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.

Systemic - Elevated Blood Pressure (Episodic/Situational)

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 11 June 2025;
- A Diagnosis Form (D9287) by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 11 June 2025;
- A trauma admission and operation report by the surgeon, Field hospital, East Timor, dated 22 January 2000;
- An infectious diseases consultation by the infectious diseases physician, dated 15 June 2000;
- A dermatology consultation and skin biopsy report by the dermatologist, dated 14 August 2003;
- A radiation oncology treatment summary and dose report by the radiation oncologist, dated 15 July 2004;
- An outpatient health record by the medical officer, Garrison health centre, dated 12 April 2005;
- A transplant operation report and discharge summary by the transplant surgeon, dated 12 June 2007;
- An MRI report and exercise test report by the rehabilitation physician, dated 10 October 2008;
- A polysomnography report by the sleep physician, dated 10 October 2008;
- An outpatient record by the headquarters medical officer, Kabul, dated 14 June 2010;
- A psychiatric assessment by the consultant psychiatrist, dated 18 July 2011;
- An ambulatory blood pressure report by the renal physician, dated 18 July 2011;
- A biopsy report by the renal physician, dated 5 September 2011;
- A doppler ultrasound report by the radiologist, dated 8 September 2011;

- A transplant clinic consultation by the renal physician, dated 24 October 2011;
- An ambulatory blood pressure report and CT angiography report by the renal physician and radiologist, dated 28 October 2011;
- A hospital admission (echocardiogram and ophthalmology review) by the physician and ophthalmologist, dated 10 February 2012.

Your service

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

12 January 1987 and 30 June 2016

Systemic - Elevated Blood Pressure (Episodic/Situational)

You have stated that your condition was caused by:

- *being overweight or obese for at least the 5 years before the clinical onset of hypertension*
- *consuming an average of at least 400 grams of alcohol per week for a continuous period of at least the 6 months before the clinical onset of hypertension*
- *consuming an average of at least 12 grams (200 millimoles) of salt per day for at least the 1 year before the clinical onset of hypertension*
- *having renal artery stenosis at the time of the clinical onset of hypertension*
- *having a solid organ, stem cell or bone marrow transplant before the clinical onset of hypertension*
- *having diabetes mellitus for at least the 5 years before the clinical onset of hypertension*
- *having chronic kidney disease at the time of the clinical onset of hypertension*
- *having an endocrine disorder from the specified list of endocrine disorders at the time of the clinical onset of hypertension*
- *having sleep apnoea at the time of the clinical onset of hypertension*
- *having extrinsic compression of the renal parenchyma from a haematoma or mass at the time of the clinical onset of hypertension*
- *having: (a) an aneurysm of the renal artery; or (b) an arteriovenous fistula involving the blood supply of the kidney; or (c) an arteriovenous malformation involving the blood supply of the kidney; before the clinical onset of hypertension*
- *having a clinically significant disorder of mental health as specified at the time of the clinical onset of hypertension*
- *taking a drug from the Specified List 1 of drugs, where that drug cannot be ceased or substituted, for a continuous period of at least the 28 days before the clinical onset of hypertension*
- *taking a drug from the Specified List 2 of drugs at the time of the clinical onset of hypertension*

- *having glucocorticoid therapy as specified before the clinical onset of hypertension, and if the glucocorticoid therapy as specified has ceased or decreased before the clinical onset of hypertension, then that onset occurred within 30 days of cessation or reduction of therapy*
- *taking medroxyprogesterone acetate or megestrol acetate for a malignant disease or human immunodeficiency virus infection: (a) for at least 28 days before the clinical onset of hypertension; and (b) if treatment has ceased before the clinical onset of hypertension, then that onset occurred within 30 days of cessation*
- *inability to undertake any physical activity greater than 3 METs for at least the 1 year before the clinical onset of hypertension*
- *being exposed to arsenic as specified before the clinical onset of hypertension*

Diagnosis: Elevated Blood Pressure (Episodic/Situational)

Basis of diagnosis: The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 11 June 2025, and is supported by an ambulatory blood pressure report and CT angiography report by the renal physician and radiologist, dated 28 October 2011.

