MILITARY (ACTIVE DUTY)-SPECIFIC ISSUES

RECOMMENDATIONS

Evaluation for possible asthma

1. Active duty service members should be diagnosed with asthma or exercise-induced bronchospasm on the basis of the following criteria:
   a. Chronic symptoms of cough, dyspnea, or wheezing
   b. Associated decrease in tolerance of exercise and/or running
   c. Normal chest radiograph (should be obtained in all active duty patients)
   d. Demonstration of persistent airway hyperreactivity
      - Baseline spirometry with reversible airflow obstruction post-bronchodilator ; OR
      - Reactive bronchoprovocation testing or lower dose of methacholine (preferred method of bronchoprovocation testing). Other methods include exercise spirometry, histamine challenge testing, or eucapneic hyperventilation.

See below for standards of fitness for each service-specific regulation concerning asthma.

Deployment issues

2. Guidelines for deploying or redeploying service members with asthma to/from a theater of operations:
   a. In general, service members should be able to perform all required duties, wear protective gear, and have stable disease not requiring frequent treatments or oral corticosteroids
   b. Failure to meet these criteria should prompt consideration for redeployment
   c. See below - Standards of Fitness: Service Specific Regulations Concerning Asthma
   d. Army; AR 40-501, Section 5–14. Medical fitness standards for deployment and certain geographical areas:

      "Asthma". See paragraph 3–27a for profile guidance and for MEB/PEB processing criteria. If it is determined that the Soldier can be returned to duty, the Soldier should not deploy if he/she cannot wear protective gear, has experienced recent emergency room visits, or requires repetitive use of oral corticosteroids."
   e. Navy, Air Force, Coast Guard – No specific regulatory guidance.

Standards of Fitness: Service-Specific Regulation Concerning Asthma

Deployment Issues

PPG-TAB A: AMPLIFICATION OF THE MINIMAL STANDARDS OF FITNESS FOR DEPLOYMENT TO THE CENTCOM AOR; TO ACCOMPANY MOD 7 TO USCINCCENT INDIVIDUAL PROTECTION AND INDIVIDUAL/UNIT DEPLOYMENT POLICY

- General. This tab accompanies MOD 7 Para 15.g., and provides amplification of the minimal standards of fitness for deployment to the CENTCOM AOR, including a list of medical conditions that should usually be sufficient basis to deny medical clearance for or to disapprove deployment of a civilian employee, volunteer, or contractor's employee. The list of conditions is not comprehensive; there are many more conditions that could be cause to deny medical clearance for deployment. Possession of one or more of the conditions listed in this chapter does not automatically mean that the individual may not deploy. Rather, it imposes the requirement to obtain a knowledgeable physician's opinion as to the deployable status of the individual. "Medical conditions" as used here also includes those health conditions usually referred to as dental, oral, psychological and/or emotional conditions. (Uniformed service members will be evaluated for fitness according to service regulations and policies, in addition to the guidance in the parent PPG Modification (MOD). The services' parent regulations are as follows.

  - **Army: AR 40-501, Standards of Medical Fitness, February 2004;**
  - **Air Force: AFI 48-123, 22 MAY 2001, Medical Examinations And Standards;**
  - **Navy: NAVMED P-117, The Manual of the Medical Department; Marine Corps: NAVMED P-117, article 15-5;**
  - **Coast Guard: Medical Manual, COMDTINST M6000.1B**

- Documented medical conditions usually precluding medical clearance. While a list of all possible diagnoses and their severity that should not be approved would be too expansive to list here, the following conditions, in general, should usually not be approved. *The medical evaluator must carefully consider whether there is any question whether the climate, the altitude, the nature of available food and housing, the availability of medical, behavioral health, dental, and surgical services, or whether other environmental and operational factors may be hazardous to the deploying person's health because of a known physical condition.*

Usually, medical clearance to deploy for persons with any of the following documented medical conditions should be granted only after consultation with

theater medical authority. The theater medical authority can determine if adequate treatment facilities and specialist support is available at the duty station.

