

This is a fictional sample medical opinion for educational purposes only. No real patient information is used. Actual opinions are personalized after review of genuine records.

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Sample Nexus Letter – Secondary Service Connection

Radiculopathy Secondary to Service-Connected Lumbar Strain – Records Review Only

February 18, 2026

Department of Veterans Affairs

Claims Intake Center

P.O. Box 4444

Janesville, WI 53547-4444

**Re: Medical Opinion – Secondary Service Connection – Bilateral Lower Extremity
Radiculopathy**

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: the veteran's Service Treatment Records (STRs); DD Form 214; the VA rating decision dated [Sample Date] establishing service connection for lumbar strain with degenerative disc disease at 20 percent; VA electronic health records including primary care, physical medicine and rehabilitation, and pain management notes; private neurology consultation notes; magnetic resonance imaging (MRI) of the lumbar spine dated November 2025; electromyography and nerve conduction study (EMG/NCS) dated November 2025; prior C&P; examination reports for the peripheral nerves and thoracolumbar spine; and lay statements from the veteran describing progression of symptoms.

Established Service-Connected Primary Condition

The veteran is service-connected for lumbar strain with degenerative disc disease, rated at 20 percent by VA rating decision dated [Sample Date]. That grant of service connection was based on

documented in-service lumbar strain events during active duty and the establishment of an unbroken chain of continuity of symptomatology from service through post-service records. That determination is not disturbed by this opinion, which addresses only whether the veteran's currently claimed bilateral lower extremity radiculopathy is proximately due to, or aggravated by, that established service-connected primary condition.

Post-Service Clinical Course of the Claimed Condition

The veteran reports insidious onset of bilateral posterior thigh discomfort in approximately 2018, seven years following honorable discharge, initially intermittent and provoked by prolonged sitting or forward bending. Symptoms progressed over the ensuing seven-year period to persistent bilateral radicular pain with associated paresthesias involving the dorsum of the feet and lateral calves. VA primary care notes document progression from complaint of 'occasional leg discomfort' in 2018 to 'constant radiating leg pain with numbness' by 2024. Motor complaints, including intermittent right foot drop noted on prolonged walking, emerged in 2024. Physical therapy conservative management and one course of bilateral L5–S1 transforaminal epidural steroid injections (May 2024) produced only transient symptomatic relief lasting approximately six weeks.

Current Diagnostic Findings

MRI of the lumbar spine (November 2025) demonstrates: L4–L5 posterior central disc protrusion of 5 mm producing moderate central canal stenosis and impingement upon the traversing L5 nerve roots bilaterally; L5–S1 posterolateral disc protrusion of 6 mm producing moderate-to-severe bilateral neuroforaminal narrowing and impingement upon the exiting L5 and traversing S1 nerve roots; ligamentum flavum hypertrophy at both levels contributing to central canal narrowing; and multilevel disc desiccation consistent with the established diagnosis of degenerative disc disease. Radiographic progression from prior imaging is documented, with the current L4–L5 disc protrusion approximately 2 mm larger than on prior study.

Electromyography and nerve conduction study (November 2025) demonstrates: chronic active bilateral L5 and S1 radiculopathy, with evidence of active denervation on needle electromyography of the bilateral tibialis anterior (L5-innervated), medial gastrocnemius (S1-innervated), and lumbar paraspinal muscles at the L5 and S1 levels; reduced motor unit recruitment in the L5 and S1 myotomes bilaterally; H-reflex prolongation bilaterally in the S1 distribution; and F-wave prolongation in the peroneal and tibial nerves bilaterally. Sensory nerve conduction studies of the sural and superficial peroneal nerves are within normal limits, excluding a length-dependent peripheral polyneuropathy as an alternative explanation.

Physical examination findings include diminished pinprick and light touch sensation in the L5 dermatome (dorsum of foot, first web space) and S1 dermatome (lateral foot, posterior calf) bilaterally; reduced motor strength of the tibialis anterior (dorsiflexion) to 4/5 bilaterally and gastrocnemius (plantarflexion) to 4/5 bilaterally; diminished Achilles reflex bilaterally; positive straight leg raise test bilaterally at 30–45 degrees reproducing radicular symptoms; positive crossed straight leg raise; and antalgic gait with shortened right stance phase.

