Ministry of Defence

JSP 950 MEDICAL POLICY
LEAFLET 6-7-7

JOINT SERVICE MANUAL OF MEDICAL FITNESS

SECTION 4: ENTRY MEDICAL EMPLOYMENT STANDARDS

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SECTION FOUR: THE INFLUENCE OF PARTICULAR CONDITIONS ON MEDICAL FITNESS FOR ENTRY

1. Introduction. These standards represent the agreed tri-Service minimum medical standards for entry. The single Services may apply a higher standard, particularly in relation to branches or trade groups where there are specific occupational fitness requirements e.g. aircrew, divers, marines, parachutists and submariners. Specific regulations on these groups are found in single Service publications[1] and referenced as appropriate in the annexes to this Section.

2. **General requirements.** New entrants to the Armed Forces must be medically fit to meet the various challenges of Service roles in which they will be expected to deploy; potentially anywhere in the world, at short notice, in locations remote from established medical care. Those with pre-existing conditions requiring periodic medical care or review, or with a requirement for long term medication, must be appropriately screened according to Section 3, in conjunction with the medical condition annexes.

3. **Physical activity.** Prior to their application, potential recruits should be capable of undertaking regular and substantial levels of exercise comparable with military training without experiencing adverse effects (e.g. symptoms of lower limb pain). This is to ensure that applicants can achieve levels of exercise that will be encountered during initial military training and Service. The following activities may be considered representative of the type of activities required:

a. Running 30 – 40 minutes a minimum of 3 x weekly.

b. Hill walking with 10 kg load (backpack) for 90 – 120 minutes (6 – 8 miles) weekly.

4. **Activity comparable with military Service/training.** It is this level of activity that is implied when the phrase “activity comparable with military service/training” is used in relevant annexes. Demonstrable evidence of said activity should be considered and highlighted in any specialist referral (if indicated).

5. Note: The potential candidate can only be advised to achieve an appropriate level of activity. Care must be taken to ensure that an “order” (and thus responsibility to the MOD) is not implied.

6. **Medical assessment.**

a. The recruitment medical assessment is to be based upon a functional assessment of the physical and mental potential to undertake military training, all general Service duties and serve in any environment worldwide for the period of the initial engagement being offered. Many conditions which may not limit civilian employment or sporting/recreational pursuits may be incompatible with military service.

b. Potential recruits are normally only accepted where they meet the standard for full deployability.

[1] Current versions of BRd1750a (RN) [accessed 12 Jan 26], AGAI 78 (Army) [accessed 12 Jan 26], AP1269A (RAF) [accessed 12 Jan 26], and any associated DINs or single Service Policy Letters.

c. Candidates with a lesser grading will not normally be accepted unless formal authority has been granted by the relevant Personnel or Executive Branch following medical advice[2].

7. **Definitions.** The following definitions apply throughout this section:

a. ***FIT*** *- Meets the Medical Entry Standard. Fit to undertake entry training and Service without restriction.*

b. ***UNFIT*** *- Not fit to undertake entry training and Service without additional medical risk.*

c. ***Normally UNFIT*** *- The expectation is that the candidate is UNFIT, but in exceptional circumstances, an experienced clinician may determine that the candidate is FIT[3].*

8. **Determining a candidate as FIT for Entry.** The annexes to this section give policy on when a candidate can be found FIT. There are 3 scenarios where a candidate may be found FIT:

a. **In the absence of conditions that are listed as excluding entry.** Candidates who meet the standard may be found FIT by examining clinicians.

b. **When candidates have a condition that determines they are 'Normally UNFIT'.** An examining clinician may determine that a candidate does not meet a medical standard and the Annex defines their condition as "are normally UNFIT". In such a scenario, after taking into account medical history, examination and function (in the context of the proposed Career Employment Group (CEG)), such candidates may be found FIT. The decision that these candidates are FIT may only be made by single Service Medical Entry Staff[4] (sSMES) or their delegated authority. The clinical justification for such decisions must be documented in the pre-employment medical assessment healthcare record. These candidates will still be fit to undertake entry training and Service without restriction.

c. **When candidates have a condition that determines they are 'UNFIT'.** Candidates who fulfil the criteria in the Annexes that would normally fulfil the definition of "are UNFIT" can, in some limited situations, after detailed consideration of medical history, examination and function and CEG be determined FIT in accordance with paragraph 9. Paragraph 9 gives single Service Occupational Physicians, responsible for Service Entry, discretion to use their clinical judgement. Such candidates will still be fit to undertake entry training and Service without restriction. The clinical justification for such decisions must be documented in the pre-employment medical assessment healthcare record.

[2] BRd1750a (RN), AGAI 78 (Army), AP 3391 Vol 3 Part B Lflt 220 (RAF).
[3] See paragraph 6b.
[4] SSMES must have appropriate oversight from a Consultant in Occupational Medicine.

9. **Determining a candidate UNFIT for Entry.** The annexes to this section give guidance on when a candidate is UNFIT.

a. These candidates will not normally be recruited.

b. Exceptionally candidates who are determined to be medically UNFIT may enter service through a single Service Executive/Personnel 'waiver'[5]. Advice must be sought by the Executive/Personnel from an Occupational Physician from the sSMES on restrictions which may be needed in training and in Service to inform the Executive decision. The responsibility for the final decision to accept a candidate into service and the recruiting risk lie solely with the Executive/Personnel function[6].

c. When a JMES (Joint Medical Employment Standard) is allocated, these candidates are to have Med Lim (Medical Limitation) 1302 allocated to facilitate longitudinal analysis and inform review of standards in future.

10. **Seeking additional guidance.** While this section and its annexes provide general direction, each case must be assessed on merit, with the intention to facilitate decision-making by examining clinicians. In addition, advice can be sought from sSMES on any candidate and in particular for those conditions not covered in the appropriate section.

11. **Discretion for single-Service Occupational Physicians responsible for Service Entry.** Occasionally, exclusion of a candidate in particular circumstances may be considered unreasonable. In such cases some discretion, consistent with single Service policies or on advice from the SSMES, may be appropriate and would normally require an Occupational Medicine Consultant opinion. Such candidates will be determined to be medically FIT. Candidates who the SSMES declare UNFIT can still enter if supported by the Executive through the waiver system (see paragraph 7).

12. Occasionally a candidate may have a number of conditions which, when taken together in their entirety either clinically or temporarily, make it reasonable to find them UNFIT[7]. This is because they have not demonstrated sufficient resilience or robustness over a sustained period and / or they are considered to be vulnerable to the demands of military service. This would normally require an Occupational Medicine Consultant opinion.

13. It may be appropriate to seek clinical opinion from civilian consultants, Service-appointed consultants or single Service or Defence Consultant Advisers through the sSMES (as required by single Service recruiting policy). In these cases, it is important for the referring medical officer to ask for an opinion about the nature and prognosis of a condition including likely requirements for treatment/medication and follow-up. The effect on function and fitness for service can then be determined by discussion with sSMES. In many cases an opinion rather than a formal consultation with the candidate will satisfy this requirement.

14. **Incidental findings**. Where previously undiagnosed conditions are discovered by examining clinicians, candidates are to be informed and their permission sought for their usual general practitioner (GP) to be notified. When such permission is not obtained,

[5] See Paragraph 4. Detail is included in single Service publications listed at Footnote 1.
[6] The Army's waiver use relates to special enlistment (specialist Knowledge, Skills & Experience). It is not a route open to most candidates who are rejected as UNFIT as it is not another level of appeal.
[7] For example, a candidate may have experienced anxiety, alcohol misuse, drug misuse, self-harm, eating disorders and depression as separate discrete episodes which may be within the entry standards if considered individually, yet may be considered UNFIT when considering the totality of their mental health issues.

candidates should be encouraged to report the circumstances to their own GP. Agreement to notify or not is to be recorded in the entry medical assessment paperwork. A letter to the GP is to be given to the candidate and a copy of the letter is to be retained in the applicant's entry medical examination record.

15. **Specific conditions.** Annexes A – N contain guidance on the effects of specific conditions on the fitness of a potential recruit to enter initial military training. The annexes are laid out by system, except for Annex N which contains a mixture of conditions that do not sit in the other annexes. Where the candidate presents with a condition not listed in the annexes, the opinion of the sSMES must be sought.

Annex A

EYES PRE-ENTRY

1. **General principles for assessing Candidates against this Annex.** The general principles against which a candidate is assessed as FIT for entry, with respect to their eyes, are:

a. **Function.** A Candidate must have the visual function, in all military environments, to safely and effectively:

(1) Perform their military role.

(2) Operate their personal weapon.

b. **Prognosis.** Where a candidate is found to have a resolved or current ophthalmic condition, the following general criteria should be met in addition to the relevant specific paragraph in policy, it should not:

(1) Be foreseeably exacerbated by military service (in particular blunt / penetrating trauma, extremes of heat / cold, atmospheric pressure, ultraviolet light or environmental conditions [e.g. dust]).

(2) Pose a significant risk of future temporary or permanent loss of function (in one or both eyes).

(3) Pose a risk of sudden deterioration / incapacitation without reasonable warning.

c. **Medical support requirements.** Where a candidate has a pre-existing or is at increased risk of an ophthalmic condition, there must be no reasonably foreseeable requirement for medical care within the deployed location beyond deployed Primary Healthcare (or equivalent). The medical condition must be stable with treatment. Should loss of medication occur for ≤ 1 week this should not lead to clinical deterioration in the condition or functional degradation during that time. In the deployed environment the condition should not foreseeably impact military medical resource.

2. **Exceptional considerations.** Criteria within each condition has been outlined to grade a candidate as FIT or UNFIT. Where there is any doubt, advice should be sought from the single Service Medical Entry Staff (sSMES).

3. **The role of P and EE qualities**. Conditions of the eye, orbit and eyesight are assessed and recorded under P. The entries under EE are records of distance visual acuity only (see Section 3). The minimum standards for both uncorrected and corrected visual acuity on recruitment are determined by single-Service authorities. These standards are dependent upon the proposed employment and trade group; irrespective of this, the

minimum standard is subject to the magnitude of correction required stated below.

Conditions affecting visual acuity and field

4. **Absence of a functioning eye.** Candidates with monocular (or uniocular) vision[1]; or reduction of corrected vision in one eye to below either entry EE standard are UNFIT. This is due to the elevated risk of blindness and incapacitation if the functioning eye is damaged by ballistic or blunt trauma on operations.

5. **Visual field defects.** Candidates with scotoma or limitation of binocular visual field (from any cause) which precludes holding Group 1 driving licence[2] or affects the central 15 degrees of right monocular vision[3] are UNFIT. Candidates require adequate visual fields to keep effective 'lookout' and operate a personal weapon safely.

6. **Double vision (diplopia).** Candidates with double vision are UNFIT. Candidates require the visual function required to perform their role safely and efficiently.

7. **Binocular Vision (stereopsis).** Binocular vision is not a requirement for Service Entry. Candidates may not meet the higher eyesight standards for certain trades. All cases should be referred for sSMES opinion on fitness.

8. **Night blindness (nyctalopia).** Candidates with night blindness, whether congenital or acquired, are UNFIT. Candidates need to be able to work in low light and tactical conditions.

9. **Refractive errors.** Candidates with refractive errors outside the limits stated below are UNFIT as the eyes are likely to be structurally abnormal. Patients with high myopia have a higher risk of traumatic or spontaneous retinal detachment which if not diagnosed and treated promptly may lead to permanent visual loss. Candidates with high hypermetropia have a higher risk of glaucoma, a sight-threatening condition.

    a. Equivalent Spherical Error (ESE) greater than +5.00 -6.00[4] dioptres.

    b. Cylindrical error greater than +3.00 or -3.00 dioptres in any meridian. Where the cylindrical error is greater than +/- 3.00 but less then +/- 5.00 dioptres, refer to footnote[5].

    c. To calculate the ESE and for further guidance on the application of this Standard see Appendix 1.

10. **Refractive Surgery.** The following methods of surgical correction of myopia or hypermetropia are suitable for entry subject to single-Service requirements:

    a. Photorefractive keratectomy (PRK).

[1] Uniocular: When one eye is normal and the other eye is either absent or is blind. Blind Eye: An eye possessing a best attainable corrected Snellen visual acuity (VA) of 6/60 or worse. Monocular: When an individual has two seeing eyes, one eye with normal vision but the other eye possessing a best corrected VA between 6/60 and 6/24.
[2] The latest edition of the DVLA publication 'Assessing fitness to drive: a guide for medical professionals' [accessed 12 Jan 26] provides guidance under 'Minimum standards for field of vision – all drivers'.
[3] Essential for safe weapon handling.
[4] Correspondence DCA Ophthalmology 16 Jun 21 to align with RCOpth definition of high myopia.
[5] Where the Cylindrical Error is greater than 3 dioptres (but less than 5D) then corneal topography along with Service Ophthalmology review is required to rule out keratoconus.

b. Laser epithelial keratomileusis (LASEK).

c. Laser in-situ keratomileusis (LASIK).

d. Small Incision Lenticule Extraction (SMILE).

e. Implantable Collamer Lens (ICL) with a central aqueous port.

11. Entry will not be considered for radial keratotomy (RK), or astigmatic keratotomy (AK), or any other form of incisional corneal refractive surgery, other than those procedures listed above. All invasive intraocular surgical procedures other than ICL implants will remain a bar to entry, as there is a higher risk of sight and non-sight threatening complications in the short and long term and the quality of vision can fluctuate. Candidates require the visual function required to perform their role safely and efficiently.

12. **Considerations.** The prospective entry candidate must provide appropriate documentary evidence that they fulfil all the following criteria:

a. The total preoperative refractive error was not outside the limits for selection. Refractive surgery does not change the underlying risks associated with high hypermetropia or myopia,

b. The preoperative best spectacle corrected visual acuity was within selection limits, as the refractive surgery outcomes for high myopia and high hypermetropia are less favourable, and refractive surgery does not change the underlying risks associated with high hypermetropia or myopia,

c. At least six months have elapsed since the date of the last surgery or enhancement (to be extended to a period of one year if the candidate was aged 21 or younger at the time of the surgery). This is to allow healing and stability of vision,

d. There have been no significant visual side effects secondary to the surgery affecting daily activities or night vision (such as glare, haloes), persistent discomfort, requirement for topical eye medication) beyond 180 days post procedure,

e. Stability of refraction post-procedure: no more than 0.50 dioptre difference in the spherical equivalent or cylindrical correction of either eye should be demonstrated by two separate refractions at least 90 days apart.

13. A single revision of corneal refractive surgery is acceptable, subject to the candidate meeting all the criteria as above, including the preoperative limits before the first corneal refractive surgery.

Conditions affecting eye movements (ocular motility)

14. **Involuntary eye movements (nystagmus).** Candidates with involuntary eye movements which impair visual function are UNFIT unless mild, long-standing, asymptomatic, and not impairing visual function. Candidates require the visual function required to perform their role safely and efficiently.

15. **Squint.** Candidates with a squint are often hypermetropic and may be amblyopic (total or partial) and may therefore fail to correct to a reasonable level of Visual Acuity.

They will also have poor binocular vision (stereopsis).[6] This may affect suitability for some roles (e.g. aircrew) although the ability to fire a standard weapon is unlikely to be compromised. Candidates with a squint and acceptable Visual Acuity are normally FIT. Candidates with a history of incomitant squint[7] are UNFIT. An incomitant squint is change in the degree of squint in different positions of gaze and is associated with blurred or double vision. Most squints do not fall into this category. Candidates require the visual function required to perform their role safely and efficiently.

16. **Squint correction surgery.** Candidates who had squint correction surgery within preceding 6 months are UNFIT. This is to allow for adequate healing and adaptation of eyesight. Candidates require the visual function required to perform their role safely and efficiently. See para 12c and 12b (above).

17. **Orbital fractures and reconstruction.** Candidates with a history of orbital fractures and reconstruction causing chronic pain or restriction of ocular motility[8] sufficient to impair performance in role are UNFIT. Candidates require the visual function required to perform their role safely and efficiently. The presence of metalwork, provided ocular function and mobility are normal, is not a bar to entry.

Conditions affecting eyelids

18. **Eyelid inflammation (blepharitis).** Candidates with eyelid inflammation are UNFIT until it is controlled without the requirement for regular prescription only medication.[9] This is foreseeably exacerbated by military service in variable environmental conditions (e.g. temperature, humidity, wind, dust) leading to reduced visual function. Candidates require the visual function required to perform their role safely and efficiently.

19. Uncontrollable closure of the eyelids (blepharospasm). Candidates with uncontrollable closure of the eyelids that impairs visual function are UNFIT. Candidates require the visual function required to perform their role safely and efficiently.

20. **Damage to the eyelids or eyelid movement.** Candidates with damage to the eyelids or eyelid movement (including ptosis) sufficient to impair protection of the eye or affecting the visual fields are UNFIT. This poses a significant risk of future temporary or permanent loss of function (in one or both eyes).

21. **Turning in or out of the eyelids (entropion or ectropion).** Candidates with turning in or out of the eyelids are UNFIT until surgically repaired.as these are foreseeably exacerbated by military service in variable environmental conditions (e.g. temperature, humidity, wind, dust). Candidates require the visual function required to perform their role safely and efficiently.

Conditions affecting tear system (lacrimal apparatus)

22. **Persistent watery eyes (chronic epiphora).** Candidates with persistent watery eyes which impairs visual function are UNFIT. Candidates require the visual function to perform their role and operate personal weapon safely and efficiently. Chronic epiphora is disabling, causing discomfort and impairing visual function.

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[6] See Para 7 (binocular vision).
[7] For example, Duane Syndrome.
[8] See Para 15 (incomitant squint).
[9] The use of over-the-counter (non-prescription) medications is acceptable.

23. **Inflammation of the tear sac (dacryocystitis) as an adult.**[10] Candidates with inflammation of the tear sac are UNFIT. Dacryocystitis is usually associated with blocked tear drainage, epiphora (as above) and is often recurrent. Candidates require the visual function required to perform their role safely and efficiently.

24. **Dry eye syndrome (keratoconjunctivitis sicca or associated with Sjogren's Syndrome)**[11]**.** Candidates with dry eye syndrome which impairs visual function UNFIT. Candidates require the visual function required to perform their role safely and efficiently.

Conditions affecting the front of the eye (cornea, conjunctiva, sclera)

25. **Keratitis / ulcer.** Candidates are UNFIT until fully resolved. Candidates with more than one episode are UNFIT. Candidates require the visual function required to perform their role safely and efficiently. This poses a significant risk of future temporary or permanent loss of function (in one or both eyes).

26. **Corneal dystrophy.** Candidates with corneal dystrophy which impairs visual function are UNFIT. Candidates require the visual function required to perform their role safely and efficiently. This poses a significant risk of future temporary or permanent loss of function (in one or both eyes).

27. **Corneal graft.** Candidates with a corneal graft are UNFIT due to risk of eyeball rupture following minor trauma and graft rejection. This poses a significant risk of future temporary or permanent loss of function (in one or both eyes).

28. **Corneal vascularisation or opacity.** Where visual acuity is below single-Service entry standards, Candidates are UNFIT. Candidates require the visual function required to perform their role safely and efficiently.

29. **Conjunctival infection / inflammation (conjunctivitis).** Candidates with acute conjunctivitis are FIT once the condition has resolved. Candidates with chronic conjunctivitis are UNFIT. Candidates require the visual function required to perform their role safely and efficiently.

30. **Conjunctival abnormality such as pterygium.**[12] If threatening the visual axis, causing irritation or pain, candidates are UNFIT. Candidates require the visual function required to perform their role safely and efficiently.

31. **Keratoconus (thinning of the cornea).** Candidates with keratoconus are FIT provided they meet all the following criteria.

a. Candidates with a diagnosis of keratoconus or corneal ectasia may be considered suitable for service after they have undergone a corneal crosslinking procedure (CXL) and subsequently demonstrate stability determined by two post-operative 'Pentacam' corneal topography examinations and subjective refractions, to be conducted not less than 12 months apart. No specific CXL technique (epithelium-on, epithelium-off) is required. Stability is defined by the following criteria:

(1) No increase in Kmax by greater than or equal to 1.00 dioptres,

[10] Childhood dacryocystitis usually affects infants and spontaneously resolves.
[11] Candidates with a single episode of episcleritis which has resolved are FIT.
[12] Recurrence is 10-30% after surgery, depending on type of surgery.

(2) No increase in cylinder by greater than or equal to 0.50 dioptres (on Pentacam or subjective refraction),

(3) No more than 0.50 dioptres myopic shift (decrease in spherical equivalent as measured by subjective refraction),

(4) Candidates must also meet visual requirements per Service with spectacle use (no Rigid Gas Permeable contact lenses to be used for one month prior to exam).

32. Candidates are UNFIT due to the presence of advanced keratoconus if either of the following post-operative criteria apply:

a. Central Corneal Thickness < 400 um.

b. Kmax > 58 dioptres.

33. Candidates with a diagnosis of progressive corneal ectasia or keratoconus who have not undergone CXL are UNFIT. Candidates require the visual function required to perform their role safely and efficiently. This poses a significant risk of future temporary or permanent loss of function (in one or both eyes).

34. **Inflammation (scleritis).** Candidates are UNFIT. Any single or recurrent episode. This poses a significant risk of future temporary or permanent loss of function (in one or both eyes). Candidates with a single episode of episcleritis which has resolved are FIT.

Conditions affecting the lens

35. **Absent lens (aphakia).** Candidates are UNFIT. Candidates require the visual function required to perform their role safely and efficiently.

36. **Intraocular lens implant (pseudophakia).** Candidates who are pseudophakic are UNFIT. Candidates require the visual function required to perform their role safely and efficiently.[13]

37. **Lens opacity (including cataracts or past cataract surgery).** Service-approved specialist opinion is required. Candidates require the visual function required to perform their role safely and efficiently.

38. **Lens dislocation, partial or complete.** Candidates are UNFIT. Candidates require the visual function required to perform their role safely and efficiently.

Conditions affecting the middle eye (iris, uveal tract)

39. **Missing tissue to the eye (coloboma) (excluding iris[14]).** Candidates are UNFIT. This condition is usually associated with abnormal visual function and risk of associated conditions, such as retinal detachment in the case of retinal coloboma and visual field defects in the case of optic nerve coloboma. Candidates require the visual function

[13] With the exception of those who have had Implantable Collamer Lens (ICL) surgery which incorporates a central aqueous port while retaining the biological lens. These candidates may be acceptable in accordance with Para 10, above.
[14] Iris colobomata are generally benign, unless associated with other systemic syndromes and are normally acceptable.

required to perform their role safely and efficiently. This poses a significant risk of future temporary or permanent loss of function (in one or both eyes).

40. **Uveitis.**[15] Candidates with chronic or recurrent (more than once); anterior, intermediate or posterior (syn-iritis, pars-planitis, vitritis, choroiditis, panuveitis) are UNFIT. Candidates require the visual function required to perform their role safely and efficiently. This poses a significant risk of future temporary or permanent loss of function (in one or both eyes).

Conditions affecting the back of the eye (retina, macula)

41. **Vascular lesions.** Coats disease, sickle cell retinopathy, choroidal neovascular membranes and retinal venous and arterial occlusions are UNFIT, due to being associated with abnormal visual function and future risk of deterioration. Candidates require the visual function required to perform their role safely and efficiently.

42. **Retinitis, active or recurrent.** Candidates are UNFIT. Retinitis poses a significant risk of future temporary or permanent loss of function (in one or both eyes). Candidates require the visual function required to perform their role safely and efficiently. Candidates with retinitis pigmentosa (not a true retinitis) are UNFIT for the reasons stated above. Non progressive sectoral Retinitis Pigmentosa may be FIT following service-approved ophthalmological review.

43. **Retinal detachment.** All cases with a history of retinal detachment[16] are to be referred to a service ophthalmologist. This poses a significant risk of future temporary or permanent loss of function (in one or both eyes).

44. **Macular dystrophies or degenerations.** Candidates are UNFIT. This poses a significant risk of future temporary or permanent loss of function (in one or both eyes).

45. **Central serous retinopathy.** Candidates are UNFIT because of the high risk of recurrence.

Conditions affecting the optic pathways (optic nerve)

46. **Neuritis.** Candidates are UNFIT. This condition is associated with systemic disease such as multiple sclerosis and poses a significant risk of future temporary or permanent loss of function (in one or both eyes).

47. **Neuropathy.** Candidates are UNFIT. This condition results in impairment of visual function and poses a significant risk of future temporary or permanent loss of function (in one or both eyes).

48. **Papilloedema**. Candidates are UNFIT. This poses a significant risk of future temporary or permanent loss of function (in one or both eyes). A history of prior self-limiting papilloedema with low risk of recurrence, such as after meningitis, must be referred to sSMES.

[15] Prognosis after traumatic uveitis, e.g. from intra-ocular foreign body, is good and recurrence uncommon. Candidates may be determined FIT following a favourable assessment by a specialist.
[16] There will be cases that may be acceptable, e.g. if the retina has been adequately reattached and the vision is good, the refraction stable and within limits, no significant anisometropia, the visual field full and the ocular motility normal.

49. **Glaucoma or history of ocular hypertension.** Candidates are UNFIT. This poses a significant risk of future temporary or permanent loss of function (in one or both eyes).

50. **Calcium aggregates in the optic nerve (Drusen).** These are rarely symptomatic but should be assessed as follows:

a. Drusen + normal visual field, FIT with no further input required.

b. Drusen with any reduction in visual field, but within normal vision entry criteria, refer to Service Ophthalmology.

c. Drusen not meeting entry criteria for visual function, UNFIT.

Other conditions and procedures

51. **Globe (eyeball) trauma.** Candidates with a history of penetrating injury to either eye resulting in abnormal function are UNFIT. Candidates require the visual function required to perform their role safely and efficiently. Those with such a history who achieve the Visual Acuity and other visual functional requirements should be referred for a Service ophthalmological opinion.

52. **Neoplasm (cancer).** Candidates with a history of ocular cancer are UNFIT. Those with such a history who achieve the Visual Acuity, other visual functional requirements and have been discharged from routine follow up should be referred for a Service ophthalmological opinion. This poses a significant risk of future temporary or permanent loss of function (in one or both eyes).

53. **Ophthalmic migraine.** See Annex G Neurological Para 11.

Appendices

1. Assessing Refractive Error - Supporting Notes and Flow Chart

2. Cylindrical Error Flowchart

Appendix 1 to
Annex A

ASSESSING REFRACTIVE ERROR - SUPPORTING NOTES AND FLOW CHART

Calculation of Spherical Equivalent (Equivalent Spherical Error (ESE))

1. The Equivalent Spherical Error (ESE) is the total refractive error, calculated as the spherical component of refraction added to HALF of the cylindrical component of refraction. The unit of measurement is dioptres (D). For example:

a. Spherical +4.00D with cylindrical +2.00D = (+4.00D) + (2.00D/2) = ESE +5.00D

b. Spherical +7.00D with cylindrical -3.00D = (+7.00D) + (-3.00D/2) = ESE +5.50D

2. The Standard refers to the calculated ESE and NOT to the Spherical Component. The individual spherical component is NOT to be used in isolation. For example:

a. Spherical -6.50D with cylindrical +2.00D = (-6.50D) + (+2.00D/2) = ESE -5.50D. In this example, even though the spherical component is greater than -6.00D, the calculated spherical equivalent is only -5.50D. The candidate is therefore FIT.

b. Spherical -5.50D with cylindrical -2.00D = (-5.50D) + (-2.00D/2) = ESE -6.50D. In this example, even though the spherical component is less than -6.00D, the spherical equivalent is greater than -6.00D. The candidate is therefore UNFIT.

3. The standard refers to the cylindrical component which IS to be used in its own right, as well as to calculate the Spherical Equivalent Error (ESE). For example:

a. Spherical +4.00D with cylindrical -2.00D = (+4.00D) + (-2.00D/2) = ESE +3.00D. In this case, the cylindrical component is less than -3.00D and the calculated ESE is less than +5.00D. The candidate is FIT.

b. Spherical +5.50D with cylindrical -2.00D = (+5.50D) + (-2.00D/2) = ESE +4.50D. In this case, the cylindrical component is less than -3.00D and the calculated ESE is less than +5.00D. The candidate is FIT.

c. Spherical +4.50D with cylindrical +2.00D = (+4.50D) + (2.00D/2) = ESE +5.50D. In this case, the cylindrical component is less than -3.00D, but the calculated ESE is greater than +5.00D. The candidate is UNFIT.

d. Spherical +2.50D with cylindrical -4.00D = (+2.50D) + (-4.00D/2) = ESE + 0.50D. In this example, even though the calculated ESE is less than +5.00D, the cylindrical component is greater than -3.00D. The candidate requires corneal topography and Service Ophthalmology opinion. The Candidate is FIT.

