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.

Dysmenorrhoea

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 25 February 2025;
- A Diagnosis Form (D9287) by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 25 February 2025;
- A periodic health examination by the medical officer, Garrison health centre, dated 3 August 2011;
- A colposcopy and operation report by the gynaecologist, dated 9 November 2011;
- A psychiatric assessment by the consultant psychiatrist, dated 20 January 2012;
- An outpatient health record and pathology by the medical officer, Garrison health centre, dated 22 March 2012;
- A procedure record (intrauterine device insertion) by the medical officer, dated 18 June 2012;
- An outpatient health record by the medical officer, Garrison health centre, dated 17 September 2012;
- An ultrasound and MRI pelvis reports and gynaecology consultation by the gynaecologist, dated 6 March 2013;
- An operation and histopathology reports by the gynaecologist, dated 15 May 2013;
- A deployed health record by the medical officer, Middle East Area of Operations, dated 12 March 2016;
- MRI pelvis and operation reports by the gynaecologist, dated 20 July 2016.

Your service

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

20 February 2007 and 11 December 2020

Dysmenorrhoea

You have stated that your condition was caused by:

- *having endometriosis at the time of the clinical onset of dysmenorrhoea*
- *having adenomyosis at the time of the clinical onset of dysmenorrhoea*
- *having a submucosal or intramural uterine fibroid at the time of the clinical onset of dysmenorrhoea*
- *having a copper intrauterine device in place at the time of the clinical onset of dysmenorrhoea*
- *having pelvic inflammatory disease within the 2 years before the clinical onset of dysmenorrhoea*
- *having cervical stenosis following an excisional procedure of the cervix before the clinical onset of dysmenorrhoea*
- *smoking an average of at least 10 cigarettes per day for at least the 1 year before the clinical onset of dysmenorrhoea*
- *having a clinically significant psychiatric disorder, including posttraumatic stress disorder, depression or an anxiety disorder, for at least the 6 months before the clinical onset of dysmenorrhoea*

Diagnosis: Dysmenorrhoea

Basis of diagnosis: The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 25 February 2025, and is supported by an ultrasound and MRI pelvis reports and gynaecology consultation by the gynaecologist, dated 6 March 2013.

I am satisfied this is the appropriate diagnosis.
There is no Statement of Principles (SOP) for this condition. In determining your claim for this condition, I have therefore considered the available evidence, applying the standard of proof:

Balance of Probabilities (reasonable satisfaction) - no Statement of Principles determined for this condition

which requires the evidence to connect the condition with service.

I am satisfied that the evidence establishes the following link to your service:

- *having endometriosis at the time of the clinical onset of dysmenorrhoea*
- *having adenomyosis at the time of the clinical onset of dysmenorrhoea*
- *having a submucosal or intramural uterine fibroid at the time of the clinical onset of dysmenorrhoea*

- *having a copper intrauterine device in place at the time of the clinical onset of dysmenorrhoea*
- *having pelvic inflammatory disease within the 2 years before the clinical onset of dysmenorrhoea*
- *having cervical stenosis following an excisional procedure of the cervix before the clinical onset of dysmenorrhoea*
- *smoking an average of at least 10 cigarettes per day for at least the 1 year before the clinical onset of dysmenorrhoea*
- *having a clinically significant psychiatric disorder, including posttraumatic stress disorder, depression or an anxiety disorder, for at least the 6 months before the clinical onset of dysmenorrhoea*

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 severe cramping lower abdominal pain beginning a day before each period and lasting four to five days, radiating to the lower back and thighs, with nausea, vomiting, diarrhoea, heavy bleeding with clots, deep dyspareunia and fatigue on 17 September 2012.

The diagnosis was made by a gynaecologist on 6 March 2013 on a history of new, severe, cyclical pelvic pain with menstruation from 14 September 2012 after previously painless periods, with associated heavy bleeding and dyspareunia, and pelvic pathology on transvaginal ultrasound and MRI: adenomyosis with a junctional zone of 14 mm, a 25 mm submucosal fibroid and a left ovarian endometrioma. Laparoscopy on 15 May 2013 confirmed stage III endometriosis histologically. Painful menstruation with identified pelvic pathology meets the accepted definition of secondary dysmenorrhoea.

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

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

I have therefore accepted that this condition is related to your service with effect from 14 September 2012.

