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.

Right Axillary - Tinea Corporis

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 22 April 2025;
- A Diagnosis Form (D9287) by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 22 April 2025;
- A deployed clinical record by the medical officer, Solomon Islands, dated 20 August 2006;
- A veterinary treatment record by the veterinary technician, Solomon Islands, dated 2 October 2006;
- A deployed clinical record and mycology report by the medical officer and pathology laboratory, dated 11 October 2006;
- An incident and casualty record by the medical officer, Afghanistan, dated 22 May 2011;
- A specialist letter by the infectious diseases physician, dated 19 September 2011;
- A haematology discharge summary by the haematologist, dated 14 November 2013;
- An outpatient health record by the medical officer, Garrison health centre, dated 3 March 2015;
- A renal medicine consultation by the renal physician, dated 5 September 2017;
- A vascular surgery consultation and duplex ultrasound report by the vascular surgeon, dated 2018;
- An outpatient health record by the medical officer, Garrison health centre, dated 12 February 2019;
- An operation report (axillary lymph node biopsy) by the general surgeon, dated 25 February 2019;
- A dermatology consultation and mycology report by the dermatologist, dated 9 March 2019;
- A dermatology review by the dermatologist, dated 20 August 2019.

Your service

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

16 January 2004 and 11 December 2020

Right Axillary - Tinea Corporis

You have stated that your condition was caused by:

- *having unprotected physical contact with: a person infected with tinea; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having unprotected physical contact with: an animal infected with tinea; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having unprotected physical contact with: objects or surfaces contaminated with dermatophytes; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having unprotected physical contact with: using communal showering or bathing facilities, swimming pool facilities or locker rooms; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having unprotected physical contact with: soil contaminated with dermatophytes; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having unprotected physical contact with: a site of tinea on the same body; between 2 days and 3 weeks before the clinical onset or clinical worsening*

Diagnosis: Tinea Corporis

Basis of diagnosis: The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 22 April 2025, and is supported by a deployed clinical record and mycology report by the medical officer and pathology laboratory, dated 11 October 2006.

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

Statement of Principles concerning Tinea (Reasonable Hypothesis) (No. 55 of 2024)

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

I am satisfied that you have met the following factor:

- *having unprotected physical contact with: a person infected with tinea; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having unprotected physical contact with: an animal infected with tinea; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having unprotected physical contact with: objects or surfaces contaminated with dermatophytes; between 2 days and 3 weeks before the clinical onset or clinical worsening*

- *having unprotected physical contact with: using communal showering or bathing facilities, swimming pool facilities or locker rooms; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having unprotected physical contact with: soil contaminated with dermatophytes; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having unprotected physical contact with: a site of tinea on the same body; between 2 days and 3 weeks before the 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 an intensely itchy, red, scaly ring in the right armpit with a raised edge, worse with heat and sweating on 11 October 2006.

The diagnosis was made on 11 October 2006 by the deployed medical officer on the typical clinical appearance of an annular scaly plaque with a raised active edge in the right axilla, and confirmed the same day by microscopy of skin scrapings showing fungal hyphae, with culture growing the dermatophyte Trichophyton rubrum. This meets the Statement of Principles definition of tinea, a superficial fungal infection of the skin caused by dermatophytes.

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

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 9 October 2006.

Right Axillary - Tinea Corporis (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 22 April 2025;
- A Diagnosis Form (D9287) by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 22 April 2025;
- A deployed clinical record by the medical officer, Solomon Islands, dated 20 August 2006;
- A veterinary treatment record by the veterinary technician, Solomon Islands, dated 2 October 2006;
- A deployed clinical record and mycology report by the medical officer and pathology laboratory, dated 11 October 2006;
- An incident and casualty record by the medical officer, Afghanistan, dated 22 May 2011;
- A specialist letter by the infectious diseases physician, dated 19 September 2011;
- A haematology discharge summary by the haematologist, dated 14 November 2013;
- An outpatient health record by the medical officer, Garrison health centre, dated 3 March 2015;
- A renal medicine consultation by the renal physician, dated 5 September 2017;
- A vascular surgery consultation and duplex ultrasound report by the vascular surgeon, dated 2018;
- An outpatient health record by the medical officer, Garrison health centre, dated 12 February 2019;
- An operation report (axillary lymph node biopsy) by the general surgeon, dated 25 February 2019;
- A dermatology consultation and mycology report by the dermatologist, dated 9 March 2019;
- A dermatology review by the dermatologist, dated 20 August 2019.

Your service

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

16 January 2004 and 11 December 2020

Right Axillary - Tinea Corporis (Worsening)

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

- *having unprotected physical contact with: a person infected with tinea; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having unprotected physical contact with: an animal infected with tinea; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having unprotected physical contact with: objects or surfaces contaminated with dermatophytes; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having unprotected physical contact with: using communal showering or bathing facilities, swimming pool facilities or locker rooms; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having unprotected physical contact with: soil contaminated with dermatophytes; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having unprotected physical contact with: a site of tinea on the same body; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having skin maceration at the affected site between 2 days and 3 weeks before the clinical worsening*
- *having diabetes mellitus at the time of clinical worsening*
- *having a substantially lowered immune function at the time of clinical worsening due to: (a) human immunodeficiency virus (HIV) infection; (b) glucocorticoids other than inhaled glucocorticoids; (c) solid organ transplant (excluding corneal transplant), stem cell or bone marrow transplantation*
- *having topical glucocorticoid applied at the site of the tinea at the time of clinical worsening*
- *having chronic renal failure at the time of clinical worsening of tinea unguium, as indicated by any of the following; (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*
- *taking risankizumab and guselkumab at the time of clinical worsening*
- *having peripheral artery disease of the lower limb at the time of clinical worsening of tinea affecting the foot*
- *having chronic venous insufficiency of the lower limb at the time of clinical worsening of tinea unguium of the toes*
- *having varicose veins of the lower limb at the time of clinical worsening of tinea unguium of the toes*
- *inability to obtain appropriate clinical management for tinea before clinical worsening*

Diagnosis: Tinea Corporis (Worsening)

Basis of diagnosis: The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 22 April 2025, and is supported by a deployed clinical record and mycology report

by the medical officer and pathology laboratory, dated 11 October 2006.

