Understanding Medical Standards for Entrance Into Military Service and Disqualifying Dermatologic Conditions

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PRACTICE **POINTS**

- Dermatologic diseases have played a substantial role in conflicts throughout US military history, representing a considerable source of morbidity to service members, loss of active-duty service members trained with necessary skills, and costly use of resources.
- The strict standards are designed to protect the health of the individual and maximize mission success.
- The Department of Defense has a publicly available document (*DoD Instruction 6130.03, Volume 1*) that details conditions that are disqualifying for entrance into the military. Dermatologists can reference this to provide guidance to adolescents and young adults interested in joining the military.

The military is a desirable career field for many young adults; however, the Department of Defense (DoD) requires its members to maintain a level of health necessary to meet the physical demands of military duties and be able to deploy to austere environments. The strict standards are designed to protect the health of the individual and maximize mission success. Standards for entrance into the US Armed Forces, called accession standards, are codified in *DoD Instruction 6130.03, Volume 1* and include a section dedicated to skin and soft tissue conditions. This document lists medical conditions that do not meet the standard due to current and prior diagnoses and is regularly updated by a board using the best available scientific evidence. Applicants who do not meet the physical and medical standards can be considered for a medical waiver, although not guaranteed. Generally, retention standards differ for those already serving in the military and will not be addressed here. The focus of this article is to inform the general dermatologic community that these standards exist, to discuss specific dermatologic conditions that are disqualifying at the current time, and to provide resources for the dermatologist or primary care physician to access current information.

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Purpose of Medical Standards in the US Military

Young adults in the United States traditionally have viewed military service as a viable career given its stable salary, career training, opportunities for progression, comprehensive health care coverage, tuition assistance, and other benefits; however, not all who desire to serve in the US Military are eligible to join. The Department of Defense (DoD) maintains fitness and health requirements (ie, accession standards), which are codified in *DoD Instruction 6130.03, Volume 1,*[1] that help ensure potential recruits can safely and fully perform their military duties. These accession standards change over time with the evolving understanding of diseases, medical advances, and accrued experience conducting operations in various environments. Accession standards serve to

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The eTable is available in the Appendix online at www.mdedge.com/dermatology.

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both preserve the health of the applicant and to ensure military mission success.

Dermatologic diseases have been prevalent in conflicts throughout US military history, representing a considerable source of morbidity to service members, inability of service members to remain on active duty, and costly use of resources. Hospitalizations of US Army soldiers for skin conditions led to the loss of more than 2 million days of service in World War I.[2] In World War II, skin diseases made up 25% and 75% of all temperate and tropical climate visits, respectively. Cutaneous diseases were the most frequently addressed category for US service members in Vietnam, representing more than 1.5 million visits and nearly 10% of disease-related evacuations.[2] Skin disease remains vital in 21st-century conflict. At a military hospital in Afghanistan, a review of 2421 outpatient medical records from June through July 2007 identified that dermatologic conditions resulted in 20% of military patient evaluations, 7% of nontraumatic hospital admissions, and 2% of total patient evacuations, at an estimated cost of $80,000 per evacuee.[3] Between 2003 and 2006, 918 service members were evacuated for dermatologic reasons from combat zones in Afghanistan and Iraq.[4]

Unpredictable military environments may result in flares of a previously controlled condition, new skin diseases, or infection with endemic diseases. Mild cases of common conditions such as psoriasis or atopic dermatitis can present an unacceptable risk for severe flare in the setting of deployed military operations.[5] Personnel may face extremes in temperature and humidity and work long hours under stress with limited or nonexistent opportunities for hygiene or self-care. Shared equipment and close living quarters permit the spread of infectious diseases and complicate the treatment of infestations. Military equipment and supplies such as gas masks and insect repellents can contain compounds that act as irritants or sensitizing agents, leading to contact dermatitis or urticaria. When dermatologic conditions develop or flare, further challenges are associated with evaluation and management. Health care resources vary considerably by location, with potential limitations in the availability of medications; supplies; refrigeration capabilities; and laboratory, microbiology, and histology services. Furthermore, dermatology referrals and services typically are not feasible in most deployed settings,[3] though teledermatology has been available in the armed forces since 2002.

Deployed environments compound the consequences of dermatologic conditions and can impact the military mission. Military units deploy with the number of personnel needed to complete a mission and cannot replace members who become ill or injured or are medically evacuated. Something seemingly trivial, such as poor sleep due to pruritic dermatitis, may impair daytime alertness with potentially grave consequences in critical tasks such as guard or flying duties. The evacuation of a service member can compromise those left behind, and losing a service member with a unique required skill set may jeopardize a unit's chance of success. Additionally, the impact of an evacuation itself extends beyond its direct cost and effects on the service member's unit. The military does not maintain dedicated medical evacuation aircraft, instead repurposing aircraft in the deployed setting as needed.[6] Evacuations can delay flights initially scheduled to move troops, ammunition, food, or other supplies and equipment elsewhere.

