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.

Groin - Tinea Cruris

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 4 August 2025;
- A Diagnosis Form (D9287) by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 4 August 2025;
- A pre-deployment medical examination by the medical officer, Garrison health centre, dated 15 January 2008;
- A patrol base treatment record and microscopy by the medic and role 2 facility, Afghanistan, dated 23 April 2008;
- A trauma admission and operation report by Role 3 hospital, Afghanistan, dated 2 July 2008;
- A venous duplex report by the vascular surgeon, dated 20 July 2008;
- A specialist letter by the infectious diseases physician, dated 14 October 2008;
- An arterial and venous duplex reports by the vascular surgeon, dated 18 May 2011;
- Mycology report on toenail clippings by the pathologist, dated 18 May 2011;
- A haematology discharge summary by the haematologist, dated 14 March 2017;
- A renal medicine consultation by the renal physician, dated 6 November 2018;
- A role 1 facility treatment record by the medical officer, Middle East, dated 18 June 2019;
- A dermatology consultation and mycology culture by the dermatologist, dated 2 July 2019.

Your service

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

17 January 1998 and 18 December 2020

Groin - Tinea Cruris

You have stated that your condition was caused by:

- *having unprotected physical contact with: (a) a person infected with tinea; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having unprotected physical contact with: (b) an animal infected with tinea; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having unprotected physical contact with: (c) objects or surfaces contaminated with dermatophytes; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having unprotected physical contact with: (d) using communal showering or bathing facilities, swimming pool facilities or locker rooms; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having unprotected physical contact with: (e) soil contaminated with dermatophytes; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having unprotected physical contact with: (f) a site of tinea on the same body; between 2 days and 3 weeks before the clinical onset or clinical worsening*

Diagnosis: Tinea Cruris

Basis of diagnosis: The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 4 August 2025, and is supported by a patrol base treatment record and microscopy by the medic and role 2 facility, Afghanistan, dated 23 April 2008.

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

Statement of Principles concerning Tinea (Reasonable Hypothesis) (No. 55 of 2024)

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

I am satisfied that you have met the following factor:

- *having unprotected physical contact with: (a) a person infected with tinea; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having unprotected physical contact with: (b) an animal infected with tinea; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having unprotected physical contact with: (c) objects or surfaces contaminated with dermatophytes; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having unprotected physical contact with: (d) using communal showering or bathing facilities, swimming pool facilities or locker rooms; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having unprotected physical contact with: (e) soil contaminated with dermatophytes; between 2 days and 3 weeks before the clinical onset or clinical worsening*

- *having unprotected physical contact with: (f) a site of tinea on the same body; between 2 days and 3 weeks before the clinical onset or clinical worsening*

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 an intensely itchy, burning red rash in both groins and on the inner thighs with a scaly advancing edge, worse with heat, sweating and walking, together with itchy, macerated skin between the toes on 23 April 2008.

The diagnosis was made on 23 April 2008 on the typical clinical appearance of well-demarcated scaly plaques with an active edge on both inner thighs, sparing the scrotum, confirmed by skin scrapings showing fungal hyphae on microscopy. Coexisting interdigital tinea pedis was present. This meets the Statement of Principles definition of tinea, a superficial fungal infection of the skin, hair or nails by dermatophytes.

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

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 21 April 2008.

Groin - Tinea Cruris (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 4 August 2025;
- A Diagnosis Form (D9287) by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 4 August 2025;
- A pre-deployment medical examination by the medical officer, Garrison health centre, dated 15 January 2008;
- A patrol base treatment record and microscopy by the medic and role 2 facility, Afghanistan, dated 23 April 2008;
- A trauma admission and operation report by Role 3 hospital, Afghanistan, dated 2 July 2008;
- A venous duplex report by the vascular surgeon, dated 20 July 2008;
- A specialist letter by the infectious diseases physician, dated 14 October 2008;
- An arterial and venous duplex reports by the vascular surgeon, dated 18 May 2011;
- Mycology report on toenail clippings by the pathologist, dated 18 May 2011;
- A haematology discharge summary by the haematologist, dated 14 March 2017;
- A renal medicine consultation by the renal physician, dated 6 November 2018;
- A role 1 facility treatment record by the medical officer, Middle East, dated 18 June 2019;
- A dermatology consultation and mycology culture by the dermatologist, dated 2 July 2019.

