Calendar No. 706

82D CONGRESS, 1st Session | SENATE | REPORT No. 750

AMENDING THE VETERANS REGULATIONS TO PROVIDE THAT MULTIPLE SCLEROSIS DEVELOPING A 10 PERCENT OR MORE DEGREE OF DISABILITY WITHIN 2 YEARS AFTER SEPARATION FROM ACTIVE SERVICE SHALL BE PRESUMED TO BE SERVICE-CONNECTED

SEPTEMBER 14 (legislative day, SEPTEMBER 13), 1951.—Ordered to be printed

Mr. GEORGE, from the Committee on Finance, submitted the following

REPORT

[To accompany H. R. 3205]

The Committee on Finance, to whom was referred the bill (H. R. 3205) to amend the Veterans Regulations to provide that multiple sclerosis developing a 10 percent or more degree of disability within 3 years after separation from active service shall be presumed to be service-connected, having considered the same, report favorably thereon with amendments, and recommend that the bill, as amended, do pass.

The amendments are as follows:

Amend the title of the bill to read:

A bill to amend the Veterans Regulations to provide that multiple sclerosis developing a 10 per centum or more degree of disability within two years after separation from active service shall be presumed to be service-connected.

Strike out all after the enacting clause and insert:

That the second last proviso of subparagraph (c) of paragraph I, part I, Veterans Regulation Numbered 1 (a), as amended, is hereby amended by inserting after the words "three years" the words ", or multiple sclerosis developing a 10 per centum degree of disability or more within two years".

EXPLANATION OF THE BILL

This bill provides that any veteran developing the disease of multiple sclerosis within a 2-year period after separation from active service shall be deemed to have acquired the disease in the service and thus presumed to be service-connected. The present law provides for a 1-year period. The net effect of the legislation would be to make veterans having multiple sclerosis, not now entitled to compensation, eligible for service-connected compensation ranging from $15 per month for 10-percent disability to $150 a month for total disability,

priority in hospitalization, and also out-patient treatment from Veterans' Administration doctors and approved private physicians.

The disease has been defined to be a chronic slowly progressive disease of the central nervous system characterized pathologically by disseminated patches of demyelinization in the brain and spinal cord, and clinically by multiple symptoms and signs and by remissions and exacerbations.

The Veterans' Affairs Committee of the House held hearings on this subject which included the testimony of a doctor of the Public Health Service who has spent the last 3 years working on the signs, symptoms, and incidence of the disease. All of the medical testimony indicates that the cause of the disease is unknown, and there is a great variance in the period of time required for various cases for diagnostic purposes. The Department of the Navy conducted a careful study of men in that branch of the service who had this disease and found that the first symptoms in some cases were diagnosed as early as 8 months after it first became manifest. In other cases the period ran as high as 20 months. Evidence was also present to the effect that in civilian cases it was often as much as 5 years before the disease was diagnosed as multiple sclerosis. From this it can be clearly seen that with the lack of medical knowledge as to this disease and the great variance in the amount of time in which the disease manifests itself, the 2-year presumptive period provided in this bill is most reasonable.

The Veterans' Administration in its report stated that there are 1,640 veterans of the Spanish-American War, World War I, and World War II who are presently receiving pension based on nonservice-connected multiple sclerosis. The Veterans' Administration advised that it has no available data on which to base an estimate of cost. The committee believes that a rough estimate would be $3,000,000.

A description of the disease as contained in the Merck Manual, eighth edition, follows, as well as the report of the Veterans' Administration:

[Excerpts from the Merck Manual, eighth edition, published by the Merck Co., Rahway, N. J.]

MULTIPLE SCLEROSIS [1]

(Disseminated sclerosis, insular sclerosis, sclerosis en plaques)

ETIOLOGY AND INCIDENCE

The cause is unknown. The disease has been variously attributed to infection by a spirochete or a virus; toxic factors, such as metallic poisons; metabolic factors, such as a myelin-splitting ferment in the blood; trauma; allergy; and vascular lesions as a result of an abnormality of the clotting mechanism of the blood. The two sexes are about equally affected. In two-thirds of the cases onset of symptoms occurs between the ages of 20 and 40. The disease is rare in warm climates.

