ARMY REGULATIONS
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DEPARTMENT OF THE ARMY
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U.S. Army. MEDICAL DEPARTMENT.

PHYSICAL STANDARDS AND PHYSICAL PROFILING FOR ENLISTMENT AND INDUCTION

*These regulations supersede MR 1–9, 19 April 1944, including C 4, 26 August 1946; and the supplement to MR 1–9, 30 June 1945, including C 1, 15 January 1947.

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SECTION I

INFORMATION AND INSTRUCTIONS

1. Purpose.—*a.* The purpose of these regulations is to—

(1) Set forth the acceptable standards of physical requirements for men procured for military service.

(2) Describe deviations from the above standards which are not acceptable for military service.

(3) Set forth the method, namely the physical profile system, for physically classifying individuals for military service.

b. These regulations will apply to men in the following categories:

(1) Men enlisted or reenlisted in the Regular Army.

(2) Men for enlistment or reenlistment in the Regular Army Reserve, Enlisted Reserve Corps, and enlisted Reservists on call to active service if they have been in the inactive Reserve longer than 90 days.

(3) Men enlisted or reenlisted in the National Guard while in Federal Service.

(4) Enlisted men of the National Guard on induction into Federal Service.

(5) Men enlisted in the Army of the United States.

(6) Men inducted into the Army.

c. The provisions of these regulations where appropriate are equally applicable to female enlisted personnel. For specific requirements applicable to enlisted women, the provisions of AR 40–100 pertaining to female personnel will apply.

2. Publication.—*a.* These regulations are published for the information and guidance of all medical examiners who may be used by the Army.

b. Medical examiners should read every section of these regulations in order that they may have a broad knowledge concerning physical standards and physical profile classification procedures.

3. Objective.—*a.* The objective of these regulations is to—

(1) Select for military service only those individuals who are physically fit for the rigors of military service and who are expected to remain so for a reasonable period of time.

(2) Adequately physically classify individuals by careful use of the physical profile serial system, and to continually review the classifications in order to train better and, subsequently, to utilize better the available manpower of the Nation.

b. Examining physicians will consider these standards as a guide to their discretion and not construe them too strictly or arbitrarily. The examination will be carried out with the utmost care in order that no individuals who are unfit for military service will be accepted. All minor defects as well as disqualifying defects will be recorded in order to protect the Government in the event of

future claims for disability compensation. The likelihood of subsequent claims on account of disability should be borne in mind by the examiners in considering the qualifications of individuals with questionable defects. Whenever an individual is accepted for military duty but who, nevertheless, has a disease or other physical condition which although not disqualifying requires medical treatment, the nature of the condition and the need for treatment will be clearly stated on the report of physical examination.

4. Physical classification.—*a. Acceptable.*—Physically qualified for military service. Individuals will be recommended acceptable for military service if they meet the requirements therefor throughout the entire physical examination and their physical profile establishes qualification for such service.

b. Nonacceptable.

(1) Physically unfit for military service. All individuals who do not meet the physical requirements for military service will be recommended as nonacceptable.

(2) Care will be taken that all defects found will be recorded fully and accurately on the report of physical examination. The defects will be listed in the summary of the physical examination report in the order of their importance. The irremediable, disqualifying, permanent defect will be listed as number one and the others in the order of their importance. The major disqualifying defect may be physical or mental.

(3) Any individual recommended as nonacceptable will not be accepted unless specific directions to that effect have been issued by the Department of the Army.

5. Defects not specifically mentioned in these regulations, and hospitalization.—*a.* If any individual is regarded by the medical examiners as physically unfit for military service by reason of physical or mental defects not specifically noted in these regulations, he will nevertheless be recommended as unsuitable for military service. A brief statement of the reasons for the rejection will be entered on the report of medical examination. So far as practicable, however, the physical classification of individuals will conform to the specified requirements.

b. Hospitalization for a period not to exceed 3 days for men whose physical fitness for military service cannot be determined without hospital study is authorized. Military or other Government hospitals will be used for this purpose when practicable. When military or other Government hospitals are not available the use of civilian hospitals is authorized. *Individuals will not be hospitalized when their fitness for military service can be determined otherwise.*

c. If any individual is regarded by the medical examiners as physically unfit for military service by reason of remediable physical defect, (R), or a defect temporary in nature, (T), he will be deferred for military service, advised as to the cause of deferment, and told to return when said defect has been remedied. The physical profile of the individual will reflect the situation by the use of a suffix to the appropriate serial as described in paragraph 7. In no case will such individuals be enlisted or inducted unless specifically directed by the Department of the Army. Reenlistments, however, are authorized; in which case necessary treatment and/or surgical intervention will be resorted to as described in paragraph 10c.

d. If any individual is regarded by the medical examiners as having defects the nature of which would make him questionable as to his ability to perform military service, such individual will be recommended as unfit for military service unless otherwise directed by the Department of the Army.

SECTION II

PHYSICAL PROFILE SERIAL

6. General.—*a.* The physical profile serial system is based primarily upon the functional ability of an individual to perform military duties and, in relation to this performance, the functions of the various organs, systems, and integral parts of the body are considered. Since the analysis of the individual's physical and mental status plays an important role in his future assignment and welfare, not only must the functional grading be executed with great care but also clear and accurate descriptions of his physical and mental conditions are essential. In developing the system, the human functions have been considered in six factors. For ease in accomplishing and applying the profile system, these factors have been designated "PULHES." The factors to be considered, the parts affected, and the bodily function involved in each of these factors are as follows:

(1) *"P" Physical capacity or stamina.*—Organic defects, age, build, strength, stamina, height, weight, agility, energy, muscular coordination, and similar factors.

(2) *"U" Upper extremities.*—Functional use of hands, arms, shoulder girdle, and spine (cervical, thoracic, and lumbar) to include strength, range of motion, and general efficiency.

(3) *"L" Lower extremities.*—Functional use, strength, range of motion, and general eficiency of feet, legs, pelvic girdle, and lower back (sacral spine).

(4) *"H" Hearing (including ear defects).*—The auditory acuity is to be considered as well as organic defects.

(5) *"E" Eyes.*—The visual acuity is to be considered as well as organic defects.

(6) *"S" Neuropsychiatric.*—Emotional stability, personality, and neuropsychiatric history and findings will be considered.

b. There are four grades in each of the six factors. For ease of application and to assure uniformity of recording, these regulations will be used as a guide for considering certain defects. For this purpose, the first three grades may be acceptable for enlistment, reenlistment, or induction. Grade 4 represents defects which are below the minimum standards for enlistment or induction, but may be considered for reenlistment, provided the defects are not of a progressive nature and applicant has been performing his duties in a satisfactory manner, in which case subject enlisted man will be graded in the third category.

c. The anatomical or pathological defect will not of itself form the sole basis of classification. Minor physical defects will not automatically down grade an individual, because defects have different values in relation to performance of duties. For instance, an individual will not be judged entirely from the point of view of his defects, but these will be weighed against his assets: intelligence, courage, motivation or special talents, and experiences, which may, in many instances, outweigh his physical assets or liabilities. While the defect must be given consideration in accomplishing the profile, it is important to consider function and prognosis, especially regarding the possibility of aggravation. In this connection, a close relationship must exist between the medical officers and classification officers. The determination of assignment is an administrative procedure. On the basis of the medical officer's report, the classification officer can more readily assess the individual's ability to fill certain duty positions. It is therefore the responsibility of the classification officer, based on his knowledge of useable categories of the individual's profile, to state whether the individual may be employed in certain duty positions.

d. The "P" factor is to be used to indicate organic defects of a nature which would not be shown in the other factors ("U," "L," "H," "E," "S"), e. g., hernia, cardiovascular disease, asthma, peptic ulcer, class I dental defects, and others. If an individual has a low grade in one of the factors other than the "P," it does not necessitate that the same grade be given under the "P" factor. An example of this would be an individual who is qualified physically to be classified as "P 1" but who has visual acuity sufficiently low to warrant an "E 3"; such a man would be classified as "P 1" and not "P 3." As a general rule, the defect in the other factors may influence the "P" factor, but this is not always true: e. g., an individual who has a 2, 3, or 4 in the "U," "L," "H," "E," or "S" factor may be graded 1, 2, 3, or 4 in the "P" factor, depending on the degree this defect is reflected into or influences the "P" factor.

7. Suffixes to serials.—In order to make the profile serial more informative, a code letter, or a combination of code letters, will be used as a suffix, where applicable, as specified below:

a. "R" will be used to indicate that the individual has a remediable physical defect which does not prevent utilization, the correction of which would improve the general health and welfare of the soldier. The correction of this defect may or may not result in a change of the profile.

b. "T" will be used to indicate that the individual has a remediable physical defect temporary in nature. Such a defect must be of a nature that when successfully corrected the individual will be physically qualified; for example, an individual with a hernia and no other defect which would prevent an oversea assignment. An "R" suffix is not to be used in this type of case.

c. "D" will be used to indicate that the individual has a physical defect which, under current instructions, is *permanently* disqualifying for oversea service.

d. "O" will be used to indicate that the individual is physically qualified for aircrew, combat type aircraft (for use only by the Air Force).

e. "N" will be used to indicate that the individual is physically qualified for aircrew, noncombat type aircraft (for use only by the Air Force).

8. Representative profile serials.—*a.* Individuals with a physical profile serial containing all numerals, 1, 2, or any combinations thereof, are considered to possess a high level of physical fitness. If a profile contains a 3, or is comprised of all 3's, it is considered that this individual has a physical defect which because of impairment of function prevents him from performing all military duties. If the profile serial contains the numeral 4, it indicates that this individual has a defect which is below the minimum acceptable standards for induction. Individuals having a grade 4 in their profile may be considered for reenlistment, provided the defects are not of a progressive nature and the applicant has been performing his duties in a satisfactory manner, in which case the soldier will be graded in the third category.

b. A chart has been prepared as a brief guide to the defects that are in each grade of each factor. This chart is not complete, and, because certain defects are not listed, it will not be assumed that they are not to be considered. The purpose of this chart is to assist the profiling officer or officers in determining the proper grading of the individual. Attention is directed to the fact that the basic principle of the physical profile serial is to provide an index to functional capacity. Therefore, the function of the particular organ or system of the body will be evaluated carefully in determining the grade, rather than the defect per se. Also, those aids, such as X-ray films, electrocardiograms, and other specific tests that give concrete results, will be given due consideration.

c. To facilitate assignment of individuals after they have been given a physical profile serial, the letters, "A," "B," "C," and "E" have been adopted as a code to represent certain combinations of grades in the various factors. These are—

(1) "A" An individual with a profile serial 111111.
(2) "B" An individual with a profile serial with the numeral 2 as the lowest grade in any factor.
(3) "C" An individual with a profile serial with the numeral 3 as the lowest grade in any factor.
(4) "E" An individual with a profile serial with the numeral 4 as the lowest grade in any factor.

These letters will not be used to represent the numerical grading of the soldier in the individual's records. They may be used for statistical, assignment, and reporting purposes only. To insure uniformity in interpretation, the alphabetical references referred to above are mandatory, and if used to represent the numerical grading, the code in (1), (2), (3), and (4) above will be used. Variations are not authorized.

9. Method of accomplishing profile serial.—*a. At armed forces induction stations, all recruiting main stations.*—An initial profile serial will be accomplished by medical officers at one of these stations or wherever initial physical examinations are accomplished. The physical profile serial will be entered under item No. 42 (Remarks), Standard Form No. 88 (Report of Medical Examination) and on NME Form No. 47 (Record of Induction), or item 37, WD AGO Form 21 (Enlistment Record, Regular Army), whichever applies. In the event a digit higher than "1" is recorded, and especially if a suffix of "R," "D," or "T" is entered, the profile serial will be followed by a very brief description of the defect, expressed in nontechnical language. Profile serials with brief diagnoses may then be readily transcribed on WD AGO Form 20 (Soldier's Qualification Card), of the enlisted man concerned. At or near the end of basic training each soldier's physical profile will be verified as described in paragraph 10*a*.

b. At hospitals.

(1) *Designation of profile officer.*—The commanding officer of the hospital will designate one or more officers who will be responsible for all profiling at the installation.

(2) *Revision of profile.*—Revision of the profile serial will be accomplished on all individuals hospitalized when, in the opinion of the profiling officer, his condition has been such as to warrant a change in the profile serial. When, in the opinion of the profiling officer, the cause for hospitalization was such that ordinarily it would not change the individual's physical profile serial, the individual will not be reprofiled, and the unit commander will be informed accordingly.

10. Verification and revision of profile.—*a. Verification.*—At or near the end of basic training each soldier's physical profile will be verified or revised upward or downward as indicated. The verification or revision of the profile serial will be accomplished by a board of three officers known as the Profile Classification Board. This board will consist of a line officer (the soldier's company, platoon, or training officer), a medical officer (preferably one with special training in neuropsychiatry), and a classification officer. It is not intended that a complete physical examination be given for this purpose. However, in the discretion of the medical officer concerned special examinations may be given. It is intended that the physical profile serial will be given in conjunction with the training officer's physical fitness test as described in chapter 17, FM 21–20. By this means the profile classification board will have the benefit of the training officer's knowledge of the condition of the soldier. In like manner, the training center neuropsychiatrist will be consulted for neuropsychiatric data which may be helpful to the profile classification board in evaluating certain cases. The closest relationship will exist between the officers on the Profile Classification Board, and only through this close relationship, as the medium of exchange of factual information, can the board effect a satisfactory verification and revision that will reflect the true functional ability of the soldier to perform military duties.

b. Revision.

(1) *At hospitals.*—When a defect which requires special consideration in the assignment of the individual concerned or which disqualifies him for oversea service is discovered at a hospital or other medical installation, or when it has been determined that a previous defect has been corrected or materially improved, the medical officer concerned will transmit to the soldier's unit commander a report which will permit reclassification and reassignment in keeping with the man's mental and physical capabilities. It will be the commander's responsibility to give the individual an assignment appropriate to his capabilities as reported. The report by the medical officer concerned will be made by letter—which will include a record of the last previous profile and revised profile as follows:

Name of medical installation
Place
Date

SUBJECT: Physical condition of _____
(Name, grade, and Army serial No.)

TO: Commanding Officer _____
(Unit or installation)

1. Profile serial.

	P	U	L	H	E	S	Suffix	Brief nontechnical diagnosis (if applicable)
Previous profile								
Revised profile								

2. The above-named individual is being returned to your unit this date.

a. He is considered *fit *unfit for return to full duty.

**b.* The defect previously noted has been removed (state briefly additional duty he may now perform).

**c.* He has the following defects which require special consideration in his assignment:

**d.* In view of the above, he is considered unfit for the following types of duty (state briefly in nontechnical language the type of activity for which he is not fitted):

3. Any limitations mentioned above are considered *permanent *temporary. If temporary, *the limitation will be automatically released _____
(Date)

*the individual should report to _____
(Medical facility)

_____ for evaluation of his physical capacity.
(Date)

_____
(Signature of medical officer)

*Strike out inapplicable words or subparagraphs.

(2) *Other than at hospitals.*—If it is believed that an individual's profile should be revised either upward or downward, the unit commander will cause the soldier to be examined by the profile classification board described in *a* above. The profile will be changed by this board if the findings warrant. It is not necessary to hospitalize such men prior to or following appearance before the profile classification board when their physical condition would not normally require hospitalization. Boards of officers for this purpose may be constituted to act over a period of time, and the order appointing the board may list such number of officers as will provide a quorum in the absence of some of the members.

c. Periodic review.—Physical profile of all individuals containing the suffix "R" or "T" will be reviewed and reevaluated in accordance with *a* above every 3 months with a view to making the physical profile serial as recorded on WD AGO Form 20 (Soldier's Qualification Card), reflect the true physical condition of the soldier concerned. Commanding officers are responsible that this periodic review of physical profile serials be conducted. This periodic review is *not* for the purpose of verification of suffix to profile serial, but for the purpose of remedial action. Commanding officers are responsible to insure that individuals with a physical profile containing the suffixes "R" (remediable defect) and "T" (temporary defect) will receive necessary medical and/or surgical intervention in order to have the suffix removed from the physical profile, unless there are contraindications to such treatment. *In no case will it be permissible to continue to carry indefinitely an individual classified with an "R" or a "T" suffix without taking positive action to remedy the situation.*

11. Records.—*a.* The initial physical profile serial (numerical grading, suffix, and nontechnical description of defect, if found) will be recorded, dated, and initialed on the soldier's qualification eard as required by TM 12–425, as changed, after its completion at the armed forces induction station or other installation where the initial physical profile is established.

b. A profile serial which has been changed will be forwarded by the profiling officer or Profile Classification Board to the unit commander, who will transcribe, date, and initial the new profile under item 23, WD AGO Form 20.

