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.

Nose - Epistaxis

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 21 October 2025;
- A Diagnosis Form (D9287) by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 21 October 2025;
- A periodic health examination by the medical officer, dated 12 March 2007;
- An outpatient health record and X-ray report by the medical officer, dated 14 August 2007;
- An operation report (nasal fracture manipulation) by the ear, nose and throat surgeon, dated 24 August 2007;
- A deployed health record by the medical officer, Middle East, dated 16 February 2009;
- A deployed health record by the medical officer, Middle East, dated 10 April 2009;
- A role 2 facility record and pathology by the medical officer, Middle East, dated 18 June 2009;
- An ear (nose and throat consultation and CT report) by the ear, nose and throat surgeon, dated 5 August 2009;
- An operation report (septoplasty and cautery) by the ear, nose and throat surgeon, dated 12 April 2011.

Your service

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

5 March 2002 and 30 September 2018

Nose - Epistaxis

You have stated that your condition was caused by:

- *breathing air of low relative humidity, including aircraft cabin air or desert air, for an average of at least 20 hours per week for at least the 4 weeks before the clinical onset of epistaxis*
- *breathing dry supplemental oxygen through a mask or nasal cannula on at least 8 occasions within the 4 weeks before the clinical onset of epistaxis*
- *undergoing repeated rapid changes in ambient pressure during flight on at least 20 occasions within the 4 weeks before the clinical onset of epistaxis*
- *having trauma to the nose, including a nasal fracture, before the clinical onset of epistaxis*
- *taking a non-steroidal anti-inflammatory drug, an antiplatelet drug or an anticoagulant at the time of the clinical onset of epistaxis*
- *using an intranasal corticosteroid spray for at least the 4 weeks before the clinical onset of epistaxis*
- *being exposed to airborne irritants, including dust, smoke or fuel vapour, for an average of at least 10 hours per week for at least the 4 weeks before the clinical onset of epistaxis*
- *having an upper respiratory tract infection within the 2 weeks before the clinical onset of epistaxis*

Diagnosis: Epistaxis

Basis of diagnosis: The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 21 October 2025, and is supported by a deployed health record by the medical officer, Middle East, dated 10 April 2009.

I am satisfied this is the appropriate diagnosis.
There is no Statement of Principles (SOP) for this condition. In determining your claim for this condition, I have therefore considered the available evidence, applying the standard of proof:

Reasonable Hypothesis - no Statement of Principles determined for this condition

which requires the evidence to connect the condition with service.

I am satisfied that the evidence establishes the following link to your service:

- *breathing air of low relative humidity, including aircraft cabin air or desert air, for an average of at least 20 hours per week for at least the 4 weeks before the clinical onset of epistaxis*
- *breathing dry supplemental oxygen through a mask or nasal cannula on at least 8 occasions within the 4 weeks before the clinical onset of epistaxis*
- *undergoing repeated rapid changes in ambient pressure during flight on at least 20 occasions within the 4 weeks before the clinical onset of epistaxis*

- *having trauma to the nose, including a nasal fracture, before the clinical onset of epistaxis*
- *taking a non-steroidal anti-inflammatory drug, an antiplatelet drug or an anticoagulant at the time of the clinical onset of epistaxis*
- *using an intranasal corticosteroid spray for at least the 4 weeks before the clinical onset of epistaxis*
- *being exposed to airborne irritants, including dust, smoke or fuel vapour, for an average of at least 10 hours per week for at least the 4 weeks before the clinical onset of epistaxis*
- *having an upper respiratory tract infection within the 2 weeks before the clinical onset of epistaxis*

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 repeated nosebleeds from the left nostril lasting 10 to 20 minutes, mostly after landing from long flights, with nasal dryness, crusting and blood-stained mucus in the mornings.After the June 2009 worsening the bleeds became longer and more frequent, one requiring packing and causing a fall in haemoglobin on 10 April 2009.

The diagnosis was made clinically by the medical officer on 10 April 2009, who recorded four episodes of left-sided nasal bleeding since 8 April 2009 and found dry, crusted anterior septal mucosa with prominent bleeding vessels in Little's area and a septal spur, confirming recurrent anterior epistaxis. An ear, nose and throat surgeon confirmed the diagnosis on 5 August 2009 on nasendoscopy and treated it with cautery, and CT showed the post-traumatic septal deviation and spur.

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

Having considered your service records and the available medical evidence, I am satisfied the evidence establishes that this condition is related to your wartime service.

I have therefore accepted that this condition is related to your service with effect from 8 April 2009.

