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.

Left Ankle - Achilles Tendinopathy

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 18 June 2025;
- A Diagnosis Form (D9287) by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 18 June 2025;
- An inpatient record and stool culture by Role 2 facility, East Timor, dated 14 November 2000;
- An emergency and intensive care admission by the regional hospital, dated 12 February 2008;
- An operation report by the renal transplant surgeon, dated 18 November 2010;
- An oncology consultation by the medical oncologist, dated 1 February 2016;
- A specialist letter by the rheumatologist, dated 9 March 2016;
- A pre-deployment medical examination by the medical officer, dated 15 January 2017;
- An outpatient health record by the medical officer, Role 1 facility, Iraq, dated 12 June 2017;
- An ultrasound left Achilles tendon by Role 2 facility, Iraq, dated 22 June 2017;
- An MRI left ankle and consultation by the sports physician, dated 25 September 2017;
- A procedure note by the sports physician, dated 3 January 2019;
- An outpatient health record by the medical officer, Afghanistan, dated 2 September 2019;
- An ultrasound left Achilles tendon by the radiologist, dated 4 September 2019;
- An operation report by the orthopaedic surgeon, dated 25 September 2019.

Your service

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

20 January 1997 and 15 March 2022

Left Ankle - Achilles Tendinopathy

You have stated that your condition was caused by:

- *running or jogging an average of at least 30 kilometres per week for the 4 weeks before clinical onset or clinical worsening*
- *undertaking weight bearing exercise involving repeated activity of the ankle joint on the affected side for: (a) a minimum intensity of 5 METS; and (b) for at least 4 hours per week; and (c) for at least the 4 weeks before clinical onset or clinical worsening*
- *increasing the frequency, duration or intensity of activity involving the ankle joint on the affected side: (a) by at least 100 percent; and (b) to a minimum intensity of 5 METs; and (c) for at least 2 hours per day; within the 1 week before the clinical onset or clinical worsening*
- *having one or more of the following conditions involving the affected lower limb at the time of clinical onset or clinical worsening: pes planus*
- *having one or more of the following conditions involving the affected lower limb at the time of clinical onset or clinical worsening: pes cavus*
- *having one or more of the following conditions involving the affected lower limb at the time of clinical onset or clinical worsening: decreased ankle or forefoot flexibility*
- *having one or more of the following conditions involving the affected lower limb at the time of clinical onset or clinical worsening: forefoot varus*
- *having one or more of the following conditions involving the affected lower limb at the time of clinical onset or clinical worsening: lateral ankle joint instability*
- *having one of the following systemic arthritic diseases at the time of clinical onset or clinical worsening: ankylosing spondylitis*
- *having one of the following systemic arthritic diseases at the time of clinical onset or clinical worsening: Behcet syndrome*
- *having one of the following systemic arthritic diseases at the time of clinical onset or clinical worsening: enteropathic spondyloarthropathy (arthritis associated with inflammatory bowel disease)*
- *having one of the following systemic arthritic diseases at the time of clinical onset or clinical worsening: gout*
- *having one of the following systemic arthritic diseases at the time of clinical onset or clinical worsening: pseudogout (calcium pyrophosphate dihydrate) or crystal-induced arthropathy from the deposition of calcium hydroxyapatite or calcium oxalate*
- *having one of the following systemic arthritic diseases at the time of clinical onset or clinical worsening: psoriatic arthropathy*
- *having one of the following systemic arthritic diseases at the time of clinical onset or clinical worsening: reactive arthritis*

- *having one of the following systemic arthritic diseases at the time of clinical onset or clinical worsening: rheumatoid arthritis*
- *having one of the following systemic arthritic diseases at the time of clinical onset or clinical worsening: undifferentiated spondyloarthropathy*
- *having chronic renal failure within the 10 years before clinical onset or clinical worsening as indicated by: (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*
- *being treated with a fluoroquinolone antibiotic within the 30 days before clinical onset or clinical worsening*
- *being treated with a glucocorticoid drug as specified before clinical onset or clinical worsening*
- *having a glucocorticoid injection into the Achilles tendon, in the region of the Achilles tendon or in the retrocalcaneal bursa, before the rupture of the Achilles tendon*
- *being treated with an aromatase inhibitor for at least 4 weeks within the 1 year before clinical onset or clinical worsening*
- *having a Body Mass Index (BMI) of 30 or greater at the time of clinical onset or clinical worsening*
- *having diabetes mellitus at the time of clinical onset or clinical worsening*

Diagnosis: Achilles Tendinopathy

Basis of diagnosis: The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 18 June 2025, and is supported by an ultrasound left Achilles tendon by Role 2 facility, Iraq, dated 22 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 Achilles Tendinopathy (Reasonable Hypothesis) (No. 86 of 2024)

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

I am satisfied that you have met the following factor:

