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.

Latent Tuberculosis

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 29 October 2025;
- A Diagnosis Form (D9287) by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 29 October 2025;
- A deployed health record by the medical officer, Rwanda, dated 20 May 1995;
- A gastroenterology consultation (elastography and liver biopsy report) by the gastroenterologist, dated 14 June 2016;
- A prostate biopsy microbiology report and specialist letters by the urologist and infectious diseases physician, dated 15 October 2016;
- A pre-deployment medical examination (interferon-gamma release assay and chest X-ray reports) by the medical officer, dated 10 January 2017;
- A contact tracing record and veterinary report by the preventive medicine officer and veterinary officer, Afghanistan, dated 28 March 2017;
- A deployed health record (interferon-gamma release assay and chest X-ray reports) by the medical officer, Role 3 hospital, Afghanistan, dated 15 June 2017;
- A specialist consultation by the infectious diseases physician, dated 22 August 2017;
- A nephrology consultation and renal biopsy report by the nephrologist, dated 12 March 2018;
- A deployed health record (chest imaging and sputum microbiology reports) by the medical officer, Role 3 hospital, Iraq, dated 2 November 2018.

Your service

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

5 February 1990 and 18 September 2020

Latent Tuberculosis

You have stated that your condition was caused by:

- *being exposed to bacteria belonging to the Mycobacterium tuberculosis complex at least 14 days before the clinical onset of tuberculosis*
- *living or working in an area which has an incidence of tuberculosis of at least 50 cases per 100,000 of population per year, before the clinical onset of tuberculosis, provided that the individual had no negative test results for tuberculosis in any intervening period between living or working in the affected area and the onset of tuberculosis*
- *consuming unpasteurised milk, unpasteurised dairy products or uncooked meat from an animal infected with Mycobacterium bovis or Mycobacterium caprae at least 14 days before the clinical onset of tuberculosis*
- *for active tuberculosis disease due to infection with Mycobacterium bovis BCG only: (a) having intravesical BCG therapy for malignant neoplasm of the bladder; or (b) being vaccinated with BCG vaccine; before the clinical onset of tuberculosis*
- *inability to access appropriate tuberculosis vaccination in accordance with contemporary medical standards before the clinical onset of tuberculosis*

Diagnosis: Latent Tuberculosis

Basis of diagnosis: The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 29 October 2025, and is supported by a deployed health record (interferon-gamma release assay and chest X-ray reports) by the medical officer, Role 3 hospital, Afghanistan, dated 15 June 2017.

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

Statement of Principles concerning Tuberculosis (Reasonable Hypothesis) (No. 47 of 2024)

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

I am satisfied that you have met the following factor:

- *being exposed to bacteria belonging to the Mycobacterium tuberculosis complex at least 14 days before the clinical onset of tuberculosis*
- *living or working in an area which has an incidence of tuberculosis of at least 50 cases per 100,000 of population per year, before the clinical onset of tuberculosis, provided that the individual had no negative test results for tuberculosis in any intervening period between living or working in the affected area and the onset of tuberculosis*
- *consuming unpasteurised milk, unpasteurised dairy products or uncooked meat from an animal infected with Mycobacterium bovis or Mycobacterium caprae at least 14 days*

before the clinical onset of tuberculosis

- *for active tuberculosis disease due to infection with Mycobacterium bovis BCG only: (a) having intravesical BCG therapy for malignant neoplasm of the bladder; or (b) being vaccinated with BCG vaccine; before the clinical onset of tuberculosis*
- *inability to access appropriate tuberculosis vaccination in accordance with contemporary medical standards before the clinical onset of tuberculosis*

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 a positive interferon-gamma release assay on contact tracing, with a normal chest X-ray and no symptoms of active tuberculosis on 15 June 2017.

Latent tuberculosis infection was diagnosed on 15 June 2017 on a positive interferon-gamma release assay (QuantiFERON 2.8 IU/mL) after documented close contact with infectious pulmonary tuberculosis, with a normal chest X-ray, no symptoms and negative sputum excluding active disease. The negative assay on 10 January 2017 documents conversion during deployment. This meets the Statement of Principles definition of tuberculosis, which includes latent tuberculosis.

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

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 15 June 2017.