Current diagnosis: Bilateral lower extremity radiculopathy (ICD-10: M54.16 – lumbosacral radiculopathy, bilateral), sciatic distribution, involving the L5 and S1 nerve roots bilaterally, causally attributable to the service-connected lumbar degenerative disc disease.

In my professional medical opinion, based on a thorough review of the records and my clinical expertise, [Sample Veteran]'s bilateral lower extremity radiculopathy is at least as likely as not (50 percent or greater probability) proximately due to, and additionally

aggravated beyond its natural progression by, the service-connected lumbar strain with degenerative disc disease.

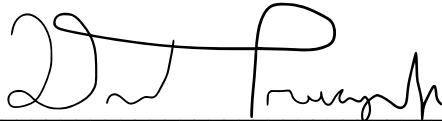
Rationale

- **Anatomical basis for the causal relationship is well established.** Radiculopathy is a well-recognized direct anatomical consequence of lumbar degenerative disc disease. Disc herniation, protrusion, and osteophyte formation at the L4–L5 and L5–S1 levels — as documented on the veteran's MRI — produce both mechanical compression of the exiting and traversing nerve roots and inflammatory irritation via release of inflammatory mediators from the injured disc, generating the classic clinical syndrome of dermatomal pain, paresthesia, sensory loss, and motor weakness (Deyo & Mirza, 2016; Kreiner et al., 2014).
- **Electrodiagnostic findings anatomically corroborate the causal linkage.** The veteran's EMG-confirmed active denervation in the bilateral L5 and S1 myotomes corresponds precisely to the anatomical levels of disc pathology documented on MRI. This anatomical concordance between imaging findings and electrodiagnostic localization is the gold standard for establishing that the radiculopathy is caused by the demonstrated disc pathology rather than by an alternative process (Ropper & Zafonte, 2015).
- **The Spicer 'but-for' causation standard is satisfied.** Under the standard set forth by the Court of Appeals for Veterans Claims in *Spicer v. McDonough*, 32 Vet. App. 116 (2019), the appropriate causation standard for secondary service connection under 38 CFR 3.310(a) is the 'but-for' standard: whether the claimed condition would exist but for the service-connected disability. In the present case, the answer is unambiguously negative — absent the veteran's service-connected lumbar disc disease, the anatomical basis for compression of the L5 and S1 nerve roots would not exist. There is no independent process producing radiculopathy in this veteran.
- **Aggravation is independently satisfied.** Under 38 CFR 3.310(b), a claimant is entitled to service connection for a non-service-connected condition that is aggravated by a service-connected disability, even in the absence of proximate causation. In the present case, radiographic progression of the disc pathology between prior imaging studies and the current MRI has been documented, and the veteran's clinical progression from intermittent complaints in 2018 to persistent bilateral radicular symptoms with motor findings by 2024 corresponds to progression of the underlying lumbar disc pathology. This satisfies the aggravation prong independently.
- **Alternative etiologies are excluded.** The differential diagnosis for lower extremity radicular symptoms includes: length-dependent peripheral polyneuropathy (excluded by normal sural and superficial peroneal sensory nerve conduction studies); diabetic neuropathy (the veteran has no diagnosis of diabetes and normoglycemia is documented in the record); alcoholic or nutritional neuropathy (no history documented); vascular claudication (the veteran has palpable bilateral distal pulses and normal ankle-brachial indices); and hip or piriformis-related pain syndromes (excluded by the presence of true motor and sensory findings in a dermatomal distribution with corroborating electrodiagnostic evidence).
- **Continuity is consistent with a secondary process.** The temporal onset of radicular symptoms seven years after separation is not evidence against causation. Progressive symptomatic radiculopathy attributable to underlying degenerative disc disease characteristically develops over years to decades and does not require immediate temporal proximity to a triggering event.
- **No contrary evidence disfavors the nexus.** The record contains no well-reasoned medical opinion attributing the veteran's radiculopathy to a non-service-connected etiology. Treating providers have consistently attributed the radicular symptoms to progression of the

underlying service-connected lumbar disc disease.

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,

A handwritten signature in black ink, appearing to read 'David Protaziuk', with a stylized flourish at the end.

David Protaziuk, MSN, APRN, FNP-C
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Scholarly Sources Cited

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