- *running or jogging an average of at least 30 kilometres per week for the 4 weeks before clinical onset or clinical worsening*
- *undertaking weight bearing exercise involving repeated activity of the ankle joint on the affected side for: (a) a minimum intensity of 5 METS; and (b) for at least 4 hours per week; and (c) for at least the 4 weeks before clinical onset or clinical worsening*
- *increasing the frequency, duration or intensity of activity involving the ankle joint on the affected side: (a) by at least 100 percent; and (b) to a minimum intensity of 5 METs; and (c) for at least 2 hours per day; within the 1 week before the clinical onset or clinical worsening*

- *having one or more of the following conditions involving the affected lower limb at the time of clinical onset or clinical worsening: pes planus*
- *having one or more of the following conditions involving the affected lower limb at the time of clinical onset or clinical worsening: pes cavus*
- *having one or more of the following conditions involving the affected lower limb at the time of clinical onset or clinical worsening: decreased ankle or forefoot flexibility*
- *having one or more of the following conditions involving the affected lower limb at the time of clinical onset or clinical worsening: forefoot varus*
- *having one or more of the following conditions involving the affected lower limb at the time of clinical onset or clinical worsening: lateral ankle joint instability*
- *having one of the following systemic arthritic diseases at the time of clinical onset or clinical worsening: ankylosing spondylitis*
- *having one of the following systemic arthritic diseases at the time of clinical onset or clinical worsening: Behcet syndrome*
- *having one of the following systemic arthritic diseases at the time of clinical onset or clinical worsening: enteropathic spondyloarthropathy (arthritis associated with inflammatory bowel disease)*
- *having one of the following systemic arthritic diseases at the time of clinical onset or clinical worsening: gout*
- *having one of the following systemic arthritic diseases at the time of clinical onset or clinical worsening: pseudogout (calcium pyrophosphate dihydrate) or crystal-induced arthropathy from the deposition of calcium hydroxyapatite or calcium oxalate*
- *having one of the following systemic arthritic diseases at the time of clinical onset or clinical worsening: psoriatic arthropathy*
- *having one of the following systemic arthritic diseases at the time of clinical onset or clinical worsening: reactive arthritis*
- *having one of the following systemic arthritic diseases at the time of clinical onset or clinical worsening: rheumatoid arthritis*
- *having one of the following systemic arthritic diseases at the time of clinical onset or clinical worsening: undifferentiated spondyloarthropathy*
- *having chronic renal failure within the 10 years before clinical onset or clinical worsening as indicated by: (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*
- *being treated with a fluoroquinolone antibiotic within the 30 days before clinical onset or clinical worsening*
- *being treated with a glucocorticoid drug as specified before clinical onset or clinical worsening*
- *having a glucocorticoid injection into the Achilles tendon, in the region of the Achilles tendon or in the retrocalcaneal bursa, before the rupture of the Achilles tendon*

- *being treated with an aromatase inhibitor for at least 4 weeks within the 1 year before clinical onset or clinical worsening*
- *having a Body Mass Index (BMI) of 30 or greater at the time of clinical onset or clinical worsening*
- *having diabetes mellitus at the time of 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 pain and morning stiffness in the left posterior heel, worse at the start of running and after rest, with a tender swelling of the tendon on 12 June 2017.

The diagnosis was confirmed by ultrasound on 22 June 2017, which showed fusiform thickening of the mid-portion of the left Achilles tendon to 9 mm with hypoechoic change and neovascularity, and by MRI on 25 September 2017, which showed intrasubstance degeneration and paratenon oedema. This meets the Statement of Principles definition of Achilles tendinopathy, which includes mid-portion tendinopathy and degenerative tears.

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

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 June 2017.

Left Ankle - Achilles Tendinopathy (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 18 June 2025;
- A Diagnosis Form (D9287) by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 18 June 2025;
- An inpatient record and stool culture by Role 2 facility, East Timor, dated 14 November 2000;
- An emergency and intensive care admission by the regional hospital, dated 12 February 2008;
- An operation report by the renal transplant surgeon, dated 18 November 2010;
- An oncology consultation by the medical oncologist, dated 1 February 2016;
- A specialist letter by the rheumatologist, dated 9 March 2016;
- A pre-deployment medical examination by the medical officer, dated 15 January 2017;
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- An outpatient health record by the medical officer, Afghanistan, dated 2 September 2019;
- An ultrasound left Achilles tendon by the radiologist, dated 4 September 2019;
- An operation report by the orthopaedic surgeon, dated 25 September 2019.

