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Sample Nexus Letter – Primary Service Connection

Musculoskeletal Conditions (Back / Neck) – Records Review Only

February 18, 2026

Department of Veterans Affairs

Claims Intake Center

P.O. Box 4444

Janesville, WI 53547-4444

**Re: Medical Opinion – Primary Service Connection – Lumbar and Cervical Spine
Records Review Only**

Veteran: [Sample Veteran]

VA File Number: [Redacted]

Date of Birth: [Redacted]

To Whom It May Concern:

I am David Protaziuk, MSN, APRN, FNP-C, a board-certified Family Nurse Practitioner licensed to practice in the State of Illinois with Full Practice Authority. I have been practicing as an FNP for over 4 years, with extensive experience reviewing medical records and preparing independent medical opinions for VA disability claims. My opinions are independent, objective, and based solely on the medical evidence reviewed.

Records Reviewed

I have conducted a thorough review of the following materials pertaining to this veteran's claim: complete Service Treatment Records (STRs) covering the entire period of active duty; Department of Defense personnel records including DD Form 214, unit assignment records, and deployment orders; VA electronic health records including primary care and specialty consultation notes from 2011 through the present; private post-service orthopedic and physical therapy treatment notes; magnetic resonance imaging (MRI) of the lumbar spine dated February 2025; MRI of the cervical spine dated March 2025; prior C&P; examination reports; and lay statements from the veteran, his spouse, and two former unit members.

Service History and Documented In-Service Events

[Sample Veteran] served honorably in the United States Army from June 2003 to August 2011, discharged under honorable conditions at pay grade E-5 (Sergeant). His Military Occupational Specialty was 11B (Infantryman) throughout his period of service. Assignments included the 3rd

Brigade Combat Team, 82nd Airborne Division (Fort Bragg, NC) and the 1st Battalion, 502nd Infantry Regiment, 101st Airborne Division (Fort Campbell, KY). The veteran completed two combat deployments to Iraq (Operation Iraqi Freedom, 2005–2006 and 2007–2008) and one deployment to Afghanistan (Operation Enduring Freedom, 2010).

The occupational duties of the veteran's MOS involved sustained axial and biomechanical loading of the cervical and lumbar spine, including but not limited to: routine 12-mile foot marches with rucksack loads of 60–80 pounds; prolonged wear of Interceptor Body Armor and Improved Outer Tactical Vest (approximate weight 33 pounds) for shifts of 8–16 hours; dismounted patrol operations across uneven terrain in Iraq and Afghanistan; Airborne School completion at Fort Benning, GA (multiple parachute jumps with attendant landing impacts); mounted patrol operations in high-mobility multipurpose wheeled vehicles (HMMWV) exposed to roadside improvised explosive devices; and physical training conducted in accordance with the Army Physical Fitness Program.

STRs contain the following relevant in-service medical entries specifically documenting lumbar and cervical spine complaints: (1) May 15, 2006 (Fort Benning, GA) — acute lumbar strain following completion of a 12-mile ruck march with a 65-pound load, treated with 800 mg ibuprofen three times daily, cyclobenzaprine 10 mg at bedtime, and a 7-day light-duty profile; (2) August 22, 2008 (Baghdad, Iraq) — recurrent lumbar pain radiating into the bilateral posterior thighs, occurring after prolonged wear of body armor during a 14-hour operational shift, treated with a 10-day profile restricting lifting to less than 25 pounds; and (3) September 4, 2009 (Fort Campbell, KY) — cervical strain and paravertebral muscle spasm following a vehicular incident in which the veteran's HMMWV struck a roadway obstacle, treated with a soft cervical collar, physical therapy referral, and 14-day light-duty profile. Symptomatic resolution is not documented in the STR entries closing each of these episodes, and no full recovery is documented at the veteran's separation examination in July 2011.

Post-Service Clinical Course

Following honorable discharge, the veteran presented to the VA Medical Center in October 2011 with continuing complaints of low back pain. Primary care notes document persistent axial low back pain rated 6/10 on the numeric rating scale, with intermittent radiation into the bilateral buttocks and posterior thighs. Cervical pain complaints emerged in the VA record in 2013, initially attributed by treating providers to residuals of the in-service 2009 vehicular incident. Conservative management has included sequential trials of physical therapy (four separate courses between 2012 and 2024), chiropractic care, activity modification, non-steroidal anti-inflammatory drugs, muscle relaxants, and lumbar epidural steroid injections in 2019 and 2022. Symptomatic response to conservative treatment has been partial and non-durable, with progressive worsening documented in serial visits over the past 10-year period. The veteran denies any post-service occupational history involving heavy lifting, industrial labor, or repetitive axial loading; post-service employment has been in office administrative roles.

Current Diagnoses and Objective Findings

Current diagnoses: (1) Lumbar degenerative disc disease with chronic strain (ICD-10: M51.36); and (2) Cervical spine degenerative disc disease with chronic strain (ICD-10: M50.30).

