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Part II

Department of Veteran Affairs

38 CFR Part 4

Schedule for Rating Disabilities; The Digestive System; Proposed Rule

DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 4

RIN 2900–AN12

Schedule for Rating Disabilities; The Digestive System

AGENCY: Department of Veterans Affairs.

ACTION: Proposed rule.

SUMMARY: The Department of Veterans Affairs (VA) proposes to amend the portion of the Schedule for Rating Disabilities that addresses the Digestive System. The purpose of this change is to incorporate medical advances that have occurred since the last review, insert current medical terminology, and provide clear criteria.

DATES: Comments must be received by VA on or before September 6, 2011.

ADDRESSES: Written comments may be submitted through *http://www.Regulations.gov;* by mail or hand-delivery to the Director, Regulations Management (02REG), Department of Veterans Affairs, 810 Vermont Ave., NW., Room 1068, Washington, DC 20420; or by fax to (202) 273–9026. Comments should indicate that they are submitted in response to RIN 2900–AN12–Schedule for Rating Disabilities; The Digestive System. Copies of comments received will be available for public inspection in the Office of Regulation Policy and Management, Room 1063B, between the hours of 8 a.m. and 4:30 p.m. Monday through Friday (except holidays). Please call (202) 461–4902 for an appointment. (This is not a toll-free number.) In addition, during the comment period, comments may be viewed online through the Federal Docket Management System at *http://www.Regulations.gov.*

FOR FURTHER INFORMATION CONTACT: Thomas J. Kniffen, Chief, Regulations Staff (211D), Compensation and Pension Service, Veterans Benefits Administration, Department of Veterans Affairs, 810 Vermont Avenue, NW., Washington, DC 20420, (202) 461–9725. (This is not a toll-free number.)

SUPPLEMENTARY INFORMATION: VA published an advance notice of proposed rulemaking in the **Federal Register** of May 2, 1991 (56 FR 20168), advising the public of our intent to revise and update the portion of the Schedule for Rating Disabilities (the rating schedule) that addresses the digestive system as well as to solicit and obtain comments and suggestions from interest groups and the general public. By revising the rating schedule, we aim to eliminate ambiguities, include medical conditions not currently in the rating schedule, and implement current medical criteria and terminology that reflect recent medical advances.

Comments in Response To Advance Notice of Proposed Rulemaking

In response to the advance notice of proposed rulemaking, we received comments from the American Legion and from several VA employees. One commenter suggested that we add to the rating schedule Crohn's disease; esophageal spasm (with its own evaluation criteria); hepatitis A, B, and C; chronic inflammation of the liver and its residuals; and malabsorption due to pancreatic disease. We propose to address each of these conditions in this revision, except for hepatitis and chronic inflammation of the liver, which were addressed in a separate rulemaking on liver disabilities (66 FR 29486, May 31, 2001).

The same commenter suggested we include reflux esophagitis with hiatal hernia, with the criteria taking into account a measurement of reflux. For esophageal abnormalities, reflux measurement (manometry), barium swallows, and esophagoscopy provide information about physiological and anatomical abnormalities, and may be useful for diagnosis and prognosis, for determining response to therapy, and to prepare for surgery. They are less useful, however, in assessing the level of disability than the severity of symptoms, the impact of the condition on the nutritional status of the patient, and the potential for remediation (''Disability Evaluation'' 379 (Stephen L. Demeter, M.D., Gunnar B.J. Anderson, M.D., and George M. Smith, M.D., 1996) and The Merck Manual 113 (18th ed. 2006)). While we propose to address reflux esophagitis in this revision, as discussed further below, we do not propose to use a measurement of reflux for evaluation.

A second commenter suggested we add Crohn's disease and also revise the criteria for hemorrhoids. We propose to do both.

One commenter suggested that we evaluate gastrectomy and vagotomy-pyloroplasty under the same criteria. The major postoperative problem related to gastrectomy is dumping syndrome, which is the common term that refers to the group of symptoms that may occur following various types of surgery for ulcer disease. Many problems may be associated with vagotomy-pyloroplasty, of which dumping syndrome is only one. We therefore propose to retain separate evaluation criteria for these conditions, as discussed in more detail below.

The same commenter suggested that we delete diagnostic codes 7201 (lips, injuries of), 7205 (esophagus, diverticulum of, acquired), 7306 (marginal ulcer), 7309 (stomach, stenosis of), 7310 (stomach, injury of, residuals), 7315 (chronic cholelithiasis), 7316 (chronic cholangitis), 7324 (distomiasis, intestinal or hepatic), and 7342 (visceroptosis) because they are rare.

We propose to remove diagnostic code 7342 (visceroptosis) because visceroptosis is an obsolete diagnosis, as discussed further below. However, we propose to retain all of the other diagnostic codes mentioned by the commenter, although some in a revised form, since some of them, such as diagnostic code 7315 (cholelithiasis), represent common digestive diseases, and others, such as those for injuries of the lips or stomach, may be the only appropriate codes under which to address injuries, including combat wounds, to those parts of the body. They may therefore be useful to VA for statistical purposes, as well as for rating purposes.

Another commenter suggested we remove diagnostic code 7201 (lips, injuries of); add esophagitis, duodenitis, and Crohn's disease; provide a diagnostic code for total gastrectomy; add a 10-percent evaluation level for cirrhosis; provide evaluation criteria for ileostomy and colostomy; and provide objective evaluation criteria for pancreatitis. We have already discussed injuries of the lips, which we propose to retain. We otherwise propose to follow all of these suggestions, with two exceptions. First, we do not propose to add a diagnostic code for total gastrectomy, because that condition can be appropriately evaluated under an existing diagnostic code (7308, Postgastrectomy syndromes). Second, we have already added a 10-percent evaluation level for cirrhosis in the separate rulemaking that addressed disabilities of the liver (66 FR 29486, May 31, 2001), so there is no need for further action in this proposed rule based on that comment. This commenter also suggested we remove diagnostic codes 7342 (visceroptosis) and 7337 (pruritus ani) and that we delete the word ''infectious'' from ''infectious hepatitis.'' We also propose to remove diagnostic codes 7342 and 7337. The suggested change concerning hepatitis was made in the separate rulemaking for liver disabilities, so there is no need for further action in this proposed rule.

Outside Consultants

In addition to publishing an advance notice of proposed rulemaking, VA contracted with an outside consulting firm for the purpose of gathering suggestions for changes in the rating schedule to help fulfill the goals of revising and updating the medical criteria. This proposed amendment includes many of their suggestions. Since one of the goals of the rating schedule revision is to eliminate ambiguities, we did not follow some of our consultants' recommendations that are based, at least, in part, on subjective or indefinite language when more objective terminology could be used. Furthermore, each group of consultants reviewed only one portion or body system of the rating schedule, and we had to assess the feasibility of their recommendations in light of the entire rating schedule, in order to assure internal consistency. Relevant recommendations from our consultants are discussed below.

Section 4.110

Current § 4.110, ''Ulcers,'' explains that ''the term 'peptic ulcer' is not sufficiently specific for rating purposes'' because there are ''manifest differences'' between ulcers of the stomach or duodenum as compared to those at an anastomotic stoma, and that, therefore, the location of an ulcer should be identified in order to evaluate it. This material is unnecessary, since there are separate diagnostic codes for ulcers of the stomach, duodenum, and gastrojejunal area (or anastomotic stoma), and the rating schedule therefore makes it clear that the site of an ulcer must be identified in order to assign the correct diagnostic code. Furthermore, this section establishes no procedures that raters must follow in evaluating ulcer disease. We therefore propose to remove the material currently in § 4.110, retitle this section ''Dyspepsia,'' and provide in it a definition of the term ''dyspepsia'' for purposes of evaluating conditions in § 4.114. We propose that § 4.110 would define dyspepsia as any combination of the following symptoms: Gnawing or burning epigastric or substernal pain that may be relieved by food (especially milk) or antacids, nausea, vomiting, anorexia (lack or loss of appetite), abdominal bloating, and belching. It would also state that when there is obstruction of the outlet of the stomach (gastric outlet obstruction), dyspepsia may also include symptoms of gastroesophageal reflux (flow of stomach contents back into the esophagus), borborygmi (audible rumbling bowel sounds), crampy pain, and obstipation (severe constipation).

Section 4.111

Current § 4.111, ''Postgastrectomy syndromes,'' discusses dumping syndrome, a condition which is relevant only to diagnostic code 7308, ''postgastrectomy syndromes,'' and we propose to list the symptoms of dumping syndrome in a note under that diagnostic code. We therefore propose to remove § 4.111.

Section 4.112

Current § 4.112, ''Weight loss,'' defines ''substantial weight loss,'' ''minor weight loss,'' ''inability to gain weight,'' and ''baseline weight,'' for purposes of evaluating conditions in § 4.114. Some of the revisions of conditions in § 4.114 that we are proposing have evaluation criteria that are based in part on malnutrition, and there is no universally accepted definition of malnutrition. We, therefore, propose to provide a definition of malnutrition for purposes of evaluating conditions in § 4.114 by expanding the title of § 4.112 to ''Weight loss and malnutrition'' and adding the following definition: '' 'malnutrition' means a deficiency state resulting from insufficient intake of one or multiple essential nutrients or the inability of the body to absorb, utilize, or retain such nutrients. It is characterized by failure of the body to maintain normal organ functions and healthy tissues.''

Section 4.113

Current § 4.113, ''Coexisting abdominal conditions,'' states that there are diseases of the digestive system that produce a common disability picture with similar symptoms and which should therefore not be rated separately, as this would be a violation of 38 CFR 4.14, ''Avoidance of pyramiding'' (which states that the evaluation of the same disability under various diagnoses is to be avoided). Current § 4.114, in an introductory paragraph, lists specific diagnostic codes that cannot be combined, and directs that a single evaluation ''be assigned under the diagnostic code that reflects the predominant disability picture, with elevation to the next higher evaluation where the severity of the overall disability warrants such evaluation.'' In order to provide clear guidance about evaluation when there are two or more coexisting digestive conditions, we propose to revise the material in §§ 4.113 and 4.114 related to this subject and place the revised directions in § 4.113.

We propose to direct the rater to separately evaluate two or more conditions in § 4.114 only if the signs and symptoms attributed to each are separable, and if they are not separable, to assign a single evaluation under the diagnostic code that best allows evaluation of the overall functional impairment resulting from both conditions. With these instructions, the list of conditions that may not be combined, given in current § 4.114, would be unnecessary, and we propose to remove it. This revision would provide a fair and equitable method of evaluation, and is not contrary to § 4.14. In addition, it would remove the somewhat unclear direction to assign a diagnostic code that reflects the predominant disability and elevate to the next higher evaluation level ''where the severity of the overall disability warrants such elevation,'' a direction that could be interpreted differently by different individuals. We also propose to change the title of § 4.113 to ''Evaluation of coexisting digestive conditions,'' since not all disabilities in this body system are abdominal, as the current title of § 4.113 implies.

Section 4.114 Schedule of Ratings-Digestive System

Mouth injuries, Lip injuries, Tongue Injuries (Including Tongue Loss), Esophageal Stricture, Achalasia (Cardiospasm) and Other Motor Disorders of the Esophagus, and Esophageal Diverticula (Diagnostic Codes 7200–7205)

The current rating schedule directs that injuries of the mouth (diagnostic code 7200) be evaluated on the basis of disfigurement and impairment of masticatory function, and injuries of the lips (diagnostic code 7201) on the basis of disfigurement of the face. Both mouth and lip injuries are therefore evaluated using criteria under other diagnostic codes. Loss of whole or part of the tongue (diagnostic code 7202) is currently evaluated at 100 percent if there is inability to communicate by speech, at 60 percent if there is loss of one-half or more of the tongue, and at 30 percent if there is marked speech impairment. Findings in these three conditions sometimes overlap, according to our consultants, with the major problems being (1) Difficulty with mastication (chewing) or swallowing, causing a restriction of diet; (2) difficulty with speech; (3) loss of part of the tongue; and (4) disfigurement. We therefore propose to provide a general rating formula for the evaluation of residuals of mouth injuries, lip injuries,

and tongue injuries, including tongue loss.

In addition, there are several esophageal abnormalities with signs and symptoms that are similar to one another, and that also overlap the findings in mouth, lip, and tongue injuries. For these reasons, we propose to include several esophageal conditions in the same general rating formula for this whole group of conditions, as discussed in more detail below. Our consultants recommended that there be a 10-percent evaluation level for each of these disabilities, and also pointed out that stricture of the esophagus, for example, can be totally disabling. We agree, and propose to provide evaluation levels of 100, 60, 30, and 10 percent in this general rating formula.

Stricture of the esophagus (diagnostic code 7203) is currently evaluated at 80 percent if it permits ''passage of liquids only, with marked impairment of general health;'' at 50 percent if it is ''severe, permitting liquids only;'' and at 30 percent if it is ''moderate.'' These criteria contain subjective terms such as ''marked,'' ''moderate,'' and ''severe,'' which could be interpreted differently by different individuals. The general rating formula we are proposing for the evaluation of this and other related conditions with symptoms in common would provide more objective criteria.

Spasm of the esophagus (cardiospasm) (diagnostic code 7204) is currently evaluated based on the degree of obstruction (stricture), if not amenable to dilation. We propose to update the title of diagnostic code 7204 from ''cardiospasm'' to ''achalasia,'' the current term for this condition. Achalasia is a condition in which, upon swallowing, there is a failure of relaxation of the lower esophageal sphincter (at the junction of the esophagus and stomach). We also propose to include in this diagnostic code other related motor disorders of the esophagus with impairment in the normal passage of food through the esophagus due to muscle or nerve abnormalities, by revising the title to ''Achalasia (cardiospasm) and other motor disorders of the esophagus (diffuse esophageal spasm, corkscrew esophagus, nutcracker esophagus, etc.).'' Our consultants suggested we provide one diagnostic code for achalasia, with 100- and 30-percent evaluation levels, and another for other esophageal motor disorders, with 50-, 30-, and 10-percent evaluation levels. However, the signs and symptoms of these conditions are very similar, and the severity of disability from any one of these conditions varies widely from individual to individual. Therefore, in our judgment, it is feasible and preferable to provide a single diagnostic code with a broad range of evaluations (100 to 10 percent), for the sake of promoting more consistent and appropriate evaluations.

Acquired diverticulum of the esophagus (diagnostic code 7205) is currently evaluated as obstruction (stricture). We propose to revise the title of diagnostic code 7205 from ''Esophagus, diverticulum of'' to ''Esophageal diverticula, including pharyngoesophageal (Zenker's), midesophageal, and epiphrenic types'' to indicate more clearly the several types of diverticula that may warrant evaluation under this diagnostic code. Achalasia and esophageal diverticulum result in impairments similar to one another, and there is overlap with impairments resulting from mouth, lip, and tongue injuries. In addition, esophageal stricture, achalasia, and esophageal diverticulum may all result in pulmonary aspiration (inhaling food or liquid into the lungs) due to regurgitation or vomiting and may require treatment with prescription medication to control symptoms. Esophageal dilation may be required for stricture or achalasia. We therefore propose to include criteria for these esophageal conditions, as well as mouth, lip, and tongue injuries, in a general rating formula that encompasses the main signs and symptoms of all.

We propose to title the general rating formula for this group of conditions as follows: ''General Rating Formula for Residuals of mouth injuries (diagnostic code 7200), Residuals of lip injuries (diagnostic code 7201), Residuals of tongue injuries, including tongue loss (diagnostic code 7202), Esophageal stricture (diagnostic code 7203), Achalasia (cardiospasm) and other motor disorders of the esophagus (diagnostic code 7204), and Esophageal diverticula (diagnostic code 7205).'' We propose to base evaluation of these conditions on the extent of limitation of diet, on the extent of the ability to speak clearly enough to be understood, on the frequency of episodes of pulmonary aspiration due to regurgitation or vomiting, and on whether or not continuous treatment with prescription medication is required. We propose to provide a list of findings at each evaluation level, any of which would warrant that percentage of evaluation.

We propose a 100-percent evaluation for any of the following: Tube feeding required; diet restricted to liquid foods, with substantial weight loss, malnutrition, and anemia; four or more episodes per year of pulmonary aspiration (with bronchitis, pneumonia, or pulmonary abscess) due to regurgitation or vomiting; or inability to speak clearly enough to be understood. We propose a 60-percent evaluation for any of the following: Diet restricted to liquid and soft solid foods, with substantial weight loss or anemia; two to three episodes per year of pulmonary aspiration (with bronchitis, pneumonia, or pulmonary abscess) due to regurgitation or vomiting; or inability to speak clearly enough to be understood at least half of the time but not all of the time. We propose a 30-percent evaluation for any of the following: Diet restricted to liquid and soft solid foods, with minor weight loss; esophageal dilation carried out five or more times per year; daily regurgitation or vomiting; one episode per year of pulmonary aspiration (with bronchitis, pneumonia, or pulmonary abscess) due to regurgitation or vomiting; or inability to speak clearly enough to be understood at times, but less than half of the time. We propose a 10-percent evaluation for any of the following: Diet restricted to liquid and soft solid foods; esophageal dilation carried out one to four times per year; heartburn (pyrosis) requiring continous treatment with prescription and at least one of the following other symptoms: Retrosternal chest pain, difficulty swallowing (dysphagia), or pain during swallowing (odynophagia); partial tongue loss; or impaired articulation for some words, but speech understandable.

We also propose to add a note directing raters to separately evaluate mouth and lip injuries under diagnostic code 7800 (Burn scar(s) of the head, face, or neck; scar(s) of the head, face, or neck due to other causes; or other disfigurement of the head, face, or neck), if applicable, and to combine this with an evaluation under this general rating formula, under the provisions of § 4.25.

