



# **Guide to the assessment of rates of veterans' pensions**

Department of Veterans' Affairs  
Canberra

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## VETERANS' ENTITLEMENTS ACT 1986

### SECTION 29

## INSTRUMENT OF APPROVAL

### *Approval*

- (1) I, BRUCE CRAIG SCOTT, Minister for Veterans' Affairs, in accordance with subsection 29(3) of the *Veterans' Entitlements Act 1986* (the Act), approve:
- (a) the instrument (No.8 of 1997) prepared by the Repatriation Commission under subsection 29(2) of the Act revoking the *Guide to the Assessment of Rates of Veterans' Pensions* prepared by it under subsection 29(1) of the Act by instrument No.7 of 1994, dated 10 June 1994; and
  - (b) the *Guide to the Assessment of Rates of Veterans' Pensions*, instrument No.9 of 1997, prepared by the Repatriation Commission under subsection 29(1) of the Act on 30 September 1997.

### *Commencement*

- (2) This instrument of approval commences on 1 March 1998.

Dated this First day of October, 1997

A handwritten signature in black ink, appearing to read 'Bruce Scott'.

BRUCE SCOTT, MP  
Minister for Veterans' Affairs



Instrument No.9 of 1997

# *Guide to the Assessment of Rates of Veterans' Pensions*

The REPATRIATION COMMISSION prepares the following Guide to the Assessment of Rates of Veterans' Pensions under subsection 29(1) of the *Veterans' Entitlements Act 1986*.

Dated: *30th September* 1997

A stylized handwritten signature in black ink.

NEIL JOHNSTON  
PRESIDENT

A handwritten signature in black ink, appearing to read 'K. Lyon'.

KEITH LYON  
DEPUTY PRESIDENT

A handwritten signature in black ink, appearing to read 'P. Stevens'.

PAUL STEVENS  
COMMISSIONER

# Introduction

## Purpose

This *Guide* is to be applied to assess the extent of incapacity from war-caused or defence-caused injury or disease. Its provisions are binding on the Repatriation Commission, the Veterans' Review Board, and the Administrative Appeals Tribunal.

## Legal background

The *Veterans' Entitlements Act 1986* (the Act) provides for pensions to veterans for incapacity resulting from war or defence-caused injuries and diseases (sections 13 and 70).

The terms "injury" and "disease" are defined in subsection 5D(1) of the Act. A veteran's incapacity is defined by subsection 5D(2) as the effects of that injury or disease.

The Act provides three fundamental rates of pension: a general rate, an intermediate rate, and a special rate.

Section 22 of the Act provides that the percentage of general rate of pension payable is to be determined by reference to the extent of the veteran's incapacity as assessed in accordance with this *Guide*. Section 29 of the Act provides that the Repatriation Commission prepare the *Guide*, setting out:

- "(a) criteria by reference to which the extent of the incapacity of a veteran resulting from war-caused injury or war-caused disease, or both, shall be assessed; and
- (b) methods by which the extent of that incapacity, as assessed in accordance with those criteria, shall be expressed as a percentage of incapacity from that injury or disease, or both, being a percentage not exceeding one hundred per centum."

Subsection 22(4) of the Act sets out the criteria in accordance with this *Guide* that must be met in order to qualify for the extreme disablement adjustment.

## Definitions

For the purposes of this *Guide*, and unless a contrary intention appears:

"Act" means the *Veterans' Entitlements Act 1986* as amended from time to time;

"accepted condition" means an injury or disease that has been determined under the Act to be war-caused or defence-caused;

"add" means find the arithmetic sum of two or more numbers;

"clinical features" includes signs and symptoms;

"combine" means produce a result by combining two or more numbers by applying Table 18.1 (Combined Values Chart) in Chapter 18 in accordance with that chapter;

"condition" means an injury or a disease;

## Introduction

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“defence-caused injury” and “defence-caused disease” have the meaning given in section 70 of the Act;

“disease” has the meaning given by section 5D of the Act;

“Guide” means this *Guide to the Assessment of Rates of Veterans’ Pensions*;

“impairment rating” means a measure of the degree of medical impairment due to accepted conditions, on a scale of 0 to 100.

“incapacity” has the meaning given in subsection 5D(2) of the Act;

“injury” has the meaning given by section 5D of the Act;

“non-accepted condition” means an injury or disease that:

- \* has not been determined under the Act to be war-caused or defence-caused; or
- \* has been determined under the Act not to be war-caused or defence-caused;

“Statement of Principles” means:

- \* a Statement of Principles determined by the Repatriation Medical Authority under section 196B of the Act; or
- \* a determination made by the Repatriation Commission under section 180A of the Act; or
- \* a statement of principles concerning a particular kind of injury or disease made available to the Veterans’ Review Board by the Repatriation Commission under paragraph 138(2)(a) of the Act;

“veteran” means a person (including a deceased person) in respect of whom an injury or disease has been determined under the Act to be war-caused or defence-caused;

“war-caused injury” and “war-caused disease” have the meaning given in section 9 of the Act;

“worksheet” means a page or pages of this *Guide*, identified as a “worksheet”, that gives a structure by which certain calculations may be set out to assist in determining an impairment rating.

Definitions of words and phrases that are used in only one chapter are to be found in that chapter, or in the Glossary.

### Acknowledgment of sources

The following published works were found to be useful in the preparation of this edition of the *Guide*:

*Guides to the Evaluation of Permanent Impairment*, 4th edition, American Medical Association, 1993;

*International Classification of Impairments, Conditions, and Handicaps*, World Health Organisation, Geneva, 1980; and

Publication No 118 of the National Acoustic Laboratories, *Improved Procedure for Determining Percentage Loss of Hearing*, by J. Macrae, Australian Government Publishing Service, Canberra, 1988.



# *How To Use This Guide*

## **The subject of assessment**

This *Guide* is to be applied to assess the degree of incapacity from injuries or diseases or both that have been determined to be war-caused or defence-caused.

In making an assessment the clinical features of war-caused or defence-caused injuries or diseases are to be taken into account. Clinical features of sequelae of accepted conditions can only be assessed after the sequelae have been determined to be war-caused or defence-caused.

## **The elements of assessment**

The two elements of the assessment of degree of incapacity are *medical impairment* and *lifestyle effects*. Lifestyle effects are dealt with in Chapter 22. Other chapters address medical impairment.

## **Medical impairment**

Medical impairment has two components:

- \* physical loss of, or disturbance to, any body part or system; and
- \* the resultant functional loss.

Chapters 1 to 16 of the *Guide* contain two principal types of tables. Physical loss is to be rated against criteria in "Other Impairment" tables. Functional loss is to be rated against criteria in "Functional Loss" tables.

Greater emphasis has been given throughout this *Guide* to functional loss as a basis for assessment. It is measured by reference to an individual's performance efficiency compared with that of an average, healthy person of the same age and sex, in a set of defined vital functions. This is a means of compensating for the loss of ability to perform everyday functions.

Each table contains benchmark values, generally at intervals of five points. In some cases the range between nil and five includes a rating of two points. In some other cases intervals are greater than five points because lesser increments of impairment cannot be distinguished.

Each benchmark is a threshold value, that is, the rating applies only if the threshold is achieved or exceeded. Ratings are not to be rounded up to the next benchmark. Similarly, ratings between benchmark values contained in the tables are not to be interpolated.

On some tables more than one criterion is stated opposite a benchmark value. The different criteria are marked by dot points. Where more than one criterion is stated for a particular value, the condition being assessed only has to satisfy one of the criteria in order to attract the impairment rating of that value.

Each chapter contains step-by-step instructions to be followed in the use and application of the tables.

### **Whole person impairment**

Medical impairment is expressed in impairment points, out of a maximum rating of 100. On this scale, zero points corresponds to no or negligible impairment from accepted conditions, and 100 points corresponds to death. Effectively, impairment points are percentages of the impairment of the whole person.

### **Functional loss**

Medical impairment is measured chiefly by loss of vital functions, addressed in twelve system specific chapters, as follows:

- \* Cardiorespiratory Impairment
- \* Hypertension and Non-Cardiac Vascular Conditions
- \* Impairment of Spine And Limbs
- \* Emotional and Behavioural
- \* Neurological Impairment
- \* Gastrointestinal Impairment
- \* Ear, Nose and Throat Impairment
- \* Visual Impairment
- \* Renal and Urinary Tract Function
- \* Sexual Function, Reproduction and Breasts
- \* Skin Impairment
- \* Endocrine and Haemopoietic Impairment

Functional loss is to be rated against criteria in “Functional Loss” tables. Each functional loss associated with an accepted condition is to be identified and rated individually. In most cases a single condition gives rise to a single functional loss.

If there is a multisystem condition in which a single condition gives rise to multiple functional losses, then such a single condition is to be rated using several Functional Loss tables. The separate ratings are only to be combined with each other in the final combining of all ratings from all accepted conditions. If two or more conditions contribute to the same functional loss, a single rating only is to be given for that functional loss.

### **Other Impairment**

Other Impairment is the physical loss of, or disturbance to, any body part or system. This concept is extended in some chapters to include discomfort, pain, poor prognosis and other, less tangible, effects of accepted conditions. It is to be rated against criteria in “Other Impairment” tables.

As a general rule, ratings from Other Impairment and Functional Loss tables are not to be combined for the same condition. Exceptions to this rule are expressly indicated in particular chapters. When ratings from both types of table can be applied, the higher rating is to be chosen.

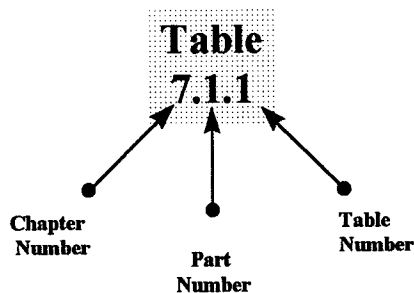
### **Lifestyle effects**

Lifestyle effects are to be assessed by applying Tables 22.1 to 22.5 in Chapter 22 in accordance with that chapter.

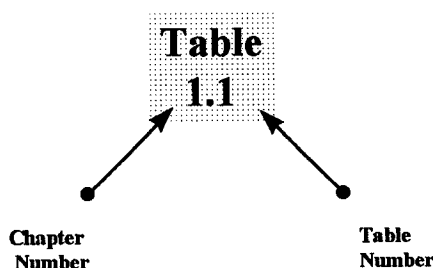
## The tables

*Types of Tables.* There are five types of tables in the *Guide*. They are “Functional Loss”, “Other Impairment”, “Scale”, “Procedural”, and “Lifestyle”. Each table carries its type identification and number in the top left hand corner.

Some chapters are divided into parts. The tables in these chapters carry a number in three segments (separated by full stops):



Tables in chapters not divided into parts carry a number in two segments:



*Gender Use.* Some tables are for men only, some for women only, and others (the majority) are not gender specific. Each table is clearly marked in the top right hand corner:

- \* the symbol ♀ means that the table is only to be used for the assessment of *female* veterans;
- \* the symbol ♂ means that the table is only to be used for the assessment of *male* veterans;
- \* the symbol ♂ means that the table may be used for *both genders*.