12. Physical profile serial chart.

Profile Serial	P	U	L
	*Physical capacity or stamina	*Upper extremities	*Lower extremities
1	Able to perform maximum sustained effort over extremely long periods.	Bones, joints, and muscles normal. Should be able to do hand-to-hand fighting.	Bones, muscles, and joints normal. Must be capable of performing long marches and continuous standing over long periods. No defects which disqualify for running, climbing, and digging.
2	Able to perform sustained effort over long periods.	Slightly limited mobility of joints, muscular weakness, or other musculo skeletal defects which do not prevent hand-to-hand fighting, and do not disqualify for prolonged effort.	Slightly limited mobility of joints, muscular weakness, or other musculo skeletal defects which do not prevent moderate marching, climbing, running, digging, or prolonged effort.
3	Able to perform sustained effort for moderate periods.	Defects causing moderate interference with function, yet capable of sustained effort for short periods.	Defects causing moderate interference with function, but capable of sustained effort for short periods.
4	Below minimum standards for induction.	Below minimum standards for induction.	Below minimum standards for induction.
Factors to be considered.	Organic defects, age, build, strength, stamina, height, weight, agility, energy, muscular coordination, function, and similar factors.	Strength, range of motion, and general efficiency of upper arm, shoulder girdle, and back, including cervical, thoracic, and lumbar vertebrae.	Strength, range of movement, and efficiency of feet, legs, pelvic girdle, and lower back.

*Initial profile at armed forces induction stations, will be based on anticipated performance at completion of training. Verified profile will be based upon observation, actual performance of duty, medical data, and physical fitness test data.

H	E	S
Hearing; ears	Vision; eyes	Neuropsychiatric
Auditory acuity normal. No auditory defects.	Meets acceptable ocular standards with a minimum vision of 20/70 in each eye, correctible with glasses to 20/20 in one eye and 20/30 in the other, when no organic disease of either eye exists.	No psychiatric disorder.
Minimum hearing 8/15 bilateral, or 15/15 in one ear and less than 8/15 in the other, with no active or progressive organic disease.	Meets acceptable standards as prescribed in these regulations and visual acuity will not be less than 20/200 in each eye correctible to 20/40 in each eye, provided the defective vision is not due to active or progressive organic disease.	Mild transient psychoneurotic reaction. Mild character and behavior disorders. Borderline mental deficiency.
No intermediate grade of auditory acuity; use 2 or 4 as indicated.	Meets acceptable standards of these regulations with minimum vision of 20/400 in each eye, correctible to 20/40 in one eye and 20/70 in the second eye or 20/30 in one eye and 20/100 in the second eye. This classification also includes those individuals with any degree of defective vision in one eye from below 20/400 to no light perception if such defective vision is not due to active or progressive organic disease with vision in the other eye of 20/100 correctible to 20/20 with glasses.	Mild chronic psychoneuroses, Moderate transient psychoneurotic reaction. Mental deficiency, mild degree. History of transient psychotic reaction.
Below minimum standards for induction.	Below minimum standards for induction.	Psychosis. Moderate or severe chronic psychoneuroses, Severe transient psychoneuroses (situational). Marked degrees of character and behavior disorders. Marked mental deficiency.
Auditory acuity, and organic defects of the ears.	Visual acuity, and organic defects of the eyes and lids.	Type, severity, and duration of the psychiatric symptoms or disorder existing at the time the profile is determined. Amount of external precipitating stress. Predisposition as determined by the basic personality makeup, intelligence, performance, and history of past psychiatric disorders. Impairment of functional capacity.

SECTION III

GENERAL AND MISCELLANEOUS DEFECTS

13. Acceptable.—*a.* Individuals with acute pathological conditions, including acute communicable diseases, except venereal diseases, from which in the natural course of the disease recovery occurs without sequelae, will be deferred until a final examination shows recovery has occurred without disqualifying sequelae.

b. Malaria, provided there is no history of incapacitating recurrences and no evidence of residuals.

c. Uncinariasis, if mild.

d. Remediable incapacity because of recent acute illness, surgical operations, injury, employment or environment in civil life, provided acceptance is deferred until recovery is complete. Following any major surgical operation an individual will be deferred for a sufficient period of time to insure complete recovery without sequelae. The minimum period of deferment following a major surgical procedure will be 3 months. The actual period of deferment longer than 3 months will depend on the condition for which operated and on the discretion of the medical examiners.

14. Nonacceptable.—*a.* Carcinoma or other malignant tumor or disease of any organ or part of the body.

b. Active tuberculosis of any degree.

c. Leprosy or actinomycosis.

d. Late syphilis affecting the cerebrospinal or cardiovascular system or the viscera.

e. Chronic metallic poisoning, except argyria.

f. Mycotic infection of the lungs or other internal organs.

g. Acute rheumatic fever, or verified history of single or recurrent attacks of rheumatic fever within the previous 2 years.

h. Osteoarthritis or rheumatoid arthritis.

i. Active osteomyelitis of any bone or a substantiated history of osteomyelitis of any of the long bones of the extremities at any time.

j. Filariasis, trypanosomiasis, amoebiasis, or schistosomiasis.

k. Hodgkin's disease.

l. Uncinariasis, if more than mild.

m. Malaria, with verified history of incapacitating recurrences or evidence of residuals.

n. Splenectomy for any cause, other than trauma or congenital hemolytic icterus.

o. Leukemia.

SECTION IV

HEIGHT, WEIGHT, AND CHEST MEASUREMENTS

15. Tables of standard and minimum acceptable measurements of height, weight, and circumference of chest.—*a. Table of standard and minimum acceptable measurements of height, weight, and circumference of chest for others than Filipinos, Puerto Ricans, and individuals of Oriental descent.*

Height (inches)	Standard		Minimum	
	Weight	Chest measurement at expiration	Weight	Chest measurement at expiration
	Pounds	*Inches*	*Pounds*	*Inches*
60	116	31. 25	105	28. 75
61	119	31. 50	107	29. 00
62	122	31. 75	109	29. 25
63	125	32. 00	111	29. 50
64	128	32. 25	113	29. 75
65	132	32. 50	115	30. 00
66	136	32. 75	117	30. 25
67	140	33. 00	121	30. 50
68	144	33. 25	125	30. 75
69	148	33. 50	129	31. 00
70	152	33. 75	133	31. 25
71	156	34. 00	137	31. 50
72	160	34. 25	141	31. 75
73	164	34. 50	145	32. 00
74	168	34. 75	149	32. 25
75	172	35. 00	153	32. 50
76	176	35. 25	157	32. 75
77	180	35. 50	161	33. 00
78	184	35. 75	165	33. 25

b. Table of standard and minimum acceptable measurements of height, weight and circumference of chest for Filipinos, Puerto Ricans, and individuals of Oriental descent.

Height (inches)	Standard		Minimum	
	Weight	Chest measurement at expiration	Weight	Chest measurement at expiration
	Pounds	*Inches*	*Pounds*	*Inches*
60	114	31. 00	101	28. 50
61	116	31. 25	102	28. 75
62	119	31. 50	103	29. 00
63	121	31. 75	105	29. 25
64	124	32. 00	107	29. 50
65	128	32. 25	110	29. 75
66	132	32. 50	113	30. 00
67	136	32. 75	117	30. 25
68	140	33. 00	121	30. 50
69	144	33. 25	125	30. 75
70	148	33. 50	129	31. 00

b. Table of standard and minimum acceptable measurements of height, weight, and circumference of chest for Filipinos, Puerto Ricans, and individuals of Oriental descent—Continued

Height (inches)	Standard		Minimum	
	Weight	Chest measurement at expiration	Weight	Chest measurement at expiration
	Pounds	*Inches*	*Pounds*	*Inches*
71	152	33. 75	133	31. 25
72	156	34. 00	137	31. 50
73	161	34. 25	140	31. 75
74	165	34. 50	143	32. 00
75	168	34. 75	147	32. 25
76	173	35. 00	151	32. 50
77	177	35. 25	156	32. 75
78	180	35. 50	160	33. 00

16. Directions for taking height and weight.—*a.* The measuring rod will consist of a board at least 2 inches wide by 80 inches long, placed vertically, firmly fixed, with accurate graduations of ¼ inch between 58 inches and the top end. Obtain the height by placing horizontally, in firm contact with the top of the head, square against the measuring rod, a board of about 6 by 6 by 2 inches, best permanently attached to the graduated board by a long cord. The individual will stand erect with back to the graduated board, eyes straight to the front. Shoes will be removed when the height is taken.

b. The weight will be taken with the clothing removed.

17. Acceptable.—*a.* Those who fall within the requirements for height, weight, and chest measurement given in the table in paragraph 15.

b. Those whose weight is greater than the standards indicated for the height, provided the overweight is not so excessive as to interfere with military training.

c. Individuals who on examination are found to present conditions not within the accepted measurements for weight and chest circumference given in the table (par. 15), who are otherwise mentally and physically fit, and who do not fall within the nonacceptable class may be accepted as physical profile classification 3.

18. Nonacceptable.—*a.* Less than 60 inches in height.

b. Less than 105 pounds in weight.

c. A height of more than 78 inches.

d. Overweight which is greatly out of proportion to the height if it interferes with normal physical activity or with proper training.

19. General considerations.—*a.* Individuals of 76 inches or more in height will be studied for the possibility of gigantism or acromegaly.

b. Examining physicians will use discretion and judgment in accepting registrants with variations in the ratio of height, weight, and chest measurements indicated in the table (par. 15). When the weight is disproportionate and is believed to be due to some temporary condition, proper allowances may be made, provided it is the opinion of the examining physician that the variation is correctible with proper food and physical training. No individual will be accepted, however, whose weight is less than 105 pounds.

SECTION V

EYES

20. Vision.—Visual acuity will be determined at a distance of 20 feet or the mirror equivalent under standard conditions of illumination. The illumination of the target chart shall be between 12- and 18-foot candles. This degree of illumination may be obtained by a 200-watt lamp, 5 feet diagonally from the 20/20 line in the target, and incident to this part of the chart at an angle of 45°. All lamps must be shielded from the direct vision of the examinee by an opaque shade. The individual to be tested, if wearing glasses, will remove them before entering the examining room, and then seated without viewing the test chart. Individuals awaiting the test must be kept out of hearing distance. The examiner holds the occluder and covers the candidate's left eye, while instructing the examinee to keep both eyes open without squinting. The occluded must not be permitted to touch any part of the eye to be shielded, but will be held in contact with the side of the nose. The examinee is then directed to begin with the first (visible) line and to read as many as possible. The acuity for the left eye is then tested, using a different chart. An individual who normally wears glasses is tested again with them in place, following the same procedure. Where there is a suspicion that the examinee has memorized the charts, he is directed to read the letters or targets in reverse order or will be shown a different chart. The individual is expected to read the letters promptly. No precise time limit will be applied, but 1 or 2 seconds per letter is ample time. When an individual fails a letter or target, he will not be asked to read it again. If the individual is a rapid reader and his mistakes are obviously careless ones, he will be cautioned to "slow down" and the test will be repeated on another chart. Vision is recorded in the form of a fraction. The upper number is the distance in feet from the target, and the lower number is the value of the smallest test chart line read correctly. Thus, a person reading the 30-foot test chart line at a distance of 20 feet is given a score of 20/30. A score of 20/20 indicates the person reads test chart line marked 20 at a distance of 20 feet. Similarly, 20/200 means that a person reads only the test chart line marked 200 from a distance of 20 feet. External examination of the eyes will include inspection of the globes, lids, lacrimal apparatus, conjunctiva and sclera, cornea, iris, pupil, lens, and vitreous. Ocular tension will be determined by digital palpation.

21. Acceptable.—*a. Vision.*—The actual possession of suitable glasses by an individual is not required for his acceptance under these standards.

(1) *Physical profile classification "E–1".*—A minimum vision of 20/70 in each eye correctible with glasses to 20/20 in one eye and 20/30 in the other, provided the defective vision is not due to active or progressive organic disease.

(2) *Physical profile classification "E–2".*—A minimum vision of 20/200 in each eye correctible with glasses to 20/40 in each eye, provided the defective vision is not due to active or progressive organic disease.

(3) *Physical profile classification "E–3".*—A minimum vision of 20/400 in each eye without glasses, correctible to 20/40 in one eye and 20/70 in the second eye, or 20/30 in one eye and 20/100 in the second eye, or 20/20 in one eye and 20/400 in the second eye, provided the defective vision is not due to active or progressive organic disease. In addition, individuals with any degree of defective vision in one eye from below 20/400 to no light perception may be included in this physical profile serial category, provided the defective vision is not due to active or progressive organic disease and the vision in the second eye is not less than 20/100 correctible to 20/20 with glasses.

b. Other than vision.

(1) Residuals from ocular surgery, if the condition for which the operation was performed has been relieved and the vision is within or above the minimum standard requirements.

(2) Nystagmoid movements, if not persistent or pronounced and if true nystagmus is excluded.

(3) Simple chronic conjunctivitis, if mild and amenable to treatment.

(4) Small pterygium not encroaching on cornea so as to interfere with vision.

(5) Ptosis which does not interfere with vision.

(6) Color blindness.

(7) Exophthalmos, if not of such degree as to threaten or have produced corneal ulceration and provided hyperthyroidism is excluded.

(8) Blepharitis marginalis, if mild.

22. Nonacceptable.—Defects such as—

a. Vision less than the minimum requirements.

b. Complete or extensive destruction of the eyelids sufficient to impair protection of the eye from exposure; disfiguring cicatrices and adhesions of the eyelids to each other or to the eyeball; inversion or eversion of the eyelids if uncorrectible; lagophthalmos if extreme; ptosis interfering with vision; blepharospasm; chronic severe blepharitis.

c. Trichiasis.

d. Malignant growth.

e. Acute or chronic dacrocystitis.

f. Acute or chronic conjunctivitis, including vernal catarrh, if more than mild; trachoma.

g. Pterygium interfering with vision.

h. Acute or chronic keratitis; intractible or recurrent corneal ulcers.

i. Acute, chronic, or recurrent inflammation of the uveal tract (iris, ciliary body, or choroid); retinitis, uveitis, neuroretinitis, optic neuritis, papilloedema, bilateral optic atrophy; pigmentary degeneration of the retina; detachment of the retina.

j. Opacities of the lens, presumably progressive, or dislocation of one lens.

k. Permanent and well-marked strabismus (over 20° deviation). Any degree of strabismus if accompanied by diplopia.

l. Nystagmus.

m. Other diseases of the eye, such as glaucoma; night blindness because of objective organic disease of the eye; malignant tumor; exophthalmos sufficient

to interfere with proper closure of the eyelids and protection of the cornea; diplopia from any cause or of any degree; any tumors of the orbit; and abnormal condition of eyes or visual fields because of diseases of the brain.

n. Loss of one eye or anophthalmos.

o. Any organic disease of the eye or adnexa not specified above which threatens continuity of vision or impairment of visual function.

23. Visual tests for detection of malingerers.—*a.* Malingerers may feign inability to open their eyes, total loss of vision in one or both eyes, or impaired vision in one or both eyes. Occasionally, an inflammation in the eyes will be produced by putting sand or other irritating substance under the lids.

b. Malingerers who wish to evade military service by feigning impairment of vision may be divided into two classes as follows:

(1) Those who claim total loss of vision in one eye.

(2) Those who claim partial loss of vision in one or both eyes. Either group may have a normal acuity of vision or may exaggerate a defect actually present.

c. In testing for malingering, the examining physician will bear in mind that detection is more likely to result when the man is allowed to believe that his case is regarded from the first as genuine and that his story is not discredited. There is something indefinable in the bearing of the malingerer which experience alone can detect. He may be self-assertive and overconfident; he may be hesitant or evasive. Careful observation will be made of his conduct and every movement noted. The nature of the man's answer will be taken into account and considered in the light of the kind of reply that is given when a nonmalingerer is being examined.

d. The following equipment will be available:

(1) Trial frame, blank, spherical lenses: +10, +3, +0.25, −3, −2, −1, −0.25.

