

incapacitating episodes we have provided for evaluating chronic liver disease without cirrhosis (diagnostic code 7345) and hepatitis C (diagnostic code 7354) in § 4.114 of the rating schedule.

We propose to change the heading of diagnostic code 5003 from "Arthritis, degenerative (hypertrophic or osteoarthritis)" to "Osteoarthritis (degenerative or hypertrophic arthritis)," as recommended by the consultants, because the disease is now most commonly referred to as osteoarthritis. Osteoarthritis established by X-ray findings is currently evaluated on the basis of limitation of motion under the appropriate diagnostic codes for the specific joint or joints involved. When the limitation of motion of the specific joint or joints is noncompensable, a rating of 10 percent is assigned for each major joint or group of minor joints with limitation of motion, and this 10 percent is combined, not added, under diagnostic code 5003. The limitation of motion must be objectively confirmed by findings such as swelling, muscle spasm, or satisfactory evidence of painful motion. There are additional directions: (1) In the absence of limitation of motion, when there is X-ray evidence of involvement of 2 or more major joints or 2 or more minor joint groups as the sole finding, with occasional incapacitating exacerbations, 20 percent will be assigned, and (2) with X-ray evidence of involvement of 2 or more major joints or 2 or more minor joint groups as the sole finding, 10 percent will be assigned. Two notes address how to apply these ratings based on X-ray findings and state that they will not be used to rate conditions under diagnostic codes 5013 to 5024. The consultants suggested no substantive change to these criteria.

The current provisions concerning evaluation of osteoarthritis are complex and have sometimes been misinterpreted. The criteria based on limitation of motion, including a noncompensable degree of limitation of motion, are the same as the current instructions for evaluating the chronic residuals of rheumatoid arthritis, and we propose changes similar to those we are proposing for rheumatoid arthritis, and for the same reasons. We propose to replace the current evaluation criteria for osteoarthritis with a direction to separately evaluate each major joint or group of minor joints affected with osteoarthritis based on limitation of motion, ankylosis, joint instability, etc., under the appropriate diagnostic code and to combine that evaluation with an

evaluation for pain under § 4.59 when appropriate.

Osteoarthritis tends to be a steadily progressive disease (although it may be better or worse at times), rather than being subject to the incapacitating exacerbations or flares that are common in rheumatoid arthritis, and we therefore do not propose evaluation criteria based on exacerbations or incapacitating episodes. As with rheumatoid arthritis, we propose to remove evaluations based on noncompensable limitation of motion, because pain is the most common symptom of osteoarthritis, and we are proposing to combine an evaluation based on other disabling findings with an evaluation for pain. In our judgment, limitation of motion in osteoarthritis that does not reach the level of a compensable evaluation would not warrant a higher evaluation than a comparable degree of limitation of motion due to other conditions, and pain would be assessed under the provisions of § 4.59, the same as pain due to any other type of musculoskeletal condition.

We also propose to remove the evaluations based on X-ray findings alone or on X-ray findings plus incapacitating exacerbations because abnormal X-ray findings in the absence of signs or symptoms do not justify a compensable evaluation, as there would be no functional impairment. In fact, most people with X-ray evidence of osteoarthritis are asymptomatic (without any symptoms) ("Osteoarthritis: Presentation, Pathogenesis, and Pharmacologic Therapy," Paulette C. Hahn, M.D. and Lawrence Edwards, M.D., Clin. Rev. Summer: 9–13, 1998). More than 90 percent of people over the age of 40 have X-ray evidence of osteoarthritis in weight-bearing joints, but only 30 percent are symptomatic ("Harrison's Principles of Internal Medicine" Eugene Braunwald, M.D., et al eds., ch. 322, 5, 15th ed. 2001). When pain is present, an evaluation under § 4.59 would appropriately compensate the individual. In addition, since incapacitating exacerbations are not characteristic of osteoarthritis, they are not an appropriate basis of evaluation, and we propose to remove that criterion as well. The proposed criteria are clearer and easier to apply than the current criteria, and would promote internal consistency within the rating schedule and consistency in ratings among veterans with similar disabling effects from different musculoskeletal conditions.

We also propose to add three notes. The first note would require that the diagnosis of osteoarthritis of any joint be

confirmed (one time only) by X-ray or other imaging procedure. Modern imaging procedures such as magnetic resonance imaging, computed tomography, and bone scans may be used in some cases instead of or in addition to conventional X-rays, and the proposed note would assure that these more sophisticated procedures will be equally accepted for diagnosing osteoarthritis for VA disability compensation purposes.

There is currently no regulatory guidance on whether osteoarthritis is or is not a systemic generalized disease. This has implications for compensation claims because if service-connected osteoarthritis is regarded as a generalized or systemic disease, osteoarthritis developing in other joints in the future would be considered part of the same disease process, and subject to additional compensation. The lack of guidance on this issue has led to inconsistency in rating. Having consulted with the VHA Orthopedic Committee and reviewed the medical literature, we propose to clarify this issue by establishing guidelines about generalized and localized osteoarthritis in two more notes.

Current medical thinking is that osteoarthritis is a group of overlapping distinct diseases. One classification is based on whether the disease is localized or generalized, with indications that the generalized type is a distinct subtype that often affects the hands, hips, knees, and spine. Some clinicians consider osteoarthritis to be generalized only if three extra-spinal (other than spine) joints are affected. The concept of localized and generalized osteoarthritis is also discussed in a recent book on osteoarthritis ("Diagnosis and Nonsurgical Management of Osteoarthritis" by Kenneth D. Brandt, M.D., 1996), which states that idiopathic osteoarthritis is divided into localized and generalized types and that the generalized type involves three or more joint groups. The book references a 1952 classic article in the *British Medical Journal* ("Generalized Osteoarthritis and Heberden's Nodes," J. H. Kellgren, F.R.C.P., F.R.C.S. and R. Moore, M.R.C.P., *British Medical Journal*, 1952. 1:181–187), which also described generalized osteoarthritis as involving three or more joint groups. A new standard medical textbook (Harrison's, ch. 322, 1) also differentiates between localized and generalized osteoarthritis, indicating that primary localized osteoarthritis is present when there is involvement of the hands, feet, knees, hips, spine, or other single sites, such as the glenohumeral (shoulder) joint,