*Age Adjustment.* Some tables incorporate age dependent criteria. Some other tables have no such criteria and require subsequent age adjustment by applying tables provided for that purpose.

Each table is clearly marked in the bottom left hand corner with instructions on age adjustment for ratings derived from that table.

## Non-system specific assessments

There are five chapters describing alternate methods of assessing certain conditions. They are:

- \* Chapter 13 — Negligible Impairment
- \* Chapter 14 — Malignant Conditions

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- \* Chapter 15 — Intermittent Impairment
- \* Chapter 16 — Activities Of Daily Living
- \* Chapter 17 — Disfigurement

A condition may be assessable under both system specific chapter(s) and non-system specific chapter(s), for example, carcinoma of the lung or epilepsy.

As a general rule, ratings from chapters 14, 15, and 16 are not to be combined with any impairment ratings for the same condition derived from one or more system specific chapters. The impairment ratings from the the system-specific chapters and the non-system specific chapters are to be compared and the higher impairment rating is to be selected.

Ratings from Chapters 13 and 17 are to be dealt with differently. Any applicable rating from Chapters 13 and 17 is to be combined with any applicable ratings from other chapters in the final combining of all ratings.

### **Conditions and their sequelae**

Only the clinical features of an accepted condition may be taken into account in making an assessment. If the accepted condition causes some other distinct and diagnosable condition (sequela), the symptoms of the sequela cannot be taken into account when assessing the original accepted condition. Sequelae can only be assessed when they have themselves been separately determined to be war-caused or defence-caused.

As a general guide, a condition that is the subject of a Statement of Principles in force on 1 March 1998 should be taken as a separate disease entity. For the purposes of the preceding sentence, "Statement of Principles" has the meaning given to it on page 2 of this *Guide*.

### **Applying the instructions**

To the extent of any inconsistency between an instruction in "How To Use This Guide" and a specific instruction concerning a particular matter in another chapter of this *Guide*, the specific instruction in that other chapter is to apply to that particular matter.

### **If assessment of impairment is not possible**

If it is impossible to assess the impairment of an accepted condition that has previously been assessed under this or an earlier edition of the *Guide*, the impairment rating that was last given for that accepted condition (under this or the earlier edition of the *Guide*, as the case may be) is to be taken to be the impairment rating for that condition.

For example, if the veteran has an accepted visual loss, which at the last assessment had been given a rating of 15 impairment points, and is now afflicted with dementia, which prevents the assessment of that visual loss, the impairment rating for that visual loss would be taken to be 15 impairment points for the purposes of the current assessment.

If there has never been a previous assessment of impairment made for a particular accepted condition (under this or an earlier edition of the *Guide*) and it is otherwise impossible to assess the impairment of that condition in accordance with this *Guide*, a

best estimate must be made based on what medical and other evidence is available concerning the extent of impairment from that condition. Such assessment of impairment must take into account the contribution to impairment from other conditions and the expected course of the condition, including the effect of aging by reference to age adjustment tables, as appropriate. The impairment rating given by this method must be as consistent as possible with the relevant steps and tables in this *Guide*.

### **Pain and suffering**

Pain and suffering have been taken into account in this *Guide* in the following manner:

- \* if pain and suffering restrict everyday activities, the functional loss caused is rated in the appropriate table;
- \* if pain and suffering occur without restriction to any activity the appropriate Other Impairment table is used; and
- \* allowance for pain and suffering is included in the lifestyle assessment.

### **Medication or treatment**

In some cases, type of medication or treatment has been used as an indicator of the severity of disablement. Examples are given in the tables. Such tables contain appropriate criteria about medication. No additional rating is therefore required.

*Persistent side effects* of long term treatment are to be assessed as part of the condition being treated, using the appropriate system specific tables. Persistent side effects are those side effects of the treatment that persist during therapy but which resolve on (or shortly after) cessation of therapy.

*Permanent side effects* of long term treatment cannot be assessed as part of the condition being treated. Permanent side effects are those side effects of the treatment that persist during therapy and which do not resolve on (or shortly after) cessation of therapy. Such permanent side effects would generally be covered by a Statement of Principles. The permanent side effects must first be determined to be war-caused or defence-caused, before they can be assessed.

### **Time reference**

The severity of many conditions fluctuates over time and may be better assessed by an averaging process. Therefore, because some criteria refer to the occurrence of symptoms during a period, it will be necessary to assess an averaged severity during that period. Twelve months is usually a suitable period, as it allows any seasonal fluctuation to be observed, but the period may be varied according to circumstances.

For tests done on a particular date, specifically spirometry, audiometry and creatinine clearance calculated from the formula, the veteran's age for the purpose of obtaining an impairment rating shall generally be his or her age on the date of the test.

### **Duration of assessment period**

While the Act requires the assessment of a rate or rates of pension over an "assessment period" (see section 19 of the Act), that assessment can in practice only be made by reference to the available medical and other material that, of necessity, relates to a

particular point or period in time. Therefore, the assessment of the impairment and lifestyle ratings during the “assessment period” must be based on the assessor’s reasonable satisfaction as to those ratings throughout the assessment period, based on the available material. If there is a significant change in impairment or lifestyle during an assessment period, the assessment period must be divided into appropriate periods to reflect those changes, and separate assessments made of the degree of incapacity.

### **Apportionment of impairment ratings**

It is sometimes necessary, for an accepted condition, to compare an impairment rating derived from one table with an impairment rating derived from another table. When two or more conditions contribute to the impairment ratings from either or both tables, and comparison is necessary, the method called “apportionment” is to be applied before making the comparison.

Details on the application of apportionment are given in Chapter 20.

### **Paired organs policy**

The paired organs policy is described in Chapter 21.

### **Combining impairment ratings**

If all accepted conditions have been given impairment ratings, the ratings are to be combined by applying Table 18.1 (Combined Values Chart).

Details on how to apply Table 18.1 are given in Chapter 18.

The combined impairment rating obtained by applying Table 18.1 (Combined Values Chart) is to be rounded to the nearest five points. If Table 18.1 is not required to be applied because only one impairment rating has been obtained and that rating is not a multiple of five, that rating is to be rounded to the nearest five points (or to zero) to produce the impairment rating for the purposes of applying Table 23.1 in Chapter 23 (Conversion to Degree of Incapacity), and for the purposes of the extreme disablement adjustment.

### **Degree of incapacity**

The combined impairment rating which is obtained by applying Chapter 18 (Combined Values Chart) is to be combined with the lifestyle rating to determine the degree of incapacity, by applying Table 23.1 (Conversion to Degree of Incapacity) in accordance with Chapter 23.

### **Degree of incapacity for specific disabilities**

If a veteran has one or more accepted conditions that are listed in Column 1 of Table 24.1, then the degree of incapacity of the veteran must be determined in accordance with Chapter 24. The veteran’s degree of incapacity from accepted conditions determined by applying chapters 1-23 of the *Guide*, is to be compared with the degree of incapacity determined by applying Chapter 24, and the higher degree of incapacity is to be taken. This is the veteran’s final degree of incapacity from all accepted conditions.

# *Medical Impairment*





*Part A:*  
*System Specific*  
*Assessment*



# CHAPTER 1

## CARDIORESPIRATORY IMPAIRMENT

### INTRODUCTION

*Cardiorespiratory impairment* results from conditions that affect the function of the heart or lungs. The procedures described in this chapter are to be applied in assessing most conditions of the heart and lungs, and will usually also be appropriate for conditions affecting the function of the thorax or diaphragm, lesions of the nerves that supply the muscles of respiration, and conditions such as anaemia. The principal exception is any condition which is predominantly intermittent in nature and which would be better assessed by applying Chapter 15 (Intermittent Impairment).

Different procedures (described in Chapter 2) are to be applied to assess hypertension and non-cardiac vascular conditions (such as aortic aneurysm and varicose veins).

In general, *cardiorespiratory impairment* is to be measured by reference to exercise tolerance. Exercise tolerance is quantified in terms of METs (see pages 21-22). However, if a respiratory component is present, measurements of lung function, such as *forced expiratory volume in one second* (FEV1), *forced vital capacity* (FVC), and *maximal expiratory flow* (MEF 25-75) are to be used in addition to exercise tolerance. FEV1 and FVC are to be measured by spirometry. For the purposes of assessment in accordance with this *Guide*, the terms “MEF 25-75” and “FEF 25-75” (*forced expiratory flow between 25% and 75% of the vital capacity*) are to be taken as equivalent.

The conversion of loss of exercise tolerance and measurements of lung function into an impairment rating is set out in Table 1.2 and Table 1.3.

Certain cardiorespiratory conditions cannot be rated by applying exercise tolerance. These include:

- \* conditions that do not decrease exercise tolerance;
- \* conditions that do not produce symptoms; and
- \* intermittent conditions.

“Exercise tolerance” refers to a person’s ability to exercise from a cardiorespiratory point of view rather than to a person’s total ability to exercise. For example, a veteran who has osteoarthritis of both knees may be greatly limited in walking but may still be able to swim a considerable distance. Such a veteran would still have good exercise tolerance from a cardiorespiratory point of view, though total ability to exercise would be reduced.

A veteran whose ability to exercise has been significantly reduced by other conditions (such as musculoskeletal conditions or being grossly overweight), or who no longer has cardiac or respiratory symptoms on exercise, cannot always be given an appropriate impairment rating for reduced exercise tolerance. However, the need to apply Chapter 19 (Partially Contributing Impairment) should always be considered before disregarding exercise tolerance figures.

## Cardiorespiratory Impairment

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### Calculation of the impairment rating for accepted cardiorespiratory conditions.

Follow the steps below to determine the impairment rating for cardiorespiratory conditions:

(Each step is elaborated in the following pages.)

<b>STEP</b> ①	Establish what cardiorespiratory conditions are present.	<i>Page 15</i>
<b>STEP</b> ②	Assess the information that is available and decide whether it is reliable and sufficient.	<i>Page 15</i>
<b>STEP</b> ③	Determine the impairment based on effort tolerance.	<i>Page 17</i>
<b>STEP</b> ④	<i>(Omit this step if no respiratory disease is present.)</i> Determine the impairment based on spirometry.	<i>Page 20</i>
<b>STEP</b> ⑤	Determine the total accepted cardiorespiratory functional impairment rating.	<i>Page 27</i>
<b>STEP</b> ⑥	Consider the effects of cardiac failure (if any).	<i>Page 30</i>
<b>STEP</b> ⑦	Moderate the total cardiorespiratory functional impairment to allow for effects of any non-accepted conditions.	<i>Page 30</i>
<b>STEP</b> ⑧	Determine whether any ratings from the relevant Other Impairment tables apply (Tables 1.7, 1.8, 1.9, 1.10).	<i>Page 31</i>

**Step 1: Establish what cardiorespiratory conditions are present.**

For the purpose of assessing cardiorespiratory impairment, both the *accepted* and the *non-accepted* conditions are to be taken into account. Both will affect the way in which cardiorespiratory functional impairment is calculated. (Their combined effect is taken into account in the application of Table 1.5 in Step 5.)