(2) Two prisms, one 6° and one 10°.

(3) Opthalmoscope (electric battery in handle).

(4) Condensing lens.

(5) Loupe.

(6) Red and green letters on glass—

(*a*) Letters varying in size.

(*b*) Spectacle frame containing red and green glasses.

(7) Special test cards, one a duplicate, with letters reversed to use with a mirror.

(8) Special illiterate test cards.

(9) Mirror large enough to reflect test cards.

(10) One stereoscope with special card.

(11) Retinoscope (electric, with battery in handle).

(12) Ruler about 1¼ inches wide.

(13) Three disks of polaroid 36-mm in diameter and 2-mm thick.

e. The principle involved in the polaroid test is that light polarized in any given meridian by a polaroid screen is selectively absorbed by an analyzing polaroid screen the axis of which is at an angle to the axis of the polarizing screen. The test may be conducted as follows: Three disks of polaroid 36-mm in diameter and 2-mm thick are required. They are held in the ordinary trial frame with the handle corresponding to the polarizing axis. One polaroid disk is placed before each eye with the polarizing axis horizontal. The individual

is then asked to read the smallest possible line of letters on the test chart with both eyes open. Immediately, the third polaroid disk is rotated so that the polarizing axis becomes vertical for the length of time that it takes to read three or four letters. The rotation of the third disk to the vertical position prevents the passage of any light so that, if the reading of the test chart is continued during this time, it is very evident that the poor eye is functioning. The disk may be used with correcting spectacle lenses if necessary. Care must be exercised to see that the poor eye is not closed while the polarized disk before the other eye is at right angles. Also, the good eye must be occluded by the opposed polaroid disk for only a short period at a time so that the individual does not become aware of the momentary elimination of visual acuity in that eye.

24. Other methods of examination.—a. *To verify total loss of vision in one eye.*

(1) *Binocular vision.*—A 6° prism, base down, is placed before the admittedly sound eye while the man looks at a distant light or candle. If he sees two candles, binocular vision is proved. The examiner may vary the test by placing the prism before the "blind" eye, either base up or base down.

(2) *Double vision.*—A prism of 10°, with base outward, is placed before the "blind" eye. If there is any sight in this eye, double vision will be produced and the eye will be seen to move inward to correct it and fuse the two images.

(3) *Monocular diplopia.*—The alleged "blind" eye is covered. A prism of 10°, with the apex up, is placed before the "seeing" eye in such a position that its edge lies horizontally across the center of the pupil. This produces monocular diplopia. The prism is then moved upward so as to be completely in front of the good eye and at the same time the "blind" eye is uncovered. If diplopia is produced or admitted, there is sight in the "blind" eye.

(4) *Test with colored glasses and letters.*—This consists in directing the individual to read a row of special red and green letters on glass through a special red and green glass. The red letters will be invisible to the eye that has the red glass, and vice versa, but if all the letters are correctly read, irrespective of their color, there must be sight in the "blind" eye. The proper illumination back of the chart must be observed. This test is not applicable to individuals who are color blind to red and green.

(5) *Test with trial glasses.*—A high plus glass is placed before the good eye and a low plus or minus before the "blind" eye. If the distant type is read, the vision in the "blind" eye is good.

(6) *Stereoscope test.*—This may be made with ordinary stereoscope, the printed matter so arranged that certain portions of it are not present before one of the eyes.

(7) *Bar test.*—Interpose a ruler about 1¼ inches wide vertically midway between the two eyes at about 4 to 5 inches' distance; direct the man to read from a printed page with lines at least 4 inches long. If able to read the lines, binocular vision exists.

(8) *Pupil action.*—The action of the pupil must be carefully tested, there usually being no movement to light stimulation when the eye is

blind. If the examiner is not satisfied, the following examination will be made:

(a) *Oblique examination.*—A careful examination of the cornea will be made with the aid of a condensing lens and a loupe.

(b) *Ophthalmoscopic examination.*—A searching examination with the ophthalmoscope will be made, together with an estimation of the refractive error. The pupil will be dilated if necessary.

b. *To verify partial loss of vision in one or both eyes.*

(1) *Most common manifestation of malingering.*—The most common manifestation of malingering takes the form of a statement that one eye is imperfect. Men pleading this disability may be divided into two classes:

(a) Those who pretend to have a visual defect.

(b) Those who are aware that they have a visual defect and exaggerate its effect.

(2) *Alertness and ingenuity of examining physician.*—No hard-and-fast tests can be prescribed for the detection of these cases. Much depends on the alertness and ingenuity of the examining physician.

(3) *Tests with prisms not applicable.*—The tests with prisms are not applicable here, for there is not pretended blindness in one eye but simply an alleged diminution of visual acuity.

(4) *Test at 30 to 35 feet from chart.*—If a room 30 to 40 feet long can be obtained for testing vision, place the individual suspected of malingering at 30 to 35 feet from the test chart. Direct him to read the letters and note the result. He should then be brought up to 20 feet from the card and retested. If he still reads only the same line and does not read any of the smaller type, he is malingering.

(5) *Mirror test with special cards.*

(a) Test cards are used which are identical, one having the letters reversed. The registrant is directed to read the letters on the chart across the room and then in a mirror beside it which reflects reverse letters that are placed over his head. The letters seen in the mirror are located double the distance of the direct letters from the man being examined. The malingerer is apt to read in the mirror the line which he read on the first card, showing that his vision is twice as good as he pretends.

(b) In order to obviate the use of test letters in the mirror test, various common objects approximately the size of the 20/40 and 20/30 letters may be used by asking an individual to differentiate between a dime and a penny, a cigarette and a pencil, a pen and a pencil, the number of spots on playing cards, or between the different aces, held on either side of his head and reflected in the mirror at 20 feet distance.

(6) *Trial frame test.*—Place a trial frame upon the man's face and put before the sound eye a high convex lens (+16D) and before the weak eye a plane or weak lens (0.25) which will not interfere with vision. If letters placed at a distance of 20 feet are read, the fraud is at once exposed.

(7) *Oblique examination.*—This is conducted with condensing lens and loupe to determine corneal or lenticular opacities.

(8) *Ophthalmoscopic examination.*

(a) It is probable that the malingerer will resist the ophthalmoscopic examination by frequent winking or rolling of the eyes. In this event, it is best to caution the man that a report of his vision must be made, and then to postpone further examination until after the next few individuals have been examined.

(b) Use the ophthalmoscope as an aid in estimating the refractive error. If no error of marked degree exists and the media and fundi are normal, the relation between the alleged vision and the refractive condition furnishes an important clue. If the error is about +4 or −2, the visual acuity could be about 20/100, but when the defect cannot be accounted for objectively and the vision is brought from 20/100 to 20/50 or 20/30 by means of a low plus or minus glass, the man is malingering.

(9) *Retinoscopy.*—Look for corneal and lenticular opacities and estimate refractive errors.

c. Occupation.

(1) The man's occupation in civil life may have been such that it could not have been followed without more vision than he claims.

(2) In the absence of ocular defects, continuous and persistent blepharospasm, the use of colored glasses, eyeshades, or eye bandages will be regarded with suspicion.

d. Diplopia.—Cases of malingering are occasionally met with in which the men complain that they see double. These must be investigated with the application of the ordinary tests as if they were genuine and with every precaution taken to guard against a serious nerve lesion being overlooked.

SECTION VI

EARS

25. Examination for disease.—The external ears and mastoid region will be examined by inspection and, if necessary, the mastoid region by palpation. The external auditory canal and membrana tympani will be examined by reflected light or by a self-illuminating otoscope. Cerumen will be removed, if necessary, in order to visualize satisfactorily the membrana tympani.

26. Determination of auditory acuity.—*a. Whispered voice test.*—Acuity of hearing will be determined by the whispered voice test. To determine the acuity of hearing, place the individual 15 feet from the examiner, with the ear being tested facing the examiner, and direct the individual to repeat promptly the words heard. If he cannot hear the words at 15 feet, the examiner will approach, foot by foot, using the same volume of whispered sound until the words are repeated correctly. Each ear will be tested separately. An assistant will occlude

the ear not being tested by pressing the tragus firmly against the meatus. The examiner will use a whispered voice produced by speaking with the lungs in a state of complete exhalation to assure uniform output. The whisper should be plainly audible to the assistant and use will be made of numerals, names of places, or other words or sentences until the individual's auditory acuity is evident. Acuity of hearing will be expressed as a fraction, the numerator will be the distance in feet at which the whispered words are detected by the examiner, and the denominator will be 15. Thus 15/15 indicates normal hearing; 10/15 indicates that the individual hears at 10 feet distance what an individual with normal auditory acuity would hear at 15 feet.

b. Conversational voice.—If the auditory acuity of an individual falls below the standards prescribed in paragraph 27*a*, the results of tests using normal conversational voice at a distance of 20 feet will be recorded, employing the technique described in *a* above (i.e., normal hearing would be recorded as 20/20).

27. Acceptable.—*a. Hearing.*

(1) *Physical profile classification "H–1".*—Hearing in each ear of 15/15 as determined by the whispered voice test.

(2) *Physical profile classification "H–2".*—Hearing in each ear of 8/15 or better, or 15/15 in one ear and less than 8/15 in the other ear, provided the defective hearing is not due to active or progressive organic disease.

(3) *Physical profile classification "H–3".*—There are no defects in hearing that warrant initial classification in this category.

b. Other than hearing.

(1) Healed scar of mastoid operation without marked deformity and hearing is not below prescribed requirements.

(2) Perforation of the membrana tympani, provided there is no active or progressive organic disease present.

28. Nonacceptable.—Defects such as—

a. Hearing less than minimum requirements.

b. Acute or chronic suppurative otitis media. Chronic catarrhal otitis media.

c. Acute or chronic mastoiditis.

d. Severe atresia of the external auditory canal or tumors of this part.

29. Tests for malingering in hearing.—Individuals who are malingerers in regard to hearing usually claim magnification of slight imperfection on one side with a complaint of past trouble. Exaggeration of defects in hearing extends usually to declarations of total deafness on one side. The following directions will be observed in examining suspected malingerers.

a. In making these examinations the observer will have a skilled assistant and all communications between them will be in a low, whispered voice.

b. The assistant will stand at the back of the suspected malingerer and will, at the direction of the examining physician, obstruct the ears of the suspect as directed, by pressing the tragus firmly into the auditory meatus.

c. The suspected malingerer's eyes will be securely and completely blindfolded.

d. An accurate notation will be made of which ear is deaf as claimed by the individual. Then a critical examination of the auditory canal, membrana tympani, and for patency of the eustachian tubes will follow.

e. Then an accurate test of the normal ear will be made.

f. If the suspect gives markedly conflicting statements when the normal ear is tightly plugged as to the distance at which he hears the voice, it is fair to assume that he is a malingerer.

g. The simplest and most available test for malingering is the use of an ordinary binaural stethoscope. The tubing leading to the earpiece to be applied to the normal ear is occluded by clamping with a hemostat and the earpieces are placed in the ears of the blindfolded suspect. The examining physician speaks in a soft tone or counts into the bell-shaped chest portion of the stethoscope and the suspect is told to repeat what he hears. The tubes are removed from the ears, and the assistant is told to occlude the normal ear. The same words or numerals are repeated. The suspect will now claim failure to hear the words or numerals which he had previously heard through the tube with the allegedly deaf ear.

h. Ehard's test is another simple method for malingerers which requires no special apparatus. If the external auditory canal of a normal ear is tightly packed with absorbent cotton, it will still conduct sound waves to a limited degree, a loud-ticking watch even under these circumstances being heard about 1 or 2 meters. The suspect has his ear which is stated to be deaf occluded with cotton, and then the test is made with the hearing of the normal ear, the suspect being told to count the ticks of the watch. The suspect's normal hearing ear is then occluded with cotton and the testing is made with the unoccluded supposedly deaf ear. Under this test, if he claims failure to hear the watch under 1 meter, he is malingering.

i. The Chiman-Noos test is made with the C2 tuning fork. The vibrating tuning fork is held at equal distance from each ear. The suspect may claim that he hears it better in the normal ear. The vibrating tuning fork is then placed on the vertex of the skull. The suspect hearing it equally well in both ears will at first hesitate and then state he hears it better in the normal ear. In diseases of the conducting apparatus he will hear it better in the diseased ear. If now the external meatus of the normal ear is tightly closed and the vibrating tuning fork is placed upon the vertex of the skull, the individual with the diseased ear will state he hears it better in the normal, closed ear, or it may be impossible for him to decide in which ear he perceives the tone better. The suspect, with the normal ear tightly obstructed, will state that he does not perceive the sound of the fork when thus placed on the vertex of the skull.

SECTION VII

MOUTH, NOSE, FAUCES, PHARYNX, TRACHEA, ESOPHAGUS, AND LARYNX

30. Acceptable.—*a. Physical profile classification 1 and 2.*

(1) Enlarged tonsils.

(2) Adenoids.

(3) Deviation of the nasal septum or enlarged turbinates which do not interfere more than mildly with nasal breathing.

(4) Acute primary sinusitis, provided the acceptance of the individual is deferred for reexamination until after a reasonable time has elasped and the sinusitis has disappeared.

(5) Hay fever, if mild.

b. Physical profile classification 3.

(1) Deviation of the nasal septum or enlarged turbinates which do not interfere more than moderately with nasal breathing.

(2) Hay fever, if moderate.

31. Nonacceptable.—Defects such as—

a. Deformities of the mouth, throat, and nose which interfere with mastication of ordinary food, with speech, or with breathing.

b. Destructive syphilitic disease of the mouth, nose, throat, larynx, or esophagus.

c. Laryngeal paralysis due to any cause.

d. Tracheostomy.

e. Stricture of the esophagus.

f. Chronic sinusitis of the accessory sinuses of the nose. (This diagnosis will be established by the presence of a chronic purulent nasal discharge, large nasal polypi, and other signs and symptoms and confirmed by transillumination or X-ray examination, or both.)

g. Chronic atrophic rhinitis with offensive odor (ozena).

h. Malignant neoplasms.

i. Nasal obstruction because of septal deviation, hypertrophic rhinitis, or other causes, if sufficient to cause mouth breathing.

j. Aphonia.

k. Hay fever, if severe.

l. Chronic laryngitis.

m. Perforation of the hard palate.

n. Stricture or other organic disease of the esophagus.

o. Harelip.

p. Perforation of the nasal septum associated with interference of function, or ulceration or crusting, and when because of organic disease.

32. Use of diagnostic aids.—Examining physicians will make use of laryngoscopy, transillumination of the sinuses, and X-ray when available to determine more definitely the physical fitness of individuals who have defects involving the upper air passages, head, or esophagus when such diagnostic aids are indicated.

Section VIII

DENTAL REQUIREMENTS

33. Acceptable.—*a. General.*—Individuals who are well-nourished, of good musculature, are free from gross dental infections, and have a minimum requirement of an edentulous upper jaw and/or an edentulous lower jaw, corrected or correctible by a full denture or dentures.

b. Malocclusion.—When it is evident from the individual's general physical condition that his malocclusion has not seriously interfered with the mastication of a normal diet, provided that in the excursions of the mandible or with the mandible at rest, the teeth do not impinge upon opposing soft tissues and that the malocclusion has not resulted in secondary pathological changes.

34. Nonacceptable.—*a.* Diseases of the jaws and associated structures which are irremediable or not easily remedied, or which are likely to incapacitate the individual for satisfactory performance of military duty.

b. Extensive loss of oral tissue in an amount that would prevent replacement of missing teeth by a satisfactory denture.

35. General considerations.—Examining dentists, to protect the interest of the Government and the individual, will exercise every care to indicate clearly the status of every tooth, as well as those extracted, missing, or unerupted. The exact teeth replaced by a prosthetic appliance or bridge (with abutments), as well as the serviceability of the appliance will be recorded. Defects, infections (including pyorrhea) will be listed and classified as to severity.

