CHAPTER 13

CARDIOVASCULAR CONDITIONS

13.01 - Cardiovascular Conditions - General Instructions

1. The first essential assessment of disability is accurate diagnosis of the cause of symptoms and signs attributed to cardiovascular disease, and the second is the distinction between pensioned and non-pensioned causes of such symptoms.

2. A pensioner for chronic bronchitis and emphysema may have heart failure due entirely to his pensionable chest disease, and the disability may be so assessed if there is no non-pensioned cardiovascular disease.

3. A pensioner for ischemic heart disease may have dyspnea from chest disease or other causes as well as from his pensioned condition, and an arbitrary distinction between pensioned and non-pensioned factors must be made if at all possible.

4. When a pension entitlement is in obsolete terms, such as D.A.H. (N.C.A. or effort syndrome), V.D.H., or Myocarditis, a stabilized assessment must be respected but there is no authority for pensioning disabilities due to other causes.

5. The direct effects of hypertension can be assessed under this diagnosis.

6. When a pensioner with hypertension develops ischemic heart disease which is, in medical opinion, not entirely due to hypertension, the degree of relationship is a matter for adjudication, on application.

7. In the above types of case and in analogous situations, there is a definite onus on the staff of Veterans Affairs Canada to inform the pensioner and/or his Advocate of the distinction between pensioned and non-pensioned disabilities, and the right to apply for entitlement for any non-pensioned condition.

8. At each examination for assessment of cardiovascular disease, the Consultant should be asked to state the Functional Capacity and Therapeutic Classification. If this opinion cannot be obtained, the Pension Medical Examiner should give his own opinion, to establish the basis on which his assessment of disability is made. The symptoms, diagnosis, response to treatment, post-operative status, etc., should be on record and taken into account.

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13.02 - Assessment for Cardiovascular Conditions

The Tables to Article 13.02, based on the functional capacity and therapeutic classification, are common to all cardiovascular diseases. However, the assessment is subject to modification in the light of the prognosis, response to treatment and other features of the disease process in the individual case.

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TABLE 1 TO ARTICLE 13.02

Functional Capacity Table (Classification of Patients)	
Class 1	Patients with cardiac disease, but without resulting limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, dyspnea or anginal pain.
Class 2	Patients with cardiac disease resulting in slight limitation of physical activity. They are comfortable at rest. Ordinary physical activity results in fatigue, palpitation, dyspnea or anginal pain.
Class 3	Patients with cardiac disease resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary activity causes fatigue, palpitation, dyspnea or anginal pain.
Class 4	Patients with cardiac disease resulting in inability to carry on any physical activity without discomfort. Symptoms of cardiac insufficiency, or of the anginal syndrome may be present even at rest. If any physical activity is undertaken discomfort is increased.

TABLE 2 TO ARTICLE 13.02

Therapeutic Classification Table (Classification of Patients)	
Class A	Patients with cardiac disease whose physical activity need not be restricted.
Class B	Patients with cardiac disease whose ordinary physical activity need not be restricted, but who should be advised against severe or competitive physical efforts.
Class C	Patients with cardiac disease whose ordinary physical activity should be moderately restricted, and whose more strenuous efforts should be discontinued.
Class D	Patients with cardiac disease whose ordinary physical activity should be markedly restricted.
Class E	Patients with cardiac disease who should be at complete rest, confined to bed or chair.

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TABLE 3 TO ARTICLE 13.02		
Functional-Therapeutic Rating		
Class 1	A or B	Nil to 20%
Class 2	B or C	25 to 50%
Class 3	C	50 to 70%
Class 4	D	70 to 85%
Class 4	E	85 to 100%

13.03 - Assessment following Treatment for Congestive Heart Failure

Following the treatment of congestive heart failure or the treatment of myocardial infarction, 100%, for mandatory review six months after release from hospital; then 75% minimum for six months mandatory review, thereafter based on the functional-therapeutic rating.

13.04 - Hypertension and Hypertensive Disease

1. Hypertension without complications may constitute a disability due to the need of supervision, treatment and other factors. An assessment of up to 10% may be made when the diastolic pressure is generally less than 110mm Hg., or up to 20% if the diastolic pressure stays higher. The assessment will be made on the function-therapeutic rating if this is more favourable.

2. Complications of hypertension fall into two categories:

   (a) Direct - left ventricular hypertrophy, cardiac failure, etc.