Any non-accepted conditions are to be subsequently allowed for by applying Chapter 19 (Partially Contributing Impairment) — see Step 7.

When considering the question: ‘What cardiorespiratory conditions are present in this veteran?’, it is not appropriate to rely simply on a list of accepted conditions. Both previously claimed but rejected cardiorespiratory conditions and unclaimed cardiorespiratory conditions may also be present.

**Step 2: Assess what information is available and decide whether it is reliable and sufficient.**

To make a reliable cardiorespiratory assessment, there should be an adequate medical history of the veteran’s cardiorespiratory conditions. In addition, there should be information relating to the veteran’s effort tolerance and, if any respiratory disease is present, there should also be one or more sets of spirometry or other physiological measurements of respiratory function. The criteria by which the evaluation of the information is to be made is set out below.

**Medical history**

An adequate history of the veteran’s illness and a description of the current symptoms and details of the current treatment should be available.

The history should be reviewed at the start of the cardiorespiratory assessment procedure to establish whether any major cardiorespiratory event (for example a myocardial infarction or bypass surgery) has occurred within the period of assessment.

An examination of the history will indicate whether any other impairment ratings (from Tables 1.7, 1.8, 1.9, 1.10) are applicable. For example, in the case of ischaemic heart disease, the history will reveal whether the veteran has had any myocardial infarctions, whether coronary bypass surgery has been performed and the outcome of any such surgery. In other cases, for example when respiratory disease is present, the current treatment will reveal whether any other impairment rating for cardiorespiratory conditions is applicable.

In long-standing respiratory conditions, there will often be a disease complex present that is more extensive than that implied by the original diagnostic label. For example, asthma may lead to chronic obstructive respiratory disease and chronic bronchitis may lead to small airways disease. Such extensions of the disease process are to be assessed as part and parcel of the original condition unless there is clear reason why they should not be - for example, they have been determined to be non-accepted conditions.

### Effort tolerance

Effort tolerance information should always be obtained except if the veteran has a condition that renders the collection of reliable effort tolerance information impracticable.

Examples of conditions that may render the collection of reliable effort tolerance information impracticable include:

- \* hemiparesis following a stroke;
- \* quadriplegia or hemiplegia;
- \* severe arthritis of the lower limbs; and
- \* certain mental conditions such as dementia (in which the veteran's ability to co-operate or provide useful information may be restricted).

The date of the effort tolerance information used must be appropriate to the period of assessment: the effort tolerance information should be *not more than six months older* than the relevant time in the assessment period to which the information is to be applied.

### Measurements of lung function

Spirometry should always be obtained if any condition affecting the function of the lungs is present unless it is not practicable or appropriate to perform spirometry because:

- \* the veteran is very old or frail and cannot reasonably attend a clinic where spirometry can be performed; or
- \* the veteran lives in a remote locality and cannot reasonably attend a clinic where spirometry can be performed; or
- \* the veteran's impairment from other accepted conditions is of such a degree that it would result in a combined impairment rating of at least 68 points.

The date of the spirometry used must be appropriate to the period of assessment: the spirometry should be *not more than six months older* than the relevant time in the assessment period to which the information is to be applied.

The nature of the spirometry should be appropriate: the nature of the spirometric readings should be *consistent with the known conditions affecting the veteran* and should also be consistent with such other information (eg, old spirometry) as is available or can reasonably be obtained. There should be no unexplained inconsistencies between the various reports.

If the nature of the spirometry cannot be reconciled with other relevant information, the spirometry may need to be repeated or the veteran referred to a respiratory physician for clarification of the situation.

If a veteran has emphysema, as evidenced by diminished carbon diffusing capacity, and diagnosed by a specialist respiratory physician, assessment can be made on the basis of effort tolerance alone.

**Step 3: Determine the impairment rating based on effort tolerance.**

To determine the impairment rating based on effort tolerance follow the substeps below.

(Each step is elaborated in the following pages.)

<b>Substep 3A</b>	<b>Determine the symptomatic activity level</b> by applying Table 1.1 — Activity Levels (with energy expenditure in METs).	<i>Page 17</i>
<b>Substep 3B</b>	<b>Convert that symptomatic activity level into an impairment rating.</b> This step involves consulting either Table 1.2. — Loss Of Cardiorespiratory Function: Exercise Tolerance (Males); or Table 1.3 — Loss Of Cardiorespiratory Function: Exercise Tolerance (Females).	<i>Pages 21-22</i>

After both substeps have been completed, a single rating will have been obtained. This rating is known as the impairment rating for effort tolerance.

If symptoms do not occur, a rating for the condition may be found in Table 1.6 (Cardiac Failure) if applicable, or in the relevant Other Impairment table.

**Substep 3A: Determine the symptomatic activity level.**

The **symptomatic activity level** is the exercise level (measured in METs) at which symptoms occur. One MET represents the energy expenditure associated with the consumption of 3.5 mL oxygen per kilogram of body weight per minute. Table 1.1 lists various activities grouped according to their energy expenditure in METs.

The symptomatic activity level is the level at which the activities from within any one METs category consistently give rise to symptoms of the accepted cardiorespiratory condition, such as angina, dyspnoea, palpitations, or fatigue. The symptomatic activity level may be determined by reference to a report specifically provided for the purpose as well as by reference to clinical notes and by comparison of the information with the activities listed in Table 1.1. (The symptomatic activity level may be determined by reference to activities other than those contained in Table 1.1 if the energy expenditure (in METs) of those activities is available in the medical or scientific literature.)

In determining the symptomatic activity level, greater reliance is to be placed on activities that involve steady, as opposed to sporadic, expenditure of energy. Such activities are more reliable as indicators of exercise tolerance. Less reliance is to be placed on activities that can be completed in less than a few minutes, as symptoms may take longer than this to occur.

Responses of the type 'I cannot do such and such' or 'I do not do so and so' are not useful in assessing the symptomatic activity level. What must be established is that level of exercise that the veteran is able to do but which results in angina, breathlessness, or some other cardiorespiratory symptom.

Symptoms that occur while an activity is performed are not necessarily a result of the energy expenditure occasioned by the activity. Many specific activities can be

performed in a way which would mean that they were no longer examples of the METs level in which they are placed in Table 1.1. For example, while driving a car sedately is an example of 2-3 METs, driving a car in a Grand Prix is not.

Scale  
1.1

## CARDIORESPIRATORY IMPAIRMENT: ACTIVITY LEVELS (with energy expenditure in METs)

### 1-2 METs — Energy expended at rest or minimal activity

- Lying down.
- Sitting and drinking tea.
- Using sewing machine (electric).
- Sitting down.
- Sitting and talking on telephone.
- Travelling in car as passenger.
- Standing.
- Sitting and knitting.
- Playing cards.
- Strolling (slowly).
- Light sweeping.
- Clerical work (desk work only).

### 2-3 METs — Energy expended in dressing, washing and performing light household duties

- Light household duties.
- Walking slowly (3.5 km/h).
- Playing piano, violin, or organ.
- Typing.
- Cooking or preparing meals.
- Playing billiards.
- Clerical work which involves moving around.
- Setting table.
- Driving power boat.
- Washing dishes.
- Playing golf (with power buggy).
- Bench assembly work (scated).
- Dressing, showering.
- Horseback riding at walk.

- Using self-propelled mower
- Light tidying, dusting
- Lawn bowls
- Polishing silver
- Driving car

### 3-4 METs — Energy expended in walking at an average pace

- Walking at average walking pace (5 km/h).
- Golf (pulling buggy).
- Machine assembly.
- Cleaning car (excludes vigorous polishing).
- Minor car repairs.
- Tidying house.
- Welding.
- Cleaning windows.
- Table tennis
- Pushing light power mower over flat suburban lawn at slow steady pace.
- Vacuuming.
- Sedate cycling (10 km/h).
- Shifting chairs.
- Light gardening (weeding and watering).
- Hanging out washing.
- Making bed.

### 4-5 METs — Moderate activity: encompasses more strenuous daily activities with the exclusion of manual labour and vigorous exercise

- Mopping floors.
- Golf (carrying bag).
- Light carpentry (eg, chiselling, hammering).
- Scrubbing floors.
- Ballroom dancing.

- Beating carpets.
- Tennis doubles (social, non-competitive).
- Stocking shelves with light objects.
- Polishing furniture.
- Wallpapering.
- Shopping and carrying groceries (10kg).
- Gentle swimming.
- Painting outside of house.
- Hoeing (soft soil).
- Stacking firewood.

### 5-6 METs — Heavy exercise: manual labour or vigorous sports

- Walking 6.5km/h (sustained brisk walk, discomfort in talking at the same time).
- Walking slowly but steadily up stairs.
- Carpentry (eg, sawing and planing with hand tools).
- Swimming laps (non-competitive).
- Pushing a full wheelbarrow (20 kg).
- Shovelling dirt (12 throws a minute).
- Digging in garden.

### 6-7 METs

- Badminton (competitive).
- Tennis (singles, non-competitive).
- Water skiing.
- Loading truck with bricks.
- Using a pick and shovel to dig trenches.

Ratings Derived  
From METs  
Are Age  
Adjusted.

The activities listed under each heading are examples. There will be other activities that have the same METs expenditure and hence can be used for reference if their METs level is known.



Estimations of exercise tolerance above the 6-7 METs level should only be made using exercise tests. The following activities are listed for information only.

**7-8 METs**

- Very heavy exercise
- Jogging (8 km/h).
- Horseback riding (galloping).
- Carrying heavy objects (30 kg) on level ground.
- Sawing hardwood with hand tools.

**8-9 METs**

- Running (9 km/h).
- Skiing (cross-country).

- Chopping hardwood.
- Callisthenics.
- Squash (non-competitive).

**10+ METs**

- Running quickly (10 km/h).
- Cycling quickly (25 km/h). Carrying loads (10 kg) up a gradient.
- Football (any code).

**Alternate procedures for establishing the symptomatic activity level**

1. The symptomatic activity level may be determined by exercise tests. These tests include:

- \* use of treadmills; or
- \* cycles; or
- \* rowing machines.

Because of their greater objectivity, the results of exercise tests (when available) are to be used in preference to the method of calculating exercise tolerance as described above. Moreover, exercise tests must always be used to make an estimate of exercise tolerance above 6-7 METs.

2. If certain levels of activity have been prohibited by the treating doctor, because of the adverse effect the prohibited activity is likely to have on the veteran's health as a result of the accepted condition, then the level of exercise that has been prohibited may be regarded as the symptomatic activity level.