SECTION IX

SKIN

36. Acceptable.—*a.* Acute nonexanthematous and noncommunicable diseases of the skin which ordinarily run a temporary course.

b. Diseases which are trivial in character and which do not interfere with the general health and are not incapacitating. Among these common and usually trivial diseases may be enumerated—

(1) Acne, mild or moderate. (Care must be taken to exclude individuals with chronic severe acne, particularly when the face is involved to the extent of being markedly disfiguring or the shoulders extensively involved, making it likely to be aggravated by shoulder straps or packs or by other military equipment.)
(2) Anomalies of pigmentation.
(3) Scars not extensive, disfiguring, nor incapacitating in character.
(4) Warts, except plantar warts on weight-bearing areas.
(5) Skin infections, if mild and considered of no significance.
(6) Acute eczema, if mild.
(7) Naevi which are not greatly disfiguring and are not so located as to be subject to irritation or trauma by the normal wearing of military equipment.
(8) All forms of pediculosis.
(9) All forms of ringworm, unless severe and not easily remediable.
(10) Scabies, unless severe and not easily remediable.
(11) Mild and not extensive psoriasis.

c. Simple ulcers or other acute pathological conditions of the skin which are easily curable.

d. Unusual skin conditions should arouse suspicion of self-inflicted lesions (dermatitis factitia). See section XXIV.

e. True alopecia areata, provided the existence of disqualifying endocrine, neurological, or other disqualifying conditions are excluded.

37. Nonacceptable.—Serious or incapacitating skin disorders such as—

a. Chronic skin disease, chronic ulcers of the skin, or cured syphilitic lesions which are so severe as to incapacitate the individual for the duties of a soldier or so disfiguring as to render the individual objectionable in common social intercourse.

b. Extensive, deep, or adherent scars that interfere with muscular movements, or with the wearing of military equipment, or that show a tendency to break down and ulcerate.

c. Actinomycosis.

d. Dermatitis herpetiformis of long duration.
e. Epidermolysis bullosa.
f. Generalized dermatitis of long duration.
g. Allergic dermatoses, if severe.
h. Mycosis fungoides.
i. Chronic pemphigus.
j. Lupus vulgaris.
k. Elephantiasis.
l. Ringworm, if very severe and not easily remediable.
m. Psoriasis, if other than mild.
n. Scabies, if very severe and not easily remediable.
o. Cysts and benign tumors of the skin of such size and/or location as to interfere with the normal wearing of military equipment.
p. Pilonidal cyst, if evidenced by the presence of a tumor mass or a discharging sinus or if there is a history of inflammation or discharging sinus.
q. Plantar warts on weight-bearing areas.

SECTION X

HEAD

38. Acceptable.—*a.* Moderate deformities of the bones of the skull such as depressions, exostoses, etc., unassociated with evidence of disease of the brain, spinal cord, or peripheral nerves and not preventing the individual from wearing military headgear.

b. Abnormalities which are apparently temporary in character resulting from recent injuries. (These include severe contusions and other wounds of the scalp and cerebral concussion. Individuals with these conditions will have the final examination temporarily deferred for 8 months.) See paragraphs 77*e* and 78*h*.

39. Nonacceptable.—*a.* Deformities of the skull in the nature of depressions, exostoses, etc., of a degree which would prevent the individual from wearing military headgear.

b. Deformities of the skull of any degree associated with evidence of disease of the brain, spinal cord, or peripheral nerves. See paragraphs 77*e* and 78*h*.

SECTION XI

SPINE, SCAPULAE, AND SACROILIAC JOINTS

40. Acceptable.—*a. Physical profile classification "1" and "2".*
(1) Lateral deviation of the spine of 1 inch or less from the midline, if the mobility and weight-bearing power are good.
(2) Fracture of the coccyx.
(3) Prominent scapulae not interfering with wearing of uniform or military equipment.
(4) Complaint of disease of the sacroiliac and lumbo-sacral joints which is unassociated with objective signs and symptoms.

(5) Fracture of the spine or pelvic bones which has healed without marked deformity and which has not interfered with the following of a useful vocation in civil life.

(6) Spina bifida occulta, provided it is asymptomatic, unassociated with objective signs and symptoms, and can be demonstrated by X-ray examination only.

b. Physical profile classification "3."—Lateral deviation of the spine from the midline of more than 1 inch and less than 2 inches.

41. Nonacceptable.—Conditions such as—

a. Tuberculosis, either active or healed.

b. Osteoarthritis or rheumatoid arthritis, or chronic arthritis from any cause.

c. Healed fractures of the vertebrae or pelvic bones with associated symptoms which have prevented the individual from following a useful vocation in civil life.

d. Lateral deviation of the spine from the midline of more than 2 inches. Curvature of the spine (scoliosis, kyphosis, or lordosis) of a degree sufficient to interfere with the wearing of a uniform or military equipment or which has prevented the individual from following a useful vocation in civil life.

e. Disease of the sacroiliac and lumbo-sacral joints which is of a chronic type and is obviously associated with pain referred to the lower extremities, muscular spasm, postural deformities, and limitation of motion in the lumbar region of the spine.

f. Nucleus pulposus (herniation intervertebral disc) or history of operation for this condition.

42. X-ray examination.—When examining physicians are in doubt concerning the cause and the extent of disease of the bones and joints, an X-ray examination will be made.

SECTION XII

EXTREMITIES

43. Acceptable.—*a. Physical profile classification "1" and "2".*

(1) Old or recent fractures which have healed normally with no resulting impairment of function.

(2) Recent injury of a bone or joint with or without fracture or dislocation which, in the opinion of the examiners, is only temporarily incapacitating. (Individuals with these conditions will be given a period of time not less than 6 weeks for recovery before the final examination is made.)

(3) Webbed fingers and toes, unless severe in degree.

(4) Entire loss of little finger of either or both hands, or the ring finger of the left hand.

(5) Loss of the terminal phalanx of index finger (right or left), or loss of the distal two phalanges of any one finger except index fingers.

(6) Scars and deformities of moderate degree of the hand or hands which do not interfere with normal function.

(7) Stiff fingers of a degree not to interfere with function.

(8) Flat foot unless accompanied with symptoms of weak foot or when the foot is weak on test.

(9) Hammertoe which does not interfere with the wearing of a military shoe.
(10) Hallux valgus, unless severe.
(11) Absence of one or two of the small toes of one or both feet, if function of the foot is good.
(12) Ingrowing toenails, unless severe.
(13) History of a satisfactory surgical correction of dislocated semilunar cartilage or loose body of the knee, provided that 1 year has elapsed since operation without recurrence; the knee ligaments are stable in lateral and anteroposterior directions in comparison with the normal knee; the X-ray is negative for pathology; there is no weakness or atrophy of the thigh musculature in comparison with the normal side; there is full active motion in flexion and extension; and there are no symptoms of internal derangement.

b. Physical profile classification "3."
(1) Total loss of little fingers in addition to total loss of any other one finger (except thumb) of one or both hands.
(2) Webbed fingers or toes, if severe in degree.
(3) Moderate deformities of one or both upper extremities which do not and have not interfered with function to a degree to prevent the individual from following a useful vocation in civil life.
(4) Loss of great toe.
(5) Loss of dorsal flexion of great toe.
(6) Slight claw toes not involving obliteration of the transverse arch and which do not interfere with the wearing of a military shoe.
(7) Other defects of the feet which preclude the performance of all military duties but do not prevent the individual from wearing a military shoe and which have not prevented him from following a useful vocation in civil life.
(8) Moderate deformities of one or both lower extremities which do not and have not interfered with function to a degree to prevent the individual from following a useful vocation in civil life.
(9) Adherent scars of the skin and soft tissues of an extremity, if not incapacitating and not likely to break down.
(10) Healed disease or injury of wrist or elbow with resulting limitation of motion, if not severe in degree.

44. Nonacceptable.—Defects such as—
a. Loss of one or both thumbs.
b. Loss of fingers in excess of minimum requirements.
c. Tuberculosis of a bone or joint.
d. Old ununited fractures.
e. Old unreduced or recurring dislocations of any of the major joints.
f. Disease of any bone or joint healed with such resulting deformity or rigidity that the function is impaired to a degree that it will interfere with military service.
g. Muscle paralysis or contraction which disturbs function to the degree of interference with military service.
h. Extensive, deep, or adherent scars that interfere with muscular movements or with the wearing of military equipment, or that show a tendency to break down and ulcerate.

i. Varicose veins, if severe in degree or if associated with edema or with present or previous ulcer of the skin.

j. Rigid flat foot or flat foot when accompanied with symptoms of weak foot or when the foot is weak on test. Pronounced cases of flat foot attended with decided eversion of the foot and marked bulging of the inner border, due to inward rotation of the astragalus, are disqualifying regardless of the presence or absence of subjective symptoms.

k. Obliteration of the transverse arch associated with permanent flexion of the small toes (claw toes).

l. Hallux valgus, if severe and associated with marked exostosis or bunion.

m. Clubfoot, of any degree.

n. Diseases of the bone or of the hip, knee, or ankle joint which interfere with function and weight-bearing power. An authentic history of dislocated semilunar cartilage or loose body of the knee, which has not been satisfactorily corrected by surgery. History of surgical correction of dislocated semilunar cartilage or loose body of the knee, if, at the end of one year's postoperative time, the knee ligaments are not stable in lateral and anteroposterior directions in comparison with the normal knee; the X-ray shows pathology; there is weakness or atrophy of the thigh musculature in comparison with the normal side; there is not full active motion in flexion and extension; or there are other symptoms of internal derangement.

o. Deformities due to fracture or other injury which seriously interfere with function and weight-bearing power.

p. Sciatica which is apparently intractable and disabling to the degree of interference with the function of walking and weight-bearing power.

q. Amputations of extremities in excess of those already cited.

r. Active osteomyelitis of any bone, or a substantiated history of osteomyelitis of any of the long bones of the extremities at any time.

s. Osteoarthritis or rheumatoid arthritis, or chronic arthritis from any cause.

t. Plantar warts on weight-bearing areas.

u. Abduction and pronation of the foot (knock ankle).

SECTION XIII

NECK

45. Acceptable.—*a.* Nonspastic contraction of the muscles of the neck which is not of great degree and will not prevent the wearing of a uniform or military equipment.

b. Simple goiter unassociated with pressure symptoms, provided the enlargement of the thyroid will not interfere with the wearing of a uniform or military equipment.

c. Enlarged lymph nodes of the neck which are not a manifestation of systemic disease, do not apparently interfere with the general health, and are not large enough to interfere with the wearing of a uniform or military equipment.

d. Healed tuberculous lymph nodes when few in number and densely calcified.

46. Nonacceptable.—*a.* Toxic goiter.

b. Tumor of thyroid or other structures of the neck, including enlarged lymph nodes and benign tumors of the neck, if the enlargement is of such degree as to interfere with wearing of a uniform or military equipment.

c. Enlargement of the lymph nodes of the neck associated with leukemia or Hodgkin's disease.

d. Lymphosarcoma.

e. Tuberculous lymph nodes, except as specified in paragraph 45*d*.

f. Nonspastic contraction of the muscles of the neck or cicatricial contraction of the neck to the extent that it interferes with the wearing of a uniform or military equipment or so disfiguring as to render the individual objectionable in common social intercourse.

g. Spastic contraction of the muscles of the neck.

h. Simple goiter, if associated with pressure symptoms confirmed by X-ray, or if enlargement is of such a degree to interfere with wearing of a uniform or military equipment.

SECTION XIV

LUNGS AND CHEST WALLS

47. Chest examination.—The chest examination will include a roentgenogram, as well as the usual methods of physical diagnosis. A pertinent history of past chest diseases will be taken. Because of its importance and frequency, special consideration must be given to the detection of tuberculosis.

48. History.—Inquiry will be made about previous and present symptoms of respiratory disorders, particularly if abnormalities of the chest are discovered, if the weight is below normal without other explainable cause, if there is unexplained fever, or if there are indications of possible tuberculous lesions in other parts of the body, such as fistula in ano or enlarged lymph nodes. The history of chronic or frequently recurring cough and expectoration, hemoptysis, pleurisy, or chronic laryngitis requires special investigation for a cause. It must be remembered, however, that pulmonary tuberculosis may exist in its earliest stages without producing any symptoms.

49. X-ray examination.—Chest X-ray films will be made as part of the physical examination of all selectees, applicants for voluntary enlistment of any type, and applicants for reenlistment, and will serve as permanent records. Care will be exercised in processing these films to insure their keeping qualities. It is imperative that these films be clearly marked as outlined in *a* below.

a. Identification of films.

(1) Identifying marks which are photographed on the film at the time of its exposure are most satisfactory. When the photoroentgenographic method of X-ray examination is employed, this may be accomplished with the special attachment which forms an integral part of the camera unit. With standard X-ray equipment as much identifying data as possible should be recorded on the film at the time of exposure by use of lead numbers, lead foil stencils, or other suitable means. The additional identifying data required should be added in ink at the bottom of the film. The Army serial number in most cases cannot be recorded photographically at the time the

film is made, as the examination precedes acceptance. The serial number will be added as soon as practicable after the film is processed, either in ink or with a perforating machine making letters and figures of the appropriate size, and is to be recorded on the light portion of the film corresponding to the subdiaphragmatic area. Data photographically recorded will be located in the upper right and left corners of the film. It is essential that the photographed identification be clearly legible without magnification. Photographing of the caption in such a way that it may be read when the film is viewed with the heart to the observer's left is recommended.

(2) The minimum identifying data will be: place of examination; date; individual's last name, first name, and middle initial; his home address; Army serial number; age in years; weight in pounds; abbreviation for race; and, in the case of Selective Service registrants, the local board identification code number. The abbreviation for race will be W, N, or O, conforming to the specifications for white, Negro, and other registrants on Record of Induction, NME Form 47. Except for the Army serial number, these data can be photographed on the film at the time this is made. They should appear in the upper corners of the film as indicated in the following example:

Armed Forces Induction Station	DOE, John D.
Philadelphia, Pa.	612 Lombard St.
28 July 1948	Philadelphia, Pa.
	LB 32-050-012
	31-W-156

(The local board identification code number will be found at the right side of the local board stamp placed on the Record of Induction, NME Form 47.)

(3) Since Army serial numbers are not assigned until men have been inducted or enlisted, the procedure to be followed in the final identification of chest X-ray films made as a part of the pre-induction examination of those men accepted for military service will be as follows:

(a) At the armed forces induction station the 4 by 10-inch chest photoroentgenogram of each individual found acceptable for military service will be placed in a properly labeled envelope and stapled to the Record of Induction, NME Form 47 for return to the registrant's local board. In each case in which a 14 by 17-inch chest roentgenogram is made instead of or in addition to the 4 by 10-inch film, the jacketed film will be stapled to the Record of Induction, NME Form 47 in the same manner. It is imperative that care be exercised in packaging forms and films of either type to prevent damage in transit. To accomplish this purpose, the 14 by 17-inch films with attached Record of Induction, NME Form 47 will be packaged separately from forms with attached 4 by 10-inch films.

(b) When accepted registrants are ordered to report to armed forces induction stations for induction, the local boards will forward the films with the Record of Induction, NME

Form 47. Immediately after registrants have been inducted into the Army, the X-ray films and covering envelopes will be labeled with Army serial numbers.

b. Disposition of films made in continental United States and Puerto Rico.

(1) Chest X-ray films made in the examination of men accepted for enlistment or induction into the service, after being carefully checked for proper identification, will be assembled in packages of appropriate size and mailed promptly under penalty cover to the Manager, Veterans Administration Records Center, 5000 Wissahickon Avenue, Philadelphia 1, Pennsylvania. All packages of films sent to the Veterans Administration will be labeled "Exposed X-ray Films" and will show the name of the Army organization making shipment.

(2) All chest X-ray films of individuals who are rejected for any reason will be delivered to the Selective Service System in accordance with agreements entered into between the Army area and the State director of the Selective Service System in the State from which the registrants are presented. Subject to such local agreements, films of rejected individuals in general will be separated and forwarded to State directors in appropriately labeled packages as indicated below:

(*a*) "Films of individuals recommended for reexamination in 6 months, or other specified period, because of borderline tuberculosis or other chest conditions."

(*b*) "Films of individuals rejected because of tuberculosis or other chest conditions."

(*c*) "Films of individuals rejected because of other than chest conditions."

c. Disposition of films made in Hawaiian Department.—Chest X-ray films made on individuals in the Hawaiian Department will be held there for the present.