Physical examination findings (per C&P; examination and treating provider notes): antalgic gait with shortened stance phase on the right; lumbar range of motion reduced to 40 degrees forward flexion (normal 90 degrees), 15 degrees extension (normal 30 degrees), 20 degrees left and right lateral flexion (normal 30 degrees), and 20 degrees left and right rotation; paraspinal muscle

spasm bilaterally at L3–L5; positive straight leg raise test bilaterally at 45 degrees reproducing radicular symptoms; cervical range of motion reduced to 30 degrees flexion (normal 45), 25 degrees extension (normal 45), 30 degrees lateral rotation bilaterally (normal 80); positive Spurling maneuver on the left; and intact motor strength in the bilateral upper and lower extremities. Functional loss during flare-ups is documented consistent with the Deluca criteria (DeLuca v. Brown, 8 Vet. App. 202 (1995)), including additional loss of range of motion, pain, weakness, fatigability, and lack of endurance during repetitive motion.

Diagnostic imaging. MRI of the lumbar spine (February 2025) demonstrates: L3–L4 mild disc desiccation with a 2-mm central disc bulge and no significant central canal or foraminal stenosis; L4–L5 moderate disc desiccation with a 4-mm posterior central disc protrusion contacting the traversing L5 nerve roots and producing mild central canal stenosis; L5–S1 severe disc desiccation with a 5-mm posterolateral disc protrusion producing mild-to-moderate bilateral neuroforaminal narrowing. MRI of the cervical spine (March 2025) demonstrates: C5–C6 disc desiccation with a 3-mm posterior disc bulge and mild left neuroforaminal narrowing; C6–C7 disc desiccation with a 3-mm posterior central disc bulge; and reversal of the normal cervical lordosis consistent with chronic paraspinal muscle spasm.

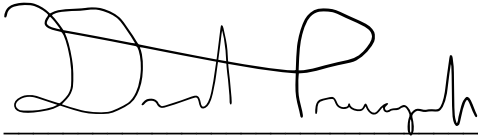
In my professional medical opinion, based on a thorough review of the records and my clinical expertise, [Sample Veteran]'s lumbar spine degenerative disc disease with chronic strain, and cervical spine degenerative disc disease with chronic strain, are at least as likely as not (50 percent or greater probability) caused by or the result of his active military service.

Rationale

- **Documented in-service events establish qualifying injury.** The STRs contain three discrete in-service medical entries documenting acute lumbar strain, recurrent lumbar radicular symptoms, and cervical strain related to defined in-service events (12-mile ruck march, prolonged body armor wear, and vehicular incident, respectively). These entries provide the requisite in-service event or injury element of primary service connection under 38 CFR 3.303(a).
- **Occupational exposure of an infantryman is a known biomechanical risk factor.** The veteran's MOS (11B) placed him in one of the most spine-loading occupations in the U.S. military. Peer-reviewed literature specifically identifies infantry service members and combat-arms MOS designations as demonstrating significantly elevated rates of degenerative musculoskeletal disease compared to non-combat-arms and civilian populations (Cameron et al., 2011; Showery et al., 2016; Knox et al., 2011).
- **Body armor load produces documented cumulative axial spinal stress.** The Interceptor Body Armor system worn by U.S. Army infantry weighs approximately 33 pounds. Prolonged wear of ballistic protection has been demonstrated to produce measurable increases in axial spinal loading, altered lumbar biomechanics, and elevated incidence of low back pain and disc pathology in load-bearing military populations (Konitzer et al., 2008; Reilly et al., 2003).
- **Ruck march loading produces documented lumbar pathology.** The load-bearing profile of the U.S. Army infantryman — routine ruck marches with loads of 60–80 pounds — is a well-established occupational risk factor for accelerated lumbar disc degeneration through cumulative axial compression, altered anterior-posterior spinal loading distribution, and disc dehydration (Roy et al., 2010; Schram et al., 2020).
- **Continuity of symptomatology is documented.** The temporal record demonstrates onset of lumbar symptoms during active duty, symptomatic complaints not fully resolved at separation, presentation to VA within two months of discharge for the same complaints, and progressive worsening over the ensuing 14 years. This uninterrupted chronology satisfies the continuity of symptomatology framework under 38 CFR 3.303(b) and Walker v. Shinseki, 708 F.3d 1331 (Fed. Cir. 2013).
- **Anatomical pattern of pathology is consistent with military biomechanical stress.** The multilevel lumbar disc pathology documented on current MRI (L3–L4 through L5–S1), and the cervical disc pathology at C5–C6 and C6–C7, correspond to the anatomical levels most susceptible to axial loading and combat-related musculoskeletal stress in military populations.
- **Alternative etiologies do not adequately account for the presentation.** The veteran denies significant post-service occupational spinal loading. There is no documented major post-service trauma. The veteran had no pre-service history of back or neck complaints. Congenital or developmental etiology (e.g., spondylolysis, spondylolisthesis) is not present on imaging. Non-service etiologic factors, individually and collectively, cannot account for the multilevel degenerative pathology in a claimant of the veteran's age with his documented in-service exposure history.
- **No offsetting evidence disfavors the nexus.** The record does not contain a well-reasoned contrary medical opinion, and the treating VA orthopedic provider has documented that the veteran's spine pathology is 'consistent with service-related injury and cumulative combat load-bearing.'

This opinion is rendered within a reasonable degree of medical certainty and probability, based solely on the evidence reviewed. This opinion constitutes competent medical evidence within the meaning of 38 CFR 3.159(a)(1); per the Court of Appeals for Veterans Claims in Nieves-Rodriguez v. Peake, 22 Vet. App. 295 (2008), the probative value of a medical opinion depends upon its underlying rationale rather than the professional title of the provider. Should additional clarification be required, please contact me at the above information.

Sincerely,



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Scholarly Sources Cited

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