Disqualifying Skin and Soft Tissue Conditions

Current accession standards, which are listed in a publicly released document (*DoD Instruction 6130.03, Volume 1*), are updated based on medical, societal, and technical advances.[1] These standards differ from retention standards, which apply to members actively serving in the military. Although the DoD creates a minimum standard for the entire military, the US Army, Navy, and Air Force adopt these standards and adjust as required for each branch's needs. An updated copy can be found on the DoD Directives Division website (https://www.esd.whs.mil/dd/) or Med Standards, a third-party mobile application (app) available as a free download for Apple iOS and Android devices (https://www.doc-apps.com/). The app also includes each military branch's interpretation of the requirements.

The accession standards outline medical conditions that, if present or verified in an applicant's medical history, preclude joining the military (eTable). These standards are organized into general systems, with a section dedicated to dermatologic (skin and soft tissue) conditions.[1] When a candidate has a potentially disqualifying medical condition identified by a screening questionnaire, medical record review, or military entrance physical examination, a referral for a determination of fitness for duty may be required. Medical accession standards are not solely driven by the diagnosis but also by the extent, nature, and timing of medical management. Procedures or prescriptions requiring frequent clinical monitoring, special handling, or severe dietary restrictions may deem the applicant's condition potentially unsuitable. The need for immunosuppressive, anticoagulant, or refrigerated medications can impact a patient's eligibility due to future deployment requirements and suitability for prolonged service, especially if treated for any substantial length of time. Chronic dermatologic conditions that are unresponsive to treatment, are susceptible to exacerbation despite treatment, require regular follow-up care, or interfere with the wear of military gear may be inconsistent with future deployment standards. Although the dermatologist should primarily focus on the skin and soft tissue conditions section of the accession standards, some dermatologic conditions can overlap with other medical systems and be located in a different section; for example, the section on lower extremity conditions includes a disqualifying condition of "[c]urrent ingrown toenails, if infected or symptomatic."[1]

Waiver Process

Medical conditions listed in the accession standards are deemed ineligible for military service; however, applicants can apply for a waiver.[1] The goal is for service members to be well controlled without treatment or with treatment widely available at military clinics and hospitals. Waivers ensure that service members are "[m]edically capable of performing duties without aggravating physical defects or medical conditions," are "[m]edically adaptable to the military environment without geographical area limitations," and are "free of medical conditions or physical defects that may reasonably be expected to require excessive time lost from duty for necessary treatment or hospitalization, or may result in separation from the Military Service for unfitness."[1] The waiver process requires an evaluation from specialists with verification and documentation but does not guarantee approval. Although each military branch follows the same guidelines for disqualifying medical conditions, the evaluation and waiver process varies.

Considerations for Civilian Dermatologists

For several reasons, accurate and detailed medical documentation is essential for patients who pursue military service. Applicants must complete detailed health questionnaires and may need to provide copies of health records. The military electronic health record connects to large civilian health information exchanges and pulls primary documentation from records at many hospitals and clinics. Although applicants may request supportive clarification from their dermatologists, the military relies on primary medical documentation throughout the recruitment process. Accurate diagnostic codes reduce ambiguity, as accession standards are organized by diagnosis; for example, an unspecified history of psoriasis disqualifies applicants unless documentation supports nonrecurrent childhood guttate psoriasis.[1] Clear documentation of symptom severity, response to treatment, or resolution of a condition may elucidate suitability for service when matching a potentially disqualifying condition to a standard is not straightforward. Correct documentation will ensure that potential service members achieve a waiver when it is appropriate. If they are found to be unfit, it may save a patient from a bad outcome or a military unit from mission failure.

Dermatologists in the United States can reference current military medical accession standards to guide patients when needed. For example, a prospective recruit may be hesitant to start isotretinoin for severe nodulocystic acne, concerned that this medication may preclude them from joining the military. The current standards state that "[a]pplicants under treatment with systemic retinoids . . . do not meet the standard until 4 weeks after completing therapy," while active severe nodulocystic acne is a disqualifying condition.[1] Therefore, the patient could proceed with isotretinoin therapy and, pending clinical response, meet accession standards as soon as 4 weeks after treatment. A clear understanding of the purpose of these standards, including protecting the applicant's health and maximizing the chance of combat mission accomplishment, helps to reinforce responsibilities when caring for patients who wish to serve.