Your service

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

17 January 1998 and 18 December 2020

Groin - Tinea Cruris (Worsening)

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

- *having unprotected physical contact with: (a) a person infected with tinea; between 2 days and 3 weeks before the clinical onset or clinical worsening*

- *having unprotected physical contact with: (b) an animal infected with tinea; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having unprotected physical contact with: (c) objects or surfaces contaminated with dermatophytes; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having unprotected physical contact with: (d) using communal showering or bathing facilities, swimming pool facilities or locker rooms; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having unprotected physical contact with: (e) soil contaminated with dermatophytes; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having unprotected physical contact with: (f) a site of tinea on the same body; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having skin maceration at the affected site between 2 days and 3 weeks before the clinical worsening*
- *having diabetes mellitus at the time of clinical worsening*
- *having a substantially lowered immune function at the time of clinical worsening due to: (a) human immunodeficiency virus (HIV) infection*
- *having a substantially lowered immune function at the time of clinical worsening due to: (b) glucocorticoids other than inhaled glucocorticoids*
- *having a substantially lowered immune function at the time of clinical worsening due to: (c) solid organ transplant (excluding corneal transplant), stem cell or bone marrow transplantation*
- *having topical glucocorticoid applied at the site of the tinea at the time of clinical worsening*
- *having chronic renal failure at the time of clinical worsening of tinea unguium, as indicated by any of the following; (a) a glomerular filtration rate of less than 15 mL/min/1.73 m2 for a period of at least 3 months; or (b) undergoing chronic dialysis for renal failure*
- *taking risankizumab and guselkumab at the time of clinical worsening*
- *having peripheral artery disease of the lower limb at the time of clinical worsening of tinea affecting the foot*
- *having chronic venous insufficiency of the lower limb at the time of clinical worsening of tinea unguium of the toes*
- *having varicose veins of the lower limb at the time of clinical worsening of tinea unguium of the toes*
- *having shaved the skin at the affected site within 3 weeks of clinical worsening*
- *inability to obtain appropriate clinical management for tinea before clinical worsening*

Diagnosis: Tinea Cruris (Worsening)

Basis of diagnosis: The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 4 August 2025, and is supported by a patrol base treatment record and microscopy by the medic and role 2 facility, Afghanistan, dated 23 April 2008.

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

Statement of Principles concerning Tinea (Reasonable Hypothesis) (No. 55 of 2024)

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

I am satisfied that you have met the following factor:

- *having unprotected physical contact with: (a) a person infected with tinea; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having unprotected physical contact with: (b) an animal infected with tinea; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having unprotected physical contact with: (c) objects or surfaces contaminated with dermatophytes; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having unprotected physical contact with: (d) using communal showering or bathing facilities, swimming pool facilities or locker rooms; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having unprotected physical contact with: (e) soil contaminated with dermatophytes; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having unprotected physical contact with: (f) a site of tinea on the same body; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having skin maceration at the affected site between 2 days and 3 weeks before the clinical worsening*
- *having diabetes mellitus at the time of clinical worsening*
- *having a substantially lowered immune function at the time of clinical worsening due to: (a) human immunodeficiency virus (HIV) infection*
- *having a substantially lowered immune function at the time of clinical worsening due to: (b) glucocorticoids other than inhaled glucocorticoids*
- *having a substantially lowered immune function at the time of clinical worsening due to: (c) solid organ transplant (excluding corneal transplant), stem cell or bone marrow transplantation*
- *having topical glucocorticoid applied at the site of the tinea at the time of clinical worsening*
- *having chronic renal failure at the time of clinical worsening of tinea unguium, as indicated by any of the following; (a) a glomerular filtration rate of less than 15 mL/min/1.73 m2 for a period of at least 3 months; or (b) undergoing chronic dialysis for renal failure*
- *taking risankizumab and guselkumab at the time of clinical worsening*
- *having peripheral artery disease of the lower limb at the time of clinical worsening of tinea affecting the foot*
- *having chronic venous insufficiency of the lower limb at the time of clinical worsening of tinea unguium of the toes*

- *having varicose veins of the lower limb at the time of clinical worsening of tinea unguium of the toes*
- *having shaved the skin at the affected site within 3 weeks of clinical worsening*
- *inability to obtain appropriate clinical management for tinea before clinical worsening*

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 an intensely itchy, burning red rash in both groins and on the inner thighs with a scaly advancing edge, worse with heat, sweating and walking, together with itchy, macerated skin between the toes on 23 April 2008.