Nose - Epistaxis (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 21 October 2025;
- A Diagnosis Form (D9287) by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 21 October 2025;
- A periodic health examination by the medical officer, dated 12 March 2007;
- An outpatient health record and X-ray report by the medical officer, dated 14 August 2007;
- An operation report (nasal fracture manipulation) by the ear, nose and throat surgeon, dated 24 August 2007;
- A deployed health record by the medical officer, Middle East, dated 16 February 2009;
- A deployed health record by the medical officer, Middle East, dated 10 April 2009;
- A role 2 facility record and pathology by the medical officer, Middle East, dated 18 June 2009;
- An ear (nose and throat consultation and CT report) by the ear, nose and throat surgeon, dated 5 August 2009;
- An operation report (septoplasty and cautery) by the ear, nose and throat surgeon, dated 12 April 2011.

Your service

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

5 March 2002 and 30 September 2018

Nose - Epistaxis (Worsening)

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

- *breathing air of low relative humidity, including aircraft cabin air or desert air, for an average of at least 20 hours per week for at least the 4 weeks before the clinical worsening of epistaxis*
- *taking a non-steroidal anti-inflammatory drug, an antiplatelet drug or an anticoagulant at the time of the clinical worsening of epistaxis*

- *using an intranasal corticosteroid spray for at least the 4 weeks before the clinical worsening of epistaxis*
- *being exposed to airborne irritants, including dust, smoke or fuel vapour, for an average of at least 10 hours per week for at least the 4 weeks before the clinical worsening of epistaxis*
- *inability to obtain appropriate clinical management for epistaxis*

Diagnosis: Epistaxis (Worsening)

Basis of diagnosis: The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 21 October 2025, and is supported by a deployed health record by the medical officer, Middle East, dated 10 April 2009.

I am satisfied this is the appropriate diagnosis.
There is no Statement of Principles (SOP) for this condition. In determining your claim for this condition, I have therefore considered the available evidence, applying the standard of proof:

Reasonable Hypothesis - no Statement of Principles determined for this condition

which requires the evidence to connect the condition with service.

I am satisfied that the evidence establishes the following link to your service:

- *breathing air of low relative humidity, including aircraft cabin air or desert air, for an average of at least 20 hours per week for at least the 4 weeks before the clinical worsening of epistaxis*
- *taking a non-steroidal anti-inflammatory drug, an antiplatelet drug or an anticoagulant at the time of the clinical worsening of epistaxis*
- *using an intranasal corticosteroid spray for at least the 4 weeks before the clinical worsening of epistaxis*
- *being exposed to airborne irritants, including dust, smoke or fuel vapour, for an average of at least 10 hours per week for at least the 4 weeks before the clinical worsening of epistaxis*
- *inability to obtain appropriate clinical management for epistaxis*

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 repeated nosebleeds from the left nostril lasting 10 to 20 minutes, mostly after landing from long flights, with nasal dryness, crusting and blood-stained mucus in the mornings.After the June 2009 worsening the bleeds became longer and more frequent, one requiring packing and causing a fall in haemoglobin on 10 April 2009.

The diagnosis was made clinically by the medical officer on 10 April 2009, who recorded four episodes of left-sided nasal bleeding since 8 April 2009 and found dry, crusted anterior septal mucosa with prominent bleeding vessels in Little's area and a septal spur, confirming recurrent anterior epistaxis. An ear, nose and throat surgeon confirmed the diagnosis on 5 August 2009 on

nasendoscopy and treated it with cautery, and CT showed the post-traumatic septal deviation and spur.

After the condition arose, it was worsened during your service. From 21 May 2009 to 18 June 2009 you continued to fly five to six long sorties a week in dry cabin air on warlike service, with high-altitude drops on oxygen, including the nine-hour sortie that immediately preceded the bleed of 18 June 2009. You were still taking ibuprofen 400 mg three times daily for your cargo-related back strain on 18 June 2009, the day of the prolonged bleed, as recorded at the role 2 facility. Mometasone nasal spray was continued daily for dust-related rhinitis throughout the 4 weeks before the worsening, from 21 May 2009 to 18 June 2009, because no alternative was available in theatre. Through May and June 2009 you continued flight line duties in dust and burn pit smoke for at least 20 hours a week on warlike service, throughout the 4 weeks before the worsening on 18 June 2009. On warlike service no ear, nose and throat surgeon or chemical cautery was available, so the bleeding vessels could not be treated for four months after onset, and you were returned to flying after 48 hours of packing because aircrew could not be replaced.

This has then led to further investigations and the diagnosis of your condition of *Epistaxis (Worsening)*. I have accepted your condition of *Epistaxis (Worsening)*.

Having considered your service records and the available medical evidence, I am satisfied the evidence establishes 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 18 June 2009.

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