Latent Tuberculosis (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 29 October 2025;
- A Diagnosis Form (D9287) by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 29 October 2025;
- A deployed health record by the medical officer, Rwanda, dated 20 May 1995;
- A gastroenterology consultation (elastography and liver biopsy report) by the gastroenterologist, dated 14 June 2016;
- A prostate biopsy microbiology report and specialist letters by the urologist and infectious diseases physician, dated 15 October 2016;
- A pre-deployment medical examination (interferon-gamma release assay and chest X-ray reports) by the medical officer, dated 10 January 2017;
- A contact tracing record and veterinary report by the preventive medicine officer and veterinary officer, Afghanistan, dated 28 March 2017;
- A deployed health record (interferon-gamma release assay and chest X-ray reports) by the medical officer, Role 3 hospital, Afghanistan, dated 15 June 2017;
- A specialist consultation by the infectious diseases physician, dated 22 August 2017;
- A nephrology consultation and renal biopsy report by the nephrologist, dated 12 March 2018;
- A deployed health record (chest imaging and sputum microbiology reports) by the medical officer, Role 3 hospital, Iraq, dated 2 November 2018.

Your service

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

5 February 1990 and 18 September 2020

Latent Tuberculosis (Worsening)

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

- *having a substantially compromised immune system due to: (a) chronic renal failure; (b) haematological malignancy; (c) infection with human immunodeficiency virus; (d) severe*

malnutrition; (e) solid organ, stem cell or bone marrow transplantation; or (f) taking an immunosuppressive drug; at the time of the clinical worsening of tuberculosis

- *inhaling at least 1,000 micrograms of beclomethasone, or equivalent inhaled glucocorticoid daily for the 3 months, before the clinical worsening of tuberculosis, and where the treatment has ceased, the last inhaled glucocorticoid dose was taken within the 30 days before the clinical worsening of tuberculosis*
- *having cirrhosis of the liver at the time of the clinical worsening of tuberculosis*
- *having diabetes mellitus at the time of the clinical worsening of tuberculosis*
- *inhaling respirable crystalline silica dust in an enclosed space: (a) for a cumulative period of at least 1,500 hours before the clinical worsening of tuberculosis; and (b) at the time material containing crystalline silica was being produced, excavated, drilled, cut or ground, or used in construction, manufacturing, cleaning or blasting; before the clinical worsening of tuberculosis*
- *inhaling respirable crystalline silica dust in an open environment: (a) for a cumulative period of at least 3,000 hours before the clinical worsening of tuberculosis; and (b) at the time material containing crystalline silica was being produced, excavated, drilled, cut or ground, or used in construction, manufacturing, cleaning or blasting; before the clinical worsening of tuberculosis*
- *for pulmonary tuberculosis only, smoking at least 1 cigarette per day, or the equivalent thereof in other tobacco products, for at least the 12 months before the clinical worsening of tuberculosis*
- *for pulmonary tuberculosis only, being in an atmosphere with a visible tobacco smoke haze in an enclosed space for at least 5,000 hours before the clinical worsening of tuberculosis*
- *having a gastrectomy or jejunoileal bypass before the clinical worsening of tuberculosis*
- *consuming at least 40 grams of alcohol per day for at least the 12 months before the clinical worsening of tuberculosis*
- *having alcohol use disorder at the time of the clinical worsening of tuberculosis*
- *having systemic lupus erythematosus before the clinical worsening of tuberculosis*
- *having hepatitis C infection at the time of the clinical worsening of tuberculosis*
- *inability to obtain appropriate clinical management for tuberculosis before the clinical worsening of tuberculosis*

Diagnosis: Latent Tuberculosis (Worsening)

Basis of diagnosis: The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 29 October 2025, and is supported by a deployed health record (interferon-gamma release assay and chest X-ray reports) by the medical officer, Role 3 hospital, Afghanistan, dated 15 June 2017.

