

PILONIDAL CYST (685)

CRITERIA	→ 1) Sinus & cyst resolved surgically > 8 wks. All f/u completed. → 2) History of one episode of symptomatic cyst or sinus, resolved. No detectable sinus tract or cyst. → 3) Asymptomatic cyst present with sinus tract, surgery not indicated per surgeon. → 4) Asymptomatic sinus, surgery not indicated per surgeon.	→	N/A	→	→ 1) History of 2 or more episodes (cyst or sinus). → 2) Currently infected.	→	N/A
ACTION	↓ CLEAR		↓ CLEAR WITH RESTRICTIONS		↓ DEFER		↓ MNQ
RESTRICTIONS/DEFER				UNTIL	1-4) Defer until cyst excised , and sinus repaired > 8 wks. post surgery.		
RATIONALE							

MEDICAL INFORMATION NEEDED:

Likelihood of recurrence or exacerbation

Specific notation regarding pilonidal area exam. On physical examination is acceptable.

Surgical evaluation needed for asymptomatic cyst or sinus.

11/28/94

ECZEMA (DERMATITIS) (692.)
Atopic (691.8) Contact (692) Nummular (692.9)

CRITERIA	→ 1) Contact Dermatitis, well controlled. → 2) Atopic Dermatitis or unspecified eczema, well controlled, no use of systemic steroids. → 3) Nummular Dermatitis, well controlled.	→ N/A	→ 1) Active contact dermatitis, not well controlled. → 2) Atopic Dermatitis, not well controlled. → 3) Nummular Dermatitis, not well controlled.	→ 1) Generalized exfoliative Dermatitis, any history. → 2) Atopic Dermatitis systemic, any history; treatment with steroids, any history.
ACTION	↓ CLEAR	↓ CLEAR WITH RESTRICTIONS	↓ DEFER	↓ MRB
RESTRICT- IONS/DEFER			UNTIL: 1-3) well controlled.	
RATIONALE				Can progress to severe, total body eczema.

**MEDICAL
INFORMATION
NEEDED:**

Generic information

Dermatologist evaluation, if any use of systemic steroids, or recurrent moderate or severe dermatitis (any type).

7/12/93

PSORIASIS (696)

CRITERIA	→ 1) Single episode, mild, 5 yrs ago. → 2) Mild, no systemic medication.	→ N/A	→ N/A	→ 1) Generalized or severe Psoriatic, any history → 2) Any use of systemic medications.	→ Psoriatic arthritis
ACTION	↓ CLEAR	↓ CLEAR WITH RESTRICTIONS	↓ DEFER	↓ MRB	↓ MNQ
RESTRICTIONS/DEFER	Note #2: Mefloquine or doxycycline should be used for malaria prophylaxis if necessary. Inform PCMO if assigned to a chloroquine-sensitive country.				
RATIONALE	<div style="display: flex; justify-content: space-between;"> <div style="width: 20%;">Note #1: Diagnosis questionable because complete remission is rare.</div> <div style="width: 40%;"> Sun helps Psoriasis <u>Chloroquine exacerbates psoriasis</u> Moist climate exacerbates condition and puts PCV at greater risk for secondary infection. </div> <div style="width: 40%;"> MNQ'd because if exacerbates can have serious problems; can exacerbate easily. Can lead to debilitating systemic disease. Appropriate treatment not available in PCMU's. </div> </div>				

MEDICAL INFORMATION NEEDED: Generic Information
Dermatologist evaluation, except if single episode, mild, > 5 yrs.