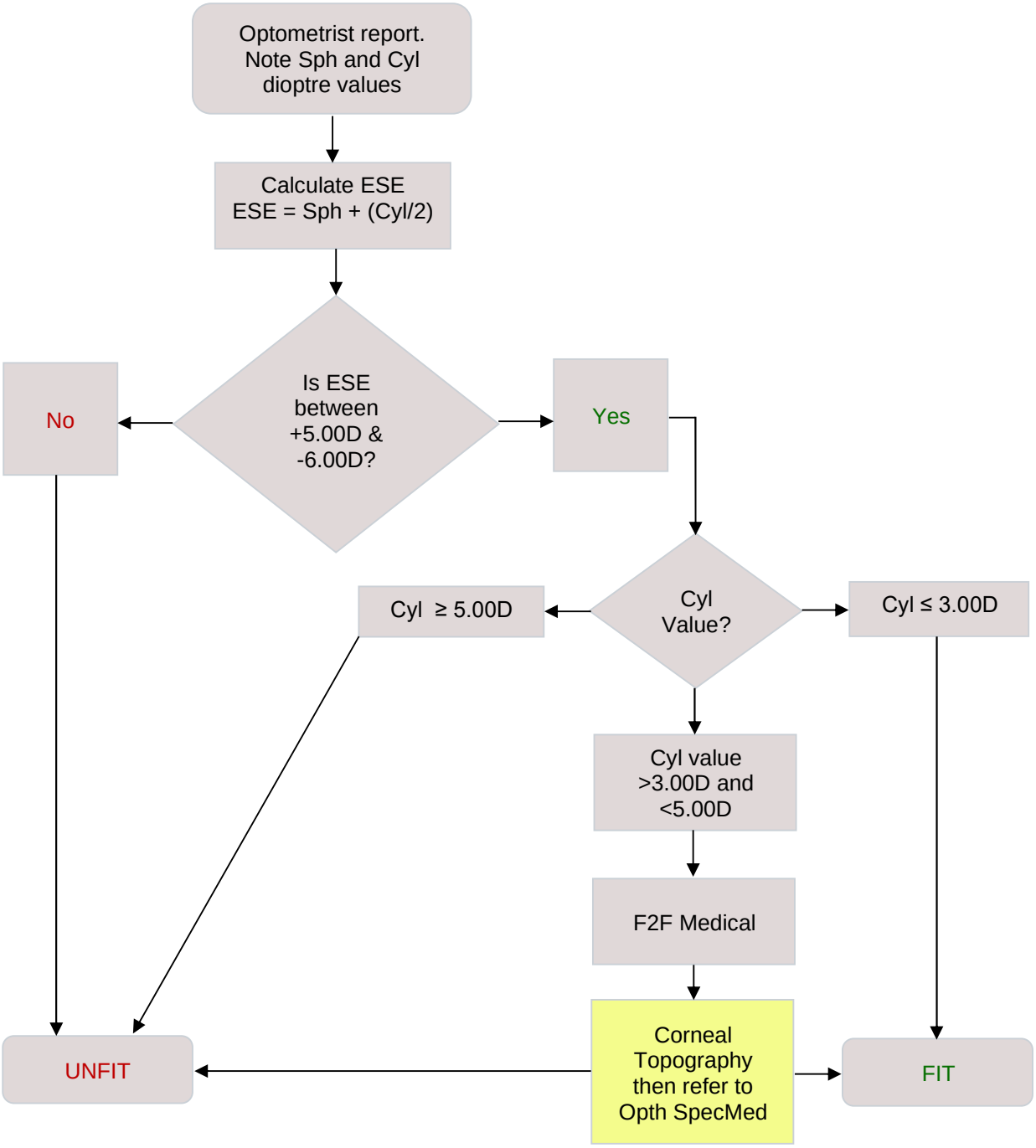
e. Spherical +2.50D with cylindrical -6.00D = (+2.50D) + (-6.00D/2) = ESE -0.50D. In this example, even though the calculated ESE is less than -6.00D, the cylindrical component is greater than -5.00D. The candidate is UNFIT.

Examples

Sph	Cyl	ESE	Outcome	Reason
+4.00D	-3.00D	+2.50D	FIT	ESE in standard
+4.00D	-5.00D	+1.50D	UNFIT	Excessive Cyl
+4.00D	-4.00D	+2.00D	Corneal Topography with Service Ophthalmology opinion – possibly FIT	Cyl >3.00D, <5.00D ESE acceptable
+4.00D	+2.50D	+5.25D	UNFIT	ESE outside standard
-5.75D	+2.00D	-4.75D	FIT	ESE in standard
-5.75D	-2.00D	-6.75D	UNFIT	ESE outside standard
-5.75D	+3.50D	-4.00D	Corneal Topography with Service Ophthalmology opinion – possibly FIT	Cyl >3.00D, <5.00D ESE acceptable
-5.75D	-3.50D	-7.50D	UNFIT	ESE outside standard

Appendix 2 to
Annex A

CYLINDRICAL ERROR FLOWCHART



Annex B

EAR, NOSE AND THROAT PRE-ENTRY

1. **General principles for assessing candidates against this Annex.** The general principles against which a candidate is assessed as FIT for entry, with respect to their ears, nose and throat (ENT) are:

a. **Function.** A candidate must have an adequate level of auditory, respiratory, vestibular (balance) function in all military environments to:

(1) Safely perform their military role.

(2) Accurately hear instructions including radio communications and auditory warnings.

b. **Prognosis.** Where a candidate is found to have a resolved or current ENT condition, the following general criteria should be met in addition to the relevant specific paragraph in policy, it should not:

(1) Be foreseeably exacerbated by the demands of military service (for example noise exposure, extremes of heat / cold, atmospheric pressure, or environmental conditions such as dust and allergens).

(2) Pose a significant risk of future temporary or permanent loss of function (for example hearing loss in one or both ears).

(3) Pose a risk of sudden deterioration / incapacitation without reasonable warning.

c. **Medical support requirements.** Where a candidate has a pre-existing or increased risk of an ENT condition, there must be no reasonably foreseeable requirement for medical care within the deployed location beyond deployed Primary Healthcare (or equivalent). The medical condition must be stable with treatment. Should loss of medication occur for ≤ 1 week this should not lead to clinical deterioration in the condition or functional degradation during that time. In the deployed environment the condition should not foreseeably impact military medical resource.

2. **Exceptional considerations.** Criteria within each condition has been outlined to grade a candidate as FIT or UNFIT. Where there is any doubt, advice should be sought from the Single Service Medical Entry Staff (sSMES).[1]

Hearing function

3. Candidates are assessed according to their un-aided hearing level. Both ears are tested and the worse grade on either ear is used as the maximal grade that the candidate can achieve.

[1] Delegated Authority arrangements may apply.

a. An audiogram result of H1 will mean the candidate is FIT.

b. A grade of H2 and within the warning range of the HSE hearing categorisation[2] but below referral level needs to be reviewed by sSMES. The candidate may be subject to additional audiometry screening in-service.

c. A grade of H3 or lower, or above HSE referral level is UNFIT due to the requirement to hear well to perform in a military environment, especially when performing safety critical tasks and the increased likelihood of disability arising from further hearing loss.

d. Any candidate who needs a hearing aid to restore normal function is UNFIT. The use of hearing aids is incompatible with military personal protective equipment and the use of communications headgear.

Conditions affecting the external ear

4. **Deformity of the pinna (outer ear).** Candidates with minor deformities of the pinna which do not interfere with the wearing of hearing protection or communication devices (in ear, on ear, and integrated) are FIT. Candidates with deformity of the pinna sufficient to interfere with the wearing of such devices (which are essential for safe and effective military operations) are UNFIT.

5. **Otitis Externa (inflammation, irritation or Infection of the external ear canal).** Candidates who have had more than one episode of Otitis Externa not requiring specialist intervention are FIT. Candidates with recurrent or persistent Otitis Externa who have required specialist treatment are UNFIT. This is because of the risk of recurrence without reasonable warning, which can cause distracting pain, narrowing of the ear canal and can affect a candidate's functional hearing ability. It can also cause issues with wearing hearing protection or communication devices (in ear, on ear, and integrated), all of which could impact their ability to safely perform their military role.

Conditions of the middle and inner ear

6. **Perforated tympanic membrane (hole or tear in the ear drum).** Candidates are FIT three months after a complete spontaneous healing or successful surgery (tympanoplasty) to repair a perforation, provided hearing acuity is within entry limits and, if tympanoplasty has occurred, tympanometry[3] is normal. Candidates with a current perforation are UNFIT because it affects their ability to hear properly and predisposes to ear infections.

7. **Acute Otitis Media (AOM) (infection of the middle ear).** Candidates who have had more than one episode of AOM not requiring specialist intervention are FIT. Candidates with recurrent or persistent AOM, who have required specialist treatment, are UNFIT. This is because of risk of recurrence without reasonable warning. Recurrent AOM affects a candidate's ability to hear properly, which impacts military performance in challenging environments. Candidates may be determined FIT provided they meet all the following

[2] The HSE categorisation is age and sex standardised, starting at age 18. Candidates aged lower than 18 at the time of application should be judged as if aged 18. (DCA ENT/ORL opinion).
[3] Tympanometry is a test that shows how well your middle ear is working. It does this by measuring how your eardrum moves NHS Hearing Tests [accessed 12 Jan 26]

criteria:

a. The last episode resolved at least 12 months ago,

b. The ear drum has healed,

c. Hearing acuity is within entry limits,

d. If tympanoplasty was required, tympanometry is normal.

8. **Chronic Otitis Media (COM) (ongoing chronic infection of the middle ear).** Candidates with inactive or healed COM who are no longer under specialist follow-up are FIT provided they meet all the following criteria:

a. The last episode resolved at least 12 months ago,

b. The ear drum has healed,

c. Hearing acuity is within entry limits,

d. If tympanoplasty was required, tympanometry is normal.

9. **Candidates with active COM (including cholesteatoma[4])** are UNFIT because it limits the ability to hear properly and perform military duties, can suddenly deteriorate without reasonable warning, predisposes to other infections and place a high demand on medical services.

10. **Surgical tubes in the ear drum.** Ventilation tubes (grommets, T- tubes). Candidates who have had ventilation tubes which are no longer in place are FIT provided they meet all the following criteria:

a. The ear drum has healed,

b. Hearing acuity is within entry limits,

c. If tympanoplasty was required, tympanometry is normal,

d. Remained symptom free for at least 6 months, due to the risk of recurrent middle ear effusion (glue ear).

11. **Candidates with ventilation tubes in place are UNFIT.** This is because it limits the ability to hear properly and safely perform their military role, can suddenly deteriorate without reasonable warning, and predisposes to other infections.

12. **Myringitis (inflammation of the ear drum).** Candidates with active or unresolved myringitis are UNFIT due to the risk of sudden deterioration without reasonable warning. This is because it affects a candidate's ability to hear properly and safely perform their military role.

13. **Mastoidectomy (surgical removal of cells from the mastoid bone within the**

[4] A cholesteatoma is an abnormal collection of skin cells deep inside the ear - https://www.nhs.uk/conditions/cholesteatoma [accessed 13 Jan 26]

ear). Candidates are FIT following successful mastoid surgery provided they meet all the following criteria:

a. The ear drum has healed,

b. Hearing acuity is within entry limits,

c. Tympanometry is normal,

d. No further specialist input required,

e. Reviewed by service approved ENT consultant and confirmed the cavity is stable and the condition is unlikely to give rise to a continuing need for medical supervision or treatment, which impacts their ability to safely perform their military role.

14. **Otosclerosis / Ossicular fixation (abnormal hardening of the small bones of the middle ear).** Otosclerosis is a progressive condition resulting in hearing loss. Candidates with this condition are UNFIT even if hearing acuity is currently within entry limits due to the risk of deterioration and hearing loss. Hearing loss will impact their ability to safely perform their military role.

15. **Meniere's disease (inner ear disorder that affects balance and hearing).** Candidates with a diagnosis of Meniere's disease are UNFIT. This is because it can deteriorate without reasonable warning, affecting a candidate's ability to hear properly and maintain balance, impacting their ability to safely perform their military role.

16. **Tinnitus (ringing / buzzing in the ears).** Candidates with acceptable hearing but who report mild, non-disabling, non-problematic episodes of tinnitus are FIT. If the symptoms have impacted the candidate's function or needed ENT referral, the candidate is UNFIT, even if the audio-vestibular examination is otherwise normal. This is because problematic tinnitus may worsen with noise exposure or stressful environments and can be extremely distracting, impacting their ability to safely perform their military role.

Conditions affecting the Nose and Sinuses

17. **Nasal deformity.** Candidates are FIT if able to breathe freely through at least one nostril. Where there is septal perforation, it must be asymptomatic (no bleeding, crusting or nasal blockage). Candidates are FIT six months following successful reconstructive surgery, providing they can breathe freely through at least one nostril. Candidates with deformity of the nose sufficient to interfere with breathing or the use of face masks, breathing apparatus and other similar devices are UNFIT because all military personnel need to be able to wear appropriate facial / respiratory personal protective equipment.

18. **Epistaxis (nose bleeds).** Candidates with minor epistaxis (not requiring specialist treatment or affecting daily function) are FIT. Candidates with recurrent epistaxis which has been successfully treated are FIT provided they no longer require specialist input. Candidates with ongoing symptomatic epistaxis or who are undergoing treatment are UNFIT because of the risk of sudden deterioration and the inability to treat in austere conditions. Candidates with hereditary haemorrhagic telangiectasia are UNFIT for this reason.

19. **Rhinosinusitis (inflammation of nose and sinus).** Candidates with mild symptoms are FIT. Candidates with seasonal rhinosinusitis are FIT if symptoms are controlled only over the counter treatment and are non-disabling. Candidates with rhinosinusitis requiring regular prescription medication[5] are UNFIT, due to the impact of symptoms on military performance and risk of sudden deterioration.

20. **Nasal polyposis (painless growths inside the nose).** Candidates with asymptomatic nasal polyposis or with a history of treated polyposis who remain asymptomatic are FIT. Candidates with symptomatic nasal polyposis are UNFIT due to the risk of further growth causing airway obstruction and blockage of sinuses, causing sudden deterioration. This would impact their ability to safely perform their military role.

Conditions affecting the Throat (Pharynx, Larynx and Trachea)

21. **Adenoid hypertrophy (obstructive condition related to increased size of the adenoids).** Candidates are FIT following successful adenoidectomy. Candidates with symptomatic adenoids are UNFIT, because the symptoms will affect breathing and the quality of sleep which will affect their ability to safely perform their military role.

22. **Obstructive sleep apnoea / hypopnoea syndrome (intermittent airway blockage whilst asleep).** Candidates with obstructive sleep apnoea / hypopnoea syndrome are UNFIT due to the requirement to access medical equipment and impact of fatigue which will affect their ability to safely perform their military role.

23. **Cleft lip / palate.** Candidates with no functional deficit are FIT. Candidates with uncorrected cleft-lip and / or hard / soft palate or any gross abnormalities of the dento-facial complex and associated soft tissues, must be referred to sSMES, who may refer to a sS or HQ DPHC Dental Officer. This is because uncorrected conditions pose difficulties to the candidate for feeding and increase risks of sinus infection. Additionally, if the condition is likely to affect wearing protective headgear and / or respirators and / or safety equipment they are UNFIT as it would be impossible to provide suitable and sufficient Personal Protective Equipment (PPE).

24. **Laryngeal conditions.** Candidates with papillomatosis (respiratory wart-like growths) or a history of respiratory papillomatosis, whether treated or not, are UNFIT. Papillomata in the larynx have a high risk of reoccurrence and can cause breathing and swallowing problems. These can place significant limits on a candidate's ability to safely perform their military role.

25. **Tracheostomy.** Candidates presenting with a healed tracheostomy are FIT provided the reason for tracheostomy is not associated with other health concerns. Candidates with an open tracheostomy are UNFIT due to the risk of infection, bleeding, sudden blockage of the trachea and risk of sudden deterioration which impacts on ability to safely perform their military role.

General conditions affecting the Ears, Nose and Throat

26. **Previous or ongoing cancer.** Candidates with a current diagnosis and ongoing treatment of ENT cancer are UNFIT. For candidates with a past history of cancer refer to Annex N.

[5] The use of over-the-counter (non-presciption) medications is acceptable.

27. **Autoimmune conditions.** Candidates with Wegener's Granulomatosis or other vasculitides are UNFIT because they can cause chronic inflammation and damage to the nasal passages, sinuses, throat and lungs, which could suddenly deteriorate and impact on ability to safely perform their military role.

28. **Facial nerve palsy.** Candidates are FIT provided they can clearly communicate and close their eyes fully. Candidates with unresolved palsy and with functional deficit are UNFIT if it impacts on their ability to use respirators and safely perform their military role.

Annex C

CARDIOVASCULAR PRE-ENTRY

1. **General principles for assessing candidates against this Annex.** The general principles against which a candidate is assessed as FIT for entry, with respect to their cardiovascular system (heart and blood vessels) are:

a. **Function.** A candidate must have the cardiac reserve, in all military environments, to safely and effectively:

(1) Undertake maximal exercise for the purposes of assessment and trade specific training.

(2) Perform their military role in the UK firm base and deployed environment.

(3) Operate their personal weapon and other role equipment.

b. **Prognosis.** Where a candidate is found to have a resolved or current cardiovascular disease (CVD), the following general criteria should be met in addition to the relevant specific paragraph in policy, it should not:

(1) Be foreseeably exacerbated by military service; in particular, extremes of heat / cold, atmospheric pressure changes, dehydration or strenuous physical exertion.

(2) Pose a risk of reduced performance, distraction, or sudden incapacitation. The same applies to any treatment required.

c. **Medical support requirements.** Where a candidate has a pre-existing or increased risk of a cardiological condition, there must be no reasonably foreseeable requirement for medical care within the deployed location beyond deployed Primary Healthcare (or equivalent). The medical condition must be stable with treatment. Should loss of medication occur for ≤ one week this should not lead to clinical deterioration in the condition or functional degradation during that time. In the deployed environment the condition should not foreseeably impact military medical resource.

2. **Exceptional considerations.** Criteria within each condition has been outlined to grade a candidate as FIT or UNFIT. Where there is any doubt, advice should be sought from the Single Service Medical Entry Staff (sSMES). The resultant FIT or UNFIT outcome will be determined by sSMES.

3. **Cardiovascular Risk Factors.** Assessment of cardiovascular risk factors is an important consideration when conducting any cardiovascular assessment in order to reduce future events. Genetic, environmental, and other factors remain important contributors to cardiovascular disease throughout a service persons career and it is essential that these be reduced or avoided wherever possible. Below are specific conditions known to increase the risk of future cardiovascular disease and must be

considered in candidates. Risk calculators, while helpful, are not validated in a young population.

a. **Hyperlipidaemia.** Hyperlipidaemia is a risk factor of coronary artery disease (CAD) which can lead to ischaemic heart disease (IHD). It often requires life-long treatment. Candidates with untreated hyperlipidaemia are UNFIT. Candidates with treated hyperlipidaemia are FIT E2[1] subject to meeting all of the following conditions:

(1) Effective treatment[2] with statin monotherapy,

(2) Stable dose requirement for six months,

(3) No side effects from treatment,

(4) No diagnosis of hypertension (treated or untreated).

b. Candidates with a familial dyslipidaemia, even if on treatment, are UNFIT.

c. **Hypertension (high blood pressure).** High blood pressure is a predictor of cardiovascular disease and is associated with ischaemic heart disease, heart failure, renal failure and stroke. The higher the blood pressure, the greater the risk of cardiovascular disease. Candidates with successfully treated hypertension (24h ABPM <135/85 mmHg) are FIT subject to meeting all the following criteria:

(1) No diagnosis of dyslipidaemia (treated or untreated),

(2) Effective treatment with monotherapy,

(3) No evidence of end organ damage (normal ECG, fundoscopy and renal function).

Cardiovascular Conditions

4. **Diseases of the coronary arteries.**

a. **Coronary artery disease (CAD).** Asymptomatic candidates with an incidental finding of coronary artery calcification should be referred to a service-approved cardiologist. All other candidates with CAD are UNFIT. CAD is a progressive and unpredictable condition. Exercise may precipitate disabling symptoms such as chest pain. It is the predominant cause of exercise-related cardiac events and primary cause of sudden death in those over 35 years of age. Approximately 50% of cardiovascular events cause death with no prior symptoms.

b. **Ischaemic heart disease (IHD).** This includes acute coronary syndromes (ACS), myocardial infarction (heart attack) and stable / unstable angina (chest pain). Following successful treatment of IHD there is an ongoing annual risk of future events. Candidates with these conditions are UNFIT due to the risk of incapacitation and requirement for access to prompt emergency medical intervention. This is

[1] Candidates must undergo annual cardiac risk assessment (BP check, lipid profile).
[2] Total chol <5, LDL-chol <4, Triglycerides <2.3 (all mmol/L)

defined as access to specialist coronary intervention within two hours of symptom onset.

c. **Other coronary artery pathology.** Anomalous coronary artery origin, spontaneous coronary artery dissection (SCAD), coronary artery bridging and coronary arteritis are rare conditions but can have significant consequences. Candidates with these conditions must be referred to a service-approved cardiologist.

5. Arrhythmias (heart rhythm abnormalities). These can vary from benign normal variants to life threatening abnormalities resulting in a significant risk of sudden incapacitation or even death. Candidates with any symptomatic rhythm abnormality or those who require medication to suppress the abnormality are UNFIT because these can result in a significant risk of sudden incapacitation or even death.

6. **Bradycardia and conduction disease.** These associated conditions are outlined below:

a. Sinus bradycardia, first degree block and Mobitz Type 1 AV nodal block are considered normal findings, especially in athletic individuals and these candidates are FIT.

b. Partial right bundle branch block, where the QRS duration is <120ms, is a normal ECG finding and needs no further investigation. These candidates are FIT.

c. Those with Mobitz type 2 and complete AV nodal block are UNFIT because these can result in a significant risk of sudden incapacitation or even death.

7. **AV nodal re-entry tachycardia (AVNRT).** Candidates with a history of AVNRT which is untreated, or which requires medication for suppression are UNFIT as AVNRT usually presents abruptly with symptoms such as palpitations, dizziness, chest pain or loss of consciousness. Those successfully treated with ablation require referral to a service-approved cardiologist.

8. **Atrio-ventricular accessory pathway.** Candidates known to have an accessory pathway are UNFIT as they can cause palpitations, breathlessness, chest pain or syncope. In rare cases this can cause arrhythmia and sudden death. Those successfully treated with ablation require referral to a service-approved cardiologist.

9. **Atrial tachycardias.** Candidates with a history of atrial tachycardias are UNFIT as they can be distracting, may incapacitate and are difficult to treat.

10. **Atrial flutter.** Candidates with a history of atrial flutter, which has not been treated with curative ablation are UNFIT as atrial flutter can be distracting, may incapacitate and is difficult to treat. Candidates with successful ablation and no recurrence within 6 months must be referred to a service-approved cardiologist.

11. **Atrial fibrillation.** Candidates with one previous episode of AF may be considered FIT subject to all the following:

a. Due to a known reversible cause.

b. No structural problem or ongoing metabolic disease.

c. At least two years have elapsed with no recurrence.

d. No ongoing treatment.

12. Candidates with a history of more than one episode of atrial fibrillation are UNFIT as there is a risk of distraction, reduced exercise tolerance and stroke.

13. **Ventricular tachycardia (VT).** Candidates with a past history of VT are UNFIT as it can cause palpitations, breathlessness, syncope or sudden death. Candidates with fascicular or outflow tract VT must be referred to a service approved cardiologist and a final decision made by sSMES.

14. **Inherited arrhythmogenic conditions (channelopathies).**[3] Candidates with a confirmed or suspected diagnosis or positive family history of a channelopathy are UNFIT because these conditions can present unpredictably with symptoms including sudden cardiac death. Exercise or elevated body temperature can also exacerbate these conditions.

15. **Implantable cardiac devices.** Candidates who have an underlying cardiac condition which requires treatment with a pacemaker or internal cardiac defibrillator (ICD) are UNFIT. These devices are associated with a risk of infection and endocarditis and will require lifelong monitoring.

16. **Implantable loop recorders.** Implantable loop recorders are purely monitoring devices. The suitability of the candidate will depend on the underlying condition. These individuals must be referred to service approved cardiologist.

17. **Heart failure.** Candidates with a diagnosis of heart failure, including those treated with cardiac transplantation, are UNFIT as it is associated with reduced exercise tolerance and generally has a poor prognosis.

18. **Cardiomyopathies (heart muscle diseases).** Candidates with a confirmed diagnosis of a cardiomyopathy are UNFIT because complications include heart rhythm abnormalities, blood clots, mechanical heart failure, pulmonary hypertension, and sudden cardiac death. Candidates without symptoms who have a positive family history must be referred to a service approved cardiologist.

19. **Inflammatory cardiac conditions.** Cardiac inflammation can occur for multiple reasons. Symptoms can be painful, distracting and associated with cardiac complications including death. Recurrent episodes after the initial acute event are common.

a. **Pericarditis.** Candidates with a single episode who meet all of the following criteria are FIT:

(1) Episode resolved more than two years ago,

(2) Episode lasted no more than six weeks,

[3] Brugada Syndrome, Catecholaminergic polymorphic ventricular tachycardia, Idiopathic ventricular fibrillation and Long and Short QT Syndromes

(3) Normal ECG and echocardiogram at least three months after resolution of acute symptoms.

b. Candidates who do not meet these criteria are UNFIT because inflammation of the pericardium is painful and associated with pericardial effusion and tamponade and requires a period of exercise restriction. Risk of recurrence is greatest in the early years after an initial episode and ranges from 15 – 30%.

c. **Myocarditis (inflammation of the heart muscle).** Candidates with a single episode who meet all the following criteria are FIT:

(1) Episode resolved more than two years ago,

(2) Normal 24 hour ECG, biomarkers (troponin and NT-proBNP), exercise tolerance test and cardiac MRI, all performed a minimum of six months after the acute episode.

d. Candidates who do not meet all of the above criteria are UNFIT because of increased risk of recurrence, approximately 25% will develop persistent heart dysfunction and 20% may acutely deteriorate and will either die or require heart transplantation.

e. **Infective endocarditis (infection of the heart lining or valves)**. All candidates with a past history of infective endocarditis are UNFIT because it is associated with a 30% risk of death over 12 months and a recurrence of 8-12%.

20. **Valvular heart disease.** Candidates without symptoms who have a structurally normal heart and MILD[4] regurgitation of a single heart valve are FIT. Candidates with any degree of valve stenosis (narrowing) or more than mild regurgitation of any valve are UNFIT (for mild pulmonary stenosis see Para 20 for pulmonary valve stenosis). All valvular abnormalities can increase the risk of infective endocarditis. Moderate regurgitation of a valve may be associated with harmful structural changes of the heart and has a tendency to worsen with exercise. Stenosis of a cardiac valve can reduce cardiac output, limit exercise capacity, and progression is unpredictable. Certain valves require specific considerations:

a. **Bicuspid aortic valve disease.** Candidates with bicuspid aortic valve disease are UNFIT because it is associated with earlier deterioration in valve function (stenosis and / or regurgitation) which can require surgical intervention anywhere from the third decade onwards. It is also associated with disease of the aorta including aneurysm and dissection.

b. **Mitral valve prolapse.** Candidates with this condition are UNFIT because there is an association between mitral valve prolapse, infective endocarditis, significant mitral regurgitation (MR) and ventricular tachyarrhythmias (fast, abnormal heart rhythm). The tachyarrhythmias are a particular concern where there is a finding of mitral valve annulus disjunction. Candidates without symptoms with no more than mild MR and no annular disjunction must be referred to a service approved cardiologist.

[4] Per British Society of Echocardiography agreed data set (or guidelines).

c. **Prosthetic cardiac valves.** Candidates who have undergone any cardiac valve intervention are UNFIT as prosthetic valves, either tissue or mechanical, are associated with an increased risk of infective endocarditis, valve deterioration over time, need long term follow up, and may require anticoagulation.

21. **Congenital heart disease.** With the exception of the conditions listed below, candidates with congenital heart disease are UNFIT due to the risk of arrhythmia, heart failure, and valve complications:

a. **Pulmonary valve stenosis.** Candidates with isolated mild pulmonary valve stenosis are FIT. This has a good prognosis and a very low risk of progression. Candidates with supra- or sub-valvular stenosis are UNFIT due to the risk of progression.

b. **Patent ductus arteriosus (PDA).** Candidates without symptoms who have an isolated PDA, which has been successfully closed more than six months ago, are FIT. All other candidates are UNFIT.

c. **Muscular ventricular septal defects (VSD).** Asymptomatic candidates with an isolated finding of previous muscular VSD which has closed spontaneously are FIT.

d. **Small Atrial Septal Defect (ASD).** This is less than or equal to 6mm who have no other abnormality on echocardiogram, are asymptomatic with their exercise training and have no prior history of stroke or TIA are FIT.

e. **Small restrictive VSD.** (hole in muscular part of ventricular septum only, less than or equal to 5mm) those who have an otherwise normal echocardiogram and no prior history of infective endocarditis are FIT. Candidates with VSDs not meeting these criteria are UNFIT due to the risk of progression of blood shunting across the defect leading to pulmonary hypertension, cardiac enlargement and impaired exercise capacity.