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

Statement of Principles concerning Hypertension (Balance of Probabilities) (No. 22 of 2022)

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

I am satisfied that you have met the following factor:

- *being overweight or obese for at least the 5 years before the clinical onset of hypertension*
- *consuming an average of at least 400 grams of alcohol per week for a continuous period of at least the 6 months before the clinical onset of hypertension*
- *consuming an average of at least 12 grams (200 millimoles) of salt per day for at least the 1 year before the clinical onset of hypertension*
- *having renal artery stenosis at the time of the clinical onset of hypertension*
- *having a solid organ, stem cell or bone marrow transplant before the clinical onset of hypertension*
- *having diabetes mellitus for at least the 5 years before the clinical onset of hypertension*
- *having chronic kidney disease at the time of the clinical onset of hypertension*
- *having an endocrine disorder from the specified list of endocrine disorders at the time of the clinical onset of hypertension*
- *having sleep apnoea at the time of the clinical onset of hypertension*
- *having extrinsic compression of the renal parenchyma from a haematoma or mass at the time of the clinical onset of hypertension*
- *having: (a) an aneurysm of the renal artery; or (b) an arteriovenous fistula involving the blood supply of the kidney; or (c) an arteriovenous malformation involving the blood*

supply of the kidney; before the clinical onset of hypertension

- *having a clinically significant disorder of mental health as specified at the time of the clinical onset of hypertension*
- *taking a drug from the Specified List 1 of drugs, where that drug cannot be ceased or substituted, for a continuous period of at least the 28 days before the clinical onset of hypertension*
- *taking a drug from the Specified List 2 of drugs at the time of the clinical onset of hypertension*
- *having glucocorticoid therapy as specified before the clinical onset of hypertension, and if the glucocorticoid therapy as specified has ceased or decreased before the clinical onset of hypertension, then that onset occurred within 30 days of cessation or reduction of therapy*
- *taking medroxyprogesterone acetate or megestrol acetate for a malignant disease or human immunodeficiency virus infection: (a) for at least 28 days before the clinical onset of hypertension; and (b) if treatment has ceased before the clinical onset of hypertension, then that onset occurred within 30 days of cessation*
- *inability to undertake any physical activity greater than 3 METs for at least the 1 year before the clinical onset of hypertension*
- *being exposed to arsenic as specified before the clinical onset of hypertension*

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 headaches, pounding palpitations and flushing, with episodes of sharply elevated blood pressure during PTSD-related panic, in medical settings and under stress, on a background of persistently raised ambulatory readings on 24 October 2011.

The diagnosis was made by a renal physician on ambulatory blood pressure monitoring on 28 October 2011, which showed a 24-hour average of 148/94 mmHg and a daytime average of 154/98 mmHg, above the equivalent ambulatory levels in the Statement of Principles, after clinic readings of 168/102 mmHg with surges to 192/112 mmHg on 24 October 2011. Regular antihypertensive therapy was started. The elevation was persistent and not a temporary rise from acute renal failure or medication, so the exclusion does not apply.

This has then led to further investigations and the diagnosis of your condition of *Elevated Blood Pressure (Episodic/Situational)*. I have accepted your condition of *Elevated Blood Pressure (Episodic/Situational)*.

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 20 October 2011.

Systemic - Elevated Blood Pressure (Episodic/Situational) (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 11 June 2025;
- A Diagnosis Form (D9287) by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 11 June 2025;
- A trauma admission and operation report by the surgeon, Field hospital, East Timor, dated 22 January 2000;
- An infectious diseases consultation by the infectious diseases physician, dated 15 June 2000;
- A dermatology consultation and skin biopsy report by the dermatologist, dated 14 August 2003;
- A radiation oncology treatment summary and dose report by the radiation oncologist, dated 15 July 2004;
- An outpatient health record by the medical officer, Garrison health centre, dated 12 April 2005;
- A transplant operation report and discharge summary by the transplant surgeon, dated 12 June 2007;
- An MRI report and exercise test report by the rehabilitation physician, dated 10 October 2008;
- A polysomnography report by the sleep physician, dated 10 October 2008;
- An outpatient record by the headquarters medical officer, Kabul, dated 14 June 2010;
- A psychiatric assessment by the consultant psychiatrist, dated 18 July 2011;
- An ambulatory blood pressure report by the renal physician, dated 18 July 2011;
- A biopsy report by the renal physician, dated 5 September 2011;
- A doppler ultrasound report by the radiologist, dated 8 September 2011;
- A transplant clinic consultation by the renal physician, dated 24 October 2011;
- An ambulatory blood pressure report and CT angiography report by the renal physician and radiologist, dated 28 October 2011;
- A hospital admission (echocardiogram and ophthalmology review) by the physician and ophthalmologist, dated 10 February 2012.

