# 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 - Rotator Cuff 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 9 September 2025;
- A Diagnosis Form (D9287) by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 9 September 2025;
- An emergency record and X-ray report by the emergency physician, dated 3 November 1986;
- An operation report by the orthopaedic surgeon, dated 22 June 1987;
- A clinical record by the medical officer, Bougainville, dated 14 April 1998;
- A clinical record by the medical officer, East Timor, dated 30 October 1999;
- An electromyography report by the neurologist, dated 18 September 2003;
- A pathology report by the medical officer, Base health centre, dated 5 May 2004;
- A general practice record by the medical officer, Base health centre, dated 12 July 2006;
- A renal medicine consultation by the nephrologist, dated 15 September 2008;
- A rheumatology consultation by the rheumatologist, dated 10 April 2012;
- An operation report by the orthopaedic surgeon, dated 4 June 2013;
- A histopathology report by the pathologist, dated 26 August 2013;
- An endocrinology consultation by the endocrinologist, dated 1 February 2014;
- A periodic health examination by the medical officer, Base health centre, dated 8 August 2014;
- An ultrasound report and aspirate microbiology by the radiologist and microbiologist, dated 12 November 2014;
- An operation report by the orthopaedic surgeon, dated 14 November 2014;
- An MRI report and aspirate microbiology by the radiologist and microbiologist, dated 18 March 2016;

- An orthopaedic consultation by the orthopaedic surgeon, dated 31 March 2016.

## Your service

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

20 January 1980 and 30 June 2017

## Left Shoulder - Rotator Cuff Tendinopathy

You have stated that your condition was caused by:

- *having an injury to the affected shoulder within the 30 days 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 160 hours within a period of 210 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 4,000 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 400 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 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*

**Diagnosis:** Rotator Cuff Tendinopathy

**Basis of diagnosis:** The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 9 September 2025, and is supported by an ultrasound report and aspirate microbiology by the radiologist and microbiologist, dated 12 November 2014.

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 (Balance of Probabilities) (No. 110 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 30 days 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 160 hours within a period of 210 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 4,000 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 400 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 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*

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 aching lateral left shoulder and upper arm pain, worse at night and with any overhead reach, a painful arc, weakness of elevation and external rotation, and pain on weight-bearing through your left crutch, with fever and a swollen shoulder.After the worsening you had constant pain, could not lift the arm above shoulder height without pain and tolerated the left crutch only briefly on 12 November 2014.

The diagnosis was confirmed by ultrasound on 12 November 2014, which showed thickened, hypoechoic supraspinatus and infraspinatus tendons consistent with tendinopathy, with bursal effusion and subacromial narrowing, and by the arthroscopic findings of 14 November 2014. This meets the Statement of Principles definition of rotator cuff syndrome, which includes rotator cuff tendinopathy or tendonitis.

This has then led to further investigations and the diagnosis of your condition of *Rotator Cuff Tendinopathy*. I have accepted your condition of *Rotator Cuff 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 peacetime service.

I have therefore accepted that this condition is related to your service with effect from 11 November 2014.

# Left Shoulder - Rotator Cuff 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 9 September 2025;
- A Diagnosis Form (D9287) by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 9 September 2025;
- An emergency record and X-ray report by the emergency physician, dated 3 November 1986;
- An operation report by the orthopaedic surgeon, dated 22 June 1987;
- A clinical record by the medical officer, Bougainville, dated 14 April 1998;
- A clinical record by the medical officer, East Timor, dated 30 October 1999;
- An electromyography report by the neurologist, dated 18 September 2003;
- A pathology report by the medical officer, Base health centre, dated 5 May 2004;
- A general practice record by the medical officer, Base health centre, dated 12 July 2006;
- A renal medicine consultation by the nephrologist, dated 15 September 2008;
- A rheumatology consultation by the rheumatologist, dated 10 April 2012;
- An operation report by the orthopaedic surgeon, dated 4 June 2013;
- A histopathology report by the pathologist, dated 26 August 2013;
- An endocrinology consultation by the endocrinologist, dated 1 February 2014;
- A periodic health examination by the medical officer, Base health centre, dated 8 August 2014;
- An ultrasound report and aspirate microbiology by the radiologist and microbiologist, dated 12 November 2014;
- An operation report by the orthopaedic surgeon, dated 14 November 2014;
- An MRI report and aspirate microbiology by the radiologist and microbiologist, dated 18 March 2016;
- An orthopaedic consultation by the orthopaedic surgeon, dated 31 March 2016.