SYMPTOMS AND SIGNS

The onset usually is insidious and the disease is characterized by the variety of complaints and findings with remarkable remissions and persistently recurring exacerbations. Occasionally, the onset is sudden; but commonly, minor visual disturbances, a fleeting ocular palsy, transient weakness, slight stiffness or unusual fatigability of a limb, minor interference with walking, vague difficulties with bladder control, occasional dizziness, or mild emotional disturbances—all evidence of scattered involvement of the nervous system—occur months or years

[1] A chronic, slowly progressive disease of the C. N. S. characterized pathologically by disseminated patches of demyelinization in the brain and spinal cord, and clinically by multiple symptoms and signs and by remissions and exacerbations.

before the existence of disease is recognized. However, on recognition of a disease process, the most frequent presenting symptoms are paresthesias involving one or more extremities or one side of the face, definite weakness or heaviness of the limbs, or visual disturbances such as partial blindness in one eye, double vision, dimness of vision, or a homonymous field defect.

The well-known Charcot's triad—nystagmus, intention tremor and scanning speech—is found late, and is uncommon in the early stages. There are many clinical syndromes, but the three most common are: Cerebral, characterized by mental symptoms, emotional lability, convulsive seizures, hemiplegia, aphasia, and hemianopsia; brain stem-cerebellar, manifested by nystagmus, scanning speech, intention tremor and ataxia; spinal, with cord involvement being evidenced by transient paresthesias, weakness and ataxia of one or more of the extremities. These and other types are not clear-cut and there is frequent overlapping. Euphoria and precipitate urination usually are common with all types.

Objective findings in multiple sclerosis are many and varied:

Mental.—Milder changes are commonly found as euphoria, apathy, lack of judgment, or inattention. The severe forms, mania or depression, are uncommon. Suicidal thoughts are frequent. Sudden weeping or forced laughter may be evidence of involvement of pathways of emotional control.

Speech.—There is no difficulty in finding words, but slow enunciation with a tendency to hesitation at the beginning of a word or syllable (scanning speech), is common.

Eyes.—One or more of the following eye signs usually are present sometime during the course of the disease: nystagmus; transient paralysis of external ocular muscles with diplopia; partial atrophy of the optic nerve with increased temporal pallor; changes in the visual fields (central scotoma for color and form or general narrowing of the fields). Choked disks and total blindness occur, but are rare, as are pupillary changes and Argyll Robertson pupils (diagnosis doubtful when pupillary changes are seen).

Cranial nerves.—These are not usually affected directly. Deafness occurs rarely but facial paralysis is not uncommon. Bulbar signs are paralysis of the vocal cords and disturbances of phonation, chewing, and swallowing.

Motor.—Deep reflexes (pyramidal tract signs) are generally increased; increased knee jerks, positive Babinski, and frequently clonus, are present. Superficial reflexes, particularly upper and lower abdominals, are diminished or absent. Tremor is commonly present and occurs when a purposeful motion is attempted. Continuation of this effort accentuates the tremor. The motion is shaky, irregular, tremulous, and ineffective (ataxic), and is described as an intention tremor. Other effects are muscular weakness and spasticity producing a stumbling, weaving (drunken) gait.

Sensory.—Paresthesias, sensations of numbness, blunting of sensation, disturbances of sense of position, and an occasional hemianesthesia occur. The changes are transient and fleeting and require careful study to elicit them.

Autonomic.—Mild disturbances of bladder function (difficulty in micturition, partial retention, slight incontinence) are frequent but usually transitory. Vesical and rectal incontinence are signs of severe and advanced involvement. Sexual impotence in the male and anesthesia in the female are not uncommon. Priapism is rare.