The proposed general rating formula for these conditions is broad enough to encompass any degree of severity of the major types of impairment from any of these conditions, and from combined injuries of more than one of these structures. It also provides more objective criteria than the current schedule because it excludes subjective descriptors like ''marked'' and more sharply defines the extent of speech impairment and dietary limitations required for various evaluations. Evaluations should, therefore, be more consistent. Although our consultants used subjective terms such as ''moderate'' and ''severe'' in their recommended criteria, we are proposing to exclude such terms whenever possible throughout the revision of the

rating schedule, for the sake of promoting consistent evaluations. Our consultants also included the nebulous phrase ''interfering with normal daily functioning,'' which could be subject to different interpretations by different people, and we do not propose to use this language. However, the criteria are otherwise substantially the same as those our consultants recommended.

Salivary Gland Disease (Diagnostic Code 7207)

Since there is no current diagnostic code under which salivary gland disease can be appropriately evaluated, and it is a common enough disability in veterans to require evaluation, we propose to add diagnostic code 7207, ''Salivary gland (parotid, submandibular, sublingual) disease other than neoplasm.'' We propose that there be 20-, 10-, and zero-percent evaluation levels, based on the presence of xerostomia (dry mouth) and its effects, chronic inflammation or swelling of a salivary gland, salivary gland calculi or stricture, increase in dental caries, and weight loss, because these are the major impairments that may result from salivary gland disease (''Textbook of Gastroenterology'' 225 (Tadataka Yamada, M.D., ed., 1991)).

We propose a 20-percent evaluation for xerostomia (dry mouth) with altered sensation of taste and difficulty with lubrication and mastication of food resulting in either weight loss or increase in dental caries; a 10-percent evaluation for xerostomia with altered sensation of taste and difficulty with lubrication and mastication of food, but without weight loss or increase in dental caries; chronic inflammation of a salivary gland with pain and swelling on eating; one or more salivary calculi; or a salivary gland stricture. We propose a zero-percent evaluation for either xerostomia without difficulty in mastication of food, or painless swelling of the salivary gland. We are proposing a zero-percent evaluation level in order to make it clear that these findings warrant a zero-, rather than a ten-percent evaluation when it might otherwise be unclear to the rater.

We also propose to provide note (1) directing that facial nerve (cranial nerve VII) impairment, which may result from parotid gland disease or its treatment, be evaluated under diagnostic code 8207 (cranial nerve VII) and that any disfigurement due to facial swelling be evaluated under diagnostic code (Burn scar(s) of the head, face, or neck; scar(s) of the head, face, or neck due to other causes; or other disfigurement of the head, face, or neck). We propose to add note (2) to explain what Sjogren's syndrome is and how it should be evaluated. It is an autoimmune disorder that causes xerostomia (dry mouth) and keratoconjunctivitis sicca (dry eyes) and may affect other parts of the body. The note directs that the effects of xerostomia (dry mouth) due to Sjogren's syndrome be evaluated under diagnostic code 7207, keratoconjunctivitis sicca under the portion of the rating schedule that addresses Organs of Special Sense, and other effects of the syndrome, if any, on other body parts under appropriate diagnostic codes in other sections of the rating schedule.

Peritoneal Adhesions (Diagnostic Code 7301)

Peritoneal adhesions, diagnostic code 7301, are currently evaluated at levels of 50, 30, 10, or zero percent. A 50-percent evaluation is assigned if adhesions are severe, with ''definite partial obstruction shown by X-ray, with frequent and prolonged episodes of severe colic distention, nausea or vomiting, following severe peritonitis, ruptured appendix, perforated ulcer, or operation with drainage.'' A 30-percent evaluation is assigned if adhesions are moderately severe, with ''partial obstruction manifested by delayed motility of barium meal and less frequent and less prolonged episodes of pain.'' A 10-percent evaluation is assigned if adhesions are moderate, with ''pulling pain on attempting work or aggravated by movements of the body, or occasional episodes of colic pain, nausea, constipation (perhaps alternating with diarrhea) or abdominal distention.'' A zero-percent evaluation is assigned if adhesions are ''mild.'' Subjective adjectives such as ''mild,'' ''moderate,'' ''moderately severe,'' and ''severe'' are used at each level.

We propose to provide evaluation levels of 60, 30, or 10 percent for peritoneal adhesions, based primarily on the number of episodes of partial intestinal obstruction with typical symptoms, which may include, but are not limited to colicky abdominal pain, abdominal distention, borborygmi (audible rumbling bowel sounds), nausea, vomiting, and obstipation (severe constipation) (Yamada, 719). X-ray confirmation of a partial bowel obstruction would be required for any level of evaluation.

We propose a 60-percent evaluation for six or more episodes per year of partial obstruction of the bowel (confirmed by X-ray), with typical signs and symptoms (which may include, but are not limited to colicky abdominal pain, abdominal distention, borborygmi (audible rumbling bowel sounds), nausea, vomiting, and obstipation) (severe constipation)); a 30-percent evaluation for three to five episodes per year of partial obstruction of the bowel, with typical signs and symptoms; and a 10-percent evaluation for either of the following: One or two episodes per year of partial obstruction of the bowel, with typical signs and symptoms, or, in the absence of such episodes, pulling pain on body movement, if not attributable to another condition.

These criteria are in general agreement with those recommended by our consultants, but they exclude subjective terms such as ''frequent,'' ''occasional,'' and ''severe'' that the consultants suggested, in favor of more objective criteria in order to promote consistent evaluations.

A current note following diagnostic code 7301 states that ratings for adhesions will be considered when there is a history of operative or other traumatic or infectious (intraabdominal) process and at least two of the following: Disturbance of motility, actual partial obstruction, reflex disturbances, or presence of pain. We propose to revise this note to state that evaluation under diagnostic code 7301 requires a history of abdominal or pelvic surgery, infection, irradiation, trauma, or other known etiology for peritoneal adhesions. We propose to add a second note listing the typical signs and symptoms of partial bowel obstruction, for purposes of evaluation under diagnostic code 7301. This would simplify the evaluation criteria by eliminating the need to repeat the list of symptoms at each level. Our consultants recommended that we provide a note similar to the current note, with both causes and symptoms of adhesions listed, and we have basically done this, but divided the material into two notes, for the sake of clarity.

General Rating Formula for Ulcer Disease (Diagnostic Codes 7304–7306)

There are currently three diagnostic codes for ulcers: diagnostic code 7304 for gastric ulcers, diagnostic code 7305 for duodenal ulcers, and diagnostic code 7306 for marginal (gastrojejunal) ulcers. No specific evaluation criteria are provided for gastric ulcers, but they are ordinarily rated under the criteria for duodenal ulcers. Duodenal ulcers are currently evaluated at levels of 60, 40, 20, or 10 percent. A 60-percent evaluation is assigned if the condition is severe, with pain only partially relieved by ulcer therapy, and there is periodic vomiting, recurrent hematemesis or melena, with manifestations of anemia and weight loss, productive of definite impairment of health. A 40-percent evaluation is assigned if the condition is moderately severe, meaning that it is

less than severe but with impairment of health manifested by anemia and weight loss, or that there are recurrent incapacitating episodes averaging 10 days or more in duration at least four or more times a year. A 20-percent evaluation is assigned if the condition is moderate, with recurring episodes of severe symptoms two or three times a year averaging 10 days in duration, or with continuous moderate manifestations. A 10-percent evaluation is assigned if the condition is mild, with recurring symptoms once or twice yearly.

Marginal ulcers are currently evaluated under a separate set of criteria that are similar to those for duodenal ulcer, except that there is also a 100-percent evaluation level, to be assigned if the condition is pronounced, with periodic or continuous pain unrelieved by standard ulcer therapy with periodic vomiting, recurring melena or hematemesis, and weight loss, and the condition is totally incapacitating. A 60-percent evaluation is assigned if the condition is severe, with symptoms of the same type as pronounced but less pronounced and less continuous, with definite impairment of health. A 40-percent evaluation is assigned if the condition is moderately severe, with intercurrent episodes of abdominal pain at least once a month partially or completely relieved by ulcer therapy, or there are mild and transient episodes of vomiting or melena. A 20-percent evaluation is assigned if the condition is moderate, with episodes of recurring symptoms several times a year. A 10-percent evaluation is assigned if the condition is mild, with brief episodes of recurring symptoms once or twice yearly. Both sets of criteria for rating ulcer disease use subjective adjectives such as ''mild,'' ''moderate,'' and ''pronounced'' throughout the formulas.

Our consultants pointed out that while ulcers may vary in location, they produce the same array of symptoms, and do not differ in functional impairment. They suggested that all types of ulcers be evaluated under the same criteria: the presence of symptoms and their response or lack of response to treatment, the extent of incapacitating or recurring episodes, and whether there is recurrent hematemesis (vomiting blood) or melena, anemia, or weight loss. We propose to adopt, with some modifications, their recommendations regarding bases of evaluations and to evaluate all types of ulcer disease under the same criteria. We propose to provide a single rating formula for gastric ulcer (diagnostic code 7304), duodenal ulcer (diagnostic code 7305), and marginal (gastrojejunal) ulcer (diagnostic code 7306), based on the recommended criteria. We also propose to change the title of diagnostic code 7305 to ''duodenal ulcer or duodenitis'' in order to include duodenitis under this code, because these conditions commonly occur together and result in similar findings. We propose to provide evaluation levels of 100, 60, 30, and 10 percent. Our consultants suggested 60 percent as the highest level of evaluation, but, because our experience has shown that a number of veterans are totally disabled by severe ulcer disease, we propose to add a 100-percent level. These levels also differ from the current schedule by substituting a 30-percent level for the current 20- and 40-percent levels. This change will provide a clearer distinction between the 10-percent level and the next higher level (which we propose to be 30 percent instead of 20 percent), a factor that will promote more consistent evaluations, and will still be sufficient to accommodate the range of severity of ulcer disease.

We propose a 100-percent evaluation for either substantial weight loss, malnutrition, and anemia due to gastrointestinal bleeding; or for hospitalization three or more times per year for vomiting, refractory pain, gastrointestinal bleeding, perforation, obstruction, or penetration to liver, pancreas, or colon. We propose a 60-percent evaluation for either periodic or constant dyspepsia with substantial weight loss and anemia due to ulcer disease; or for hospitalization two times per year for vomiting, refractory pain, gastrointestinal bleeding, perforation, obstruction, or penetration to liver, pancreas, or colon. We propose a 30-percent evaluation for either periodic or constant dyspepsia with at least minor weight loss; or for hospitalization once per year for vomiting, refractory pain, gastrointestinal bleeding, perforation, obstruction, or penetration to liver, pancreas, or colon. We propose a 10-percent evaluation for recurring dyspepsia that requires continuous treatment with prescription medication for control.

We also propose to add a note under the general rating formula for ulcer disease stating that the diagnosis of ulcer disease or duodenitis requires confirmation on at least one occasion by imaging or endoscopy. Because the symptoms of ulcer disease are not specific, the note would assure that the diagnosis of ulcer disease is not based on symptoms alone.

Chronic Gastritis (Diagnostic Code 7307)

We propose to revise the title of diagnostic code 7307 from the current ''gastritis, hypertrophic (identified by gastroscope)'' to ''chronic gastritis (including but not limited to erosive, hypertrophic, hemorrhagic, bile reflux, alcoholic, and drug-induced gastritis)'' to indicate that there are several types of gastritis that may be evaluated under this code.

Gastritis is an inflammation of the gastric (stomach) mucosa. Common causes include Helicobacter pylori infection, non-steroidal anti-inflammatory drugs, alcohol, stress, and autoimmune phenomena (atrophic gastritis) (Merck, 117). While chronic gastritis is often asymptomatic (symptom-free), it may cause dyspepsia and sometimes gastro-intestinal bleeding with resulting anemia. A rare type of gastritis results in protein-losing gastropathy (disease of the stomach), in which hypoalbuminia (low albumin level in blood), diarrhea, weight loss, and edema may occur. Gastritis is currently evaluated at 60, 30, or 10 percent, with a 60-percent evaluation assigned when the condition is chronic, with severe hemorrhages or large ulcerated or eroded areas; a 30-percent evaluation when the condition is chronic, ''with multiple small eroded or ulcerated areas, and symptoms;'' and a 10-percent evaluation when the condition is chronic, ''with small nodular lesions, and symptoms.'' We propose to continue these evaluation levels, but to provide different criteria, based more on objective clinical findings, which are common indicators of disability, than on the pathologic appearance of the gastric mucosa.

We propose a 60-percent evaluation for any of the following: Periodic or continuous dyspepsia with anemia due to gastrointestinal bleeding; protein-losing gastropathy with substantial weight loss and peripheral edema; or hospitalization two or more times per year for gastrointestinal bleeding, intractable vomiting, or other complication of chronic gastritis. We propose a 30-percent evaluation for either of the following: Protein-losing gastropathy with at least minor weight loss, or hospitalization once per year for gastrointestinal bleeding, intractable vomiting, or other complication of chronic gastritis. We propose a 10-percent evaluation for dyspepsia that requires continuous treatment with prescription medication.

These proposed criteria are similar to those recommended by our consultants, but have been modified to remove

subjective terms, and for the sake of internal consistency. In order to document that gastritis, which is often hard to diagnose, is definitely present, we also propose to add a note stating that evaluation under diagnostic code 7307 requires that the diagnosis of chronic gastritis be confirmed on at least one occasion by endoscopy. The condition of ''gastritis, atrophic'' is listed in the current schedule at the end of the criteria for hypertrophic gastritis. It is followed by a statement that this is ''a complication of a number of diseases, including pernicious anemia,'' and a direction to rate the underlying condition. We propose to include this information in a second note under diagnostic code 7307, to provide clear guidance to the raters on how to evaluate atrophic gastritis.

Postgastrectomy Syndromes (Diagnostic Code 7308)

Postgastrectomy syndromes (diagnostic code 7308) are currently evaluated at levels of 60, 40, or 20 percent, based on frequency of episodes of symptoms. A 60-percent evaluation is assigned when the condition is severe, meaning that it is associated with nausea, sweating, circulatory disturbance after meals, diarrhea, hypoglycemic symptoms, and weight loss with malnutrition and anemia; a 40-percent evaluation when the condition is moderate, with less frequent episodes of epigastric disorders with characteristic mild circulatory symptoms after meals but with diarrhea and weight loss; and a 20-percent evaluation when the condition is mild, with infrequent episodes of epigastric distress with characteristic mild circulatory symptoms or continuous mild manifestations.

We propose to base evaluations of postgastrectomy syndromes on more objective criteria, such as the frequency of dumping syndrome (which is the common term for the group of symptoms that may occur following various types of surgery for ulcer disease), whether there is weight loss, malnutrition or anemia, and whether a restricted diet is needed. For the sake of simplicity, we propose to list the possible signs and symptoms of postgastrectomy syndromes in a note rather than listing all possible manifestations at every evaluation level.

Several types of problems may occur after gastrectomy, with the onset, frequency, and types of symptoms varying with the particular type of surgery performed (Merck, 123). One problem is the dumping syndrome. There are two types of dumping syndrome, an early type that occurs within 30 minutes of eating, and a late type that occurs 90 minutes to 3 hours after eating (''Harrison's Principles of Internal Medicine'' 1240 (Jean D. Wilson, M.D. *et al.* eds., 12th ed. 1991)). Although early and late types have different causes, their symptoms overlap. Rather than experiencing a dumping syndrome, some individuals experience only severe diarrhea as a major postgastrectomy problem. Others experience abdominal pain, bilious vomiting (vomiting of bile), anemia, and weight loss due to a condition called alkaline reflux gastritis (also called biliary gastritis or bile reflux gastritis); and some individuals have malabsorption and poor absorption of vitamins and minerals resulting in malnutrition and anemia as their most significant problems (Yamada, 1394).

Since the signs and symptoms of these postgastrectomy syndromes overlap, and ''dumping syndrome'' is the commonly used designation for postgastrectomy signs and symptoms, we propose to lump the various postgastrectomy syndromes together as ''dumping syndrome'' and to add a note under diagnostic code 7308 stating that for purposes of evaluation under diagnostic code 7308, the term ''dumping syndrome'' includes symptoms that are associated with any of the following postgastrectomy syndromes: Early and late types of dumping syndrome, postgastrectomy diarrhea, and alkaline reflux gastritis. These symptoms include any combination of weakness, dizziness, lightheadedness, diaphoresis (sweating), palpitations, tachycardia, postural hypotension, confusion, syncope (fainting), nausea, vomiting (often with bile), diarrhea, steatorrhea (fatty stools), borborygmi (audible rumbling bowel sounds), abdominal pain, anorexia (lack or loss of appetite), abdominal bloating, and belching. In order to include both types of postgastrectomy dumping syndromes, we also propose to state, in the same note, that symptoms may occur immediately after eating or up to three hours later.

We propose to provide evaluation levels of 100, 60, 30, and 10 percent, instead of the current 60, 40, and 20 percent. Our consultants suggested that we add a 100-percent evaluation level, since postgastrectomy syndromes may be severely disabling, and we propose to do so. As with gastritis, to promote consistent evaluations, we propose to substitute a 30-percent evaluation level for the 20- and 40-percent levels to provide a clearer distinction between adjacent levels. We also propose to add a 10-percent evaluation level for milder cases of dumping syndrome. We propose a 100-percent evaluation for dumping syndrome that occurs after most meals, with substantial weight loss, malnutrition, and anemia. We propose a 60-percent evaluation for dumping syndrome that occurs after most meals, with substantial weight loss and anemia. We propose a 30-percent evaluation for dumping syndrome that occurs daily or nearly so, despite treatment, with at least minor weight loss. We propose a 10-percent evaluation for intermittent dumping syndrome (occurring at least three times a week) requiring dietary restrictions.