**Substep 3B: Convert the symptomatic activity level into an impairment rating**

The symptomatic activity level is used, in conjunction with the veteran's age, height, and sex, to obtain an impairment rating.

In the case of a male, Table 1.2 is to be applied.

In the case of a female, Table 1.3 is to be applied.

For the purposes of Tables 1.2 and 1.3, a veteran's age is taken to be his or her age in whole years at the date of the report relating to the exercise tolerance (unless the report is of a retrospective type and clearly refers to some earlier period, in which case the veteran's age is taken to be his or her age in whole years at the relevant time).

**Step 4: (Omit this step if no respiratory disease is present.)**

**Determine the impairment rating based on measurements of lung function.**

FEV1, FVC, and MEF 25-75 are the usual physiological measurements of lung function. Determinations of FEV1, FVC, and MEF 25-75 should be conducted by an experienced operator without specific administration of a bronchodilator. The best set of results should be selected, that is, the set of results which indicates the greatest degree of health and, consequently, the lowest degree of impairment.

If both pre-bronchodilator and post-bronchodilator results are available the pre-bronchodilator results are to be applied in determining the impairment rating based on measurements of lung function..

To determine the impairment rating based on measurements of lung function, follow the substeps below.

**Substep  
4A**

Obtain the measured FEV1, FVC, and MEF 25-75 from the data.

**Substep  
4B**

Work out the predicted FEV1, FVC, and MEF 25-75 for a person of the same age, height, and gender. This can be done either by applying the nomograms Figure 1a (for males) or Figure 1b (for females) or by applying the formula relating to each nomogram.

**Substep  
4C**

Express the measured FEV1 as a percentage of the predicted FEV1, and Express the measured FVC as a percentage of the predicted FVC, and Express the measured MEF 25-75 (if appropriate) as a percentage of the predicted MEF 25-75.

These conversions are performed by applying the formula:

$$\text{Measured value as \% of predicted value} = \frac{\text{Actual value} \times 100}{\text{Predicted value}}$$

**Substep  
4D**

Determine an impairment rating from a physiological measurement by using the percentage obtained in substep 4C in conjunction with Table 1.4.

Separate impairment ratings can be obtained from each physiological measurement (that is, from the FEV1, FVC, and MEF 25-75).

**Substep  
4E**

The final impairment rating is the highest (or equal highest) of the ratings obtained in substep 4D.

Functional Loss  
Table  
1.2

**LOSS OF CARDIORESPIRATORY FUNCTION: EXERCISE TOLERANCE**  
(Males)



Age	Symptomatic Activity Level (METs*)										Age	Symptomatic Activity Level (METs*)									
	1-2	2-3	3-4	4-5	5-6	6-7	7-8	8-9	10+	1-2		2-3	3-4	4-5	5-6	6-7	7-8	8-9	10+		
less than 25	90	80	70	60	50	40	30	20	10	55	80	70	55	40	25	15	10				
25	90	80	70	60	50	40	30	20	10	56	80	70	54	39	24	15	9				
26	90	80	70	60	50	40	30	20	10	57	80	69	53	38	23	14	8				
27	89	80	70	59	48	38	28	19	10	58	80	69	52	37	22	14	7				
28	89	80	70	59	47	37	27	19	10	59	80	68	51	36	21	13	6				
29	88	80	70	58	46	36	26	18	10	60	80	68	50	35	20	13	5				
30	88	80	70	58	45	35	25	18	10	61	80	67	49	34	19	12	4				
31	87	80	70	57	44	34	24	17	10	62	80	67	48	33	18	12	3				
32	87	80	70	57	43	33	23	17	10	63	80	66	47	32	17	11	2				
33	86	80	70	56	42	32	22	16	10	64	80	66	46	31	16	11					
34	86	80	70	56	41	31	21	16	10	65	80	65	45	30	15	10					
35	85	80	70	55	40	30	20	15	10	66	80	64	44	29	15	9					
36	85	80	70	55	39	29	20	15	9	67	79	63	43	28	14	8					
37	85	79	69	54	38	28	19	14	8	68	79	62	42	27	14	7					
38	85	79	69	54	37	27	19	14	7	69	78	61	41	26	13	6					
39	85	78	68	53	36	26	18	13	6	70	78	60	40	25	13	5					
40	85	78	68	53	35	25	18	13	5	71	77	59	39	24	12	4					
41	85	77	67	52	34	24	17	12	4	72	77	58	38	23	12	3					
42	85	77	67	52	33	23	17	12	3	73	76	57	37	22	11	2					
43	85	76	66	51	32	22	16	11	2	74	76	56	36	21	11	1					
44	85	76	66	51	31	21	16	11		75	75	55	35	20	10						
45	85	75	65	50	30	20	15	10		76	75	55	35	19	9						
46	85	75	64	49	30	20	15	9		77	75	54	34	18	8						
47	84	74	63	48	29	19	14	8		78	75	54	34	17	7						
48	84	74	62	47	29	19	14	7		79	75	53	33	16	6						
49	83	73	61	46	28	18	13	6		80	75	53	33	15	5						
50	83	73	60	45	28	18	13	5		81	75	52	32	14	4						
51	82	72	59	44	27	17	12	4		82	75	52	32	13	3						
52	82	72	58	43	27	17	12	3		83	75	51	31	12	2						
53	81	71	57	42	26	16	11	2		84	75	51	31	11	1						
54	81	71	56	41	26	16	11			85	75	50	30	10							
										above 85	75	50	30	10							

Ratings Derived  
From METs  
Are Age  
Adjusted.

\* One MET represents the energy expenditure associated with the consumption of 3.5 mL oxygen/kg body weight/min.

# Cardiorespiratory Impairment

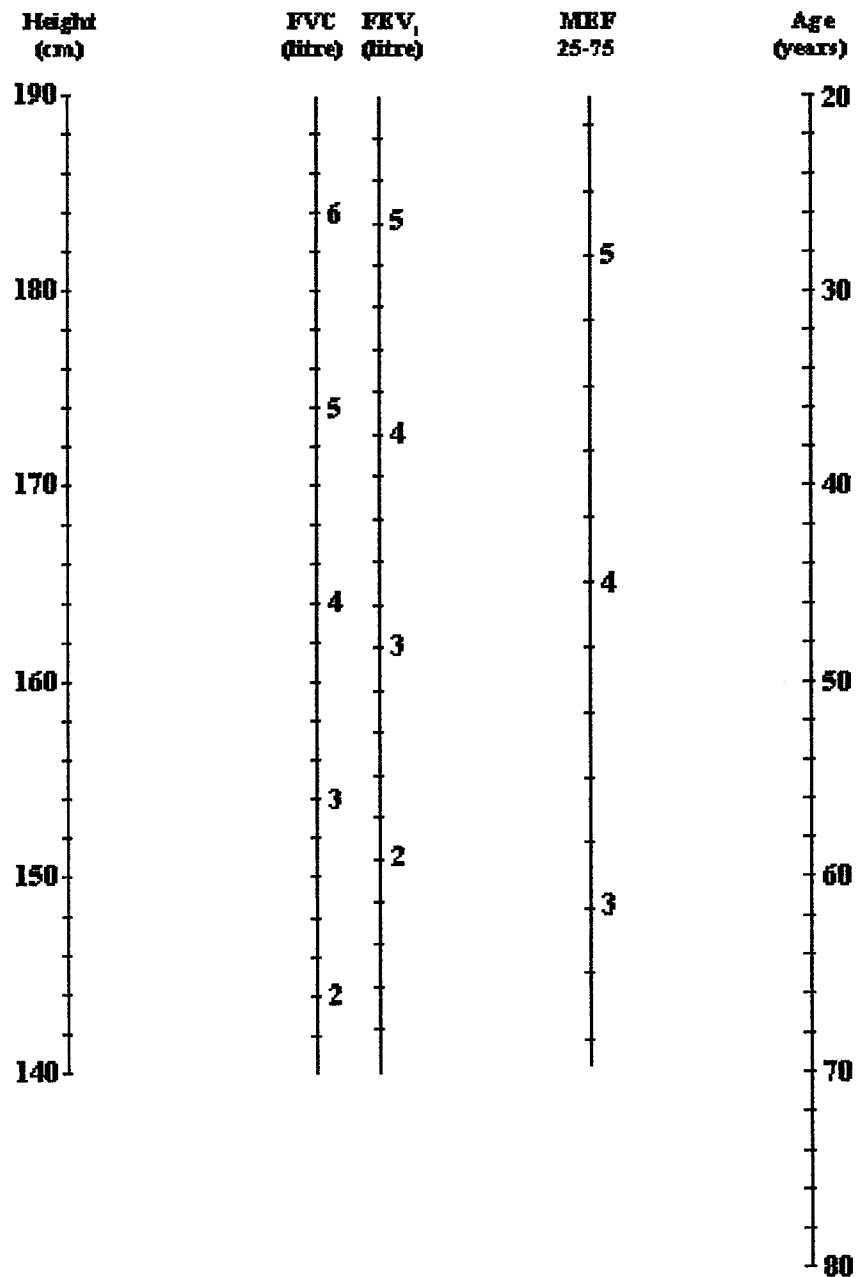
Functional Loss  
Table  
1.3

## LOSS OF CARDIORESPIRATORY FUNCTION: EXERCISE TOLERANCE (Females)

Age	Symptomatic Activity Level (METs*)										Age	Symptomatic Activity Level (METs*)									
	1-2	2-3	3-4	4-5	5-6	6-7	7-8	8-9	10+	1-2		2-3	3-4	4-5	5-6	6-7	7-8	8-9	10+		
less than 25	90	80	70	55	40	30	20	15	10	55	80	65	50	30	20	15	10				
25	90	80	70	55	40	30	20	15	10	56	80	65	49	29	20	15	9				
26	90	80	69	54	40	30	20	15	10	57	80	64	48	28	19	14	8				
27	89	79	68	53	39	29	20	15	10	58	80	64	47	27	19	14	7				
28	89	79	67	52	39	29	20	15	10	59	80	63	46	26	18	13	6				
29	88	78	66	51	38	28	20	15	10	60	80	63	45	25	18	13	5				
30	88	78	65	50	38	28	20	15	10	61	80	62	44	24	17	12	4				
31	87	77	64	49	37	27	20	15	10	62	80	62	43	23	17	12	3				
32	87	77	63	48	37	27	20	15	10	63	80	61	42	22	16	11	2				
33	86	76	62	47	36	26	20	15	10	64	80	61	41	21	16	11					
34	86	76	61	46	36	26	20	15	10	65	80	60	40	20	15	10					
35	85	75	60	45	35	25	20	15	10	66	80	59	39	20	15	9					
36	85	75	60	43	34	25	20	15	9	67	79	58	38	19	14	8					
37	85	75	60	44	33	24	19	14	8	68	79	57	37	19	14	7					
38	85	75	60	44	32	24	19	14	7	69	78	56	36	18	13	6					
39	85	75	60	43	31	23	18	13	6	70	78	55	35	18	13	5					
40	85	75	60	43	30	23	18	13	5	71	77	54	34	17	12	4					
41	85	75	60	42	29	22	17	12	4	72	77	53	33	17	12	3					
42	85	75	60	42	28	22	17	12	3	73	76	52	32	16	11	2					
43	85	75	60	41	27	21	16	11	2	74	76	51	31	16	11	1					
44	85	75	60	41	26	21	16	11		75	75	50	30	15	10						
45	85	75	60	40	25	20	15	10		76	75	49	29	15	9						
46	85	74	59	39	25	20	15	9		77	75	48	28	14	8						
47	84	73	58	38	24	19	14	8		78	75	47	27	14	7						
48	84	72	57	37	24	19	14	7		79	75	46	26	13	6						
49	83	71	56	36	23	18	13	6		80	75	45	25	13	5						
50	83	70	55	35	23	18	13	5		81	75	44	24	12	4						
51	82	69	54	34	22	17	12	4		82	75	43	23	12	3						
52	82	68	53	33	22	17	12	3		83	75	42	22	11	2						
53	81	67	52	32	21	16	11	2		84	75	41	21	11	1						
54	81	66	51	31	21	16	11			85	75	40	20	10							
above 85										above 85	75	40	20	10							

Ratings Derived  
From METs  
Are Age  
Adjusted.