Dysmenorrhoea (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 25 February 2025;
- A Diagnosis Form (D9287) by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 25 February 2025;
- A periodic health examination by the medical officer, Garrison health centre, dated 3 August 2011;
- A colposcopy and operation report by the gynaecologist, dated 9 November 2011;
- A psychiatric assessment by the consultant psychiatrist, dated 20 January 2012;
- An outpatient health record and pathology by the medical officer, Garrison health centre, dated 22 March 2012;
- A procedure record (intrauterine device insertion) by the medical officer, dated 18 June 2012;
- An outpatient health record by the medical officer, Garrison health centre, dated 17 September 2012;
- An ultrasound and MRI pelvis reports and gynaecology consultation by the gynaecologist, dated 6 March 2013;
- An operation and histopathology reports by the gynaecologist, dated 15 May 2013;
- A deployed health record by the medical officer, Middle East Area of Operations, dated 12 March 2016;
- MRI pelvis and operation reports by the gynaecologist, dated 20 July 2016.

Your service

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

20 February 2007 and 11 December 2020

Dysmenorrhoea (Worsening)

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

- *having progression of endometriosis or adenomyosis at the time of the clinical worsening of dysmenorrhoea*

- *having a clinically significant psychiatric disorder, including posttraumatic stress disorder, depression or an anxiety disorder, for at least the 6 months before the clinical worsening of dysmenorrhoea*
- *smoking an average of at least 10 cigarettes per day for at least the 1 year before the clinical worsening of dysmenorrhoea*
- *inability to obtain appropriate clinical management for dysmenorrhoea*

Diagnosis: Dysmenorrhoea (Worsening)

Basis of diagnosis: The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 25 February 2025, and is supported by an ultrasound and MRI pelvis reports and gynaecology consultation by the gynaecologist, dated 6 March 2013.

I am satisfied this is the appropriate diagnosis.
There is no Statement of Principles (SOP) for this condition. In determining your claim for this condition, I have therefore considered the available evidence, applying the standard of proof:

Reasonable Hypothesis - no Statement of Principles determined for this condition

which requires the evidence to connect the condition with service.

I am satisfied that the evidence establishes the following link to your service:

- *having progression of endometriosis or adenomyosis at the time of the clinical worsening of dysmenorrhoea*
- *having a clinically significant psychiatric disorder, including posttraumatic stress disorder, depression or an anxiety disorder, for at least the 6 months before the clinical worsening of dysmenorrhoea*
- *smoking an average of at least 10 cigarettes per day for at least the 1 year before the clinical worsening of dysmenorrhoea*
- *inability to obtain appropriate clinical management for dysmenorrhoea*

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 severe cramping lower abdominal pain beginning a day before each period and lasting four to five days, radiating to the lower back and thighs, with nausea, vomiting, diarrhoea, heavy bleeding with clots, deep dyspareunia and fatigue on 17 September 2012.

The diagnosis was made by a gynaecologist on 6 March 2013 on a history of new, severe, cyclical pelvic pain with menstruation from 14 September 2012 after previously painless periods, with associated heavy bleeding and dyspareunia, and pelvic pathology on transvaginal ultrasound and MRI: adenomyosis with a junctional zone of 14 mm, a 25 mm submucosal fibroid and a left ovarian endometrioma. Laparoscopy on 15 May 2013 confirmed stage III endometriosis

histologically. Painful menstruation with identified pelvic pathology meets the accepted definition of secondary dysmenorrhoea.

After the condition arose, it was worsened during your service. MRI and laparoscopy on 20 July 2016 showed progression from stage III to stage IV endometriosis, with a new 18 mm deep infiltrating rectovaginal nodule and enlargement of the endometrioma from 22 to 41 mm, and an increase in the adenomyotic junctional zone from 14 to 18 mm. Your posttraumatic stress disorder relapsed on warlike service in Iraq from November 2015, with nightmares and hypervigilance after repeated indirect fire alarms, recorded by the deployed psychologist, and it was active throughout the 6 months before the worsening, from 12 September 2015 to 12 March 2016. You smoked 10 to 15 cigarettes a day throughout the 1 year before the worsening, from 12 March 2015 to 12 March 2016, increasing on warlike service in Iraq, as recorded at your pre-deployment and deployed health reviews. The levonorgestrel intrauterine system that controlled your endometriosis and dysmenorrhoea was expelled in January 2016 on warlike service in Iraq.

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

Having considered your service records and the available medical evidence, I am satisfied the evidence establishes 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 12 March 2016.

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