Your service

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

12 January 1987 and 30 June 2016

Systemic - Elevated Blood Pressure (Episodic/Situational) (Worsening)

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

- *being overweight or obese for at least the 5 years before the clinical worsening of hypertension*
- *consuming an average of at least 400 grams of alcohol per week for a continuous period of at least the 6 months before the clinical worsening of hypertension*
- *consuming an average of at least 12 grams (200 millimoles) of salt per day for at least the 1 year before the clinical worsening of hypertension*
- *having renal artery stenosis at the time of the clinical worsening of hypertension*
- *having a solid organ, stem cell or bone marrow transplant before the clinical worsening of hypertension*
- *having diabetes mellitus for at least the 5 years before the clinical worsening of hypertension*
- *having chronic kidney disease at the time of the clinical worsening of hypertension*
- *having an endocrine disorder from the specified list of endocrine disorders at the time of the clinical worsening of hypertension*
- *having sleep apnoea at the time of the clinical worsening of hypertension*
- *having extrinsic compression of the renal parenchyma from a haematoma or mass at the time of the clinical worsening of hypertension*
- *having: (a) an aneurysm of the renal artery; or (b) an arteriovenous fistula involving the blood supply of the kidney; or (c) an arteriovenous malformation involving the blood supply of the kidney; before the clinical worsening of hypertension*
- *having a clinically significant disorder of mental health as specified at the time of the clinical worsening of hypertension*
- *taking a drug from the Specified List 1 of drugs, where that drug cannot be ceased or substituted, for a continuous period of at least the 28 days before the clinical worsening of hypertension*
- *taking a drug from the Specified List 2 of drugs at the time of the clinical worsening of hypertension*
- *having glucocorticoid therapy as specified before the clinical worsening of hypertension, and if the glucocorticoid therapy as specified has ceased or decreased before the clinical*

worsening of hypertension, then that worsening occurred within 30 days of cessation or reduction of therapy

- *taking medroxyprogesterone acetate or megestrol acetate for a malignant disease or human immunodeficiency virus infection: (a) for at least 28 days before the clinical worsening of hypertension; and (b) if treatment has ceased before the clinical worsening of hypertension, then that worsening occurred within 30 days of cessation*
- *inability to undertake any physical activity greater than 3 METs for at least the 1 year before the clinical worsening of hypertension*
- *being exposed to arsenic as specified before the clinical worsening of hypertension*
- *inability to obtain appropriate clinical management for hypertension*

Diagnosis: Elevated Blood Pressure (Episodic/Situational) (Worsening)

Basis of diagnosis: The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 11 June 2025, and is supported by an ambulatory blood pressure report and CT angiography report by the renal physician and radiologist, dated 28 October 2011.

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

Statement of Principles concerning Hypertension (Balance of Probabilities) (No. 22 of 2022)

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

I am satisfied that you have met the following factor:

- *being overweight or obese for at least the 5 years before the clinical worsening of hypertension*
- *consuming an average of at least 400 grams of alcohol per week for a continuous period of at least the 6 months before the clinical worsening of hypertension*
- *consuming an average of at least 12 grams (200 millimoles) of salt per day for at least the 1 year before the clinical worsening of hypertension*
- *having renal artery stenosis at the time of the clinical worsening of hypertension*
- *having a solid organ, stem cell or bone marrow transplant before the clinical worsening of hypertension*
- *having diabetes mellitus for at least the 5 years before the clinical worsening of hypertension*
- *having chronic kidney disease at the time of the clinical worsening of hypertension*
- *having an endocrine disorder from the specified list of endocrine disorders at the time of the clinical worsening of hypertension*
- *having sleep apnoea at the time of the clinical worsening of hypertension*
- *having extrinsic compression of the renal parenchyma from a haematoma or mass at the time of the clinical worsening of hypertension*