50. Physical examination.—This will include inspection, palpation, percussion, and auscultation of the chest.

a. Structural abnormalities of the thoracic wall and striking rapidity, limitation, or inequality of the respiratory movements are to be noted.

b. Abnormal physical signs in the lungs, pleura, or mediastinum will be carefully checked to ascertain whether they persist or are only transitory.

c. Particular attention will be focused upon the occurrence of pulmonary rales, which may be elicited only after the expiratory cough. The subject will be instructed to exhale completely with the mouth open, immediately to cough before inhaling, and then to inhale deeply but quietly. Rales are heard most often at the beginning of inhalation after such an expiratory cough. A small patch of persistent rales at the apex, in the interscapular area, or in some other part of the chest may be the only evidence of tuberculosis shown by physical examination.

d. It must be borne in mind that many tuberculous lesions will not produce abnormal physical signs. In other words, the absence of abnormal signs does not exclude tuberculosis.

e. Certain signs may arouse suspicion, but will be disregarded unless X-ray and other studies reveal evidence of disease. These are—

(1) Slightly harsh breath sounds and slightly prolonged expiration over the right apex above the clavicle and the third thoracic spine and/or the same signs at the extreme left apex.

(2) Slight alteration of the breath sounds anywhere in the chest, without other abnormal signs.

(3) Clicks or crepitations which disappear after a few deep breaths or coughs.

51. Other examinations.—It may be necessary to postpone decision in some cases until special studies and adequate observations have been completed. For example, so-called atypical pneumonia in an upper lobe of the lung may simulate tuberculosis, but proper laboratory studies and another X-ray film and physical examination after 2 months usually suffice to make the differential diagnosis.

52. Acceptable.—*a. Physical profile classification "1" and "2."*

(1) Residual calcified lesions of primary tuberculosis in the pulmonary parenchyma or hilum lymph nodes, provided the size, number, and character of such lesions are not such as to suggest the possibility of reactivation. Specific limiting criteria for the size, number, and character of calcified lesions cannot be laid down as an absolute basis for determination of potential clinical activity, but, for guidance, the following considerations will apply. Single lesions in the lungs exceeding 1.5 centimeters in diameter and multiple lesions exceeding 1 centimeter in diameter and single or multiple lesions in the hilum or pulmonary lymph nodes exceeding 2 centimeters in diameter will be cause for suspicion and require proof of stability. A negative tuberculin reaction or roentgenological evidence of absence of change within 1 year will be accepted as such proof. Multiple nodules will call for additional study. For practical purposes, the presence of approximately 50 calcified nodules will be considered as requiring special measures to rule out the possible existence of foci of active tuberculosis in the lungs or elsewhere. The usual clinical procedures will be followed for this purpose. In this case, also, negative tuberculin reaction and absence of change in X-ray films a year apart will be acceptable evidence of stability. Due recognition must be given to the fact that excessive calcification, if discovered later, may be a cause for hospitalization for study. Therefore, an accurate record of the pulmonary involvement must be made in such cases in the registrant's report of physical examination for future reference. Partially calcified lesions in subjects under 25 years of age must be viewed with greater suspicion. In all such cases, stability must be demonstrated by absence of change over a period of at least 2 years. It is important to distinguish between agglomerations of small calcified nodules and truly incomplete calcification. The former, which commonly produce the effect of dense stippling, are ordinarily entirely stable. Masses with ring-like peripheral calcium density and enlarged lymph nodes with irregular flecks of calcium or questionable calcium deposition must be looked upon as potentially active. In all cases of calcification, consideration must be given to the possibility that the lesion in question is nontuberculous and judgment as to acceptability be guided accordingly. Failure to react to 0.005 mg., of the purified protein derivative of tuberculin or 1.0 mg., of old tuberculin will be accepted as evidence of absence of tuberculous activity. In cases of doubt, the erythrocyte sedimentation test by one of the standard methods should be used. Repeated

sedimentation within accepted normal limits will be considered strong evidence of inactivity.

(2) Scarred fibroid or fibrocalcific tuberculous lesions of the lungs, not associated with symptoms of clinical activity within the preceding 5 years and represented in roentgenograms as sharply demarcated strand-like or well-defined small nodular shadows not exceeding a total area of 4 square centimeters after serial observation of roentgenograms has demonstrated stability for a period of not less than 1 year.

(3) Fibrous pleural scars and adhesions, revealed most often in the roentgenogram by simple thickening of the apical pleura, deformity of the dome of the diaphragm, or visualization of an intolobar fissure, provided there is no evidence of disqualifying tuberculosis of the pulmonary parenchyma.

(4) Scar of operation for nontuberculous empyema which has been healed for 1 year or longer, provided the function of the lung is not significantly impaired, and provided no residue of the empyema, other than some fibrous thickening of the pleura, is evident upon X-ray and physical examination.

(5) Healed fracture of the rib or ribs, provided the residual deformity, if any, does not interfere seriously with respiratory movements.

(6) Benign tumor of the breast or of the chest wall, provided the mass does not interfere with the wearing of a uniform or military equipment.

(7) Small palpable lymph nodes of the axilla which apparently are not evidence of disease.

(8) The following conditions are temporarily disqualifying:

(*a*) Acute bronchitis, until a final examination shows recovery without disqualifying sequelae.

(*b*) So-called atypical or other types of pneumonia, until a final examination shows recovery without disqualifying sequelae. Ordinarily resolution, as shown by X-ray films, will be complete within 2 months. Other cause of the shadow in the X-ray film than pneumonia must be considered if complete clearing has not occurred in 3 months.

(*c*) Acute or subacute fibrinous pleurisy, definitely nontuberculous in origin, until a final examination shows recovery without disqualifying sequelae. Pleurisy of this type is suspected or demonstrated on physical examination more frequently than on X-ray examination.

(*d*) Recent fracture of a rib or ribs, until a final examination shows recovery with or without deformity and provided the residual deformity, if any, does not interfere seriously with respiratory movements.

b. Physical profile classification "3."—Deformity of clavicle, ribs, or scapula of a degree disqualifying for general military service but not preventing the individual from successfully following a useful vocation in civil life.

53. Nonacceptable.—*a.* History of—

(1) Clinical tuberculosis exceeding minimal extent.

(2) Tuberculosis of minimal extent clinically active within the preceding 5 years.

(3) Known tuberculosis pleurisy with effusion.

(4) Pleurisy with effusion of unknown origin within the preceding 5 years.

b. Active tuberculosis, including pleurisy with effusion which is to be considered of tuberculous origin if no other cause can be proved.

c. Inactive pulmonary tuberculosis, except as defined in paragraph 52.

d. Nontuberculous defects—

(1) Spontaneous pneumothorax, history of spontaneous pneumothorax within the last 3 years, or history of repeated spontaneous pneumothorax authenticated by properly dated X-ray films.

(2) Empyema; residual sacculation or unhealed sinuses of the chest wall following operation for empyema.

(3) Chronic bronchitis.

(4) Bronchiectasis.

(5) Asthma of any degree or a history of asthma, except a history of childhood asthma with a trustworthy history of freedom from symptoms since the twelfth birthday.

(6) Bullous or generalized pulmonary emphysema.

(7) Cystic disease of the lung.

(8) Silicosis as represented in the roentgenogram by strand-like and nodular shadows; any other form of severe pulmonary fibrosis.

(9) Abscess of the lung.

(10) Active coccidiomycosis or other mycotic disease of the lung or history of active coccidiomycosis within the last 3 years; residual cavitation because of mycotic disease.

(11) Foreign body in the lung, exceeding 1 centimeter in size or any foreign body with evidence of surrounding pulmonary reaction; foreign body in a bronchus.

(12) Chronic adhesive pleuritis of such extent as to interfere with respiratory function or obscure a lung field in roentgenograms.

(13) History of pneumonectomy or lobectomy for any cause.

(14) Tumor, benign, or malignant, of the trachea, bronchi, lungs, pleura, or mediastinum.

(15) Any malignant tumor of the breast or chest wall.

(16) Tuberculosis of the ribs or of other parts of the chest wall.

(17) Suppurative periostitis, osteomyelitis, caries, or necrosis of the ribs, sternum, clavicles, scapulae, or vertebrae.

(18) Benign tumor of the breast or of the chest wall of such size and location as to interfere with the wearing of the uniform or military equipment.

54. General considerations.—*a. Tuberculosis.*—An alleged history of tuberculosis will not be considered a cause for rejection unless supported by objective evidence substantiating the claim. Examining physicians should make every effort to determine the validity of the alleged history by requesting the individual's X-ray films and a summary of the clinical record. This will be necessary only when the present chest X-ray film of an individual alleging a history of tuberculosis reveals no evidence of disqualifying defects. It should be recognized that in some instances moderately extensive pulmonary tuberculosis may resolve, leaving no residuals of disqualifying character or extent visible on X-ray examination. An authenticated history of active moderately or far advanced tuberculosis will be considered as disqualifying. An authenticated

history of active minimal pulmonary tuberculosis within the past 5 years also will be considered as disqualifying. In those cases in which pulmonary tuberculosis has been previously diagnosed on the ground of subjective symptoms and of physical signs which are without pathological significance, the conclusions of examining physicians will be based on their own findings and their own evaluation of the cases.

b. Bronchiectasis.—Not infrequently a routine chest X-ray examination will reveal no obvious abnormalities even though bronchiectasis of marked degree is present. When the history of physical examination suggests the possibility of bronchiectasis, individuals should be held for study under the provisions of paragraph 5*a* and *b*.

SECTION XV

HEART, BLOOD VESSELS, AND CIRCULATION

55. History.—Questions will be asked during the course of the examination concerning past history of rheumatic fever, chorea, spells of rapid heart action, syphilis, and reaction to physical effort which may be helpful in the interpretation of the findings, but chief reliance will not be placed on the history alone.

56. Procedure.—The following procedure will govern in the physical examination of the heart. For the information of the examiners it is suggested that reference be made to the publication adopted and distributed by the American Heart Association entitled "The Nomenclature and Criteria for the Diagnosis of Diseases of the Heart."

a Location of apex impulse and determination of character.

b. Auscultation of the heart sounds over apex, lower sternum, and second and third interspaces to right and left of sternum, noting accentuation of sounds, the presence of murmurs, rate, and rhythm. Compare the heart rate with the radial pulse rate.

c. Inspection of root of neck and upper thorax followed by percussion of first interspace on each side of the manubrium for evidence of aneurysm.

d. Count of radial pulse, observation of its rhythm, and palpation of radial arteries for unusual thickening or high tension.

e. The blood pressure will be routinely measured. It will be determined with the subject in the sitting position. If orthostatic hypotension is suspected, the blood pressure will also be measured while the subject is standing. If the blood pressure appears to be abnormally high, it will be measured after the subject has rested in the recumbent position. When measured in other than the sitting position, a statement will be appended as to the position of the subject at the time of measurement.

f. Exercise (stepping 12 times briskly upon a common chair) will be used in selected cases to bring out significant heart murmurs, but this test in itself is not to be considered a reliable estimate of the functional capacity of the heart.

g. If in doubt about an unexplained tachycardia, take the temperature. Fever that is sometimes not very obvious can account for otherwise unexplained tachycardia.

h. If there is doubt as to the presence of cardiovascular disease, the individual will be held for detailed reexamination.

57. Acceptable.—*a.* A heart will be considered normal when the apex impulse is within the left midclavicular line and not below the fifth interspace; when sounds are normal and there are no thrills or important murmurs; when there is no abnormal pulsation or dullness above the base of the heart; when pulse rate is normal and regular and there is no unusual thickening of the arteries or significant elevation of blood pressure.

b. Given a heart of normal size, responding normally to exercise, a slight to moderate pulmonary systolic murmur, louder in the recumbent position and on expiration and largely or entirely abolished by deep inspiration, is the commonest of all murmurs and is to be considered physiological (functional). A faint systolic murmur localized at the aortic area without thrill and followed by a normal second sound may be considered normal, but any aortic systolic murmur of moderate intensity or louder probably indicates disease (for example, aortic dilatation or stenosis), and demands further study. A loud systolic murmur (usually with thrill), maximal at the left of the sternum in the third and fourth spaces, suggests the probability of a congenital ventricular septal defect and is a cause for rejection. A faint systolic murmur at the apex, varying in intensity, with forced respiration, less well heard in the erect position than when recumbent and unattended by cardiac enlargement or other evidence of heart disease, or by a verified history of rheumatic fever, may be considered to be physiological (functional), but a moderate or loud apical systolic murmur which persists in all phases of respiration and body positions and is intensified by exercise is evidence of abnormality of the heart. Any diastolic murmur heard over any portion of the cardiac area is evidence of disease. The presystolic (or middiastolic) murmur of mitral stenosis may be confined to a small area at or just within the cardiac apex and heard only in the recumbent position (best in the left lateral decubitus and with the bell stethoscopic chest piece); it is accentuated by exercise. A slight aortic diastolic murmur, on the other hand, may be heard only along the left sternal border, with the patient erect or leaning slightly forward, best at the end of forced expiration; it is more easily heard with the Bowles stethoscopic chest piece. Frequently, interpretation must be based on cumulative evidence or a number of relatively slight deviations from the normal.

c. A pulse rate of 100 or over which is not persistent and is not due to paroxysmal tachycardia. (A pulse rate of 100 or over may be temporary and because of excitement or recent infection, such as pneumonia or local infections about the nose, mouth, and throat, or may be induced by drugs.)

d. A pulse rate of not lower than 50 per minute.

e. Sinus arrhythmia. (This consists in a quickening of the pulse rate during inspiration and a slowing during expiration and is best recognized with the individual recumbent and breathing deeply.)

f. Elevation of blood pressure from excitement, proved to be temporary.

58. Nonacceptable.—*a.* Circulatory failure evidenced by definite symptoms such as undue breathlessness, pain, and evidence of congestive failure (engorged neck veins, enlarged liver, edema, as well as dyspnea).

b. Hypertrophy and/or dilation of the heart evidenced by displacement of the apex impulse to the left of the midclavicular line or below the sixth rib, and of a heaving or diffuse character, or by X-ray evidence.

c. A persistent heart rate of 100 or over when this is proved to be persistent in the recumbent posture and on observation and reexamination over a sufficient period of time, unless in the opinion of the medical examiner the increased cardiac rate is due to psychic reaction and not secondary to any disease condition, including infection.

d. Paroxysmal tachycardia if recurrent and disabling. See also section XXIV.

e. Heart block.

f. Any serious disturbance of rhythm, such as auricular fibrillation.

g. Valvular disease.

h. Congenital heart disease.

i. Persistent blood pressure at rest above 150-mm systolic or above 90-mm diastolic. If the blood pressure reading is somewhat (10–20-mm) above 150-mm systolic on the first reading, it should be repeated after ½-hour's rest recumbent.

j. Thrombophlebitis of one or more extremities if there is a persistence of the thrombus or any evidence of circulatory obstruction in the involved vein or veins.

k. Other abnormalities of the peripheral vascular system, including large varicose veins, Raynaud's disease, Buerger's disease (thromboangiitis obliterans), erythromelalgia, and arteriosclerosis. In doubtful cases, special tests should be employed.

l. Aneurysm of any vessel.

m. Pericarditis.

n. Endocarditis.

o. True angina pectoris.

p. Authenticated history of coronary thrombosis, and/or myocardial infarction.

q. (1) Neurocirculatory asthenia (effort syndrome). Usual symptoms of this condition are exhaustion, breathlessness, heartache, and palpitation. These symptoms may follow exertion such as would not produce them in healthy individuals. These, and other symptoms such as dizziness or fainting, may arise without evidence of organic disease sufficient to account for the disability of the individual. Cases of effort syndrome may occur—

(*a*) As an accompaniment of organic heart disease.

(*b*) Following infections.

(*c*) In individuals with poor physique or insufficient training for the work required.

(2) In some cases more than one of the above factors is present.

(3) It is important to observe that neurocirculatory asthenia should not be confused with tachycardia alone or increased blood pressure alone or both together, although such conditions may be present with neurocirculatory asthenia. The diagnosis must be clear and based on the symptom complex.

r. Orthostatic hypotension or tachycardia. The blood pressure and pulse rate will be taken with the individual in the recumbent position and after standing 3 minutes. An increase in pulse from normal in recumbent position to 120 beats per minute or more when the individual stands or a decrease of a normal blood

pressure (when the individual is recumbent) to values less than 90 systolic and 60 diastolic when the individual stands may be considered evidence of a definite physiologic disturbance and in itself cause for rejection unless the condition is very temporary following an illness, operation, or exhausted state.

s. Acute rheumatic fever, or *verified* history of single or recurrent attacks of rheumatic fever within the previous 2 years.