22. **Patent foramen ovale (PFO).** PFO is a common variant in the general population (~25%). Candidates with no cardiovascular complications (stroke or transient ischaemic attack) are FIT. Candidates without symptoms who have had successful PFO closure must be referred to a service-approved cardiologist to assess the risk of arrhythmia.

23. **Inherited aortopathies (aortic disease).** Candidates with these conditions are UNFIT. Inherited aortopathies and connective tissue diseases[5] have high risks of complications including aortic dissection, valve dysfunction, aneurysm / rupture, and unpredictable rates of progression.

24. **Anticoagulation.** See Annex N Para 8.

25. **Cardiotoxic drugs.** See Annex N Para 12b footnote 10.

Peripheral vascular diseases.

26. **Raynaud's phenomenon or vasospastic disease.** See Annex N.

[5] Including but not limited to Marfan syndrome, Ehlers Danlos, and Loeys-Dietz.

27. **Congenital arterio-venous malformations (AVMs).** Candidates with small, symptom-free congenital AVMs are FIT. Those with AVMs affecting function are UNFIT due to interference with military duty and equipment.

28. **Congenital lymphoedema.** All candidates with congenital lymphoedema are UNFIT due to functional limitation and risk of infection.

29. **Deep venous thrombosis (DVT).** See Annex N Para 6.

30. **Varicose veins.** Candidates with symptom-free minor varicose veins or who have undergone successful treatment are FIT. Candidates with symptomatic varicose veins (skin changes or ulceration around the ankle) affecting lower limb function are UNFIT.

31. **Vascular trauma.** Candidates with a history of vascular trauma require a referral to a service-approved vascular surgeon.

Annex D

RESPIRATORY PRE-ENTRY

1. **General principles for assessing Candidates against this Annex.** The general principles against which a candidate is assessed as FIT for entry, with respect to their respiratory system are:

a. **Function.** A candidate must have the respiratory reserve, in all military environments, to safely and effectively:

(1) Undertake maximal exercise for the purposes of assessment and trade specific training.

(2) Perform their military role in the UK firm base and deployed environment.

(3) Operate their personal weapon and other role equipment.

b. **Prognosis.** Where a candidate is found to have a resolved or current respiratory condition the following general criteria should be met in addition to the relevant specific paragraph in policy, it should not:

(1) Be foreseeably exacerbated by military service, in particular have risk of being made worse or brought on by extremes of heat or cold, atmospheric pressure or environmental conditions, e.g. dust or fumes.

(2) Pose a significant risk of future temporary or permanent loss of function.

(3) Pose a risk of sudden deterioration or incapacitation without reasonable warning.

c. **Medical Support Requirements.** Where a candidate has a pre-existing or increased risk of a Respiratory condition, there must be no reasonably foreseeable requirement for medical care within the deployed location beyond deployed Primary Healthcare (or equivalent). The medical condition must be stable with treatment. Should loss of medication occur for ≤ one week this should not lead to clinical deterioration in the condition or functional degradation during that time. In the deployed environment the condition should not foreseeably impact military medical resource.

2. **Exceptional considerations.** Criteria within each condition have been outlined to grade a candidate as FIT or UNFIT. Where there is any doubt, advice should be sought from the Single Service Medical Entry Staff (sSMES).[1] The resultant FIT or UNFIT outcome will be determined by sSMES.

Conditions affecting the respiratory system

3. Candidates with active or previous history of clinician-diagnosed respiratory disease

[1] Delegated Authority arrangements may apply.

with a spirometry which is currently below the Lower Limit of Normal (LLN)[2] (standardised for age, birth sex, height, and ethnicity) from whatever cause are UNFIT. These candidates would need access to routine specialist medical services unavailable in austere locations with limited medical support and would lack the respiratory function to safely perform their military role. Candidates must also be able to safely undertake maximal exercise for the purposes of assessment and training.

4. **Abnormalities of the chest wall (including pectus excavatum and pectus carinatum).** Candidates with chest wall abnormalities require careful clinical and functional assessment (to ensure PPE such as combat body armour can be worn). Those without respiratory symptoms or impaired exercise capacity and who have no other functional limitations, with a normal clinical examination and ECG are FIT. Those with mild to moderate impairment or surgical correction will require further assessment to include normal spirometry, echocardiography and chest x-ray (anterior posterior and lateral views) and will require referral to sSMES[3] for final decision. In some cases, if the candidate is still growing, deferral until skeletal maturity[4] may be required. Those with significant impairment of function are UNFIT.

Airway disease

5. **Asthma.** The diagnosis of asthma is a clinical one (supported by objective tests). The absence of consistent gold-standard diagnostic criteria means that it is not possible to make unequivocal evidence-based recommendations on how to make a diagnosis of asthma and there is no single diagnostic test. However, it is accepted that asthma is a chronic disease characterised by airway inflammation, typical symptoms and airflow obstruction, all of which are intermittent and variable. It is important to distinguish a diagnosis of asthma from other conditions where similar signs and symptoms occur, such as respiratory tract infections, particularly when trying to establish a diagnosis of asthma based on historic records in those who are currently symptom-free.

a. A focussed respiratory medical history is the best tool to help establish the probability that a candidate has asthma. This must include assessment of:

(1) Any clinician-delivered diagnosis of asthma.

(2) The presence of typical symptoms – wheeze, chest tightness, breathlessness, and cough (the presence of more than one increases the probability significantly).

(3) The variability of symptoms over time.

(4) Symptom triggers, such as exercise, change in air temperature, fumes, dust, allergens.

[2] Normal range is between LLN = 5% percentile and Upper Limit of Normal (ULN) = 95th percentile. Use of fixed ratio FEV1/FVC <0.7 and 80% predicted not recommended for defining normal range. Recommendation to use GLI reference equations for spirometry, biological sex, not gender used to interpret lung function. Stanojevic S, Kaminsky DA, Miller MR, et al. ERS/ATS technical standard on interpretive strategies for routine lung function tests. Eur Respir J 2022; 60: 2101499 [DOI: 10.1183/13993003.01499-2021].
[3] ECHO not normally required for mild chest wall abnormalities but would be required for those where connective tissue conditions are suspected e.g., Marfans, or more than mild chest wall deformity.
[4] Skeletal maturity. Ascertaining whether a candidate has reached skeletal maturity might be relevant in some conditions. In general, this means being aged 16 years and over for women and 18 years for men.

(5) A history of exacerbations precipitated by respiratory tract infection.

(6) Prescription of medications usually used for asthma, including inhaled bronchodilators and inhaled steroids.

(7) A history of requirement for oral steroids, nebulised bronchodilators and / or hospital treatment (including emergency department attendance).

b. Factors in the history which increase the probability of a diagnosis of asthma include:

(1) Documented evidence of wheeze heard by a clinician on auscultation of the chest.

(2) Documented evidence of airflow obstruction (PEF, FEV1, FEV1 / FVC ratio below LLN).

(3) A history of atopy (allergic rhinitis, allergic eczema).

(4) Recurrent episodes of typical symptoms after age three years.

6. Candidates with no symptoms after their fourth birthday[5] are FIT as the probability of developing asthma is no higher than the rest of the population.

7. Candidates with any of the following features are UNFIT as they have a high probability of current or future asthma:

b. Those with current asthma-like symptoms (including exercise-induced).

c. Those diagnosed with asthma who have experienced symptoms and / or have been prescribed any treatment for asthma in the preceding one year.[6]

d. Those who have had more than five acute episodes of asthma-like symptoms requiring primary healthcare intervention after their fourth birthday.[7]

e. Those who have required specialist / secondary healthcare management of their asthma.[8]

8. Where there is Inducible Laryngeal Obstruction (ILO) or Breathing Pattern Disorder (BPD) is suspected refer to sSMES.

9. **Chronic Obstructive Pulmonary Disease (COPD).** Candidates with a confirmed diagnosis of COPD[9] are UNFIT. Candidates require the respiratory function to safely perform their military role and these candidates would need access to routine specialist

[5] Morgan WI, Stern DA, et al Outcome of Asthma and Wheezing in the First 6 Years of Life. *Am J Respir Crit Care Med.* 2005;172; 1253-1258 DOI: https://doi.org/10.1164/rccm.200504-525oc [accessed 13 Jan 26]
[6] Army entry standards condition based waiver under the 5-point plan has been enabling entry for Candidates 1 year off treatment. Defence Statistics analysis paper 20231012-Asthma Med Waivers Cohort Analysis found 'no evidence that personnel granted asthma med waivers on entry have experienced adverse employment or health outcomes.'
[7] Von Mutius E. Paediatric origins of adult lung disease. *Thorax.* 2001; 56:153-159. Decline in presence of asthma in adolescent years may be related to a specific phenotype of wheezing associated with viral respiratory tract infections. Predictors of progression over puberty into adulthood are severity of illness, presence and severity of atopy and uptake of smoking.
[8] Tri-Service Respiratory Specialists consensus.
[9] Chronic condition which leads to progressive loss of function over time.

medical services which are unavailable in austere locations.

10. **Bronchiectasis.** Candidates with a confirmed diagnosis of bronchiectasis (including cystic fibrosis) are UNFIT. Candidates require the respiratory function to safely perform their military role and these candidates would need access to routine specialist medical services which are unavailable in austere locations.

11. **Alpha-1 Antitrypsin Deficiency.** Those with PiMZ or PiMS carrier status are FIT because the risk of developing lung disease is very low.[10] Candidates with a confirmed diagnosis of Alpha-1 Antitrypsin Deficiency, whether they have evidence of associated organ dysfunction or not, are UNFIT. This is a progressive disease, candidates require the respiratory function to safely perform their military role and these candidates would need access to routine specialist medical services which are unavailable in austere locations.

Pleural Disease

12. **Spontaneous Pneumothorax.** Primary spontaneous pneumothorax (PSP) occurs in otherwise healthy people, usually before the age of 40 years whereas secondary spontaneous pneumothorax occurs in people with underlying chronic lung disease, most commonly COPD. Recurrence after PSP is common, mostly within the first year, with rates as high as 30% after a first occurrence, and 50% following a second.[11] Referral for consideration of surgical management to reduce the risk of recurrence may be recommended after a second pneumothorax.

13. Candidates who have had a PSP are FIT if either of the following criteria are met:

    a. A period of five years has passed after a single PSP which was not definitively treated and there have been no recurrences[12] and the candidate is functionally unrestricted.

    b. Candidates with single or recurrent PSP who have had definitive treatment (normally pleurectomy by open or Video-Assisted Thoracoscopic Surgery (VATS)) after one year[13], provided there is no evidence of recurrence, and the candidate has no functional restrictions.[14]

14. Candidates with either of the following features are UNFIT:

    a. Those who have had a secondary spontaneous pneumothorax (because of the underlying condition), or

    b. Those who have had a second PSP without definitive treatment.

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[10] Santos G, and Turner AM. Alpha-1 antitrypsin deficiency: an update on clinical aspects of diagnosis and management: an updated review. Faculty Reviews 2020 9:(1) https://doi.org/10.12703/b/9-1 [accessed 13 Jan 26]

[11] Walker SP, Bibby AC, Halford P, et al. Recurrence rates in primary spontaneous pneumothorax: a systematic review and meta-analysis. Eur Respir J 2018; 52: 1800864 [https://doi.org/10.1183/13993003.00864-2018 [accessed 13 Jan 26]] After 5 years background risk approximating same as general population.

[12] Walker SP, Bibby AC, Halford P, et al. Recurrence rates in primary spontaneous pneumothorax: a systematic review and meta-analysis. Eur Respir J 2018; 52: 1800864 [https://doi.org/10.1183/13993003.00864-2018 [accessed 13 Jan 26]] After 5 years background risk approximating same as general population.

[13] Consensus Respiratory Specialist opinion- evidence poor, risk of recurrence varied but general risk of surgical failure is early post procedure, less than 1 year. Old data suggestive of overall risk of recurrence 4.4%, at 1 year approximately 2%. (Cardillo G, et al. Videothoracoscopic treatment of primary spontaneous pneumothorax: a 6 year experience. *The annuals of Thoracic Surgery.*2000; 69(2);357-361. https://doi.org/10.1016/S0003-4975(99)01299-0 [accessed 13 Jan 26].) Risk of recurrence likely less now due to improvement in techniques and in procedure at specialist thoracic centres.

[14] Pleurodesis is not considered definitive treatment for certain occupational groups (e.g. aircrew and divers). VATS is not acceptable for aircrew.

15. **Traumatic pneumothorax.** Pneumothorax in which a clear traumatic (or iatrogenic) cause is identified, does not carry the same high likelihood of recurrence as spontaneous pneumothorax. Candidates who have made a full clinical recovery, have achieved activity comparable with military service for a period of at least three months and have normal spirometry[15] are FIT.

Parenchymal lung disease (affecting lung tissue)

16. **Sarcoidosis.** Sarcoidosis is an uncommon, multi-system disorder of unknown aetiology. Acute sarcoidosis is usually self-limiting but even after resolution carries a lifetime risk of recurrence.[16] Chronic disease most commonly affects the lungs and the lympho-reticular system and may cause long-term, progressive organ dysfunction. Cardiac, neurological, and ophthalmic sarcoidosis are of particular concern, as are the treatments for sarcoidosis which may include oral corticosteroids or immunosuppressive drugs.

17. Candidates with any confirmed history of sarcoidosis are UNFIT because they need access to routine specialist medical services and pose a risk of sudden deterioration or incapacitation.

18. Candidates with a history of any parenchymal lung disease, including interstitial pneumonias and pulmonary fibrosis are UNFIT because they are progressive diseases and they need access to routine specialist medical services and pose a risk of sudden deterioration or incapacitation.

Respiratory infection

19. **Tuberculosis.** A candidate who has made a complete recovery from TB infection or has completed appropriate treatment for Latent TB must be referred to sSMES along with details of treatment received. Candidates with active TB, or untreated Latent TB are UNFIT. Candidates require respiratory function to safely perform their military role, may pose an infection risk to others and would need access to routine specialist medical services which are unavailable in austere locations.

20. **Pneumonia (including COVID-19).** Candidates with a history of resolved pneumonia are FIT, provided there is no evidence of recurrence and they have achieved activity comparable with military service for a period of at least three months. Candidates with persistent symptoms are UNFIT (see Annex N for Chronic fatigue syndrome and associated conditions). Candidates require the respiratory function to safely perform their military role, may pose an infection risk to others and would need access to routine specialist medical services which are unavailable in austere locations.

Breathing related sleep disorders

[15] Military SME judgement

[16] Presenting with acute presentation, organ dysfunction and/ or required treatment there is a >10% risk of recurrence. Grunewald J, Eklund A. Lofgren's Syndrome. *Am J Respir Crit Care Med.*2009; 179;307-312. DOI: https://10.1164/rccm.200807-1082OC [accessed 13 Jan 26]. Inoue Y, Inui N, Hashimoto D, Enomoto N,Fujisawa T, Nakamura Y, et al. Cumulative Incidence and Predictors of Progression in Corticosteroid-sNaive Patients with Sarcoidosis. *PLoS One*. 2015; 10(11). DOI: https://10.1371/jpurnal.pone.0143371 [accessed 13 Jan 26] Baughman RP, Judson, MA. Relapse of sarcoidosis: what are they and can we predict who will get them? *Eur Respi J.* 2014; 43:337-339. DOI: https://doi.org/10.1183/09031936.00138913 [accessed 13 Jan 26]

22. **Obstructive sleep apnoea / hypopnoea syndrome (intermittent airway blockage whilst asleep).** Please see Annex B ENT Para 22.

Pulmonary Embolism (PE)

23. Candidates with a history of PE with a clearly identified provoking factor are FIT[17], provided all the following criteria are met:

a. A full recovery has been made with no evidence of complications

b. The initial provoking factor is no longer present or likely to reoccur,

c. No previous episodes of Venous Thromboembolism (VTE),

d. A period of six months has passed after withdrawal of treatment with no recurrence of Venous Thromboembolism (VTE),

e. The candidate is functionally unrestricted.

24. Candidates with a history of unprovoked PE are UNFIT because there is an unacceptably high risk of recurrence.[18] These candidates would need access to specialist medical services and there is a risk of sudden deterioration and incapacitation.

25. Candidates on anticoagulant treatment are UNFIT. Anticoagulant treatment carries an unacceptably high risk of bleeding, which would compromise the ability to achieve haemostasis in an operational environment as laid out in Annex N Para 8.

[17] Iorio A, Kearon C, Filippucci E, et al. Risk of Recurrence After a First Episode of Symptomatic Venous Thromboembolism Provoked by a Transient Risk Factor: A Systematic Review. *Arch Intern Med.* 2010;170(19):1710–1716. doi: https://10.1001/archinternmed.2010.367 [accessed 13 Jan 26]

[18] Khan F, Rahman A, et al. Long term risk of symptomatic recurrent venous thromboembolism after discontinuation of anticoagulant treatment for first unprovoked venous thromboembolism event: systematic review and meta-analysis. *BMJ.* 2019; 366:4363 DOI: https://doi.org/10.1136/bmj.l4363 [accessed 13 Jan 26]

Annex E

GASTROINTESTINAL PRE-ENTRY

1. The general principles against which a candidate is assessed as FIT for entry, with respect to their Gastrointestinal system are:

a. **Function**. Candidates must have the physical and cognitive function to operate in all military environments, to safely and effectively perform their military role.

b. **Prognosis.** Where a candidate is found to have a resolved or current gastrointestinal condition, the following general criteria should be met in addition to the relevant specific paragraph in policy, it should not:

i. Be foreseeably exacerbated by military service (in particular, extremes of cold / heat, changes in atmospheric pressure or environmental conditions, or inability to access dietary modifications).

ii. Pose a significant risk of future exacerbation or complications of the condition.

iii. Pose a risk of sudden deterioration / incapacitation without reasonable warning.

c. **Medical Support Requirements.** Where a candidate has a pre-existing, or is at increased risk of a gastroenterological condition, there must be no reasonably foreseeable requirement for medical care within the deployed location beyond deployed Primary Healthcare (or equivalent). The medical condition must be stable with treatment. Should loss of medication occur for ≤ one week this should not lead to clinical deterioration in the condition or functional degradation during that time. In the deployed environment the condition should not foreseeably impact military medical resource.

2. **Exceptional considerations.** Criteria within each condition has been outlined to grade a candidate as FIT or UNFIT. Where there is any doubt, advice should be sought from the Single Service Medical Entry Staff (sSMES).[1]

Conditions affecting the Upper GI Tract (oesophagus, stomach and duodenum)

3. **Motility disorders**. Candidates with oesophageal motility disorders (including, but not limited to, achalasia) are UNFIT, including those with a good response to surgery. This is due to the ongoing risk of motility disorders causing choking in an environment where endoscopic intervention is not available.

4. **Eosinophilic oesophagitis**. Candidates are FIT if symptom-free for a period of one-year post-treatment completion.[2] Candidates requiring maintenance therapy are UNFIT even if symptom free for one year. This is due to the risk of recurrence of symptoms,

[1] Delegated Authority arrangements may apply.
[2] Eosinophilic Esophagitis: A Review - PMC (nih.gov) [accessed 13 Jan 26]

including incapacitating food bolus, and serious long-term health risks of the underlying condition, such as oesophageal stricturing.

5. **Unexplained Dysphagia** (difficulty swallowing). Candidates with a history of unexplained dysphagia and / or food bolus obstruction who have been asymptomatic for five years are FIT because they are unlikely to have a recurrence which needs urgent access to gastroscopy.

6. **Dyspepsia (indigestion) and / or Gastro Oesophageal Reflux Disease (GORD) (Heartburn).** If symptoms respond to lifestyle changes, such as weight loss and avoidance of spicy foods, alcohol, and smoking, and do not require regular prescribed medication the candidate is FIT. Endoscopic review for dyspepsia / GORD prior to entry is not needed. Those with persistent dyspepsia and / or GORD symptoms requiring regular prescribed medication to control symptoms are UNFIT because uninterrupted medication supplies cannot be guaranteed and symptoms can be distracting or incapacitating.

7. **Barrett's oesophagus.** Candidates with Barrett's oesophagus are UNFIT because daily prescribed medications are essential to reduce the risk of progression to cancer and uninterrupted medication supplies cannot be guaranteed.

8. **Peptic ulcer disease (ulcers of the oesophagus, stomach or duodenum)**. Candidates with medically or endoscopically (as per national guidelines[3]), resolved peptic ulcer disease are FIT after 12 months, providing they meet all the following criteria:

a) Remain asymptomatic,

b) Do not require regular prescribed medication,

c) Proof of successful Helicobacter pylori eradication if identified.

9. Candidates with a history of abdominal surgery for peptic ulceration or perforation are UNFIT due to the risk of complications, requiring further medical, endoscopic and/or surgical input.

10. **Anti reflux / hiatus hernia surgery.** Candidates who have had anti reflux surgery are FIT provided they meet all the following criteria:

a) They are six months post-surgery,

b) Able to swallow and eat normally,

c) Do not have any disabling symptoms[4],

d) Are no longer under secondary care follow-up.

11. Candidates with post-operative dysphagia are UNFIT as they may develop complications which require urgent access to gastroscopy.

[3] Quality standards in upper gastrointestinal endoscopy: a position statement of the British Society of Gastroenterology (BSG) and Association of Upper Gastrointestinal Surgeons of Great Britain and Ireland (AUGIS) [accessed 12 Jan 26]

[4] Disabling symptoms include any dysphagia, gas bloat (inability to belch) or the return of dyspeptic symptoms not controlled by standard PPI therapy.

Liver, biliary tree and pancreas

12. Candidates with a congenital / developmental, chronic or fibrotic / cirrhotic disease of the liver, biliary tree or pancreas are UNFIT due to the risk of progression of disease to cirrhosis and liver failure.

13. **Fatty liver.** Candidates with an isolated diagnosis of fatty liver on ultrasound with normal liver function tests are FIT. Candidates with fatty liver on ultrasound and abnormal liver function tests should be referred to sSMES.

14. **Viral hepatitis.** Refer to Annex N Para 19.

15. **Pancreatitis.** Candidates who fully recover from a single episode of acute pancreatitis, with no evidence of chronic pancreatitis, gastric outlet obstruction or pancreatic insufficiency or diabetes after 12 months are FIT provided any treatable causes of the pancreatitis have been addressed. Candidates with previous gallstone pancreatitis who have undergone cholecystectomy are FIT. Candidates with a history of alcohol-induced pancreatitis are UNFIT due to likely recurrence of symptoms and functional impairment.

16. **Cholecystitis (gallbladder inflammation).** Candidates who have had procedures to correct sphincter of Oddi dysfunction more than six months ago and remain asymptomatic are FIT. Candidates who have had cholecystectomy (removal of gallbladder) more than six months ago are FIT. Candidates with a current or previous history of symptomatic cholecystitis, or other disorders of the gallbladder and biliary system are UNFIT until six months after definitive surgical treatment due to the risk of recurrence and potential complications.

17. **Metabolic liver disease.** Candidates with suspected haemochromatosis who are subsequently confirmed H63D homozygous state or compound heterozygotes (C282Y / H63D) are FIT.[5] Candidates with a current or previous history of metabolic liver disease, including, but not limited to C282Y homozygous haemochromatosis, Wilson's disease and alpha-1 anti-trypsin deficiency, are UNFIT due to the risk of complications, progression to cirrhosis and liver failure.

18. **Splenomegaly (enlarged spleen).** Candidates with splenomegaly are UNFIT as the underlying condition is incompatible with service due to the risk of splenic rupture from any abdominal trauma.

19. **Gilbert's syndrome.** Candidates with Gilbert's syndrome are FIT.

Bowel conditions (small bowel and colon).

20. **Irritable bowel syndrome (IBS).** Candidates with symptoms not requiring prescribed medication (or last issued more than six months ago), who only infrequently use over-the-counter medications and are able to tolerate a varied diet[6] are FIT. Candidates with a current or previous history of IBS requiring ongoing medical review, or of sufficient severity to interfere with normal daily activities (for example repeated time off school, work, or having to change plans due to symptoms) are UNFIT. This is because candidates must be

[5] H63D homozygous state or compound heterozygotes (C282Y/H63D) do not have genetic haemochromatosis and very rarely develop iron overload.
[6] The requirement to tolerate the diet while deployed, at sea or on field rations, should be borne in mind.

able to work in challenging environments, in a physically demanding job with limited medical support and without immediate access to hygiene facilities where specific diets cannot be guaranteed.

21. **Inflammatory bowel disease (IBD).** Candidates with a history of IBD, including ulcerative colitis, Crohn's disease or IBD-unspecified, regardless of treatment or period of remission are UNFIT. This is due to the risk of increased severity of gastrointestinal infection[7] and / or risk of a flare in an austere environment[8,9], where UK gold standard care cannot be reached within the required timelines. Cold chain storage for medications cannot be guaranteed on deployments

22. **Hereditary GI cancer syndromes.** A genetic predisposition to hereditary GI cancer syndromes is not a bar to entry. All cases should be referred for sSMES opinion with all available clinical information. Genetic testing should not be undertaken solely to facilitate application to join the Military. Consideration will be given to risk of progression to cancer, likely age of onset and if military service could increase the risk to health or impede surveillance requirements.[10]

23. **Hirschsprung's disease.** Candidates with Hirschsprung's Disease are UNFIT because symptoms are likely to persist and require ongoing medication following surgery. Candidates must be able to work in challenging environments, in a physically demanding job with limited medical support and immediate access to hygiene facilities.

Intestinal malabsorption syndrome

24. **Pernicious anaemia.** Candidates with pernicious anaemia on an established vitamin B12 replacement schedule are FIT E2 provided there is no evidence of anaemia and normal vitamin B12 levels have been demonstrated within six months of application. Candidates with current anaemia or a low vitamin B12 level are UNFIT until effectively treated due to the potential impact of symptoms.

25. **Coeliac disease.** Candidates with a history of gluten sensitive enteropathy (coeliac disease) are UNFIT, due to the current inability to provide a sustained gluten-free diet throughout a service career, causing both short- and long-term illness. Coeliac disease is a condition with the potential for significant systemic illness if a gluten free diet is not maintained.[11]

26. **Lactose, gluten or other food sensitivity / intolerance**. Candidates able to tolerate a varied diet, who infrequently use over-the-counter medications and who have not required prescribed medication within six months are FIT. Candidates requiring ongoing medical review, or with symptoms severe enough to interfere with normal daily activities (for example repeated time off school, work, or having to change plans due to symptoms) are UNFIT. Candidates must be able to work in challenging environments, in a physically

[7] Increased risk of gastrointestinal infections, especially in areas of high diarrhoeal disease rates, due to potential mucosal inflammation and compromise. This is compounded by the use of immunosuppression.
[8] An untreated flare of Crohn risks include stricturing with potential for life threatening small bowel obstruction, fistula or abscess development.
[9]Acute severe UC flare requires immediate access to IV steroids, and potentially subsequent rescue therapy and possible colectomy by a colorectal surgeon if no response to rescue therapy.
[10] Guidelines for the management of hereditary colorectal cancer from the British Society of Gastroenterology (BSG)/Association of Coloproctology of Great Britain and Ireland (ACPGBI)/United Kingdom Cancer Genetics Group (UKCGG) [accessed 12 Jan 26]
[11] Symptoms may include: anaemia, abdominal pain, nausea, diarrhoea, rash, arthropathy, headaches, fatigue and poor concentration. Small bowel lymphoma is a rare complication associated with an un-sustained gluten free diet.

demanding job with limited medical support and without immediate access to hygiene facilities, where specific diets cannot be guaranteed.

Weight loss surgery

27. **Bariatric surgery.** Candidates who have had a sleeve gastrectomy > two years ago are FIT provided they can reach and maintain entry standard BMI, have no further symptoms or associated conditions[12] and require no further supplementation (except multivitamins[13]). Candidates who have undergone bariatric surgery within the last two years are UNFIT because their physiology is still adapting to the surgery. Candidates whose surgery has included gastrointestinal anastomosis formation[14] are permanently UNFIT because of the risk of major complications such as internal herniation and hypoglycaemia. Candidates who have a gastric band in place are UNFIT due to the risk of complications requiring surgical intervention. Candidates who have had a gastric band removed and recovered without problem are FIT provided other selection criteria are met.

Abdominal and Bowel Surgery

28. **Splenectomy.** See Annex N Para 41.

Herniae (bulging of organ or tissue through an abnormal opening)

29. **Abdominal wall hernia**. Candidates with an easily reducible umbilical hernia that does not affect physical activity or interfere with wearing military clothing or equipment are FIT. Candidates with repaired hernia who are six months post-surgery and have no clinical suspicion of recurrence are FIT if they can tolerate activities comparable with military training / Service over a minimum period of three months. Candidates are UNFIT if any other abdominal wall hernia (inguinal, epigastric, spigelian or incisional) is present. Any candidate awaiting surgery to repair any hernia is UNFIT. This is to allow the abdominal muscles to repair and allow time for the candidate to return to fitness standards needed to successfully complete military training.

