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.

Lumbar - Pars Defect

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 24 April 2025;
- A Diagnosis Form (D9287) by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 24 April 2025;
- A trauma admission and CT report by the spinal surgeon and radiologist, dated 14 March 2005;
- A medical employment classification review by the senior medical officer, dated 20 February 2006;
- A pre-deployment medical examination by the medical officer, Garrison health centre, dated 18 January 2010;
- A role 2 enhanced facility admission and CT report by the afghanistan, dated 22 June 2010;
- A sports medicine consultation and X-ray report by the sports physician, dated 14 March 2011;
- A rheumatology consultation and MRI report by the rheumatologist and radiologist, dated 9 August 2012;
- An operation report by the spinal surgeon, dated 10 April 2013;
- An infectious diseases consultation and MRI report by the infectious diseases physician, dated 28 May 2013;
- A spinal surgical review by the spinal surgeon, dated 21 November 2016;
- A role 2 facility consultation and X-ray report by the middle east, dated 7 June 2017;
- An MRI lumbar spine report by the radiologist, dated 18 October 2017;
- An operation report by the spinal surgeon, dated 12 March 2018.

Your service

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

20 January 2004 and 14 August 2019

Lumbar - Pars Defect

You have stated that your condition was caused by:

- *experiencing a high impact trauma to the spine resulting in an acute fracture of the vertebral arch at the time of clinical onset or clinical worsening*
- *experiencing a high impact trauma to the spine resulting in an acute fracture of the vertebral arch or dislocation of the involved vertebra within the 1 year before clinical onset or clinical worsening of spondylolisthesis*
- *for persons less than 25 years of age only, engaging in activities involving repetitive and forceful hyperextension, torsion or rotation against resistance of the spine for an average period of at least 10 hours per week for the 6 months before clinical onset or clinical worsening of spondylolysis or spondylolytic spondylolisthesis*
- *having undergone a spinal fusion of a segment of adjacent vertebrae to permanently connect 2 or more vertebrae in the spine, eliminating motion between them before clinical onset*
- *having undergone spinal surgery involving resection of the facet joints or parts of the vertebral arch (including laminectomy, laminotomy and facetectomy) at the level of the involved vertebra, or surgery to the spine that damages the integrity and stability of the spine at the level of the involved vertebra before clinical onset or clinical worsening*
- *having spondylosis at the level of the involved vertebra, before clinical onset or clinical worsening of degenerative spondylolisthesis of the lumbar or cervical spine*
- *having pathological damage to the affected vertebra at the time of clinical onset or clinical worsening*
- *having rheumatoid arthritis involving the affected vertebra at the time of clinical onset or clinical worsening of spondylolisthesis*
- *having a Body Mass Index (BMI) of 30 or greater for the 5 years before clinical onset or clinical worsening of degenerative anterolisthesis*

Diagnosis: Pars Defect

Basis of diagnosis: The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 24 April 2025, and is supported by a role 2 enhanced facility admission and CT report by the afghanistan, dated 22 June 2010.

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

Statement of Principles concerning Spondylolisthesis and Spondylolysis (Reasonable Hypothesis) (No. 56 of 2025)

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

I am satisfied that you have met the following factor:

- *experiencing a high impact trauma to the spine resulting in an acute fracture of the vertebral arch at the time of clinical onset or clinical worsening*
- *experiencing a high impact trauma to the spine resulting in an acute fracture of the vertebral arch or dislocation of the involved vertebra within the 1 year before clinical onset or clinical worsening of spondylolisthesis*
- *for persons less than 25 years of age only, engaging in activities involving repetitive and forceful hyperextension, torsion or rotation against resistance of the spine for an average period of at least 10 hours per week for the 6 months before clinical onset or clinical worsening of spondylolysis or spondylolytic spondylolisthesis*
- *having undergone a spinal fusion of a segment of adjacent vertebrae to permanently connect 2 or more vertebrae in the spine, eliminating motion between them before clinical onset*
- *having undergone spinal surgery involving resection of the facet joints or parts of the vertebral arch (including laminectomy, laminotomy and facetectomy) at the level of the involved vertebra, or surgery to the spine that damages the integrity and stability of the spine at the level of the involved vertebra before clinical onset or clinical worsening*
- *having spondylosis at the level of the involved vertebra, before clinical onset or clinical worsening of degenerative spondylolisthesis of the lumbar or cervical spine*
- *having pathological damage to the affected vertebra at the time of clinical onset or clinical worsening*
- *having rheumatoid arthritis involving the affected vertebra at the time of clinical onset or clinical worsening of spondylolisthesis*
- *having a Body Mass Index (BMI) of 30 or greater for the 5 years before clinical onset or clinical worsening of degenerative anterolisthesis*

