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 Shoulder - Biceps Tenosynovitis

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 11 February 2025;
- A Diagnosis Form (D9287) by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 11 February 2025;
- A deployed health record and evacuation summary by the medical officer, East Timor, dated 18 June 2000;
- A renal medicine consultation by the renal physician, dated 22 July 2000;
- A transplant operation and synovial biopsy reports by the transplant surgeon and pathologist, dated 22 March 2005;
- An endocrinology consultation by the endocrinologist, dated 9 May 2006;
- An MRI left shoulder report by the radiologist, dated 30 August 2006;
- An operation report by the orthopaedic surgeon, dated 5 March 2007;
- A rheumatology consultation by the rheumatologist, dated 12 June 2007;
- A pre-deployment health assessment by the medical officer, dated 12 December 2008;
- A deployed health record by the regimental medical officer, Afghanistan, dated 28 June 2009;
- An ultrasound by the x-ray and microbiology reports, Role 2 medical facility, dated 22 July 2009;
- An MRI left shoulder report by the radiologist, dated 5 August 2009;
- An orthopaedic consultation by the orthopaedic surgeon, dated 12 August 2009;
- An operation report by the orthopaedic surgeon, dated 16 March 2010;
- A deployed health record and microbiology report by the medical officer, Middle East, dated 15 October 2013;
- An MRI left shoulder report by the radiologist, dated 10 December 2013.

Your service

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

14 February 1998 and 30 November 2018

Left Shoulder - Biceps Tenosynovitis

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: Biceps Tenosynovitis

Basis of diagnosis: The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 11 February 2025, and is supported by an ultrasound by the x-ray and microbiology reports, Role 2 medical facility, dated 22 July 2009.

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*
- *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*

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 anterior left shoulder pain radiating into the upper arm, swelling over the bicipital groove, pain on lifting and on resisted elbow flexion and supination, clicking, and night pain on 22 July 2009.

The diagnosis was confirmed by ultrasound on 22 July 2009, which showed fluid distending the biceps tendon sheath with a thickened, hyperaemic long head of biceps tendon, and by MRI on 5 August 2009, which showed tenosynovitis with sheath effusion and synovial enhancement, in a veteran with anterior shoulder pain, bicipital groove tenderness and positive Speed's and Yergason's tests. This meets the Statement of Principles definition of rotator cuff syndrome as a

clinically symptomatic inflammatory disorder of the long head of biceps and its associated bursae.

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

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 20 July 2009.

Left Shoulder - Biceps Tenosynovitis (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 11 February 2025;
- A Diagnosis Form (D9287) by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 11 February 2025;
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- A rheumatology consultation by the rheumatologist, dated 12 June 2007;
- A pre-deployment health assessment by the medical officer, dated 12 December 2008;
- A deployed health record by the regimental medical officer, Afghanistan, dated 28 June 2009;
- An ultrasound by the x-ray and microbiology reports, Role 2 medical facility, dated 22 July 2009;
- An MRI left shoulder report by the radiologist, dated 5 August 2009;
- An orthopaedic consultation by the orthopaedic surgeon, dated 12 August 2009;
- An operation report by the orthopaedic surgeon, dated 16 March 2010;
- A deployed health record and microbiology report by the medical officer, Middle East, dated 15 October 2013;
- An MRI left shoulder report by the radiologist, dated 10 December 2013.

Your service

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

14 February 1998 and 30 November 2018

Left Shoulder - Biceps Tenosynovitis (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: Biceps Tenosynovitis (Worsening)

Basis of diagnosis: The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 11 February 2025, and is supported by an ultrasound by the x-ray and microbiology reports, Role 2 medical facility, dated 22 July 2009.

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*
- *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*
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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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- *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*

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 anterior left shoulder pain radiating into the upper arm, swelling over the bicipital groove, pain on lifting and on resisted elbow flexion and supination, clicking, and night pain on 22 July 2009.