Other abdominal Surgical procedures

30. Provided the original reason for abdominal surgery is not a bar to entry, candidates with a history of abdominal surgery should be assessed following the guidance below.

a) **Open abdominal Surgery.** Candidates who have undergone abdominal surgery during the preceding six months are UNFIT. This is to allow the abdominal muscles to repair and allow time for the candidate to return to fitness standards needed to successfully complete military training.

b) **Laparoscopy.** Candidates who have had diagnostic laparoscopy and or other simple procedures such as appendicectomy or laparoscopic sterilisation are FIT once

[12] such as arthritis, hypertension and diabetes. NICE criteria only offers surgery to patients with a BMI over 35 with associated comorbidities, or a BMI over 40. Of note:
1. Comorbidities do improve/resolve.
2. As a rule of thumb, 65+% T2DM cases go into remission,
3. At least 33% with hypertension become normotensive and off meds.

[13] Current recommendations are B12 injections every 3 months (some people may be taking high doses oral vitamin B12 instead), iron supplements, AdCalD3 and multivitamins

[14] these procedures include: roux-en-Y and one anastomosis, duodenal switch (DS) operations, and single anastomosis duodeno-ileal (SADI) procedures. As new procedures are being developed, any procedure outwith this list, must be discussed with sSMES

able to return to full physical activity. They must be able to conduct activities comparable with military training / service over a minimum period of three months without symptoms.

Bowel, anal and perianal conditions which may require surgery.

31. **Stomas.** Candidates who have a history of a stoma for trauma, which has been successfully reversed, are FIT once recovered from surgery, provided there is no evidence of incisional hernia or disqualifying associated injuries. Candidates who have had successful reversal of a stoma formed for other reasons must be referred to sSMES. Candidates with a current colostomy or ileostomy are UNFIT. Candidates must be able to work in challenging environments, in a physically demanding job, including austere locations with limited access to medical support and hygiene facilities.

32. **Pouch surgery.** Candidates who have undergone colectomy and pouch surgery are UNFIT as they require prolonged medical specialist follow-up and significant long-term sequelae / complications are expected.[15] Candidates must be able to work in challenging environments, in a physically demanding job, including in austere locations with limited access to medical support and hygiene facilities.

33. **Pilonidal sinus (cyst).** A previous history of acute abscess drainage is not a bar to Service. Candidates with "off midline"[16] excision and closure techniques are FIT following complete healing. Those who have had wide excision with healing by secondary intention are UNFIT until 12 months have elapsed since complete healing of the wound, because early recurrence of pilonidal sinus is common. Candidates with active disease or a history of more than two planned, definitive surgical procedures for pilonidal sinus are UNFIT due to the high risk of further recurrence.[17]

34. **Haemorrhoids (piles).** Candidates with treated haemorrhoids who are asymptomatic and have no post-treatment complications are FIT. Candidates with active haemorrhoids (internal or external), which are symptomatic and causing significant functional limitation (including school, workplaces, or exercise adjustments) are UNFIT. Candidates must be able to work in challenging environments including extremes of heat and cold, in a physically demanding job with limited access to medical support and hygiene facilities.

[15] A "well-functioning" ileoanal pouch will see the patient opening their bowels, on average, six times per day and twice at night. Pouchitis is common, with an incidence of 20-50%. (increased frequency, urgency, abdominal cramping, incontinence).
Initial treatment is with antibiotics (metronidazole or cipro), but second-line and subsequent treatments may include dual antibiotic therapy or biologics.
30% of patients who have one episode of pouchitis will progress to chronic pouchitis, while up to 90% will experience further episodes.
Up to 20% of pouches "fail" (5-10% early, 10% late), requiring ileostomy or pouch excision.

[16] "Off midline" excision and closure techniques (Karydakis Flap, Bascom Cleft-Lift, or Limburg (Rhomboid) Flap, other flap techniques) flatten the natal cleft and have markedly higher success rates (90%+) and would be FIT once healing complete.

[17] Wide excision and healing by secondary intention" is an attempt at definitive treatment, but may require prolonged healing of potentially wide, deep open wounds. Excision and healing by secondary intention is associated with a high rate of recurrence as it does not address the anatomical contribution of the natal cleft to pilonidal disease.

Annex F

RENAL AND UROLOGICAL PRE-ENTRY

Introduction

1. **General principles for assessing candidates against this Annex.** The general principles against which a candidate is assessed as FIT for entry, with respect to the renal and urological system are:

a. **Function**. A candidate must have stable renal and urinary tract function in all military environments to perform their military role safely and effectively including in austere locations with limited medical support.

b. **Prognosis.** Where a candidate is found to have a resolved or current renal and/or urological condition, the following general criteria should be met in addition to the relevant specific paragraph in policy, it should not:

(1) Be foreseeably exacerbated or precipitated by military service (in particular extremes of heat/strenuous exercise/dehydration).

(2) Pose a significant risk of future temporary or permanent loss of function.

(3) Pose a risk of sudden deterioration/incapacitation without reasonable warning.

c. **Medical Support Requirements.** Where a candidate has a pre-existing or increased risk of a renal or urological condition, there must be no reasonably foreseeable requirement for medical care within the deployed location beyond deployed Primary Healthcare (or equivalent). The medical condition must be stable with treatment. Should loss of medication occur for ≤ 1 week this should not lead to clinical deterioration in the condition or functional degradation during that time. In the deployed environment the condition should not foreseeably impact military medical resource.

2. **Exceptional considerations.** Criteria within each condition has been outlined to grade a candidate as FIT or UNFIT. Where there is any doubt, advice should be sought from the Single Service Medical Entry Staff (sSMES).[1] The resultant FIT or UNFIT outcome will be determined by sSMES.

3. **Examination.** Examination of the genitalia is **not** required at the recruit medical examination and should **not** be performed. There are no indications for such examinations during an occupational health assessment.

Abnormalities of Urinalysis

4. **Haematuria (blood in the urine).**[2] Whilst the sensitivity of urine dipsticks may vary from one manufacturer to another, trace haematuria should be considered negative and

[1] Delegated Authority arrangements may apply.
[2] Based on British Association of Urological Surgeons (BAUS), NICE and UK Renal Association guidelines.

significant haematuria is considered to be 1+ or greater. There is no distinction in significance between non-haemolysed and haemolysed dipstick-positive haematuria. 1+ positive for either should be considered of equal significance.

a. **Visible haematuria**. Candidates with visible haematuria related to menstruation are FIT. Other candidates with a single episode of visible haematuria are FIT E2 (for annual monitoring) if they meet all the following criteria

(1) Blood pressure estimated Glomular Filtration Rate (eGFR) and urine Albumin to Creatinine Ratio (ACR) or Protein to Creatinine Ratio (PCR) are within normal parameters.

(2) Other causes of transient haematuria (inc. Urine Tract Infection (UTI)) are excluded.

(3) Normal urology assessment including cystoscopy and relevant imaging (if renal impairment, proteinuria or hypertension consider simultaneous referral to nephrology).

b. Candidates with visible haematuria who do not meet the above criteria are UNFIT due to the likelihood of underlying disease and the requirement for medical support.

c. **Asymptomatic non-visible haematuria.** Candidates with non-visible haematuria related to menstruation are FIT. Candidates with uninvestigated unexplained asymptomatic non-visible haematuria (more than a trace of blood), on two of three dipsticks, two weeks between tests are UNFIT as this may signify an underlying undiagnosed renal or urological condition that may affect their ability to safely and effectively perform their military role and requires further specialist investigation. If a suitable urological and/or renal assessment excludes an underlying medical condition[3,4,5] as the cause for the blood in the urine, the candidate is FIT E2 (for annual monitoring)

d. **Symptomatic non-visible haematuria.** Candidates with a single episode of symptomatic (dysuria, abdominal pain, urgency) non-visible haematuria (i.e., more than a trace of blood on dipstick) are FIT E2 (for annual monitoring) if they meet all the following criteria:

(1) Blood pressure, eGFR and urine ACR or PCR are within normal parameters.

(2) Other causes of transient haematuria (inc. UTI) are excluded.

(3) Normal urology assessment including cystoscopy and relevant imaging (if renal impairment, proteinuria or hypertension consider simultaneous referral to nephrology).

[3] candidates who are aged 40 years and over require urological assessment including cystoscopy and imaging to exclude both benign and malignant urological conditions.
[4] Candidates who are under 40 years of age, with any of the following blood pressure ≥140/90 mmHg or eGFR <60ml/min or ACR>3 or PCR >5, will require a nephrology assessment.
[5] Candidates who are under 40 years of age and do not require renal assessment should be referred to sSMES to determine FIT E2.

e. Candidates who do not meet the above criteria are UNFIT due to the likelihood of underlying disease and the requirement for medical support.

5. **Glycosuria (Sugar in the urine).** If sugar is found on urinalysis, this may indicate an underlying diagnosis of diabetes and requires further specialist investigation. Further assessment is required before the candidate can be accepted as per JSP 950 section 4, 6-7-7 Annex H para 17 Endocrinology pre-entry.

6. **Proteinuria (Protein in urine).** If protein is found on urinalysis (more than trace on two of three dipstick tests, two weeks between tests, a trace can be ignored) the candidate is UNFIT as this may signify an underlying undiagnosed renal or urological condition that may affect their ability to perform their military role safely and effectively. If a suitable renal assessment excludes an underlying medical condition as the cause, the candidate should be referred to sSMES. Of note proteinuria can be present because of urinary tract infections and / or use of protein supplements.

7. **Glomerulonephritis (inflammation of the kidneys).** Candidates with a history of glomerulonephritis are UNFIT because glomerulonephritis is a disease process, resulting in inflammation of the kidneys, which may follow a relapsing or progressive course resulting in kidney failure which is likely to place an unacceptable demand on medical resources.

8. **Chronic Kidney Disease (CKD).** Candidates with CKD stage 1-2 who meet all the following criteria are FIT E2. These candidates will require regular review inline with NICE guidelines:

a. No hypertension,

b. No diuretic use,

c. No proteinuria,

d. No active renal comorbidity.

9. Candidates with CKD stage 3-5 (eGFR 60 or less) are UNFIT because of the risk of further deterioration in kidney function, the increased risk posed to the individual within the military deployed environments and an increased risk of cardiovascular disease.

10. **Urinary Tract Infection (UTI).** UTIs may be a sign of an underlying abnormality of the urinary tract which may predispose the candidate to recurrent infections impacting on their ability to perform their military role safely and effectively and risk sudden deterioration / incapacitation.

a. **Lower UTIs**. Candidates may be diagnosed with a UTI and treated with antibiotics on the history alone, urine dipstick or urine microscopy and culture. All should be interpreted as a diagnosis of UTI.

(1) **Childhood UTIs.** Candidates with a history of recurrent lower UTIs (two or more infections in a 12-month period) in childhood are FIT if previous investigations have confirmed normal anatomy and function. If the candidate has not been investigated previously the results of an ultrasound of the kidneys, ureter and bladder is required.

(2) **Post-pubertal male.** Candidates who had one infection post puberty are FIT if previous investigations have confirmed normal anatomy and function. If the candidate has not been investigated previously the results of an ultrasound of the kidneys, ureter and bladder is required.

(3) **Post-pubertal female**. Candidates with a history of a UTI more than two years ago are FIT. Those with a history of a UTI within the last two years are FIT unless the results of an ultrasound of the kidneys, ureter and bladder since the last UTI shows abnormality.

b. **Upper UTIs**. Candidates with a single episode of upper UTI more than two years earlier[6] are FIT in the absence of predisposing factors which as a minimum requires confirmation of a normal ultrasound of the kidneys, ureter and bladder.

c. **Vesicoureteric reflux.** This is a condition where urine flows backwards from the bladder to one or both ureters and sometimes the kidneys. This can lead to UTIs and kidney damage.

(1) A history of mild vesicoureteric reflux (Grades I-III) where an individual has been discharged from follow-up, has been free of infection for at least two years[7], has no requirement for antibiotic prophylaxis, normal urinalysis and normal blood pressure are FIT.

(2) Those with Grades IV-V reflux that required surgical correction and have been discharged from follow-up, and are free of infection for at least two years[8], with evidence of GFR or eGFR of >60ml/min, require referral to a Service approved urologist**.**

Urethral abnormality

11. **Urethral abnormalities**.

a. Abnormalities of the urethra such as a stricture (narrowing) may affect a candidate's ability to pass urine and lead to discomfort, distraction and UTI. Candidates with unsuccessful or continuing treatment for urethral abnormalities are UNFIT as it may impact on their ability to perform their military role safely and effectively and risk sudden deterioration / incapacitation. Those who have been successfully treated for a single urethral stricture and discharged from follow-up, require referral to Service approved urology**.**

b. Candidates with genital piercing (excluding the urethra) that has fully healed (the piercing can remain in place) without complications are FIT. Due to the risk of developing urethral stricture at a later date, candidates with history of genital piercing involving the urethra will require referral to Service approved urology.

12. **Urinary incontinence.** Candidates with a history of persistent urinary incontinence, or an episode of nocturnal enuresis (bed wetting) in the two years preceding entry are UNFIT regardless of the presence of normal neurological and psychological

[6] Service Urologist expert opinion.
[7] Service Urologist expert opinion.
[8] Service Urologist expert opinion.

investigations. Urinary incontinence may cause distraction and embarrassment for a candidate and affect their ability to perform their military role in all military environments.

13. **Genital infections.** Candidates with a current or previous history of genital infection or ulceration, including, but not limited to Herpes Genitalis or Condyloma Acuminatum (genital warts), that can be managed routinely by primary healthcare or interfere with function are FIT.

Congenital abnormalities

14. **Polycystic kidney disease.** Candidates with a family history of polycystic kidney disease and a normal screening ultrasound after the age of 16 years are FIT. Candidates with confirmed polycystic kidney disease are UNFIT due to the risk of developing kidney failure.

15. **Hypospadias.** In this condition the opening of the urethra is not located at the tip of the penis. Hypospadias, with no history of UTI, urethral stricture, or voiding dysfunction are FIT subject to review by a service-approved Urologist.

16. **Duplex kidneys.** In this condition the kidney has two ureters draining urine from the kidney which can lead to complications such as recurrent UTIs, abdominal pain and urinary incontinence. Candidates with a normal ultrasound within the last two years, with no hydronephrosis or unequal kidney size, are FIT subject to review by a service-approved Urologist.

17. **Pelviureteric Junction (PUJ) Obstruction.** Candidates with surgically corrected PUJ obstruction are FIT subject to review by a service-approved Urologist provided all the following criteria are met:

a. Treatment and specialist follow-up are complete,

b. There is evidence of correction and preservation of good renal function (as assessed on isotope renography, no earlier than 12 months post-surgery),

c. Candidates with unilateral PUJ obstruction with a non-functioning kidney or those treated with nephrectomy should be regarded as having a single kidney (see Para 20, below, relating to Absence, loss or malfunction of a kidney).

18. **Megaureter (enlarged ureter).** Candidates with a history of megaureter are prone to UTIs and kidney damage. Candidates with resolved or surgically corrected megaureter are FIT subject to review by a service-approved Urologist. If the eGFR exceeds 60ml/min and they have been discharged from follow-up.

19. **Other congenital conditions.** Candidates with all other congenital conditions are UNFIT due to the risk of developing kidney failure or other urinary tract effects which could affect function.

20. **Absence, loss or malfunction of a kidney.**

a. Candidates with a single functioning kidney are FIT subject to review by a service-approved Nephrologist / Urologist, provided all the following criteria are met:

(1) No evidence of disease in the remaining kidney,

(2) No persistent abnormality on urinalysis,

(3) GFR or eGFR of at least 60ml/min,

(4) Absence of raised blood pressure,

(5) No risk or recurrence of disease in the remaining kidney.

b. Candidates with renal transplants are UNFIT as the ongoing requirement for intensive specialist follow up, immunosuppressive medication and risk of transplant failure is incompatible with unrestricted employment and the ability to perform their military role safely and effectively.

21. **Ureteric spasm.** Candidates with a history of a single episode of ureteric spasm (or suspected renal colic), which has been investigated without demonstration of underlying pathology, are FIT. More than one episode of ureteric spasm requires referral for Service approved urology opinion.

22. **Renal and Ureteric Stone Disease (RUSD).** Candidates who have a confirmed history of urinary tract stone formation in the collecting system are UNFIT because there is an elevated risk of recurrence. This may be exacerbated in austere conditions. Renal colic may present without warning and result in severe, distracting and potentially incapacitating pain. Prolonged renal tract obstruction requires decompression to prevent permanent renal damage. Those with small, stable areas of calcification in the renal parenchyma require Service approved urology opinion.

23. **Bladder stones.** The pathology of bladder stones / calcification differs from RUSD; all candidates with a history of bladder stones / calcification require referral for Service approved urology opinion.

24. **Malignant disorders.** Candidates with Wilms' tumour treated in early childhood which successfully treated and discharged from specialist follow-up are FIT. For all other urological / nephrological malignant disorders, see Annex N Paras 12 and 13.

25. **Other painful urological conditions.** Candidates with a past history of non-specific or undiagnosed groin, scrotal, pelvic or loin pain who have been symptom and treatment free whilst undertaking exercise comparable with military training for 12 months[9] in the presence of normal or stable investigations are FIT. All other Candidates are UNFIT because these symptoms may indicate the need for further specialist investigation and may affect the candidate's ability to undertake military duties.

[9] DCA urology expert opinion.

Annex G

NEUROLOGICAL PRE-ENTRY

1. **General principles for assessing Candidates against this Annex.** The general principles against which a candidate is assessed as FIT for entry are:

a. **Function.** A Candidate must have the physical function, in all military environments, to safely and effectively:

(1) Perform their military role. Where the branch or trade being applied for has specific requirements, (e.g. aircrew) these must be met.

(2) Operate their personal weapon.

b. **Prognosis.** Where a candidate is found to have a resolved or current neurological condition, the following general criteria should be met in addition to the relevant specific paragraph in policy, it should not:

(1) Be foreseeably exacerbated by military service, particularly by:

(a) Fatigue.

(b) Stress.

(c) Alteration of time-zones.

(d) Dehydration.

(e) Prolonged standing.

(f) Missed meals.

(g) Infection.

(h) Exposure to bright light or loud noise.

(i) Exposure to certain dietary factors.

(2) Pose a significant risk of future temporary or permanent loss of function.

(3) Candidates with a neurological condition which either causes loss of function or sudden incapacitation, poses a risk on operations to both the candidate and others, as well as the mission, and are therefore UNFIT.

c. **Medical support requirements.** Where a candidate has a pre-existing or increased risk of a neurological condition, there must be no reasonably foreseeable requirement for medical care within the deployed location beyond deployed Primary Healthcare (or equivalent). The medical condition must be stable with treatment. Should loss of medication ≤ one week this should not lead to clinical deterioration in the condition or functional degradation during that time. In the

deployed environment the condition should not foreseeably impact military medical resource.

d. **Exceptional considerations.** Criteria within each condition has been outlined to grade a candidate as FIT or UNFIT. Where there is any doubt, advice should be sought from the single Service Medical Entry Staff (sSMES)[1] The resultant FIT or UNFIT outcome will be determined by sSMES.

Conditions which may cause sudden incapacitation

Seizures

2. **Single seizure.**

a. **Provoked seizures.** Depending on the cause, these candidates have a lower risk of recurrence than unprovoked seizures. Candidates are FIT, subject to sSMES review, provided they meet all the following criteria:

(1) There is a clearly defined provoking stimulus such as:

(a) Cardiovascular syncope resulting in tonic-clonic seizure activity. This differs from convulsive syncope in which myoclonic twitches occur on loss of conscious. Candidates with a history of convulsive syncope are FIT provided they meet the requirements of the paragraphs in the annex relating to vasovagal syncope, reflex syncope and unexplained loss of consciousness or altered awareness.

(b) A seizure occurring within one week of an acquired brain injury, including head injury, stroke, TIA, subdural haemorrhage, or intracranial surgery.

(c) A seizure occurring within 24 hours of a documented electrolyte or biochemical abnormality (eg hyponatraemia or hypoglycaemia). See Annex H Para 25 – Endocrinology.

(d) A seizure associated with drug use where the drug is known to increases the risk of seizure (epileptogenicity).

(e) An alcohol withdrawal seizure.[2]

(2) The stimulus must be easily avoidable in service.

b. **Unprovoked seizures.** These are associated with a high risk of recurrence. Candidates who have a single unprovoked seizure are FIT provided they meet all the following criteria:

(1) More than five years has elapsed since the seizure,

(2) The individual has not required treatment in the past five years,

[1] Delegated Authority arrangements may apply.
[2] As opposed to an alcohol-induced seizure which is a strong marker of epilepsy.

(3) Neurologist confirms the seizure risk is no greater than 2% per year.

3. **Epilepsy or multiple seizures.** Candidates diagnosed as having epilepsy or who have had more than one seizure are UNFIT due to the risk of sudden incapacitation which may result in harm to self and / or others when conducting safety-critical tasks unless they meet the following criteria:

a. **Febrile convulsions.** Candidates with febrile convulsions no later than their sixth birthday, and who have had no further seizures thereafter, are FIT.

b. **Benign childhood epilepsy (e.g. Rolandic epilepsy).** Candidates with a confirmed diagnosis of a benign childhood epilepsy, who have been seizure-free for five years without treatment, are FIT.

c. **Epilepsy in remission.** This is defined as being seizure free, without medication, for 10 years. This includes absence seizures (petit mal). Candidates are FIT.

Blackouts, faints, loss of consciousness and altered awareness

4. Clarification regarding any warning symptoms, triggers, length of unconsciousness, physical appearance before, during, and after the event (paying close attention to skin colour, body posture, and whether or not the eyes were open), degree of amnesia, and any confusion on recovery must be obtained[3]. The underlying cause should be identified where possible. The results of any cardiological and neurological investigations (including imaging) must be acceptable or any underlying abnormalities fully treated. Candidates who have not been adequately investigated are UNFIT due to the unknown risk of sudden incapacitation.

5. **Vasovagal and reflex syncope (simple faints)**. These have definite provoking factors, are unlikely to occur whilst lying or sitting and are benign in nature. Candidates are FIT provided they meet all the following criteria:

a. A clear provoking factor(s) is identified,

b. The provoking factor(s) can easily be avoided in service,

c. At least one warning symptom is present,

d. The faint may be avoided by corrective action.

6. All other candidates are UNFIT due to the risk of sudden incapacitation which may result in harm to self and / or others when conducting safety-critical tasks.

7. **Loss of consciousness.**

a. **Unexplained loss of consciousness or altered awareness.** Candidates who have had a single episode with no definite provoking factors, who have normal cardiac and neurological examination and a normal ECG, are FIT provided 12 months have elapsed since the episode. Candidates with more than one episode

[3] The account of those who witnessed the event may be of use.

where no underlying cause can be found are UNFIT, due to the risk of sudden incapacitation which may result in harm to self and / or others when conducting safety-critical tasks.

b. **Loss of consciousness / altered awareness with seizure markers.** Candidates with a history of altered or loss of consciousness and seizure markers (e.g. loss of awareness or amnesia lasting more than five minutes, lateral tongue biting, urinary incontinence, or confusion on waking) are FIT provided they have been symptom-free for five years and all cardiac and neurological investigations are normal. All other candidates are UNFIT due to the risk of sudden incapacitation which may result in harm to self and / or others when conducting safety-critical tasks.

Stroke / Transient Ischaemic Attack (TIA)

8. Candidates who have had a stroke or TIA and have made a full functional recovery require service-approved neurological review, when the provoking factor is one of the following:

a. Patent Foramen Ovale (PFO) which has subsequently been closed (see Annex C Para 21 Cardiology for further requirements).

b. Cervical artery dissection.

9. All other candidates are UNFIT due to the risk of sudden incapacitation which may result in harm to self and / or others when conducting safety-critical tasks.

Conditions which may impair function

Non-migrainous headache

10. Candidates with headaches within the last two years are FIT provided all the following criteria are met:

a. Not disrupted normal activities, including loss of time from school or work, or required medical attention,

b. Been successfully managed using Over-The-Counter (OTC) medication,

c. Not required the use of medication to prevent (rather than treat) their onset (prophylaxis),

d. Not occurred more than once every six months where aggravated by factors experienced in service (see list above).

Migraine

11. Migraine is an episodic disorder that affects a wide range of neurological functions and can occur both with and without a headache. The risk of recurrence is unpredictable, and attacks can be disabling or performance limiting. Typical migraine triggers are commonly encountered in service and include irregular sleep patterns, missed meals, exposure to bright light and loud noise, and relaxation after periods of stress. Migraine is likely when a headache attack lasts 2-72 hours, is unilateral, occipital or retro-orbital, and /

or has a pulsing quality. It is often aggravated by routine physical activity and it can be associated with nausea and / or vomiting, light, sound and / or motion sensitivity, fatigue and cognitive blunting ('brain fog'). Candidates with a history of migraine are FIT provided that in the last two years they have:

a. Not had a migraine which is severe enough to disrupt normal activities, including loss of time from school or work or been associated with difficulty with lights (photophobia), sounds, or motion difficulties or any other accompanying neurological features,

b. Not had more than two episodes of migraine,

c. Not required any prescribed medication or preventative (prophylactic) treatment.

12. Candidates who do not meet the above criteria are UNFIT as risk of recurrence whilst in service, especially where unavoidable tiggers are present can significantly impact on the individual's ability to function and perform their duties.

Traumatic Brain Injury (TBI)

13. For the purposes of assessing occupational risk, TBIs must be classified according to the following criteria[4]:

a. **Mild.** Any of the following features:

(1) Loss of consciousness lasting for less than 30 minutes.

(2) Post-traumatic Amnesia (memory loss associated with the injury) lasting for less than 30 minutes.

b. **Moderate.** Any of the following:

(1) Loss of consciousness lasting for 30 minutes to 24 hours.

(2) Post-traumatic Amnesia (memory loss associated with the injury) lasting for 30 minutes to 24 hours.

(3) An undisplaced skull fracture.

c. **Severe.** Any of the following:

(1) Loss of consciousness for more than 24 hours.

(2) Post-traumatic amnesia (memory loss associated with the injury) lasting more than 24 hours.

(3) Bleeding inside the skull (intracranial haematoma).

(4) Depressed skull fracture.

[4] The use of other categorisation systems is not permitted.

(5) Brain contusion (bruising).

d. **Very Severe.** Any of the following:

(1) Penetrating brain injury.

(2) Enduring neurological deficit.

(3) Seizures occurring after seven days.

14. The risk of seizures following head injury is directly related to the severity of the head injury, therefore the following restrictions to entry apply:

a. Candidates with a history of mild head injury are FIT.

b. Candidates with a history of moderate head injury are FIT.

c. Candidates with a history of severe head injury are FIT after one year providing all the following criteria are met:

(1) No requirement for medication in the past year,

(2) No seizures in the past year,

(3) No ongoing neuro-behavioural symptoms.

d. Candidates with a history of very severe head injury are UNFIT due to the risk of sudden incapacitation which may result in harm to self and / or others when conducting safety-critical tasks.

15. **Seizures related to head injuries**. Seizures occurring at the exact time of a head injury do not increase the risk of subsequent seizures and do not affect the restrictions listed above. Seizures occurring within seven days of a head injury are provoked seizures and should be managed accordingly (see guidance above Para 2a). One or more seizures occurring more than seven days after head injury are considered a remote seizure(s) and should be managed as epilepsy (see guidance above Para 3).

16. Candidates with a past history of TBI who show any evidence of persisting intellectual, psychiatric or neurological deficit are UNFIT. The persistence of such features indicates a very severe injury with a high risk of seizures and the potential for symptom exacerbation attributable to Service.

Other Conditions

17. **Demyelinating disorders.** In cases where demyelination is likely to be a single event (e.g. Acute Disseminated Encephalomyelitis), provided there is no evidence of enduring neurological or intellectual deficit the candidate is FIT subject to service-approved neurology opinion. Candidates with conditions causing progressive demyelination (multiple sclerosis, anti-MOG disease, and neuro-myelitis optica) are UNFIT as these conditions are typically recurrent and can cause sudden incapacitation and need

urgent specialist medical support. They often require treatment with potent immunosuppression that may also lead to opportunistic infection and limited deployability.

18. **Functional neurological disorders (FND).** Candidates with a past history of FND which was functionally limiting and which have been fully investigated are FIT provided they have been symptom-free for two years and undertaken activities comparable with military service.

19. **Hydrocephalus**. Candidates with a history of non-progressive hydrocephalus developed in childhood, without neurological deficit, are FIT E2 (unfit contact sports, including milling) subject to service-approved neurology opinion. Candidates with symptomatic hydrocephalus, neurological deficit, or the presence of an intra-cranial shunt are UNFIT due to the potential need for urgent access to highly specialised medical care.

20. **Arachnoid cyst.** Candidates with an arachnoid cyst not causing mass effect and who has no neurological deficit, are FIT E2 (unfit contact sports, including milling). Candidates with an arachnoid cyst treated more than one year ago who has no evidence of neurological deficit are FIT E2 (unfit contact sports, including milling).