** Note: PCMO needs to NOT give chloroquine*

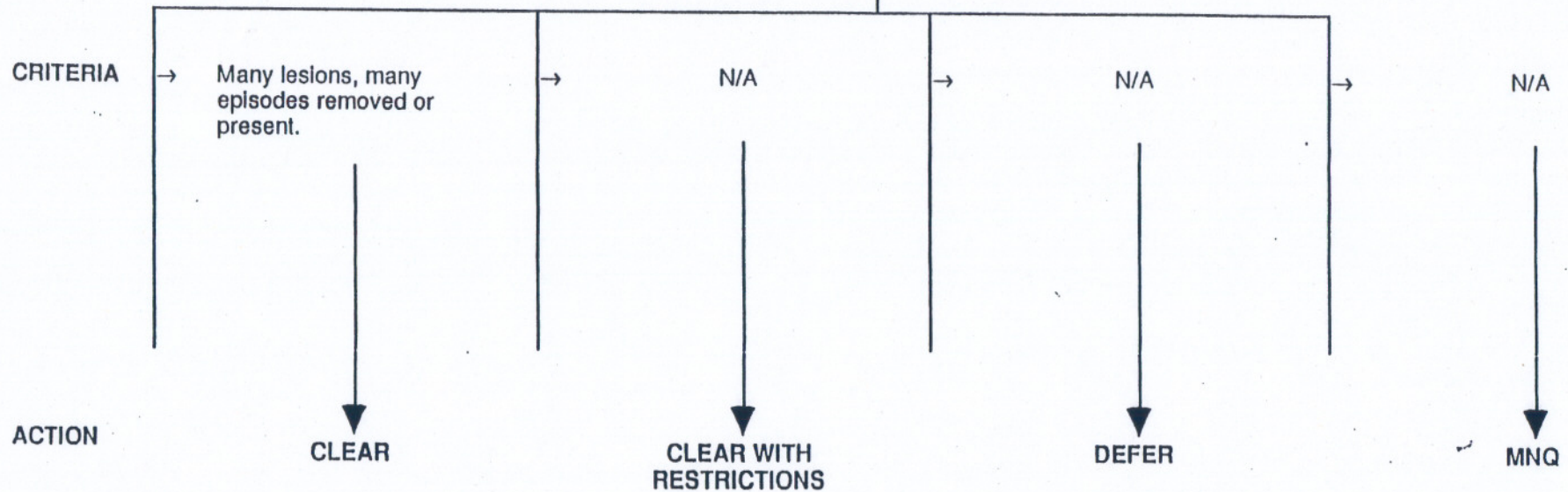
SEBACEOUS (KERATINOUS) CYST (706.2), LIPOMA (214)

CRITERIA	→ 1) Sebaceous cyst, non-infected, non-draining → 2) Lipoma, asymptomatic, not irritated by clothing.	→ N/A	→ 1) Sebaceous cyst (infected or draining) → 2) Lipoma, symptomatic or enlarging.	→ N/A
ACTION	CLEAR	CLEAR WITH RESTRICTIONS	DEFER	MNQ
RESTRICTIONS/DEFER			UNTIL 1 & 2) Removed or resolved.	
RATIONALE			Should be treated before departure. At risk for secondary infection.	

MEDICAL
INFORMATION
NEEDED:

Generic Information

SEBORRHEIC KERATOSIS (702)



RESTRICT- IONS/DEFER

RATIONALE

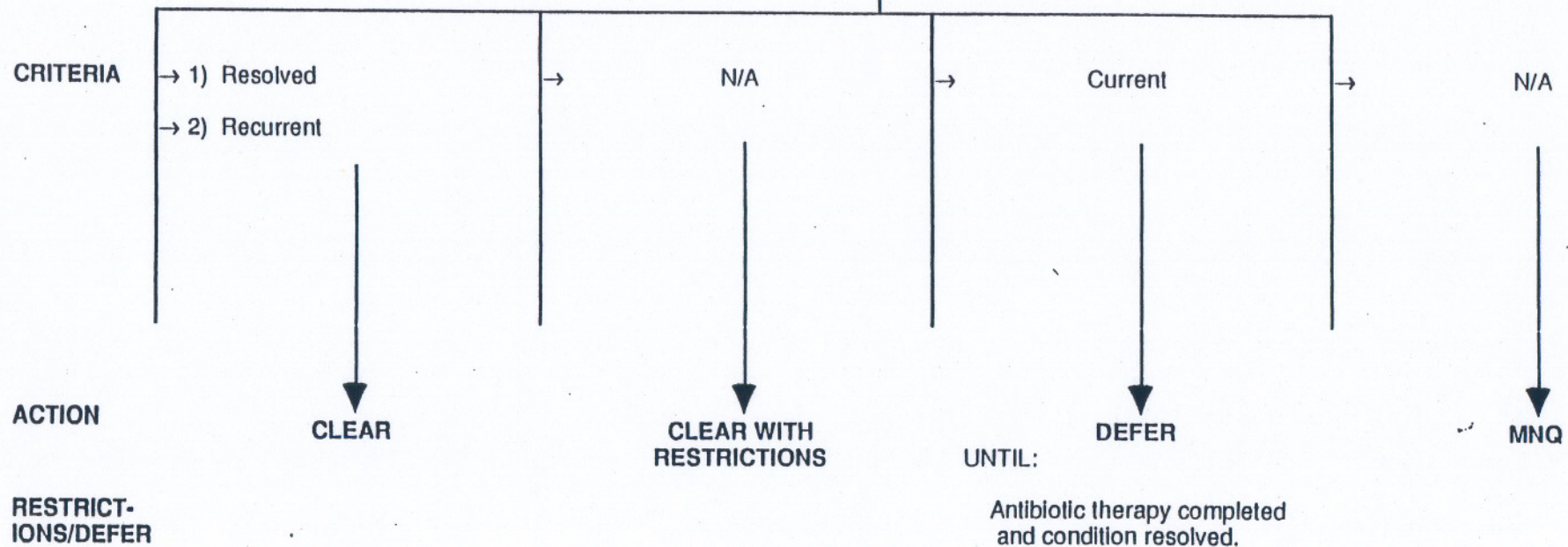
Non-malignant cosmetic problem only. Not precancerous.

