



DEPARTMENT OF THE ARMY  
OFFICE OF THE SURGEON GENERAL  
5109 LEESBURG PIKE  
FALLS CHURCH, VA 22041-3258

REPLY TO  
ATTENTION OF

DASG-HS-AS

31 Mar 2004

## MEMORANDUM FOR REGIONAL MEDICAL COMMANDS

**SUBJECT:** Management and Deployment Issues Involving Soldiers with Diabetes

1. The purpose of this memorandum is to provide guidance on managing diabetic Soldiers in terms of: Referral to a Medical Evaluation Board (MEB) and Physical Evaluation Board (PEB); physical profile criteria; and factors to be considered in rendering recommendations for or against deployment.
2. In accordance with AR 40-501, paragraph 3-11, Soldiers on active duty with diabetes who require insulin or oral medication(s) for control do not meet medical retention standards. They must be referred to an MEB and PEB for a fitness for duty determination.
3. In accordance with paragraph 9-10, AR 40-501, Reserve Component Soldiers not on active duty who do not meet medical retention standards (including those with diabetes) are transferred to the retired reserve unless they obtain a waiver to continue in the Reserves or unless a non-duty-related PEB finds them fit for duty.
4. Diabetes is a progressive disease. The Soldier with "diet-controlled" diabetes today will require oral medication(s) in the not-too-distant future. Eventually oral agents will also fail and insulin will be required. However, a Soldier with diabetes need not be referred to a PEB until he/she requires medication(s) to normalize his/her hemoglobin A1c. The number in the profile is not the determinant for referring a Soldier to a PEB. Soldiers with diabetes who require medication to achieve their target hemoglobin A1c must be referred to a PEB regardless of whether the Soldier has a P2 or P3 profile.
5. Profiles: A P2 profile may be appropriate for the lifestyle- or medically-managed Soldier with type 2 diabetes who has had no episodes of nor is at substantial risk for hypoglycemia, has a normal HbA1c, and is physically fit. Soldiers not meeting such requirements should be issued a P3 profile.
6. A number of factors should be considered before determining whether deployment, to certain locations, of a Soldier with diabetes is medically contraindicated. These

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factors include the medical history (particularly in terms of incapacitating hypoglycemic episodes, complexity of management, the composition of available Meals Ready to Eat (MREs) and other rations, the availability of and storage requirements for medications, and the ability to appropriately monitor treatment of the Soldier.

a. Soldiers with diabetes may have coexistent hypertension and hyperlipidemia. Monitoring and treating these co-morbidities will increase the complexity of management, and should be factored into any recommendation regarding deployment of the Soldier.

b. Dietary management of diabetes in a field environment can pose a challenge. MREs can conform to American Diabetes Association recommendations, i.e., 10-20% of calories derived from protein, 30% from fat, and the remainder from carbohydrates. The contents of one MRE meal bag provides an average of 1250 kilocalories (13 % protein, 36 % fat, and 51 % carbohydrates). It also provides 1/3 of the Military Recommended Daily Allowance of vitamins and minerals determined essential by the Surgeon General of the United States. MREs are labeled with Nutrition Facts to facilitate carbohydrate counting. The Soldier with diabetes who is treated with oral agents or insulin must have ready access to snacks in the event of hypoglycemia.

c. It is recommended that Soldiers with diabetes should not be deployed if they cannot obtain access to required medications that can be distributed to theater and properly stored. For example, insulin manufacturers recommend that insulin be stored under refrigeration. Further, Soldiers with diabetes will require access to equipment necessary to perform self-monitoring of blood glucose.

d. It is recommended that Soldiers with diabetes should not be deployed if inadequate resources exist for necessary monitoring. For example, the Soldier on rosiglitazone (Avandia) or pioglitazone (Actos) should have liver transaminases checked every other month; the Soldier on metformin should stop taking it in the event of surgery, exposure to intravenous contrast, or in the event of renal insufficiency (serum creatinine > 1.5 mg/dL for males or > 1.4 mg/dL for females).

7. The template below outlines criteria that may be used to assist in making deployment recommendations. Assuming that the Soldier with diabetes was found fit for duty despite the limitations of his/her profile, he/she should be triaged at the SRP site using the following criteria as a starting point:

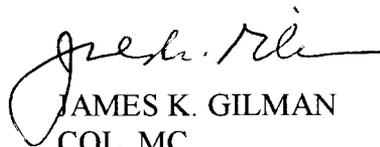
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Factor	OK to Deploy	Should Not Be Deployed
HbA	At target	Not at target
Monofilament discrimination	Present	Absent
Autonomic neuropathy	Absent	Present
Knowledge of Sick Day Rules	Complete	Incomplete
Proliferative diabetic retinopathy	Absent	Present
Severe hypoglycemia (> 1 episode per month)	No	Yes
History of diabetic ketoacidosis in previous year	No	Yes
Self-management skills	Good	Poor
Hypoglycemia unawareness	Absent	Present
Parameters of permanent profile can be followed	Yes	No
Significant co-morbidities (e.g., congestive heart failure, renal insufficiency, significant coronary artery disease, poorly controlled hypertension).	Absent	Present

8. Questions on AR 40-501 may be directed to Ms. Tina Wortzel at DSN 761-0020. Questions on management of diabetic Soldiers may be directed to The Surgeon General's Endocrinology Consultant, COL Curtis Hobbs at 253-968-0438.

FOR THE SURGEON GENERAL:



JAMES K. GILMAN  
COL, MC  
Director, Health Policy and Services

CF:  
FORSCOM SURGEON  
TRADOC SURGEON