Our consultants suggested criteria that retain the same subjective terms of ''infrequent,'' ''mild,'' and ''less frequent,'' as the current schedule. For example, our consultants recommended that a 20-percent evaluation be assigned for post-gastrectomy syndrome that is ''mild'' with ''infrequent'' episodes of epigastric distress with ''characteristic mild'' circulatory symptoms or continuous ''mild'' manifestations. We propose to use more specific terms such as ''after most meals'' and ''daily or nearly so,'' since making the criteria less ambiguous is one of the goals of the revision of the rating schedule. In order to make the criteria clear to everyone who uses the rating schedule, we propose to list the actual symptoms (many of which overlap) of hypoglycemia and circulatory disturbance in the note defining dumping syndrome, rather than use less clear terms such as ''hypoglycemic symptoms'' or ''circulatory symptoms,'' as the consultants suggested. We also propose a second note to direct raters to separately evaluate complications, such as osteomalacia, under an appropriate diagnostic code.

Gastric Emptying Disorders (Diagnostic Code 7309)

Diagnostic code 7309 is currently titled ''stomach, stenosis of'' and includes an instruction to ''[r]ate as for gastric ulcer'' (diagnostic code 7304), which in turn is usually rated as duodenal ulcer (diagnostic code 7305). We propose to make diagnostic code 7309 more inclusive by changing the title to ''gastric emptying disorders (including gastroparesis (delayed gastric emptying), and pyloric, gastric, and other motility disturbances)'' because all of these conditions, which are not uncommon and are not currently listed in the current rating schedule, may produce similar signs and symptoms.

We propose to provide evaluation levels of 100, 60, 30, and 10 percent for diagnostic code 7309. As our consultants pointed out, these conditions can be very debilitating. We

propose to base the evaluation on criteria specific to gastric emptying disorders—epigastric pain or fullness, anorexia (lack or loss of appetite), nausea, vomiting, gastroesophageal reflux, early satiety (feeling that hunger and thirst are satisfied), and abdominal bloating (Yamada, 1264). We propose to add a note listing the signs and symptoms of gastric emptying disorders, for purposes of evaluation under diagnostic code 7309.

We propose a 100-percent evaluation for daily or near-daily signs and symptoms with substantial weight loss and malnutrition. We propose a 60-percent evaluation for periodic or daily or near-daily signs and symptoms with substantial weight loss. We propose a 30-percent evaluation for periodic signs and symptoms with minor weight loss. We propose a 10-percent evaluation for periodic signs and symptoms without weight loss, but requiring continuous treatment with prescription medication. These criteria are specific to the disability and are clearer and more objective than those proposed by our consultants. While the consultants used similar symptoms, they also included modifiers like ''pronounced,'' ''severe,'' and ''moderate,'' which are subjective terms that we are trying to exclude from the rating schedule when possible, for the sake of consistent evaluations.

Injury of the Stomach (Diagnostic Code 7310)

Injury of the stomach, diagnostic code 7310, is currently evaluated under the criteria for peritoneal adhesions (diagnostic code 7301). We propose to retain that direction and to add an alternative direction, as recommended by our consultants, to evaluate as postgastrectomy syndromes (diagnostic code 7308) if the injury required a gastric resection.

Liver Disease

In a separate rulemaking, we previously revised the portion of § 4.114 that addresses liver disease, including injury of the liver (diagnostic code 7311), cirrhosis of the liver (diagnostic code 7312), deletion of residuals of abscess of liver (diagnostic code 7313), infectious hepatitis (diagnostic code 7345), benign new growths of the digestive system (7344), and malignant new growths of the digestive system, exclusive of skin growths (diagnostic code 7343). Following notice and comment, this rulemaking was published as a final rule on May 31, 2001 (66 FR 29486). We do not propose any further changes to those diagnostic codes.

Biliary Tract Disease or Injury (Diagnostic Code 7314)

Diagnostic code 7314 is currently titled ''cholecystitis, chronic'' and has evaluation levels of 30, 10, and zero percent. A 30-percent evaluation is assigned if the condition is severe, with frequent attacks of gall bladder colic; a 10-percent evaluation if the condition is moderate, with gall bladder dyspepsia, confirmed by X-ray technique, and with infrequent attacks (not over two or three a year) of gall bladder colic, with or without jaundice; and a zero-percent evaluation if the condition is mild.

Chronic cholelithiasis (diagnostic code 7315) and chronic cholangitis (diagnostic code 7316) are evaluated under the same criteria as chronic cholecystitis. All of these conditions are closely related and may co-exist, and can readily be evaluated under a single diagnostic code and set of evaluation criteria. In addition, diagnostic code 7318, ''Gall bladder, removal of,'' can result in signs and symptoms similar to those of the above three conditions. It is currently evaluated at 30, 10, or zero percent, under subjectively-defined criteria. A 30-percent evaluation is assigned if there are ''severe symptoms,'' a 10-percent evaluation if there are ''mild symptoms,'' and a zero-percent evaluation if the condition is nonsymptomatic. ''Gall bladder, injury of'' (diagnostic code 7317) is currently rated as peritoneal adhesions.

We, therefore, propose to revise the title of diagnostic code 7314 to the more inclusive ''Biliary tract disease or injury (chronic cholecystitis, cholelithiasis, choledocholithiasis, chronic cholangitis, status post-cholecystectomy, gall bladder or bile duct injury, biliary dyskinesia, cholesterolosis, polyps of gall bladder, sclerosing cholangitis, stricture or infection of the bile ducts, choledochal cyst)'' because all of these conditions are related and may produce similar effects. It is therefore appropriate to evaluate them under the same criteria. It is not uncommon for more than one of these conditions to be present at the same time, and using a single set of criteria would better allow an appropriate overall evaluation in those cases, since the signs and symptoms overlap and may be identical. Our consultants did not suggest combining these conditions under a single diagnostic code, as we are proposing, but did suggest evaluating them under the same criteria. The evaluation criteria we are proposing are similar to those they suggested, but would eliminate the subjective terms ''severe,'' ''moderate'' and ''mild''.

Although the current evaluation levels for these conditions are limited to 30, 10, and zero percent, we propose to provide evaluation levels of 100, 60, 30, and 10 percent for biliary tract disease or injury, to accommodate more severe cases, including those that are totally disabling. We propose to base evaluations on the frequency of acute attacks of signs and symptoms of biliary tract disease or injury per year; the frequency of hospitalizations for biliary tract disease or injury per year; the response to medical or surgical treatment; and whether liver failure is present. We propose to describe the usual signs and symptoms of biliary tract disease and injury in a note, as discussed below.

We propose a 100-percent evaluation for any of the following: Near-constant debilitating attacks of biliary tract disease or injury that are refractory to medical or surgical treatment; liver failure; or hospitalization three or more times per year for biliary tract disease or injury. We propose a 60-percent evaluation for either of the following: Six or more attacks of biliary tract disease or injury per year, partially responsive to treatment; or hospitalization two times per year for biliary tract disease or injury. We propose a 30-percent evaluation for either of the following: Three to five attacks of biliary tract disease or injury per year, or hospitalization once per year for biliary tract disease or injury. We propose a 10-percent evaluation for either of the following: One or two attacks of biliary tract disease or injury per year; or biliary tract pain occurring at least monthly, despite medical treatment. We propose to remove the zero-percent level as unnecessary (see § 4.31).

The proposed criteria would provide more objective criteria for evaluating these conditions and also provide a wider range of percentage evaluations, consistent with the potential disabling effects of these conditions.

We propose to add four notes under diagnostic code 7314, with the first stating that for purposes of evaluation under diagnostic code 7314, attacks of biliary tract disease or injury include any combination of such signs and symptoms as abdominal pain (including biliary colic), dyspepsia, jaundice, anorexia (lack or loss of appetite), nausea, vomiting, chills, and fever (Merck, 242–245). So that the presence of biliary tract disease is substantiated, and not based on symptoms alone, the second proposed note would state that evaluation under diagnostic code 7314 requires that the diagnosis of any of these conditions be confirmed by X-ray

or other imaging procedure, laboratory findings, or other objective evidence. The third proposed note would direct raters to separately evaluate peritoneal adhesions (diagnostic code 7301) if applicable, and combine (under the provisions of § 4.25) with an evaluation under diagnostic code 7314, as long as the same findings are not used to support more than one evaluation. This would assure that traumatic or postoperative manifestations due to adhesions would be properly evaluated. The fourth proposed note would direct raters to evaluate the cirrhotic phase of sclerosing cholangitis under diagnostic code 7312 (cirrhosis of liver), a more appropriate diagnostic code for evaluating that condition than 7314.

Since chronic cholelithiasis (current diagnostic code 7315), chronic cholangitis (current diagnostic code 7316), injury of gall bladder (current diagnostic code 7317), and removal of gall bladder (current diagnostic code 7318) would all be included in diagnostic code 7314, for reasons discussed above, we propose to delete the separate diagnostic codes for those conditions.

Disease or Injury of the Spleen

There is currently a reference to disease or injury of the spleen under diagnostic code 7318, directing raters to the hemic and lymphatic systems. We propose to remove that reference as unnecessary, since the spleen, although in the abdominal cavity, is part of the lymphatic, not the digestive system. Evaluation criteria for splenectomy (diagnostic code 7706) and healed injury of the spleen (diagnostic code 7707) are included in the hemic and lymphatic portion of the rating schedule (38 CFR 4.117), and both conditions are listed in the index to the rating schedule as part of the hemic and lymphatic systems.

Irritable Bowel Syndrome (Diagnostic Code 7319)

Diagnostic code 7319 is currently titled ''Irritable colon syndrome (spastic colitis, mucous colitis, *etc.*).'' We propose to retitle it ''Irritable bowel syndrome (irritable colon, spastic colitis, mucous colitis),'' since this is current terminology for the condition. The current evaluation levels are 30, 10, and zero percent. A 30-percent evaluation is assigned if the condition is severe, with diarrhea or alternating diarrhea and constipation, with more or less constant abdominal distress. A 10-percent evaluation is assigned if the condition is moderate, with frequent episodes of bowel disturbance with abdominal distress. A zero-percent evaluation is assigned if the condition is mild, with ''disturbances of bowel function with occasional episodes of abdominal distress.'' Our consultants suggested evaluation levels of 30 and 10 percent, with essentially the same criteria as the current ones, except for adding ''refractory to medical treatment'' to the criteria for 30 percent, and ''partially responsive to treatment'' to the criteria for 10 percent. We are proposing to remove the subjective terms ''severe,'' ''frequent,'' ''occasional,'' *etc.,* from the criteria and to base evaluation on more objective criteria, in order to decrease the reliance on ambiguous descriptive terms. We propose a 30-percent evaluation for daily or near-daily disturbances of bowel function (diarrhea, or alternating diarrhea and constipation), bloating, and abdominal cramping or pain, refractory to medical treatment, and a 10-percent evaluation for disturbances of bowel function (diarrhea, or alternating diarrhea and constipation), bloating, and abdominal cramping or pain that occur three or more times a month and that respond partially to medical treatment. We propose to remove the zero-percent level as unnecessary (see § 4.31). These proposed criteria would ensure consistency of evaluations and still be in keeping with our consultants' recommendations.

Amebiasis and Bacillary Dysentery

In the current rating schedule, diagnostic code 7321 is amebiasis, and diagnostic code 7322 is bacillary dysentery. Both conditions are uncommon today except as acute short-term illnesses. They ordinarily resolve without residuals because they are highly responsive to modern drug treatment. In accordance with our consultants' suggestion, we therefore propose to delete diagnostic code 7321 and diagnostic code 7322 as unnecessary.

Ulcerative Colitis (Diagnostic Code 7323)

Ulcerative colitis (diagnostic code 7323) is currently evaluated at 100, 60 30, or 10 percent. A 100-percent evaluation is assigned if the condition is pronounced, resulting in marked malnutrition, anemia, and general debility, or if there are serious complications, such as liver abscess. A 60-percent evaluation is assigned if the condition is severe, with numerous attacks a year and malnutrition, with the health only fair during remissions. A 30-percent evaluation is assigned if the condition is moderately severe, with frequent exacerbations; and a 10-percent evaluation is assigned if the condition is moderate, with infrequent exacerbations.

The most common symptoms of ulcerative colitis are abdominal pain and bloody diarrhea, but there may also be rectal pain, fever, tachycardia, anorexia, malaise, weakness, and other symptoms. In severe cases, there may be weight loss, malnutrition, anemia, and hypoalbuminemia. Common complications include perforation, stricture, hemorrhage, dehydration, fulminant (sudden and intense) colitis, and toxic megacolon (a severe distention of the colon that can be life threatening). Among other possible complications are liver disease, skin nodules, eye problems, colon cancer, and arthritis (Merck, 155–156 and *http://digestive.niddk.nih.gov/ddiseases/pubs/colitis/index.htm#symptoms,* National Digestive Diseases Information Clearinghouse, February 2006).

Our consultants suggested we continue evaluations based on frequency of episodes, attacks, and exacerbations, and they provided some timeframes for their frequency and duration. We propose to use their suggestions, in a modified form, removing the subjective language such as ''severe'' and ''marked'' that they included. We also further propose to specify the usual symptoms of ulcerative colitis in the criteria, with bloody diarrhea being the major symptom, and to include criteria based on the need for hospitalization for complications or continuous treatment with prescription medication. We propose a 100-percent evaluation for either of the following: malnutrition, substantial weight loss, anemia, and general debility with multiple attacks of colitis per year, with bloody diarrhea, abdominal or rectal pain, fever, and malaise; or hospitalization three or more times per year for complications such as hemorrhage, dehydration, obstruction, fulminant (sudden and intense) colitis, toxic megacolon, or perforation.

We propose a 60-percent evaluation for either of the following: substantial weight loss and anemia, with multiple attacks of colitis per year, with bloody diarrhea, abdominal or rectal pain, fever, and malaise; or hospitalization two times per year for complications such as hemorrhage, dehydration, obstruction, fulminant colitis, toxic megacolon, or perforation. We propose a 30-percent evaluation for either of the following: three or more attacks of colitis (each lasting 5 or more days) per year, with diarrhea with blood, pus, or mucous, and abdominal or rectal pain; or hospitalization one time per year for

complications such as hemorrhage, dehydration, obstruction, fulminant colitis, toxic megacolon, or perforation. We propose a 10-percent evaluation for either of the following: One or two attacks of colitis (each lasting 5 or more days) per year with diarrhea with blood, pus, or mucous, and abdominal or rectal pain; or continuous treatment with prescription medication either to control symptoms or to maintain remission.

We also propose to add a note directing raters to evaluate other complications, such as uveitis, ankylosing spondylitis, sclerosing cholangitis, *etc.,* separately under an appropriate diagnostic code. We propose to add a second note directing raters, if there has been a colon resection, to evaluate under diagnostic codes 7350 (colostomy or ileostomy) and 7329 (resection of large intestine), as applicable, and to combine the evaluations under the provisions of § 4.25, as long as the same findings are not used to support more than one evaluation.

Intestinal Parasitic Infections (Diagnostic Code 7324)

We propose to change the title of diagnostic code 7324 from ''distomiasis, intestinal or hepatic'' to ''parasitic infections of the intestinal tract'' because our consultants advised us that distomiasis (formerly used to refer to trematodes or flukes) is a term that is no longer used. The generic term ''parasitic infections'' includes all types of parasitic infections, not just trematodes or flukes. Parasitic infections that do not primarily affect the digestive tract are evaluated in the portion of the rating schedule that addresses Infectious Diseases, Immune Disorders and Nutritional Deficiencies. The current evaluation criteria, with levels of 30, 10, and zero percent, are based on whether there are ''severe,'' ''moderate,'' or ''mild'' symptoms, with no specific guidance as to the type of symptoms.

Our consultants suggested criteria of ''severe symptoms including diarrhea, abdominal distress, and weight loss, refractory to medical treatment'' for a 30-percent evaluation and ''moderate symptoms'' for a 10-percent evaluation. While more specific than the current criteria, they retain subjective language. We propose to remove the subjective terms and base evaluation on the presence of diarrhea (which commonly means more than three loose watery stools in one day (*http://digestive.niddk.nih.gov/ddiseases/pubs/diarrhea/,* National Digestive Diseases Information Clearinghouse, October 2003)), abdominal pain, and weight loss, and on whether continuous treatment with prescription medication is required. We propose to delete the zero-percent level, since a parasitic infection that does not meet the criteria for a ten-percent evaluation would be assigned a non-compensable evaluation, and this is sufficiently clear without the need for a zero-percent evaluation level (see § 4.31).

We propose to evaluate parasitic infections of the intestinal tract at 30 percent if there is daily diarrhea (occurring more than three times per day) and abdominal pain, with at least minor weight loss. We propose to evaluate them at 10 percent if diarrhea and abdominal pain occur, and they require continuous treatment with prescription medication for control. In addition, since parasitic infection of the gastrointestinal tract may result in a malabsorption syndrome, we propose to add a note directing raters to evaluate under proposed diagnostic code 7353 (malabsorption syndrome), if malabsorption is present, and doing so would result in a higher evaluation.

Chronic Diarrhea of Unknown Etiology (Diagnostic Code 7325)

Diagnostic code 7325 is currently titled ''Enteritis, chronic'' and directs that the condition be rated as irritable colon syndrome (diagnostic code 7319). At the suggestion of our consultants, we propose to revise the title to ''chronic diarrhea of unknown etiology'' because chronic enteritis is no longer considered a specific diagnostic entity. We also propose to provide evaluation criteria specific to this condition, in accordance with the recommendation of our consultants, since those for evaluating irritable colon syndrome (which include ''alternating constipation and diarrhea'') are not appropriate for evaluating chronic diarrhea.