## Your service

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

20 January 1980 and 30 June 2017

# Left Shoulder - Rotator Cuff Tendinopathy (Worsening)

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

- *having an injury to the affected shoulder within the 30 days 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 160 hours within a period of 210 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 4,000 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 400 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 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*
- *inability to obtain appropriate clinical management for rotator cuff syndrome*

**Diagnosis:** Rotator Cuff Tendinopathy (Worsening)

**Basis of diagnosis:** The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 9 September 2025, and is supported by an ultrasound report and aspirate microbiology by the radiologist and microbiologist, dated 12 November 2014.

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 (Balance of Probabilities) (No. 110 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 30 days 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 160 hours within a period of 210 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 4,000 hours within the 10 years before the clinical worsening of rotator cuff syndrome*
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- *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 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*
- *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 aching lateral left shoulder and upper arm pain, worse at night and with any overhead reach, a painful arc, weakness of elevation and external rotation, and pain on weight-bearing through your left crutch, with fever and a swollen shoulder.After the worsening you had constant pain, could not lift the arm above shoulder height without pain and tolerated the left crutch only briefly on 12 November 2014.

The diagnosis was confirmed by ultrasound on 12 November 2014, which showed thickened, hypoechoic supraspinatus and infraspinatus tendons consistent with tendinopathy, with bursal effusion and subacromial narrowing, and by the arthroscopic findings of 14 November 2014. This meets the Statement of Principles definition of rotator cuff syndrome, which includes rotator cuff tendinopathy or tendonitis.

After the condition arose, it was worsened during your service. On 1 March 2016 you fell while transferring from your wheelchair at the airfield works depot, landing on your outstretched left arm. On 14 November 2014 you also underwent arthroscopic washout and subacromial bursectomy for the infected bursa present at onset. Crutch walking continued after the 2014 arthroscopy, and in the 210 consecutive days before the worsening, from 21 August 2015 to 18 March 2016, it exceeded 600 hours and continued to the worsening. Within the 10 years before the worsening, from 18 March 2006 to 18 March 2016, you performed about 4,680 hours of overhead work, between March 2006 and June 2013. Within the 10 years before the worsening, from 18 March 2006 to 18 March 2016, you carried loads of 20 kg or more with the left arm for about 540 hours. Haemodialysis continued and dialysis-related amyloidosis was present before the worsening. Crutch walking and transfers continued throughout the year before the worsening, from 18 March 2015 to 18 March 2016. MRI on 18 March 2016 again showed the acromial spur and acromioclavicular osteophytes narrowing the subacromial space at the worsening. The 1986 dislocation and the 1999 subluxation preceded the worsening. Aspiration on 18 March 2016 grew Streptococcus pyogenes from the subacromial bursa, present at the worsening. Polymyalgia rheumatica relapsed with left subdeltoid bursitis on the MRI of 18 March 2016, before the worsening. Urate crystals were again present in the aspirate of 18 March 2016, at the worsening. Diabetes persisted with an HbA1c of 8.2 per cent in January 2016, before the worsening.

Atorvastatin continued as regular drug therapy to normalise blood lipid levels before the worsening. Prednisolone was increased to 15 mg daily for a relapse in 2015, bringing the cumulative oral dose to about 10.5 grams before the worsening, exceeding 10 grams. Ciprofloxacin 250 mg twice daily was taken from 20 February 2016 to 5 March 2016 to suppress infection around your knee spacer, within the 60 days before the worsening that run from 18 January 2016 to 18 March 2016. MET.

This has then led to further investigations and the diagnosis of your condition of *Rotator Cuff Tendinopathy (Worsening)*. I have accepted your condition of *Rotator Cuff 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 peacetime service.

I have therefore accepted that the worsening of this condition is related to your service with effect from 18 March 2016.

*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.*