MEDICAL INFORMATION NEEDED:

Generic Information

5/4/93

IMPETIGO (BACTERIAL INFECTION AND CARBUNCLES) (684)



RATIONALE Easily treated and rarely recurs.

Recurrent impetigo sometimes caused by recurrent staph carriers, usually in nostrils.

**MEDICAL
INFORMATION
NEEDED:** Generic Information
MD evaluation

5/4/93

FUNGAL INFECTION (TINEA CRURIS, PEDIS, VERSICOLOR, UNGUIUM) (110)
T. Cruris (110.3) T. Pedis (110.4) T. Vesicular (111.0) T. Unguium (110.1)

CRITERIA	→ 1) Chronic ungulium: no separation of toe nail from base. → 2) Tinea versicolor current or past history.	→ 1) Chronic Pedis, Cruris (resistant to treatment) → 2) Chronic Ungulium (toe nail separating from base).	→ On griseofulvin, or Ketoconazole	→ N/A
ACTION	↓ CLEAR	↓ CLEAR WITH RESTRICTIONS	↓ DEFER	↓ MNQ
RESTRICTIONS/DEFER		Climate restrictions, per Dermatologist recommendations	UNTIL: Treatment completed	
RATIONALE	Chronic ungulium cosmetic problem usually no pain little risk of secondary bacterial infection. Recurrs in hot, humid climate, secondary to perspiration. But not serious med. problem, can cause white patches on body, not at risk for secondary infection.	Fungal infections will increase in severity in warm, wet climates. Both at risk for secondary bacterial infection.	These medications may cause hepatic or other side effects; monitoring is needed during therapy.	

MEDICAL INFORMATION NEEDED:

Generic Information

Dermatologist evaluation and recommendations to include climate restrictions (chronic, ungium, cruris, pedis, only)

5/4/93

VARICELLA (CHICKEN POX) (052) HERPES ZOSTER (SHINGLES) (053)

CRITERIA	→ 1) Varicella resolved with no complications → 2) Zoster acute episode with no sequelae. → 3) Post Herpetic Neuralgia (PHN) (mild-controlled with non-narcotic meds) stable for 6 mos.	→ N/A	→ 1) Active → 2) Post Herpetic Neuralgia (Severe, controlled with narcotics)	→ N/A
ACTION	CLEAR	CLEAR WITH RESTRICTIONS	UNTIL DEFER	MNQ
RESTRICT- IONS/DEFER			Resolved	
RATIONALE	Only 2% relapse rate in shingles		Pain interferes with performance	

MEDICAL INFORMATION NEEDED:

MD evaluation if current, or if continues to have post-herpetic neuralgia.

5/4/93

**VIRAL WARTS (078)
PAPILLOMA VIRUS (WARTS) (078)
PLANTAR WARTS (078.1)**

CRITERIA	→ All non-genital warts except Plantar Warts	→ N/A	→ Plantar Warts	→ N/A
ACTION	↓ CLEAR	↓ CLEAR WITH RESTRICTIONS	↓ DEFER	↓ MNQ
RESTRICT- IONS/DEFER			UNTIL: Removed or resolved	

RATIONALE Warts are not dangerous. Cosmetic problems. Warts can return at any time under any circumstances.

