened during your service. The traction injury of 22 August 2018, when you caught yourself on a work platform rail with both arms on warlike service in the Middle East, produced pain and loss of elevation lasting more than 7 days, 19 days before the worsening. The shoulder operations of 2007 to 2009, which treated injuries sustained on warlike service in 2007, preceded the worsening. The 120 days before the worsening, from 13 May to 10 September 2018, fell within your warlike service, during which you performed about 500 hours of overhead repair work and used crutches daily, continuing until 22 August 2018. In the 10 years before the worsening you performed about 4,500 hours of overhead work, including about 800 hours on warlike service in the Middle East in 2018. In the 10 years before the worsening you lifted loads of 20 to 40 kg for about 540 hours, including about 190 hours on warlike service in 2018. In the 10 years before the worsening you used rivet guns, bucking bars and pneumatic drills for about 2,300 hours, including about 450 hours on warlike service in the Middle East in 2018. Dialysis-related amyloidosis was present before the worsening on warlike service in September 2018. You used forearm crutches continuously throughout the year before the worsening, including six months of warlike service. Subacromial narrowing from the malunited acromion fracture of warlike service in 2007 was present at the worsening, with an acromiohumeral distance of 5 mm on the right. The dislocation and subluxation sustained on warlike service in 2007 preceded the worsening. Recurrent bilateral Staphylococcus aureus septic bursitis was confirmed on warlike service on 10 September 2018, at the worsening. Systemic lupus erythematosus involving both shoulders preceded the worsening and was active on warlike service in August 2018. Urate crystals were again present in both bursal aspirates on warlike service on 10 September 2018. Bilateral scapular winging from the long thoracic neuropathy of warlike service in 2007 was recorded at the worsening on 10 September 2018. You had smoked about 29 pack-years before the worsening, smoking 30 cigarettes a day on warlike service in 2018. Post-transplant diabetes was present before the worsening, with an HbA1c of 8.4 per cent on warlike service in August 2018. Dyslipidaemia treated with atorvastatin was present before the worsening on warlike service. Prednisolone continued throughout your warlike service, meeting each Table 1 combination before the worsening. Ciprofloxacin was prescribed on warlike service on 25 July 2018 for gastroenteritis, 47 days before the worsening. Anastrozole continued throughout the 2 years before the worsening, including six months of warlike service. On warlike service in the Middle East from July to September 2018 there was no MRI, orthopaedic surgeon or physiotherapist in theatre.

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

I have therefore accepted that the worsening of this condition is related to your service with effect from 10 September 2018.

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.