

[CLINICIAN: letterhead: practice name, address, phone]

[CLINICIAN: date]

RE: **[VETERAN: full name], [VETERAN: last four of SSN or VA file number]**

Medical nexus opinion: lumbar spine condition and direct connection to an in-service lifting injury or repetitive stress

To whom it may concern:

I am a **[CLINICIAN: specialty and board certification]** physician licensed in **[CLINICIAN: state and license number]**. **[CLINICIAN: relationship to the veteran: treating since (date), or records review only]**. I was asked to give a medical opinion on whether the veteran's lumbar spine condition was incurred in or caused by an in-service injury or repetitive stress. I have reviewed the records listed below in full, and I have reviewed the medical literature cited at the end of this letter.

Records reviewed

1. Service clinic note, dated April 18, 2012, page 1.
2. Separation history, dated July 9, 2014, page 2.
3. Urgent care note, dated February 12, 2019, page 3.
4. Current spine assessment, dated November 6, 2025, page 4.
5. The veteran's written statement describing the history, symptoms and course, as supplied to me.

Pertinent history

The April 18, 2012 service clinic note documents a lumbar strain after the veteran lifted an equipment case during duty. The clinician recorded localized tenderness and no leg symptoms. The veteran received a temporary lifting restriction. This record establishes both a specific in-service lifting event and an acute lumbar response diagnosed at the time as a strain.

The July 9, 2014 separation history documents intermittent back discomfort with heavy lifting. Strength and gait were normal, and no imaging was obtained at that visit. This is important because it documents recurring activity-related back symptoms after the service injury and before the later furniture-moving event.

The February 12, 2019 urgent care note documents new back pain after moving furniture at home. The same note records earlier intermittent discomfort, although no treatment records for the intervening period were supplied. The November 6, 2025 current spine assessment documents activity-related low back pain and lower lumbar disc degeneration on imaging. The veteran currently reports back discomfort with prolonged standing and lifting.

Current diagnosis

The November 6, 2025 current spine assessment states the diagnosis as lumbar degenerative disc disease. The assessment is supported by imaging that describes lower lumbar disc degeneration and by documented activity-related low back pain. The supplied record does not state a current treatment.

Opinion

It is at least as likely as not (a 50 percent or greater probability) that the veteran's lumbar spine condition was incurred in or caused by the documented in-service lifting injury described in the April 18, 2012 service clinic note.

Rationale

Lifting places compression and shear forces across the lumbar discs and supporting tissues. Greater load, an off-center position, or an unfavorable lifting posture increases those forces. When the load exceeds tissue tolerance, an acute mechanical injury can occur. Later lifting and prolonged weight-bearing can continue to provoke symptoms in previously injured lumbar tissues. This mechanism does not require the service injury to be the veteran's only lifetime mechanical exposure.

Skals studied dynamic joint loading during 1832 lifts by 22 subjects and found that load mass had the most substantial effect on L5-S1 compression, while asymmetry increased mediolateral shear and both load mass and asymmetry significantly affected anteroposterior shear (Skals, 2021, PMID 34126573). This applies because the April 18, 2012 service clinic note documents an actual lifting injury involving an equipment case, and the July 9, 2014 separation history documents recurring discomfort with heavy lifting. Luoma reported that occupational load affected the risk of lumbar disc degeneration and that all signs of disc degeneration in the study were related to a history of back accidents; accidental back injuries and motor vehicle driving were associated with increased risk of degeneration (Luoma, 1998, PMID 9869307). This applies because the veteran had a documented back injury during duty and later had lower lumbar disc degeneration on imaging. McGill reviewed the types of tissue loads involved in low-back injury and identified spine posture and prolonged tissue loading over time as important considerations in injury risk (McGill, 1997, PMID 9109558). This applies to the veteran's repeated activity-related pattern involving lifting during service, discomfort with heavy lifting at separation, and current discomfort with lifting and prolonged standing.

The veteran's documented course fits this mechanical pathway. The April 18, 2012 service clinic note establishes immediate lumbar symptoms, localized tenderness, a diagnosis of lumbar strain, and a lifting restriction after the duty-related lift. The July 9, 2014 separation history shows that back discomfort still occurred with heavy lifting. The February 12, 2019 urgent care note again records earlier intermittent discomfort, even though the immediate reason for that visit was new pain after moving furniture. The November 6, 2025 current spine assessment then documents lower lumbar disc degeneration and activity-related pain. The recurring association with lifting links the in-service presentation, the later symptom history, and the current functional complaint through the same mechanical pattern.

The timing supports the nexus. Back symptoms began with a documented in-service event rather than first appearing after service. Symptoms were still reported in the July 9, 2014 separation history. Although continuous treatment records were not supplied, the February 12, 2019 urgent care note independently records earlier intermittent discomfort. The record therefore shows symptom recurrence before the furniture-moving injury rather than a symptom history beginning with that later event. The absence of imaging during service means the exact onset of disc degeneration cannot be dated, but it does not negate the documented onset and persistence of mechanical low-back symptoms.