\* One MET represents the energy expenditure associated with the consumption of 3.5 mL oxygen/kg body weight/min.

**Figure 1a — Prediction Nomogram: Male (BTPS)**

For veterans older than 80 years the various scales are to be extended linearly.

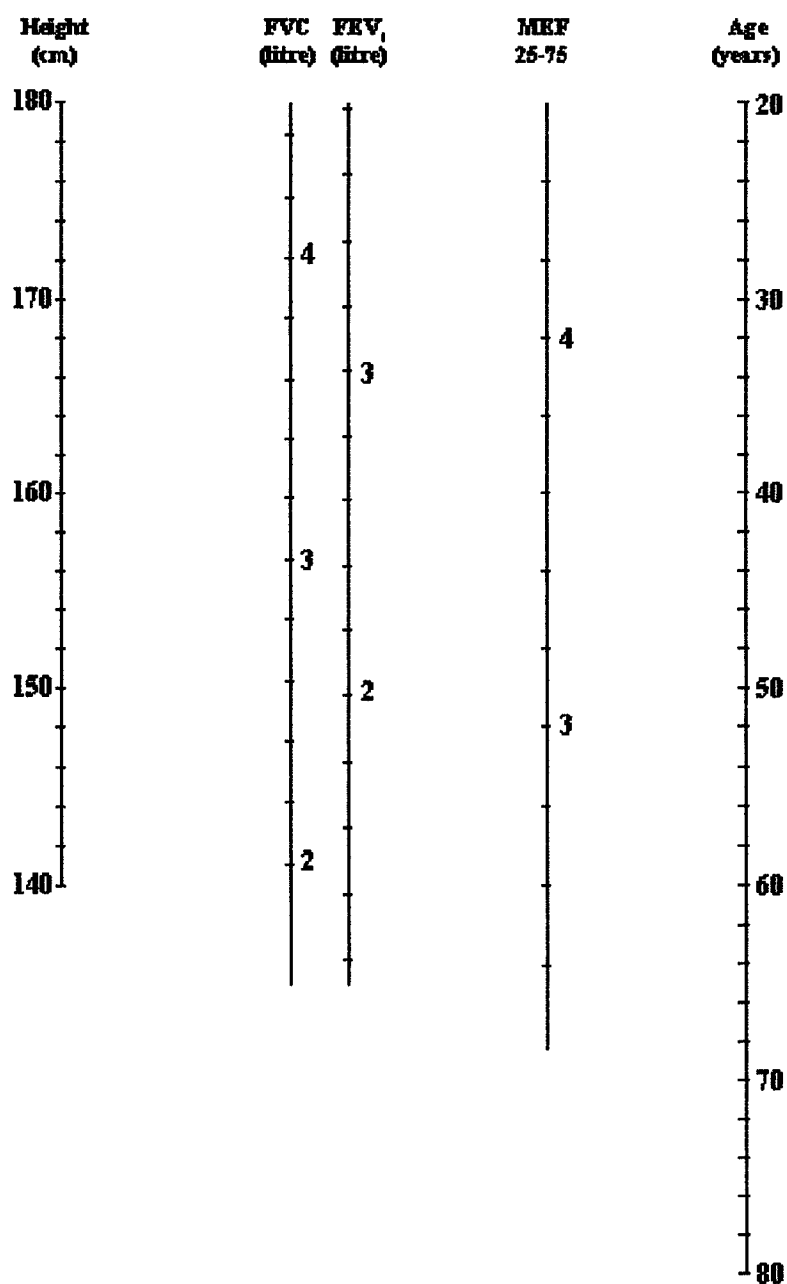
This nomogram corresponds to the formulas:

$$\text{FEV}_1 = 0.0553 \times \text{Height} - 0.036 \times \text{Age} - 4.182$$

$$\text{FVC} = 0.0713 \times \text{Height} - 0.0265 \times \text{Age} - 6.463$$

$$\text{MEF 25-75} = 2.683 + 1.95 \times \text{Height} - 0.043 \times \text{Age}$$

**Figure 1b — Prediction Nomogram: Female (BTPS)**



For veterans older than 80 years the various scales are to be extended linearly.

This nomogram corresponds to the formulas:

$$\text{FEV}_1 = 0.0347 \times \text{Height} - 0.0252 \times \text{Age} - 1.929$$

$$\text{FVC} = 0.04315 \times \text{Height} - 0.02185 \times \text{Age} - 2.83$$

$$\text{MEF 25-75} = 2.918 + 1.25 \times \text{Height} - 0.034 \times \text{Age}$$

Functional Loss  
Table  
1.4

## LOSS OF CARDIORESPIRATORY FUNCTION: PHYSIOLOGICAL MEASUREMENTS

Impairment Rating	FEV1 as a percentage of predicted	FVC as a percentage of predicted	MEF 25-75 as a percentage of predicted	Impairment Rating	FEV1 as a percentage of predicted	FVC as a percentage of predicted	MEF 25-75 as a percentage of predicted
NIL	85	85	85	THIRTY-EIGHT	58	56	58
TWO		84		THIRTY-NINE	57	65	57
SIX	84		84	FORTY		64	
SEVEN		83		FORTY-ONE	56	63	56
EIGHT	83		83	FORTY-TWO	55	62	55
TEN	82		82	FORTY-THREE	54	61	54
ELEVEN	81	82	81	FORTY-FOUR	53	60	53
TWELVE				FORTY-FIVE	52		52
THIRTEEN	80		80	FORTY-SIX	51	59	51
FOURTEEN	79	81	79	FORTY-SEVEN	50	58	50
FIFTEEN				FORTY-EIGHT	49	57	49
SIXTEEN	78	80	78	FORTY-NINE	48	56	48
SEVENTEEN	77		77	FIFTY	47	55	47
EIGHTEEN	76	79	76	FIFTY-ONE	46	54	46
NINETEEN				FIFTY-TWO	45	53	45
TWENTY	75	78	75	FIFTY-THREE	44	52	44
TWENTY-ONE	74		74	FIFTY-FOUR	43	51	43
TWENTY-TWO	73	77	73	FIFTY-FIVE	42	50	42
TWENTY-THREE	72			FIFTY-SIX	41	49	41
TWENTY-FOUR	71	76	71	FIFTY-SEVEN	40		40
TWENTY-FIVE				FIFTY-EIGHT	39	48	39
TWENTY-SIX	70	75	70	FIFTY-NINE	38	47	38
TWENTY-SEVEN	69	74		SIXTY	37	46	37
TWENTY-EIGHT	68		68	SIXTY-ONE	36	45	36
TWENTY-NINE	67	73	67	SIXTY-TWO	35	44	35
THIRTY	66	72	66	SIXTY-THREE	34	43	34
THIRTY-ONE	65	71	65	SIXTY-FOUR	33	42	33
THIRTY-TWO	64		64	SIXTY-FIVE	32	41	32
THIRTY-THREE	63	70	63	SIXTY-SIX	31	40	31
THIRTY-FOUR	62	69	62	SIXTY-SEVEN	30	39	30
THIRTY-FIVE	61	68	61	SIXTY-EIGHT	29	38	29
THIRTY-SIX	60	67	60	SIXTY-NINE	28	37	28
THIRTY-SEVEN	59		59	SEVENTY	27	36	27

Ratings Derived  
From This  
Table Are  
Age Adjusted.

Table 1.4 corresponds to the following formulas:

$$\text{Impairment rating based on FEV1} = 98 - \% \text{FEV1} + \frac{50}{(\% \text{FEV1} - 90)}$$

$$\text{Impairment rating based on FVC} = 108 - \% \text{FVC} + \frac{100}{(\% \text{FVC} - 88.5)}$$

$$\text{Impairment rating based on MEF 25-75} = 98 - \% \text{MEF} + \frac{50}{(\% \text{MEF} - 90)}$$

“%FEV1” means measured FEV1 expressed as a percentage of predicted FEV1.

“%FVC” means measured FVC expressed as a percentage of predicted FVC.

“%MEF” means measured MEF 25-75 expressed as a percentage of predicted MEF 25-75.

In each case the percentage is to be rounded to the nearest integer before the formula is applied.

If these formulas are applied the resulting impairment rating is always to be rounded to the nearest integer.



**Step 5: Calculate the total accepted cardiorespiratory functional impairment rating.**

At this stage there will usually be an impairment rating derived from effort tolerance information and there may also be an impairment rating derived from measurements of lung function. These must be combined into a single cardiorespiratory functional impairment rating. The method by which that is to be done is set out in Table 1.5.

**Procedural  
Table  
1.5**

**CARDIORESPIRATORY FUNCTIONAL IMPAIRMENT**

		Respiratory disease present		No respiratory disease
		Spirometry obtainable	Spirometry not obtainable	
Cardiac disease present	METs data obtainable	FI = higher of METs and Spirometry	FI = METs	FI = METs
	METs data not obtainable	FI = Spirometry	No FI	No FI
No cardiac disease	METs data obtainable	FI = average of METs and Spirometry	FI = METs	
	METs data not obtainable	FI = Spirometry	No FI	

In applying this table, both accepted and non-accepted conditions are to be taken into account.