We propose to provide evaluation levels of 60, 30, and 10 percent (our consultants recommended levels of 60 and 30 percent) based on the frequency of watery bowel movements, their requirement for and response to medical treatment, and on the number of episodes per year of fluid and electrolyte imbalance requiring parenteral (intravenous or intramuscular) hydration. We propose a 60-percent evaluation if there are five or more watery bowel movements daily, refractory to medical treatment, and three or more episodes per year of fluid and electrolyte imbalance requiring parenteral (intravenous or intramuscular) hydration. We propose a 30-percent evaluation if there are five or more watery bowel movements daily, partially responsive to medical treatment, and one or two episodes per year of fluid and electrolyte imbalance requiring parenteral (intravenous or intramuscular) hydration. We propose a 10-percent evaluation if the condition requires continuous treatment with prescription medication for control.

These criteria for evaluating chronic diarrhea of unknown etiology are both objective and specific to the disability, and are in general agreement with the suggestions of our consultants, although they recommended that we require at least six watery bowel movements per day, instead of five or more, as we are proposing. In our judgment, five or more watery bowel movements a day constitute a sufficient indication of severity of the major disabling symptom of this condition. The consultants also recommended a 60-percent evaluation for one episode of biochemical alteration, but it is our opinion that one episode would not be sufficiently disabling to warrant a 60-percent evaluation, in comparison to other disabilities evaluated at a 60-percent level. We propose instead that there be three or more episodes of fluid and electrolyte imbalance to warrant a 60-percent evaluation, and one or two episodes to warrant a 30-percent evaluation.

Crohn's Disease (Diagnostic Code 7326)

Diagnostic code 7326 is currently titled ''Enterocolitis, chronic'' and directs that the condition be rated as irritable colon syndrome (diagnostic code 7319), with evaluation levels of 30, 10, and zero-percent, but as suggested by our consultants, we propose to change the title to ''Crohn's disease,'' the current medical term for this condition, and to provide criteria more specific to the disabling effects of this disease. Our consultants pointed out that Crohn's disease can be very disabling, and we therefore propose to provide a broader range of evaluation levels—100, 60, 30, and 10 percent—in order to encompass the whole range of disabling effects that may result from this condition. The most common signs and symptoms of Crohn's disease, which is often episodic, include diarrhea, abdominal pain and tenderness, fever, anorexia, and weight loss; also there may be pallor, weakness, malnutrition, abscesses, fistula, bowel obstruction, and other complications, as pointed out by our consultants, and as found in standard medical books (Merck, 153; Yamada, 1599).

We propose a 100-percent evaluation for either of the following: multiple attacks or flareups of Crohn's disease per year with abdominal pain or tenderness, diarrhea, fever, anorexia

(lack or loss of appetite), and fatigue plus malnutrition, substantial weight loss, hypoalbuminemia, and anemia; or hospitalization three or more times per year for complications such as abscess, stricture, obstruction, or fistula.

We propose a 60-percent evaluation for any of the following: multiple attacks or flareups of Crohn's disease per year with abdominal pain or tenderness, diarrhea, fever, anorexia (lack or loss of appetite), and fatigue plus substantial weight loss and anemia; hospitalization two times per year for recurrent complications such as abscess, stricture, obstruction, or fistula; or constant or near-constant treatment with high dose systemic (oral or parenteral [intravenous or intramuscular]) corticosteroids.

We propose a 30-percent evaluation for any of the following: three or more attacks or flareups of Crohn's disease per year with abdominal pain or tenderness, diarrhea, fever, anorexia (lack or loss of appetite), and fatigue, plus at least minor weight loss; hospitalization one time per year for complications such as abscess, stricture, obstruction, or fistula; or three or more (but not constant) courses of treatment per year with high dose systemic (oral or parenteral [intravenous or intramuscular]) corticosteroids.

We propose a 10-percent evaluation for any of the following: One or two attacks or flareups of Crohn's disease per year with abdominal pain or tenderness, diarrhea, and fever; one or two courses of treatment per year with high dose systemic (oral or parenteral [intravenous or intramuscular]) corticosteroids; or continuous treatment with prescription medication other than high dose systemic (oral or parenteral [intravenous or intramuscular]) corticosteroids.

These criteria are more specific to Crohn's disease than those in the current rating schedule, and represent modifications of the criteria suggested by our consultants (for example, to remove subjective language). They would provide a clear and objective basis for evaluation, as well as a suitable range of evaluation levels.

We also propose to add a note directing raters to evaluate complications, such as external gastrointestinal fistula, arthritis, episcleritis (inflammation of the outer layers of the sclera of the eye), *etc.,* separately under an appropriate diagnostic code as long as the same findings are not used to support more than one evaluation (see § 4.14). We propose to add a second note, because bowel surgery is often needed, directing raters to evaluate under diagnostic code 7350 (colostomy or ileostomy) if an ostomy is present, and under diagnostic code 7328 (resection of the small intestine) or 7329 (resection of large intestine), if applicable, as long as the same findings are not used to support more than one evaluation.

Diverticulitis (Diagnostic Code 7327)

The current rating schedule does not provide specific criteria for diverticulitis, diagnostic code 7327, but directs that it be evaluated as either irritable colon syndrome (diagnostic code 7319), peritoneal adhesions (diagnostic code 7301), or ulcerative colitis (diagnostic code 7323), depending on the predominant disability picture. We propose to provide evaluation criteria specific to this condition, with evaluation levels of 100, 60, 30, and 10 percent, to reflect its range of severity. The most common signs and symptoms of diverticulitis are abdominal pain and tenderness, fever, and an elevated white blood count (Merck, 160; Yamada, 1737). There may also be peritoneal irritation, with or without bleeding; irregular defecation; and such complications as fistula formation, intestinal obstruction, abscess formation, or perforation. Milder attacks can be treated with antibiotics, bed rest, and a liquid diet as an outpatient, but more serious attacks may require hospitalization for intravenous antibiotics and other measures, and, sometimes, surgery.

We therefore propose a 100-percent evaluation for either of the following: near-constant signs and symptoms of diverticulitis, with abdominal pain and tenderness, fever, and irregular defecation (constipation, diarrhea, or alternating constipation and diarrhea); or hospitalization at least three times per year for complications such as abscess, perforation, obstruction, or fistula.

We propose a 60-percent evaluation for any of the following: six or more attacks of diverticulitis per year with abdominal pain and tenderness, fever, and irregular defecation (constipation, diarrhea, or alternating constipation and diarrhea), requiring outpatient treatment with a course of antibiotics, bed rest, and a liquid diet; hospitalization two times per year for complications such as abscess, perforation, obstruction, or fistula; or hospitalization three or more times per year for acute diverticulitis requiring intravenous antibiotics.

We propose a 30-percent evaluation for any of the following: three to five attacks of diverticulitis per year with abdominal pain and tenderness, fever, and irregular defecation (constipation, diarrhea, or alternating constipation and diarrhea), requiring outpatient treatment with a course of antibiotics, bed rest, and a liquid diet; hospitalization one time per year for complications such as abscess, perforation, obstruction, or fistula; or hospitalization once or twice per year for acute diverticulitis requiring intravenous antibiotics.

We propose a 10-percent evaluation for the following: One or two attacks of diverticulitis per year with abdominal pain and tenderness, fever, and irregular defecation (constipation, diarrhea, or alternating constipation and diarrhea), requiring a course of antibiotics.

We also propose to add a note to address evaluation after surgery, which is often needed to treat diverticulitis. The note would direct raters to evaluate under diagnostic code 7350 (colostomy or ileostomy) if an ostomy is present, and under diagnostic code 7329 (resection of large intestine), if applicable, as long as the same findings are not used to support more than one evaluation (see § 4.14).

These criteria are similar to those suggested by our consultants, but modified, to remove indefinite terms such as ''severe,'' ''moderate,'' and ''frequent,'' and to substitute criteria that are both more specific and more objective, in order to promote consistent evaluations.

Resection of Small Intestine (Diagnostic Code 7328)

Resection of the small intestine, diagnostic code 7328, currently has evaluation levels of 60, 40 and 20 percent, with criteria for the various levels based on the extent of interference with absorption and nutrition, the degree of impairment of health with either weight loss or inability to gain weight, and whether there are symptoms. A 60-percent evaluation is assigned if the condition shows marked interference with absorption and nutrition, manifested by severe impairment of health objectively supported by examination findings including material weight loss; a 40-percent evaluation if the condition produces definite interference with absorption and nutrition, manifested by impairment of health objectively supported by examination findings, including definite weight loss; and a 20-percent evaluation if the condition is symptomatic, with diarrhea, anemia, and inability to gain weight. These criteria contain indefinite criteria, such as ''material'' or ''definite'' weight loss and ''marked'' or ''definite'' interference with absorption. In addition, our consultants advised us that the current criteria, based partly on weight loss or inability to gain weight, are no longer

appropriate because the parenteral (intravenous or intramuscular) and supplemental nutrition now available will ordinarily allow body weight to be maintained. They pointed out that the type and frequency of nutritional support needed is related to the severity of the condition.

We therefore propose to provide evaluation criteria that are both more objective and more characteristic of the disabling effects of resection of the small intestine than the current criteria, in light of modern medicine. We propose that the condition be evaluated based on the need for oral or parenteral (intravenous or intramuscular) nutritional support and on the presence of diarrhea and other symptoms. Our consultants said that the need for total parenteral (intravenous or intramuscular) nutrition indicates a debilitating condition that would be totally disabling. We therefore propose a 100-percent evaluation if total parenteral (intravenous or intramuscular) nutrition is required. We propose a 60-percent evaluation for diarrhea, weakness, fatigue, abdominal cramps, and bloating, with anemia, requiring daily (oral) nutritional supplementation, plus parenteral (intravenous or intramuscular) nutrition for a total of at least 28 days per year; a 30-percent evaluation for diarrhea, weakness, fatigue, abdominal cramps, and bloating requiring daily (oral) nutritional supplementation plus parenteral (intravenous or intramuscular) nutrition for a total of at least 14 days, but less than 28 days per year; and a 10-percent evaluation for diarrhea, weakness, fatigue, abdominal cramps, and bloating requiring daily (oral) nutritional supplementation.

We propose to modify the current note under diagnostic code 7328. It now directs that the condition be rated under diagnostic code 7301, where residual adhesions constitute the predominant disability. We propose that the note instruct raters to separately evaluate peritoneal adhesions, diagnostic code 7301, if applicable, as long as the same findings are not used to support an evaluation both under diagnostic code 7301 and under diagnostic code 7328.

Resection of Large Intestine (Diagnostic Code 7329)

Resection of the large intestine, diagnostic code 7329, currently has evaluation levels of 40, 20, and 10 percent, based on the indefinite criteria of whether symptoms are ''severe'' and ''objectively supported by examination findings'' (for 40 percent), ''moderate'' (for 20 percent), or ''slight'' (for 10 percent). We propose to remove these subjective terms and provide more objective criteria based on the primary symptoms of diarrhea and abdominal pain and the number of complications, as recommended by our consultants. We propose that there be a broader range of evaluation levels, 100, 60, 30, and 10 percent, consistent with the range of severity of the condition.

We propose a 100-percent evaluation for multiple daily episodes of diarrhea and abdominal pain that are refractory to treatment, plus at least two hospitalizations per year for complications such as obstruction, fistula, or abscess; a 60-percent evaluation for multiple attacks of diarrhea and abdominal pain per year requiring medical treatment plus at least one hospitalization per year for complications such as obstruction, fistula, or abscess; a 30-percent evaluation for four or more attacks of diarrhea and abdominal pain per year requiring medical treatment; and a 10-percent evaluation for two or three attacks per year of diarrhea and abdominal pain requiring medical treatment. These criteria are more objective and would therefore promote more consistent evaluations, and they are consistent with the disabling effects that sometimes occur after large bowel resection. They are similar to the suggestions of our consultants, but with less subjective language and with modifications of the criteria at various levels, for the sake of internal consistency.

Although the current note following diagnostic code 7329 instructs raters to evaluate the condition as peritoneal adhesions, diagnostic code 7301, if adhesions are the predominant disability, we propose to direct raters to separately evaluate peritoneal adhesions (diagnostic code 7301), if applicable, and combine (under the provisions of § 4.25) with an evaluation under diagnostic code 7329, as long as the same findings are not used to support more than one evaluation. This is clearer and more appropriate, since evaluation under both cited diagnostic codes is feasible under certain circumstances (see § 4.14, Avoidance of pyramiding). We also propose to add a second note directing raters to evaluate under diagnostic code 7350 (colostomy or ileostomy), if applicable, and combine (under the provisions of § 4.25) with an evaluation under diagnostic code 7329, as long as the same findings are not used to support more than one evaluation.

External Gastrointestinal Fistula (Diagnostic Code 7330)

Diagnostic code 7330 is currently titled ''Intestine, fistula of, persistent, or after attempt at operative closure.'' External gastrointestinal fistulas (fistulas that drain from the gastrointestinal tract to the surface of the skin) other than fistulas from the intestine are not currently included in the rating schedule. Our consultants stated that the symptoms and complications of external gastrointestinal fistula include fluid discharge, skin problems, fluid and electrolyte imbalance, recurrent sepsis, and malnutrition. We propose to base the evaluation on such manifestations, regardless of the type of discharge, rather than solely on the presence and amount of the discharge. Only fecal discharge is currently evaluated under this diagnostic code, and the criteria do not take into account the type of treatment or the potential specific effects that might result from fecal or other types of discharges. As recommended by our consultants, we propose to expand the category of fistula of the intestine and change the title to ''external gastrointestinal fistula (including biliary, pancreatic, esophageal, gastric, and intestinal fistulas)'' in order to include all external fistulas of gastrointestinal origin. The current criteria are ''copious and frequent, fecal discharge'' for a 100-percent evaluation; ''constant or frequent, fecal discharge'' for a 60-percent evaluation; and ''slight infrequent, fecal discharge'' for a 30-percent evaluation. The current provision also directs that if healed, fistulas are to be rated as peritoneal adhesions. We propose to delete the ambiguous and subjective terms ''slight,'' ''frequent,'' and ''infrequent,'' and replace them with more objective and specific criteria, in order to assure more consistent evaluations. We also propose to delete the reference to fecal discharge because we are proposing that this diagnostic code include fistulas where the discharge may be bile, gastric fluid, etc., instead of fecal material. We also propose to delete the direction to rate healed fistulas as peritoneal adhesions, since our consultants said that adhesions are not a usual complication of fistulas.

Our consultants stated that the symptoms and complications of external gastrointestinal fistula include fluid discharge, skin problems, fluid and electrolyte imbalance, recurrent sepsis, and malnutrition. We propose to base the evaluation on such manifestations,

rather than simply on the extent and frequency of fecal discharge.

We propose a 100-percent evaluation for external gastrointestinal fistula if there is constant or near-constant copious discharge that cannot be contained, and any of the following is present: A need for total parenteral (intravenous or intramuscular) nutritional support, malnutrition, seven or more episodes per year of fluid and electrolyte imbalance requiring parenteral (intravenous or intramuscular) hydration, or two or more episodes per year of sepsis (a serious and sometimes life-threatening infection with a widespread inflammatory response). We propose a 60-percent evaluation for constant or near-constant copious discharge that cannot be contained, and with any of the following: Persistent skin breakdown, despite treatment, five or six episodes per year of fluid and electrolyte imbalance requiring parenteral (intravenous or intramuscular) hydration, or one episode of sepsis per year. We propose a 30-percent evaluation for constant or intermittent discharge with either of the following: Six or more episodes per year of skin breakdown requiring treatment, or two to four episodes per year of fluid and electrolyte imbalance requiring parenteral (intravenous or intramuscular) hydration. We propose a 10-percent evaluation for constant or intermittent discharge with either of the following: At least two, but less than six, episodes per year of skin breakdown requiring treatment, or one episode per year of fluid and electrolyte imbalance requiring parenteral (intravenous or intramuscular) hydration.

The proposed criteria are more precise and better take into account the actual disabling effects of a fistula. These changes would provide raters with clearly delineated objective criteria for evaluation and are in general agreement with revisions suggested by our consultants. Our consultants recommended that we direct raters to evaluate internal gastrointestinal fistulas (fistulas that drain from one area of the gastrointestinal tract to another) under the criteria for malabsorption (diagnostic code 7353) or other appropriate condition, depending on the particular findings, since malabsorption is a common effect of internal fistulas. We propose to add this direction in a note under diagnostic code 7330.

Tuberculous Peritonitis (Diagnostic Code 7331)

Diagnostic code 7331, ''peritonitis, tuberculous, active or inactive,'' currently directs that inactive tuberculous peritonitis be evaluated under §§ 4.88b or 4.89 (of this part). We propose to correct this reference because § 4.88b was redesignated § 4.88c in a separate rulemaking (59 FR 60902), which was published in the Federal Register on November 29, 1994. The correct section references should be 4.88c and 4.89. Otherwise, we propose no change to the rating criteria, but we do propose to simplify the title of this diagnostic code to ''Tuberculous peritonitis.''

Impaired Control of the Anal Sphincter (Diagnostic Code 7332)

Diagnostic code 7332 is currently titled ''Rectum and anus, impairment of sphincter control.'' We propose to change the title to ''Impaired control of the anal sphincter (anal incontinence)'' for more accuracy, because our consultants stated that inclusion of the rectum in this category is not appropriate, since the sphincter is actually an anal, rather than a rectal, structure. There are currently evaluation levels of 100, 60, 30, 10 and zero percent. A 100-percent evaluation is assigned if there is complete loss of sphincter control; a 60-percent evaluation if there is extensive leakage and fairly frequent involuntary bowel movements; a 30-percent evaluation if there are occasional involuntary bowel movements necessitating wearing of pad; a 10-percent evaluation if there is constant slight, or occasional moderate leakage; and a zero-percent evaluation if the condition is healed or slight, without leakage. These criteria contain numerous indefinite terms, such as ''extensive,'' ''frequent,'' ''occasional,'' and ''slight,'' that allow different individuals to make different interpretations of the criteria.

