

sacroiliac joints, or temporomandibular joints and that primary generalized osteoarthritis is characterized by involvement of three or more joints or groups of joints (distal interphalangeal and proximal interphalangeal joints are counted as one group each). The VHA Orthopedic Committee also suggested that we consider osteoarthritis to be the generalized type if there is positive evidence of osteoarthritis on X-ray or other imaging procedure and on physical examination of at least three joints during service.

Therefore, with the generalized type of osteoarthritis, we propose that additional joints that later develop osteoarthritis would be recognized as part of the same generalized systemic process. If less than three joints have positive evidence of osteoarthritis on X-ray or other imaging procedure and on physical examination, the condition would be considered localized osteoarthritis, and joints later developing osteoarthritis would not be considered part of the same process. Since arthritis is a chronic condition subject to presumptive service condition under the provisions of 38 CFR 3.309(a), meaning that osteoarthritis of a joint is presumed to be service-connected if it manifests to at least a 10-percent level of disability within 1 year of the date of separation from service, we propose to include the 1-year period for presumptive service connection in our guidelines that determine when generalized osteoarthritis is present. We propose to add a second note titled "Generalized osteoarthritis," which states that if osteoarthritis is diagnosed on the basis of positive X-ray or other imaging procedure and positive physical findings in three or more joints (major joints, groups of minor joints, or both) during service or within 1 year following the date of separation from service, the condition will be considered to be generalized osteoarthritis and recognized as a systemic condition. It also says that once generalized osteoarthritis has been established based on these criteria, all joints subsequently diagnosed with osteoarthritis will be considered to be part of the same condition.

We propose to add a third note titled "Localized osteoarthritis" that would state that osteoarthritis diagnosed on the basis of positive X-ray or other imaging procedure and positive physical findings in fewer than three joints (major joints, groups of minor joints, or both) during service or within 1 year following the date of separation from service will be considered to be localized osteoarthritis rather than a systemic condition. It also says that

with localized osteoarthritis, any joints subsequently diagnosed with osteoarthritis will not be considered to be part of the same condition. Adding notes (2) and (3) would promote more consistent determinations about when joints with osteoarthritis diagnosed after service and the 1-year period following separation from service will and will not be considered to be part of the osteoarthritis already related to service, and this guidance is consistent with current medical thinking.

Other types of arthritis are currently evaluated under diagnostic code 5004 (Arthritis, gonorrheal), 5005 (Arthritis, pneumococcic), 5006 (Arthritis, typhoid), 5007 (Arthritis, syphilitic), 5008 (Arthritis, streptococcic), 5009 (Arthritis, other types (specify)), 5010 (Arthritis, due to trauma, substantiated by X-ray findings), and 5017 (Gout or pseudogout), with directions that all but traumatic arthritis are to be rated as rheumatoid arthritis. Since the specific infectious types of arthritis are uncommon, we propose to combine them all under diagnostic code 5004, to be retitled "Infectious arthritis (gonorrheal, pneumococcic, typhoid, syphilitic, streptococcic, etc.)." We propose to retitle diagnostic code 5009 as "Other types of noninfectious inflammatory arthritis (including ankylosing spondylitis, Reiter's syndrome, psoriatic arthritis, arthritis associated with inflammatory bowel disease, and other seronegative types of arthritis)." We propose to retitle diagnostic code 5017, currently "Gout," as "Gout or pseudogout" to make it clear that it encompasses both conditions. These changes will provide the rater with clear instructions on evaluating each of these disabilities. The groupings are possible because of the similar effects of each of these groups of arthritis.

Infectious arthritis is currently evaluated on the same basis as rheumatoid arthritis. However, infectious arthritis is ordinarily an acute condition involving only one joint. In about 60 percent of cases, the infection will heal without residuals if treatment is prompt and adequate, particularly with the use of modern antibiotics. However, some cases of infectious arthritis involve multiple joints, and some are intractable to treatment and leave severe joint disability. Infectious arthritis is therefore unlike rheumatoid arthritis, which is a chronic disease affecting multiple joints, and the current direction to evaluate as rheumatoid arthritis is not ideal. Infectious arthritis is somewhat similar in behavior to osteomyelitis. We therefore propose to provide two bases of evaluation that are

similar to those for osteomyelitis, with one set of criteria to be used for evaluation during the active infection and for three months following cessation of therapy for active infectious arthritis, with the evaluation depending on which joint or joints are infected, as with osteomyelitis. The other set of criteria would be used for evaluating the chronic residuals of infectious arthritis after the three-month period following the cessation of therapy for the active infection has ended. We propose that active infectious arthritis of the spine, the pelvis, or a major joint be evaluated at 100 percent during and for three months following cessation of therapy; that active infectious arthritis not involving the spine, the pelvis, or a major joint, and not limited to a single finger or toe be evaluated at 40 percent during and for three months following cessation of therapy; and that active infectious arthritis of a single finger or toe be evaluated at 10 percent during and for three months following cessation of therapy. While the course may be prolonged, there are not usually multiple recurrences as with osteomyelitis, and we do not propose to use evaluation criteria based on recurrences as we have for osteomyelitis. We propose to add a note under diagnostic code 5004 directing that raters separately evaluate chronic residuals, if any, of each joint affected with infectious arthritis, based on limitation of motion, ankylosis, joint instability, post-surgical residuals (such as arthroplasty), *etc.*, under the appropriate diagnostic code, and combine the evaluation for chronic residuals of each joint with an evaluation for pain under § 4.59 when appropriate, subject to the limitations of § 4.68. This method of evaluating residuals is proposed because, although many active infections heal without residuals, some result in destruction of a joint resulting in arthritis, instability, *etc.*, and some lead to such severe residuals that arthroplasty is required. These proposed criteria are more specific to the effects of infectious arthritis than the current criteria and provide a broad range of objective evaluations for both the active stage of infection and any chronic disability that might develop.

We propose to retitle diagnostic code 5009, "Arthritis, other types," as "Other types of noninfectious inflammatory arthritis (including ankylosing spondylitis, Reiter's syndrome, psoriatic arthritis, arthritis associated with inflammatory bowel disease, and other seronegative types of arthritis)" for clarity. There is currently a direction to