Muscular atrophy.—Uncommon, although atypical types of the disease may occur in the form of persisting spastic paraplegia (often associated with optic atrophy).

DIAGNOSIS

The cerebral type must be differentiated from expanding intracranial lesions such as brain tumors or abscesses and from cerebrovascular accidents. When the brain stem is involved it is necessary to rule out acoustic neuroma, cerebellar tumors, gliomas of the brain stem and tumors outside of the brain stem. In the presence of spinal cord symptoms, cord tumor, syringomyelia, amyotrophic lateral sclerosis, syphilis, subacute combined system degeneration and the hereditary ataxias must be considered.

A definite diagnosis rarely can be made during the first attack. History of remissions and exacerbations is most important confirmation. The spinal fluid is normal in over 50 percent of cases. The most characteristic abnormality is a first-zone (paretic) gold curve. A slight increase in cells (lymphocytes) may be seen but the spinal fluid findings are not characteristic. Late spinal fluid findings may include a slight increase in cells and a positive globulin. The triad of intention tremor, nystagmus and scanning speech occurs late in the disease.

PROGNOSIS AND TREATMENT

Although the average duration of life is 10 to 15 years following the onset of the disease, many patients live much longer. This course is variable. Some patients have frequent attacks and are rapidly incapacitated, while others have remissions for as long as 25 years.

There is no specific therapy. Spontaneous remissions make it difficult to evaluate any form of treatment.

General management.—Efforts should be made to keep the patient as near a normal level of activity as is consistent with his physical state. Overwork and fatigue should be avoided. Bedridden patients should be watched carefully to prevent the development of decubitus (q. v.) and efforts made to avoid urinary tract infections. Urinary frequency may be lessened by the use of tincture of belladonna, 10 drops 3 times a day (℞ 30). Belladonna should be used for as long as there is evidence of urinary frequency and evidence that the belladonna is effective. The presence of dryness of the throat, slight delirium, severe nausea, and constipation should lead to either a discontinuance of, or a reduction in, the amount of the drug.

Physiotherapy.—Massage and passive movement of the weakened, spastic limbs are of some value. Muscle training is beneficial to the patient both physically and psychologically.

Psychotherapy.—Encouragement and reassurance are essential, and the hopeless outlook should be minimized. Invalidism should be postponed as long as possible, and some form of therapy maintained constantly.

Pharmacotherapy.—None of the recommended modes of drug therapy has proved to be of definite value. However, for their psychotherapeutic and tonic effects, drugs such as arsenic and quinine may be worth a trial. Arsenic may be given in the form of one of the arsphenamines (℞ 71), I. V. at weekly intervals for a period of 4 to 6 weeks. The course may be repeated every few months. Fowler's solution (℞ 72) can be given by mouth, beginning with 1 drop in water 3 times daily and gradually increasing the dose to 10 drops 3 times a day for a period of 6 weeks. There should be a rest period of at least equal extent before the course is repeated. Arsenic also may be given in the form of sodium cacodylate (℞ 73) up to 60 mg. (gr.i) daily for 1 month; subsequent monthly courses of therapy may be given every other month for an indefinite period. Quinine (℞ 74) usually is given as the hydrochloride in a dose of 0.3 gm. (gr. v) once or twice a day for several weeks. Use of anticoagulants such as dicumarol and heparin still is in the experimental stage and may cause severe hemorrhages. Massive doses of all the vitamins have been given, particularly vitamin B and its components.

Climatotherapy.—Since multiple sclerosis is relatively uncommon in the subtropics, it has been recommended that patients with this disease move to such a climate if possible.

Miscellaneous.—Fever therapy, produced artificially or by the use of typhoid vaccine, is sometimes followed by a remission of symptoms. However, this treatment is debatable, since an acute exacerbation may follow it, or the condition of the patient may become worse.

JUNE 29, 1951.

Hon. WALTER F. GEORGE,
Chairman, Committee on Finance, United States Senate,
Washington, D. C.