A. Conditions resulting in inability to wear personal protective equipment, including protective mask, ballistic helmet, body armor, and chemical/biological protective garments, regardless of the nature of the condition that causes the inability.

Service-specific regulations regarding medical standards of fitness for asthma or other deployment issues are available on the asthma CPG homepage under resource material at: https://www.qmo.amedd.army.mil/asthma/Asthfr.htm

Standards of Fitness

U.S. Army, AR 40-51, Section 3-27a

Asthma. This includes reactive airway disease, exercise-induced bronchospasm, asthmatic bronchospasm, or asthmatic bronchitis within the criteria outlined in paragraphs (1) through (4) below.

(1) Definitions/diagnostic criteria are as follows.

(a) Asthma is a clinical syndrome characterized by cough, wheeze, or dyspnea and physiologic evidence of reversible airflow obstruction or airway hyperactivity that persists over a prolonged period of time (generally more than 6 to 12 months).

(b) Reversible airflow obstruction is defined as more than 15 percent increase in forced expiratory volume in 1 second (FEVI) following the administration of an inhaled bronchodilator or prolonged corticosteroid therapy.

(c) Increased bronchial responsiveness is the presence of an exaggerated decrease in airflow induced by a standard bronchoprovocation challenge such as methacholine inhalation (PD20 FEV_1 less than or equal to 4mg/ml). Demonstration of exercise induced bronchospasm (15 percent decline in FEV_1) is also diagnostic of increased bronchial responsiveness; however, failure to induce bronchospasm with exercise does not rule out the diagnosis of asthma. Bronchoprovocation or exercise testing should be performed by a credentialed provider privileged to perform the procedures.

(d) If at the end of that period, the Soldier is unable to perform all military training and duty as cited below, the Soldier will be referred to MEB.

(e) Acute, self limited, reversible airflow obstruction and airway hyperactivity can be caused by upper respiratory infections and inhalation of irritant gases or

pollutants. This should not be permanently diagnosed as asthma unless significant symptoms or airflow abnormalities persist for more than 12 months.

(2) Chronic asthma is cause for a permanent P-3 or P-4 profile and MEB referral if it—

(a) Results in repetitive hospitalizations, repetitive emergency room visits or excessive time lost from duty.

(b) Requires repetitive use of oral corticosteroids to enable the Soldier to perform all military training and duties.

(c) Results in inability to run outdoors at a pace that meets the standards for the timed 2-mile run despite medications. (The P–3 for the inability to perform the run refers to the inability due to asthma and should not be confused with giving an L2 or L3 based on an underlying orthopedic condition that requires an alternate Army Physical Fitness Test (APFT).)

(d) Prevents the Soldier from wearing a protective mask.

(3) All Soldiers meeting an MEB for asthma should receive a consultation from an internist, pulmonologist, or allergist.

(4) Chronic asthma meets retention standards, but is a cause for a permanent P–2 profile if it—

(a) Requires regular medications including low dose inhaled corticosteroids and/or oral or inhaled bronchodilators; but

(b) Does not prevent the Soldier from otherwise performing all military training and duties including the 2 mile run within time standards.

(5) Soldiers with a diagnosis of asthma who require no medications or activity limitations require no profiling action.

U.S. Navy, U.S. Marine Corps, NAVMED P-117, The Manual of the Medical Department; Article 15-6, Personnel Already on Active Duty

(1) Qualification for continued active duty service or retention, reenlistment, or separation should be based on the ability of a service member to perform the functions of his or her rate, rank, or occupational specialty without physical or medical limitations.

(a) Examiners should consult SECNAVINST 1850.4 series (Disability Evaluation Manual) and Manual of the Medical Department (MANMED),

Chapter 18 for guidance regarding service members who are unable to perform their duties as a results of a physical defect or medical condition.

(b) In situations where a member is unable to perform their duties secondary to a physical condition not considered a disability, guidance may be found in MANMED, Chapter 18, as well as MILPERSMAN articles 1920 series (officers), 1910-120 (enlisted), and the Marine Corps Separations Manual, Chapter 8.

