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.

Skin - Tinea

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 4 August 2025;
- A Diagnosis Form (D9287) by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 4 August 2025;
- A pre-deployment medical examination by the medical officer, dated 12 January 2006;
- A ship's medical record by the medical officer, Persian Gulf, dated 20 May 2006;
- A ship's medical record by the medical officer, Persian Gulf, dated 6 June 2006;
- A ship's medical record and mycology report by the medical officer and pathologist, dated 14 June 2006;
- A specialist letter by the infectious diseases physician, dated 18 October 2006;
- An outpatient health record and mycology report by the medical officer, dated 12 March 2009;
- A venous duplex ultrasound report by the vascular sonographer, dated 5 September 2018;
- An arterial duplex ultrasound report by the vascular surgeon, dated 19 August 2019;
- A renal medicine letter by the renal physician, dated 3 February 2020;
- An angiography and procedure report by the vascular surgeon, dated 22 October 2020;
- A podiatry record by the podiatrist, dated 30 October 2020;
- A dermatology consultation and mycology report by the dermatologist, dated 10 November 2020.

Your service

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

8 February 1991 and 19 July 2022

Skin - Tinea

You have stated that your condition was caused by:

- *having unprotected physical contact with: (a) a person infected with tinea; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having unprotected physical contact with: (b) an animal infected with tinea; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having unprotected physical contact with: (c) objects or surfaces contaminated with dermatophytes; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having unprotected physical contact with: (d) 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: (e) soil contaminated with dermatophytes; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having unprotected physical contact with: (f) a site of tinea on the same body; between 2 days and 3 weeks before the clinical onset or clinical worsening*

Diagnosis: Tinea

Basis of diagnosis: The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 4 August 2025, and is supported by a ship's medical record and mycology report by the medical officer and pathologist, dated 14 June 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) a person infected with tinea; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having unprotected physical contact with: (b) an animal infected with tinea; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having unprotected physical contact with: (c) objects or surfaces contaminated with dermatophytes; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having unprotected physical contact with: (d) 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: (e) soil contaminated with dermatophytes; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having unprotected physical contact with: (f) 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 intense itch, burning and peeling between the toes of both feet, with white soggy skin in the webs and fine scaling on the soles, worse after watches in wet boots on 14 June 2006.

The diagnosis was confirmed on 14 June 2006 by skin scrapings showing fungal hyphae on microscopy and culture of Trichophyton rubrum and Trichophyton interdigitale, dermatophytes named in the Statement of Principles definition of tinea. The clinical picture of interdigital maceration, peeling and plantar scaling was typical of tinea pedis.

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

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 14 June 2006.

Skin - Tinea (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 4 August 2025;
- A Diagnosis Form (D9287) by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 4 August 2025;
- A pre-deployment medical examination by the medical officer, dated 12 January 2006;
- A ship's medical record by the medical officer, Persian Gulf, dated 20 May 2006;
- A ship's medical record by the medical officer, Persian Gulf, dated 6 June 2006;
- A ship's medical record and mycology report by the medical officer and pathologist, dated 14 June 2006;
- A specialist letter by the infectious diseases physician, dated 18 October 2006;
- An outpatient health record and mycology report by the medical officer, dated 12 March 2009;
- A venous duplex ultrasound report by the vascular sonographer, dated 5 September 2018;
- An arterial duplex ultrasound report by the vascular surgeon, dated 19 August 2019;
- A renal medicine letter by the renal physician, dated 3 February 2020;
- An angiography and procedure report by the vascular surgeon, dated 22 October 2020;
- A podiatry record by the podiatrist, dated 30 October 2020;
- A dermatology consultation and mycology report by the dermatologist, dated 10 November 2020.

Your service

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

8 February 1991 and 19 July 2022

Skin - Tinea (Worsening)

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

- *having unprotected physical contact with: (a) a person infected with tinea; between 2 days and 3 weeks before the clinical onset or clinical worsening*

- *having unprotected physical contact with: (b) an animal infected with tinea; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having unprotected physical contact with: (c) objects or surfaces contaminated with dermatophytes; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having unprotected physical contact with: (d) 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: (e) soil contaminated with dermatophytes; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having unprotected physical contact with: (f) 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*
- *having a substantially lowered immune function at the time of clinical worsening due to: (b) glucocorticoids other than inhaled glucocorticoids*
- *having a substantially lowered immune function at the time of clinical worsening due to: (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 (Worsening)