DEAR SENATOR GEORGE: Further reference is made to your letter of June 23, 1951, requesting a report by the Veterans' Administration relating to H. R. 3205, Eighty-second Congress, an act to amend the Veterans Regulations to provide that multiple sclerosis developing a 10 percent or more degree of disability within 3 years after separation from active service shall be presumed to be service-connected, which passed the House of Representatives June 20, 1951.

The purpose of the bill is to extend from 1 year to 3 years after separation from active wartime service the period during which recourse may be had to the rebuttable presumption of service-connection for the chronic disease of multiple sclerosis.

Veterans Regulation numbered 1 (a), part I, paragraph I, subparagraph (c), as amended, provides that a chronic disease (other than pulmonary tuberculosis) becoming manifest to a degree of 10 percent or more within 1 year after the date of separation from active service, as defined in subparagraph (a) of said regula-

tion, shall be considered to have been incurred in or aggravated by such service, notwithstanding there is no record of evidence of such disease during the period of active service, if the person suffering from such disease served 90 days or more in the active service, except where there is affirmative evidence to the contrary, or evidence to establish that an intercurrent injury or disease which is a recognized cause of such chronic disease has been suffered between the date of discharge and the onset of the chronic disease, or the disability is due to the person's own willful misconduct. The presumptive period provided for active pulmonary tuberculosis was increased from 1 to 3 years by Public Law 573, Eighty-first Congress, June 23, 1950.

Public Law 748, Eightieth Congress, approved June 24, 1948, provides that the term "chronic disease" as used in the mentioned paragraph of Veterans Regulations shall include certain specified diseases. Among such diseases specified are "organic diseases of the nervous system" and the specific disease of multiple sclerosis is in that category.

The present 1-year presumptive period does not preclude the granting of direct service-connection for the condition of multiple sclerosis when first diagnosed more than 1 year after discharge from service when the evidence of record is deemed adequate to warrant a finding of service-connection. In such cases the provisions of Public Law 361, Seventy-seventh Congress, December 20, 1941, authorizing consideration of places, types, and circumstances of service as factors in the matter of granting service-connection are liberally applied.

Multiple sclerosis is a disease marked by an induration or hardening, occurring in sporadic patches throughout the brain or spinal cord, or both. Although the exact cause of the disease is unknown, there is nothing in the circumstances of military service in time of war which from a medical and scientific standpoint would warrant a presumption of fact that a manifestation of the disease 3 years after discharge is in any way related to the fact or circumstances of service. In this connection, it does not appear that the disease is any more prevalent among the veteran population than the nonveteran population. Because of the difficulty of determining the exact cause of multiple sclerosis it would rarely be possible to secure affirmative evidence to rebut the presumption of service-connection proposed by the bill.

Singling out multiple sclerosis as a disease which should be accorded a further presumptive period of service-connection of up to 3 years, as proposed by the bill, would be discriminatory and could be urged as a precedent for extending the presumptive period for many other chronic diseases. It should further be considered that a statutory directive which may require a finding of service-connection contrary to fact results in placing cases without merit, from the standpoint of service-connection, on a par with cases of veterans having medically proven service-connected conditions.

In addition to granting service-connection for compensation purposes, the bill, if enacted, would confer the same priority right in such cases to hospitalization by the Veterans' Administration which is now afforded by law to veterans having service-connected conditions. Under existing law, the Veterans' Administration is required to furnish hospital care to eligible veterans needing such care for service-connected conditions, and this may be provided in hospitals under the direct control of the Veterans' Administration, through bed allocations in other Government hospitals, or in appropriate cases by contract with State, municipal, or private institutions. By contrast, veterans suffering from non-service-connected disabilities may be furnished hospital care by the Veterans' Administration only if beds are available in Veterans' Administration or other Federal Government hospitals. Further, admission of non-service-connected cases is generally conditioned on the inability of the applicant to defray the cost of hospitalization as established by an affidavit procedure. The bill would also have the effect of providing out-patient treatment for the group affected because of the service-connected status which would be granted to them under the bill. Existing law and regulations generally limit out-patient treatment to those requiring such treatment for service-connected disabilities.