**No Age  
Adjustment  
Permitted For  
This Table.**

## Cardiorespiratory Impairment

---

For the purposes of Table 1.5, the following abbreviations have been used:

Abbreviation		Meaning
“FI”	means	cardiorespiratory functional impairment rating.
“No FI”	means	a cardiorespiratory functional impairment rating cannot be calculated from either effort tolerance information or measurements of lung function.
“METs”	means	the cardiorespiratory functional impairment rating is to be taken as the impairment rating derived from METs alone.
“Spirometry”	means	the cardiorespiratory functional impairment rating is to be taken as the impairment rating derived from measurements of respiratory function.
“average of METs and Spirometry”	means	the average of the cardiorespiratory functional impairment rating derived from METs alone and the cardiorespiratory functional impairment rating derived from measurements of respiratory function alone — using the ordinary formula for averaging two quantities or by use of the nomogram in Figure 1c. In either case, the result is to be rounded to the nearest integer.

From Table 1.5 it will be seen that:

- \* if cardiac conditions exist in the absence of respiratory disease, cardiorespiratory functional impairment should be measured by effort tolerance alone;
- \* if respiratory conditions exist in the absence of cardiac disease, the cardiorespiratory functional impairment rating is the rounded average of (i) impairment as measured by effort tolerance, and (ii) impairment as measured by spirometry;
- \* if both cardiac and respiratory conditions co-exist, the cardiorespiratory functional impairment rating is the greater of (i) the impairment rating as measured by effort tolerance, and (ii) the impairment rating as measured by spirometry.

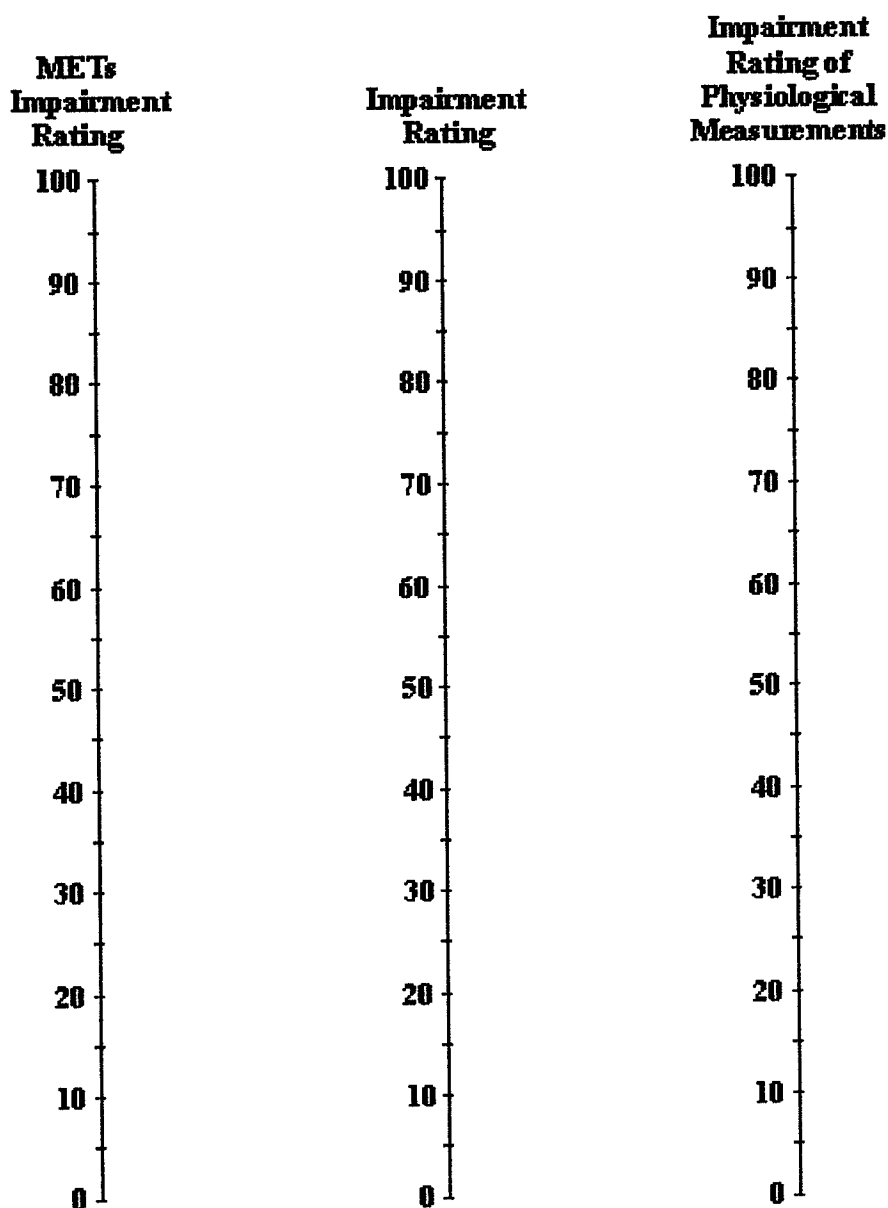
In applying these rules, both accepted and non-accepted cardiac and respiratory conditions are to be taken into account.

Only one rating for effort tolerance is to be given irrespective of the number of conditions that contribute to the relevant impairment.

Only one rating is to be given for physiological measurements of lung function irrespective of the number of conditions that contribute to the relevant impairment.

This single “total cardiorespiratory functional impairment” is due to the combined effect of all cardiorespiratory conditions whether accepted or not.

**Figure 1c — Loss of Respiratory Function  
Respiratory Nomogram**



This nomogram is to be used in accordance with the instructions in Step 5A and the procedural Table 1.5.

Results from this nomogram are to be rounded to the nearest five points. 2.5 is to be rounded up to 5 and 7.5 is to be rounded up to 10.

This nomogram corresponds to the formula:

$$\text{Impairment Rating} = \frac{\text{METs Impairment Rating} + \text{Impairment Rating of Physiological Measurement}}{2}$$

### Step 6: Consider the effects of cardiac failure (if any).

For the purposes of assessment under this *Guide*, cardiac failure is considered to be a surrogate measure of cardiorespiratory impairment. When cardiac failure is present, the impairment rating calculated using effort tolerance will usually exceed any possible impairment rating from Table 1.6. Table 1.6 is of particular importance in assessing a veteran who is unable to be rated using effort tolerance because of significant conditions such as hemiplegia.

Functional Loss Table 1.6	CARDIAC FAILURE		
Impairment Ratings	Criteria		
NIL	No cardiac failure; that is neither symptoms nor X-ray evidence of cardiac failure.		
TEN	<ul style="list-style-type: none"><li>• No symptoms, but X-ray evidence of early cardiac failure.</li><li>• Evidence of right ventricular failure.</li></ul>		
FIFTEEN	Left or biventricular cardiac failure demonstrated by ejection fraction of between 40% and 60% and persisting despite therapy.		
TWENTY	Left or biventricular cardiac failure demonstrated on X-ray or by ejection fraction of less than or equal to 40% and persisting despite therapy.		
Only one rating is to be selected from this table for any condition or combination of conditions. If more than one criterion applies, that which gives the higher or highest rating is to be chosen.			
No Age Adjustment Permitted For This Table.			

A rating from Table 1.6 is to be compared with the total cardiorespiratory functional impairment rating and the higher of the two is to be chosen.

### Step 7: Moderate the total cardiorespiratory functional impairment rating to allow for effects of any non-accepted conditions.

#### Partially contributing impairment

If non-accepted conditions contribute to the impairment, Chapter 19 (Partially Contributing Impairment) is to be applied to determine impairment from the accepted conditions.

*If cardiac conditions exist in the absence of respiratory disease:* if there is more than one cardiac condition present (for example ischaemic heart disease and a valvular heart disease) and some are accepted and some are not accepted, then the total cardiorespiratory functional impairment rating must be moderated by applying Chapter 19 to determine the impairment due to the accepted condition.

*If a respiratory condition exists in the absence of cardiac disease,* the symptomatic activity level will generally be the exercise level (in METs) at which dyspnoea occurs.

If there is more than one respiratory condition present and at least one is accepted and at least one is not accepted, then the total cardiorespiratory functional impairment rating must be moderated by applying Chapter 19 to determine the impairment due to the accepted condition or conditions.

*If cardiac and respiratory conditions co-exist, and at least one is accepted and at least one is not accepted, it is necessary to determine the total cardiorespiratory functional impairment rating (as set out in the previous steps), and then to moderate that rating by applying Chapter 19 to determine the impairment due to the accepted condition.*

The result that is then derived is the “total accepted cardiorespiratory functional impairment rating”.

**Step 8: Determine whether any ratings from the cardiorespiratory other impairment tables apply.**

### **Cardiorespiratory Other Impairment tables**

Once the total accepted cardiorespiratory functional impairment rating has been determined, it must be compared with the relevant cardiorespiratory other impairment tables. For assessment purposes, four categories of cardiorespiratory condition are recognised. These categories are:

- \* ischaemic heart disease;
- \* valvular heart disease;
- \* miscellaneous heart disease; and
- \* lower respiratory tract conditions.

There are four cardiorespiratory other impairment tables — corresponding to each of the above categories. These tables are:

- Table 1.7 — Cardiorespiratory Impairment: Ischaemic;
- Table 1.8 — Cardiorespiratory Impairment: Valvular;
- Table 1.9 — Cardiorespiratory Impairment: Miscellaneous; and
- Table 1.10 — Cardiorespiratory Impairment: Respiratory.

Only one rating is to be selected from each of these cardiorespiratory other impairment tables (Tables 1.7, 1.8, 1.9, and 1.10) for any condition or combination of conditions.

If accepted conditions belonging to more than one of the four categories of cardiorespiratory disease above are present, then the relative contribution of their effect on the total accepted cardiorespiratory functional impairment must be estimated by applying Chapter 20 (Apportionment). The rating for each condition will be the higher of the cardiorespiratory functional impairment rating attributed to it and its cardiorespiratory Other Impairment rating.

The cardiorespiratory worksheet (at page 35) should also be consulted.

**Other  
Impairment  
Table 1.7**

## **CARDIORESPIRATORY IMPAIRMENT: ISCHAEMIC HEART DISEASE**

<b>Impairment Ratings</b>	<b>Criteria</b>
NIL	No history of symptoms but evidence of transient ischaemia on exercise ECG testing.
TEN	<ul style="list-style-type: none"> <li>Coronary artery disease, characterised by typical history of angina pectoris.</li> <li>Coronary artery disease, characterised by history of uncomplicated myocardial infarct, with no subsequent evidence of cardiac failure and infrequent or no angina.</li> <li>Coronary artery disease, with single vessel disease (other than left main coronary) demonstrated on angiogram.</li> <li>Coronary artery disease with successful coronary artery surgery, followed by no angina or only infrequent angina but no further infarcts or cardiac failure.</li> </ul>
FIFTEEN	Coronary artery disease with multi-vessel disease (not successfully corrected) demonstrated on angiogram.
TWENTY	<ul style="list-style-type: none"> <li>Coronary artery disease characterised by a history of myocardial infarct followed, immediately or after a lapse of time, by continuing angina or further infarcts.</li> <li>Coronary artery disease characterised by left main coronary artery disease (not successfully corrected) demonstrated on angiogram.</li> <li>Coronary artery disease with successful coronary artery surgery, followed, after a lapse of time, by frequent angina or further infarcts or cardiac failure.</li> </ul>

**No Age  
Adjustment  
Permitted For  
This Table.**

Only one rating is to be selected from this table for any condition or combination of conditions. If more than one criterion applies, that which gives the higher or highest rating is to be chosen.