- *having: (a) an aneurysm of the renal artery; or (b) an arteriovenous fistula involving the blood supply of the kidney; or (c) an arteriovenous malformation involving the blood supply of the kidney; before the clinical worsening of hypertension*
- *having a clinically significant disorder of mental health as specified at the time of the clinical worsening of hypertension*
- *taking a drug from the Specified List 1 of drugs, where that drug cannot be ceased or substituted, for a continuous period of at least the 28 days before the clinical worsening of hypertension*
- *taking a drug from the Specified List 2 of drugs at the time of the clinical worsening of hypertension*
- *having glucocorticoid therapy as specified before the clinical worsening of hypertension, and if the glucocorticoid therapy as specified has ceased or decreased before the clinical worsening of hypertension, then that worsening occurred within 30 days of cessation or reduction of therapy*
- *taking medroxyprogesterone acetate or megestrol acetate for a malignant disease or human immunodeficiency virus infection: (a) for at least 28 days before the clinical worsening of hypertension; and (b) if treatment has ceased before the clinical worsening of hypertension, then that worsening occurred within 30 days of cessation*
- *inability to undertake any physical activity greater than 3 METs for at least the 1 year before the clinical worsening of hypertension*
- *being exposed to arsenic as specified before the clinical worsening of hypertension*
- *inability to obtain appropriate clinical management for hypertension*

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 headaches, pounding palpitations and flushing, with episodes of sharply elevated blood pressure during PTSD-related panic, in medical settings and under stress, on a background of persistently raised ambulatory readings on 24 October 2011.

The diagnosis was made by a renal physician on ambulatory blood pressure monitoring on 28 October 2011, which showed a 24-hour average of 148/94 mmHg and a daytime average of 154/98 mmHg, above the equivalent ambulatory levels in the Statement of Principles, after clinic readings of 168/102 mmHg with surges to 192/112 mmHg on 24 October 2011. Regular antihypertensive therapy was started. The elevation was persistent and not a temporary rise from acute renal failure or medication, so the exclusion does not apply.

After the condition arose, it was worsened during your service. You remained overweight, with a waist of 107 cm on 10 February 2012, and had been overweight throughout the 5 years before the worsening, from 10 February 2007 to 10 February 2012. You drank an average of about 45 standard drinks, 450 grams of alcohol, a week throughout the 6 months before the worsening, from 10 August 2011 to 10 February 2012. Your salt intake of about 13 to 14 grams a day, including sodium bicarbonate tablets, continued throughout the 1 year before the worsening, from 10 February 2011 to 10 February 2012. The 75 per cent transplant renal artery stenosis

remained untreated at the worsening on 10 February 2012; angioplasty was not performed until August 2012. The kidney transplant of 12 June 2007 preceded the worsening on 10 February 2012. Type 2 diabetes mellitus had been present continuously since April 2005, more than 5 years before the worsening on 10 February 2012. Chronic kidney disease persisted, with an allograft eGFR of 34 mL/min/1.73 m2 on 10 February 2012, at the worsening. Tertiary hyperparathyroidism persisted, with a PTH of 30 pmol/L on 10 February 2012, at the worsening. Untreated obstructive sleep apnoea was present at the worsening on 10 February 2012. The organised subcapsular haematoma continued to compress the allograft parenchyma at the worsening on 10 February 2012. The arteriovenous fistula in the transplant kidney was present before the worsening on 10 February 2012. Posttraumatic stress disorder under monthly psychiatric management was present at the worsening, with increased nightmares and panic episodes recorded in January 2012. Antiretroviral therapy, which could not be ceased or substituted, was taken continuously throughout the 28 days before the worsening, from 13 January 2012 to 10 February 2012. Tacrolimus was being taken at the worsening on 10 February 2012, with a trough level at the upper end of the target range. Prednisolone with ritonavir continued daily, without reduction, up to the worsening on 10 February 2012. Megestrol acetate 160 mg daily continued from 1 August 2011 to beyond the worsening, more than 28 days before 10 February 2012, without cessation. The inability to undertake any activity above 3 METs continued throughout the 1 year before the worsening, from 10 February 2011 to 10 February 2012. The clinical evidence of chronic arsenic toxicity persisted before the worsening on 10 February 2012. During your 25-month posting in Kabul your episodic elevated readings, including 164/100 mmHg on 14 June 2010, were not investigated, as no ambulatory monitoring or transplant review was available.

This has then led to further investigations and the diagnosis of your condition of *Elevated Blood Pressure (Episodic/Situational) (Worsening)*. I have accepted your condition of *Elevated Blood Pressure (Episodic/Situational) (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 February 2012.

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.