The Veterans' Administration has no available data upon which to base an estimate of the cost of the bill, if enacted. However, as of June 30, 1950, there were 1,640 veterans of World Wars I and II and the Spanish-American War in receipt of disability pension because of non-service-connected multiple sclerosis, permanently and totally disabling, a substantial number of whom would probably be eligible for the benefits of the bill. An unknown number of World War I and World War II multiple sclerosis cases having a disability of less than total in degree, and therefore not pensionable under existing legislation, would also

qualify for service-connection under H. R. 3205. By virtue of the provisions of Public Law 28, Eighty-second Congress, May 11, 1951, the presumption proposed by the bill would also be applicable to those who shall have served in the active service in the Armed Forces of the United States on or after June 27, 1950, and prior to such date as shall thereafter be determined by Presidential proclamation or concurrent resolution of the Congress.

Advice has been received from the Bureau of the Budget that the enactment of the proposed legislation would not be in accord with the program of the President.

Sincerely yours,

CARL R. GRAY, JR., *Administrator.*

CHANGES IN EXISTING LAW

In compliance with subsection 4 of rule XXIX of the Standing Rules of the Senate, changes in existing law made by the bill are as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italics, existing law in which no change is proposed is shown in roman):

SUBPARAGRAPH (C) OF PARAGRAPH I, PART I, VETERANS REGULATION NO. 1 (A), AS AMENDED

That for the purposes of paragraph I (a) hereof a chronic disease becoming manifest to a degree of 10 percent or more within one year from the date of separation from active service as set forth therein shall be considered to have been incurred in or aggravated by service as specified therein notwithstanding there is no record of evidence of such disease during the period of active service: *Provided,* The person suffering from such disease served 00 days or more in the active service as specified therein; *Provided, however,* that—Where there is affirmative evidence to the contrary, or evidence to establish that an intercurrent injury or disease which is a recognized cause of such chronic disease, has been suffered between the date of discharge and the onset of the chronic disease, or the disability is due to the person's own misconduct, service connection will not be in order: *Provided further,* That the term "chronic disease" as used in this paragraph shall include anemia, primary; arteriosclerosis; arthritis, bronchiectasis; calculi of the kidney, bladder, or gall bladder; cardiovascular-renal disease, including hypertension, myocarditis, Buerger's disease and Raynaud's disease; cirrhosis of the liver; coccidiomycosis; endocarditis; diabetes, mellitus; endocrinopathies; epilepsies; Hodgkin's disease; leukemia, nephritis; osteitis, deformans; osteomalacia; organic diseases of the nervous system, including tumors of the brain, cord, or peripheral nerves; encephalitis lethargica residuals; scleroderma; tuberculosis, active (other than pulmonary); tumors, malignant; ulcers, peptic (gastric or duodenal) and such other chronic diseases as the Administrator of Veterans' Affairs may add to this list: *Provided further,* That active pulmonary tuberculosis developing a 10 per centum degree of disability or more within three years, *or multiple sclerosis developing a 10 per centum degree of disability or more within two years* from the date of separation from active service, shall, in the absence of affirmative evidence to the contrary, be deemed to have been incurred in or aggravated by active service: *And provided further,* That, subject to the limitations of this subparagraph, tropical diseases, such as cholera; dysentery; filariasis; leishmaniasis; leprosy; loiasis, malaria, black water fever, onchocerciasis; oroya fever; dracontiasis; pinta; plague; schistosomiasis; yaws; yellow fever and others and the resultant disorders or diseases originating because of therapy, administered in connection with such diseases, or as a preventative thereof, shall be accorded service connection when shown to exist within one year after separation from active service or at a time when standard and accepted treatises indicate that the incubation period thereof commenced during active service. Nothing in this paragraph shall be construed to prevent service connection for any disease or disorder otherwise shown by sound judgment to have been incurred in or aggravated by active service.

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