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Sample Nexus Letter – Toxic Exposure Risk Activity (TERA)

Respiratory Conditions – Burn Pit and Particulate Matter Exposure – Records Review Only

February 18, 2026

Department of Veterans Affairs
Claims Intake Center
P.O. Box 4444
Janesville, WI 53547-4444

Re: Medical Opinion – Service Connection – Toxic Exposure Risk Activity (TERA) – Respiratory Condition
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); Department of Defense personnel records including DD Form 214 and unit assignment records; deployment orders confirming service in a qualifying Southwest Asia theater of operations; VA electronic health records including primary care and otolaryngology consultation notes; private allergy and immunology consultation notes; computed tomography (CT) of the paranasal sinuses dated August 2025; findings from diagnostic nasal endoscopy performed by an otolaryngologist in September 2025; the veteran's registration in the Department of Veterans Affairs Airborne Hazards and Open Burn Pit Registry; and lay statements from the veteran and a former squadron member.

Service History and Documented TERA Exposure

[Sample Veteran] served honorably in the United States Air Force from 2004 to 2012, with confirmed deployments to Balad Air Base, Iraq (also known as Joint Base Balad; deployment period 2005–2006) and Bagram Air Base, Afghanistan (deployment period 2010–2011). Both installations are recognized within the peer-reviewed literature and by the Department of Defense as sites of substantial open-air burn pit operations during the veteran's periods of assignment.

The open-air burn pit at Balad Air Base — one of the largest documented burn pits of the post-9/11 conflicts — operated continuously during the veteran's 2005–2006 deployment. It was used for combustion of a mixed waste stream that included plastics, medical and biohazardous waste, human waste, petroleum products, unexploded ordnance, munitions residues, and other refuse. Aerial imagery and Department of Defense environmental assessments have documented that airborne emissions from the Balad burn pit produced a characteristic plume that extended over housing, work, and recreational areas of the installation for extended periods depending on wind conditions. The Bagram Air Base burn pit operated on a similar basis during the veteran's 2010–2011 deployment.

In addition to burn pit exposure, the veteran was routinely exposed during both deployments to fine and ultrafine ambient particulate matter (PM2.5 and PM10) originating from regional dust storms, ground operations, and mechanized vehicle exhaust. Environmental monitoring in Southwest Asia deployment settings during this period has documented PM2.5 and PM10 concentrations substantially in excess of U.S. Environmental Protection Agency reference standards for ambient air quality, with peak values during dust events exceeding the reference standard by an order of magnitude or greater.

Symptomatic Onset and Post-Service Clinical Course

STRs document the emergence of persistent nasal congestion, post-nasal drip, and paranasal facial pressure beginning approximately six months into the Balad deployment (fall 2005). Initial evaluation attributed these symptoms to environmental exposure and prescribed conservative treatment with saline nasal irrigation and pseudoephedrine as needed. Symptoms persisted intermittently for the remainder of the veteran's active service, with intermittent flares treated conservatively. STRs at separation document ongoing complaints of 'chronic sinus congestion since Iraq deployment,' without documentation of full symptomatic resolution.

Post-service records document progression to chronic rhinitis with recurrent acute sinus infections. Between 2013 and the present, the veteran has been treated for approximately two to three episodes of acute rhinosinusitis per year, several of which have required courses of oral antibiotics. Sustained management has consisted of daily fluticasone nasal spray, high-volume saline irrigation, and second-generation antihistamines. Allergen skin-prick testing performed in 2023 was negative for common regional aeroallergens, ruling out atopic allergic rhinitis as the primary etiology. The veteran has no documented pre-service history of chronic sinonasal disease.

Current Diagnostic Findings

Computed tomography of the paranasal sinuses (August 2025) demonstrates: mucosal thickening of the bilateral maxillary sinuses ranging 4–6 mm in maximal dimension; mucosal thickening of the anterior and posterior ethmoid air cells bilaterally; retained secretions within the right maxillary sinus consistent with subacute inflammation; patent osteomeatal complexes without complete obstruction; no bone erosion; and mild deviation of the nasal septum without complete obstruction of either nasal passage. Findings are reported as 'consistent with chronic rhinosinusitis.'

Nasal endoscopy (September 2025) demonstrates pale, boggy, and edematous nasal mucosa with copious thin clear discharge in the bilateral inferior meatus and middle meatus; mild inferior turbinate hypertrophy bilaterally; no purulent secretions; no nasal polyps; and mild septal deviation without functional obstruction. The endoscopic findings are documented as consistent with chronic non-allergic rhinitis and chronic rhinosinusitis.

Current diagnoses: (1) Chronic rhinitis, non-allergic (ICD-10: J31.0); and (2) Chronic rhinosinusitis (ICD-10: J32.9).