**MEDICAL
INFORMATION
NEEDED:**

Generic Information

DERMATOLOGY

1. Acne and Cystic Acne:

- a). Mild acne is easily treated with topical ointments, low-dose oral tetracycline and occasionally birth control pills. Comedones are treated with Retin-A. Retin-A causes sun sensitivity and the patient could easily become sun-burned. The patient could conceivably change from Retin-A to a milder topical treatment to prevent sun damage. If the acne follows the menstrual cycle, no placement restrictions are required. The acne is hormonally influenced.
- b). Cystic acne usually responds to one course of Accutane consisting of 20 weeks of therapy. It is given to patients in their 20's with heavy facial, chest, back and shoulder involvement. While on Accutane, the patients need LFS, triglycerides, and pregnancy testing at 2 week intervals. Cystic acne usually reverts to simple acne after Accutane treatment. Occasionally, patients require more than one course of treatment. There is no way to predict which patients will relapse and require additional Accutane treatment. All acne becomes worse in hot, humid, tropical climates. Cystic acne that has responded to Accutane and is now simple acne could worsen to cystic acne in tropical climates. Applicants with a history of cystic acne could go to cold or temperate climates without risking an exacerbation. The applicants themselves, if given this information would in many cases, prefer temperate zone placement. No precise way exists to predict which patients will require repeat courses of Accutane. However, a two month waiting period after a course of Accutane provides a realistic period to identify any relapsing patients.

2. Alopecia; Hereditary, Areata, Totalis, and Universalis:

Alopecia Hereditary (simple male baldness), Areata (loss of hair in small areas) and Totalis (total loss of head hair) are benign conditions considered of no great medical consequence. In 90% of cases of Alopecia Areata, the hair returns spontaneously.

Universalis: an autoimmune disease where the body attacks its own hair follicles and all the hair falls out. The applicant is in no greater risk of relapse overseas versus stateside after treatment and hair regrowth. The applicant is at high risk for relapse wherever they are. If the applicant does not desire treatment or re-treatment if the alopecia returns, there is no medical reason for not allowing the applicant to serve.

For Alopecia Totalis and Universalis a cultural consideration may play a part. There may be certain cultures where a totally hairless person is considered in a negative way and the PCV would be less effective. PCMO concurrence is recommended.

3. Dermatitis (Eczema):

- a. Contact Dermatitis: If the allergen is easily avoided and the applicant has a mild reaction, this condition is of no significance. However, if the allergen is a common substance and cannot easily be avoided, this condition could be a severe problem. The allergen must be identified. If it is easily avoided, the applicant is in no great risk of developing severe contact dermatitis. However, if the allergen cannot be easily avoided the applicant may have to be deferred or restricted. People with severe Contact Dermatitis probably have Atopic Dermatitis.