Your service

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

20 January 1997 and 15 March 2022

Left Ankle - Achilles Tendinopathy (Worsening)

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

- *running or jogging an average of at least 30 kilometres per week for the 4 weeks before clinical onset or clinical worsening*

- *undertaking weight bearing exercise involving repeated activity of the ankle joint on the affected side for: (a) a minimum intensity of 5 METS; and (b) for at least 4 hours per week; and (c) for at least the 4 weeks before clinical onset or clinical worsening*
- *increasing the frequency, duration or intensity of activity involving the ankle joint on the affected side: (a) by at least 100 percent; and (b) to a minimum intensity of 5 METs; and (c) for at least 2 hours per day; within the 1 week before the clinical onset or clinical worsening*
- *having one or more of the following conditions involving the affected lower limb at the time of clinical onset or clinical worsening: pes planus*
- *having one or more of the following conditions involving the affected lower limb at the time of clinical onset or clinical worsening: pes cavus*
- *having one or more of the following conditions involving the affected lower limb at the time of clinical onset or clinical worsening: decreased ankle or forefoot flexibility*
- *having one or more of the following conditions involving the affected lower limb at the time of clinical onset or clinical worsening: forefoot varus*
- *having one or more of the following conditions involving the affected lower limb at the time of clinical onset or clinical worsening: lateral ankle joint instability*
- *having one of the following systemic arthritic diseases at the time of clinical onset or clinical worsening: ankylosing spondylitis*
- *having one of the following systemic arthritic diseases at the time of clinical onset or clinical worsening: Behcet syndrome*
- *having one of the following systemic arthritic diseases at the time of clinical onset or clinical worsening: enteropathic spondyloarthropathy (arthritis associated with inflammatory bowel disease)*
- *having one of the following systemic arthritic diseases at the time of clinical onset or clinical worsening: gout*
- *having one of the following systemic arthritic diseases at the time of clinical onset or clinical worsening: pseudogout (calcium pyrophosphate dihydrate) or crystal-induced arthropathy from the deposition of calcium hydroxyapatite or calcium oxalate*
- *having one of the following systemic arthritic diseases at the time of clinical onset or clinical worsening: psoriatic arthropathy*
- *having one of the following systemic arthritic diseases at the time of clinical onset or clinical worsening: reactive arthritis*
- *having one of the following systemic arthritic diseases at the time of clinical onset or clinical worsening: rheumatoid arthritis*
- *having one of the following systemic arthritic diseases at the time of clinical onset or clinical worsening: undifferentiated spondyloarthropathy*
- *having chronic renal failure within the 10 years before clinical onset or clinical worsening as indicated by: (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*

- *being treated with a fluoroquinolone antibiotic within the 30 days before clinical onset or clinical worsening*
- *being treated with a glucocorticoid drug as specified before clinical onset or clinical worsening*
- *being treated with an aromatase inhibitor for at least 4 weeks within the 1 year before clinical onset or clinical worsening*
- *having a Body Mass Index (BMI) of 30 or greater at the time of clinical onset or clinical worsening*
- *having diabetes mellitus at the time of clinical onset or clinical worsening*
- *inability to obtain appropriate clinical management for Achilles tendinopathy before clinical worsening*

Diagnosis: Achilles Tendinopathy (Worsening)

Basis of diagnosis: The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 18 June 2025, and is supported by an ultrasound left Achilles tendon by Role 2 facility, Iraq, dated 22 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 Achilles Tendinopathy (Reasonable Hypothesis) (No. 86 of 2024)

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

I am satisfied that you have met the following factor:

- *running or jogging an average of at least 30 kilometres per week for the 4 weeks before clinical onset or clinical worsening*
- *undertaking weight bearing exercise involving repeated activity of the ankle joint on the affected side for: (a) a minimum intensity of 5 METS; and (b) for at least 4 hours per week; and (c) for at least the 4 weeks before clinical onset or clinical worsening*
- *increasing the frequency, duration or intensity of activity involving the ankle joint on the affected side: (a) by at least 100 percent; and (b) to a minimum intensity of 5 METs; and (c) for at least 2 hours per day; within the 1 week before the clinical onset or clinical worsening*
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- *having one or more of the following conditions involving the affected lower limb at the time of clinical onset or clinical worsening: decreased ankle or forefoot flexibility*

- *having one or more of the following conditions involving the affected lower limb at the time of clinical onset or clinical worsening: forefoot varus*
- *having one or more of the following conditions involving the affected lower limb at the time of clinical onset or clinical worsening: lateral ankle joint instability*
- *having one of the following systemic arthritic diseases at the time of clinical onset or clinical worsening: ankylosing spondylitis*
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- *having one of the following systemic arthritic diseases at the time of clinical onset or clinical worsening: enteropathic spondyloarthropathy (arthritis associated with inflammatory bowel disease)*
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- *being treated with an aromatase inhibitor for at least 4 weeks within the 1 year before clinical onset or clinical worsening*
- *having a Body Mass Index (BMI) of 30 or greater at the time of clinical onset or clinical worsening*
- *having diabetes mellitus at the time of clinical onset or clinical worsening*
- *inability to obtain appropriate clinical management for Achilles tendinopathy 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 pain and morning stiffness in the left posterior heel, worse at the start of running and after rest, with a tender swelling of the tendon on 12 June 2017.