59. Electrocardiogram.—The electrocardiogram is of great assistance in deciding the nature of certain cardiac abnormalities the most important of which are various arrhythmias, defects of conduction, and diseases of the myocardium. Electrocardiographic findings will be evaluated according to accepted usual standards. In case of abnormality or equivocal findings, multiple precordial leads will be recorded and used as an aid in evaluation.

60. X-ray.—In doubtful cases, fluoroscopy or teleoroentgenography is advised to determine the size and shape of the heart and great vessels. Films should be taken at a distance of 2 meters. The total transverse diameter of the heart is the most useful measurement in estimating cardiac size. If this exceeds the predicted transverse diameter (calculated according to the Hodges-Eyster formula), by more than 1 cm., the heart is considered to be enlarged. In the case of certain short, thick-set men a slightly greater figure may, at the discretion of the examiner, be regarded as within the range of normal, provided no other signs of cardiovascular disease are present. Films taken for the study of the lungs are not suitable for accurate estimation of the size of the heart.

61. General considerations.—*a.* It is incumbent upon examining physicians to—

(1) Accept for service men with functional murmurs or other findings which do not indicate disease and do not impair the individual's ability to undergo severe bodily exertion.

(2) Exclude from active service in the Army any individual affected with disease of the heart or blood vessels which impairs his ability to undergo severe bodily exertion. Although many men with compensated valvular heart disease are able to undergo severe bodily exertion, the question of aggravation in service, especially by activation of rheumatic carditis, is likely to arise and incidentally to create a pension problem. Therefore, all individuals with valvular heart disease are to be regarded as unfit for service and will be rejected.

b. Men who desire to serve their country may, from patriotic motives, endeavor to conceal a known valvular lesion which has given no symptoms. On the other hand, men drafted for service may allege or feign symptoms to obtain exception. Individuals may be expected to present physicians' certificates to substantiate the existence of valvular disease. Many of these may be given in good faith because of inadequate knowledge of the significance of certain physiological murmurs. Such certificates will not be accepted but examiners will satisfy themselves by their personal examinations as to the physical qualifications of individuals.

c. It is necessary, therefore, that the conclusions of the examining physician in doubtful cases be based on objective evidence in the widest sense, including physical signs, cardiac rhythm, measurement of blood pressure, and the observed effect of effort. Nevertheless, in the presence of questionable signs or symptoms, the verified history, especially of rheumatic fever, may be a factor in the final

decision. No statement, however, will be accepted as proof of the existence of a cardiovascular defect unless supported by objective evidence.

d. It is the duty of examining physicians to protect the interest of the Government by preventing the entrance into the service of men whose circulatory systems may be expected to break down under the strain. It is also their duty to prevent the exemption or discharge of fit subjects because of unimportant deviations from the normal. They will exercise care in the interpretation of their findings and bear in mind constantly accidental murmurs and other departure from the supposed normal which may occur in perfectly healthy hearts.

SECTION XVI

ABDOMINAL ORGANS AND WALL

62. Acceptable.—*a. Physical profile classification "1" and "2."*

(1) Abdominal scars because of surgical operation or accident which show no hernial bulging.

(2) Scar pain when found not associated with any disturbance of function of abdominal wall or contained viscera.

(3) Splenic enlargement of mild degree unassociated with evidence of other disqualifying disease.

(4) Small benign tumors of the abdominal wall.

(5) Internal and external hemorrhoids, if mild in degree.

(6) Relaxed inguinal ring, provided there is no hernial sac present.

(7) Hernia, small umbilical (patent umbilical ring).

(8) History of cholecystectomy, provided there are no residual disqualifying sequelae.

b. Physical profile classification "3."—Hernia, inguinal, which has not descended into the scrotum; femoral.

63. Nonacceptable.—Defects such as—

a. Hernia, inguinal, which has descended into the scrotum; recurrent; postoperative; ventral; umbilical, if moderate or large in size.

b. Acute or chronic cholecystitis with or without cholelithiasis, if diagnosis is confirmed by usual laboratory procedures or authentic medical history.

c. Ulcer of the stomach or duodenum, if diagnosis is confirmed by the usual laboratory procedures or authentic history of gastric or duodenal ulcer.

d. Authenticated history of surgical operations for gastric or duodenal ulcer.

e. Authenticated history of true intestinal obstruction of any kind.

f. Sinuses of the abdominal wall.

g. Stricture or prolapse of the rectum.

h. Fistula in ano.

i. Enlargement of the spleen associated with leukemia, Hodgkin's disease, aplenic anemia, or other disqualifying disease; great enlargement of the spleen from any cause.

j. External hemorrhoids sufficient in size to produce marked symptoms. Internal hemorrhoids, if large or accompanied with hemorrhage, or protruding intermittently or constantly.

k. Megacolon, diverticulitis, ileitis, and ulcerative coalitis.

l. Splenectomy for any cause, other than trauma or congenital hemolytic icterus.

m. Cirrhosis of the liver.

64. General considerations.—*a.* When necessary to confirm a diagnosis, examining physicians will avail themselves of fluroscopy and rontgengraphy.

b. When examining physicians are able to command hospital facilities and the necessary diagnostic apparatus, they will, within their discretion, use test meals and chemical and microscopic examination of the stomach contents and stools.

c. Examining physicians will make use of digital rectal examination of defects referable to that region and, when necessary, proctoscopy will also be utilized.

d. Individuals who are found to have parasites or their eggs in stools will have this condition indicated on report of examination.

e. Moderate impulse produced by cough at the inguinal, femoral, or umbilical ring, or at the site of a scar is not necessarily indicative of hernia.

f. In cases of suspected gastric or duodenal ulcer every effort will be made to obtain a trustworthy history, including authentic medical records.

SECTION XVII

VENEREAL DISEASES

65. Acceptable.—*a.* Gonorrhea, uncomplicated, acute, or chronic.

b. Syphilis, except cardiovascular, cerebrospinal, or visceral.

c. Chancroid, uncomplicated.

(Freedom from active or chronic venereal disease is required for enlistment or reenlistment in the Regular Army.)

66. Nonacceptable.—*a.* Stricture of the urethra, severe.

b. Gonorrheal arthritis.

c. Other complications of gonorrhea, including acute prostatitis, seminal vesiculitis, and epididymitis.

d. Cardiovascular, cerebrospinal, and visceral syphilis.

e. Granuloma inguinale.

f. Lymphogranuloma venereum (active).

67. General considerations.—Examination for the detection of venereal disease will include inspection of the skin and genitalia for lesions; cardiac and neurological examination to detect late complications of syphilis; blood serological test for syphilis, and in the case of each individual with latent syphilis, spinal fluid examination. Each individual requiring a spinal fluid examination will be hospitalized for this purpose, as authorized in paragraph 5*b*.

SECTION XVIII

GENITO-URINARY ORGANS

68. Acceptable.—*a.* Mild albuminuria without casts which is proved by observation and repeated examination to be temporary in character or orthostatic in type.

b. Absence of one testicle, unless removed on account of malignant disease or tuberculosis.

c. Undescended testicle which lies within the abdominal cavity.

d. Varicocele of moderate size.

e. Hydrocele of moderate size.

f. Epispadias or hypospadias, if mild in degree.

g. History of unilateral renal calculus with freedom from symptoms and if the X-ray is negative for calculi.

h. Phimosis.

69. Nonacceptable.—*a.* Acute or chronic nephritis.

b. Stricture of the uretha.

c. Urinary fistula or incontinence.

d. Acute or chronic infections of the kidney.

e. Absence of one kidney.

f. The presence of renal calculus, or a substantiated history of bilateral renal calculi at any time.

g. Chronic pyelitis.

h. Hydronephrosis or pyonephrosis.

i. Tumors of the kidney, bladder, or testicle.

j. Chronic cystitis.

k. Amputation of the penis, if the resulting stump is insufficient to permit normal function of micturition.

l. Hermaphroditism.

m. Hypertrophy of the prostate gland with urinary retention.

n. Episadias or hypospadias when urine cannot be voided in such a manner to avoid soiling of clothing or surroundings, or when accompanied by evidence of chronic infection of the genito-urinary tract.

o. Bed wetting, if substantiated by physician's affidavit or by other acceptable documentary evidence.

p. Varicocele, if large.

q. Hydrocele, if large.

r. Undescended testicle which lies within the inguinal canal.

s. Floating kidney (one that is freely movable).

70. General considerations.—*a.* Routine urinalysis to include determination of specific gravity and the absence or presence of albumen and sugar will be done on all individuals. Microscopic study of the urine will be done when indicated. Examining physicians should require examinees to void the urine in their presence. It must be emphasized here that prior to voiding the examinee must be examined for the presence of venereal disease. When albumin and/or casts are found in the urine, urinalysis should be repeated not less than twice a day on two or more successive days. If the urine shows albumin and/or casts and this condition of the urine is associated with enlargement of the heart, high blood pressure, and other evidences of cardiovascular-renal disease, the diagnosis of chronic nephritis may be made immediately. If the presence in the urine of albumin and/or casts is proved to be inconstant and if the condition is unassociated with evidence of cardiovascular and/or renal disease, decision should lie within the judgment and discretion of the examining physicians. When blood is found in the urine a thorough study will be made to determine the underlying cause.

b. When it is deemed necessary, examining physicians will employ X-ray facilities to verify diagnosis of defects of the genito-urinary organs.

SECTION XIX

ENDROCRINE AND METABOLIC DISORDERS

71. Acceptable.—*a. Physical profile classification "1" and "2."*

(1) Simple colloid goiter, provided the enlargement of the thyroid will not interfere with the wearing of a uniform or military equipment. See paragraph 45.

(2) Frohlich's syndrome, if mild in degree.

b. Physical profile classification "3."

(1) Frohlich's syndrome, if moderate in degree.

(2) Pellagra, beriberi, scurvy, sprue, and other nutritional deficiencies, if mild and remediable by diet and appropriate treatment.

72. Nonacceptable.—*a.* Toxic goiter. (It should be remembered that malingerers may use thyroid medication to produce many of the symptoms of thyrotoxicosis.)

b. Simple goiter with definite pressure symptoms or so large in size as to interfere with wearing a uniform or military equipment.

c. Cretinism.

d. Myxedema, spontaneous or postoperative (with clinical manifestations and diagnosis not based solely on low basal metabolic rate).

e. Gigantism or acromegaly.

f. Frohlich's syndrome, if severe.

g. Hyperparathyroidism and hypoparathyroidism when the diagnosis is supported by adequate laboratory studies.

h. Addison's disease.

i. Diabetes mellitus. If sugar is found in the urine, further specimens should be voided in the presence of the physician or authorized assistant, and on more than one occasion. In doubtful cases the fasting blood sugar should be determined. Consideration will be given to authentic medical records indicating the existence of diabetes mellitus.

j. Diabetes insipidus. (Before diabetes insipidus is diagnosed, malingering by drinking large quantities of water will be excluded.)

k. Nutritional deficiency diseases (including sprue, beriberi, pellagra, and scurvy) which are severe or not readily remediable or in which the permanent pathological changes have been established.

l. Persisting glycosuria.

m. Gout.

n. Simmonds' disease; Cushing's syndrome; other diseases because of a disorder of the pituitary gland.

o. Hyperinsulinism when established by adequate investigation and if regarded by the examiners as of sufficient degree to disqualify for military service.

SECTION XX

DISEASES OF BLOOD AND BLOOD-FORMING TISSUES

73. Acceptable.—*a.* Secondary anemia, mild, because of easily remediable causes.

b. Malaria, provided there is no history of incapacitating recurrences and no evidence of residuals.

74. Nonacceptable.—a. Hemophilia.
b. Thrombocytopenic purpura.
c. Pernicious anemia.
d. Aplastic anemia.
e. Hemolytic ictero-anemia (hemolytic jaundice).
f. Splenic anemia.
g. Polycythemia vera.
h. Leukemia, acute or chronic, of any type.
i. Malaria, with verified history of incapacitating recurrences or evidence of residuals.
j. Sickle cell anemia.
k. Hodgkin's disease.

SECTION XXI

NEUROLOGICAL DISORDERS

75. Methods of examination.—a. In order to detect the presence of certain common neurological diseases, particularly epilepsy, postencephalitic and post-traumatic syndromes, multiple sclerosis, drug addiction, and hysteria, information regarding the life history of the individual is essential. Therefore, a history will be obtained relative to convulsions, fainting spells, attacks of unconsciousness, routine use of any medicines, hospitalization, severe head injury, and educational and occupational history.

b. The neurological examination will be conducted as follows: The individual will be examined, stripped. He will walk a straight line at a brisk pace with his eyes open, stop, and turn around. He will then return in the same manner with his eyes closed, stop, and turn around. Look for spastic, ataxic, incoordinate or limping gait; absence of normal associated movements; deviation to one side or the other; the presence of abnormal involuntary movements; undue difference in performances with the eyes open and closed. The individual will then stand erect, feet together, arms extended in front. Look for unsteadiness and swaying, deviation of one or both of the arms from the assumed position, tremors, or other involuntary movements. With eyes closed, he will then touch his nose with the right and then the left index finger. Look for ataxia, tremors, overshooting, particularly at the end of the movement. Examine joint and spine movements and muscle condition. Look for muscular atrophy or pseudo-hypertrophy, muscular weakness, limitation of joint movement and spine stiffness. As to pupils, look for irregularity, inequality, diminished or absent contraction to light; movement of eyes, facial muscles, and tongue. Look for strabismus, ptosis, sustained nystagmus, tremors of retracted lips, asymmetry or tremors of face or tongue. Sensation will be examined by pressing lightly each side of the forehead, bridge of nose and chin, across the volar surface of each wrist, and dorsum of each foot. Look for inequality of sensation right and left. If these sensations are abnormal, vibration sense should be tested at ankles and wrists by tuning fork. With the eyes closed, he will run each heel from the opposite

knee to the ankle. Test sense of movement of great toes and thumbs. Look for diminution or loss of vibration and sense of position, and ataxia. Knee jerks and plantar reflexes should be tested. When indicated, appropriate laboratory tests and X-ray examinations will be made.

76. Acceptable.—These registrants present—

a. A healthy nervous system as manifested by absence of signs of disease of the brain, spinal cord, cranial, and peripheral nerves.

b. Certain variations clearly within physiological limits such as minor tremors.

c. Minor paralyses such as those resulting from poliomyelitis or lesions of the peripheral nerves not likely to interfere with training duties.

d. Individuals with local paralyses such as those because of poliomyelitis or nonprogressive disease of the peripheral nerves which have not interfered with locomotion and have not prevented the individual from successfully following a useful vocation in civil life.

77. Nonacceptable.—Any serious neurological disorders such as—

a. Neurosyphilis of any form (general paresis, tabes dorsalis, meningovascular syphilis).

b. Degenerative disorders (multiple sclerosis, encephalomyelitis, cerebellar and Friedreich's ataxia, athetoses, Huntington's chorea, muscular atrophies and dystrophies of any type; cerebral arteriosclerosis).

c. Residuals of infection (meningitis and abscesses, paralysis agitans, postencephalitic syndromes, Sydenham's chorea).

d. Peripheral nerve disorder (chronic or recurrent neuritis or neuralgia of an intensity which is periodically incapacitating, multiple neuritis, neurofibromatosis).

e. Residuals of trauma (incapacitating residuals of concussion or severe cerebral trauma, post-traumatic cerebral syndrome, incapacitating severe injuries to peripheral nerves).

f. Paroxysmal convulsive disorders and disturbances of consciousness (grand mal, petit mal, and psychomotor attacks, narcolepsy, not controlled by medication).

g. Miscellaneous disorders (spasmodic torticollis, brain and spinal cord tumors, operated and unoperated, cerebro-vascular disease, congenital malformations, including spina bifida if associated with neurological manifestations and meningocele even if uncomplicated, Meniere's disease).

78. Diagnostic criteria.—The following brief summary of diagnostic criteria is intended as a general guide for examiners. It includes the common manifestations of the more usual neurological disorders, but it is not intended to cover all diagnostic criteria or all neurological disorders.

a. Syphilis of central nervous system.