21. **Tumours (brain cancers and growths).** Candidates with a benign tumour[5] or treated low-grade cancer[6] are FIT subject to service-approved neurology opinion. Candidates with a history of other intracranial tumours are UNFIT due to the possibility of recurrence or progression, and because of an increased risk of seizures and / or neurological deficits. Refer to Annex N Paras 12 and 13, for further guidance.

22. **Degenerative genetic conditions affecting the nervous system (including but not limited to Huntington's Disease and Hereditary Neuropathy with Pressure Palsies).** See Annex N Other Conditions paragraphs on Congenital, chromosomal and genetic conditions.

23. **Neurosurgery (brain surgery).** Candidates with a history of neurosurgery with ongoing symptoms, functional deficit or treatment are UNFIT. Candidates who have fully recovered and have no functional deficit, and who have been discharged from specialist care, may be UNFIT because of the risk of post-surgery seizure. Such candidates should be referred to service-approved neurology including on risk of seizure. In all cases, the underlying reason for surgery must be considered under the appropriate paragraph of this annex.

24. **Dementia.** Candidates with a diagnosis of dementia are UNFIT as these conditions are progressive and affect the ability to conduct safety-critical tasks.

25. **Degenerative movement disorders.** Candidates with degenerative movement disorders, including Parkinson's Disease, dystonia, multiple system atrophy, progressive supranuclear palsy, tardive dyskinesia, cortico-basal degeneration are UNFIT as these conditions are progressive and affect the ability to conduct safety-critical tasks.

26. **Other movements disorders:**

    a. **Tics.** Candidates with mild tics are FIT provided they meet all the following criteria:

[5] e.g. meningioma
[6] including low-grade gliomas with full excision

(1) It does not significantly impact on function or ability to perform safety-critical tasks (without medication),

(2) It is not part of a progressive condition.

b. **Tremors.** Candidates with tremors are FIT provided they do not significantly impact on function or ability to perform safety critical tasks (even when undertaking activities comparable to military duties). Where the tremor is part of an underlying progressive disorder (including benign essential tremor), the candidate should be referred to service-approved neurology.

c. Candidates with significant involuntary movement disorders affecting daily function are UNFIT as it may affect their ability to conduct safety-critical activities.

Sleep disorders

27. **Fatigue.** Is associated with poor workplace performance and increased risk of safety critical errors. Candidates with any sleep disorder affecting performance including alertness, concentration and reaction times are UNFIT.

28. **Insomnia** (inability to sleep). Insomnia is defined as difficulty falling and / or staying asleep (including early morning waking), for at least three months, resulting in significant impairment of function in the absence of an underlying physical, psychiatric or external factor which interrupts sleep (e.g. noise, poor accommodation). Candidates with a current or past history of insomnia should be assessed for possible underlying causes of the insomnia with a full physical and mental health assessment to exclude cardiovascular, respiratory, neurological, pain, medication, depressive or anxiety related causes. Any underlying cause identified should be considered elsewhere in Section 4.

29. Candidates with past history of insomnia are FIT provided they meet all the following criteria:

a. There was only a single episode of insomnia in the last two years,

b. There is no other history of insomnia,

c. There were no associated mental health issues,

d. There were no associated co-morbidities,

e. Any identified trigger is unlikely to recur in Service,

f. The candidate did not receive more than 14 days[7] of prescribed sleep medicine (hypnotics).

[7] Pre-existing significant insomnia is a significant risk factor for development of PTSD or Depression post-Deployment. Insomnia varies from “normal” experience of sleeplessness from time-to-time to that requiring significant hypnotic treatment. Up to 14 days hypnotic treatment can be considered not significant treatment, thereafter it is. A one off or infrequent requirement for treatment (up to 14 days hypnotic treatment in any 3 month period) can also be regarded as not achieving the significance threshold for barring entry. However, in all cases, irrespective of the type or degree of treatment, careful consideration must be given to the effect on function in the military setting of sedating side-effects of hypnotic medication. Reference for increased risk of mental disorder in those with insomnia: Gehrman

30. All other candidates with any history of insomnia are UNFIT, due to fatigue being associated with poor workplace performance and increased risk of safety-critical errors.

31. **Hypersomnolence (excessive sleepiness).** Candidates with a current or past history of hypersomnolence should be assessed for possible underlying causes with a full physical and mental health assessment to exclude cardiovascular, respiratory, neurological, pain, medication, depressive or anxiety-related causes. Any underlying cause identified should be considered elsewhere in Section 4. Candidates with a history of hypersomnolence with no underlying cause are UNFIT due to fatigue being associated with poor workplace performance and increased risk of safety-critical errors.

32. **Parasomnias (sleep disruption).** Parasomnias are episodic disorders of arousal, partial arousal or sleep-stage transition that may be initiated or worsened by sleep. Common parasomnias include sleep-walking and night terrors. Candidates with a history of either of these conditions prior to the age of 13 are FIT, provided they did not require specialist medical assessment or intervention. Candidates with episodes of sleep-walking or night terrors after the age of 13 are UNFIT as episodes will impact on their ability to operate safely in the military environment.

33. **REM sleep behaviour disorder (RBD).** RBD is characterised by the intermittent loss of atonia (abnormal retention of active movements that are typical of REM sleep), causing suffers to physically enact their dreams, which can result in injury to self and others. RBD is also significantly associated with neurodegenerative conditions that are not compatible with service. Candidates with a history of RBD are UNFIT as this is likely to impede their ability to operate safely in the military environment.

34. **Nightmares.** Nightmares are frightening dreams that usually awaken the sleeper from REM sleep (night terrors are non-REM sleep events and do not involve awakening). Candidates with a history of nightmares are FIT provided they meet all the following criteria:

a. Have not had any episodes causing significant dysfunction to daily activities in the past two years,

b. Have no underlying psychiatric cause (such as PTSD) affecting fitness elsewhere - see Annex L Psychiatry.

35. **Circadian rhythm sleep-wake disorders.** Candidates with a sleep specialist confirmed history of circadian rhythm sleep-wake disorder are UNFIT due to fatigue being associated with poor workplace performance and increased risk of safety-critical errors.

36. **Narcolepsy (tendency to fall asleep).** Candidates with a sleep specialist confirmed history of Narcolepsy, current or past, are UNFIT as episodes of this life-long condition will impact on their ability to operate safely in the military environment.

37. **Breathing related sleep disorders.** Refer to Annex B Para 22.

P; Seelig AD; Jacobson IG; Boyko EJ; Hooper TI; Gackstetter GD; Ulmer CS; Smith TC; for the Millennium Cohort Study Team. Predeployment sleep duration and insomnia symptoms as risk factors for new-onset mental health disorders following military deployment. SLEEP 2013;36(7):1009-1018.

38. **Restless leg syndrome.** This condition is common (general population prevalence is 15%), and in majority of cases is mild and causes little dysfunction. Candidates are FIT provided they meet all the following criteria:

a. Their restless leg syndrome does not cause any loss of function,

b. Underlying causes, including hypoferritinaemia (low ferritin level), chronic neck or spine pathology have been excluded.

39. Candidates whose restless leg syndrome causes any loss of function should be referred to sSMES.

Annex H

ENDOCRINE PRE-ENTRY

1. **General principles for assessing candidates against this Annex.** The general principles against which a candidate is assessed as FIT for entry, with respect to their Endocrine conditions, are:

    a. **Function**. A candidate must have an adequate level of physical and cognitive function in all environments to:

        (1) Safely perform their military role.

    b. **Prognosis**. Where a candidate is found to have a resolved or current medical condition, the following general criteria should be met in addition to the relevant specific paragraph in policy, it should not:

        (1) Be foreseeably exacerbated by the demands of military service including but not limited to extremes of heat / cold, atmospheric pressure, or environmental conditions such as dust and allergens.

        (2) Pose a significant risk of future temporary or permanent loss of function.

        (3) Pose an unacceptable risk of sudden deterioration / incapacitation without reasonable warning.

    c. **Medical support requirements**. Where a candidate has a pre-existing or increased risk of an endocrine condition, there must be no reasonably foreseeable requirement for medical care within the deployed location beyond deployed Primary Healthcare (or equivalent). The medical condition must be stable with treatment. Should loss of medication occur for ≤ 1 week this should not lead to clinical deterioration in the condition or functional degradation during that time. In the deployed environment the condition should not foreseeably impact military medical resource.

2. **Exceptional considerations.** Criteria within each condition has been outlined to grade a candidate as FIT or UNFIT. Where there is any doubt, advice should be sought from the Single Service Medical Entry Staff (sSMES)[1].

Conditions affecting the pituitary gland

3. **Pituitary hormone production excess or insufficiency (hyper- and hypo secretory conditions of the pituitary gland).** Candidates with an established diagnosis of pituitary hormone excess or deficiency are UNFIT with the exception of thyroid stimulating hormone (TSH) deficiency (managed as per Paras 6 and 7). These conditions are likely to result in long-term treatment and follow up, with potentially life-threatening consequences if medication is interrupted.

4. **Pituitary adrenocorticotropic hormone (ACTH) insufficiency.** Candidates with ACTH deficiency are UNFIT due to potentially life-threatening complications which can be

induced by physiological stress with requirement for secondary care treatment during serious illness. Candidates must be able to work in challenging environments, in a physically demanding job, including in austere locations with limited medical support.

5. **Non-functioning[1] pituitary mass:**

a. Pituitary tumours <9mm (microadenoma) that are stable (no enlargement demonstrated on two MRI scans performed a minimum of 12-months apart), are FIT subject to sSMES review.

b. Pituitary tumours > 9mm (macroadenoma) are UNFIT (extant clinical guidelines[2,3] state that tumours > 9mm require ongoing monitoring). Candidates must be able to work in challenging environments, in a physically demanding job, including in austere locations with limited medical support.

Conditions affecting the thyroid gland

6. **Hypothyroidism (underactive thyroid).**

a. **Euthyroid (normal Thyroid Stimulating Hormone (TSH) blood test)**. Candidates on a stable dose[4] of thyroid replacement therapy (for a minimum of 12-months), in the absence of an associated autoimmune condition (in the absence of symptoms testing should not be initiated for employment purposes),[5] are FIT E2. Successfully treated hypothyroidism poses little health risk from short-term failure to take medication,[6] however, the condition requires continuous medication and regular monitoring.

b. Candidates who are not stable on thyroid replacement medications or who require more regular blood tests and / or specialist medical follow up are UNFIT pending further treatment under existing medical provider until the requirements in Para 6a are met.

c. Candidates with Autoimmune Polyendocrine Syndromes (APS) 1 or 2 are to be referred to a service-approved endocrinologist.

d. Candidates must be able to work in challenging environments, in a physically demanding job, including in austere locations with limited medical support.

7. **Hyperthyroidism (overactive thyroid).** Candidates with a history of an overactive thyroid condition are FIT if all the following criteria are met:

a. Successful definitive treatment with radioactive iodine or surgery.

[1] Normal prolactin, stimulated cortisol and TSH.
[2] https://www.endocrine.org/clinical-practice-guidelines/pituitary-incidentaloma [accessed 12 Jan 26]
[3] Consensus guideline for the diagnosis and management of pituitary adenomas in childhood and adolescence: Part 2, specific diseases | Nature Reviews Endocrinology [accessed 12 Jan 26]
[4] Variations of dose of no more than 25mcg are acceptable in symptom-free candidates.
[5] For example: Addison's disease, coeliac disease, pernicious anaemia and some cases of primary ovarian failure.
[6] Functional impairment (including muscular fatigue, cold intolerance and slowing of cognition) would develop over 1-2 months.

b. Have remained biochemically euthyroid without ongoing treatment for a minimum of 12-months.[7]

c. If replacement levothyroxine treatment is required, the candidate must have a normal thyroid stimulating hormone blood test (Euthyroid) after being on treatment for a minimum of 12-months. Individuals are then FIT E2.

8. **Grave's.** Candidates with previous Grave's treated with thionamide medications (e.g. carbimazole or propylthiouracil) are FIT provided they meet all the following criteria:

a. Have remained euthyroid for five years or longer,

b. Documented discussion with service-approved endocrinologist to determine the risk of hyperthyroidism recurrence.[8] Relapse after treatment is of occupational importance since this is associated with short-term distractibility, excessive psychological and physiological disturbance including a risk of cardiac arrhythmia[9] (atrial fibrillation in 10%) in a physically demanding job, including in austere locations with limited medical support.

9. **Thyroid cysts and nodules.** Thyroid cysts and nodules deemed benign on ultrasound (grade U2), histology or cytology (Thy2) and not requiring ongoing surveillance are FIT. Thyroid cysts and nodules that do not meet the FIT criteria should be referred to sSMES, where medical follow up requirement and supportability will be considered.

10. **Thyroid Cancer.** Candidates with active thyroid cancer are UNFIT, due to the requirement for long-term monitoring. Candidates with a history of anaplastic or medullary cancers are UNFIT. Other candidates with a history of thyroid cancer (such as with incidentally diagnosed microcarcinomas), that meet the cancer criteria laid out in Annex N (Paras 12 and 13) are FIT provided they also meet all the following criteria:

a. Five years of follow up has been completed with no recurrence,

b. Candidates must be able to work in challenging environments, in a physically demanding job, including in austere locations with limited medical support.

Disorders of calcium metabolism

11. **Hyperparathyroidism (overactive parathyroid gland).** Candidates with hyperparathyroidism who have had definitive surgery, made a full recovery and have been discharged from follow up are FIT.

12. **Other calcium disorders.** Candidates with a history of calcium abnormalities (e.g. vitamin D deficiency) are FIT provided serum calcium levels remain normal for a period of six months without treatment. Candidates with familial hypocalciuric hypercalcaemia are FIT subject to sSMES review. Conditions associated with hypercalcaemia (high calcium) increase the risk of dehydration, osteoporosis and renal stone disease.

[7] Following RAI, approx. 5% of patients per year will become hypothyroid (dose dependent) and require replacement therapy.
[8] For example: 36% relapse rate 2 years following cessation of an 18-month course of carbimazole: Antithyroid drugs and Graves' disease – prospective randomized assessment of long-term treatment. Clin Endocrinol (Oxf). 1999 Jan;50(1):127-32. Relapse is more common in individuals who were young, had raised thyroid receptor antibody, higher thyroid hormone levels or large goitre at diagnosis http://dx.doi.org/10.1530/EJE-16-0725 [accessed 12 Jan 26]
[9] Atrial fibrillation in patients with Graves disease: incidence, risk factors and outcomes - European Heart Journal" [accessed 12 Jan 26]

13. **Hypoparathyroidism (insufficient parathyroid gland activity).** Candidates with hypoparathyroidism are UNFIT, due to lifelong medication and monitoring requirements to prevent hypocalcaemia (low calcium), that can cause muscle weakness and heart arrhythmias which are incompatible with service in austere locations with limited medical support.

Conditions affecting the pancreas

14. **Diabetes mellitus.** Candidates with diabetes mellitus are UNFIT. Both the disease and its treatment can lead to disabilities and complications[10] which affect employability and deployability. Candidates must be able to work in challenging environments, in a physically demanding job, including in austere locations with limited medical support.

15. **Pre-diabetes mellitus.** Candidates with a history of pre-diabetes[11] that have reversed the diagnosis for a period of 24 months[12] and, at the two-year point, can demonstrate two normal HbA1cs (<42mmol/mol) three months apart are FIT E2. Candidates with pre-diabetes[11] not meeting all these criteria are UNFIT. Candidates must be able to work in challenging environments, in a physically demanding job, including in austere locations with limited medical support.

16. **Gestational diabetes mellitus.** Candidates with a history of gestational diabetes mellitus are FIT E2 (requiring life-long HbA1c surveillance due to the raised life-long risk of developing diabetes mellitus) provided they:

a. Have not required anti-diabetic / anti-hyperglycaemic medication during the preceding five years.[13]

b. Demonstrate a normal HbA1c (<42mmol/mol) or Oral Glucose Tolerance Test, without evidence of prediabetes[11] during the past 24 months.

17. **Glycosuria.** Candidates with asymptomatic glycosuria, in the absence of underlying disease (e.g., diabetes, pre-diabetes and or renal disease), are FIT following a normal HbA1c (<42mmol/mol) taken three months after the positive urinalysis. A normal Oral Glucose Tolerance Test (<7.8 mmol/L) taken at any time would meet this criteria.

Conditions affecting the adrenal gland

18. **Adrenal insufficiency.** Candidates with a history of adrenal insufficiency are FIT provided they meet the following criteria:

a. Has not required treatment for one year,

b. Has demonstrated an acceptable response to stimulated cortisol test and has been discharged from follow-up.

19. Candidates with adrenal conditions requiring treatment are UNFIT. Interruption to therapy can be life threatening. Candidates must be able to work in challenging

[10] For example: hypoglycaemia, infections, metabolic disturbance, ketoacidosis, retinopathy, peripheral vascular disease, coronary heart disease, neuropathy and renal disease.
[11] as defined by the World Health Organisation
[12] his figure is based on the consensus view of the contributing Service Endocrinology Consultants
[13] this figure is based on evidence that the risk of developing diabetes mellitus is higher in the first 5 years, and is attenuated over time: *Diabetes Care* 2002;25(10):1862–1868; Diabetes Care. 1993;16(12):1598–1605, Clin Obstet Gynecol. 2021 Mar 1; 64(1): 234–243

environments, in a physically demanding job, including in austere locations with limited medical support.

20. **Adrenal adenomas (benign non-cancerous tumour)**. Candidates with an adrenal adenoma <4cm in size that demonstrate attenuation of ≤10 HU (Hounsfield Unit) on CT scanning, which are non-functioning[14,15] are FIT. Adrenal adenomas not meeting these criteria that remain stable for 12-months and are non-functional may be considered FIT following a referral to a service-approved Endocrinologist for specialist opinion. Candidates must be able to work in challenging environments, in a physically demanding job, including in austere locations with limited medical support.

Conditions affecting the ovary or testicle

21. **Male hypogonadism (insufficient gonad function) and testosterone.** Candidates requiring testosterone replacement are FIT E2, providing the following are met:

a. The candidate is receiving intra-muscular testosterone undecanoate in oil suspension (e.g., Nebido) only,

b. The candidate is self-administering treatment (does not require a health care professional or medical support to administer),

c. Due to the challenges of self-administering, the candidate needs to demonstrate that they are sufficiently trained, able and experienced to self-administer,

d. Stable concentration levels within the local reference range for six months.

22. Candidates who use topical testosterone for menopausal and peri-menopausal symptoms are FIT due to low dose involved and minimal impact on interruption. Other candidates using topical testosterone preparations (e.g. gel) are UNFIT. With exogenous testosterone administration (unlike the administration of exogenous oestradiol (HRT)), stability of concentration is important because the on / off effect carries significant implications for performance. Gels give poor stability of concentration, as do more frequent depot injections (i.e. Enanthate, Sustanon).

23. Candidates using other testosterone preparations (including but not limited to Sustanon and Enanthate) and Human Chorionic Gonadotrophin injections (e.g. choriogonadotropin alfa) are UNFIT, for reasons of testosterone stability,[16] cold chain supply, storage, and ease of administration.

24. **Polycystic Ovary Syndrome (PCOS)**.[17] Candidates whose symptoms have been adequately controlled (use of contraceptives, eflornithine and metformin[18] are acceptable) and have regular periods (menses) (at least four menses per year) for at least 12-months are FIT E2. Candidates prescribed spironolactone are UNFIT due to monitoring requirements and risk of hyperkalaemia (elevated potassium levels) which can affect heart

[14] This figure is based on the consensus view of the contributing Service Endocrinology Consultants
[15] Normal 1mg over-night dexamethasone suppression test, plasma or urine metanephrines, no hypokalaemia, no hypertension, or evidence of clinical steroid hormone excess.
[16] Topical testosterone absorption is affected by a host of individual and environmental factors.
[17] Evidence provided by Birmingham Women's Hospital.
[18] Side effects must be absent. These are commonly gastrointestinal, usually in the form of nausea, and can be ameliorated by taking the medication with food. Stopping treatment with metformin has no sequelae and if BMI = 29 there is no increased incidence of NIDDM.

function. Candidates that do not meet the FIT E2 criteria should be referred to sSMES, where medical follow up requirement and supportability will be considered.

Other Endocrine Conditions

25. **Hyponatremia (low sodium levels).** Asymptomatic candidates whose sodium levels have remained in the normal range and stable for 12 months should be discussed with a service-approved endocrinologist.

26. **Carcinoid tumours, thymic tumours and multiple endocrine neoplasia.** Candidates are UNFIT due to the requirement for continuous monitoring and regular medication. See Annex N Paras 12 and 13.

27. **Diabetes insipidus (arginine vasopressin (AVP) deficiency or resistance).** Due to requirement for monitoring and potential difficulty adapting treatment to achieve normal water balance in adverse environments, candidates with AVP deficiency or resistance are UNFIT.

Novel Weight Loss Drugs

28. **Incretin Mimetics (GLP-1 and GLP-1 + GIP receptor agonist drugs for weight loss).** Candidates are FIT once they have been off medication for a minimum of 6 weeks, allowing sufficient time for the drug to clear, and for appetite, hydration status, and gastrointestinal function to return to baseline. Candidates currently using incretin mimetics (e.g. dulaglutide, exenatide, liraglutide, lixisenatide, semaglutide, or tirzepatide) for weight loss purposes are UNFIT until they have been off medication for a minimum of 6 weeks. These medications act by increasing satiety to reduce caloric intake and increase the potential for dehydration (due to the medication effects on satiety). Dehydration, when present, increases many of the normal risks of physically demanding training, including exertional collapse. This risk may be further increased if gastrointestinal side effects, such as vomiting or diarrhoea, are present.

Annex I

DERMATOLOGICAL PRE-ENTRY

1. **General principles for assessing candidates against this Annex.** The general principles against which a candidate is assessed as FIT for entry, with respect to their skin, are:

a. **Function.** A candidate must have the skin health, in all military environments, to safely and effectively:

(1) Perform their military role wearing appropriate military clothing, including Personal Protective Equipment (PPE) where required.

(2) Operate their personal weapon and use military equipment as required by their role.

b. **Prognosis.** Where a candidate is found to have a resolved, or current or is at an increased risk of developing a skin condition, the following general criteria should be met in addition to the relevant specific paragraph in policy, it should not:

(1) Be foreseeably exacerbated by military service (in particular extremes of heat, cold, or humidity, UV light, environmental conditions (e.g. dust), chemicals (including oils), or use of military equipment).

(2) Pose a significant risk of future temporary or permanent loss of occupational function.

(3) Pose a risk of sudden deterioration / incapacitation without reasonable warning.

(4) Interfere with their ability to wear military clothing, PPE, or other military equipment (including but not limited to body armour, respirators, CBRN equipment, backpacks, camouflage cream).

c. **Medical support requirements.** Where a candidate has a pre-existing or increased risk of a dermatological condition, there must be no reasonably foreseeable requirement for medical care within the deployed location beyond deployed Primary Healthcare (or equivalent). The medical condition must be stable with treatment. Should loss of medication occur for ≤ one week this should not lead to clinical deterioration in the condition or functional degradation during that time. In the deployed environment the condition should not foreseeably impact military medical resource.

2. **Exceptional considerations.** Criteria within each condition has been outlined to grade a candidate as FIT or UNFIT. Where there is any doubt, advice should be sought from the single Service Medical Entry Staff (sSMES).

Assessment of skin conditions

3. Skin conditions are often long term (chronic) and relapsing with times when the skin appears 'normal' and times when the skin is clearly affected. A detailed history of skin symptoms, conditions, and predictable triggers should be taken, alongside adequate examination, noting that the examination may be normal at the time of assessment.

4. Skin conditions associated with underlying systemic conditions should prompt careful examination and candidates may need to be advised to return to their GP for further investigations.

Inflammatory skin conditions

5. **Acne.** Candidates with acne that has resolved with or without treatment, are FIT. Candidates with current acne are assessed as follows:

a. **Current treatment – topical and / or oral antibiotics**. Candidates with current acne using topical treatments and / or oral antibiotics are FIT providing that there are no significant treatment side effects[1] and they are able to wear military clothing and PPE (including respirators) and shave for operational purposes.

b. **Current treatment – isotretinoin**. Candidates who are taking isotretinoin are UNFIT but are FIT a minimum of four weeks after successful completion of treatment as most adverse treatment side effects should have settled. If adverse side effects are ongoing, candidates should be referred to sSMES. Candidates must be able to wear military clothing and PPE (including respirators) and shave for operational purposes.

c. **Current treatment – spironolactone**. Candidates taking spironolactone are UNFIT due to the risk of hyperkalaemia (high blood potassium) and the requirement for ongoing blood monitoring.

d. **Untreated.** Candidates who have active acne that affects the ability to wear military clothing and PPE (including respirators) and shave for operational purposes are UNFIT.

6. **Hidradenitis suppurativa (Acne like condition affecting armpits and groins).** Candidates with a history of hidradenitis suppurativa who have been symptom-free without treatment for a minimum period of three years[2] are FIT. Candidates with active hidradenitis suppurativa are UNFIT as military service is physically demanding and is likely to result in worsening of symptoms.

Dermatitis

7. **Atopic dermatitis (Eczema).** Living in field conditions is associated with multiple triggers for exacerbations of eczema. Safe use of treatments such as topical steroids and calcineurin inhibitors (e.g. Protopic®) may be limited by reduced access to normal personal hygiene facilities. A history of eczema is also associated with a higher likelihood of developing infection, irritant and allergic contact dermatitis.

[1] For example, acid reflux, sun sensitivity
[2] Military SME judgement

8. Severity should be classified following national guidance[3] as summarised in the following table:

Severity	Characteristics
Clear	Normal skin and no evidence of active eczema
Mild	Areas of dry skin, and infrequent itching (with or without small areas of redness)
Moderate	Areas of dry skin, frequent itching, and redness (with or without excoriation and localized skin thickening)
Severe	Widespread areas of dry skin, incessant itching, and redness (with or without excoriation, extensive skin thickening, bleeding, oozing, cracking, and alteration of pigmentation).

9. Candidates with a history and evidence from medical records compatible with mild or moderate eczema and no active eczema are FIT provided they meet all the following criteria:

a. There is no history or evidence from medical records indicating intense itching in the last year[4], such as documented or observed presence of excoriations or a history of distractibility affecting ability to work / function due to itching,

b. There is no history or evidence from medical records indicating recurrent sleep disturbance caused by itching or skin discomfort, within the last year[5],

c. There has been no specialist or shared care management required to sustain function (education or work attendance, or limiting exercise) and / or skin integrity within the last three years.[6]

d. Potent or strongly potent topical steroids[7] have not been prescribed in the last three years[8], as use of these treatments are usually indicative of a more severe condition.

e. Use of occlusive dressings has not been recommended in the last three years[9], as this is usually indicative of a more severe condition.

f. Systemic immunomodulatory therapy (including disease-modifying antirheumatic drugs and biologics[10]) has never been prescribed, as this is usually indicative of a more severe condition.

g. Phototherapy has not been prescribed in the last three years.[11]

h. There has been no involvement of the hands or feet in the last three years[12] to an extent that affects function (affecting education or work attendance, limiting

[3] Adapted from NICE CKS: Eczema – Atopic. Updated Mar 25 [accessed 12 Jan 26]
[4] Military SME judgement
[5] Military SME judgement
[6] Military SME judgement
[7] BNF Topical corticosteroid preparation potencies [accessed 12 Jan 26]
[8] Military SME judgement
[9] Military SME judgement
[10] Including but not limited to methotrexate, sulphasalazine, hydroxychloroquine, daily prednisolone, cytokine modulators, TNF-alpha inhibitors, monoclonal antibodies
[11] Military SME judgement
[12] Military SME judgement

exercise. or resulting in sleep disturbance) or that would result in difficulty wearing military gloves or military footwear.

i. There has been no involvement of the face or scalp in the last three years[13] that would affect wearing military personal protective equipment such as helmet and the General Service Respirator.

10. Candidates with mild active eczema which does not affect function or the ability to wear or use military clothing or equipment, who meet the criteria in Para 9, should be referred to sSMES for a determination of FIT / UNFIT.

11. Candidates with moderate or severe active eczema or history from their medical records indicating severe eczema after the age of 12 years are UNFIT due to the potential for further exacerbations as a result of military service.

12. **Contact dermatitis.** All Service Personnel may be called upon to operate in environments where exposure to skin irritants and / or sensitisers cannot always be adequately controlled.

a. **Irritant contact dermatitis.** A candidate who has experienced isolated episodes of irritant contact dermatitis are FIT subject to a normal skin assessment at entry medical examination. Candidates with significant irritant contact dermatitis related to a hazard likely to occur in service are UNFIT due to the risk of exacerbation.

b. **Allergic contact dermatitis.** Candidates with mild local reaction to nickel products (e.g. jewellery, watches, belt buckles) are FIT. Candidates with a history of allergic contact dermatitis confirmed by patch testing may be FIT if the allergen is unlikely to be encountered during military service[14], subject to assessment by sSMES.