In my professional medical opinion, based on a thorough review of the records and my clinical expertise, [Sample Veteran]'s chronic rhinitis and chronic rhinosinusitis are at least as likely as not (50 percent or greater probability) caused by, or related to, participation in a Toxic Exposure Risk Activity — specifically, documented exposure to open-air burn pit emissions and ambient particulate matter during qualifying service in the Southwest Asia theater of operations.

Rationale

- **PACT Act presumptive service connection is triggered.** Under Section 406 of the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act of 2022, chronic rhinitis and chronic sinusitis are among the conditions afforded a presumption of service connection for veterans with qualifying Gulf War and post-9/11 combat operations service. The presumption applies to the veteran based on his confirmed qualifying deployments to Iraq and Afghanistan and does not carry a manifestation time-limit for these two specific conditions.

- **The veteran's deployments included documented burn pit exposure at recognized sites.** The veteran's assignments to Balad Air Base and Bagram Air Base — both formally documented open burn pit sites within the qualifying Southwest Asia theater — establish participation in a Toxic Exposure Risk Activity as defined under the statute. Registration in the VA Airborne Hazards and Open Burn Pit Registry provides additional corroboration of the exposure history.

- **Pathophysiologic mechanism linking exposure to the diagnosis is established.** Burn pit emissions in Southwest Asia deployment settings contained a complex mixture of combustion byproducts including polycyclic aromatic hydrocarbons, dioxins, furans, volatile organic compounds, and fine and ultrafine particulate matter. These agents are established biological irritants of the upper respiratory epithelium. Chronic or repeated exposure produces sustained mucosal inflammation, goblet cell metaplasia, impaired mucociliary clearance, and remodeling of the sinonasal mucosa — the pathologic changes underlying chronic non-allergic rhinitis and chronic rhinosinusitis (Krefft et al., 2023; Garshick et al., 2019).

- **Epidemiologic evidence supports the causal linkage.** Population studies of Southwest Asia deployed veterans have documented significantly elevated rates of chronic rhinitis and chronic rhinosinusitis compared to non-deployed populations, with dose-response relationships identified between duration of burn pit proximity and incidence of chronic upper airway disease (Maccarone et al., 2024). The reported prevalence of new-onset chronic rhinosinusitis in this population is on the order of two to three times that of demographically matched non-deployed comparators.

- **Temporal onset supports the causal linkage.** STR documentation of nasal symptom onset during the 2005–2006 Balad deployment, followed by unbroken continuity of complaint through separation and post-service records, establishes both the temporal linkage to the veteran's toxic exposure and the chronic nature of the resulting disease process.

- **Alternative etiologies have been considered and excluded.** The veteran has no pre-service history of chronic sinonasal disease. Allergen skin-prick testing was negative, excluding atopic allergic rhinitis as the primary etiology. The veteran does not smoke tobacco and has never smoked, excluding smoking as a contributing factor. Structural anatomic causes (nasal polyps, significant septal deviation with obstruction, choanal atresia) are excluded on nasal endoscopy. Occupational post-service exposure is not present in the veteran's post-service employment history in office administrative roles.

- **No offsetting evidence disfavors the nexus.** The record contains no well-reasoned contrary medical opinion. Treating providers have documented the veteran's chronic rhinosinusitis as 'consistent with post-deployment environmental exposure syndrome' and attributed the etiology to Southwest Asia burn pit exposure.

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,

David Protaziuk, MSN, APRN, FNP-C
Board-Certified Family Nurse Practitioner
Illinois APRN License #277002570 (Full Practice Authority)
NPI #1275200149

Scholarly Sources Cited

- Falvo MJ, Osinubi OY, Sotolongo AM, Helmer DA. Airborne hazards exposure and respiratory health of Iraq and Afghanistan veterans. Epidemiol Rev. 2015;37:116-130. doi:10.1093/epirev/mxu009.
- Garshick E, Abraham JH, Baird CP, et al. Respiratory Health after Military Service in Southwest Asia and Afghanistan. An Official American Thoracic Society Workshop Report. Ann Am Thorac Soc. 2019;16(10):e1-e16. doi:10.1513/AnnalsATS.201904-344WS.
- Krefft SD, Strand M, Rose CS. Military burn pit exposure and airway disease: Implications for our Veteran population. Ann Allergy Asthma Immunol. 2023;131(5):559-569. doi:10.1016/j.anai.2023.06.012.
- Maccarone JL, Redlich CA, Timmons AC, et al. Sinusitis and rhinitis among US veterans deployed to Southwest Asia and Afghanistan after September 11, 2001. J Allergy Clin Immunol Glob. 2024;3(4):100367. doi:10.1016/j.jacig.2024.100367.
- Szema AM, Salihi W, Savary K, Chen JJ. Respiratory symptoms necessitating spirometry among soldiers with Iraq/Afghanistan war lung injury. J Occup Environ Med. 2011;53(9):961-965. doi:10.1097/JOM.0b013e31822c9f05.
- Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act of 2022, Pub. L. No. 117-168, 136 Stat. 1759 (2022).