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

Statement of Principles concerning Tinea (Balance of Probabilities) (No. 56 of 2024)

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

I am satisfied that you have met the following factor:

- *having unprotected physical contact with: a person infected with tinea; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having unprotected physical contact with: an animal infected with tinea; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having unprotected physical contact with: objects or surfaces contaminated with dermatophytes; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having unprotected physical contact with: using communal showering or bathing facilities, swimming pool facilities or locker rooms; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having unprotected physical contact with: soil contaminated with dermatophytes; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having unprotected physical contact with: a site of tinea on the same body; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having skin maceration at the affected site between 2 days and 3 weeks before the clinical worsening*
- *having diabetes mellitus at the time of clinical worsening*
- *having a substantially lowered immune function at the time of clinical worsening due to: (a) human immunodeficiency virus (HIV) infection; (b) glucocorticoids other than inhaled glucocorticoids; (c) solid organ transplant (excluding corneal transplant), stem cell or bone marrow transplantation*
- *having topical glucocorticoid applied at the site of the tinea at the time of clinical worsening*
- *having chronic renal failure at the time of clinical worsening of tinea unguium, as indicated by any of the following; (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*
- *taking risankizumab and guselkumab at the time of clinical worsening*
- *having peripheral artery disease of the lower limb at the time of clinical worsening of tinea affecting the foot*
- *having chronic venous insufficiency of the lower limb at the time of clinical worsening of tinea unguium of the toes*
- *having varicose veins of the lower limb at the time of clinical worsening of tinea unguium of the toes*

- *inability to obtain appropriate clinical management for tinea 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 an intensely itchy, red, scaly ring in the right armpit with a raised edge, worse with heat and sweating on 11 October 2006.

The diagnosis was made on 11 October 2006 by the deployed medical officer on the typical clinical appearance of an annular scaly plaque with a raised active edge in the right axilla, and confirmed the same day by microscopy of skin scrapings showing fungal hyphae, with culture growing the dermatophyte Trichophyton rubrum. This meets the Statement of Principles definition of tinea, a superficial fungal infection of the skin caused by dermatophytes.

After the condition arose, it was worsened during your service. Between 18 September and 7 October 2006, as part of your duties as a medic, you examined and dressed village children with tinea corporis and tinea capitis at community health clinics without gloves, because glove supplies had run out. A stray dog with patchy hair loss and scaly skin lived in the patrol base, and you handled and treated it repeatedly in late September 2006. Between 18 September and 7 October 2006 you wore body armour and webbing reissued from other soldiers and shared towels in the patrol base, at a time when the medical officer was treating several soldiers for tinea. Throughout the window from 18 September to 7 October 2006 you used the patrol base's communal showers and ablution block daily, barefoot, shared with about 60 soldiers. During patrols between 20 September and 5 October 2006 you dug shell scrapes and slept in pits in wet, humus-rich tropical soil with your arms bare. You had active tinea pedis and tinea unguium of the right foot, diagnosed on 20 August 2006, throughout the window from 18 September to 7 October 2006. From 16 February to 7 March 2019, while serving in Darwin during the wet season, you sweated heavily in uniform and the right axilla was recorded on 25 February 2019 as moist, white and macerated around the biopsy site. Type 2 diabetes mellitus was diagnosed on 3 March 2015 with an HbA1c of 8.1 per cent, following the stem cell transplant and glucocorticoid treatment for lymphoma. At the worsening on 9 March 2019 your immune function was substantially lowered by all three listed causes: (a) HIV infection acquired from a needle-stick injury on service in 2011, with a CD4 count of 240 cells per microlitre in February 2019; (b) oral prednisolone 20 mg daily taken from 10 February 2019; and (c) the autologous stem cell transplant of 14 November 2013. From 12 February 2019 you applied betamethasone dipropionate 0.05 per cent ointment twice daily to the right axilla, prescribed for a presumed inverse psoriasis without skin scrapings. Your eGFR had been below 15 mL/min/1.73 m2 since June 2017, more than 3 months, and you had undergone haemodialysis three times a week since 5 September 2017 for HIV-associated nephropathy. You received guselkumab 100 mg on 7 January 2019 for HIV-associated psoriasis and, after a partial response, risankizumab 150 mg on 18 February 2019. A vascular surgeon diagnosed right lower limb peripheral artery disease in 2018, with an ankle-brachial index of 0.68 and calf claudication at 200 metres. Duplex ultrasound in 2018 showed chronic venous insufficiency of the right leg, with deep and superficial venous reflux following the deep vein thrombosis of July 2013. You had varicose veins of the right great saphenous territory, documented on examination and duplex ultrasound in

2018, which were present when the tinea unguium of the right toes worsened on 9 March 2019. On 12 February 2019 the rash in your right axilla was treated as inverse psoriasis without skin scrapings, despite your documented history of axillary tinea and your immunosuppression, and a potent topical steroid was prescribed.

This has then led to further investigations and the diagnosis of your condition of *Tinea Corporis (Worsening)*. I have accepted your condition of *Tinea Corporis (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 9 March 2019.

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