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APPENDIX

Disqualifying Skin and Soft Tissue Conditions From the US Department of Defense[1]

a. Applicants under treatment with systemic retinoids, including, but not limited to, isotretinoin (eg, Accutane®), do not meet the standard until 4 weeks after completing therapy.

b. Severe nodulocystic acne, on or off antibiotics.

c. History of dissecting scalp cellulitis, acne inversa, or hidradenitis suppurativa.

d. History of atopic dermatitis or eczema requiring treatment other than over-the-counter hydrocortisone or moisturizer therapy in the previous 36 months or with active lesions or residual hyperpigmented or hypopigmented areas at the time of the entrance examination.

e. History of recurrent or chronic non-specific dermatitis within the previous 24 months, including contact (irritant or allergic) or dyshidrotic dermatitis requiring treatment other than over-the-counter medication.

f. Cysts, if:

(1) The current cyst (other than pilonidal cyst) is of such a size or location as to reasonably be expected to interfere with properly wearing military equipment.

(2) The current pilonidal cyst is associated with a tumor mass or discharging sinus or is a surgically resected pilonidal cyst that is symptomatic, unhealed, or less than 6 months postoperative. A pilonidal cyst that has been simply incised and drained does not meet the military accession medical entrance standard.

g. History of bullous dermatoses, including, but not limited to, dermatitis herpetiformis, pemphigus, and epidermolysis bullosa.

h. Current or chronic lymphedema.

i. History of furunculosis or carbuncle if extensive, recurrent, or chronic.

j. History of severe hyperhidrosis of hands or feet unless controlled by topical medications.

k. History of congenital or acquired anomalies of the skin, such as nevi or vascular tumors that may interfere with military duties or cause constant irritation.

l. Current lichen planus (either cutaneous or oral).

m. History of oculocutaneous albinism, Neurofibromatosis I (Von Recklinghausen's Disease), Neurofibromatosis II, and tuberous sclerosis.

n. History of photosensitivity, including, but not limited to, any primary sun-sensitive condition, such as polymorphous light eruption or solar urticaria, or any dermatosis aggravated by sunlight, such as lupus erythematosus, porphyria, and xeroderma pigmentosa.

o. History of psoriasis excluding non-recurrent childhood guttate psoriasis.

p. History of chronic radiation dermatitis (radiodermatitis).

q. History of scleroderma.

r. History of chronic urticaria lasting longer than six weeks even if it is asymptomatic when controlled by daily maintenance therapy.

s. Current symptomatic plantar wart(s).

t. Current scars or keloids that can reasonably be expected to interfere with properly wearing military clothing or equipment, or to interfere with satisfactorily performing military duty due to pain or decreased range of motion, strength, or agility.

u. Prior burn injury involving 18 percent or more body surface area (including graft sites), or resulting in functional impairment to such a degree, due to scarring, as to interfere with satisfactorily performing military duty due to pain or decreased range of motion, strength, temperature regulation, or agility.

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eTABLE. (continued)

v. Current localized fungal infections, if they can be reasonably expected to interfere with properly wearing military equipment or performing military duties. For systemic fungal infections, refer to Paragraph 6.23.s.

w. History of any dermatologic condition severe enough to warrant use of systemic steroids for greater than 2 months, or any use of other systemic immunosuppressant medications.

x. Conditions with malignant potential in the skin including, but not limited to, high-grade atypia, basal cell nevus syndrome, oculocutaneous albinism, xeroderma pigmentosum, Muir-Torre Syndrome, Dyskeratosis Congenita, Gardner Syndrome, Peutz-Jeghers Syndrome, Cowden Syndrome, Multiple Endocrine Neoplasia, Familial Atypical Multiple Mole Melanoma Syndrome, and Birt-Hogg-Dube Syndrome.

y. History of cutaneous malignancy before the 25th birthday including, but not limited to, basal cell carcinoma and squamous cell carcinoma. History of the following skin cancers at any age: malignant melanoma, Merkel cell carcinoma, sebaceous carcinoma, Paget's disease, extramammary Paget's disease, microcystic adnexal carcinoma, other adnexal neoplasms, and cutaneous lymphoma including mycosis fungoides.

z. History of lupus erythematosus.

aa. History of congenital disorders of cornification including, but not limited to, ichthyosis vulgaris, x-linked ichthyosis, lamellar ichthyosis, Darier's Disease, Epidermal Nevus Syndrome, and any palmoplantar keratoderma.

ab. History of congenital disorder of the hair and nails including, but not limited to, pachyonychia congenita or ectodermal dysplasia.

ac. History of dermatomyositis.