We propose to retain evaluation levels of 100, 60, 30, and 10 percent, but omit the zero-percent evaluation level as unnecessary (see § 4.31). We further propose to make the criteria more objective by basing them on the specific frequency of fecal soiling, the extent of inability to control solid or liquid feces, and the need for wearing absorbent material. We propose a 100-percent evaluation if there is complete inability to control solid and liquid feces; a 60-percent evaluation if there is daily fecal soiling and complete inability to control liquid feces; a 30-percent evaluation if there is fecal soiling that, although less than daily, is frequent enough or extensive enough to require daily wearing of absorbent material; and a 10-percent evaluation if there is fecal soiling that is intermittent, and not frequent enough or extensive enough to require daily wearing of absorbent material. We propose to remove the zero-percent level as unnecessary (see § 4.31). These more objective and condition-specific criteria would promote consistent evaluations of this disability and are in general agreement with, although more detailed than, the revisions suggested by our consultants. They also exclude the subjective terms such as ''pronounced'' and ''moderate'' that our consultants used. We also propose to add a note directing raters to evaluate under diagnostic code 7350 (colostomy or ileostomy) if an ostomy is present, since fecal incontinence may require a colostomy.

Stricture of the Anus (Diagnostic Code 7333)

Diagnostic code 7333 is currently titled ''Rectum and anus, stricture of.'' Because our consultants suggested that rectal strictures would be more appropriately evaluated with bowel strictures under diagnostic code 7349, we propose to remove rectal strictures from this diagnostic code and change the title to ''Stricture of the anus.'' The current evaluation criteria are ''requiring colostomy,'' for a 100-percent evaluation; ''great reduction of lumen, or extensive leakage,'' for a 50-percent evaluation; and ''moderate reduction of lumen, or moderate constant leakage,'' for a 30-percent evaluation. We propose to remove the indefinite terms, such as ''great,'' ''extensive,'' and ''moderate,'' and base the evaluation on objective criteria, such as the extent of reduction of the lumen, the frequency and extent of fecal soiling, and the necessity for daily wearing of absorbent material.

Because we are proposing a separate diagnostic code for the evaluation of colostomy and ileostomy, there is no longer a need to include colostomy in these criteria. We propose to change the current evaluation levels of 100, 50, and 30 percent to 100, 60, and 30 percent, and to add a 10-percent level, for the sake of more internal consistency. These are also the levels we propose to provide for diagnostic code 7332, and the type and range of disability due to this condition are very similar to those of disability due to impaired control of the anal sphincter. We propose a 100-percent evaluation if there is inability to open or completely close the anus, with complete inability to control liquid or solid feces. We propose a 60-percent evaluation if there is reduction of the lumen by at least 50 percent, with pain and prolonged straining during defecation, and complete inability to control liquid feces. We propose a 30-percent evaluation if there is reduction of the lumen, but by less than 50 percent, with straining during

defecation, and fecal incontinence that requires daily wearing of absorbent material; and a 10-percent evaluation if there is reduction of the lumen, with fecal soiling that is not frequent enough or extensive enough to require daily wearing of absorbent material.

Because a colostomy may be required for treatment of this condition, we also propose to add a note directing raters to evaluate under diagnostic code 7350 (colostomy or ileostomy), if an ostomy is present. In addition to proposing more objective criteria in order to promote consistency of evaluations, we have proposed criteria that are generally in agreement with our consultants' suggestions, excluding the subjective modifiers, such as ''moderate'' and ''occasional,'' that they used. These criteria are also internally consistent with the proposed criteria for evaluating impaired control of the anal sphincter.

Prolapse of Rectum (Diagnostic Code 7334)

Diagnostic code 7334, ''rectum, prolapse of,'' currently has evaluation levels of 50, 30, and 10 percent. A 50-percent evaluation is assigned if there is ''severe (or complete), persistent'' rectal prolapse. A 30-percent evaluation is assigned if there is ''moderate, persistent or frequently recurring'' rectal prolapse, and a 10-percent evaluation is assigned if there is mild rectal prolapse, ''with constant slight or occasional moderate leakage.'' These criteria require raters to subjectively determine whether the condition is ''mild,'' ''moderate,'' or ''severe,'' and what level of frequency the term ''frequently recurring'' implies.

Our consultants noted that incontinence is the major problem associated with prolapse of the rectum and that higher evaluation levels should be available for this condition. We therefore propose to provide levels of 100, 60, 30, and 10 percent, as we are proposing for diagnostic codes 7332 and 7333, the codes for other conditions that are also characterized primarily by fecal incontinence. We propose to remove the subjective language and base evaluation on more objective criteria, such as the frequency of prolapse, the presence of incontinence, and the extent of fecal soiling.

We propose a 100-percent evaluation for persistent prolapse with complete inability to control liquid or solid feces; a 60-percent evaluation for intermittent prolapse (occurring three or more times weekly) with complete inability to control liquid or solid feces during periods of prolapse; a 30-percent evaluation for intermittent prolapse (occurring three or more times weekly) without complete inability to control liquid or solid feces during periods of prolapse, but with difficulty in bowel evacuation and fecal soiling that is frequent enough or extensive enough to require daily wearing of absorbent material; and a 10-percent evaluation if there is intermittent prolapse with difficulty in bowel evacuation and fecal soiling that is not frequent enough or extensive enough to require daily wearing of absorbent material.

These criteria would promote more consistent evaluations, and they provide a range of evaluation levels consistent with the range of severity of this condition. Our consultants recommended criteria based on frequency of prolapse, whether or not there is incontinence, difficult evacuation, and soiling. However, they used numerous subjective terms, such as ''mild,'' ''moderate,'' ''severe,'' ''frequently,'' and ''occasional,'' and our proposed criteria represent a modification of their recommendations for the sake of objectivity and internal consistency with other digestive condition evaluations.

Our consultants also recommended that solitary rectal ulcer syndrome be included in this code. However, in our experience, this condition occurs too infrequently to warrant inclusion, and in addition, the symptoms of solitary rectal ulcer syndrome—altered bowel habits with blood and mucous in the stool, anorectal pain, a feeling of incomplete evacuation, and straining at defecation (Yamada, 1824)—are not entirely consistent with the condition-specific criteria we are proposing for rectal prolapse. If solitary rectal ulcer syndrome requires evaluation, it may be rated as an analogous condition under the evaluation criteria for prolapse of the rectum or other digestive condition in the rating schedule, depending on the particular signs and symptoms found.

Fistula in Ano (Diagnostic Code 7335)

Fistula in ano, diagnostic code 7335, is currently evaluated as impairment of sphincter control, diagnostic code 7332. The current evaluation criteria for impairment of sphincter control are not ideal for evaluating fistula in ano, however, because they do not take into account abscesses with pain and drainage, which our consultants pointed out are the primary disabling effects of fistulas. We therefore propose to provide a specific set of evaluation criteria based on these effects, with evaluation levels of 100, 60, 30, and 10 percent, the same levels as for other anal disabilities.

Fistula in ano may also be called anorectal fistula or anorectal abscess, and we propose to add those names to the title. We propose a 100-percent evaluation for fistula in ano with constant or near-constant abscesses with drainage and pain that are refractory to medical and surgical treatment; a 60-percent evaluation for four or more abscesses (each lasting a week or more) per year with drainage and pain; a 30-percent evaluation for three or more abscesses (each lasting less than a week) per year with drainage and pain ; and a 10-percent evaluation either for one or two abscesses (each lasting less than a week) per year with drainage and pain, or for a fistula with pain and discharge but without associated abscesses. We propose to delete the zero-percent evaluation as unnecessary for clarity (see § 4.31). These evaluation criteria are better suited and more appropriate for evaluating this disability because, in addition to being more objective, they are based on the usual disabling effects of fistula in ano. They represent modifications of the suggestions made by our consultants, faithful in substance, but with some changes made partly for the sake of internal consistency and partly to remove subjective terms.

Our consultants suggested we add a diagnostic code for the evaluation of other defecation disorders, such as Hirschprung's disease (congenital megacolon), anismus (paradoxical pelvic muscle contraction), levator spasm syndrome, functional constipation, and outlet obstruction. We do not propose to do so because these conditions are either uncommon in our experience, congenital in origin and likely to disqualify for military service, or have no organic basis. Any condition that requires evaluation for compensation purposes can be evaluated under existing codes as an analogous condition.

Hemorrhoids (Diagnostic Code 7336)

Hemorrhoids, external or internal, (diagnostic code 7336) are currently evaluated at 20, 10, or zero percent. A 20-percent evaluation is provided for ''persistent bleeding and with secondary anemia, or for fissures;'' a 10-percent evaluation for hemorrhoids that are ''large or thrombotic, irreducible, with excessive redundant tissue, evidencing frequent recurrences;'' and a zero-percent evaluation if they are ''mild or moderate.'' According to our consultants, external hemorrhoids are seldom chronically disabling, but can cause intermittent problems when they undergo thrombosis. Internal hemorrhoids may undergo frequent or permanent prolapse, thrombosis, and bleeding sufficient to cause anemia. The

current evaluation criteria under diagnostic code 7336 do not differentiate between internal and external hemorrhoids.

We propose to change the title of diagnostic code 7336 from ''hemorrhoids, external or internal'' to ''hemorrhoids,'' because the single term encompasses all types of hemorrhoids, and to provide criteria that apply in part to any type of hemorrhoids and in part only to either internal or external hemorrhoids. We propose to retain evaluation levels of 20 and 10 percent, but to remove the zero-percent evaluation criteria as unnecessary (see § 4.31). We also propose to remove subjective terms such as ''mild,'' ''moderate,'' ''excessive,'' and ''frequent'' that are in the current criteria and replace them with more objective criteria. We propose a 20-percent evaluation for either of the following: Persistent bleeding with anemia, or permanently prolapsed internal hemorrhoids with three or more episodes per year of thrombosis. We propose a 10-percent evaluation for either permanently or intermittently prolapsed internal hemorrhoids with one or two episodes per year of thrombosis, or for external hemorrhoids with three or more episodes per year of thrombosis. These criteria would provide raters with a clear, objective way to evaluate any type of hemorrhoids, while taking into account the differences in the disabling effects of external and internal hemorrhoids.

Hernia, Inguinal or Femoral (Diagnostic Code 7338)

Inguinal hernia, diagnostic code 7338, and femoral hernia, diagnostic code 7340, have similar disabling effects and are currently rated under the same criteria. There is no statistical need for VA purposes to retain separate diagnostic codes for each type of hernia, and we therefore propose to combine them under diagnostic code 7338, and retitle that diagnostic code ''Hernia, inguinal or femoral (both post-operative recurrent and non-operated).'' We propose to delete diagnostic code 7340. The issue of whether or not a hernia had been previously repaired is part of the current evaluation criteria, but we are proposing criteria that would apply to both initial and recurrent hernias because the potential signs and symptoms are the same. At the time the current evaluation criteria were developed, the repair of recurrent hernias, which is more difficult than the repair of initial hernias, was not as reliable or effective as it is with modern surgical techniques for hernia repair, such as the use of mesh to cover a hernia defect (first introduced in 1962 (*http://www.ednf.org/medical/content/view/321/38/,* Ehlers-Danlos National Foundation, 2006)) and surgical repair performed by laparoscopy (first described in 1990 (*http://www.rcsed.ac.uk/Journal/vol45_1/4510006.htm,* P. Ridings and D.S. Evans, J.R.Coll.Surg.Edinb., 45; 1: 29–32, February 2000)). Therefore, we do not propose to include the fact that a hernia is or is not recurrent in the evaluation criteria. Recurrent (or initial) hernias that cannot be repaired are encompassed by the evaluation criterion of ''cannot be corrected by surgery'' in proposed diagnostic code 7338 at the 60- and 30-percent evaluation levels, and complications resulting from the repair of any hernia can be evaluated separately.

The current evaluation levels are 60, 30, 10, and zero percent, and we propose to retain all but the zero-percent level. A 60-percent evaluation is now assigned for a hernia that is ''large, postoperative, recurrent, not well supported under ordinary conditions and not readily reducible, when considered inoperable;'' a 30-percent evaluation for a hernia that is ''small, postoperative recurrent, or unoperated irremediable, not well supported by truss, or not readily reducible;'' a 10-percent evaluation for a hernia that is ''postoperative recurrent, readily reducible and well supported by truss or belt;'' and a zero-percent evaluation both for a hernia that is ''not operated, but remediable'' and for one that is ''small, reducible, or without true hernia protrusion.''

We propose to remove the subjective terms and provide more objective criteria, for example, replacing ''large'' and ''small'' with the actual greatest diameter of the hernia, in order to remove ambiguity. Since both femoral and inguinal hernias may or may not be correctable by surgery (although not being correctable is less common with modern surgical and anesthetic techniques), may or may not be supportable by external devices, and may or may not be easily reducible, regardless of whether or not they have been operated, we propose to differentiate the criteria for 60- and 30-percent evaluations only on the basis of the size of the hernia. We propose a 60-percent evaluation for a hernia with all of the following: greatest diameter is 15 centimeters (5.91 inches) or more, cannot be corrected by surgery, and requires support but is not well supported by external devices or is not easily reducible; a 30-percent evaluation for a hernia with the same findings as for a 60-percent evaluation except for a greatest diameter that is less than 15 centimeters; and a 10-percent evaluation for a hernia with all of the following: is of any size, can be corrected by surgery, requires support and is supportable by external devices, and is easily reducible. We do not propose to retain a zero-percent level as it is not needed for clarity (*see* § 4.31).

In addition to being more objective, these criteria provide sharper distinctions between the levels of disability. There is currently a note under this diagnostic code directing raters to add 10 percent for bilateral involvement, provided the second hernia is compensable, and explaining that this means that the more severely disabling hernia is to be evaluated, and 10 percent only is to be added for the second hernia, if the latter is of compensable degree. In our judgment, two hernias, each of which meets the criteria for a 60-percent evaluation, for example, would be more disabling in combination than two hernias, one of which meets the criteria for a 60-percent evaluation, and the other for a 10-percent evaluation, although under current regulations they would be evaluated the same. We therefore propose to remove this note, and to replace it with a note directing that each hernia be separately evaluated and the evaluations combined (under the provisions of § 4.25).

Our consultants suggested evaluation levels for inguinal and femoral hernias of 80 10, and zero percent. We do not believe that this sequence of evaluation levels would allow adequate assessment of the potential disabling effects of femoral and inguinal hernias because of the very large gap between the 80- and 10-percent evaluation levels. In our judgment, some hernias would fall into a level of severity between these levels. In addition, based on our experience, including an 80-percent level is not warranted because there are very few veterans with hernias that are currently evaluated at a level higher than 30 percent. It is very unlikely that evaluations as high as 80 percent would be appropriate or necessary. For the exceptional case that might present a picture of disability more severe than is warranted under the proposed 60-percent upper limit of evaluation, 38 CFR 3.321(b)(1), which provides for extra-schedular evaluations in cases where an evaluation is inadequate because the condition presents such an unusual disability picture that applying the regular schedular standards would be impractical, provides a way to assign a higher evaluation. The consultants' suggested evaluation criteria also included subjective language such as

''moderate,'' ''mild,'' and ''small,'' and they retained the references to recurrent hernia. We have already explained why we are not basing evaluation on whether or not a hernia is recurrent. In addition, they suggested using pain as one of the criteria, but, in our judgment, the more objective criteria we are proposing would take pain, a subjective symptom, into account as part of the effects of a hernia (for example, as part of whether or not a hernia is supportable or reducible, and its size), and the more objective criteria would promote accurate and more consistent evaluations. For these reasons, we do not propose to adopt our consultants' suggestions for the evaluation of hernias.

Ventral Hernia, Postoperative (Diagnostic Code 7339)

Diagnostic code 7339 is currently titled ''Hernia, ventral, postoperative.'' We propose to retitle this diagnostic code as ''Ventral (incisional) hernia, and other abdominal hernias postoperative.'' ''Incisional'' is another term for ventral hernia, and other incisional hernias that might not be ventral (flank incisions, for example), would also be most appropriately evaluated under this diagnostic code. Ventral hernia is currently evaluated at levels of 100, 40, 20, and zero percent. A 100-percent evaluation is assigned if a ventral hernia is massive, persistent, and there is severe diastasis of recti muscles or extensive diffuse destruction or weakening of muscular and fascial support of the abdominal wall so as to be inoperable; a 40-percent evaluation if a hernia is large and not well supported by a belt under ordinary conditions; a 20-percent evaluation if a hernia is small and not well supported by a belt under ordinary conditions, or if there is a healed ventral hernia or postoperative wounds with weakening of the abdominal wall and there is an indication for a supporting belt; and a zero-percent evaluation if there are postoperative wounds that are healed, with no disability, and a belt is not indicated. These criteria contain the indefinite terms ''massive,'' ''large,'' and ''small,'' which could be interpreted differently by different people.

According to our consultants, whether or not a ventral hernia is supportable is more useful than size, which is currently used to distinguish between the 20- and 40-percent levels of disability. However, both to distinguish more clearly the levels of evaluation, and because, in our judgment, a large hernia that is not supportable is likely to interfere with activities more than a small non-supportable hernia, we propose to base evaluation in part on size, but also in part on whether or not the hernia is externally supportable. The presence of pain or incarceration (being irreducible) is also relevant to the extent of disability, according to our consultants. However, as discussed above under inguinal and femoral hernias, we consider pain to be included as part of the effects of other criteria we are proposing to use.

We propose evaluation levels of 100, 60, 30, and 10 percent for ventral hernia, instead of the current levels of 100, 40, 20, and zero percent. These levels would provide a range of evaluations appropriate to ventral hernias, and allow a clear distinction between the levels, while eliminating the large gap between 100 and 40 percent. In our opinion, some hernias would fall into the area between 100 and 40 percent levels of severity. The evaluation levels are also comparable to the proposed levels for inguinal and femoral hernia under diagnostic code 7338.