The diagnosis was made on 23 April 2008 on the typical clinical appearance of well-demarcated scaly plaques with an active edge on both inner thighs, sparing the scrotum, confirmed by skin scrapings showing fungal hyphae on microscopy. Coexisting interdigital tinea pedis was present. This meets the Statement of Principles definition of tinea, a superficial fungal infection of the skin, hair or nails by dermatophytes.

After the condition arose, it was worsened during your service. On 10 April 2008, during warlike service in Afghanistan, you grappled in unarmed combatives training at the patrol base with a section member diagnosed with tinea corporis on 6 April 2008. During warlike service in Afghanistan, from 05 April to 19 April 2008, you fed and handled a stray dog at the patrol base whose skin lesions grew Microsporum canis on culture. During warlike service in Afghanistan, with no laundry at the patrol base, you shared towels, socks and a sleeping bag liner with section members, including the soldier with tinea corporis, up to 19 April 2008, within 2 days to 3 weeks before onset. During warlike service in Afghanistan you used the patrol base's communal shower tent daily from 1 April 2008, throughout the window from 31 March to 19 April 2008. During warlike service in Afghanistan, from 08 April to 18 April 2008, you filled sandbags by hand and dug and slept in fighting pits, with soil worked into the groin of a uniform you could not change for up to nine days. Tinea pedis of both feet began on 28 March 2008 during warlike service in Afghanistan, after weeks in wet, occlusive boots, and persisted through the window from 31 March to 19 April 2008. During warlike service in the Middle East you worked in up to 46 degrees in occlusive uniform, and macerated skin in both groin folds was recorded on 10 June 2019, 8 days before the worsening on 18 June 2019. Type 2 diabetes was diagnosed on 9 March 2015. HIV-1 infection was acquired from fresh whole blood transfused from a walking blood bank after the improvised explosive device blast on warlike service in Afghanistan on 2 July 2008, and confirmed on 14 October 2008. Prednisolone 25 mg daily was prescribed by the deployed medical officer on 20 May 2019, during warlike service in the Middle East, for psoriatic arthritis, and was being taken at the worsening on 18 June 2019. The autologous stem cell transplant of 14 March 2017 treated HIV-associated lymphoma, the HIV having been acquired by transfusion on warlike service in Afghanistan in 2008. Betamethasone dipropionate cream was prescribed to the groin on 25 May 2019 by the role 1 facility during warlike service in the Middle East, when the tinea was misdiagnosed as flexural psoriasis, and was being applied at the worsening on 18 June 2019. Chronic renal failure followed nephrotoxicity from tenofovir for

transfusion-acquired HIV and cisplatin for HIV-associated lymphoma, both linked to warlike service in Afghanistan. Guselkumab and risankizumab, prescribed for plaque psoriasis, were both being taken during warlike service in the Middle East, with doses on 22 May and 5 June 2019, at the worsening on 18 June 2019. Peripheral artery disease of the left leg resulted from the popliteal artery injury sustained in the blast on warlike service in Afghanistan on 2 July 2008 and was present at the worsening of left foot tinea on 18 June 2019. Chronic venous insufficiency of the left leg followed the deep vein thrombosis of 20 July 2008, a complication of the blast injuries sustained on warlike service in Afghanistan, and was present at the worsening of tinea unguium of the toes on 18 June 2019. Varicose veins of the left leg followed the post-blast deep vein thrombosis of 2008 linked to warlike service in Afghanistan and were present at the worsening of tinea unguium of the toes on 18 June 2019. On 6 June 2019, during warlike service in the Middle East, the skin of the right groin was shaved for insertion of a temporary femoral dialysis catheter after your tunnelled line thrombosed. During warlike service in the Middle East, from 25 May to 18 June 2019, you could not obtain skin microscopy, dermatology review or oral antifungal treatment, and the misdiagnosed rash was treated with a potent topical steroid.

This has then led to further investigations and the diagnosis of your condition of *Tinea Cruris (Worsening)*. I have accepted your condition of *Tinea Cruris (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 18 June 2019.

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