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

Statement of Principles concerning Tuberculosis (Reasonable Hypothesis) (No. 47 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 a substantially compromised immune system due to: (a) chronic renal failure; (b) haematological malignancy; (c) infection with human immunodeficiency virus; (d) severe malnutrition; (e) solid organ, stem cell or bone marrow transplantation; or (f) taking an immunosuppressive drug; at the time of the clinical worsening of tuberculosis*
- *inhaling at least 1,000 micrograms of beclomethasone, or equivalent inhaled glucocorticoid daily for the 3 months, before the clinical worsening of tuberculosis, and where the treatment has ceased, the last inhaled glucocorticoid dose was taken within the 30 days before the clinical worsening of tuberculosis*
- *having cirrhosis of the liver at the time of the clinical worsening of tuberculosis*
- *having diabetes mellitus at the time of the clinical worsening of tuberculosis*
- *inhaling respirable crystalline silica dust in an enclosed space: (a) for a cumulative period of at least 1,500 hours before the clinical worsening of tuberculosis; and (b) at the time material containing crystalline silica was being produced, excavated, drilled, cut or ground, or used in construction, manufacturing, cleaning or blasting; before the clinical worsening of tuberculosis*
- *inhaling respirable crystalline silica dust in an open environment: (a) for a cumulative period of at least 3,000 hours before the clinical worsening of tuberculosis; and (b) at the time material containing crystalline silica was being produced, excavated, drilled, cut or ground, or used in construction, manufacturing, cleaning or blasting; before the clinical worsening of tuberculosis*
- *for pulmonary tuberculosis only, smoking at least 1 cigarette per day, or the equivalent thereof in other tobacco products, for at least the 12 months before the clinical worsening of tuberculosis*
- *for pulmonary tuberculosis only, being in an atmosphere with a visible tobacco smoke haze in an enclosed space for at least 5,000 hours before the clinical worsening of tuberculosis*
- *having a gastrectomy or jejunoileal bypass before the clinical worsening of tuberculosis*
- *consuming at least 40 grams of alcohol per day for at least the 12 months before the clinical worsening of tuberculosis*
- *having alcohol use disorder at the time of the clinical worsening of tuberculosis*
- *having systemic lupus erythematosus before the clinical worsening of tuberculosis*
- *having hepatitis C infection at the time of the clinical worsening of tuberculosis*
- *inability to obtain appropriate clinical management for tuberculosis before the clinical worsening of tuberculosis*

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 a positive interferon-gamma release assay on contact tracing, with a normal chest X-ray and no symptoms of active tuberculosis on 15 June 2017.

Latent tuberculosis infection was diagnosed on 15 June 2017 on a positive interferon-gamma release assay (QuantiFERON 2.8 IU/mL) after documented close contact with infectious pulmonary tuberculosis, with a normal chest X-ray, no symptoms and negative sputum excluding active disease. The negative assay on 10 January 2017 documents conversion during deployment. This meets the Statement of Principles definition of tuberculosis, which includes latent tuberculosis.

After the condition arose, it was worsened during your service. Mycophenolate and prednisolone for lupus nephritis were being taken at the worsening on warlike service in Iraq on 2 November 2018. Fluticasone equivalent to about 2,000 micrograms of beclomethasone daily, for asthma following burn pit smoke exposure on warlike service in Afghanistan, was inhaled throughout the 3 months before the worsening, from 2 August 2018 to 2 November 2018, on warlike service in Iraq. Cirrhosis from hepatitis C acquired on service in Rwanda and alcohol use that escalated after that deployment was present at the worsening in Iraq. Type 2 diabetes mellitus, poorly controlled on warlike service in Iraq with an HbA1c of 8.9 per cent, was present at the worsening. You drilled and cut rock and concrete in bunkers and enclosed structures for about 1,650 hours on warlike service in East Timor in 1999 and 2000 and in Afghanistan in 2017, within your total of about 3,400 enclosed hours, before the worsening. You worked about 3,200 hours at open quarries and road and base construction sites on operational service in Somalia, Rwanda, East Timor, Afghanistan and Iraq while rock was drilled, crushed and cut, before the worsening. You smoked 20 cigarettes a day throughout the 12 months before the progression to pulmonary tuberculosis, including on warlike service in Iraq from June 2018. You spent more than 5,000 hours in messes, accommodation, vehicles and site offices with a visible tobacco smoke haze between 1990 and 2005, including crowded shelters on warlike service in Somalia and East Timor, before the worsening to pulmonary tuberculosis. A partial gastrectomy was performed in 2011 for a perforated gastric ulcer caused by anti-inflammatory medication for injuries that included a knee injury on warlike service in East Timor, before the worsening. You drank about 60 grams of alcohol a day throughout the 12 months before the worsening, an intake that began after your service in Rwanda and continued on warlike service in Iraq. Alcohol use disorder, related by the treating psychiatrist to traumatic experiences on service in Rwanda and Somalia, was present at the worsening. Systemic lupus erythematosus was diagnosed in 2014, with lupus nephritis in 2018, and was present before the worsening on warlike service in Iraq. Chronic hepatitis C from blood exposure while treating casualties on non-warlike service in Rwanda in 1995 was present at the worsening. Preventive treatment was deferred on warlike service in Afghanistan in June 2017, was not started afterwards because hepatology monitoring was unavailable at your posting, and was not available on warlike service in Iraq, where the infection progressed to active disease.

This has then led to further investigations and the diagnosis of your condition of *Latent Tuberculosis (Worsening)*. I have accepted your condition of *Latent Tuberculosis (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 2 November 2018.

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