We propose to revise the criteria to make them less ambiguous and clearer for more ease of use and consistency of evaluations. For example, we propose to provide an evaluation of 100 percent for a hernia with a diameter of 30 or more centimeters, rather than employing the term ''massive''. In our judgment, a ventral hernia with a diameter of 30 centimeters (11.81 inches) or greater is a hernia of such size that it would be totally disabling if it cannot be repaired because of loss of tissue support. We also propose to remove the reference to diastasis of recti muscles because our consultants pointed out that diastasis recti is a congenital condition of the abdominal wall that is not necessarily accompanied by a hernia. We further propose to substitute ''refractory to further operative correction due to extensive loss of muscular and fascial support'' in lieu of considered ''inoperable'' to indicate that it must be the status of the hernia itself, rather than unrelated medical reasons, that makes the hernia unsuitable for surgical correction.

We therefore propose a 100-percent evaluation for a ventral hernia with both of the following: greatest diameter is 30 centimeters (11.81 inches) or more and is refractory to further operative correction due to extensive loss of muscular and fascial support. We propose a 60-percent evaluation for a ventral hernia with both of the following: greatest diameter is 20 centimeters (7.87 inches) or more and requires support but is not well supported by external devices or is not easily reducible. We propose a 30-percent evaluation for the same criteria as for a 60-percent evaluation except that it applies to a ventral hernia with greatest diameter less than 20 centimeters (7.87 inches), and a 10-percent evaluation for a ventral hernia of any size that requires support, and is supportable by external devices, and that is easily reducible. We also propose to delete the zero-percent level, with current criteria of postoperative wounds that are healed, with no disability, and a belt not indicated, since those criteria all indicate the absence of any disability and are not necessary for evaluation.

Visceroptosis

Our consultants noted that the term ''visceroptosis,'' the title of current diagnostic code 7342, is obsolete. This term was used to describe variations in positions of the organs in the body, which medical practitioners once considered to be significant. The differing positions of the organs are currently viewed as normal anatomical variations that are of no pathological significance. We therefore propose to delete diagnostic code 7342 from the schedule.

Gastroesophageal Reflux Disease (Diagnostic Code 7346)

Hiatal hernia is currently evaluated under diagnostic code 7346. According to our consultants, the most disabling manifestation of hiatal hernia is gastroesophageal reflux. To reflect this fact, we propose to change the title of diagnostic code 7346 from ''hernia hiatal'' to ''gastroesophageal reflux disease (GERD), hiatal hernia, esophagitis, lower esophageal (Schatzki's) ring.'' These conditions are closely related, and their symptoms overlap, so evaluating them under the same criteria is appropriate and would promote more consistent evaluations. The current evaluation levels are 60, 30, and 10 percent. We propose to retain these levels, and to add a zero-percent level for the sake of clarity. The current criteria under diagnostic code 7346 call for a 60-percent evaluation if there are ''symptoms of pain, vomiting, material weight loss[,] and hematemesis or melena with moderate anemia, or other symptom combinations productive of severe impairment of health;'' a 30-percent evaluation if there is persistently ''recurrent epigastric distress with dysphagia, pyrosis, and regurgitation, accompanied by substernal or arm or shoulder pain, productive of considerable impairment of health;'' and a 10-percent evaluation if there are two or more of the same symptoms as for the 30-percent evaluation, but of less severity.

These criteria rely on subjective interpretations of terms such as ''severe'' or ''considerable'' impairment of health, symptoms of ''less severity,'' and ''persistently recurrent'' symptoms and could lead to different interpretations by different individuals. We propose to remove the indefinite language and base evaluation on more objective criteria that are also more inclusive of the effects of this group of conditions than the current evaluation criteria. The proposed criteria would be based on such signs and symptoms as the presence of erosive reflux esophagitis, anemia, hemorrhage, weight loss, and pulmonary aspiration, and of certain symptoms such as pyrosis, retrosternal or arm or shoulder pain, dysphagia, and odynophagia.

We propose a 60-percent evaluation for erosive reflux esophagitis (inflammation and ulceration of the esophagus due to reflux of gastric contents into the esophagus) confirmed by endoscopy, imaging, or other laboratory procedure, with at least one of the following: anemia and substantial weight loss, one or more episodes per year of gastrointestinal hemorrhage, or two or more episodes per year of pulmonary aspiration (with bronchitis, pneumonia, or pulmonary abscess) due to regurgitation. We propose a 30-percent evaluation for confirmed erosive reflux esophagitis, with symptoms such as pyrosis (heartburn), retrosternal or arm or shoulder pain, regurgitation of gastric contents into the mouth, dysphagia (difficulty swallowing), and odynophagia (pain during swallowing) that are intractable despite treatment, or with one episode per year of pulmonary aspiration (with bronchitis, pneumonia, or pulmonary abscess) due to regurgitation. We propose a 10-percent evaluation for the same symptoms as for the 30-percent level, but that are largely controlled by continuous treatment with prescription medication; and a zero-percent evaluation for the same symptoms, but that are intermittent and that respond to dietary changes, lifestyle changes, or treatment with antacids or other nonprescription medications. In this case, we are proposing a zero-percent level because the criteria that are provided list items such as lifestyle and dietary changes that are not otherwise addressed in the criteria but that are used to treat these conditions, and it might be unclear to raters whether they warrant a zero- or a 10-percent evaluation. These criteria are in general agreement with the suggestions of our consultants, but with replacement of subjective language such as ''mild,'' ''moderate,'' and ''severe'' with more objective criteria.

We also propose to add a note directing that raters evaluate esophageal stricture, which may result from esophagitis, under the General Rating Formula for Residuals of mouth injuries (7200), Residuals of lip injuries (7201), Residuals of tongue injuries, including tongue loss (7202), Esophageal stricture (7203), Achalasia (cardiospasm) and other motor disorders of the esophagus (7204), and Esophageal diverticula (7205).

Pancreatitis, Total Pancreatectomy, and Partial Pancreatectomy (Diagnostic Code 7347)

Diagnostic code 7347, pancreatitis, is currently evaluated at levels of 100, 60, 30, or 10 percent. The criteria call for a 100-percent evaluation if there are frequently recurrent disabling attacks of abdominal pain with few pain free intermissions and with steatorrhea, malabsorption, diarrhea and severe malnutrition; a 60-percent evaluation if there are frequent attacks of abdominal pain, loss of normal body weight, and other findings showing continuous pancreatic insufficiency between acute attacks; a 30-percent evaluation if the condition is moderately severe, with at least 4–7 typical attacks of abdominal pain per year with good remission between attacks; and a 10-percent evaluation if there is at least one recurring attack of typical severe abdominal pain in the past year. We propose to evaluate pancreatitis on the basis of similar criteria, but to remove the indefinite adjectives ''frequent,'' ''severe,'' and ''moderately severe'' in favor of more objective criteria.

We propose a 100-percent evaluation if all of the following are present: daily or near-daily debilitating attacks of pancreatitis (to be defined in a note) with few pain-free intermissions; two or more signs of pancreatic insufficiency (such as steatorrhea, diabetes, malabsorption, diarrhea, and malnutrition); and unresponsive to medical treatment. We propose a 60-percent evaluation if the following is present: seven or more documented attacks of pancreatitis per year with at least one sign of pancreatic insufficiency (such as steatorrhea, diabetes, malabsorption, diarrhea, or malnutrition) between acute attacks. We propose a 30-percent evaluation if any of the following is present: three to six documented attacks of pancreatitis per year with at least one sign of pancreatic insufficiency (such as steatorrhea, diabetes, malabsorption, diarrhea, or malnutrition) between acute attacks; minimum evaluation following partial pancreatectomy, if symptomatic and requiring continuous treatment with prescription medication; or minimum evaluation following total pancreatectomy. We propose a 10-percent evaluation for one or two documented attacks of pancreatitis per year, and a zero-percent evaluation for partial pancreatectomy, if asymptomatic and not requiring continuous treatment with prescription medication. We are proposing to add the zero-percent evaluation level for asymptomatic partial pancreatectomy, since it might not be clear to raters what the evaluation would be in this case, and as recommended by our consultants.

Total pancreatectomy is disabling in that it requires the administration of pancreatic enzymes and insulin (''Textbook of Surgery'' 1096 (David C. Sabiston, Jr., M.D., ed., 14th ed. 1991)), but, according to our consultants, a partial pancreatectomy without residual symptoms and not requiring ongoing medical treatment is not disabling. These criteria are generally in accord with the suggestions of our consultants and are more objective and measurable than the current criteria. They would, therefore, promote consistent evaluations.

Including information about pancreatectomy in the criteria themselves makes the current note on that subject (note two under current diagnostic code 7347) unnecessary, and we propose to delete it. Current note one under diagnostic code 7347 states, ''Abdominal pain in this condition must be confirmed as resulting from pancreatitis by appropriate laboratory and clinical studies.'' We propose to retain that note, but to edit it, and to add a paragraph describing the signs and symptoms of an attack of pancreatitis. Note one would say that for purposes of evaluation under diagnostic code 7347, an attack of pancreatitis means abdominal pain, often very severe, and sometimes radiating through to the back, with any combination of nausea, vomiting, anorexia (lack or loss of appetite), fever, and abdominal tenderness and swelling. (Merck, 1129 and *http://digestive.niddk.nih.gov/ddiseases/pubs/pancreatitis/index.htm#acute,* National Digestive Diseases Information Clearinghouse, February 2004). These symptoms must be confirmed as resulting from pancreatitis by appropriate laboratory and clinical studies.

We propose to add a second note directing raters to evaluate complications, such as diabetes mellitus, external gastrointestinal fistula, and malabsorption, separately under an appropriate diagnostic code, as

long as the same findings are not used to support more than one evaluation.

Pyloroplasty With Vagotomy or Gastroenterostomy With Vagotomy (Diagnostic Code 7348)

Vagotomy with pyloroplasty or gastroenterostomy, diagnostic code 7348, is currently evaluated at 40, 30 or 20 percent. A 40-percent evaluation is assigned if there are demonstrably confirmative postoperative complications of stricture or continuing gastric retention; a 30-percent evaluation if there are symptoms and a confirmed diagnosis of alkaline gastritis, or of confirmed persisting diarrhea; and a 20-percent evaluation if there is recurrent ulcer with incomplete vagotomy. There is also a note directing raters to evaluate recurrent ulcer following complete vagotomy under diagnostic code 7305 (duodenal ulcer), with a minimum evaluation of 20 percent, and to rate dumping syndrome under diagnostic code 7308 (postgastrectomy syndromes). We propose to direct that this condition be evaluated as duodenal ulcer (diagnostic code 7305); gastritis (diagnostic code 7307); postgastrectomy syndromes (diagnostic code 7308); or gastric emptying disorders (diagnostic code 7309), depending upon symptoms and findings, in order to provide a wide range of objective evaluation criteria appropriate to the numerous signs and symptoms that may result from this disability, and to assure more consistent evaluations. This is in accord with recommendations by our consultants. With the directions for using this broader range of evaluation criteria, the note is not necessary, and we propose to remove it. In addition, since the major impairments from these conditions are ordinarily due to the gastric surgery, or to the combined effects of gastric surgery and vagotomy, rather than primarily due to the vagotomy, we propose to change the title to ‘‘pyloroplasty with vagotomy or gastroenterostomy with vagotomy’’ to indicate this.

Consultant-Recommended Conditions To Be Added

Our consultants suggested adding several conditions to the rating schedule—gastrointestinal hemorrhage, non-ulcerative dyspepsia, and porto-systemic shunting. Our experience has shown that these conditions do not occur commonly enough to warrant inclusion. Furthermore, the first two are signs or symptoms rather than diseases or injuries, and they may not be appropriate in the schedule for that reason. When necessary, digestive conditions not listed in the rating schedule can be evaluated under analogous codes.

Proposed Conditions To Be Added

We do propose to add four commonly occurring digestive conditions to the rating schedule: Bowel stricture, as diagnostic code 7349, colostomy or ileostomy, as diagnostic code 7350, pancreatic transplant, as diagnostic code 7352, and malabsorption syndrome, as diagnostic code 7353, as described below.

Bowel Stricture (Diagnostic Code 7349)

Currently, the only evaluation criteria in the rating schedule for stricture of the bowel are those provided under diagnostic code 7333, stricture of the rectum and anus. We are proposing to delete stricture of the rectum from diagnostic code 7333, as recommended by our consultants, and instead provide a new diagnostic code, diagnostic code 7349, ‘‘Bowel stricture,’’ for the evaluation of stricture of the bowel at any level, including the rectum. This would remove the need to evaluate a bowel stricture under an analogous code.

We propose to establish evaluation levels of 60, 30, and 10 percent for bowel strictures. These levels are the same as those we are proposing for peritoneal adhesions (Diagnostic Code 7301), and the evaluation criteria are also almost identical, because partial bowel obstruction due to peritoneal adhesions results in similar signs and symptoms as bowel stricture. We propose a 60-percent evaluation for six or more episodes per year of partial obstruction of the bowel (confirmed by an imaging procedure), with typical signs and symptoms; a 30-percent evaluation for three to five such episodes; and a 10-percent evaluation for one or two such episodes. As with peritoneal adhesions, we are proposing to add a note to list the typical signs and symptoms of bowel stricture. The note would state that they include colicky abdominal pain and at least one of the following other symptoms: Abdominal distention, borborygmi (audible rumbling bowel sounds), nausea, vomiting, and obstipation (severe constipation). These proposed criteria are specific to the condition, are objective, and are similar to criteria we are proposing to use to evaluate peritoneal adhesions, as recommended by our consultants.

Colostomy or Ileostomy (Diagnostic Code 7350)

In the current rating schedule, colostomy is mentioned only under diagnostic code 7333, stricture of the rectum and anus, where a 100-percent evaluation is assigned if a colostomy is required for that condition. Since a colostomy (an opening on the abdominal wall from the colon) may be required for many conditions, however, and is a common finding, we propose to establish a separate code, diagnostic code 7350, for the evaluation of either colostomy or ileostomy (an opening on the abdominal wall from the ileum), a related and also common condition, with evaluation criteria specific to these disabilities.

Individuals vary in the extent of disability they experience following ileostomy or colostomy. For example, following ileostomy, patients generally return to an active physical life and resume their previous work, and restriction of their activities may vary from mild to severe (Yamada, 799). Many patients with a colostomy, and some with an ileostomy, do not require a bag or appliance (Sabiston, 903; Yamada, 799). Some individuals, however, have persistent infection or other ostomy problems that may be very disabling. We therefore propose to base the evaluation on whether or not there is an ostomy complication and on whether or not the ostomy is continent.

We propose to provide evaluation levels of 100, 60, and 30 percent, in order to provide a range of appropriate evaluation levels. We propose a 100-percent evaluation for at least one ostomy complication (such as infection or signs of irritation of the peristomal area, prolapse, retraction, or stenosis) that is refractory to treatment; a 60-percent evaluation for incontinence, requiring the use of an external appliance or absorbent material; and a 30-percent evaluation if the individual is continent, with no external appliance or absorbent material required.

Pancreas Transplant (Diagnostic Code 7352)

We propose to add pancreatic transplant as diagnostic code 7352, because this surgical procedure has been developed since the current schedule went into effect and is done frequently enough to warrant inclusion. We propose a 100-percent evaluation following transplant surgery. We further propose the addition of a note explaining the requirement of a VA examination one year following hospital discharge. We propose to provide instructions to evaluate thereafter on residuals, based on the VA examination, and subject to the provisions of 38 CFR 3.105(e). Any proposed reduction would be based on the examination, and the notification process could begin only

after the examination had been reviewed. This gives the claimant current notice of any proposed action and the opportunity to present evidence showing that the proposed action should not be taken. We propose a minimum 30-percent evaluation for pancreatic transplant, because of the need for long-term immunosuppressive medication and its associated problems. The evaluation criteria we are proposing are the same as those used for kidney transplant (diagnostic code 7531) in the genitourinary section of the rating schedule, because both types of transplant require similar periods of convalescence and long-term immunosuppressive therapy following convalescence.

Malabsorption Syndrome (Diagnostic Code 7353)

Malabsorption syndrome (including celiac disease, small bowel bacterial overgrowth, Whipple's disease (intestinal lipodystrophy), and fistulous disorders) is a common syndrome that can result from a number of conditions and result in significant impairment, and we propose to add it as diagnostic code 7353, with evaluation levels of 100, 60, 30, and 10 percent. We propose a 100-percent evaluation if total parenteral (intravenous or intramuscular) nutritional support is required; a 60-percent evaluation for diarrhea, anemia, weakness, and fatigue requiring daily (oral) nutritional supplementation, plus parenteral (intravenous or intramuscular) nutrition for a total of at least 28 days per year; a 30-percent evaluation for diarrhea, weakness, and fatigue requiring daily (oral) nutritional supplementation, plus parenteral (intravenous or intramuscular) nutrition for a total of at least 14 days, but less than 28 days per year; and a 10-percent evaluation for diarrhea, weakness, and fatigue requiring daily (oral) nutritional supplementation. These are similar to the criteria proposed for small bowel resection (diagnostic code 7328) because the effects are similar. Our consultants recommended that the diagnosis of malabsorption syndrome be confirmed based on a fecal fat loss of 17mEq or greater per day. However, this is not the primary diagnostic test for every type of malabsorption syndrome, and we do not propose to require it.

Paperwork Reduction Act

This document contains no provisions constituting a collection of information under the Paperwork Reduction Act (44 U.S.C. 3501–3521).