Asthma. A clinical syndrome characterized by cough, wheeze, dyspnea and physiological evidence of reversible airflow obstruction or airway hyperreactivity that generally persists over 6 months. Reversible air flow obstruction is defined as more than 15 percent increase in FEV-1 following administration of an inhaled bronchodilator. Airway hyperreactivity is defined as the exaggerated decrease in airflow induced by a standard methacholine challenge test. Chronic asthma requires the regular use of medication to allow the individual to perform the preponderance of military duties.

Lower Airway. Rating is usually based upon Pulmonary Function Tests (PFTs) measuring residual function. There must be a minimum of one set of PFTs.

(1) Studies should be performed both before and after medication:

(a) When the results of pre-bronchodilator PFTs are normal, post-bronchodilator studies are not required.

(b) In all other cases, post-bronchodilator studies should be done unless contraindicated (because of allergy to medication, etc.) or if a patient was on bronchodilators before the test and had taken his/her medication within a few hours of the study.

(c) A physician who determines that a post-bronchodilator study should not be done in a given case should provide an explanation.

(2) Where warranted, the member should have a methacholine challenge, especially when the original set of PFTs are “normal”.

(3) In cases of exercise-induced asthma, PFTs after exercise should be performed.

U.S. Air Force, AFI48-123V2, Attachment 2

MEDICAL STANDARDS FOR CONTINUED MILITARY SERVICE (RETENTION)
A2.1. Conditions listed in this attachment require Medical Evaluation Board (MEB) processing for active duty members, worldwide duty evaluation for ARC members when appropriate (see Chapter 5), and are not all-inclusive. These standards and other diseases or defects not specifically listed can be cause for rejection based upon the medical judgment of the examining physician or reviewing authority.

A2.7.5. Asthma, recurrent bronchospasm, or reactive airway disease.

U.S. Coast Guard, Medical Manual, COMDTINST M6000.1C, Chapter 3, Physical Standards and Examination

Section C. Medical Examination Techniques and Lab Testing Standards.

Asthma bronchiectasis, and tuberculosis. There are three conditions that are most often inadequately evaluated and result in unnecessary and avoidable expense and time loss. These three are asthma (to include "asthmatic bronchitis"), bronchiectasis, and tuberculosis.

(1) Asthma. In evaluating asthma, a careful history is of prime importance since this condition is characteristically intermittent and may be absent at the time of examination. Careful attention to a history of episodic wheezing with or without accompanying respiratory infection is essential. If documentation of asthma after age 12 is obtained from the evaluee's physician, this shall result in rejection even though physical examination is normal. Ask about the use of prescription or over-the-counter bronchodilators

Section D. Medical Standards for Appointment, Enlistment and Induction in the Armed Forces

Asthma. Asthma (493), including reactive airway disease, exercise-induced bronchospasm or asthmatic bronchitis, reliably diagnosed and symptomatic after the 13th birthday is disqualifying. Reliable diagnostic criteria may include any of the following elements: Substantiated history of cough, wheeze, chest tightness and/or dyspnea which persists or recurs over a prolonged period of time, generally more than 12 months.

Section F. Physical Standards Applicable to All Personnel (Regular and Reserve) For:
Reenlistment; Enlistment of Prior Service USCG Personnel; Retention; Overseas Duty; and Sea Duty

Nontuberculous Conditions. Pulmonary diseases, other than acute infections, must be evaluated in terms of respiratory function, manifested clinically by measurements that must be interpreted as exertional or altitudinal tolerance. Symptoms of cough, pain, and recurrent infections may limit a member's activity. Many of the conditions listed below may coexist and in combination may produce unfitness.

(2) Bronchial Asthma. Associated with emphysema of sufficient severity to interfere with the satisfactory performance of duty, or with frequent attacks not controlled by inhaled or oral medications, or requiring oral corticosteroids more than twice a year.