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 sudden severe central low back pain after the blast, worse on arching backwards, twisting, standing and wearing body armour, with spasm and difficulty lying flat on 22 June 2010.

The diagnosis was confirmed by CT on 22 June 2010, which showed acute bilateral fractures of the L5 pars interarticularis with sharp, non-corticated margins, meeting the Statement of Principles definition of spondylolysis as a defect or fracture involving the pars interarticularis. X-ray on 14 March 2011 showed non-union of both defects and a grade 1 slip of L5 on S1, establishing spondylolytic spondylolisthesis.

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

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 22 June 2010.

Lumbar - Pars Defect (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 24 April 2025;
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- A rheumatology consultation and MRI report by the rheumatologist and radiologist, dated 9 August 2012;
- An operation report by the spinal surgeon, dated 10 April 2013;
- An infectious diseases consultation and MRI report by the infectious diseases physician, dated 28 May 2013;
- A spinal surgical review by the spinal surgeon, dated 21 November 2016;
- A role 2 facility consultation and X-ray report by the middle east, dated 7 June 2017;
- An MRI lumbar spine report by the radiologist, dated 18 October 2017;
- An operation report by the spinal surgeon, dated 12 March 2018.

Your service

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

20 January 2004 and 14 August 2019

Lumbar - Pars Defect (Worsening)

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

- *experiencing a high impact trauma to the spine resulting in an acute fracture of the vertebral arch at the time of clinical onset or clinical worsening*
- *experiencing a high impact trauma to the spine resulting in an acute fracture of the vertebral arch or dislocation of the involved vertebra within the 1 year before clinical onset or clinical worsening of spondylolisthesis*
- *for persons less than 25 years of age only, engaging in activities involving repetitive and forceful hyperextension, torsion or rotation against resistance of the spine for an average period of at least 10 hours per week for the 6 months before clinical onset or clinical worsening of spondylolysis or spondylolytic spondylolisthesis*
- *having undergone spinal surgery involving resection of the facet joints or parts of the vertebral arch (including laminectomy, laminotomy and facetectomy) at the level of the involved vertebra, or surgery to the spine that damages the integrity and stability of the spine at the level of the involved vertebra before clinical onset or clinical worsening*
- *having spondylosis at the level of the involved vertebra, before clinical onset or clinical worsening of degenerative spondylolisthesis of the lumbar or cervical spine*
- *having pathological damage to the affected vertebra at the time of clinical onset or clinical worsening*
- *having rheumatoid arthritis involving the affected vertebra at the time of clinical onset or clinical worsening of spondylolisthesis*
- *having a Body Mass Index (BMI) of 30 or greater for the 5 years before clinical onset or clinical worsening of degenerative anterolisthesis*
- *having trauma to affected region of the spine at the time of clinical worsening of spondylolytic spondylolisthesis*
- *inability to obtain appropriate clinical management for spondylolisthesis or spondylolysis before clinical worsening*

Diagnosis: Pars Defect (Worsening)

Basis of diagnosis: The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 24 April 2025, and is supported by a role 2 enhanced facility admission and CT report by the afghanistan, dated 22 June 2010.