Regulatory Flexibility Act

The Secretary hereby certifies that this proposed rule would not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act, 5 U.S.C. 601–612. This proposed rule would not affect any small entities. Only VA beneficiaries could be directly affected. Therefore, pursuant to 5 U.S.C. 605(b), this proposed rule is exempt from the initial and final regulatory flexibility analysis requirements of sections 603 and 604.

Executive Order 12866

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety, and other advantages; distributive impacts; and equity). The Executive Order classifies a "significant regulatory action," requiring review by the Office of Management and Budget (OMB), unless OMB waives such review, as any regulatory action that is likely to result in a rule that may: (1) Have an annual effect on the economy of $100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities; (2) create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raise novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

The economic, interagency, budgetary, legal, and policy implications of this proposed rule has been examined and it has been determined to be a significant regulatory action under Executive Order 12866 because it is likely to result in a rule that may raise novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

Unfunded Mandates

The Unfunded Mandates Reform Act of 1995 requires, at 2 U.S.C. 1532, that agencies prepare an assessment of anticipated costs and benefits before issuing any rule that may result in an expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of $100 million or more (adjusted annually for inflation) in any given year. This proposed rule would have no such effect on State, local, and tribal governments, or on the private sector.

Catalog of Federal Domestic Assistance Numbers and Titles

The Catalog of Federal Domestic Assistance program numbers and titles for this proposal are 64.104, Pension for Non-Service-Connected Disability for Veterans, and 64.109, Veterans Compensation for Service-Connected Disability.

Signing Authority

The Secretary of Veterans Affairs, or designee, approved this document and authorized the undersigned to sign and submit the document to the Office of the Federal Register for publication electronically as an official document of the Department of Veterans Affairs. John R. Gingrich, Chief of Staff, Department of Veterans Affairs, approved this document on March 31, 2011, for publication.

List of Subjects in 38 CFR Part 4

Disability benefits, Pensions, Veterans.

Dated: June 20, 2011.

William F. Russo,

Deputy Director, Office of Regulation Policy & Management, Department of Veterans Affairs.

For the reasons set forth in the preamble, VA proposes to amend 38 CFR part 4, subpart B, as set forth below:

PART 4—SCHEDULE FOR RATING DISABILITIES

1. The authority citation for part 4 continues to read as follows:

Authority: 38 U.S.C. 1155, unless otherwise noted.

2. Revise § 4.110 to read as follows:

§ 4.110 Dyspepsia.

For purposes of evaluating conditions in § 4.114, "dyspepsia" means any combination of the following symptoms: Gnawing or burning epigastric or substernal pain that may be relieved by food (especially milk) or antacids, nausea, vomiting, anorexia (lack or loss of appetite), abdominal bloating, and belching. When there is obstruction of the outlet of the stomach (gastric outlet obstruction), dyspepsia may also include symptoms of gastroesophageal reflux (flow of stomach contents back into the esophagus), borborygmi (audible rumbling bowel sounds),

crampy pain, and obstipation (severe constipation).

§ 4.110 [Removed and Reserved]

3. Remove and reserve § 4.111.

4. In § 4.112, revise the section heading and add two sentences at the end of the paragraph to read as follows:

§ 4.112 Weight loss and malnutrition.

* * * ''Malnutrition'' means a deficiency state resulting from insufficient intake of one or multiple essential nutrients or the inability of the body to absorb, utilize, or retain such nutrients. It is characterized by failure of the body to maintain normal organ functions and healthy tissues.

5. Revise § 4.113 to read as follows:

§ 4.113 Evaluation of coexisting digestive conditions.

Separately evaluate two or more conditions in § 4.114 only if the signs and symptoms attributed to each are separable. If they are not, assign a single evaluation under the diagnostic code that best allows evaluation of the overall functional impairment resulting from both conditions.

Authority: (38 U.S.C. 1155)

6. Amend § 4.114 by:

a. Removing the introductory text.

b. Removing diagnostic codes 7315, 7316, 7317, 7318, 7321, 7322, 7337, 7340, and 7342.

c. Revising diagnostic codes 7200 through 7310, 7314 through 7339, and 7346 through 7348.

d. Adding diagnostic codes 7207, 7349, 7350, 7352, and 7353.

The revisions and additions read as follows:

§ 4.114 Schedule of ratings—Digestive system.

	Rating
7200 Residuals of mouth injuries.	
7201 Residuals of lip injuries.	
7202 Residuals of tongue injuries, including tongue loss.	
7203 Esophageal stricture.	
7204 Achalasia (cardiospasm) and other motor disorders of the esophagus (diffuse esophageal spasm, corkscrew esophagus, nutcracker esophagus, *etc.*).	
7205 Esophageal diverticula, including pharyngoesophageal (Zenker's), midesophageal, and epiphrenic types.	
General Rating Formula for:	
Residuals of mouth injuries (diagnostic code 7200),	
Residuals of lip injuries (diagnostic code 7201),	
Residuals of tongue injuries, including tongue loss (diagnostic code 7202),	
Esophageal stricture (diagnostic code 7203),	
Achalasia (cardiospasm) and other motor disorders of the esophagus (diagnostic code 7204), and	
Esophageal diverticulum (diagnostic code 7205):	
With any of the following	100
Tube feeding required;	
Diet restricted to liquid foods, with substantial weight loss, malnutrition, and anemia;	
Four or more episodes per year of pulmonary aspiration (with bronchitis, pneumonia, or pulmonary abscess) due to regurgitation or vomiting; or	
Inability to speak clearly enough to be understood.	
With any of the following	60
Diet restricted to liquid and soft solid foods, with substantial weight loss or anemia;	
Two to three episodes per year of pulmonary aspiration (with bronchitis, pneumonia, or pulmonary abscess) due to regurgitation or vomiting; or	
Inability to speak clearly enough to be understood at least half of the time but not all of the time.	
With any of the following	30
Diet restricted to liquid and soft solid foods with minor weight loss;	
Esophageal dilation carried out five or more times per year;	
Daily regurgitation or vomiting;	
One episode per year of pulmonary aspiration (with bronchitis, pneumonia, or pulmonary abscess) due to regurgitation or vomiting; or	
Inability to speak clearly enough to be understood at times, but less than half of the time;	
With any of the following	10
Diet restricted to liquid and soft solid foods;	
Esophageal dilation carried out one to four times per year;	
Heartburn (pyrosis) requiring continuous treatment with prescription medication and at least one of the following other symptoms: retrosternal chest pain, difficulty swallowing (dysphagia), or pain during swallowing (odynophagia);	
Partial tongue loss; or	
Impaired articulation for some words, but speech understandable.	
Note: Separately evaluate mouth and lip injuries under diagnostic code 7800 (Burn scar(s) of the head, face, or neck; scar(s) of the head, face, or neck due to other causes; or other disfigurement of the head, face, or neck), if applicable, and combine with an evaluation under this general rating formula, under the provisions of § 4.25..	
7207 Salivary gland (parotid, submandibular, sublingual) disease other than neoplasm:	
Xerostomia (dry mouth) with altered sensation of taste and difficulty with lubrication and mastication of food, resulting in either weight loss or increase in dental caries	20
With any of the following	10
Xerostomia (dry mouth) with altered sensation of taste and difficulty with lubrication and mastication of food, but without weight loss or increase in dental caries;	
Chronic inflammation of salivary gland with pain and swelling on eating;	
One or more salivary calculi; or	
Salivary gland stricture.	
With either of the following	0
Xerostomia (dry mouth) without difficulty in mastication of food; or	
Painless swelling of salivary gland.	

	Rating
Note (1): Evaluate facial nerve (cranial nerve VII) impairment under diagnostic code 8207 (Paralysis of seventh (facial) cranial nerve), and any disfigurement due to facial swelling under diagnostic code 7800 (Burn scar(s) of the head, face, or neck; scar(s) of the head, face, or neck due to other causes; or other disfigurement of the head, face, or neck).	
Note (2): Xerostomia (dry mouth) is a common symptom of Sjogren's syndrome, an autoimmune disorder that also causes keratoconjunctivitis sicca (dry eyes), and may affect other parts of the body. Evaluate xerostomia due to Sjogren's syndrome under diagnostic code 7207, keratoconjunctivitis sicca under the portion of the rating schedule that addresses Organs of Special Sense, and the effects of the syndrome, if any, on other body parts under appropriate diagnostic codes.	
7301 Peritoneal adhesions.	
Six or more episodes per year of partial obstruction of the bowel (confirmed by X-ray), with typical signs and symptoms	60
Three to five episodes per year of partial obstruction of the bowel (confirmed by X-ray), with typical signs and symptoms	30
One or two episodes per year of partial obstruction of the bowel (confirmed by X-ray), with typical signs and symptoms, or in the absence of such episodes, pulling pain on body movement, if not attributable to another condition	10
Note (1): Evaluation under diagnostic code 7301 requires a history of abdominal or pelvic surgery, infection, irradiation, trauma, or other known etiology for peritoneal adhesions.	
Note (2): For purposes of evaluation under diagnostic code 7301 typical signs and symptoms of partial obstruction of the bowel include colicky abdominal pain, and at least one of the following other symptoms: abdominal distention, borborygmi (audible rumbling bowel sounds), nausea, vomiting, and diarrhea.	
7304 Gastric ulcer.	
7305 Duodenal ulcer or duodenitis.	
7306 Marginal (gastrojejunal) ulcer.	
General Rating Formula for:	
Ulcer Disease (diagnostic code 7304, diagnostic code 7305, and diagnostic code 7306):	
With either of the following	100
Substantial weight loss, malnutrition, and anemia due to gastrointestinal bleeding; or	
Requiring hospitalization three or more times per year for vomiting, refractory pain, gastrointestinal bleeding, perforation, obstruction, or penetration to liver, pancreas, or colon.	
With either of the following	60
Periodic or constant dyspepsia with substantial weight loss and anemia due to gastrointestinal bleeding; or	
Hospitalization twice per year for vomiting, refractory pain, gastrointestinal bleeding, perforation, obstruction, or penetration to liver, pancreas, or colon.	
With either of the following	30
Periodic or constant dyspepsia with at least minor weight loss; or	
Hospitalization once per year for vomiting, refractory pain, gastrointestinal bleeding, perforation, obstruction, or penetration to liver, pancreas, or colon.	
Recurring dyspepsia that requires continuous treatment with prescription medication for control	10
Note: Evaluation under diagnostic codes 7304, 7305, or 7306 requires that the diagnosis of ulcer disease or duodenitis be confirmed on at least one occasion by imaging or endoscopy.	
7307 Chronic gastritis (including but not limited to erosive, hypertrophic, hemorrhagic, bile reflux, alcoholic, and drug-induced gastritis):	
With any of the following	60
Periodic or continuous dyspepsia with anemia due to gastrointestinal bleeding;	
Protein-losing gastropathy with substantial weight loss and peripheral edema; or	
Hospitalization two or more times per year for gastrointestinal bleeding, intractable vomiting, or other complication of chronic gastritis.	
With either of the following	30
Protein-losing gastropathy with at least minor weight loss; or	
Hospitalization once per year for gastrointestinal bleeding, intractable vomiting, or other complication of chronic gastritis.	
Dyspepsia that requires continuous treatment with prescription medication	10
Note (1): Evaluation under diagnostic code 7307 requires that the diagnosis of chronic gastritis be confirmed on at least one occasion by endoscopy.	
Note (2): Evaluate atrophic gastritis, which is a complication of a number of diseases, including pernicious anemia, as part of the underlying condition.	
7308 Postgastrectomy syndromes:	
Dumping syndrome that occurs after most meals, with substantial weight loss, malnutrition, and anemia	100
Dumping syndrome that occurs after most meals, with substantial weight loss and anemia	60
Dumping syndrome occurring daily or nearly so, despite treatment, with at least minor weight loss	30
Intermittent dumping syndrome (occurring at least three times a week) requiring dietary restrictions	10
Note (1): For purposes of evaluation under diagnostic code 7308, the term "dumping syndrome" includes symptoms that are associated with any of the following postgastrectomy syndromes: early and late types of dumping syndrome, postgastrectomy diarrhea, and alkaline reflux gastritis. These symptoms include any combination of weakness, dizziness, lightheadedness, diaphoresis (sweating), palpitations, tachycardia, postural hypotension, confusion, syncope (fainting), nausea, vomiting (often with bile), diarrhea, steatorrhea (fatty stools), borborygmi (audible rumbling bowel sounds), abdominal pain, anorexia (lack or loss of appetite), abdominal bloating, and belching. Symptoms may occur immediately after eating or up to three hours later.	
Note (2): Separately evaluate complications, such as osteomalacia, under an appropriate diagnostic code.	
7309 Gastric emptying disorders (including gastroparesis (delayed gastric emptying), and pyloric, gastric, and other motility disturbances):	
Daily or near-daily signs and symptoms with substantial weight loss and malnutrition	100
Periodic or daily or near-daily signs and symptoms with substantial weight loss	60
Periodic signs and symptoms with minor weight loss	30
Periodic signs and symptoms, without weight loss, but requiring continuous treatment with prescription medication	10
Note: For purposes of evaluation under diagnostic code 7309, the signs and symptoms of gastric emptying disorders include epigastric pain or fullness and at least one of the following other symptoms: anorexia (lack or loss of appetite), nausea, vomiting, gastroesophageal reflux, early satiety (feeling that hunger and thirst are satisfied), and abdominal bloating.	
7310 Residuals of injury of the stomach:	

	Rating
Evaluate as peritoneal adhesions (diagnostic code 7301), or, if the injury required a gastric resection, as postgastrectomy syndromes (diagnostic code 7308).	
* * * * * * *	
7314 Biliary tract disease or injury (chronic cholecystitis, cholelithiasis, choledocholithiasis, chronic cholangitis, status post-cholecystectomy, gall bladder or bile duct injury, biliary dyskinesia, cholesterolosis, polyps of gall bladder, sclerosing cholangitis, stricture or infection of the bile ducts, choledochal cyst):	
With any of the following	100
Near-constant debilitating attacks of biliary tract disease or injury that are refractory to medical or surgical treatment;	
Liver failure; or	
Hospitalization three or more times per year for biliary tract disease or injury.	
With either of the following	60
Six or more attacks of biliary tract disease or injury per year, partially responsive to treatment; or	
Hospitalization two times per year for biliary tract disease or injury.	
With either of the following	30
Three to five attacks of biliary tract disease or injury per year; or	
Hospitalization once per year for biliary tract disease or injury.	
With either of the following	10
One or two attacks of biliary tract disease or injury per year; or	
Intermittent biliary tract pain occurring at least monthly, despite medical treatment.	
Note (1): For purposes of evaluation under diagnostic code 7314, attacks of biliary tract disease or injury include any combination of such signs and symptoms as abdominal pain (including biliary colic), dyspepsia, jaundice, anorexia (lack or loss of appetite), nausea, vomiting, chills, and fever.	
Note (2): Evaluation under diagnostic code 7314 requires that the diagnosis of any of these conditions be confirmed by X-ray or other imaging procedure, laboratory findings, or other objective evidence.	
Note (3): Separately evaluate peritoneal adhesions (diagnostic code 7301), if applicable, and combine (under the provisions of § 4.25) with an evaluation under diagnostic code 7314, as long as the same findings are not used to support more than one evaluation (see § 4.14).	
Note (4): Evaluate the cirrhotic phase of sclerosing cholangitis under diagnostic code 7312 (cirrhosis of the liver).	
7319 Irritable bowel syndrome (irritable colon, spastic colitis, mucous colitis):	
Daily or near-daily disturbances of bowel function (diarrhea, or alternating diarrhea and constipation), bloating, and abdominal cramping or pain, refractory to medical treatment	30
Disturbances of bowel function (diarrhea, or alternating diarrhea and constipation), bloating, and abdominal cramping or pain that occur three or more times a month and that respond partially to medical treatment	10
7323 Ulcerative colitis:	
With either of the following	100
Malnutrition, substantial weight loss, anemia, and general debility with multiple attacks of colitis per year, with bloody diarrhea, abdominal or rectal pain, fever, and malaise.	
Hospitalization three or more times per year for complications such as hemorrhage, dehydration, obstruction, fulminant (sudden and intense) colitis, toxic megacolon (a severe distention of the colon that can be life threatening), or perforation.	
With either of the following	60
Substantial weight loss and anemia, with multiple attacks of colitis per year, with bloody diarrhea, abdominal or rectal pain, fever, and malaise; or	
Hospitalization two times per year for complications such as hemorrhage, dehydration, obstruction, fulminant (sudden and intense) colitis, toxic megacolon (a severe distention of the colon that can be life threatening), or perforation.	
With either of the following	30
Three or more attacks of colitis (each lasting 5 or more days) per year, with diarrhea with blood, pus, or mucus, and abdominal or rectal pain; or	
Hospitalization one time per year for complications such as hemorrhage, dehydration, obstruction, fulminant (sudden and intense) colitis, toxic megacolon (a severe distention of the colon that can be life threatening), or perforation.	
With either of the following	10
One or two attacks of colitis (each lasting 5 or more days) per year with diarrhea with blood, pus, or mucus, and abdominal or rectal pain; or	
Continuous treatment with prescription medication either to control symptoms or to maintain remission.	
Note (1): Separately evaluate other complications, such as uveitis, ankylosing spondylitis, and sclerosing cholangitis, under an appropriate diagnostic code.	
Note (2): If there has been a colon resection, evaluate under diagnostic codes 7350 (colostomy or ileostomy) and 7329 (resection of large intestine), as applicable, and combine the evaluations under the provisions of § 4.25, as long as the same findings are not used to support more than one evaluation (see § 4.14).	
7324 Parasitic infections of the intestinal tract:	
Daily diarrhea (occurring more than three times per day) and abdominal pain, with at least minor weight loss	30
Diarrhea and abdominal pain requiring continuous treatment with prescription medication for control	10
Note: If malabsorption is present, evaluate instead under diagnostic code 7353 (malabsorption syndrome), if doing so would result in a higher evaluation.	
7325 Chronic diarrhea of unknown etiology:	
Five or more watery bowel movements occurring daily, refractory to medical treatment, and with three or more episodes per year of fluid and electrolyte imbalance requiring parenteral (intravenous or intramuscular) hydration	60
Five or more watery bowel movements occurring daily, partially responsive to medical treatment, and with one or two episodes per year of fluid and electrolyte imbalance requiring parenteral (intravenous or intramuscular) hydration	30
Requiring continuous treatment with prescription medication for control	10
7326 Crohn's disease:	
With either of the following	100
Multiple attacks or flareups of Crohn's disease per year with abdominal pain or tenderness, diarrhea, fever, anorexia (lack or loss of appetite), and fatigue plus malnutrition, substantial weight loss, hypoalbuminemia, and anemia; or	