13. **Pompholyx (hand and / or foot eczema with tiny blisters).** Candidates with a history of recurrent and / or active pompholyx-type dermatitis should be assessed under the criteria for atopic dermatitis (eczema Para 7).

Psoriasis

14. Candidates with psoriasis affecting <10% Body Surface Area (BSA)[15,16] are FIT provided they meet all the following criteria:

a. The condition has not involved the hands[17] or feet to an extent that affects function (affecting education or work attendance, or limiting exercise, or resulting in sleep disturbance) or that would result in difficulty wearing gloves, footwear, or head coverings (e.g. helmet, beret, etc) or is in a location that would affect the ability to wear military clothing or PPE (e.g. body armour, respirator etc).

[13] Military SME judgement
[14] Potential exposures may be specific to role / specialism
[15] Body Surface Area: Sect 1 and Figure 2 from Hanifin JM et al. The Eczema area and Severity Index – A Practical Guide. Dermatitis. 2022;33(3):187-192 [accessed 12 Jan 26]
[16] NICE CKS requirement for specialist referral includes >10% BSA (https://cks.nice.org.uk/topics/psoriasis/ [accessed 12 Jan 26])
[17] Mild nail involvement is acceptable (pitting, leukonychia, Beau lines)

b. Treatment is self-managed and limited to emollients (moisturisers), soap substitutes, bath additives, topical Vitamin D analogues, topical calcineurin inhibitors, and / or up to topical potent steroids.[18,19] Candidates using very potent steroids[20] are UNFIT because of the risk of rebound (symptoms getting worse) when they stop using the steroid.

c. The candidate has never required treatment with systemic agents (including but not limited to methotrexate, ciclosporin, acitretin, apremilast, dimethyl fumarate, prednisolone, cytokine modulators, TNF-alpha inhibitors, or monoclonal antibodies).

d. Flexural areas are not currently affected (including under the breasts, in the armpits, and / or in the groin) as these areas are more difficult to treat and are likely to become problematic during Phase one training.

e. Previous treatment with phototherapy (not including systemic photochemotherapy[21]) is acceptable, provided criteria above are met.

15. Candidates with previous history of psoriasis affecting >10% BSA are FIT providing they meet the criteria under Para 14 for the last five years.

16. **Guttate psoriasis.** Candidates with a history of guttate psoriasis which has fully resolved (irrespective of treatment) and are symptom free for a minimum period of two years[22] are FIT. Candidates with a history of guttate psoriasis that has developed into plaque psoriasis should be assessed under Para 14 and 15 above.

17. **Nail changes due to psoriasis.** Candidates with mild nail changes (e.g. pitting, leukonychia, ridging, oil spots, onycholysis) are FIT provided that there is no impact on ability to wear military clothing (e.g. gloves, footwear etc) and use military equipment including PPE.

18. **Psoriatic arthritis.** Candidates with psoriatic arthritis should be assessed under Annex K Para 4.

Other skin diseases

19. **Cysts, scars and keloids.** Candidates are FIT provided that the size or location of cysts, scars or keloids (from whatever cause) does not affect the ability to wear military clothing or the ability to operate military equipment.

20. **Birthmarks.** Candidates are FIT unless the size or location of pigmented or vascular lesions could affect the ability to wear military clothing or the ability to operate military equipment.

21. **Bullous dermatoses (blistering skin conditions).** Candidates with any immuno-bullous disease such as dermatitis herpetiformis or any genetic bullous disease such as

[18] BNF Topical corticosteroid preparation potencies [accessed 12 Jan 26]
[19] Treatment for eczema and psoriasis is differs because of disease biology, therefore acceptable level of topical steroids is different.
[20] BNF Topical corticosteroid preparation potencies [accessed 12 Jan 26]
[21] Oral PUVA
[22] Persistent psoriasis is common post a single episode of guttate psoriasis (around 50%) but no increasing pattern in years 2 to 11 of follow-up: Galili E, Levy SR, Tzanani I, et al. New-Onset Guttate Psoriasis: A Long-Term Follow-Up Study. *Dermatology.* 2023;239(2):188-194 [accessed 12 Jan 26]

epidermolysis bullosa are UNFIT as military environment may exacerbate blistering from minor trauma.

22. **Fungal infections.** Candidates with mild or limited fungal infections, that do not impact function (e.g. ability to undertake physical training) are FIT. Candidates with extensive or difficult to treat fungal infections to an extent that affects function (affecting education or work attendance, or limiting exercise, or resulting in sleep disturbance) or that would result in difficulty wearing military clothing or PPE are UNFIT due to the impact on function, the risk of spread of infection, and the requirement for medical treatment.

23. **Viral warts and verrucae.** Candidates with mild or limited verrucae or viral warts, that do not impact function (e.g. ability to undertake physical training) are FIT. Candidates with extensive or difficult to treat viral warts or verrucae to an extent that affects function (affecting education or work attendance, or limiting exercise, or resulting in sleep disturbance) or that would result in difficulty wearing military clothing or PPE are UNFIT due to the impact on function.

24. **Bacterial Skin Infection**. Candidates with active bacterial skin infection are UNFIT due to the impact on function, the risk of spread of infection, and the requirement for medical treatment.

25. **Infestations (Scabies or lice).** Candidates with a history of an infestation are FIT provided it has been treated. Candidates with active infestations are UNFIT due to the impact on function, the risk of spread of infection, and the requirement for medical treatment.

26. **Tropical skin diseases (including but not limited to cutaneous leishmaniasis, cutaneous larva migrans, leprosy).** Candidates with a history of a tropical skin disease are FIT provided it has been treated. Candidates with active tropical skin disease are UNFIT due to the impact on function, the risk of spread of infection, and the requirement for medical treatment.

27. **Folliculitis including pseudofolliculitis barbae.** Candidates with facial folliculitis (inflamed hair follicles) who are able to shave for operational reasons for a minimum of two weeks duration (i.e. a CBRN environment) and don't require medically prescribed treatment or supplies are FIT. Candidates with extensive or difficult to treat inflammation of the hair follicles that would affect the ability to wear miliary clothing or PPE are UNFIT.

28. **Hyperhidrosis (excessive sweating).** Candidates with hyperhidrosis who only require topical treatment (e.g. antiperspirants) are FIT. Candidates with hyperhidrosis affecting function (e.g. having to frequently change clothing, socks, footwear etc) or who are receiving iontophoresis or botulinum toxin injections are UNFIT due to the requirement for regular specialist medical appointments.

29. **Malignant skin disease (skin cancer).** Candidates with a history of malignant skin disease including malignant melanoma, squamous cell carcinoma, or basal cell carcinoma, should be assessed in accordance with the guidance for malignant disease in Annex N Paras 12 and 13. Candidates with malignant skin disease including malignant melanoma, squamous cell carcinoma, or basal cell carcinoma, who are currently undergoing treatment or who have not been discharged from follow-up are UNFIT.

30. **Pre-malignant skin conditions.** Candidates with a history of pre-malignant skin conditions are FIT if they are no longer under active dermatological review.

a. Candidates with a history of keratinocyte derived disease such as actinic keratosis, Bowen's disease, vulval or penile intra-epithelial neoplasia who have completed specialist treatment are FIT.

b. Candidates who have had complete excision of dysplastic naevus / naevi are FIT.

31. **Photosensitivity.** Candidates with a history of polymorphic light eruption and / or juvenile spring eruption not requiring secondary care treatment in the last three years[23] are FIT. Candidates with a medical condition that causes sun-sensitivity (including but not limited to cutaneous lupus, solar urticaria, porphyria) requiring treatment, including specialist non-issue sunscreen or prescribed treatment, are UNFIT due to the requirement for ongoing access to specialist medical care.

32. **Vitiligo.** Candidates with vitiligo not associated with any other auto-immune disorder are FIT. Candidates with vitiligo have a comparable risk profile for photosensitivity and skin cancer as those with Type 1 skin.[24]

33. **Scleroderma.** Refer to Annex K Musculoskeletal Para 10. Candidates with limited or diffuse systemic sclerosis are UNFIT due to the ongoing requirement for secondary care input.

34. **Morphoea.** Candidates with morphoea that has been stable in size over the last three years[25] and does not affect their ability to wear military clothing, PPE, or operate military equipment are FIT.

35. **Urticaria.**

a. **Acute urticaria.** Candidates with a history of acute idiopathic (no clear provoking factor) urticaria or urticaria associated with viral illness are FIT if they have been symptom free for six months.[26] Candidates who have active acute urticaria are UNFIT, even in the absence of systemic symptoms such as angioedema, because of the distracting or incapacitating symptoms. Candidates with a history of acute urticaria provoked by allergens should be assessed Annex N Other Conditions from Para 33 - 36.

b. **Chronic spontaneous urticaria.** Candidates with chronic spontaneous urticaria (symptoms present for more than six weeks) which has fully resolved and have been free from symptoms without medication for two years[27] are FIT. Candidates who have active chronic spontaneous urticaria are UNFIT, even if this is controlled with regular medication, due to the distracting or incapacitating symptoms.

c. **Chronic physical urticaria.** Candidates with a history of chronic physical urticaria (i.e. in response to heat, cold, physical exercise, or sunlight) are UNFIT,

[23] Military SME judgement
[24] The Fitzpatrick skin type scale type 1 Ivory: pale skin, light or red hair, prone to freckles. Burns very easily and rarely tans.
[25] Military SME judgement
[26] Military SME judgement
[27] Military SME judgement

even if fully controlled with medication, due to the distracting or incapacitating symptoms.

Annex J

GENDER HEALTH PRE-ENTRY

1. The general principles against which an individual is assessed are:

   a. **Function**. Service personnel must have the physical and cognitive function, in all military environments, to safely and effectively:

      (1) Perform their military role.

      (2) Operate their personal weapon.

   b. **Prognosis.** Where a candidate is found to have a resolved or current medical condition, the following general criteria should be met in addition to the relevant specific paragraph in policy, it should not:

      (1) Be foreseeably exacerbated by military service (in particular, extremes of cold/heat, atmospheric pressure, environmental conditions, or chemicals).

      (2) Pose a significant risk of future temporary or permanent loss of function.

      (3) Pose a risk of sudden deterioration/incapacitation without reasonable warning.

   c. **Medical support requirements.** Where a candidate has a pre-existing or increased risk of a gender health condition, there must be no reasonably foreseeable requirement for medical care within the deployed location beyond deployed Primary Healthcare (or equivalent). The medical condition must be stable with treatment. Should loss of medication occur for ≤ one week this should not lead to clinical deterioration in the condition or functional degradation during that time. In the deployed environment the condition should not foreseeably impact military medical resource

2. **Exceptional considerations.** Criteria within each condition has been outlined to grade a candidate as FIT or UNFIT. Where there is any doubt, advice should be sought from the Single Service Medical Entry Staff (sSMES).[1]The resultant FIT or UNFIT outcome will be determined by sSMES.

Women's Health

Breast conditions

3. **Breast Pain.** Candidates with chronic breast pain are FIT provided their functional ability to wear Personal Protective Equipment (e.g. body armour) or use military equipment (e.g. Bergen, weapons) is not affected and they are able to fully participate in activities comparable with military training. Candidates with chronic breast pain that causes functional impairment are UNFIT.

[1] Delegated Authority arrangements may apply.

4. **Breast Surgery**. Candidates with a history of breast surgery (including but not limited to enhancement or reduction) are FIT provided their functional ability to wear Personal Protective Equipment (e.g. body armour) or use military equipment (e.g. bergen, weapons etc) is not affected and they are able to tolerate activities comparable with military training for at least three months following surgery.

5. **Benign (non-cancerous) breast conditions**. Candidates with a history of benign (non-cancerous) breast conditions (including but not limited to fibroadenoma, breast cysts, fat necrosis, breast abscess) are FIT following specialist breast clinic assessment that no further medical or surgical management is required. Candidates who require ongoing medical or surgical management are UNFIT until this has been completed and they are able to tolerate activities comparable with military training over a minimum of three months after surgery, due to the requirement to access specialist medical care.

6. **Breast cancer.** Candidates with a history of breast cancer should be considered under Annex N Paras 12 & 13. Candidates who are undergoing treatment for breast cancer are UNFIT due to the requirement for uninterrupted access to specialist medical care.

7. **Pre-malignant (pre-cancerous) or pre-invasive breast conditions.**

   a. **Lobular carcinoma in situ (LCIS)**. Candidates with a history of LCIS are FIT provided surgical treatment (if indicated) is completed, specialist follow-up is no more frequent than every six months and the candidate has tolerated activities comparable with military training over a minimum period of three months after surgery.

   b. **Ductal carcinoma in situ (DCIS).**[2] Candidates with a history of DCIS are FIT provided surgical treatment (if indicated) is completed, specialist follow-up is no more frequent than every six months and the candidate has tolerated activities comparable with military training over a minimum period of three months after surgery.

8. **Breast cancer (BRCA) gene carriers[3] and equivalent risks**. Candidates who have a genetic predisposition to hereditary breast cancer are FIT E2 provided their health surveillance requirements are compatible with service. Genetic testing should NOT be initiated solely for the purposes of recruitment.

Conditions related to menstrual health (periods)

9. **Menorrhagia (heavy periods).**[4] Candidates with heavy periods (including those with a diagnosis of adenomyosis[5]) are FIT provided there is no functional impairment (affecting education or work attendance, or limiting exercise), or symptoms successfully treated with readily available medication.[6] Candidates who have heavy periods affecting education or work attendance, limiting exercise, or causing anaemia, are UNFIT.

10. **Amenorrhoea (absent periods).** Candidates with absent periods due to hormonal / contraceptive treatment are FIT. Candidates with absent periods not caused by hormonal /

[2] This condition is a pre-invasive cancer, affecting the cells of the milk ducts in the breast. Local recurrence is reported as between 1-in-3 and 1-in-6 patients at 5 years and patients are likely to require at least annual follow-up for a minimum of 5 years.
[3] A beginner's guide to BRCA1 and BRCA2 | Royal Marsden Patient Information Library [accessed 12 Jan 26].
[4] Defined by NICE as excessive menstrual blood loss which interferes with a woman's physical, social, emotional and/or material quality of life.
[5] Adenomyosis is a condition where the lining of the womb (uterus) starts growing into the muscle in the wall of the womb.
[6] Including but not limited to Oral Contraceptive Pill, simple analgesia, tranexamic acid, mefenamic acid.

contraceptive treatment who have not been investigated to identify a cause are UNFIT. Candidates with an established cause (not thought to be caused by a hormonal treatment) should be discussed with the sSMES because absent periods are linked to an increased risk of bone stress injury and musculoskeletal injury associated with physically demanding activity.[7]

11. **Oligomenorrhoea (infrequent periods).** Candidates who have at least four periods per year are FIT. Candidates having three or fewer periods per year, who have not been investigated to confirm the underlying reason are UNFIT because of the increased risk of health complications (e.g. stress fractures).

12. **Unscheduled bleeding**. Candidates with a benign or treated cause of unscheduled bleeding are FIT provided there is no functional impairment (affecting education or work attendance, or limiting exercise. Candidates with undiagnosed, unscheduled bleeding (such as intermenstrual or post coital bleeding) are UNFIT until underlying conditions have been excluded.

Pelvic conditions

13. **Chronic / Persistent pelvic pain.** Chronic / persistent pelvic pain (defined as a duration of over six months) is a symptom, not a diagnosis, and can be caused by a number of conditions. These conditions are often complex to manage and can cause significant functional limitations. The following list is not exhaustive:

a. **Dysmenorrhoea (painful periods)**. Candidates with a history of painful periods (including those with a diagnosis of adenomyosis) are FIT provided there is no significant functional impairment (affecting education or work attendance, or limiting exercise), or they are successfully treated with readily available medication.[8]

b. **Endometriosis.** Candidates with diagnosed endometriosis whose symptoms remain well controlled with readily available medication[9] (excluding GnRH analogues, due to medical follow-up requirements) or 12 months post-surgery[10] are FIT. Those who continue to have symptoms after treatment that require time off education, work, or limit exercise are UNFIT.

c. **Chronic / persistent or functional pelvic pain symptoms.** Candidates with chronic pelvic pain symptoms that do not cause functional impairment (affecting education or work attendance, or limiting exercise), or which has been successfully controlled with readily available medication[11], are FIT. Candidates with undiagnosed chronic pelvic pain symptoms or a diagnosis of functional pelvic pain or chronic pelvic pain syndrome are UNFIT due to the requirement for ongoing access to specialist care.

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[7] Ackerman KE et al. Fractures in relation to menstrual status and bone parameters in young athletes. Med Sci Sports Exerc. 2015; 47(8):1577–86. Lloyd T, Triantafyllou SJ, Baker ER, et al. Women athletes with menstrual irregularity have increased musculoskeletal injuries. MedSci Sports Exerc. 1986;18(4):374–9. Hutson MJ, O'Donnell E, Petherick E, Brooke-Wavell K, Blagrove RC. Incidence of bone stress injury is greater in competitive female distance runners with menstrual disturbances independent of participation in plyometric training. J Sports Sci. 2021;39(22):2558–66. Heikura IA, Uusitalo ALT, Stellingwerff T, Bergland D, Mero AA, Burke LM. Low energy availability is difficult to assess but outcomes have large impact on bone injury rates in elite distance athletes. Int J Sport Nutr Exerc Metab. 2018;28(4):403–11.

[8] Including but not limited to Oral Contraceptive Pill, simple analgesia, tranexamic acid, mefenamic acid

[9] E.g. Mirena coil, oral contraceptive pill, simple analgesia, tranexamic acid, mefenamic acid

[10] Due to post-surgical complications

[11] Including but not limited to Oral Contraceptive Pill, simple analgesia, tranexamic acid, mefenamic acid

14. **Pelvic Inflammatory Disease (PID).** Candidates with a history of uncomplicated pelvic inflammatory disease (PID) are FIT. Those with treated complications of PID without ongoing functional impairment (affecting education or work attendance or limiting exercise) are FIT. Only those with long-term sequelae of PID causing significant functional impairment (affecting education or work attendance or limiting exercise) are UNFIT.

15. **Pelvic organ prolapse.** This includes vaginal, urinary tract, and anorectal prolapse symptoms. Candidates who are symptom-free with no functional impairment (affecting education or work attendance, or limiting exercise) are FIT. Candidates who have received successful treatment or surgical repair (without mesh) with no functional impairment (affecting education or work attendance, or limiting exercise) are FIT. Candidates who have undergone mesh repair should be referred to sSMES. Candidates with symptomatic prolapse are UNFIT due to functional limitations associated with physical activity.

Uterine conditions

16. **Uterine tumours.** Uterine tumours are classified as benign or malignant.

    a. **Benign (non-cancerous).** Candidates with uterine fibroids and adenomyomas that do not cause significant functional impairment (affecting education or work attendance, or limiting exercise), or those which have been successfully treated, are FIT.

    b. **Malignant (cancer).** Candidates with a history of malignant uterine tumours should be assessed in accordance with the guidance for malignant disease at Annex N Paras 12 and 13.

17. **Hysterectomy.** Candidates who have undergone laparoscopic, vaginal, or abdominal hysterectomy more than three months previously and have no functional impairment are FIT. Candidates with a history of malignancy (cancer) resulting in hysterectomy should be assessed in accordance with the guidance for malignant disease at Annex N Paras 12 and 13.

Ovarian conditions

18. **Polycystic Ovary Syndrome (PCOS).**[12] Candidates should be assessed under Annex H Endocrine Para 24.

19. **Absence or removal of ovary / ies**. Candidates with one ovary are FIT. Candidates with no ovaries should be assessed under the Premature Ovarian Insufficiency paragraph, below.

20. **Ovarian cysts**. Are classified as benign (non-cancerous), borderline, or malignant (cancerous):

    a. **Benign (non-cancerous).** Candidates with small (<5 cm) simple (follicular) ovarian cysts who have no symptoms are FIT. Candidates with successfully treated large (>5 cm) ovarian cysts, and no functional impairment (affecting education or work attendance, or limiting exercise) are FIT. Candidates with symptomatic cysts or those >5 cm are UNFIT due to the risk of torsion and need for further investigation

[12] Evidence provided by ESHRE https://www.eshre.eu/Guidelines-and-Legal/Guidelines/Polycystic-Ovary-Syndrome [accessed 12 Jan 26]

and treatment. Candidates with dermoid cysts >5 cm are UNFIT due to risk of torsion. Candidates with dermoid cysts <5 cm may require long term monitoring and all cases should be referred to sSMES.

b. **Borderline.** Candidates with a confirmed diagnosis of borderline ovarian cyst(s) who have completed treatment but require long term monitoring should be referred to sSMES.

c. **Malignant (cancerous).** Candidates with a history of malignant ovarian tumours should be graded in accordance with the guidance for malignant disease at Annex N Paras 12 and 13.

21. **Premature Ovarian Insufficiency (POI).** Candidates with a history of premature ovarian insufficiency that has been investigated and treated by a specialist, who have been returned to their GP for ongoing care, and who have no symptoms causing functional impairment, and no concurrent co-morbidities[13] needing treatment are FIT. Candidates who are not adequately treated are UNFIT as they are at increased risk of long-term health consequences.

Cervical Conditions

22. **Abnormal cervical screening test.** Candidates with abnormal cervical screening test should be assessed according to planned recall to the National Cervical Screening Programme[14], and need for investigation and treatment:

a. The following candidates are FIT:

(1) Candidates whose most recent cervical screening is a high-risk Human Papilloma Virus (hrHPV) NEGATIVE sample.

(2) Candidates whose most recent cervical screening is a hrHPV POSITIVE sample on 12-month recall for cervical screening.

(3) Candidates whose most recent cervical screening is a hrHPV POSITIVE sample who have had colposcopy and are on either 12-month or 36-month recall for cervical screening.

(4) Candidates whose most recent cervical screening is a hrHPV POSITIVE sample who have had colposcopy and a subsequent LLETZ[15] and are on six-month recall for cervical screening.

b. The following candidates are UNFIT whilst they are under active clinical management:

(1) Candidates whose most recent cervical screening result is INADEQUATE SAMPLE as this must be repeated at three-months. Once the repeat result is available, fitness should be considered under the appropriate result.

[13] Hypertension, diabetes, hyperlipidaemia, cardiovascular disease, osteoporosis, osteopaenia
[14] Cervical screening: programme overview - GOV.UK (www.gov.uk) [accessed 12 Jan 26]
[15] Large Loop Excision of Transformation Zone

(2) Candidates whose most recent cervical screening is a hrHPV POSITIVE sample, who have had colposcopy and require colposcopy follow-up.

(3) Candidates whose most recent cervical screening is a hrHPV POSITIVE sample, who have had colposcopy and a subsequent LLETZ, and who have been diagnosed with cervical cancer. These candidates should be assessed under Annex N Paras 12 and 13.

c. Participation in the National Cervical Screening Programme is not required for the purposes of recruitment.

d. Please see Figure 1 Flowchart

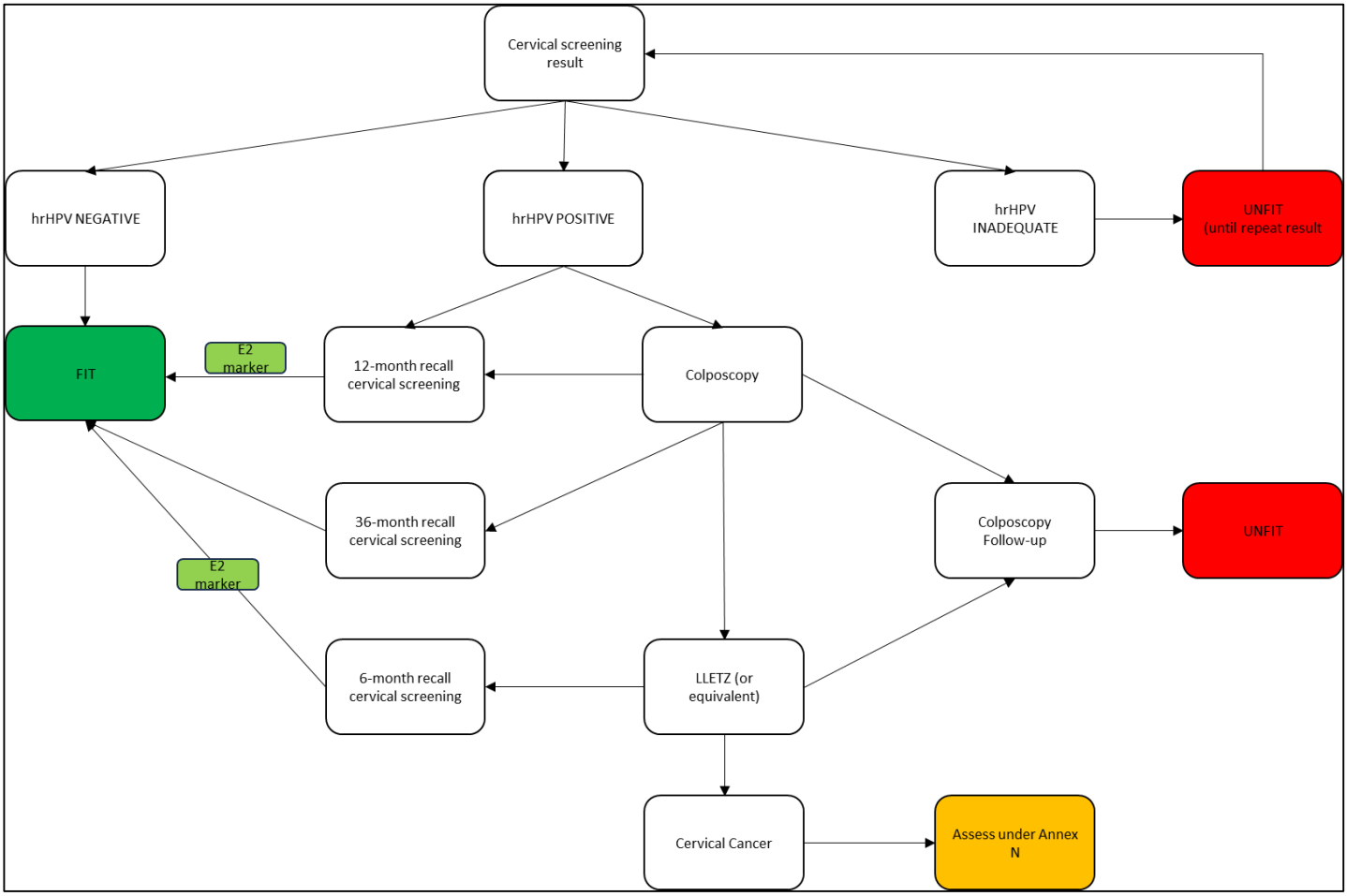

Figure 1 – Cervical Screening Flowchart

23. **Cervical cancer.** Candidates with a history of cervical cancer should be in accordance with the guidance for malignant disease at Annex N Paras 12 and 13. Candidates with a history of treated cervical cancer Stage 1a1 may be FIT and should be discussed with the sSMES.

Perimenopause / Menopause

24. Candidates with perimenopausal or menopausal symptoms that do not cause cognitive and / or physical functional impairment, including those using hormone replacement therapy (HRT), are FIT. Candidates who have uncontrolled symptoms that cause cognitive and / or physical functional impairment (impact on education or work attendance, or limiting exercise) are UNFIT.

Fertility

25. Candidates actively undergoing fertility investigations or treatment, within secondary care, are UNFIT until complete due to the requirement for timely access to treatment, urgent review for treatment complications, and geographical stability.

Conditions related to pregnancy

26. **Pregnancy.** Candidates who are pregnant are UNFIT due to the risk to the unborn baby and maternal health. Candidates are FIT 26 weeks after birth provided there are no significant post-natal complications.

27. **Pregnancy loss.** Candidates who have had a recent pregnancy loss (within the last 26 weeks) are FIT provided there are no unresolved complications (e.g. excessive bleeding, pain or ongoing medical care) as follows:

a. **Early (<14 weeks gestation).** Candidates are FIT at six weeks after an early pregnancy loss.

b. **Second trimester (14 – 24 weeks gestation).** Candidates are FIT at 12 weeks after a second trimester pregnancy loss.

c. **Late (>24 weeks).** Candidates are FIT at 26 weeks after a late pregnancy loss.

28. **Termination of pregnancy.** Candidates who have had a recent termination of pregnancy (within the last 26 weeks) are FIT provided there are no unresolved complications (e.g. excessive bleeding, pain or ongoing medical care) as follows:

a. **Early (<14 weeks gestation).** Candidates are FIT at six weeks after an early termination of pregnancy.

b. **Second trimester (14 – 24 weeks gestation).** Candidates are FIT at 12 weeks after a second trimester termination of pregnancy.

c. **Late (>24 weeks).** Candidates are FIT at 26 weeks after termination of pregnancy.