The diagnosis was confirmed by ultrasound on 22 July 2009, which showed fluid distending the biceps tendon sheath with a thickened, hyperaemic long head of biceps tendon, and by MRI on 5 August 2009, which showed tenosynovitis with sheath effusion and synovial enhancement, in a veteran with anterior shoulder pain, bicipital groove tenderness and positive Speed's and Yergason's tests. This meets the Statement of Principles definition of rotator cuff syndrome as a

clinically symptomatic inflammatory disorder of the long head of biceps and its associated bursae.

After the condition arose, it was worsened during your service. On 28 September 2013 you slipped on a vehicle ladder and caught your full body weight with your left arm, with immediate anterior shoulder pain, tenderness and restricted movement recorded the same day, 17 days before the documented worsening on 15 October 2013. On 16 March 2010 you underwent arthroscopic debridement of the biceps tendon sheath and subacromial bursectomy of the left shoulder, in addition to the 2007 stabilisation, before the documented worsening on 15 October 2013. From 5 June 2013 to the worsening you again worked as a crew commander on the same duties, more than 160 hours within the 132 days before the documented worsening on 15 October 2013, without any break. The same overhead work continued, about 4,400 hours within the 10 years before the documented worsening, from 15 October 2003 to 15 October 2013. The same lifting and carrying, about 900 hours within the 10 years before the documented worsening on 15 October 2013, continued until the worsening. The same heavy percussive tool use amounted to about 2,100 hours within the 10 years before the documented worsening on 15 October 2013, including on warlike service in Afghanistan and the Middle East. The dialysis-related amyloidosis of the left shoulder persisted after transplantation and was present before the documented worsening on 15 October 2013. You continued to bear your body weight through the upper limbs in this way every working day from 2012 to the documented worsening on 15 October 2013, a continuous period of more than 1 year. MRI on 10 December 2013 showed enlarging inferior acromioclavicular osteophytes and suture anchor material narrowing the subacromial space, present at the time of the worsening. The subluxation and instability of 2006 preceded the documented worsening on 15 October 2013. Aspiration of the left subacromial bursa on 17 October 2013 again grew Staphylococcus aureus, an infection present at the time of the documented worsening on 15 October 2013. Rheumatoid arthritis involving the left shoulder persisted and was present before the documented worsening on 15 October 2013. Urate crystals were again present in the left shoulder aspirate of 17 October 2013, confirming gout involving the shoulder at the time of the documented worsening on 15 October 2013. Winging of the left scapula from the long thoracic nerve palsy of 2009 persisted and was present at the documented worsening on 15 October 2013, during your warlike service in the Middle East. You continued to smoke about 30 cigarettes a day to the worsening, about 27 pack-years by 15 October 2013, including on warlike service in the Middle East. Diabetes mellitus, requiring insulin from 2011, was present before the documented worsening on 15 October 2013. Dyslipidaemia, treated continuously with atorvastatin, was present before the documented worsening on 15 October 2013. Prednisolone continued at 5 to 7.5 mg daily, more than 10 grams in total, and on 4 October 2013, eleven days before the documented worsening on 15 October 2013, a triamcinolone injection was given into the bicipital tendon region. Ciprofloxacin was taken from 20 to 26 August 2013 for a urinary tract infection, 56 days before the documented worsening on 15 October 2013. Anastrozole was taken again from 10 January 2012 to 30 June 2013, more than 4 weeks within the 2 years before the documented worsening on 15 October 2013, including the first weeks of your warlike service in the Middle East. From 28 September to 5 December 2013, on warlike service in the Middle East, no ultrasound, orthopaedic or physiotherapy services were

available and your return for specialist care was deferred for operational reasons, so the worsening tenosynovitis went untreated beyond aspiration and analgesia.

This has then led to further investigations and the diagnosis of your condition of *Biceps Tenosynovitis (Worsening)*. I have accepted your condition of *Biceps Tenosynovitis (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 15 October 2013.

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.