- b. **Atopic Dermatitis:** The disorder has the potential for exacerbation in humid, hot climates. If the applicant has a history of other allergies (esp. asthma, hay fever, hives), they are at great risk for severe attacks of eczema. Severe attacks place the PCV in great discomfort and are very difficult to treat anywhere, but especially under PC conditions. The condition could progress to total body involvement. Treatment includes application of steroid cream, which places the applicant at greater risk for secondary bacterial infections. Systemic steroids are almost never used. Mild childhood eczema is sometimes outgrown. Applicants with a childhood history of eczema, no other allergies, and no adult episodes should be at no added medical risk. However, adults with episodes requiring treatment with steroid cream, should be carefully screened for positive family history for eczema and for other allergies. Depending on the other allergies (asthma, hives or hay fever), these applicants should be placed only in temperate climates or not allowed to serve.
- c. **Nummular Dermatitis:** a mild skin condition, usually on the lower legs. The condition usually appears during the 40th decade of life. If the applicant has additional allergies such as hay fever, asthma, or hives, they should not go to very humid or very cold climates. These extremes of climate can lead to exacerbations of the condition. Their placement should be restricted to temperate zones.
4. **Impetigo:** Easily treated with antibiotics. If the impetigo frequently recurs, the applicant should be investigated and treated appropriately for possible staphylococcal carrier status. The patient must have been treated appropriately after each outbreak before one can assume the possibility the applicant is a staph carrier. The nares and other suspicious sites should be cultured and the patient treated appropriately.
5. **Fungal Infections:** Tinea Cruris and Pedis are usually easily treated. On occasion, tinea pedis is resistant to treatment and becomes chronic. Those applicants are at risk for developing secondary bacterial infections if placed in tropical climates. This may have the potential for interfering with the applicants' ability to function. Tinea Unguium does not cause discomfort, but is a cosmetic problem. It is treated with long-term griseofulvin therapy and requires q 3 month LFS. They are also at risk for developing secondary bacterial infection. If the toenail is separating from the nail bed or base, it indicates the infection is severe. The applicant is then at risk for a secondary infection. If the toenail is still securely attached to the base and it is brown and powdery, the infection is not severe. The risk for a secondary bacterial infection is low. Tinea Versicolor is purely a cosmetic problem. It causes mild itching and scaling and is usually cured with a few weeks treatment. If the applicant has received griseofulvin or Ketacanzole treatment, the fungal infection was moderate to severe. The applicant should be placed in a non-tropical country, because they are at risk for relapse in a tropical country.
6. **Herpes Zoster:** The condition usually heals totally in 4-6 weeks. It recurs in only 2% of cases. Very rarely a post-herpetic neuralgia persists from some weeks to months. After one year, the post herpetic syndrome is stable. The neuralgia can be severe or mild. If the condition is controlled with aspirin or non-steroidal anti-inflammatories, the applicant is medically acceptable.
7. **Actinic Keratosis:** Sun-induced pre-malignant tumors. One-third of these patients develop squamous cell carcinoma. Thus, the condition needs follow-up every six months by a board certified Dermatologist. It is not unusual in this condition to have 15-20 lesions removed at one time. The applicant should wait 2 years (lesion free) before going overseas with an episode of 15 lesions. The applicant should be restricted to a non-tropical climate, to minimize any additional sun exposure. With more episodes consisting of numerous lesions each episode, the applicant should consider staying in the US for adequate follow-up. If the patient was treated with topical 5 FU, the patient had numerous lesions and is at high risk for recurrence. With one episode of 5 or less lesions, the patient is not at particularly high risk, but needs to be followed closely by a board certified Dermatologist. The likelihood of developing more lesions and developing cancer increases with greater number of episodes and lesions and the longer the time interval since damaging sun exposure.
8. **Sebacous Keratosis:** This is a cosmetic problem only. The lesions are not malignant nor pre-cancerous. Applicants with a history of sebaceous keratosis do not need any F/U or a restriction to a non-tropical country.
9. **Basal Cell Carcinoma and Squamous Cell Carcinoma:** These applicants need a Dermatology evaluation for the amount of sun damage and to ascertain past history of x-ray treatment for acne. These factors increase the risk of developing further lesions. Applicants with one lesion, mild sun damage, and no history of x-ray therapy can go to a Dermatology

NON TROPICAL country after one year post lesion removal. Applicants with a history of x-ray treatment or moderate sun damage should wait five years before going to a sun restricted country. Those applicants with Basal Cell Nevus Syndrome are at high risk for developing Cancer and should not be allowed to serve.

10. **Malignant Melanoma:** A relatively rare malignant skin cancer. Lesions < 0.75 mm thick (also called in situ or Stage IA) have minimal risk for recurrence after 5 years post lesion removal. However, those individuals with a deeper lesion, particularly with a positive family history of melanoma, and a large number of moles of the dysplastic nevi type, are still at high risk for recurrence, 5 years post treatment and lesion free. These applicants should remain in the US close to their Dermatologists for adequate follow-up.
11. **Peri-orbital Dermatitis and Rosacea:** Easily treated with antibiotics. These applicants are at no great risk for recurrence.
12. **Pilonidal Cyst:** Some patients have asymptomatic sinuses which are found on routine examinations. All patients with asymptomatic sinuses and/or pilonidal cysts are at greater risk for developing secondary infections. The applicant must have the cyst excised and the sinus repaired.
13. **Psoriasis:** The severity of the disease can be judged by a). age of onset (the younger the age of onset the more severe the disease), b). positive family history of psoriasis, and c). amount of area involved. Complete remission of psoriasis is rare. Mild psoriasis only involving small patches on the elbows and knees is not dangerous, if the applicant has never had any more extensive disease. An applicant with any history of more extensive disease is at high risk for a serious exacerbation. Moist climates exacerbate the condition. Sun exposure helps the condition. A temperate or dry sunny climate is recommended.
14. **Herpes Zoster:** Self-limiting disease that should be no of no medical consequence.
15. **Wart; Common and Plantar's:** Warts can recur at any time after removal, so there is no need for removal. Plantar's warts should be removed by a Podiatrist or Dermatologist only if the wart interferes with walking.
16. **Sebaceous Cyst:** A present cyst < 1 cm and never infected is at no great risk for secondary infection and is acceptable. Cysts greater than 1 cm. are at risk for secondary infection and should be surgically excised. Milia are a cosmetic problem and only at risk for secondary infection in the tropics. The milia should be removed if the applicant wishes to be placed in a tropical country.