(1) *General paresis or meningoencephalitic syphilis.*—Look for unequal, irregular, or sluggishly reacting pupils or Argyll-Robertson pupil; facial tremor; speech defect in test phrases and in the slurring and distortion of words in conversation; writing defects, consisting of omissions and distortions of letters; defective memory; discrepancies in relating facts of life; inability to perform quickly and accurately simple problems of addition and subtraction in mental arithmetic. Knee jerks may be normal or overactive or underactive. The mood may be apathetic, depressed, or euphoric; other psychiatric symptoms may be of a schizophrenic or neurasthenic type.

(2) *Meningo-vascular or cerebrospinal syphilis.*—The prominent diagnostic signs and symptoms are headaches, history of mood changes or convulsions, varying deep and superficial reflexes, pupillary changes, ptosis, ocular palsies, and facial paresis. The mental state is normal, dull, or apathetic. Motor weakness may occur on one side of the body or in one extremity.

(3) *Tabes dorsalis (locomotor ataxia).*—Look for unequal, irregular, or sluggishly reacting pupils or Argyll-Robertson pupil; absent knee jerks; positive Romberg, ataxia gait, especially when the eyes are closed; hypotonia; and anesthetic areas of the skin. The history, usually of slow progression, may show failing sexual power or sphincter disturbances and pains in the legs or back, usually an irregular series of short, identical attacks of pain coming at intervals.

b. Multiple sclerosis.—A history of transitory weakness, numbness, ataxia of one or more extremities, transient diplopia, scotomata, or bladder disturbances should arouse a suspicion of multiple sclerosis. The presence of optic atrophy, scotomata, definite nystagmus, corneal hypoesthesia, absence or irregularity of abdominal reflexes, exaggerated deep reflexes, a Babinski or similar signs, or ataxia and euphoria are common manifestations.

c. Muscular dystrophies.—There is atrophy of the muscles in some forms, hypertrophy in others and, in general, decrease or loss of muscle power. In the pseudo-hypertrophic form some muscles are atrophied, others hypertrophied. In myasthenia gravis there is rapid fatigue of muscle power, appearing first in the facial and extrinsic eye muscles and later becoming generalized.

d. Athetosis, dystonia, torticollis, chronic chorea.—These are names given to various types of irregular, intermittent, involuntary movements, affecting various parts of the body, often associated with evidence of spastic paralysis. Simulation is possible and in doubtful cases previous medical records should be sought. Even mild manifestations disqualify.

e. Paralysis agitans.—Paralysis agitans is recognized by frozen facies, unwinking stare, rigidity of the muscles, stooped posture, slowness of movement, tremors, slow, monotonous speech, and typical gait. It may be unilateral. A history of encephalitis or influenza is obtained in only about one-half the cases. Even mild manifestations disqualify.

f. Multiple neuritis.—This may be associated with the dietary deficiencies, infection, or intoxication. The symptoms depend upon the cause and duration. They consist of pain, various combinations of dimunition or loss of motor power most marked in the distal part of the extremities, sensory diminution or loss, tenderness of the muscles and nerves, loss or diminution of reflexes.

g. Chronic neuralgias.—A history of severe constant or recurrent pain, confined to the area of distribution of a single nerve or segment, without objective changes, suggests this diagnosis. Clearly defined entities are sciatic and trigeminal neuralgias. Less common are suboccipital, brachial, and glossopharyngeal neuralgias. Neuralgias of other nerves are extremely rare and the diagnosis will be made with extreme caution. Neuritis, arthritis, bursitis, sinusitis and also hysteria and malingering must be considered in differential diagnosis. Evidence of previous treatment and the injection of procaine into the nerve presumably affected are important diagnostic aids.

h. Posttraumatic cerebral syndrome.—A history of head injury followed by headache, dizziness, loss of initiative, or change of personality is suggestive, but

independent confirmation of such alterations should be sought if possible. A dull apathetic expression, slight nystagmus, fine tremors, vasomotor changes, or abnormal sweating, are confirmatory evidence. If the syndrome is definite, even though mild, the individual should be rejected. The presence of signs indicating a focal lesion, even though mild, is also cause for rejection.

i. Paroxysmal convulsive disorders.—Look for deep scars on tongue, face, and head. Since no physical findings are pathognomonic, it is necessary to discover if the individual has had spells of unconsciousness, convulsions, "fits," "falling out," "spells," "lapses," "dizziness," or "fainting." The individual will be disqualified on a verified history of such spells or of multiple attacks of loss of consciousness, especially with incontinence or twitching, or of frequent momentary episodes of being dazed, or of uncontrollable outbursts of rage or irrational conduct or fugues, or unsuccessful treatment with anticonvulsive drugs. Such a history will be verified, if practicable, by a confirmatory medical record from a trustworthy source. The electroencephalograph is of great assistance in diagnosis, particularly in doubtful cases, but will not be used routinely. When a registrant is rejected for epilepsy, a statement will be made by the examining board giving the basis for the diagnosis. When the diagnosis is based wholly on the registrant's statement, in the absence of stigmata or a verified history, it will be so stated. It should be remembered that the epileptic may attempt to conceal severe defects in order to gain entrance to the military service.

j. Cerebral vascular accidents.—Characteristically, the onset is acute, with or without unconsciousness. Almost any focal disturbance may result. Evidence of peripheral arterial disease may be inconspicuous. The diagnosis disqualifies.

SECTION XXII

PSYCHOSES, PSYCHONEUROSES, AND PERSONALITY DISORDERS

79. General considerations.—The object of the psychiatric examination is to procure men who are without psychiatric disorders of such a degree of severity as to make impossible their rendering effective military service. To be effective, a man must have had the capacity, as demonstrated in civilian life, to function and adapt effectively.

80. Routine procedure.—The diagnosis of psychiatric disorders depends on whether an individual possesses qualities or patterns of behavior of such a nature and severity as to have seriously handicapped him in the conduct of his private life and affairs and/or in his interpersonal relationships. The evaluation of such factors in a man is accomplished by psychiatric examination and a knowledge of his past history. The latter may be gathered together from various sources; the man himself, his physician, the medical survey forms provided by the Selective Service System, hospital and court records, and other social service or welfare agencies. Attention will be given not only to unfavorable or negative data in the history, but also to the favorable or positive data, since a history of good adjustment in the past may be reasonably accepted as favoring a good adjustment in the military service as well.

81. **Minimum psychiatric examination.**—*a.* Mental and personality difficulties are most clearly revealed in the subject's behavior toward those with whom he feels relatively at ease. The most successful approach is often one of the straightforward professional inquiry coupled with real respect for the individual's personality and due consideration for his feelings, which does not mean diffidence. The routine or habitual use of questions that are emotionally charged, psychologically shocking, in bad taste, and are not customarily used in comparable civilian examination and practice, will be avoided.

b. The psychiatric examination will be made (at the end of the medical investigation) outside of easy hearing of other men. Matter of diagnostic significance is often concealed when the individual feels that he must be impersonal and give replies that will not impress listeners with his peculiarity.

c. Questioning will begin with something that is obviously relevant to the immediate situation. Information is elicited as to whether the individual suffers any symptoms of a psychiatric nature, and as to whether he has been well or poorly adjusted in the past and at present. The examiner pays close attention to content and implication of everything said and to any other clues and, in a matter-of-fact manner, follows up whatever is not self-evidently commonplace.

d. Despite the handicap of time limitations, the neuropsychiatrist will carefully avoid unscientific methods which give inadequate or inaccurate data. Thus, a neuropsychiatric examination consisting of a few leading and suggestive questions, such as "Do you worry?" "Are you nervous?" or "Do you have headaches or stomach trouble?" is inadequate, and positive answers to such questions are not in themselves justifiable cause for rejection. Isolated signs, such as nail biting, slight tremor, or vasomotor symptoms, are not disqualifying.

e. The probable presence of some types of psychiatric disorders, in particular the major psychoses and marked degrees of feeble-mindedness, may often be suspected by alert observation of the individual's behavior if the examiner knows what to look for and what to regard as significant. In other cases, one would not be able to suspect the presence of any morbid condition without some knowledge of the individual's history.

82. **Acceptable.**—*a.* Personalities usually classed as normal, attributes of which are—

(1) Evidence of ability to get along tolerably with family, friends, casual acquaintances, authorities in school or society, employers, and fellow workers.
(2) Conventional attitude toward sexual problems.
(3) Acceptable minimum mental requirements as indicated in profile serial chart, section II will be based upon levels of intelligence which have permitted a satisfactory adjustment in civilian life. Moderate degrees of mental deficiency in an emotionally stable individual are usually not incapacitating for military service.
(4) Sufficient stability and ability to obtain and keep, or at least to seek a job.

b. Stuttering or stammering of a degree which has not prevented the man from successfully following a useful vocation in civil life.

c. Psychoneurosis of any degree will be acceptable if it has not incapacitated in civil life.

d. History of transient psychotic reactions in an individual of otherwise clearly demonstrated stability are acceptable.

83. Nonacceptable.—Individuals who are found to have any serious psychiatric disorders such as—

a. Emotional instability of a degree which has incapacitated for civil life. Mental deficiency as an incapacitative disability will be determined in accordance with profile serial chart, section II.

b. Psychosis or authenticated recent history of psychosis.

c. Pathological personality types of a degree to have incapacitated for adjustment in civil life.

84. Diagnostic criteria.—*a. Mental deficiency.*—See paragraphs 85 to 87.

b. Psychosis.—Schizophrenic reaction (dementia praecox). This mental disorder is manifested by obscurely motivated peculiarities of behavior and thought. Of these, the so-called hebephrenic type is the most obvious. More difficult to identify is the simple type. These are the numerous shiftless, untidy, perhaps morose, sometimes nomadic individuals who have had what was regarded as a normal childhood. Somewhere between the ages of 12 and 25 they underwent a change, acute or insidious, with dilapidation of their social interests and the habits in which they had been trained. They may or may not have received treatment in hospitals for mental disease. The paranoid type is another large division. These persons cling to fantastic beliefs in their overwhelming importance, and often feel that people are persecuting them or otherwise interfering with their career or well-being. Some of them believe that they are in communion with supernatural beings. Others believe that they are victims of plots, secret organizations, spy rings, or religious or fraternal groups. They are often plausible in supporting these delusions by clever misinterpretation of facts. Some of them are very evasive and skillful at concealing the pattern of their disorder. A morbid suspiciousness of anyone who takes an interest in them is frequent. They may become tense and hateful when interrogated. An attitude of unusual cautiousness of suspiciousness toward the examining physician or toward fellow individuals should suggest the possibility that the individual may be paranoid. The catatonic states present great difficulty in diagnosis. Perhaps the only sign of these conditions is the impression of queerness which the person makes on anyone who seeks to get acquainted with him. The actual oddities of behavior or thought may be subtle; it may be difficult, in retrospect, to point to any particular instances of the unusual. The most striking signs of these conditions may in fact come out in connection with the physical examination. The physician, at some state of the physical examination, may observe a peculiar reaction which upon questioning may awaken a suspicion of a prepsychotic state. These individuals frequently entertain unfounded convictions as to bodily peculiarities or disorders which they attribute to excessive sexual acts of one sort or another. These beliefs, sometimes hard to elicit, are often medically incredible and bizarre. Questioning them on intimate personal matters often leads to great embarrassment, confused speech, or actual blocking of thought, so that they do not know what to say. Get history of family life and of school, vocational, and personal career.

c. Psychoneurosis.

(1) *Evaluating the degree of severity.*—In evaluating the degree of severity of psychoneurosis, the following factors will be considered:

(*a*) Type, severity, and duration of the symptoms existing at the time of the examination and/or in the past.

(*b*) Amount of external precipitating stress.

(c) Predisposition as determined by the basic personality makeup, intelligence, performance, and history of past psychiatric disorders.

(d) Impairment of functional capacity in civil life.

(2) *Types of reactions.*—The accepted types of neurotic reactions are as follows:

(a) *Anxiety reaction.*—In this type of reaction the anxiety is diffuse and not restricted to definite situations or objects, as in the case of the phobias. In such reactions, both the psychological and physiological aspects of the anxiety are felt by the patient, but only the physiological aspects are observable by the physician.

(b) *Dissociative reaction.*—This may occur in well-integrated personalities. In less acute cases, or in less well-integrated personalities, the repressed impulse giving rise to anxiety, may be either discharged or deflected into various symptomatic expressions such as fugue, amnesia, etc. Often this may occur with little or no participation on the part of the conscious personality. The diagnosis should specify the symptomatic manifestations of the reaction, such as depersonalization, dissociated personality, stupor, fugue, amnesia, dream state, somnambulism.

(c) *Phobic reaction.*—By an automatic mental mechanism, the anxiety in these cases becomes detached from some specific idea or situation in the daily life behavior and is displaced to some symbolic object or situation in the form of a specific neurotic fear. In civilian life, the commonly observed forms of phobic reaction include fear of syphilis, dirt, closed places, high places, open places, some animals, etc.; in military life, other specific fears have been observed, such as fear of specific weapons, combat noise, airplanes, etc. The patient can control his anxiety if he avoids the phobic object or situation.

(d) *Conversion reaction.*—This term is synonymous with "conversion hysteria." Instead of being experienced consciously (either diffusely or displaced as in phobias), the impulse causing the anxiety in conversion reaction is "converted" into functional symptoms or parts of the body, mainly under voluntary control.

(e) *Somatization reaction.*—The anxiety is relieved in such reactions by channeling the originating impulses through the autonomic nervous system into visceral organ symptoms and complaints. These reactions represent the visceral expression of the anxiety which is thereby largely prevented from being conscious. The symptom is due to a chronic and exaggerated state of the normal physiology of the emotion, with the feeling or subjective part repressed. Long continued visceral dysfunction may eventuate in structural changes. This group includes the so-called organ neuroses. It also includes certain of the cases formerly classified under a wide variety of diagnostic

terms such as "conversion hysteria," "anxiety state," "cardiac neurosis," "gastric neurosis," etc.

1. *Psychogenic gastrointestinal reaction.* —This subcategory may include some instances of such specified types of gastrointestinal disorders as peptic ulcer-like reaction, chronic gastritis, mucous colitis, constipation, "heart burn," hyperacidity, pylorospasm, "irritable colon," etc.
2. *Psychogenic cardiovascular reaction.*—This subcategory includes most cases of such established types of cardiovascular disorders as paroxysmal tachycardia, pseudoangina pectoris, neurocirculatory asthenia, and some types of hypertension.
3. *Psychogenic genito-urinary reaction.*—This subcategory includes some types of menstrual disturbances, impotence, frigidity, dysuria, etc.
4. *Psychogenic allergic reaction.*—Occasional instances of apparent allergic responses, including some cases of hives and angioneurotic edema, have a major emotional element in their production.
5. *Psychogenic skin reaction.*—This subcategory includes the so-called neurodermatoses, dermographis, and other related disorders when involving major emotional factors.
6. *Psychogenic asthenic reaction.*—General fatigue is the predominating complaint of such reactions. It may be associated with visceral complaints, but it may also include "mixed" visceral organ symptoms and complaints. Present weakness and fatigue may indicate a physiological neuroendocrine residue of a previous anxiety and not necessarily an active psychological conflict. The term includes cases previously termed "neurasthenia."

(*f*) *Obsessive-compulsive reaction.*—In this reaction, the anxiety may be observable in connection with obsessional fear of uncontrollable impulses. The patient himself may regard his ideas and behavior unreasonable and even silly, but nevertheless is compelled to carry out his rituals. The symptomatic expressions include such reactions as touching, counting, ceremonials, hand washing, recurring thoughts accompanied often by compulsion to repetitive action. They may include food, dirt, or germ phobias, or inflexible rituals of behavior.

(*g*) *Hypochondriacal reaction.*—Characterized by obsessive concern of the individual about his state of health or the condition of his organs. It is often accompanied by a multiplicity of complaints about different organs or body symptoms. Some of such reactions may become excessively and persistently obsessional and develop associated compulsions. Such cases may be classified more accurately as "obsessive-compulsive reactions."