**Other  
Impairment  
Table 1.8**

## **CARDIORESPIRATORY IMPAIRMENT: VALVULAR HEART DISEASE**

<b>Impairment Ratings</b>	<b>Criteria</b>
NIL	<ul style="list-style-type: none"> <li>Mitral valve prolapse with no or minimal symptoms.</li> <li>Aortic sclerosis with no or minimal symptoms.</li> </ul>
FIVE	Diagnosed valvular heart disease (other than mitral valve prolapse or aortic sclerosis) with no symptoms and no X-ray evidence of cardiac failure.
TEN	Valvular heart disease with successful valve replacement, not requiring anticoagulant medication, with no subsequent symptoms or evidence of cardiac failure.
FIFTEEN	Valvular heart disease with successful valve replacement, requiring anticoagulant medication, with no subsequent symptoms or evidence of cardiac failure.

**No Age  
Adjustment  
Permitted For  
This Table.**

Only one rating is to be selected from this table for any condition or combination of conditions. If more than one criterion applies, that which gives the higher or highest rating is to be chosen.

Other  
Impairment  
Table 1.9

**CARDIORESPIRATORY IMPAIRMENT: MISCELLANEOUS**

Impairment Ratings	Criteria
NIL	Flow murmurs.
TWO	Chronic asymptomatic arrhythmia, eg, atrial fibrillation, atrial or ventricular ectopic beats.
FIVE	Need for a permanent pacemaker.

Only one rating is to be selected from this table for any condition or combination of conditions. If more than one criterion applies, that which gives the higher or highest rating is to be chosen.

No Age  
Adjustment  
Permitted For  
This Table.

Arrhythmias are usually to be rated by applying Chapter 15 (Intermittent Impairment) unless they cause a permanent restriction of exercise tolerance, in which case they are to be assessed by their effect on effort tolerance.

Other  
Impairment  
Table 1.10

**CARDIORESPIRATORY IMPAIRMENT:  
LOWER RESPIRATORY TRACT**

Impairment Ratings	Criteria
NIL	Asymptomatic pleural plaques
TWO	<ul style="list-style-type: none"> <li>Recurrent lower respiratory infections (at least 6 per year)</li> <li>Intermittent use of bronchodilator medication.</li> </ul>
FIVE	<ul style="list-style-type: none"> <li>Daily use of inhaled steroids required.</li> <li>Regular, daily use of bronchodilator medication.</li> <li>Chronic cough, with production of at least 50mL sputum/day.</li> </ul>
TEN	<ul style="list-style-type: none"> <li>Regular, daily use of bronchodilator medication required in addition to daily inhaled steroids.</li> <li>Chronic cough, with production of at least 100 mL sputum/day.</li> </ul>
TWENTY	Repeated courses (at least several courses per year) or permanent use of oral steroids required.

Only one rating is to be selected from this table for any condition or combination of conditions. If more than one criterion applies, that which gives the higher or highest rating is to be chosen.

No Age  
Adjustment  
Permitted For  
This Table.

### **Peripheral Vascular Conditions**

Tables 1.2 and 1.3 are to be applied to assess those conditions that affect exercise tolerance from a cardiorespiratory point of view. Peripheral vascular conditions typically cause loss of function of the lower limbs only and therefore are to be assessed under lower limb impairment (using Chapter 3).

Atherosclerosis frequently causes both a cardiorespiratory condition and a peripheral vascular condition. In such cases, if both types of conditions are accepted conditions, then both conditions are to be rated using the appropriate assessment procedure.

**The rating of asthma** depends on the clinical circumstances. If asthma has caused chronic airways obstruction the method of assessment described in this chapter is to be applied. If there is little fixed obstruction and a large reversible component, the rating is to be based on the occurrence of attacks using the method of intermittent impairment (Chapter 15). Asthma can also be rated, if there is minimal loss of function, from Table 1.10.





## Cardiorespiratory Worksheet

File No.

Veteran's given names

Veteran's surname

Condition(s) accepted for assessment

Veteran's height

Veteran's D.o.B.

Gender

### METs Assessment

Date of report

Age

Limiting Symptoms =

METs level =

METs Impairment  
Rating

**A**

### Lung Function Assessment

Date of test

Age

	FEV1	FVC	MEF 25-75
Actual (post-Bronchodilator)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Predicted	<input type="text"/>	<input type="text"/>	<input type="text"/>
(Act/Pred) × 100	<input type="text"/>	<input type="text"/>	<input type="text"/>
Impairment (Table 1.1.4)	<input type="text"/>	<input type="text"/>	<input type="text"/>

Physiological Impairment Rating  
(Use highest assessment value)

**B**

Find the Accepted Functional Impairment from Values A and B by using Table 1.1.5.

Please note that Partially Contributing Impairment (Chapter 19) may need to be used in calculating the accepted functional impairment.

Was Chapter 19 used ?

Yes ☐  
No ☐

Accepted Functional Impairment

**C**

	D	E	F	G
Category	Relative contribution to Functional Impairment (as ratio)	Functional Impairment for each category (by apportionment)	Applicable Other Impairment Rating	Final Rating for category (Greater of E and F)
Ischaemic	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Valvular	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other cardiac	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Respiratory	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

The ratings in column F are not rounded or combined at this stage. They are all carried forward to be combined in the final combining of all ratings. However, if all the ratings in Column G are obtained from Column E, then the accepted functional impairment rating (C) should be taken as the cardiorespiratory impairment rating instead of the various ratings in column G.

Signature <input type="text"/>	Name (Please print) <input type="text"/>	Date <input type="text"/>
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## Cardiorespiratory Impairment

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## CHAPTER 2

# HYPERTENSION AND NON-CARDIAC VASCULAR CONDITIONS

**This chapter contains three parts:**

**Part 2.1 - Hypertension**

**Part 2.2 - Vascular Conditions of The Lower Limbs**

**Part 2.3 - Other Non Cardiac Vascular Conditions**

### INTRODUCTION

This chapter is to be applied in determining impairment ratings for hypertension and non-cardiac vascular conditions. For conditions affecting the heart itself refer to Chapter 1 (Cardiorespiratory Impairment).

### PART 2.1

### HYPERTENSION

Hypertension, of itself, does not affect effort tolerance. Therefore, uncomplicated hypertension is not to be assessed under Chapter 1 (Cardiorespiratory Impairment) but in the manner set out below.

#### Calculation of the impairment rating for hypertension

Follow the steps below to calculate the impairment rating for hypertension.

#### STEP

①

Establish whether any target organ damage is present. *Page 38*

#### STEP

②

*(Omit this step if there is no target organ damage.) Page 38*  
Calculate the total functional impairment for any accepted target organ damage.

#### STEP

③

Calculate the Other Impairment rating for the accepted hypertension by applying Table 2.1.1. *Page 39*

#### STEP

④

*(Omit this step if there is no target organ damage.) Page 40*  
Compare the ratings obtained in Step 2 with the ratings obtained in Step 3. Take the higher of these two ratings.

### **Step 1: Establish whether any target organ damage is present.**

For the purposes of this chapter, “target organ damage” means any of the following:

- \* hypertensive retinopathy, grade III or IV;
- \* hypertensive cardiac disease, with ECG or X-ray evidence of left ventricular hypertrophy;
- \* hypertensive nephropathy demonstrated at biopsy, or by presence of proteinuria or elevated serum creatinine level; or
- \* hypertensive cerebral haemorrhage.

Certain other conditions have hypertension as a contributing factor in their aetiology (for example: ischaemic heart disease and peripheral vascular disease). Such conditions are not to be regarded as being target organ damage when applying this part.

### **Step 2: Calculate the total functional impairment due to any accepted target organ damage.**

*Accepted hypertensive retinopathy* is to be assessed by applying Chapter 8.

If other ophthalmic conditions are present, they must be allowed for by applying Chapter 20 (Apportionment) or Chapter 19 (Partially Contributing Impairment) as appropriate.

*Accepted hypertensive cardiac disease* is to be assessed by applying Chapter 1.

If other cardiorespiratory conditions are present, they must be allowed for by applying Chapter 20 (Apportionment) or Chapter 19 (Partially Contributing Impairment) as appropriate.

*Accepted hypertensive nephropathy* is to be assessed by applying Chapter 9.

If other renal conditions are present, they must be allowed for by applying Chapter 20 (Apportionment) or Chapter 19 (Partially Contributing Impairment) as appropriate.

*Accepted hypertensive cerebral haemorrhage* is to be assessed according to the specific effects of the haemorrhage.

The impairment ratings attributable to the accepted target organ damage are to be combined by applying Chapter 18 (Combined Values Chart) to obtain the total impairment rating for accepted target organ damage.

Target organ damage which is not an accepted condition cannot be assessed under this *Guide*. Target organ damage can be assessed under this *Guide* only after it has been claimed and has become an accepted condition.

The criterion in Table 2.1.1 which refers to “hypertension of such a degree that target organ damage is present” is not an assessment of the target organ damage itself but is a measure of the severity of the hypertension.

**Step 3: Determine an impairment rating for hypertension from Table 2.1.1**

Other Impairment Table 2.1.1	<p style="text-align: center;"><b><i>HYPERTENSION</i></b></p>	
	Impairment Ratings	Criteria
	NIL	Hypertension adequately controlled by diet and weight loss without long-term medication.
	TWO	Hypertension requiring long-term medication but without side-effects of the medication and with no evidence of target organ damage.
	FIVE	<ul style="list-style-type: none"> <li>• Hypertension with diastolic pressure consistently at or greater than 90 mm Hg despite treatment.</li> <li>• Hypertension: controlled but frequent minor side effects of medication which cause no loss of function.</li> </ul>
	TEN	<ul style="list-style-type: none"> <li>• Hypertension: diastolic pressure consistently greater than 100 mmHg.</li> <li>• Hypertension of such a degree that target organ damage is present.</li> <li>• Hypertension: controlled but with side effects of medication causing a significant and persistent loss of function.</li> </ul>
No Age Adjustment Permitted For This Table.	<p style="text-align: center;">Only one rating is to be selected from this table.</p>	

For the purpose of determining a rating of 10 impairment points from Table 2.1.1. (dot point 2) target organ damage has to be present *either* as an accepted condition *or* as a non-accepted condition.

**Step 4:** *(Omit this step if there is no target organ damage.)*  
Compare the rating obtained in Step 2 with the rating obtained in Step 3.  
Take the higher rating.