   (b) Indirect - acceleration of the arteriosclerotic process wherever it may occur in the body, resulting in arterial thrombosis, embolism or hemorrhage.

3. The direct complications may be given higher assessments without the need for a separate consequential ruling. The indirect complications require a separate consequential ruling for arteriosclerosis, regardless of the site of damage. In the past, some cases of indirect complications (arteriosclerotic were given higher assessments for hypertension of 30% or more). Should further complications arise, a separate consequential entitlement is required.

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13.05 - Cardiac Surgery

Assessment shall be 100% following surgical treatment, for mandatory review in six months.

Subsequently assessment shall be not less than 50% for six months.

13.06 - Rheumatic Heart Disease

Rheumatic heart disease following treatment of active carditis shall be assessed at 100% for mandatory review in six months.

13.07 - Luetic Cardiovascular Disease

Luetic cardiovascular disease is subject to Subsection 22(3) of the Pension Act and the functional-therapeutic rating in Table 3 to Article 13.02 of the Table of Disabilities.

13.08 - Peripheral Vascular Disease - General Instructions

1. Peripheral vascular disease refers to disease of the vessels affecting the extremities and may include involvement of the aorta and vena cava.

2. Permanent disability from peripheral vascular disease may arise as a result of:

   (a) reduced blood flow due to arterial disease, or;

   (b) impairment of venous return.

3. Entitlement for disease of the venous system may be limited to the superficial veins under the diagnosis of varicose veins. Entitlement for deep vein thrombosis will include the superficial varicosities which arise secondarily to the deep vein occlusion.

4. Entitlement is granted separately for either arterial or venous disease except in Thromboangiitis Obliterans where the pathological changes involve both the arterial and venous systems.

5. If the system, venous or arterial, is not specified in the entitlement, the term peripheral vascular disease, by common usage, refers to arterial disease only.

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13.09 - Assessment of Peripheral Vascular Disease

The Tables to 13.09 for peripheral vascular disease are Table 1 for peripheral arterial disorders and Table 2 for peripheral venous disorders.

TABLE TO ARTICLE 13.09

	Peripheral Arterial Disorders	
1.	No intermittent claudication or rest pain. Diagnosis based on loss of pulses and/or calcification of arteries detected by x-ray, probably dependent rubor -	NIL
2.	Intermittent claudication after walking 400 meters at normal pace, relieved by rest. Minimal cold intolerance. Dependent rubor -	0-10%
3.	Intermittent claudication after walking 100 meters at normal pace and possible intermittent pain at rest. Atrophic changes with evidence of impending ulceration -	10%-20%
4.	Intermittent claudication after walking less than 25 meters at normal pace and recurring pain at rest. Ulceration or impending gangrene -	20%-40%
5.	Amputations as a result of arterial disorders will be assessed on individual merit according to amputation assessments.	
6.	Arterial disorders of the upper extremities are rare and will be assessed on individual merit.	

TABLE 2 TO ARTICLE 13.09 ASSESSMENT OF PERIPHERAL VENOUS DISORDERS						
ASSESSMENT	SYMPTOMS	ANATOMICAL DISTRIBUTION	EDEMA	SKIN	SUPPORT STOCKINGS	LIMB ENLARGEMENT
0% to 5%	Mild	Unilateral Or Bilateral Below Knee	Nil to Minimal	No Change	No	No
	Mild	Unilateral Above and Below Knee	Nil to Minimal	No Change	No	No
5% to 10%	Mild	Bilateral Above and Below Knee	Minimal	No Change or Dry Scaling	No	No
	Unilateral Above and Below Knee	Unilateral Above and Below Knee	Mild	No Change or Dry Scaling	Possible	No
10% to 20%	Moderate	Extensive Bilateral Involvement	Mild	Probable Bronzing	May or May Not Wear Support Hose	Possible
	Moderate	Severe Unilateral Involvement	Mild	Bronzing with Early Skin Atrophy	May or May Not Wear Support Hose	Possible

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20% to 30%	Pronounced	Severe Unilateral or Bilateral Involvement	Moderate	Bronzing, Scaling Possible Healed Ulcer or Mild Chronic Ulceration	Probable	Probable
Cases in which there is more severe disability will be assessed on individual merit. Disease of veins of the upper extremities is rare and will be assessed on individual merit.						