29. **Ectopic Pregnancy and Pregnancy of Unknown Location (PUL).** Candidates who have had a recent ectopic pregnancy or PUL (within the last 12 weeks) should be assessed as follows:

a. **Conservative Management.** Candidates who have been conservatively or medically managed for an ectopic pregnancy or PUL are FIT after six weeks provided they have been discharged from follow up and no ongoing treatment is needed.

b. **Surgical Management.** Candidates with a history of surgically managed ectopic pregnancy or PUL are FIT 12 weeks after surgery once discharged from follow up and no ongoing treatment is needed.

30. **Gestational trophoblast disease (Molar pregnancy).** Molar pregnancies are classified as invasive, non-invasive, or malignant (cancerous).

a. Candidates with a history of non-invasive molar pregnancy are FIT once discharged from follow up without ongoing treatment or functional impairment.

b. Candidates with a history of invasive molar pregnancy may be FIT provided they meet all the following criteria:

(1) Specialist follow-up is no more frequent than six-monthly.

(2) Surgical treatment (if indicated) has been completed.

(3) The candidate has tolerated activities comparable with military training for at least three months following surgery.

(4) Each candidate should be considered on a case-by-case basis and referred to sSMES for assessment.

c. Candidates with a history of other malignant (cancerous) pregnancy should be managed in accordance with Annex N Paras 12 and 13.

31. **Breastfeeding**. Candidates who have given birth within the last 12 months should be asked whether they are breastfeeding because this is associated with reduced bone mineral density[16] which may increase the risk of bone stress injuries. Candidates will be expected to confirm they are able to conduct physical activities comparable with military training / service.

Female Genital Mutilation (FGM)

32. Candidates who have undergone FGM, do not have ongoing physical symptoms and have no functional impairment (impact on education or work attendance, or limiting exercise) are FIT. Candidates who report that they have undergone FGM and have complications or symptoms are to be referred to sSMES. Candidates are **NOT** to be examined for signs of FGM. There is a mandatory reporting duty in UK legislation[17]; health professionals MUST make a report to the police where they have been informed by a girl under 18 that an act of FGM has been carried out on her.

Men's Health

33. Prostate conditions, testicular conditions, and penile conditions are covered in Annex F Renal and Urology.

34. **Male Pattern Baldness / Hair Loss**. Candidates who are taking finasteride for treatment of male pattern baldness / hair loss are FIT provided they have been taking the medication for more than 28 days, and do not report any treatment side effects (including but not limited to low mood and / or thoughts of self-harm or suicide). Candidates with treatment side effects are UNFIT whilst they continue to take finasteride because military training is physically and mentally demanding and could exacerbate mental health side effects.

[16] which returns to normal once breastfeeding has finished.
[17] Mandatory reporting of female genital mutilation: procedural information (accessible version) - GOV.UK (www.gov.uk) [accessed 12 Jan 26]

35. **Breast cancer (BRCA) gene carriers[18] and equivalent risks**. Candidates who have a genetic predisposition to hereditary breast cancer are FIT E2 provided their health surveillance requirements are compatible with service. Genetic testing should NOT be initiated solely for the purposes of recruitment.

Fertility

36. Candidates actively undergoing fertility investigations or treatment, within secondary care, are UNFIT until complete due to the requirement for timely access to treatment, urgent review for treatment complications, and geographical stability.

Trans[19] Medicine

Introduction

37. These paragraphs should be read in conjunction with JSP 889 Policy for the Recruitment and Management of Transgender Personnel in the Armed Forces V1.1 dated Aug 2019.[20]

38. Many Trans women and men change their gender expression to bring it into alignment with their gender identity (which may include non-binary identities).[21] This process is known as 'transition' and may include physical, psychological, social and emotional changes. It may also (but does not necessarily) involve various types of medical treatment (e.g. hormones, surgery), to bring a person's characteristics more into conformity with their preferred gender identity and expression. Some Trans and non-binary people have no desire to undergo surgery or take medicines to change their body. They may transition in other ways.[22]

39. Whilst a 'transgender applicant is ordinarily under no obligation to reveal to a recruiter', (or to anyone in the recruitment process) that they are transgender, or their gender history'[23], there is a requirement to understand the medical history and needs of every candidate. Medical information about Trans medicine obtained, produced and recorded by medical personnel involved in recruitment will be handled confidentially and is not routinely disclosed to non-medical personnel.

40. Trans candidates are required to meet the same medical entry standards as any other candidate. The requirements for assessment for specialist career employment groups (e.g. aircrew, divers) are not included in this Section. Reference should be made to the relevant single-Service guidelines.[24]

41. **Gender-questioning.** Candidates who may be processing, questioning, or exploring how they want to express their gender identity (gender-questioning) are FIT, noting the requirements of Paras 37 – 40, above.

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[18] A beginner's guide to BRCA1 and BRCA2 | Royal Marsden Patient Information Library [accessed 12 Jan 26].
[19] An 'umbrella' term incorporating all personnel who do not identify as cisgender, including but not limited to trans, non-binary, etc.
[20] Available from: https://www.gov.uk/government/collections/joint-service-publication-jsp
[21] This is an umbrella term used to describe people who do not feel male or female. They may feel they embody elements of both, that they are somewhere in between or that they are something different. Non-binary people can find it very distressing to be told that they must identify themselves as male or female. This may include gender-fluidity.
[22] 2023 BMA Inclusive care of trans and non-binary patients (bma.org.uk) [accessed 12 Jan 26].
[23] JSP 889 Policy for the Recruitment and Management of Transgender Personnel in the Armed Forces V1.1 dated Aug 2019 [accessed 13 Jan 26]
[24] Current versions of BRd 1750A [accessed 13 Jan 26] (RN), AGAI 78 [accessed 13 Jan 26] (Army), AP1269A [accessed 13 Jan 26] (RAF) and any associated DINs or single Service Policy Letters.

42. **Gender Affirming Hormone Assessment.** Candidates who are awaiting assessment for Gender Affirming Hormone Treatment (GAHT) and / or gender incongruence surgery are FIT, noting the requirements of Para 37 – 40, above.

43. **Interim medical assessment process.** To ensure optimal assessment, all Trans Candidates are to be referred to sSMES after relevant information gathering as detailed in this leaflet.

Medication considerations

44. In the UK, medications and treatments used in Gender Affirming Hormone Treatment (GAHT) are generally unlicensed for this purpose. The General Medical Council (GMC) produces guidance on the prescribing of unlicensed medicines in general[25] and Trans healthcare in particular.[26] Defence Medical Services also publish guidance on the 'Use of Unlicensed and Off-Label Medicines within the MOD'.[27]

45. **Transition history.** Candidates who have commenced GAHT before the age of 17 years may need more detailed assessment.[28] Where a candidate has a pre-existing or is at increased risk of a medical condition, the condition must be manageable through reasonably accessible routine and / or emergency specialist care.

46. **Prescribing.** The following applies:

a. Candidates prescribed GAHT by an NHS Gender Identity Clinic (GIC)[29] or a Care Quality Commission (CQC)[30] accredited Trans Medicine service provider are FIT. This is to ensure that Trans candidates are managed to the safest available standards.

b. Candidates prescribed GAHT by a non-accredited UK-based Trans Medicine service provider or overseas Trans Medicine service provider are UNFIT. This is to ensure that Trans candidates are managed by the safest available standards. Where a candidate has a pre-existing or is at increased risk of a medical condition, the condition must be manageable through reasonably accessible routine and / or emergency specialist care.

c. Candidates who source GAHT from independent sources[31] are UNFIT. Such candidates will be considered UNFIT until reviewed by an appropriate Gender Identity Clinic (see Paras 12a and 12b, above) and prescribed authorised medicines. This is to ensure that Trans candidates are managed by the safest available standards.[32] Where a candidate has a pre-existing or is at increased risk of a medical condition, the condition must be manageable through reasonably accessible routine and / or emergency specialist care.

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[25] Prescribing unlicensed medicines - GMC (gmc-uk.org) [accessed 12 Jan 26]
[26] Trans healthcare - GMC (gmc-uk.org) [accessed 12 Jan 26]
[27] JSP 950 Lft 9-3-3 Use of Unlicensed and Off-label Medicines within the MOD (V1.5 Nov 23) [accessed 12 Jan 26]
[28] 'There is a significant lack of robust, comprehensive evidence around the outcomes, side effects and unintended consequences of such treatments for people with gender dysphoria, particularly children and young people […]'. Source: https://www.rcgp.org.uk/policy/rcgp-policy-areas/transgender-care [accessed 12 Jan 26]
[29] Or NHS Primary Healthcare provider, on behalf of the GIC.
[30] Or equivalent National body.
[31] Including online.
[32] Including: correct clinical indication, correct dose, correct formulation from a from a regulated pharmaceutical supplier.

47. **Access to Medication.** A candidate's medication needs to be routinely available. This may be provided by Defence Primary Health Care (DPHC) or through sS provision (through Joint Medical Capability) when deployed. Medications must be compatible with deployment (considering administration, storage and resupply). If a candidate is unable to safely change to medications available through DPHC/sS then they will be found UNFIT because DPHC/sS cannot safely and effectively meet the clinical needs of the candidate.

48. **Commencement and changes to medication.** Candidates are UNFIT until twelve months after commencing any form of GAHT. This is to allow sufficient time for:

a. Optimal therapeutic outcome.

b. Dose monitoring / stabilisation.

c. Freedom of side effects and functional impairment to be confirmed.

49. A candidate must have the physical ability and mental stability required to perform their role safely and efficiently in all military environments. Where a candidate has a pre-existing or is at increased risk of a medical condition, the condition must be manageable through reasonably accessible routine and / or emergency specialist care.

50. **Bone health considerations.** The use of unopposed GnRH agonists (listed at Appendix 1, Table 2) (i.e. in the absence of relevant sex hormone replacement) reduce bone mineral density (BMD), foreseeably increasing the risk of fracture. Candidates who have used GnRH agonist without the relevant sex hormone replacement for a period of six months or more at any time require a DEXA scan to confirm acceptable BMD to inform fitness for service in the context of the proposed branch and trade. Candidates are graded FIT, provided the following criteria is met, depending on age:

a. **Candidate under 50 yrs.** The Z-score must be greater than or equal to -2 SD.

b. **Candidate over 50 yrs.** The T-score must be greater than or equal to -1.5 SD.

51. **Feminising hormone treatment.** Candidates prescribed feminising hormone preparations are FIT provided that:

a. If prescribed oestrogen preparations, all of the following conditions are met:

(1) Using only acceptable medications (detailed at Appendix 1) and dose has been stable for at least six months,

(2) Candidates have completed 12 months of treatment and are stable. Stability on treatment and absence of side effects from oestrogen therapy will reduce the risk of deterioration / incapacitation at the start of military service,

(3) Transgender recruits taking oral oestrogen therapy who have a past history of VTE should be assessed in accordance with Annex N. This is because where oral oestrogen is used, there is a front-loaded risk of blood clots (venous thromboembolic events [VTE] including deep vein thrombosis [DVT] and pulmonary embolism [PE]),

(4) Blood test hormone levels, HbA1c and lipid profile (including triglycerides and HDL) are within the target range set by their Trans medicine specialist,

(5) Prolactin level (as defined by the Trans medicine specialist) recorded as normal in the six months prior to joining. Those with a history of prolactinoma should be managed in accordance with Annex H Endocrinology.

b. If prescribed gonadotrophin releasing hormone (GnRH) analogues, all of the following conditions are met:

(1) Using only acceptable medications (detailed at Appendix 1) and dose has been stable for at least six months,

(2) Candidates have completed 12 months of treatment,

(3) Blood test hormone levels (including oestrogen and testosterone) are within the target range set by their Trans medicine specialist.

52. **Masculinising hormone treatment.** Candidates prescribed masculinising hormone preparations are FIT provided that:

a. If prescribed Testosterone preparations, all of the following conditions are met:

(1) Using only acceptable medications (detailed at Appendix 1) and dose has been stable for at least six months,

(2) Candidates have completed 12 months of treatment,

(3) Baseline blood test results, prior to commencement of therapy, (including Testosterone, FBC, LFTs, FSH / LH, Oestradiol, Lipids, SHBG, U&Es, HbA1c and Prolactin) were within the target range set by their Trans medicine specialist,

(4) Routine blood test results (including Testosterone, FBC, LFTs, FSH / LH) are within the target range set by their Trans medicine specialist,

(5) Haematocrit should be in the normal range (50% or below) within three months of medical assessment. This is due to the risk of an excessive concentration of circulating red blood cells (polycythaemia) which may lead to life-threatening blood clots in the first year of testosterone therapy.

53. **Monitoring.** To be graded FIT, all Transgender candidates on GAHT are required to have normal measurements as defined by their Trans medicine specialist of the following in the six months prior to entry:

a. Sex hormone.

b. Full blood count (FBC).

c. Lipid profile (including triglycerides).

d. Liver function tests (LFTs).

54. Monitoring of bloods should not normally be required more often than six monthly. Where a candidate has a pre-existing or is at increased risk of a medical condition, the condition must be manageable through reasonably accessible routine and / or emergency specialist care.

55. The GMC advocates: 'Once the patient has been discharged by a GIC or gender specialist, the prescribing and monitoring of hormone therapy can be carried out in primary care without specialist input. However, it is reasonable for a GP to expect the GIC or specialist to remain available to provide timely support and advice where necessary. From the patient's perspective, management in primary care is far easier, and there is no specific expertise necessary to prescribe for and monitor patients on hormone therapy.[33]

Surgical considerations

56. Candidates who have undergone functional surgical procedures (listed at Appendix 2) are FIT provided they meet all the following criteria:

a. There has been full recovery and stability,

b. They have been discharged from routine follow-up,

c. Unimpaired relevant function has been achieved (e.g. urination),

d. The provisions of Para 1, above, are met.

57. Candidates who have undergone aesthetic surgical procedures and treatments (listed at Appendix 2) are FIT provided they meet all the following criteria:

a. There has been full recovery and stability,

b. They have been discharged from routine follow-up,

c. The provisions of Para 1, above, are met.

58. As with any surgical procedure, candidates who are on a waiting list or booked for surgical procedures are UNFIT until those procedures are complete and they have met the requirements of para 22, above. This is to ensure that initial training can be completed uninterrupted and to ensure that treatment is not delayed and can be completed without complication to the individual.[34]

Mental Health considerations

59. Transgender candidates are required to meet the same mental health entry standards as any other candidate and careful assessment is required, see JSP 950 Lft 6-7-7 Section 4 Annex L.

Clinical Monitoring

[33] Role of GPs in managing adult patients with gender dysphoria, BMA, Mar 22 [accessed 12 Jan 26]
[34] JSP 889 [accessed 12 Jan 26]. "A transgender Service person wanting to maintain stability in order for them to complete treatment will need to consult their health professional and inform their CoC in order to set the conditions for stability as early as possible."

60. **Biological and physiological criteria.** When considering biological and physiological values, Trans candidates should be assessed against their biological sex at birth criteria, including:

a. Blood test results.

b. Spirometry.

c. Baseline audiometry.

61. **Body composition.** Body mass index (BMI) and waist circumference (WC) will be considered by sSMES. Where there are borderline values, potentially attributed to their hormone treatment, such cases should be discussed with sSMES before making a final determination on fitness.

General

62. **E2 Marker.** All Trans candidates are FIT E2 for annual medical oversight to ensure:

a. Appropriate medical monitoring is in line with individual treatment plans.

b. Hearing Health Surveillance (routine periodic audiometry) is conducted with reference to the candidate's biological birth sex.

c. Appropriate, personalised health screening is offered in accordance with national guidelines.[35]

[35] Information about national NHS screening Programmes for transgender and non-binary people can be found at: www.gov.uk/government/publications/nhs-population-screening-information-for-transgender-people [accessed 12 Jan 26].

Appendix 1 to
Annex J

ACCEPTABLE GENDER AFFIRMING HORMONE TREATMENT FOR ADULTS

1. Oestrogen therapy.

Preparation	Dose range
Tablets	
Estradiol Valerate (generic) Progynova (Oestradiol Valerate) Elleste solo (oestradiol hemihydrate)	1 mg bd – 4 mg bd 1 mg bd – 4 mg bd 1 mg bd – 4 mg bd
Gel	
Sandrena sachet (0.5 or 1mg sachet) Oestragel pump pack (1 measure 1.25g = 0.75 mg)	0.5 - 6 mg daily 0.75 – 6 mg daily
Patches	
Evorel (25, 50, 75 and 100 mcg/24 hr patches) Estradot (25, 37.5, 50, 75 and 100 mcg/24 hr patches)	50 mcg - 400 mcg/24hr patches twice weekly 50 mcg - 400 mcg/24hr patches twice weekly

Target oestradiol level 400-600pmol/L.[1]

2. GnRH therapy (GnRH agonists / testosterone blockers).

Frequency	Every 3 months	
Drug and dose	Leuprorelin 11.25mg	Triptorelin 11.25mg
Brand name	Prostap 3	Decapeptyl SR
Form	Powder to reconstitute	Powder to reconstitute
Injection route	Subcutaneous (under the surface of the skin)	Subcutaneous (under the surface of the skin)

3. Testosterone therapy.[2]

Preparation and dose	Testosterone
Dose and frequency	1000mg commonly every 12 weeks based on testosterone levels
Brand name	Nebido®
Form	Intramuscular (IM) Injection[3]
Typical target range	8-14nmol/L

[1] Adapted from: Feminising Hormone Treatment for Adults, Nottinghamshire Area Prescribing Committee, dated July 2022. Available from: https://www.nottsapc.nhs.uk/media/qaafcl52/feminising-hormones-information-sheet.pdf [accessed 12 Jan 26]
[2] Adapted from: Masculinising Hormone Treatment for Adults, Nottinghamshire Area Prescribing Committee, dated July 2022. Available from: https://www.nottsapc.nhs.uk/media/gxfnn13a/masculinising-hormones-information-sheet.pdf [accessed 12 Jan 26]
[3] Topical testosterone is not permitted as it is associated with less reliable concentration and absorption is impaired by environmental conditions experienced in service (heat, cold, dust, damp). Testosterone administered more frequently than 3 monthly is associated with 'on-off' symptoms which can affect physical and cognitive function.

Appendix 2 to
Annex J

ACCEPTABLE TRANSGENDER SURGICAL PROCEDURES AND TREATMENTS

1. Female to Male (FtM) functional procedures.

    a. **Genital surgery.** Procedures may include hysterectomy, ovariectomy (salpingo-oophorectomy), vaginectomy, metoidioplasty, scrotoplasty, urethroplasty, placement of testicular prostheses, and phalloplasty.

    b. **Chest wall surgery.** Procedures may include mastectomy and / or creation of male chest.

2. Male to Female (MtF) functional procedures.

    a. **Genital surgery**. Procedures may include: orchidectomy, penectomy, vaginoplasty, clitoroplasty, and labiaplasty.

    b. **Chest wall surgery**. Breast augmentation (augmentation mammoplasty)

3. Aesthetic surgery and treatments.

    a. Voice-modifying surgery.

    b. Facial feminisation surgery – treatments may include:

        (1) Thyroid chondroplasty / tracheal shave (reducing size of larynx)

        (2) Rhinoplasty (nasal surgery).

        (3) Facial bone reduction.

        (4) Blepharoplasty / facelift.

    c. Liposuction and / or body sculpture.

Annex K

MUSCULOSKELETAL PRE-ENTRY

1. **General principles for assessing candidates against this Annex.** All candidates must be able to meet and maintain the physical fitness needed to complete military activity in all deployed environments for the duration of their employment, recognising musculoskeletal injuries significantly impact operational effectiveness. The general principles against which a candidate is assessed as FIT for entry, with respect to their musculoskeletal (MSK) system, are:

a. **Function**. Candidates must have the physical function in all environments, to safely and effectively complete training and perform their military role:

(1) **Movement.** Candidates must be able to walk, run, jump, climb, lift, throw and drag.

(2) **Weapon handling.** Candidates must be able to safely handle their personal weapon and adopt the required firing positions (standing, kneeling, squatting, prone).

(3) **PPE.** Candidates must be able to use issued military personal protective equipment (PPE) and equipment e.g., clothing (especially gloves and boots), body armour, helmet, eye protection and CBRN Individual Protective Equipment (IPE).

(4) **Safety.** Candidates must be able to carry out personal safety drills.

b. **Prognosis.** Where a candidate is found to have a resolved or current MSK condition, the following general criteria should be met in addition to the relevant specific paragraph in this policy:

(1) There is no unacceptable risk of sudden deterioration / incapacitation without reasonable warning.

(2) Conditions will not foreseeably be exacerbated by military service (in particular, extremes of cold / heat, atmospheric pressure, environment, chemical and arduous training).

(3) The risk of future temporary / permanent loss of function and ability due to military training / service is low.

(4) Conditions will be required to heal to a functional standard, others will require a time bar to reflect underlying risk of recurrence.

c. **Medical support requirements.** Where a candidate has a pre-existing or increased risk of a musculoskeletal condition, there must be no reasonably foreseeable requirement for medical care within the deployed location beyond deployed Primary Healthcare (or equivalent). The medical condition must be stable with treatment. Should loss of medication occur for ≤ one week this should not lead to clinical deterioration in the condition or functional degradation during that time. In the

deployed environment the condition should not foreseeably impact military medical resource.

2. **Exceptional considerations.** Criteria within each condition has been outlined to grade a candidate as FIT or UNFIT. Where there is any doubt, advice should be sought from the single Service Medical Entry Staff (sSMES).[1] The resultant outcome of FIT or UNFIT will be determined by sSMES.

a. **Skeletal maturity.** Ascertaining whether a candidate has reached skeletal maturity might be relevant in some conditions. In general, this means being aged 16 years and over for women and 18 years for men. Skeletal maturity relates to growth rather than attaining maximum mass or strength.

3. **Fractures.** Specific guidance is provided in the relevant paragraphs below. The following general considerations apply:

a. **Non-union (fractures that have not healed).** Candidates with fractures which have not healed are UNFIT as they are unlikely to achieve the required level of function required for military service and are at increased risk of foreseeable injury associated with military training or service.

b. **Stress fractures.** Stress fractures are described in various paragraphs of this annex.[2] Where specific guidance is not provided, this paragraph applies. Candidates who have recovered from uncomplicated, single stress fractures (with the exemption of lower limb stress fractures, which are listed separately) who are symptom free with proven activity comparable with military training for a minimum of three months and radiological confirmation of healing are FIT. Those with multiple or recurrent stress fractures at any site are UNFIT, however exceptional cases (such as those where no more than two fractures occurred during excessive / intensive training and the candidate has since returned to activity comparable with military training) may be referred to sSMES for a determination on FIT E2 / UNFIT. Previous pre-disposing factors, including Vitamin D deficiency and reduced bone mineral density, should be excluded prior to entry.

c. **Pathological fractures (fractures due to underlying disease).** All Candidates with pathological fractures are UNFIT as there is risk of further fractures caused by military training or service.

Arthropathies / arthritidies (arthritis)

4. **Inflammatory arthritis / arthritides**. Candidates with a history of rheumatoid arthritis, ankylosing spondylitis, psoriatic arthritis, enteropathic arthritis or any other form of auto-immune related inflammatory arthritis (including those in remission) are UNFIT. Such conditions may require regular specialist medical review, with current / future potential for immune-modulating medication and monitoring. Military service is physically demanding and may include working in challenging and austere environments, with limited medical support.

[1] Delegated Authority arrangements may apply.
[2] Para 90. Spondylolysis (pars fractures, stress fractures and defects).
Para 126. Stress fracture to the femur.
Para 172. Medical Tibial Stress Syndrome.
Para 173. Tibial stress response or fracture.
Para 222f. Metatarsal fracture, including stress fracture.

5. **Reactive arthritis (following gastrointestinal or genitourinary infection).** Reactive arthritis is common in younger people following exposure to an infective organism. The condition is typically self-limiting with most recovering within one year, however 15-20% can have longer-term symptoms and some may develop other forms of inflammatory arthritis. Asymptomatic candidates should be assessed according to the criteria below:

a. **Single episode.** Candidates with a history of a single episode of reactive arthritis who meet all the following criteria are FIT:

(1) Not requiring treatment for the last 12 months,

(2) Symptom-free for at least 24 months,

(3) No radiographic evidence of degenerative joint disease on available imaging,

(4) Undertaking regular and substantial levels of exercise comparable with military training without experiencing adverse effects,

(5) No functionally significant deformity with normal joint mobility and range of movement.

b. **Family history and / or HLA B-27 positive.** Candidates who have a family history of inflammatory arthritis and / or are HLA B-27 positive with no personal history of reactive arthritis are considered FIT for military service.

c. **Multiple episodes.** Candidates with more than one episode of reactive arthritis are UNFIT because of the increased risk of recurrence and development of other forms of inflammatory arthritis which would restrict their ability to perform usual military duties. Recurrence risk is difficult to quantify, and the more common presentation is ongoing low-level inflammatory symptoms which then begin to represent chronic inflammatory arthritis.

6. **Septic arthritis (joint infection).** Candidates with a history of uncomplicated infection who meet all the following criteria are FIT:

a. Single episode of infection affecting a single joint,

b. More than 24 months since being discharged from follow up,

c. Discharged from specialist care within six months of onset of symptoms,

d. No functionally significant deformity with normal joint mobility and range of movement, and no significant joint changes on available imaging,

e. Undertaking regular and substantial levels of exercise comparable with military training without experiencing adverse effects,

f. No associated co-morbidity[3],

g. Unrelated to intravenous (IV) drug use including anabolic steroids.[4]

7. Candidates who do not meet these criteria are UNFIT.

8. **Juvenile Idiopathic Arthritis (JIA)**. JIA describes the onset of inflammatory arthritis before the 16th birthday. Most people with JIA make full recovery with 75% achieving sustained remission (symptom-free for 24 months). The remainder continue with symptoms into adulthood and are UNFIT as they are unlikely to achieve the required level of function required for military service and are at increased risk of foreseeable injury during training or service. Candidates are FIT provided they meet all the following criteria:

a. Discharged from follow up,

b. Symptom-free for 24 months without medication,

c. No evidence of active systemic disease or systemic deficit due to previous systemic disease (e.g. cardiac / respiratory / neurological / ophthalmological involvement as outlined in other Annexes),

d. No functionally significant deformity with normal joint mobility and range of movement, and no significant joint changes on available imaging.

9. **Gout.** Acute gout can be severely disabling with repeat episodes causing permanent joint damage. Recurrence is common with functionally limiting symptoms, requiring lifestyle modification and long-term prophylactic oral medication. Candidates are FIT E2 provided they meet all the following criteria:

a. A single episode or multiple episodes more than 24 months apart,

b. Symptom-free for at least 24 months,

c. No medication requirement (including over-the-counter treatment such as NSAIDs[5]),

d. No functionally significant deformity with normal joint mobility and range of movement, and no significant joint changes on available imaging.

Hypermobility Disorders

10. **Hypermobility (flexible joints).** Joint hypermobility is very common affecting up to 20% of the population. Symptom-free joint hypermobility alone is unlikely to lead to functional problems. Candidates should be assessed against the following criteria:

[3] E.g. diabetes mellitus, rheumatoid arthritis, recent joint surgery, hip or knee prosthesis, skin infection, and immunosuppressive medication use. Source: Earwood JS, Walker TR, Sue GJC. Septic Arthritis: Diagnosis and Treatment. Am Fam Physician. 2021 Dec 1;104(6):589-597. PMID: 34913662.
[4] Septic arthritis amongst those who inject drugs tends to affect the sternoclavicular, sacroiliac, spinal facet joints. Septic arthritis affecting these joints reflects a long-term susceptibility to osteoarthritis and back pain.
[5] E.g. ibuprofen, diclofenac.

a. **Hyperextension of less than 10° at the knee.** Candidates are FIT provided they meet all the following criteria:

(1) Symptom-free,

(2) Undertaking regular and substantial levels of exercise comparable with military training without experiencing adverse effects,

(3) Good knee control assessed at pre-service medical assessment (PSMA).

b. **Hyperextension of more than 10° at the knee.** Candidates with hyperextension of greater than 10° in either knee are UNFIT. Generalised ligamentous laxity (hypermobility) may result in symptoms when walking, running and / or jumping. A candidate with >10° of hypermobility is unlikely to be able to lock their joints to achieve the required level of function required for military service. They are unlikely to achieve the required level of function required for military service and are at increased risk of foreseeable injury during training or service.

c. **Hypermobility diagnosed in adulthood.**[6] Candidates with a formal diagnosis of hypermobility syndrome made in adulthood are UNFIT. This is due to an increased risk of injuries such as anterior cruciate ligament (ACL) rupture. Candidates are also unlikely to be able to tolerate wearing PPE such as body armour and carry weight for lengthy periods of time. They are unlikely to achieve the required level of function required for military service and are at increased risk of foreseeable injury during training or service.

d. **Hypermobility Spectrum Disorder (HSD) and hypermobile Ehlers-Danlos Syndrome (hEDS).** Symptomatic hypermobility is associated with systemic disorders. The MSK manifestations include recurrent MSK pain, diffuse chronic pain, atraumatic joint dislocations and joint instability. Candidates with HSD and / or hEDS are UNFIT as they are unlikely to achieve the required level of function required for military service and are at increased risk of foreseeable injury during training or service.