The total impairment rating for accepted target organ damage is to be compared with any applicable rating from Table 2.1.1, and the higher of the two is to be taken as the impairment rating for the accepted hypertension.

**Substep  
4A**

If the impairment rating from Table 2.1.1 is higher than the total rating for accepted target organ damage, the latter rating is to be discarded and its components are not to be used in any further calculations.

**Substep  
4B**

If the impairment rating for accepted target organ damage is higher than the rating from Table 2.1.1, the rating from Table 2.1.1 is to be discarded and each of the components of the rating for accepted target organ damage is to be included in the final combining of all impairment ratings.

Impairment ratings from Table 2.1.1 are not routinely compared with ratings from the functional loss tables in Chapter 1 (Cardiorespiratory Impairment) except if hypertensive cardiomyopathy is present. Instead, they are to be compared with the impairment rating for the total loss of function due to target organ damage.

The total impairment rating for target organ damage is not to be combined with the impairment rating obtained from Table 2.2.1.

## PART 2.2

### VASCULAR CONDITIONS OF THE LOWER LIMBS

Each vascular condition of the lower limbs is characterised as belonging to one or more of three categories. These categories are:

- \* (arterial) peripheral vascular disease;
- \* varicose veins and vascular leg ulcers; and
- \* oedema.

Each category is to be assessed by applying a specific table from this part of the *Guide*. Depending on their effects, vascular conditions of the lower limbs may be rated under one or more of these tables.

#### Determination of the impairment rating for vascular conditions of the lower limbs

Follow the steps below to determine the impairment rating for each type of accepted vascular condition of the lower limbs.

(Each step is elaborated in the following pages.)

<b>STEP</b> ①	Establish whether any effect on lower limb function is present.	<i>Page</i> 42
<b>STEP</b> ②	Establish whether any effect on the skin is present.	<i>Page</i> 42
<b>STEP</b> ③	<i>(Omit this step if there is no effect on lower limb function.)</i> Determine the impairment rating for the effects on lower limb function.	<i>Page</i> 42
<b>STEP</b> ④	<i>(Omit this step if there is no effect on skin.)</i> Determine the impairment rating for the effects on the skin.	<i>Page</i> 43
<b>STEP</b> ⑤	Determine the Other Impairment rating for the vascular conditions of the lower limbs by applying Tables 2.2.1, 2.2.2, and 2.2.3..	<i>Page</i> 43
<b>STEP</b> ⑥	Combine the impairment ratings obtained in Steps 3 and 4.	<i>Page</i> 45

## Hypertension And Non-Cardiac Vascular Conditions

<b>STEP</b> <b>②</b>	Combine the impairment ratings obtained in Step 5.	<i>Page</i> 45
<b>STEP</b> <b>③</b>	Compare the impairment ratings obtained in Steps 6 and 7.	<i>Page</i> 45
<b>STEP</b> <b>④</b>	If the comparison made in Step 8 shows that the impairment rating obtained in Step 6 is greater than the impairment rating obtained in Step 7, then the ratings obtained in Steps 3 and 4 are the final impairment ratings for the vascular condition.	<i>Page</i> 45
<b>STEP</b> <b>⑤</b>	If the comparison made in Step 8 shows that the impairment rating obtained in Step 7 is greater than the impairment rating obtained in Step 6, then the separate ratings that have been combined in Step 5 are the final impairment rating(s) for the vascular condition.	<i>Page</i> 45

### **Step 1: Establish whether any effect on lower limb function is present.**

Lower limb function may be affected by peripheral vascular disease. If peripheral vascular disease is present, the veteran's walking distance is likely to be reduced as a result of intermittent claudication (cramplike pain in the calves of the legs).

### **Step 2: Establish whether any effect on the skin is present.**

Varicose veins can affect the skin of the lower limbs. They may cause discolouration or pruritus (itching). Excoriations (scratch marks) may be present.

### **Step 3: (Omit this step if there is no effect on lower limb function.) Determine the impairment rating for the effects on lower limb function.**

Lower Limb Function is to be assessed by applying Chapter 3 (Impairment of Spine And Limbs) - Part 3.2. If other conditions affecting lower limb function are present, they must be allowed for by applying Chapter 20 (Apportionment) or Chapter 19 (Partially Contributing Impairment) as appropriate.

The effects of vascular conditions of the lower limbs on lower limb function are taken to be symptoms or manifestations of the condition. Hence, they are to be assessed as part of the vascular condition of the lower limb.



**Step 4: (Omit this step if there is no effect on the skin.)**  
**Determine the impairment rating for the effects on the skin.**

Skin conditions are to be assessed by applying Chapter 11 (Skin Impairment). If other conditions affecting the skin are present, they must be allowed for by applying Chapter 20 (Apportionment) or Chapter 19 (Partially Contributing Impairment) as appropriate.

The effects of vascular conditions of the lower limbs on the skin of the lower limbs are taken to be symptoms or manifestations of the condition. Hence, they are to be assessed as part of the vascular condition of the lower limb.

**Step 5: Determine the Other Impairment rating for the vascular conditions of the lower limbs by applying Tables 2.2.1, 2.2.2, and 2.2.3.**

There are three Other Impairment tables relating to the effects of vascular conditions of the lower limbs. A condition may be rated under more than one table if appropriate. However, only one rating may be taken from each table irrespective of how many conditions contribute to the type of impairment to which that table relates.

The three Other Impairment tables are:

Table 2.2.1 — (Arterial) Peripheral Vascular Disease

Table 2.2.2 — Varicose Veins

Table 2.2.3 — Oedema.

Other Impairment  
Table 2.2.1

**(ARTERIAL) PERIPHERAL VASCULAR DISEASE**



**Impairment  
Ratings**

**Criteria**

NIL	No peripheral vascular disease is present.
TWO	Minor peripheral vascular disease or peripheral vascular disease that has been successfully treated.
FIVE	Moderate peripheral vascular disease is present but causes little restriction of activities.
TEN	Severe peripheral vascular disease, the expected effects of which are masked by a non-accepted condition (eg, masked by restriction on walking due to a musculoskeletal disorder).

Irrespective of whether one or two legs are affected,  
only one rating may be selected from this table.

No Age  
Adjustment  
Permitted For  
This Table.

Amputations arising from peripheral vascular disease cannot be assessed unless they have been separately accepted. They can then be assessed under Chapter 3 (Impairment of Spine And Limbs).

Other Impairment  
Table 2.2.2

## VARICOSE VEINS



### Impairment Ratings

### Criteria

- |      |  |
|------|--|
| NIL  | <ul style="list-style-type: none"> <li>Varicose veins which are not greatly disfiguring, which cause only trivial symptoms, and which impose no significant restriction on activities.</li> <li>Superficial, small or transient ulceration.</li> </ul> |
| TWO  | Varicose veins which are unsightly or even gross but which impose no significant restriction on activities.  |
| FIVE | Varicose veins, varicose ulcers — causing constant or almost constant symptoms which are not easily tolerated and require medication or therapy.   |
| TEN  | Very severe varicose veins or ulceration — difficult to control and requiring periodic confinement or hospital admissions.   |

Irrespective of whether one or two legs are affected, only one rating may be selected from this table.

No Age  
Adjustment  
Permitted For  
This Table.

Other Impairment  
Table 2.2.3

## OEDEMA



### Impairment Ratings

### Criteria

- |      |  |
|------|--|
| NIL  | Mild or transient oedema.  |
| FIVE | Moderate and persistent oedema.  |
| TEN  | Marked oedema, that is only partly controlled by treatment or therapy. |

Irrespective of whether one or two legs are affected, only one rating may be selected from this table.

No Age  
Adjustment  
Permitted For  
This Table.

An impairment rating from this table may be given in addition to an impairment rating from Chapter 1 even when both arise from the same condition (eg, heart failure).

**Step 6: Combine the impairment ratings obtained in Steps 3 and 4.**

If ratings were obtained both in Step 3 and in Step 4, then the ratings are to be combined. This combining is for the purpose of the comparison to be made in Step 8. If only one rating has been given in Steps 3 and 4, then the result to be obtained in Step 6 is to be the same as the one rating given in either Step 3 or Step 4.

**Step 7: Combine the impairment ratings obtained in Step 5**

If more than one rating has been given in Step 5 then the ratings are to be combined. This combining is for the purpose of the comparison to be made in Step 8. If only one rating has been given in Step 5, then the result to be obtained in Step 7 is to be the same as the result obtained in Step 5.

**Step 8: Compare the impairment ratings obtained in Steps 6 and 7**

**Step 9: If the comparison made in Step 8 shows that the impairment rating obtained in Step 6 is higher than the impairment rating obtained in Step 7, then the the ratings obtained in Steps 3 and 4 are the final impairment ratings for the vascular condition**

If more than one rating was obtained in Steps 3 and 4 those ratings are not to be combined at this stage, but each is to be included in the final combining of all ratings.

**Step 10: If the comparison made in Step 8 shows that the impairment rating obtained in Step 7 is higher than the impairment rating obtained in Step 6, then the rating(s) obtained in Step 5 are the final impairment rating(s) for the vascular condition**

If more than one rating was obtained in Step 5 those ratings are not to be combined at this stage, but each is to be included in the final combining of all ratings.

PART 2.3

OTHER NON-CARDIAC VASCULAR CONDITIONS

This part is to be applied for a variety of vascular conditions not covered elsewhere in the *Guide*.

Other Impairment  
Table 2.3.1

ANEURYSMS AND INTRA-VASCULAR CONDITIONS

Impairment Ratings	Criteria
NIL	No aneurysms or intra-vascular conditions present.
TWO	<ul style="list-style-type: none"> <li>• Aortic aneurysm of diameter less than 6 cm.</li> <li>• Renal artery stenosis.</li> <li>• Iliac or femoral or carotid aneurysms.</li> </ul>
FIVE	<ul style="list-style-type: none"> <li>• Embolus requiring anticoagulant medication.</li> <li>• Non-valvular vascular conditions requiring anti-coagulant medication.</li> <li>• Aortic aneurysm of 6 cm diameter or more.</li> <li>• Aortic aneurysm surgically corrected.</li> </ul>
TEN	Other vascular conditions (eg severe deep venous thrombosis) that are difficult to control.

The impairment from any single condition can only receive one rating from this table. If the impairment from a given condition (eg, an aortic aneurysm) satisfies more than one criterion, it is to be given only the highest applicable rating.

No Age  
Adjustment  
Permitted For  
This Table.

**Aneurysms, atherosclerosis, and cerebrovascular disease**

Impairment from atherosclerosis is to be rated by applying the appropriate tables in Chapter 1, Part 2.2 of Chapter 2, and Chapter 5 (Neurological Impairment) according to the losses of function or other impairments which it causes.

Impairment from cerebral aneurysms and cerebrovascular disease is to be rated by applying Chapter 5 (Neurological Impairment) and any other applicable chapter, according to the other effects of the cerebrovascular disease.