I considered each contrary fact. Normal strength and gait in the July 9, 2014 separation history do not refute intermittent axial back pain because strength and gait assess neurologic and functional status at that visit, while the same record expressly documents discomfort with heavy lifting. The absence of leg symptoms in the April 18, 2012 service clinic note also does not refute the diagnosed lumbar strain or the later activity-related low-back pain. The gap in supplied treatment records limits documentation of frequency, but it is answered by the separation history and the February 12, 2019 report of earlier intermittent discomfort. The furniture-moving injury is a competing mechanical exposure, but it does not establish the original onset of the back condition because service and separation records already documented lumbar symptoms. Luoma's study was cross-sectional and found that decreased disc signal intensity was not related to occupation, so I do not rely on it to claim that occupational loading alone establishes causation. I rely on its separately reported association between a history of back accidents and all signs of disc degeneration, together with this veteran's documented injury and symptom chronology. Finally, the November 6, 2025 assessment does not identify when degeneration began or assign it to a particular injury. That omission is neutral rather than contrary evidence, and the earlier records provide the necessary chronology.

Summary of the basis for this opinion

1. The April 18, 2012 service clinic note documents a lumbar strain immediately after lifting an equipment case during duty.
2. The July 9, 2014 separation history documents intermittent back discomfort with heavy lifting before the later furniture-moving injury.
3. The February 12, 2019 urgent care note records earlier intermittent discomfort despite documenting a new furniture-moving episode.
4. The November 6, 2025 current spine assessment establishes lumbar degenerative disc disease through imaging showing lower lumbar disc degeneration.
5. The cited literature supports a biomechanical link among lifting loads, back accidents, lumbar tissue loading, and disc degeneration.

Conclusion

After reviewing the documented in-service injury, the subsequent activity-related symptom history, the current imaging findings, the competing furniture-moving event, and the cited literature, I conclude that it is at least as likely as not (a 50 percent or greater probability) that the veteran's lumbar spine condition was incurred in or caused by the documented in-service lifting injury. I am available to provide further explanation if needed.

[CLINICIAN: signature]

[CLINICIAN: name and degree]

[CLINICIAN: specialty and board certification]

[CLINICIAN: state license number]

[CLINICIAN: practice address and phone]

Date: **[CLINICIAN: date]**

I have reviewed the records listed above.

Literature cited

1. Sebastian Skals, Rúni Bláfoss, Mark de Zee, et al. Effects of load mass and position on the dynamic loading of the knees, shoulders and lumbar spine during lifting: a musculoskeletal modelling approach. Applied ergonomics. 2021. PMID 34126573.
<https://pubmed.ncbi.nlm.nih.gov/34126573/>
2. K Luoma, H Riihimäki, R Raininko, et al. Lumbar disc degeneration in relation to occupation. Scandinavian journal of work, environment & health. 1998. PMID 9869307.
<https://pubmed.ncbi.nlm.nih.gov/9869307/>
3. S M McGill. The biomechanics of low back injury: implications on current practice in industry and the clinic. Journal of biomechanics. 1997. PMID 9109558.
<https://pubmed.ncbi.nlm.nih.gov/9109558/>

Review notes for the practitioner

Supporting instructions outside the letter body.

Draft for clinician review

Every date, value and citation in this letter was traced to a supplied source and the reasoning passed an independent check. That is completeness, not medical validation. The clinician reviews the records and literature, changes what they disagree with, and signs only what they believe.

Clinical statements written from general medical knowledge rather than a cited source. By signing, the clinician adopts these as their own:

- Lifting places compression and shear forces across the lumbar discs and supporting tissues.
- Greater load, an off-center position, or an unfavorable lifting posture increases those forces.
- When the load exceeds tissue tolerance, an acute mechanical injury can occur.
- Later lifting and prolonged weight-bearing can continue to provoke symptoms in previously injured lumbar tissues.
- This mechanism does not require the service injury to be the veteran's only lifetime mechanical exposure.
- Normal strength and gait in the July 9, 2014 separation history do not refute intermittent axial back pain because strength and gait assess neurologic and functional status at that visit, while the same record expressly documents discomfort with heavy lifting.
- The absence of leg symptoms in the April 18, 2012 service clinic note also does not refute the diagnosed lumbar strain or the later activity-related low-back pain.

FICTIONAL EXAMPLE. These invented records were processed through the Raven Nexus draft engine. No real veteran, clinician, or medical opinion is represented. Do not submit this example as evidence.

This is an unreviewed working draft, not medical evidence. The clinician must independently review the records and literature, reach their own conclusion, and author or adopt any final opinion.

Bold bracketed fields identify actions for the clinician. Review all drafted medical content, not only those fields. Correct, remove, or independently adopt the proposed reasoning before signing a final opinion. This packet does not verify a signature or make a draft ready to submit to VA.