The diagnosis was confirmed by ultrasound on 22 June 2017, which showed fusiform thickening of the mid-portion of the left Achilles tendon to 9 mm with hypoechoic change and neovascularity, and by MRI on 25 September 2017, which showed intrasubstance degeneration and paratenon oedema. This meets the Statement of Principles definition of Achilles tendinopathy, which includes mid-portion tendinopathy and degenerative tears.

After the condition arose, it was worsened during your service. In the 4 weeks before onset, from 13 May 2017 to 10 June 2017, you ran about 65 kilometres a week while on warlike service in Iraq, and in the 4 weeks before the rupture you ran about 62 kilometres a week on warlike service in Afghanistan, both well above 30 kilometres. On warlike service in Iraq you undertook about 10 hours a week of pack marching, plyometric and obstacle-course instruction at well over 5 METs in the 4 weeks before onset, and about 9 hours a week in Afghanistan in the 4 weeks before the rupture. On warlike service in Iraq your daily activity rose from about 2 to 4.5 hours of running, marching and jumping drills from 3 June 2017, within the 1 week before onset. Before April 2018 the left foot had a high-arched cavus shape, but after the left tibialis posterior tendon rupture of April 2018 the arch collapsed. A left pes cavus foot with a calcaneal pitch of 32 degrees was recorded at enlistment and by a podiatrist in 2014, and was present at onset on warlike service in Iraq on 10 June 2017. Left ankle dorsiflexion was limited to 5 degrees after the inversion injury on warlike service in East Timor in 2000, and was present at onset in Iraq and at the rupture in Afghanistan. A left forefoot varus of 8 degrees was recorded in 2014 and at presentation in Iraq on 12 June 2017, and was present at the rupture. A severe inversion injury of the left ankle on patrol on warlike service in East Timor in November 2000 led to recurrent giving way, with a positive anterior drawer test recorded at presentation on 12 June 2017. Ankylosing spondylitis evolved from the reactive arthritis that followed Shigella dysentery on warlike service in East Timor in 2000, and was active at onset in Iraq and at the rupture in Afghanistan. Behcet syndrome, diagnosed in 2014, was present at onset on warlike service in Iraq and at the rupture on warlike service in Afghanistan. Enteropathic spondyloarthropathy with Crohn disease, diagnosed in 2011, was present at onset in Iraq and at the rupture in Afghanistan. Gout caused by tacrolimus after your renal transplant was present at onset in Iraq and at the rupture in Afghanistan. Calcium pyrophosphate arthropathy, linked to tacrolimus-induced hypomagnesaemia, was present at onset in Iraq and at the rupture in Afghanistan. Psoriatic arthropathy, diagnosed in 2013, was present at onset in Iraq and at the rupture in Afghanistan. Reactive arthritis followed Shigella dysentery contracted on warlike service in East Timor in November 2000 and was present at onset in Iraq and at the rupture in Afghanistan. Seropositive rheumatoid arthritis, diagnosed in 2015, was present at onset in Iraq and at the rupture in Afghanistan. Undifferentiated spondyloarthropathy with heel enthesitis, first recorded in 2003 after the East Timor reactive arthritis, was present at onset and at the rupture. Exertional heat stroke on a field exercise in February 2008 caused renal failure, and you underwent chronic haemodialysis from 20 February 2008 to 18 November 2010, with an eGFR below 15 mL/min/1.73 m2 for more than 3 months. Ciprofloxacin was given from 20 to 27 May 2017 on

warlike service in Iraq, within the 30 days before onset, and from 14 to 20 August 2019 on warlike service in Afghanistan, within the 30 days before the rupture. Prednisolone was taken continuously from November 2010, a cumulative dose of more than 23 grams before onset in Iraq, plus a 10-day course of 50 mg daily in December 2018 before the rupture in Afghanistan. Letrozole was taken daily from 1 February 2016, for more than 4 weeks within the 1 year before onset in Iraq and within the 1 year before the rupture in Afghanistan. Your BMI was 31.4 at presentation on warlike service in Iraq on 12 June 2017 and 32.0 at the rupture in Afghanistan. Diabetes mellitus after transplantation, diagnosed in 2012, was present at onset in Iraq and at the rupture in Afghanistan. On warlike service in Afghanistan from February to September 2019 you could not obtain physiotherapy, podiatry, imaging or specialist review for your diagnosed tendinopathy, and you continued full duties until the tendon ruptured on 2 September 2019.

This has then led to further investigations and the diagnosis of your condition of *Achilles Tendinopathy (Worsening)*. I have accepted your condition of *Achilles Tendinopathy (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 12 June 2017.

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.