

times bone pain or pathologic fracture is the major problem. Many are asymptomatic and discovered as an incidental finding when a bone is X-rayed for another problem. We therefore propose to expand the directions to include evaluation under the appropriate diagnostic code based on osteoarthritis (diagnostic code 5003), residuals of fracture (such as shortening, limitation of motion), *etc.*, to be combined with an evaluation for bone pain (under § 4.59) when appropriate.

#### **Paget's Disease, Gout and Pseudogout**

We propose to update the title of diagnostic code 5016, currently "Osteitis deformans" to the modern name for this disease, "Paget's disease." Paget's disease is currently evaluated based on limitation of motion as osteoarthritis. It is a disease characterized by enlarged, heavily calcified, and often deformed, but also weak, bones in any area of the body, most commonly the pelvis, femur, tibia, skull, vertebrae, clavicle, and humerus. The most common symptom is bone pain, and deformity, arthritis, and fractures may occur. Pressure on cranial nerves due to enlargement of the skull by the disease can lead to impaired hearing or vision. We therefore propose to provide a broader set of evaluation criteria that encompass more of the disabling effects of Paget's disease by directing raters to evaluate it based on osteoarthritis or residuals of fracture, combined with an evaluation for pain (under § 4.59) when appropriate, and to separately evaluate complications such as impaired hearing or vision.

"Gout" (diagnostic code 5017), which we propose to retitle "Gout or pseudogout," is currently evaluated as rheumatoid arthritis. However, there are major differences between rheumatoid arthritis and gout. Gout, for example, which is a type of arthritis in which uric acid crystals are deposited around joints, usually involves acute inflammation of only a single joint at a time, rather than the widespread joint involvement common in rheumatoid arthritis. Also, gout is not associated with the same types of extra-articular manifestations as rheumatoid arthritis, and there may be none at all except late in the course of the disease when tophi (deposits of sodium urate that develop in gout) have been deposited in tissues other than joint areas. Pseudogout (caused by deposits of calcium pyrophosphate crystals in joint tissues) has manifestations that are similar to gout, but usually milder. We therefore propose to provide a modified version of the rheumatoid arthritis evaluation criteria for evaluating gout and

pseudogout. We propose not to provide a 100-percent evaluation level for gout or pseudogout, since neither condition is likely to be totally disabling. We propose to retain 60-, 40-, and 20-percent evaluation levels and to add a 10-percent evaluation level for gout and pseudogout based on inflammatory synovitis with such findings as weakness and fatigue, acute pain, swelling, heat, tenderness, or limitation of motion. The 60-percent level would require incapacitating exacerbations or flares with a total duration of at least 6 weeks during the past 12-month period requiring treatment by a health care provider, due to inflammatory synovitis with such findings as weakness and fatigue, acute pain, swelling, heat, tenderness, or limitation of motion of multiple joints. The 40-percent level would be the same except that it requires incapacitating exacerbations or flares of multiple joints with a total duration of at least 4 weeks but less than 6 weeks during the past 12-month period. The 20-percent level would require incapacitating exacerbations or flares with a total duration of at least 2 weeks but less than 4 weeks during the past 12-month period of multiple joints. The 10-percent evaluation would require incapacitating exacerbations or flares with a total duration of at least 1 week but less than 2 weeks during the past 12-month period of a single joint or multiple joints. This would provide appropriate criteria to evaluate the acute attacks of inflammation of either single or multiple joints. We propose to provide notes similar to those under diagnostic code 5002 (rheumatoid arthritis). The first note would direct that evaluation be made either on the basis of incapacitating exacerbations or flares under the criteria for diagnostic code 5017 or on the combined evaluation of chronic residuals of gout or pseudogout, whichever results in the higher evaluation. The second note would direct that if not evaluating under the criteria under diagnostic code 5017, chronic residuals of each major joint or group of minor joints with gout or pseudogout will be separately evaluated based on limitation of motion, ankylosis, joint instability, *etc.*, under the appropriate diagnostic code. It further directs that an evaluation for chronic residuals of each major joint or group of minor joints be combined with an evaluation for pain under § 4.59 when appropriate. The third note would direct that manifestations of gout other than joint disease, such as urinary tract calculi or gouty nephropathy, be separately evaluated. The fourth note would define an incapacitating

exacerbation or flare as one requiring bedrest or wheelchair use and treatment by a health care provider. The proposed criteria are more specific to gout and pseudogout than the current criteria and will therefore promote consistent and appropriate evaluations in veterans with one of these joint diseases.

#### **Joint Effusion, Bursitis, Tenosynovitis, Synovitis, Myositis, Periostitis, Myositis Ossificans**

Diagnostic code 5018 is titled "Hydrarthrosis, intermittent," which means fluid occurring in a joint from time to time. This finding may be a sign of various joint diseases and does not indicate a specific diagnosis. We propose updating the title of this code to "Joint effusion," which is the current medical term for this condition. The current schedule directs that evaluation be based on limitation of motion as osteoarthritis. Since osteoarthritis is one of the conditions that may result in joint effusion, it is more likely that osteoarthritis would be evaluated as joint effusion than vice versa. Joint effusion, being a nonspecific response to injury or disease of a joint, may result from any number of types of injury, both bone and soft tissue; from almost any type of arthritis, including infectious arthritis; from osteomyelitis; from surgery in or near a joint; *etc.* The criteria for evaluation under this diagnostic code would be used in evaluating musculoskeletal conditions where joint effusion is the predominant finding. We propose that evaluation of joint effusion be based on limitation of motion, a common concomitant of joint effusion, and this evaluation would be combined with an evaluation for pain under § 4.59 when appropriate. The current schedule requires that the joint effusion be "intermittent," but does not define "intermittent". To promote consistency, we propose to add a statement that a joint effusion that is present constantly, or nearly so, or if intermittent, that occurred at least two times during the past 12-month period, may be evaluated under this diagnostic code and that evaluation will be based on limitation of motion, to be combined with an evaluation for pain under § 4.59 when appropriate. We require at least two episodes of joint effusion because a single episode would represent only an acute condition that might never recur. These criteria are both more objective and more specific to joint effusion than the current criteria.

"Bursitis," diagnostic code 5019, is currently evaluated based on limitation of motion as osteoarthritis, as are all the conditions in diagnostic codes 5013 through 5024 except gout. Bursae are