(h) *Neurotic depressive reaction.*—A nonpsychotic response precipitated by a current situation—frequently some loss sustained by the patient—although dynamically the depression is usually related to a repressed (unconscious) aggression. The degree of the reaction in such cases is dependent upon the intensity of the patient's ambivalent feeling towards his loss (love, possessions, etc.), as well as upon the realistic circumstances of the loss. This reaction must be differentiated from the corresponding psychotic response.

d. Pathological personality types.—Such disorders are characterized by pathological trends in the personality structure, with minimal subjective anxiety, and little or no sense of distress. In most instances, the disorder is manifested by a life-long pattern of action or behavior ("acting out"), rather than by mental or emotional symptoms. The maladjustment of many individuals is evidenced by life-long behavior patterns. Such individuals are frequently described as personality types. In the evolution of psychoneuroses or psychoses, these types may be likened to abortive stages. They do not usually progress to the stage of psychosis. Nor do they justify a diagnosis of any type of neurosis or psychosis, although they may show some of the characteristics of both. They represent borderline adjustment states. The following types of pathological personality types will be differentiated:

(1) *Schizoid personality.*—Such individuals react with unsociability, seclusiveness, nomadism, and often with eccentricity.

(2) *Paranoid personality.*—Such individuals are characterized by many traits of the schizoid personality, coupled with a conspicuous trend to utilize a projection mechanism, expressed by suspiciousness, envy, extreme jealousy, and stubbornness.

(3) *Cyclothymic personality.*—Such individuals are characterized by frequently alternating moods of elation and sadness, stimulated apparently by internal factors rather than by external events. The patient may occasionally be either persistently euphoric or depressed, without falsification or distortion of reality.

(4) *Inadequate personality.*—Such individuals are characterized by inadequate response to intellectual, emotional, social, and physical demands. They are neither physically nor mentally grossly deficient on examination, but they do show inadaptability, ineptness, poor judgment, and social incompatibility.

(5) *Antisocial personality.*—This term refers to chronically antisocial individuals who, despite a normal background, are always in trouble, profiting neither from experience nor punishment, and maintaining no real loyalties to any person, group, or code. Ordinarily an individual of this type is not the calculating criminal, but one who is on the verge of criminal conduct and may eventually become involved in such conduct. This term includes most cases formerly classified as "constitutional psychopathic state" and "psychopathic personality" but, as defined here, the term is more limited as well as more specific in its application.

(6) *Asocial personality.*—This term applies to individuals who manifest their disregard for social codes and often come in conflict with them by becoming gangsters, vagabonds, racketeers, prostitutes, and generally environmental ("normal") criminals. Many such indi-

viduals are to be regarded as the normal product of a life-long abnormal environment. This term includes most cases formerly designated as "psychopathic personality, with asocial and amoral trends."

(7) *Sexual deviate.*—These conditions are often a symptom complex, seen in more extensive syndromes as schizophrenic and obsessional reaction. The term includes most of the cases formerly classed as "psychopathic personality, with pathologic sexuality." State whether overt or latent, and specify the specific type of the pathologic behavior, such as homosexuality, transvestitism, pedophilia, fetishism, and sexual sadism (including rape, sexual assault, mutilation).

e. Chronic addiction.

(1) *Addiction to alcohol.*—An individual will be regarded as a chronic alcoholic if he habitually uses alcohol to the point of social or physical disablement, as evidenced by loss of job, repeated arrests, or hospital treatment because of alcoholism. Such a history, if obtained, should be verified. Many chronic alcoholics exhibit the following signs and symptoms: suffused eyes, prominent superficial blood vessels of nose and cheek, flabby, bloated face, red or pale purplish discoloration of mucous membrane of pharnyx and palate; muscular tremor in the protruded tongue and extended fingers, tremulous handwriting, emotionalism, prevarication, suspicion, auditory or visual hallucinations, and persecutory ideas.

(2) *Addiction to drugs.*—The habitual use (or authentic history thereof) of narcotics is cause for rejection. If narcotics have been taken by hypodermic injection, there will be scars, usually on the skin of the forearms. Constricted pupils should be viewed with suspicion and the possibility of the use of narcotics investigated.

f. Behavior disorders.—These may or may not be cause for rejection depending upon their severity. They are cause for rejection if it is considered that the symptom itself has prevented adjustment and has been incapacitating in civil life. These disorders fall into the following groups:

(1) *Emotional immaturity.*—Certain individuals in rare instances are too inexperienced or too dependent on family ties to function effectively in the armed forces.

(2) *Stammering and stuttering.*—Cause for rejection if of such a degree that registrant is normally unable to express himself clearly or to repeat commands.

g. Not suited for military service.—Information and time are oftentimes inadequate to establish accurate diagnoses. In many instances the symptomatology and/or behavior may make disqualification of the registrant necessary, although not sufficiently well-crystallized to warrant the diagnosis of a clinical disease entity. To label a registrant with a diagnostic term in so brief an examination without adequate data available, is unscientific and unfair to the individual. Each clinical diagnosis will be based upon adequate historical and examinational evidence. In those instances where insufficient data are available to arrive at a diagnosis and where it is the neuropsychiatrist's considered opinion that the registrant is not acceptable, he will indicate that the individual is disqualified as "not suited for military service." The above clause, "not suited for military service," will be amplified by one of the following qualifications:

(1) *Because of severe antisocial tendencies.*—This will refer to instances of repeated conflicts with the law, severe truancy, a history of repeated stealing, check forging, combativeness, and other similar antisocial tendencies.

(2) *Because of severe neurotic symptoms.*—This will refer to long-standing psychosomatic complaints, persistent phobias or obsessions, frequent and long-continued medical and/or neuropsychiatric treatment, and recent or self-damaging somnambulism.

(3) *Because of severe emotional instability.*—This will refer to extreme fluctuations or excessive emotional states, mental hospital treatment.

(4) *Because of severe schizoid tendencies.*—This will refer to extreme seclusiveness, pronounced mannerisms, and queer or eccentric behavior.

(5) *Because of mental deficiency.*

(6) *Other.*—Other specific qualifying phrases may be utilized, such as "sexual deviate," or other pertinent phrases.

SECTION XXIII

INTELLIGENCE

85. General considerations.—Minimum intelligence requirements for military service are prescribed to insure that only men capable of absorbing training within reasonable limits of time will be inducted. Factors of intelligence measured by prescribed Army tests are not necessarily those measured by other tests of intelligence; therefore, intelligence tests other than authorized Army tests will not be used. Concepts such as *mental age* and *intelligence quotient* are not applicable to results achieved on Army tests, and will not be used to describe the mental level of individuals being tested. Further, since intelligence rather than education, is the criterion used to determine the trainability of an individual, references to the educational level attained by an individual are irrelevant when used to describe the level of intelligence.

86. Acceptable.—A man achieving the critical score or a higher score on one or more of the authorized tests is acceptable for induction. Examiners will use extreme care and judgment in reporting their findings on individuals' records. Such terms as "imbecile" and "moron" will not be used. A diagnosis of mental deficiency will be based on the results of objective tests interpreted in the light of the above considerations. Illiteracy per se is not to be classified as mental deficiency.

87. Nonacceptable.—Individuals whose intelligence level places them in profile 4, as shown in profile serial chart, section II, are not acceptable.

SECTION XXIV

PURPOSELY CAUSED PHYSICAL DEFECTS

88. Report of apparently purposely caused defects.—Whenever it appears to an examining physician that an individual is suffering from self-inflicted or

purposely caused physical defects which under the standards of physical examination prescribed herein would render him disqualified for military service of any kind, a full statement of the facts and of the condition of the individual and of the examining physician's recommendation will be prepared and submitted to the Director of Selective Service.

SECTION XXV

MALINGERING

89. Definition.—The malingerer is one whose complaints of bodily disorders and whose behavior or acts are in simulation of some physical or mental disease for the definite purpose of attaining a particular end which is more satisfactory to him or of seeking an escape from a fear-infested situation. Malingering is encountered in a number of situations but more frequently during the preliminary examinations and early training periods of military service. The simulation of neuroses and of physical disorders includes a wide variety of problems which must be differentiated from the ordinary neuroses as well as from physical illnesses. However, simulation is always in keeping with the extent of the knowledge possessed by the indivdual regarding the particular disorder from which he pretends to suffer and therefore constantly changes its methods and its maladies. A person gifted with histrionic talent and who has a considerable degree of knowledge and skill at his command may be able to simulate physical or mental conditions to such perfection that physicians may sometimes be deceived.

90. Differentiation.—*a.* For a disorder to be classed as *true* malingering, it must fulfill three conditions that—

(1) No obvious or frank disease or personality disorder is present.

(2) The individual is consciously aware of what he is doing and of the motive responsible for his attitude.

(3) He is fixed in carrying out a purpose to a preconceived result.

b. When confronted with a case of malingering the observer will try to ascertain how much of what constitutes the total picture is well-acted drama and consciously done and how much is true in part and more or less unconscious. For practical purposes these reactions may be divided into the following:

(1) Malingering for the purpose of attaining a definite end by simulation of a disease by one who has no past history of similar patterns of reaction but who is making an attempt to escape an emergency (temporary reaction); one who feigns his symptoms as a bluff and hopes to get away with it.

(2) Malingering to the extent of exaggerating or "capitalizing" conditions or symptoms that are present for the purpose of avoiding service. This includes an enlargement on minor physical ailments

or on relatively insignificant diseases, emphasizing mild personality problems or neuroses, and overemphasis on symptoms of fatigue, etc.

(3) Malingering as a manifestation of a psychopathic personality with a suggestion or definite history of previous psychopathic behavior. In intelligence, the psychopath may be retarded, of average endowment, or superior, but he is incapable of adjustment under ordinary life conditions. The ranks of psychopathic personality contain many persons having an irresistible tendency to alcoholism, drug addiction, sex perversion, and criminality, including numbers of cranks, extremists, eccentrics, hobos, and queer social misfits.

(4) The psychoneurotic suffering with hysteria, who believes in the reality of a disability which on the surface appears to be a definite simulation requires a special investigation. The confusion of hysteria with true malingering is not infrequently made by those who consider nearly all hysterics as malingerers with symptoms that could be controlled voluntarily. Some of these psychoneurotics exaggerate more or less unconsciously their symptoms to gain their ends, thus emphasizing the questions of how much is neurosis, how much is simulation, and how much is associated with a change in personality.

(5) Malingering or reactions considered to be malingering may appear in those basically psychoneurotic, insecure, and apprehensive, or physically ill, as well as in those suffering from psychoses, epilepsy, and organic brain disorders where there has been a definite change in personality. These reactions frequently confused with pure malingering may become much worse during investigation or attempted correction.

(6) It is believed that a firm, just, and positive leadership is the most effective aid in the prevention of malingering, and even more important, in the prevention of psychiatric disabilities. It is well known that there is a large group of individuals whose ability to withstand unfavorable stress is strengthened or weakened by the prevailing attitudes of their associates. They are dependent upon the support afforded them by those people in their immediate environment and particularly by such authoritarian figures as their leaders. In all social units, including the Army, the individual is dependent to some degree upon group pressure for support, and his actions are largely determined by group standards of acceptable and unacceptable behavior. If deviations from the acceptable standards of behavior are allowed to go unchallenged by those in leadership roles, the individual may conclude that the standards are wrong or that higher authority condones or even approves of such deviations. The loss of this important support obtained from authority may further increase the individual's conflict between his wishes (to escape unfavorable stress) and his sense of duty. Consequently, when misbehavior such as malingering is not dealt with promptly, it is conceivable that the added conflictual, psychological burden placed upon any personality under stress may precipitate a psychoneurotic response.

e. Among these five groups, the typical members are readily distinguished but intermediate and doubtful cases which resist differentiation do occur. It should

be kept in mind that it is even more difficult for a healthy person to feign disease than it is for a diseased person to simulate health and that a malingerer may be able to simulate and to accentuate single symptoms but he is practically always unable to feign the entire picture of the disease he has selected, and thus the expert can usually detect omissions, discrepancies, and contraditions in the situation.

91. Feigned medical diseases.—*a.* The detection and management of malingerers simulating medical diseases depend upon the absence of positive findings in an individual who presents the general characteristics of the malingerer. There is especial need for the physical examination to be thorough in this group. Some of the cardiac cases at first regarded as malingerers may later be found to have mitral stenosis or bacterial endocarditis. Similarly, proper tests may show the existence of peptic ulcer in those suspected of feigning digestive abnormalities. The estimation of the reality of rheumatic pains is always a difficult matter.

b. Tachycardia and thyrotoxicosis may be temporarily induced by ingestion of drugs such as thyroid extract. Egg albumin or sugar may be added to urine. Canned milk may be utilized to simulate urethral discharge. Cantharides may be taken to cause albuminuria. Digitalis and strophanthus may be taken to cause abnormal heart findings. The skin may be irritated by various substances. Cathartics may be taken to bring about purging or to simulate a chronic diarrhea. An appearance of hemoptysis may be produced by adding blood, either human or that of animals, to the sputa. Sometimes merely coloring matter is added. Those who can vomit voluntarily what they swallow use the same means to create the appearance of hematemesis. Similarly, coloring matter may be added to the stools. Mechanical and chemical irritants may be used to cause inflammation about practically all the body orifices. Jaundice may be simulated by taking picric acid. Artificial jaundice is recognized by demonstration of picric acid in the urine.

92. Feigned surgical conditions.—*a.* Under this are included old scars and injuries of the bones, fractures, and orthopedic conditions. Others may shoot or cut off their fingers or toes, usually on the right side, to disqualify themselves for service. Some may put their hands under cars for this purpose. Retention of urine may be simulated. Substances may be injected under the skin to create abscesses. Crutches, braces, strappings, or trusses may be used to give the appearance of disability. Wounds are rarely self-inflicted when witnesses are present, consequently it is almost impossible to be certain of malingering in some cases.

b. The motivation in self-inflicted wounds is a complicated psychological phenomenon. A type of personality is recognized as "accident prone," as attested to by long experience in industrial plants where 90 percent of all accidents occur in 15 percent of the workers. Most self-destructive attempts, both mutilation and suicide, are symptoms of grossly abnormal mental states, and many of these mental conditions are not classifiable as psychoses (insanity). Such "accidents" are recognized to occur in mentally dissociated states such as amnesia or fugues. Individuals with psychoneurosis of certain types are known to attempt self-destruction, either by incomplete or completely successful suicides. In all cases, therefore, not only is it essential to exclude the self-inflicted wound as a symptomatic expression of mental illness, but it is also necessary to prove intent to evade duty.

93. Feigned nervous or mental illness.—*a. Psychosis.*—Rarely feigned by individuals and then usually a silly, foolish type. In case of doubt, hospital observation is necessary, with verification of past records. Mental deficiency is frequently feigned, especially by illiterates.

b. Pain and hyperesthesia.—The most frequent of all complaints. History inconsistent, ordinary indications of suffering absent. Absence of other symptoms usually accompanies types of pain of which complaint is made. Absence of objective evidence of localized pains. Note behavior when the registrant believes himself unobserved.

c. Anesthesia.—Complaint of anesthesia itself creates a suspicion of malingering as most patients with anesthesia are ignorant of it.

d. Epilepsy.—Men who have sustained head injury may claim fits. These complaints may be in reference to grand mal or petit mal. Petit mal attacks are spoken of as fainting attacks. In grand mal attacks there is loss of pupil response to light, knee jerks are lost, and the Babinski reflex may be present.

e. Hysteria.—Not feigned in itself but its existence creates confusion as to malingering. The question to be decided is whether the individual is too seriously affected with the neurosis to be useful as a soldier.

f. Stiff back.—Stiff back is a frequent symptom of hysteria in mobilization among selected men. In cases of this kind, organic disease of the vertebrae can and will be excluded, if necessary by X-ray.

94. Simulated defects of vision.—See section V.

95. Simulated defects of hearing.—See section VI.

96. Bed wetting.—Bonafide severe enuresis substantiated by a physician's affidavit or other acceptable documentary evidence is cause for unconditional rejection.

97. General considerations.—*a.* All men suspected of malingering will be subjected immediately to a thorough psychiatric survey, which will include a careful history of their previous behavior and adjustment record and a complete physical, neurological, and laboratory evaluation. Observation in hospital may be required. Suspected malingerers found suffering from definite psychoneuroses and others in whom signs of mental disorders are detected will be rejected for military service.

b. Whenever it appears to an examining physician that an individual is endeavoring to escape service by malingering, if otherwise mentally and physically fit, he will be accepted.

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BY ORDER OF THE SECRETARY OF THE ARMY:

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