	Rating
Hospitalization three or more times per year for complications such as abscess, stricture, obstruction, or fistula.	
With any of the following	60
Multiple attacks or flareups of Crohn's disease per year with abdominal pain or tenderness, diarrhea, fever, anorexia (lack or loss of appetite), and fatigue plus substantial weight loss and anemia;	
Hospitalization two times per year for recurrent complications such as abscess, stricture, obstruction, or fistula; or	
Constant or near-constant treatment with high dose systemic (oral or parenteral [intravenous or intramuscular]) corticosteroids.	
With any of the following	30
Three or more attacks or flareups of Crohn's disease per year with abdominal pain or tenderness, diarrhea, fever, anorexia (lack or loss of appetite), and fatigue, plus at least minor weight loss;	
Hospitalization one time per year for complications such as abscess, stricture, obstruction, or fistula; or	
Three or more (but not constant) courses of treatment per year with high dose systemic (oral or parenteral [intravenous or intramuscular]) corticosteroids.	
With any of the following	10
One or two attacks or flareups of Crohn's disease per year with abdominal pain or tenderness, diarrhea, and fever;	
One or two courses of treatment per year with high dose systemic (oral or parenteral [intravenous or intramuscular]) corticosteroids;	
Continuous treatment with prescription medication other than high dose systemic (oral or parenteral [intravenous or intramuscular]) corticosteroids.	
Note (1): Separately evaluate complications, such as external gastrointestinal fistula, arthritis, episcleritis (inflammation of the outer layers of the sclera of the eye), *etc.,* under an appropriate diagnostic code as long as the same findings are not used to support more than one evaluation (see § 4.14).	
Note (2): Evaluate under diagnostic code 7350 (colostomy or ileostomy) if an ostomy is present, and under diagnostic code 7328 (resection of the small intestine) or 7329 (resection of large intestine), if applicable, as long as the same findings are not used to support more than one evaluation (see § 4.14).	
7327 Diverticulitis:	
With either of the following	100
Near-constant signs and symptoms of diverticulitis, with abdominal pain and tenderness, fever, and irregular defecation (constipation, diarrhea, or alternating constipation and diarrhea); or	
Hospitalization at least three times per year for complications such as abscess, perforation, obstruction, or fistula.	
With any of the following	60
Six or more attacks of diverticulitis per year with abdominal pain and tenderness, fever, and irregular defecation (constipation, diarrhea, or alternating constipation and diarrhea), requiring outpatient treatment with a course of antibiotics, bed rest, and a liquid diet;	
Hospitalization two times per year for complications such as abscess, perforation, obstruction, or fistula; or	
Hospitalization three or more times per year for acute diverticulitis requiring intravenous antibiotics.	
With any of the following	30
Three to five attacks of diverticulitis per year with abdominal pain and tenderness, fever, and irregular defecation (constipation, diarrhea, or alternating constipation and diarrhea), requiring outpatient treatment with a course of antibiotics, bed rest, and a liquid diet;	
Hospitalization one time per year for complications such as abscess, perforation, obstruction, or fistula; or	
Hospitalization once or twice per year for acute diverticulitis requiring intravenous antibiotics.	
With one or two attacks of diverticulitis per year with abdominal pain and tenderness, fever, and irregular defecation (constipation, diarrhea, or alternating constipation and diarrhea), requiring a course of antibiotics	10
Note: Evaluate under diagnostic code 7350 (colostomy or ileostomy) if an ostomy is present, and under diagnostic code 7329 (resection of large intestine), if applicable, as long as the same findings are not used to support more than one evaluation (see § 4.14).	
7328 Resection of small intestine:	
Requiring total parenteral (intravenous or intramuscular) nutritional support	100
Diarrhea, weakness, fatigue, abdominal cramps, and bloating, with anemia, requiring daily (oral) nutritional supplementation, plus parenteral (intravenous or intramuscular) nutrition for a total of at least 28 days per year	60
Diarrhea, weakness, fatigue, abdominal cramps, and bloating requiring daily (oral) nutritional supplementation, plus parenteral (intravenous or intramuscular) nutrition for a total of at least 14 days, but less than 28 days per year	30
Diarrhea, weakness, fatigue, abdominal cramps, and bloating requiring daily (oral) nutritional supplementation	10
Note: Separately evaluate peritoneal adhesions (diagnostic code 7301), if applicable, as long as the same findings are not used to support an evaluation both under diagnostic code 7301 and under diagnostic code 7328 (see § 4.14).	
7329 Resection of large intestine:	
Multiple daily episodes of diarrhea and abdominal pain that are refractory to treatment, plus at least two hospitalizations per year for complications such as obstruction, fistula, or abscess	100
Multiple attacks of diarrhea and abdominal pain per year requiring medical treatment, plus at least one hospitalization per year for complications such as obstruction, fistula, or abscess	60
Four or more attacks of diarrhea and abdominal pain per year requiring medical treatment	30
Two or three attacks of diarrhea and abdominal pain per year requiring medical treatment	10
Note (1): Separately evaluate peritoneal adhesions (diagnostic code 7301), if applicable, and combine (under the provisions of § 4.25) with an evaluation under diagnostic code 7329, as long as the same findings are not used to support more than one evaluation (see § 4.14).	
Note (2): Evaluate under diagnostic code 7350 (colostomy or ileostomy), if applicable, and combine (under the provisions of § 4.25) with an evaluation under diagnostic code 7329, as long as the same findings are not used to support more than one evaluation (see § 4.14).	
7330 External gastrointestinal fistula (including biliary, pancreatic, esophageal, gastric, and intestinal fistulas):	
Constant or near-constant copious discharge that cannot be contained, and with any of the following	100
Requiring total parenteral (intravenous or intramuscular) nutritional support;	
Malnutrition;	
Seven or more episodes per year of fluid and electrolyte imbalance requiring parenteral (intravenous or intramuscular) hydration; or	

	Rating
Two or more episodes per year of sepsis (a serious and sometimes life-threatening infection with a widespread inflammatory response).	
Constant or near-constant, copious discharge that cannot be contained, and with any of the following	60
Persistent skin breakdown, despite treatment;	
Five or six episodes per year of fluid and electrolyte imbalance requiring parenteral (intravenous or intramuscular) hydration; or	
One episode per year of sepsis (a serious and sometimes life-threatening infection with a widespread inflammatory response).	
Constant or intermittent discharge with either of the following	30
Six or more episodes per year of skin breakdown that require treatment; or	
Two to four episodes per year of fluid and electrolyte imbalance requiring parenteral (intravenous or intramuscular) hydration.	
Constant or intermittent discharge with either of the following	10
At least two, but less than six, episodes per year of skin breakdown requiring treatment;	
One episode per year of fluid and electrolyte imbalance requiring parenteral (intravenous or intramuscular) hydration.	
Note: Evaluate internal gastrointestinal fistulas (fistulas that drain from one area of the gastrointestinal tract to another) under the criteria for malabsorption (diagnostic code 7353) or other appropriate condition, depending on the particular findings.	
7331 Tuberculous peritonitis:	
Active	100
Inactive: Evaluate in accordance with §§ 4.88c or 4.89, whichever is applicable.	
7332 Impaired control of the anal sphincter (anal incontinence):	
Complete inability to control solid and liquid feces	100
Daily fecal soiling and complete inability to control liquid feces	60
Fecal soiling that, although less than daily, is frequent enough or extensive enough to require daily wearing of absorbent material	30
Fecal soiling that is intermittent, and not frequent enough or extensive enough to require daily wearing of absorbent material	10
Note: Evaluate under diagnostic code 7350 (colostomy or ileostomy), if an ostomy is present.	
7333 Stricture of the anus:	
Inability to open or completely close the anus, with complete inability to control liquid or solid feces	100
Reduction of the lumen by at least 50 percent, with pain and prolonged straining during defecation, and complete inability to control liquid feces	60
Reduction of the lumen, but by less than 50 percent, with straining during defecation, and fecal incontinence that requires daily wearing of absorbent material	30
Reduction of the lumen, with fecal soiling that is not frequent enough or extensive enough to require daily wearing of absorbent material	10
Note: Evaluate under diagnostic code 7350 (colostomy or ileostomy), if an ostomy is present.	
7334 Prolapse of rectum:	
Persistent prolapse with complete inability to control liquid or solid feces	100
Intermittent prolapse (occurring three or more times weekly): with complete inability to control liquid or solid feces during periods of prolapse	60
Intermittent prolapse (occurring three or more times weekly): without complete inability to control liquid or solid feces during periods of prolapse, but with difficulty in bowel evacuation and fecal soiling that is frequent enough or extensive enough to require daily wearing of absorbent material	30
Intermittent prolapse with difficulty in bowel evacuation and fecal soiling that is not frequent enough or extensive enough to require daily wearing of absorbent material	10
7335 Fistula in ano (anorectal fistula, anorectal abscess):	
Constant or near-constant abscesses with drainage and pain, refractory to medical and surgical treatment	100
Four or more abscesses (each lasting a week or more) per year with drainage and pain	60
Three or more abscesses (each lasting less than a week) per year with drainage and pain	30
One or two abscesses (each lasting less than a week) per year with drainage and pain, or; fistula with pain and discharge but without associated abscesses	10
7336 Hemorrhoids:	
With either of the following	20
Persistent bleeding with anemia; or	
Permanently prolapsed internal hemorrhoids with three or more episodes per year of thrombosis.	
With either of the following	10
Permanently or intermittently prolapsed internal hemorrhoids with one or two episodes per year of thrombosis; or	
External hemorrhoids with three or more episodes per year of Thrombosis.	
7338 Hernia, inguinal or femoral (both post-operative recurrent and non-operated):	
Hernia with all of the following	60
Greatest diameter is 15 centimeters (5.91 inches) or more;	
Cannot be corrected by surgery; and	
Requires support but is not well supported by external devices or is not easily reducible.	
Hernia with all of the following	30
Greatest diameter is less than 15 centimeters (5.91 inches);	
Cannot be corrected by surgery; and	
Requires support but is not well supported by external devices or is not easily reducible.	
Hernia with all of the following	10
Of any size;	
Can be corrected by surgery;	
Requires support and is supportable by external devices; and	
Easily reducible.	
Note: If there are bilateral hernias, evaluate each hernia separately, and combine (under the provisions of § 4.25).	
7339 Ventral (incisional) hernia, and other abdominal hernias postoperative:	
Hernia with both of the following	100
Greatest diameter is 30 centimeters (11.81 inches) or more; and	
Refractory to further operative correction due to extensive loss of muscular and fascial support.	

	Rating
Hernia with both of the following	60
Greatest diameter is 20 centimeters (7.87 inches) or more; and	
Requires support but is not well supported by external devices or not easily reducible.	
Hernia with both of the following	30
Greatest diameter is less than 20 centimeters (7.87 inches); and	
Requires support but is not well supported by external devices or not easily reducible.	
Hernia with all of the following	10
Of any size;	
Requires support and is supportable by external devices; and	
Easily reducible.	
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7346 Gastroesophageal reflux disease (GERD), hiatal hernia, esophagitis, lower esophageal (Schatzki's) ring:	
Erosive reflux esophagitis (inflammation and ulceration of the esophagus due to reflux of gastric contents into the esophagus) confirmed by endoscopy, imaging, or other laboratory procedure, with at least one of the following	60
Anemia and substantial weight loss;	
One or more episodes per year of gastrointestinal hemorrhage; or	
Two or more episodes per year of pulmonary aspiration (with bronchitis, pneumonia, or pulmonary abscess) due to regurgitation.	
Erosive reflux esophagitis (inflammation and ulceration of the esophagus due to reflux of gastric contents into the esophagus) confirmed by endoscopy, imaging, or other laboratory procedure, with either of the following	30
Symptoms such as pyrosis (heartburn), retrosternal or arm or shoulder pain, regurgitation of gastric contents into the mouth, dysphagia (difficulty swallowing), and odynophagia (pain during swallowing) that are intractable despite treatment; or	
One episode per year of pulmonary aspiration (with bronchitis, pneumonia, or pulmonary abscess) due to regurgitation.	
Symptoms such as pyrosis (heartburn), retrosternal or arm or shoulder pain, regurgitation of gastric contents into the mouth, dysphagia (difficulty swallowing), and odynophagia (pain during swallowing) that are largely controlled by continuous treatment with prescription medication	10
Intermittent symptoms such as pyrosis (heartburn), retrosternal or arm or shoulder pain, regurgitation of gastric contents into the mouth, dysphagia (difficulty swallowing), and odynophagia (pain during swallowing) that respond to dietary changes, lifestyle changes, or treatment with antacids or other nonprescription medications	0
Note: Evaluate esophageal strictures under the General Rating Formula for Residuals of mouth injuries (7200), Residuals of lip injuries (7201), Residuals of tongue injuries, including tongue loss (7202), Esophageal stricture (7203), Achalasia (cardiospasm) and other motor disorders of the esophagus (7204), and Esophageal diverticula (7205).	
7347 Pancreatitis, total pancreatectomy, and partial pancreatectomy:	
With all of the following	100
Daily or near-daily debilitating attacks of pancreatitis with few pain-free intermissions;	
Two or more signs of pancreatic insufficiency (such as steatorrhea, diabetes, malabsorption, diarrhea, and malnutrition); and	
Unresponsive to medical treatment.	
With the following	60
Seven or more documented attacks of pancreatitis per year with at least one sign of pancreatic insufficiency (such as steatorrhea, diabetes, malabsorption, diarrhea, or malnutrition) between acute attacks.	
With any of the following	30
Three to six documented attacks of pancreatitis per year with at least one sign of pancreatic insufficiency (such as steatorrhea, diabetes, malabsorption, diarrhea, or malnutrition) between acute attacks;	
Minimum evaluation following partial pancreatectomy, if symptomatic and requiring continuous treatment with prescription medication; or	
Minimum evaluation following total pancreatectomy.	
One or two documented attacks of pancreatitis per year	10
Partial pancreatectomy, if asymptomatic and not requiring continuous treatment with prescription medication	0
Note (1): For purposes of evaluation under diagnostic code 7347, an attack of pancreatitis means abdominal pain, often very severe, and sometimes radiating through to the back, with any combination of nausea, vomiting, anorexia (lack or loss of appetite), fever, and abdominal tenderness and swelling.	
Evaluation under diagnostic code 7347 requires that the attacks of abdominal pain and other symptoms be confirmed by appropriate laboratory and clinical studies as resulting from pancreatitis	
Note (2): Separately evaluate complications, such as diabetes mellitus, external gastrointestinal fistula, and malabsorption, as long as the same findings are not used to support more than one evaluation (see § 4.14).	
7348 Pyloroplasty with vagotomy or gastroenterostomy with vagotomy:	
Depending upon symptoms and findings, evaluate as: duodenal ulcer (diagnostic code 7305); gastritis (diagnostic code 7307); postgastrectomy syndromes (diagnostic code 7308); or gastric emptying disorders (diagnostic code 7309).	
7349 Bowel stricture:	
Six or more episodes per year of partial obstruction of the bowel (confirmed by an imaging procedure), with typical signs and symptoms	60
Three to five episodes per year of partial obstruction of the bowel (confirmed by an imaging procedure), with typical signs and symptoms	30
One or two episodes per year of partial obstruction of the bowel (confirmed by an imaging procedure), with typical signs and symptoms	10
Note: For purposes of evaluation under diagnostic code 7349, typical signs and symptoms of bowel stricture include colicky abdominal pain, and at least one of the following other symptoms: abdominal distention, borborygmi (audible rumbling bowel sounds), nausea, vomiting, and obstipation (severe constipation).	
7350 Colostomy or ileostomy:	
With at least one ostomy complication (such as infection or signs of irritation of the peristomal area, prolapse, retraction, or stenosis) that is refractory to treatment	100
Incontinent, requiring the use of an external appliance or absorbent material	60
Continent, not requiring external appliance or absorbent material	30

	Rating
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7352 Pancreas transplant:	
Following transplant surgery	100
Thereafter, evaluate on residuals. Minimum evaluation 30 percent.	
Note: The 100 percent rating shall be assigned as of the date of hospital admission for transplant surgery and shall continue with a mandatory VA examination one year following hospital discharge. Any change in evaluation shall be subject to the provisions of § 3.105(e) of this chapter.	
7353 Malabsorption syndrome (including celiac disease, small bowel bacterial overgrowth, Whipple's disease (intestinal lipodystrophy), and fistulous disorders):	
Requiring total parenteral (intravenous or intramuscular) nutritional support	100
Diarrhea, anemia, weakness, and fatigue requiring daily (oral) nutritional supplementation, plus parenteral (intravenous or intramuscular) nutrition for a total of at least 28 days per year	60
Diarrhea, weakness, and fatigue requiring daily (oral) nutritional supplementation plus parenteral (intravenous or intramuscular) nutrition for a total of at least 14 days, but less than 28 days per year	30
Diarrhea, weakness, and fatigue requiring daily (oral) nutritional supplementation	10
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