Basis of diagnosis: The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 4 August 2025, and is supported by a ship's medical record and mycology report by the medical officer and pathologist, dated 14 June 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) a person infected with tinea; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having unprotected physical contact with: (b) an animal infected with tinea; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having unprotected physical contact with: (c) objects or surfaces contaminated with dermatophytes; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having unprotected physical contact with: (d) 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: (e) soil contaminated with dermatophytes; between 2 days and 3 weeks before the clinical onset or clinical worsening*
- *having unprotected physical contact with: (f) 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*
- *having a substantially lowered immune function at the time of clinical worsening due to: (b) glucocorticoids other than inhaled glucocorticoids*
- *having a substantially lowered immune function at the time of clinical worsening due to: (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 intense itch, burning and peeling between the toes of both feet, with white soggy skin in the webs and fine scaling on the soles, worse after watches in wet boots on 14 June 2006.

The diagnosis was confirmed on 14 June 2006 by skin scrapings showing fungal hyphae on microscopy and culture of Trichophyton rubrum and Trichophyton interdigitale, dermatophytes named in the Statement of Principles definition of tinea. The clinical picture of interdigital maceration, peeling and plantar scaling was typical of tinea pedis.

After the condition arose, it was worsened during your service. Between 24 May and 12 June 2006 you shared a bunk space, mess and heads with your bunk-mate, one of eleven members of the engineering department with tinea pedis recorded by the medical officer on 6 June 2006. From 28 May to 10 June 2006 you were a member of boarding parties that searched dhows carrying goats with visible ringworm lesions, and you handled and moved the animals to search the holds without gloves. Boarding boots were shared between boarding party members and left to dry together in a common locker, and the mess and heads decks were contaminated during the outbreak. You showered in the ship's communal showers after every watch, usually twice a day, without footwear because thongs were not available in the ship's canteen, throughout 24 May to 12 June 2006, while eleven members of your department had tinea pedis. The dhow decks and holds you searched from 28 May to 10 June 2006 were covered in soil, straw and dung from the infected goats. Tinea cruris of both groins was diagnosed on 20 May 2006 and remained active throughout 24 May to 12 June 2006. From 20 October to 8 November 2020, within 2 days to 3 weeks before the worsening on 10 November 2020, you worked ten-hour days in a technical workshop in northern Australia in steel-capped safety boots in temperatures of 33 to 36 degrees Celsius. Post-transplant diabetes mellitus was diagnosed in 2017, caused by tacrolimus and prednisolone, and treated with insulin. You had HIV infection, acquired from a needle-stick injury on 2 July 2006 while assisting the ship's medic, and your CD4 count was 280 cells/uL in October 2020. You had taken oral prednisolone continuously since your transplant in April 2016, at 10 mg daily throughout 2020, and was taking it at the worsening on 10 November 2020. You received a kidney transplant on 14 April 2016. Betamethasone dipropionate 0.05 per cent cream was prescribed for presumed eczema of the feet and applied twice daily to both feet from 1 October 2020 until the dermatologist stopped it on 10 November 2020, the date of the worsening. You had been on haemodialysis three times a week since 3 February 2020 for failure of your transplant, with an eGFR below 10 mL/min/1.73 m2 throughout 2020, meeting both (a) and (b). You received guselkumab 100 mg every eight weeks for psoriasis from February 2019, with the last dose on 7 October 2020, and was switched to risankizumab 150 mg, first given on 21 October 2020. Peripheral artery disease of the right leg was confirmed on 19 August 2019,

with a 70 to 80 per cent superficial femoral artery stenosis and an ankle-brachial index of 0.58, and diffuse tibial disease persisted after angioplasty on 22 October 2020. Venous duplex on 5 September 2018 showed chronic venous insufficiency with saphenous reflux in both legs, attributed to decades of prolonged standing on steel decks. Varicose veins of both calves were documented on the duplex of 5 September 2018 and on examination on 10 November 2020, at the worsening of the toenail tinea. Topical antifungal supplies ran out on board in June 2006, systemic treatment recommended in 2009 was not started because of a sea posting, and from March to October 2020 podiatry and dermatology appointments were suspended under pandemic restrictions while your dialysis schedule limited access, so the tinea was misdiagnosed and treated with a steroid.

This has then led to further investigations and the diagnosis of your condition of *Tinea (Worsening)*. I have accepted your condition of *Tinea (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 10 November 2020.

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