

fluid-filled structures that assist motion between adjacent structures (skin, bones, muscles, tendons) by decreasing friction. Bursitis is an inflammation of the lining of the bursa, which is a sac made up of synovial tissue, the same tissue that lines joints. Bursitis is commonly due to chronic overuse or an injury, although it may also be associated with systemic diseases such as rheumatoid arthritis or scleroderma. The bursae in the area of the hip, patella or other knee area, shoulder, and olecranon process of the ulna are common sites of bursitis. Signs and symptoms of bursitis include pain, tenderness, redness, heat, swelling, and limitation of motion. We therefore propose to revise the evaluation criteria to base evaluation on limitation of motion, to be combined with an evaluation for pain under § 4.59 when appropriate.

The causes of, and findings in, tenosynovitis, diagnostic code 5024, and synovitis, diagnostic code 5020, are similar to those for bursitis, and they may also be infectious in origin. Tenosynovitis (also called tendinitis) is an inflammation of the tendon and tendon sheath and may result in pain, limitation of motion, tenderness, and swelling. Synovitis is an inflammation of the synovial (joint-lining) tissue only. We propose to provide the same evaluation criteria for synovitis and tenosynovitis as for bursitis.

Myositis (diagnostic code 5021) is an inflammation of muscles with pain, tenderness, and sometimes swelling. It may be due to trauma or a virus, or may be drug-related. We propose that it be evaluated based on limitation of motion, to be combined with an evaluation for pain under § 4.59 when appropriate. There is another category of more widespread myositis that includes systemic autoimmune connective tissue diseases like polymyositis, dermatomyositis, and inclusion body myositis. They are diseases that may also affect joints, the heart, lungs, intestines, and skin. Because these types of myositis affect multiple body systems, they are more appropriately evaluated in the "Infectious Diseases, Immune Disorders and Nutritional Deficiencies (Systemic Conditions)" portion of the rating schedule, perhaps analogous to systemic lupus erythematosus (diagnostic code 6350), rather than under this diagnostic code.

Periostitis (diagnostic code 5022) is another inflammatory condition (of the periosteum or outer covering of a bone) that may develop as a result of overuse or infection. At times it follows severe tenosynovitis. Periostitis is one of the causes, along with stress fractures and

tenosynovitis, of shin splints (pain in the lower leg that occurs during exercise) or posterior tibial stress syndrome or lower leg stress. Tennis elbow (periostitis of the lateral epicondyle of the humerus, often following tendinitis of the extensor carpi radialis brevis in the area of the lateral epicondyle), golfer's elbow (periostitis of the medial epicondylitis of the humerus often following tendinitis of the flexor pronator muscles), and osteitis pubis are other common types of periostitis. We propose to evaluate this condition based on limitation of motion, and to combine this with an evaluation for pain under § 4.59 when appropriate.

Myositis ossificans, diagnostic code 5023, is a condition in which there is ossification (bone formation) in soft tissues such as muscle and tendons. It most often results from trauma or repetitive stress, sometimes representing an ossified intramuscular hematoma. In many cases, the cause is unknown. It may result in pain, tenderness, redness, heat, a palpable mass, and decreased range of motion. We therefore propose to evaluate it based on limitation of motion, and to combine this with an evaluation for pain under § 4.59 when appropriate.

Other than terminology changes, which we are proposing to adopt, the consultants offered few suggestions for changes under diagnostic codes 5011 to 5024. One exception was osteoporosis (diagnostic code 5013), for which they suggested evaluation levels of zero, 20, 50, and 100 percent, based on such criteria as X-ray evidence of "some" "moderate," "severe" demineralization, on the severity of spine pain ("mild," "moderate," or "disabling"), and on the history of fractures (requiring a history of two fractures for 50 percent, and three or more fractures for 100 percent). These criteria would require subjective determinations of various degrees of spine pain and X-ray findings. In addition, in our judgment, how many fractures have occurred is not as significant as how disabling the residuals of those fractures are. We therefore propose to evaluate based on the actual residuals of fractures and any secondary complications, as discussed above. We believe these criteria would provide an evaluation that presents a truer picture of disability and would promote consistent evaluations by correlating evaluations with disabling residuals of fractures rather than simply with numbers of fractures.

Prosthetic Joint Implants

The diagnostic codes for prosthetic joint implants (joint replacements or

arthroplasties) (5051 through 5056) currently provide a 100-percent evaluation for one year of convalescence following hospital discharge. This provision is applied at the time of rating by assigning a 100-percent evaluation for one month under § 4.30 ("Convalescent ratings"), followed by a 100-percent evaluation with a prospective reduction one year later based on medical findings. As the consultants recommended, we propose to continue the 100-percent evaluation indefinitely from date of hospital admission and to examine the veteran six months following discharge from the hospital, because almost all individuals are stabilized within six months of implant. Any reduction in the 100-percent evaluation would be effected under 38 CFR 3.105(e) in the same manner as proposed under diagnostic code 5012 (malignant neoplasm of bone). This would ensure that a veteran receives advance notice of any reduction and has the opportunity to submit additional evidence showing that the reduction is not warranted. We also propose to state that the same method of evaluation will be applied when an arthroplasty is revised or redone, since this procedure is at least as disabling as the original arthroplasty.

The consultants suggested deleting separate evaluations for dominant and nondominant upper extremity joint replacements. We do not propose to do so, because joint replacements of a dominant side—that is, the side normally used for writing, feeding, grooming, and other important tasks—would clearly be more disabling to an individual than joint replacement of the less used nondominant side.

Diagnostic code 5051, "Shoulder replacement (prosthesis)" is currently evaluated at 100 percent for one year following implantation; at 60 or 50 percent (for dominant or nondominant side) if there are chronic residuals consisting of severe, painful motion or weakness in the affected extremity; analogous to diagnostic codes 5200 (ankylosis of scapulohumeral articulation) and 5203 (impairment of clavicle or scapula) if there are intermediate degrees of residual weakness, pain, or limitation of motion; and at 30 or 20 percent as a minimum evaluation. The consultants suggested no change. We propose to revise and update the title to "Total or partial shoulder arthroplasty or replacement (with prosthesis)" and to make similar changes to the titles of arthroplasty of all major joints, elbow (diagnostic code 5052), wrist (diagnostic code 5053), hip (diagnostic code 5054), knee (diagnostic code 5055), and ankle (diagnostic code