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

Statement of Principles concerning Spondylolisthesis and Spondylolysis (Reasonable Hypothesis) (No. 56 of 2025)

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

I am satisfied that you have met the following factor:

- *experiencing a high impact trauma to the spine resulting in an acute fracture of the vertebral arch at the time of clinical onset or clinical worsening*

- *experiencing a high impact trauma to the spine resulting in an acute fracture of the vertebral arch or dislocation of the involved vertebra within the 1 year before clinical onset or clinical worsening of spondylolisthesis*
- *for persons less than 25 years of age only, engaging in activities involving repetitive and forceful hyperextension, torsion or rotation against resistance of the spine for an average period of at least 10 hours per week for the 6 months before clinical onset or clinical worsening of spondylolysis or spondylolytic spondylolisthesis*
- *having undergone spinal surgery involving resection of the facet joints or parts of the vertebral arch (including laminectomy, laminotomy and facetectomy) at the level of the involved vertebra, or surgery to the spine that damages the integrity and stability of the spine at the level of the involved vertebra before clinical onset or clinical worsening*
- *having spondylosis at the level of the involved vertebra, before clinical onset or clinical worsening of degenerative spondylolisthesis of the lumbar or cervical spine*
- *having pathological damage to the affected vertebra at the time of clinical onset or clinical worsening*
- *having rheumatoid arthritis involving the affected vertebra at the time of clinical onset or clinical worsening of spondylolisthesis*
- *having a Body Mass Index (BMI) of 30 or greater for the 5 years before clinical onset or clinical worsening of degenerative anterolisthesis*
- *having trauma to affected region of the spine at the time of clinical worsening of spondylolytic spondylolisthesis*
- *inability to obtain appropriate clinical management for spondylolisthesis or spondylolysis 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 sudden severe central low back pain after the blast, worse on arching backwards, twisting, standing and wearing body armour, with spasm and difficulty lying flat on 22 June 2010.

The diagnosis was confirmed by CT on 22 June 2010, which showed acute bilateral fractures of the L5 pars interarticularis with sharp, non-corticated margins, meeting the Statement of Principles definition of spondylolysis as a defect or fracture involving the pars interarticularis. X-ray on 14 March 2011 showed non-union of both defects and a grade 1 slip of L5 on S1, establishing spondylolytic spondylolisthesis.

After the condition arose, it was worsened during your service. The improvised explosive device strike of 22 June 2010 occurred on warlike service in Afghanistan. The L5 arch fractures sustained on warlike service in Afghanistan on 22 June 2010 did not unite, and a grade 1 spondylolytic spondylolisthesis of L5 on S1 was first shown on X-ray on 14 March 2011, within the 1 year after the blast. You, aged 24 at onset, trained in wrestling, judo and Olympic lifts for an average of 12 hours a week from June 2009, including in the base gymnasium on warlike service in Afghanistan from 5 February 2010 until the blast of 22 June 2010. The Gill procedure

of 10 April 2013, which removed the loose posterior arch of L5 and parts of the L5/S1 facet joints at the level of the involved vertebra, was performed to treat the defects sustained on warlike service in Afghanistan. Spondylosis at L4/5, with disc degeneration and facet arthropathy, was present on MRI on 9 August 2012, having developed after the L5 injury sustained on warlike service in Afghanistan. The L5 vertebral osteomyelitis of May 2013, which followed surgery for the defects sustained on warlike service in Afghanistan, destroyed part of the L5 pedicles and vertebral body. Seropositive rheumatoid arthritis with synovitis and erosion of the L5/S1 facet joints was diagnosed on 9 August 2012 and remained active, with raised inflammatory markers recorded before deployment, at the time of the clinical worsening on warlike service in the Middle East on 5 June 2017. Your BMI was 30 or greater from 15 February 2012, with a BMI of 33.4 on 30 January 2017, throughout the 5 years before the clinical worsening on warlike service in the Middle East on 5 June 2017, including the development of the degenerative anterolisthesis at L4/5. On warlike service in the Middle East on 5 June 2017 the convoy vehicle in which you were travelling was struck from behind at speed, applying trauma to the lumbosacral spine. Recommended L5/S1 stabilisation surgery was still awaited when you deployed, and on warlike service in the Middle East from 10 February 2017 you had no access to spinal surgical review, MRI or physiotherapy.

This has then led to further investigations and the diagnosis of your condition of *Pars Defect (Worsening)*. I have accepted your condition of *Pars Defect (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 5 June 2017.

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