11. **Connective Tissue Disease (CTD).** CTD is a group of heritable and systemic autoimmune conditions affecting multiple organs. Heritable CTD includes Marfan's Syndrome, Ehlers-Danlos syndrome, Osteogenesis Imperfecta, Stickler Syndrome, Alport Syndrome, Beals Syndrome and Loeys-Dietz Syndrome. Autoimmune CTD includes Systemic Lupus Erythematosus (SLE), Scleroderma, Sjogren's[7] Syndrome, mixed connective tissue disease (MCTD) (including polymyositis and dermatomyositis) and Undifferentiated CTD. Specialist diagnosis is essential as other conditions are sometimes mislabelled. Candidates with these conditions are UNFIT because they are likely to require long term specialist follow up and treatments, and will be unable to work in challenging environments, in a physically demanding job, including in austere locations with limited medical support.

[6] As stated under skeletal maturity.
[7] Also termed, Sjögren's.

Muscle disorders

12. **Myopathy.** Those with minimal post-traumatic wasting, causing no significant loss of function, are FIT provided functional assessment is normal. All other causes of myopathy, or those with functionally significant muscle wasting, are UNFIT as they are unlikely to achieve the required level of function required for military service and are at increased risk of foreseeable injury during training or service.

13. **Myositis.** Candidates who have experienced a brief episode of myositis (e.g. secondary to infection or statin use) are FIT provided they meet all the following criteria:

a. Symptom-free for a period of three months,

b. Undertaking regular and substantial levels of exercise comparable with military training without experiencing adverse effects,

c. Underlying cause which is likely to be provoke recurrence has been excluded,

d. Normal dynamic functional assessment.[8]

14. Candidates with active myositis[9] are UNFIT as they are unlikely to achieve the required level of function required for military service and are at increased risk of foreseeable injury during training or service.

15. **Inherited muscular dystrophies (genetic diseases of the muscles).** See Annex N Other Conditions, Congenital, chromosomal and genetic conditions.

Bone disorders

16. **Osteomyelitis (inflammation (including infection) of the bone).** Candidates who meet all the following criteria are FIT:

a. A single episode that recovered more than three years ago without any complications or joint involvement and discharged from specialist follow-up,

b. Symptom-free and with full function undertaking activities comparable with military service for at least three months,

c. Evidence of resolved infection on available imaging,

d. No functionally significant deformity with normal joint mobility and range of movement.

17. Candidates who do not meet the criteria above, or who have evidence of unresolved infection such as a non-discharging sinus are UNFIT as there is a high risk of recurrence of infection requiring long-term specialist follow up. They are unlikely to achieve the required level of function required for military service and will be unable to work in challenging environments, in a physically demanding job, including in austere locations with limited medical support.

[8] See Annex B, Guidelines for the conduct of a pre-service medical assessment.
[9] Including autoimmune myositis.

18. **Osteopenia and osteoporosis (reduced bone density).** Candidates with a history of osteopenia and / or osteoporosis who meet all the following criteria are FIT:

a. Fully resolved,

b. Normal bone mass on DXA,

c. Vitamin D level normal,

d. Symptom-free and with full function undertaking activities comparable with military service for at least three months.

19. Candidates with a current diagnosis of osteopenia[10] or osteoporosis due to any cause, are UNFIT. These candidates are at increased risk of fractures which is incompatible with the demands of service life and are at increased risk of foreseeable injury during training or service.

20. **Vitamin D.** Vitamin D protects MSK and immune health. The following applies where Vitamin D levels have been assessed:

a. Candidates with adequate 25-hydroxyvitamin D levels (above 50 nmol / L) are FIT.

b. Candidates with insufficient or severely deficient 25-hydroxyvitamin D levels (50 nmol / L and below) are UNFIT due to the increased risk of fracture during military training and service.

21. **Osteogenesis imperfecta (brittle bone disease).** Candidates with osteogenesis imperfecta are UNFIT due to the increased risk of fracture during military training and service.

Conditions Affecting the Upper Limb

General considerations

22. **Overuse injuries.** Candidates with a history of an overuse injury (for example tendonitis, bursitis and / or epicondylitis) which has resolved are FIT. Candidates with ongoing or recurrent pain related to overuse are UNFIT due to the risk of recurrence and deterioration in symptoms during training or service requiring extended non-operative or surgical treatment.

23. **Peripheral nerve entrapment syndromes**. Candidates with history of a peripheral nerve entrapment syndrome (for example carpal tunnel syndrome and / or cubital tunnel syndrome) which has resolved are FIT. Candidates with ongoing (constant or intermittent) pain, weakness or abnormal sensation related to peripheral nerve entrapment are UNFIT due to the risk of recurrence and deterioration in symptoms during training or service requiring extended non-operative or surgical treatment.

[10] Osteopenia is defined as a T Score of between -1 and -2.5 SD http://www.iofbonehealth.org/diagnosing-osteoporosis [accessed 12 Jan 26]

Fractures (Broken Bones) of the Upper Limb

24. **Fractures (broken bones).** Guidance about upper limb fractures is provided below. Fractures of the clavicle, wrist, hand and fingers are described separately.

25. **Extra-articular fractures without surgical fixation (fracture of the upper limb where the joint surface was not involved, and surgery was not required).** Candidates are FIT provided they meet all the following criteria:

a. At least six months following injury,

b. Fracture union is confirmed without a deformity affecting function,

c. Discharged from treatment and rehabilitation,

d. Symptom-free for three months while undertaking activity comparable with military training (including the ability to perform press ups),

e. Normal dynamic functional assessment.[11]

26. Candidates with any symptoms or deformity resulting in reduced function are UNFIT, whether treated surgically or not, as they are unlikely to achieve the required level of function required for military service and are at increased risk of foreseeable injury during training or service.

27. **Extra-articular fractures with surgical fixation (fracture of the upper limb where the joint surface was not involved, treated with surgery).** Candidates are FIT provided they meet all the following criteria:

a. At least six months following injury,

b. Fracture union is confirmed without a deformity affecting function,

c. Discharged from treatment and rehabilitation,

d. Symptom-free for three months, including from metalwork, while undertaking activity comparable with military training (including the ability to perform press ups),

e. Normal dynamic functional assessment.[12]

28. Candidates with any symptoms or deformity resulting in reduced function are UNFIT, as they are unlikely to achieve the required level of function required for military service and are at increased risk of foreseeable injury during training or service.

29. **Intra-articular fractures (broken bone of the upper limb where the joint surface was involved).** Following fractures involving a joint, early osteoarthritis is common. Candidates are FIT provided they meet all the following criteria:

a. At least twelve months following injury,

[11] See Annex B, Guidelines for the conduct of a pre-service medical assessment.
[12] See Annex B, Guidelines for the conduct of a pre-service medical assessment.

b. Fracture union is confirmed without a deformity affecting function,

c. Discharged from treatment and rehabilitation,

d. No evidence of joint surface problems (e.g. a step in the cartilage on existing imaging),

e. Symptom-free for three months, including from metalwork, while undertaking activity comparable with military training (including the ability to perform press ups),

f. No suggestion of joint surface problems (such as stiffness, crepitus on movement), normal dynamic functional assessment.[13]

30. If the candidate does not meet criteria above, they are UNFIT. These joint injuries often degenerate with the activities expected of military personnel meaning they are unlikely to achieve the required level of function required for military service and are at increased risk of foreseeable injury during training or service.

Conditions of the Shoulder

31. **Shoulder.** Candidates with functional limitation of shoulder movement or pain are UNFIT due to the requirement to have full use of the upper limb / s to perform usual military duties (e.g pushing, pulling, climbing, equipment and weapon handling).

32. **Clavicle fractures (broken collar bone).** A history of clavicle fracture may affect the ability to carry load on the shoulders. Mid-shaft fractures may leave a deformity or symptomatic metalwork that makes load carriage difficult. Fractures of the medial or lateral ends of the clavicle may lead to joint instability. Candidates are FIT provided they meet all the following criteria:

a. At least twelve months since injury.

b. Discharged from treatment and rehabilitation.

c. Full shoulder movement with normal scapula control.

d. No evidence of sternoclavicular or acromioclavicular joint instability or pain.

e. Symptom-free (including from metalwork) when carrying weight, with activity comparable with military training, and where carrying weight on their shoulders for minimum of three months, (including the ability to perform press ups).

f. Normal dynamic functional assessment.[14]

33. Candidates who do not meet all the above criteria are UNFIT as they are unlikely to achieve the required level of function required for military service and are at increased risk of foreseeable injury during training or service.

34. **Sternoclavicular joints.** The sternoclavicular joint is critical to upper limb function, and posterior dislocation may compromise blood supply. Candidates with a history of

[13] See Annex B, Guidelines for the conduct of a pre-service medical assessment.
[14] See Annex B, Guidelines for the conduct of a pre-service medical assessment.

sternoclavicular joint injury, but who are symptom-free with normal function are FIT provided they meet all the following criteria:

a. At least six months from the time of injury to allow for recovery,

b. Symptom-free during activity comparable with military training for a minimum of three months, including when carrying weight on their shoulders (including the ability to perform press ups).

c. No evidence of reduced upper limb circulation.

d. Normal dynamic functional assessment.[15]

35. Where there is significant functional compromise candidates are UNFIT as they are unlikely to achieve the required level of function required for military service and are at increased risk of foreseeable injury during training or service.

36. **Acromioclavicular sprains and dislocations.** These are common injuries. Mild sprains often return to full function even with persistent anatomical abnormality. The grade relates to the degree of anatomical disruption and is therefore of functional relevance. Grade I-II injuries represent sprained ligaments, whereas higher grade injuries are normally associated with a ligament rupture.

a. **Grade I / II.** Candidates who are symptom-free with normal function are FIT provided they meet all the following criteria:

(1) At least six months from the time of injury to allow for recovery,

(2) Full shoulder movement with normal scapula control,

(3) Symptom-free during activity comparable with military training for a minimum of three months, including when carrying weight on their shoulders (including the ability to perform press ups),

(4) Normal dynamic functional assessment.[16]

b. **Grade III.** Candidates managed either surgically or non-surgically are FIT after a period of six months from the time of injury to allow recovery from injury or surgery and rehabilitation provided they meet all the following criteria:

(1) Discharged from treatment and rehabilitation, with full shoulder movement with normal scapula control,

(2) Symptom-free during activity comparable with military training for a minimum of three months, including when carrying weight on their shoulders (including the ability to perform press ups),

(3) Normal dynamic functional assessment.[17]

[15] See Annex B, Guidelines for the conduct of a pre-service medical assessment.
[16] See Annex B, Guidelines for the conduct of a pre-service medical assessment.
[17] See Annex B, Guidelines for the conduct of a pre-service medical assessment.

c. Candidates who do not meet these criteria are UNFIT as they are unlikely to achieve the required level of function required for military service and are at increased risk of foreseeable injury during training or service.

d. **Grades IV-VI.** Candidates are FIT six months following surgery provided they meet all the following criteria:

(1) Successful stabilisation surgery,

(2) Discharged from treatment and rehabilitation, with full shoulder movement with normal scapula control,

(3) Symptom-free during activity comparable with military training for a minimum of three months, including when carrying weight on their shoulders (including the ability to perform press ups),

(4) Normal dynamic functional assessment.[18]

e. Candidates with grade IV-VI injuries with persistent instability or who have not had surgery are UNFIT as they are unlikely to achieve the required level of function required for military service and are at increased risk of foreseeable injury during training or service.

37. **Single episode of shoulder dislocation or subluxation (partial dislocation).** This paragraph includes subluxation regardless of requirement for acute medical intervention and includes both anterior and posterior[19] dislocations. Candidates are FIT provided they meet all the following criteria:

a. 12 months since the dislocation / surgery to allow recovery and rehabilitation,

b. Discharged from treatment and rehabilitation with full shoulder function and negative apprehension test[10] following full rehabilitation or surgery,

c. No evidence of degenerative joint disease on available imaging,

d. Symptom-free during activity comparable with military training for three months (including the ability to perform press ups),

e. Normal dynamic functional assessment.[20]

38. **Multiple anterior or posterior dislocations (in the same or both shoulders).** Candidates are FIT provided they meet all the following criteria[9]:

a. There is no history of multi-directional instability in the same shoulder,

b. Successful surgical stabilisation, either by primary stabilisation or if an unsuccessful primary soft tissue stabilisation is followed by a successful revision bony stabilisation procedure, e.g. Latarjet or a bone graft procedure,

[18] See Annex B, Guidelines for the conduct of a pre-service medical assessment.
[19] Candidates who have had a posterior dislocation without traumatic cause, and where seizure has not been ruled out, are UNFIT due to the risk of undiagnosed neurological disorder (see Annex G Neurology).
[20] See Annex B, Guidelines for the conduct of a pre-service medical assessment.

c. 12 months must have elapsed since the dislocation / surgery to allow recovery and rehabilitation,

d. Discharged from treatment and rehabilitation with full shoulder function and negative apprehension test[21] following full rehabilitation or surgery,

e. No subsequent dislocations in the same shoulder following surgery,

f. No evidence of degenerative joint disease on available imaging,

g. Symptom-free during activity comparable with military training for three months (including the ability to perform press ups),

h. Normal dynamic functional assessment.[22]

39. Candidates with a history of two or more dislocations in the same shoulder that have not been surgically stabilised are UNFIT because there is an unacceptably high risk of further dislocation during training or in service requiring extended non-operative or surgical treatment.

40. Candidates who have had multiple soft tissue stabilisation procedures in the same shoulder, regardless of current symptoms and findings on examination are UNFIT because the risk of recurrence remains unacceptably high.

41. **Bankart lesions and Hill-Sachs defects.** Candidates whose dislocation has resulted in a Bankart lesion (glenoid labral tear) and / or a Hill Sachs defect (posterolateral humeral head depression fracture) are FIT provided they meet all the following criteria:

a. 12 months must have elapsed since the dislocation / surgery to allow recovery and rehabilitation,

b. Discharged from treatment and rehabilitation with full shoulder function and negative apprehension test[10],

c. No evidence of degenerative joint disease on available imaging,

d. Symptom-free during activity comparable with military training for three months (including the ability to perform press ups),

e. Normal dynamic functional assessment.[23]

42. Candidates who do not meet these criteria are UNFIT due to the risk of recurrence and deterioration in symptoms during training or service requiring extended non-operative or surgical treatment.

[21] Shoulder apprehension test: candidate's elbow is flexed to 90° and the shoulder is abducted to 90°. The examiner holds the candidate's wrist and with the other hand applies forward pressure from behind the shoulder. The shoulder is then externally rotated by manoeuvring the wrist. The test is positive if the manoeuvre produces pain.
[22] See Annex B, Guidelines for the conduct of a pre-service medical assessment.
[23] See Annex B, Guidelines for the conduct of a pre-service medical assessment.

43. **Chondral defect of the shoulder joint (cartilage damage to the humeral head or glenoid).** Candidates with partial thickness chondral defects are FIT provided they meet all the following criteria:

a. 12 months must have elapsed since the injury to allow recovery and rehabilitation,

b. Discharged from treatment and rehabilitation with full shoulder function,

c. No evidence of degenerative joint disease on available imaging[24],

d. Symptom-free during activity comparable with military training for three months (including the ability to perform press ups),

e. Normal dynamic functional assessment.[25]

44. Candidates with full thickness defects are UNFIT due to the risk of deterioration in symptoms during training or service requiring extended non-operative or surgical treatment.

45. **Rotator cuff injuries.** Candidates with rotator cuff tears (partial or full thickness) managed non-operatively or with surgery are FIT provided they meet all the following criteria:

a. At least six months symptom-free,

b. Discharged from treatment and rehabilitation with full shoulder function,

c. Symptom-free during activity comparable with military training for three months (including the ability to perform press ups),

d. Normal dynamic functional assessment.[26]

46. Candidates who do not meet the above criteria are UNFIT due to the risk of deterioration in symptoms during training or service requiring extended non-operative or surgical treatment.

47. **Winged Scapula.** Causes of winged scapula include trauma of the long thoracic nerve (unilateral), weakness of scapular stabilisers and rare genetic reasons (e.g facioscapulohumeral muscular dystrophy [FSHD]). Candidates with isolated winged scapula are FIT provided they meet all the following criteria:

a. No underlying medical cause,

b. Symptom-free during activity comparable with military training for three months (including the ability to perform press ups),

[24] Including early arthritic change.
[25] See Annex B, Guidelines for the conduct of a pre-service medical assessment.
[26] See Annex B, Guidelines for the conduct of a pre-service medical assessment.

c. Normal dynamic functional assessment.[27]

48. Candidates who do not meet the above criteria are UNFIT due to the risk of deterioration in symptoms during training or service.

49. **Poland Syndrome.** Poland syndrome refers to a congenital unilateral absence of the pectoralis major and minor muscles and is non-progressive. Candidates are FIT provided they meet all the following criteria:

a. Symptom-free during activity comparable with military training for three months (including the ability to perform press ups),

b. Normal dynamic functional assessment.[28]

50. Candidates who do not fulfil these criteria are UNFIT as they are unlikely to have sufficient function to carry out the full range of basic military tasks such as safely operating their personal weapon.

51. **Pectoralis major tear.** Pectoralis major tears are uncommon. Candidates with a history of pectoralis major tear, managed non-operatively or with surgery, are FIT provided they meet all the following criteria:

a. Discharged from treatment and rehabilitation with full upper limb function,

b. At least six months symptom-free including conducting activity comparable with military training for three months (including the ability to perform press ups),

c. Normal dynamic functional assessment.[29]

52. Candidates who do not meet the above criteria are UNFIT due to the risk of deterioration in symptoms during training or service requiring extended non-operative or surgical treatment.

53. **Glenohumeral joint (shoulder) arthritis.** Care should be taken to distinguish glenohumeral joint arthritis from acromio-clavicular joint arthritis. Glenohumeral joint arthritis can be primary or post-traumatic in nature. To be diagnosed and investigated, candidates will usually have reported symptoms such as pain, stiffness and loss of function. It is rare for glenohumeral joint arthritis to be an incidental finding. Candidates with proven arthritis of the glenohumeral joint are UNFIT because the condition will result in pain, stiffness and loss of function which will impede the candidate's ability to function in the military environment. In addition, there is an unacceptably high risk of progression of symptoms requiring extended non-operative or surgical treatment.

54. **Acromio-clavicular joint arthritis.** This is a common condition which rarely presents with significant functional impairment. Candidates are FIT provided provided they meet all the following criteria, regardless of treatment modality (including excision):

a. Full shoulder movement,

[27] See Annex B, Guidelines for the conduct of a pre-service medical assessment.
[28] See Annex B, Guidelines for the conduct of a pre-service medical assessment.
[29] See Annex B, Guidelines for the conduct of a pre-service medical assessment.

b. Symptom-free during activity comparable with military training for a minimum of three months, including when carrying weight on their shoulders (including the ability to perform press ups),

c. Normal dynamic functional assessment.[30]

55. Candidates are UNFIT if symptomatic with pain, stiffness and loss of function due to the risk of deterioration in symptoms during training or service.

Conditions of the Elbow

56. **Elbow trauma.** Following elbow injury, stiffness and instability are both common. To function in a deployed role, the elbow must be stable to allow function and strength with an outstretched arm and have adequate range of movement for the role. Candidates with a history of elbow disorders are FIT provided they meet all the following criteria:

a. No significant loss of elbow extension and / or flexion,[31]

b. No significant loss of pronation or supination,[32]

c. No significant varus or valgus angulation,

d. Symptom-free during activity comparable with military training for a minimum of three months, including when carrying weight on their shoulders (including the ability to perform press ups),

e. Normal dynamic functional assessment.[33]

57. Candidates who do not meet the above criteria are UNFIT due to the requirement to have full use of the elbow to perform usual military duties (e.g pushing, pulling, climbing, equipment and weapon handling).

58. **Elbow arthritis.** For diagnosis and investigation to have occurred, candidates will usually have reported symptoms such as pain, stiffness and loss of function. It is rare for elbow arthritis to be an incidental finding. Candidates with proven arthritis of the elbow are UNFIT due to the requirement to have full use of the elbow to perform usual military duties (e.g pushing, pulling, climbing, equipment and weapon handling). In addition, there is an unacceptably high risk of progression of symptoms requiring extended non-operative or surgical treatment.

59. **Bicep tendon injuries.** Candidates with a history of bicep tendon injury, whether proximal or distal and regardless of treatment modality, are FIT provided they meet all the following criteria:

a. At least six months symptom-free,

b. Discharged from treatment and rehabilitation with full upper limb function,

[30] See Annex B, Guidelines for the conduct of a pre-service medical assessment.
[31] Less than 15° loss of extension and, or flexion.
[32] Less than 20° loss of supination and, or pronation.
[33] See Annex B, Guidelines for the conduct of a pre-service medical assessment.

c. Symptom-free during activity comparable with military training for a minimum of three months, including when carrying weight on their shoulders (including the ability to perform press ups),

d. Normal dynamic functional assessment.[34]

60. Candidates who do not meet the above criteria are UNFIT due to the requirement to have full use of the elbow to perform usual military duties (e.g pushing, pulling, climbing, equipment and weapon handling).

61. **Lateral or medial epicondylitis (Tennis or Golfer's Elbow).** This is a common cause of pain at the outer (lateral) or inner (medial) aspect of the elbow felt when lifting and on palpation. Candidates are FIT after successful non-operative or operative treatment, provided they meet all the following criteria:

a. At least six months symptom-free,

b. Discharged from treatment and rehabilitation with full upper limb function,

c. Symptom-free during activity comparable with military training for a minimum of three months (including the ability to perform press ups),

d. Normal dynamic functional assessment.[35]

62. Candidates who do not fulfil the above criteria are UNFIT due to the requirement to have full use of the elbow to perform usual military duties (e.g pushing, pulling, climbing, equipment and weapon handling).

Conditions of the wrist

63. **Extra-articular wrist fractures (not inside the joint capsule).** Candidates are FIT provided they meet all the following criteria:

a. 12 months since injury,

b. The fracture has healed normally and in good alignment,

c. Discharged from treatment and rehabilitation with normal wrist function,

d. At least three months symptom-free including conducting activity comparable with military training for three months (including the ability to perform press ups),

e. Normal dynamic functional assessment.[36]

64. Candidates who do not fulfil the above criteria are UNFIT due to the requirement to have full use of the wrist to perform usual military duties (e.g pushing, pulling, climbing, equipment and weapon handling). In addition, there is an unacceptably high risk of progression of symptoms requiring extended non-operative or surgical treatment.

[34] See Annex B, Guidelines for the conduct of a pre-service medical assessment.
[35] See Annex B, Guidelines for the conduct of a pre-service medical assessment.
[36] See Annex B, Guidelines for the conduct of a pre-service medical assessment.

65. **Intra-articular wrist fractures.** Candidates are FIT provided they meet all the following criteria:

a. 12 months since injury,

b. The fracture has healed normally and in good alignment,

c. Discharged from treatment and rehabilitation with normal wrist function,

d. No evidence of joint surface problems (e.g. a step in the joint surface on existing imaging),

e. At least three months symptom-free including conducting activity comparable with military training for three months (including the ability to perform press ups),

f. Normal dynamic functional assessment.[37]

66. Candidates who do not fulfil the above criteria are UNFIT due to the requirement to have full use of the wrist to perform usual military duties (e.g pushing, pulling, climbing, equipment and weapon handling). In addition, there is an unacceptably high risk of progression of symptoms requiring extended non-operative or surgical treatment. Fractures that involve the joint surface have a risk of degeneration during service.

67. **Carpal (wrist) bone fractures.** Candidates are FIT provided they meet all the following criteria:

a. 12 months since injury,

b. No evidence of wrist ligament injury leading to instability,

c. No evidence of avascular necrosis (see below),

d. Discharged from treatment and rehabilitation with normal wrist function,

e. No evidence of joint surface problems (e.g. a step of greater than 2mm in the joint surface on existing imaging),

f. At least three months symptom-free including conducting activity comparable with military training for three months (including the ability to perform press ups),

g. Normal dynamic functional assessment.[38]

68. Candidates who do not fulfil the above criteria are UNFIT due to the requirement to have full use of the wrist to perform usual military duties (e.g pushing, pulling, climbing, equipment and weapon handling). In addition, there is an unacceptably high risk of progression of symptoms requiring extended non-operative or surgical treatment. Fractures that involve the joint surface have a risk of degeneration during service. Carpal instability will not allow the strength or dexterity required for military roles.

[37] See Annex B, Guidelines for the conduct of a pre-service medical assessment.
[38] See Annex B, Guidelines for the conduct of a pre-service medical assessment.

69. **Avascular necrosis of the carpal bones (disruption to the blood supply of the wrist bones).** All candidates with known avascular necrosis of any carpal bone are UNFIT as there is an increased risk of post traumatic arthrosis and / or pain and stiffness limiting their ability to perform usual military duties (e.g pushing, pulling, climbing, equipment and weapon handling). In addition, there is an unacceptably high risk of progression of symptoms requiring extended non-operative or surgical treatment.

70. **Wrist arthritis.** Candidates with an incidental finding of mild degenerative changes on imaging in a symptom-free wrist are FIT. Candidates with symptomatic arthritis of the wrist are UNFIT due to the requirement to have full use of the wrist to perform usual military duties (e.g pushing, pulling, climbing, equipment and weapon handling). In addition, there is an unacceptably high risk of progression of symptoms requiring extended non-operative or surgical treatment.

71. **Soft tissue injuries of the wrist.** Candidates with normal range of movement following injury are FIT provided they meet all the following criteria:

a. Discharged from treatment and rehabilitation with normal wrist function,

b. At least three months symptom-free including conducting activity comparable with military training for three months (including the ability to perform press ups),

c. Normal dynamic functional assessment.[39]

72. Candidates who do not meet all the above criteria are UNFIT due to the requirement to have full use of the wrist to perform usual military duties (e.g pushing, pulling, climbing, equipment and weapon handling). In addition, there is an unacceptably high risk of progression of symptoms requiring extended non-operative or surgical treatment.

Conditions of the hands

73. **Loss of or absence of a finger (complete or partial) or partial loss or absence of a thumb (distal to the interphalangeal joint).** Candidates are FIT provided they meet all the following criteria:

a. Discharged from treatment and rehabilitation with normal hand function,

b. Symptom-free including conducting activity comparable with military training for three months,

c. Normal dynamic functional assessment.[40]

74. Candidates who do not meet all the above criteria are UNFIT due to the requirement to have full use of the hands to perform usual military duties (e.g holding, grabbing, pulling, climbing, equipment and weapon handling).

75. **Thumb reconstruction.** Candidates who have had reconstruction surgery for the absence of a thumb should be assessed by the above criteria. Candidates who do not meet these criteria are UNFIT due to the requirement to have full use of the hands to perform usual military duties (e.g holding, grabbing, pulling, climbing, equipment and

[39] See Annex B, Guidelines for the conduct of a pre-service medical assessment.
[40] See Annex B, Guidelines for the conduct of a pre-service medical assessment.

weapon handling).

76. **Absence of the thumb.** Candidates with the absence of a thumb at or proximal to the interphalangeal joint are UNFIT. Candidates who do not meet these criteria are UNFIT due to the requirement to have full use of the hands to perform usual military duties (e.g holding, grabbing, pulling, climbing, equipment and weapon handling).

77. **Metacarpal and phalangeal (hand and finger) fractures.** Candidates are FIT provided they meet all the following criteria:

a. Three months since injury for uncomplicated fractures (surgical fixation not required) not involving a joint,

b. Six months since injury where surgical fixation (including k-wire, screw, plate) was required or where a joint was involved or where there was a volar plate injury,

c. The fracture has healed normally and in good alignment,

d. Discharged from treatment and rehabilitation with normal hand function,

e. At least three months symptom-free including conducting activity comparable with military training for three months,

f. Normal dynamic functional assessment.[41]

78. Candidates who do not meet all the above criteria are UNFIT due to the requirement to have full use of the hands to perform usual military duties (e.g holding, grabbing, pulling, climbing, equipment and weapon handling).

79. **Hand and digit arthritis.** Candidates with an incidental finding of mild degenerative changes on imaging in a symptom-free hand are FIT. Candidates with symptomatic arthritis of the hand (including pain, stiffness and loss of dexterity) are UNFIT due to the requirement to have full use of the hands to perform usual military duties (e.g holding, grabbing, pulling, climbing, equipment and weapon handling).

80. **Ulnar collateral ligament avulsion injury.** These injuries have the potential to result in an unstable thumb. Whether treated surgically or non surgically, candidates are FIT provided they meet all the following criteria:

a. Six months since injury,

b. Discharged from treatment and rehabilitation with normal hand function,

c. At least three months symptom-free including conducting activity comparable with military training for three months,

d. Normal dynamic functional assessment.[42]

81. Candidates who do not meet all the above criteria (including those with untreated ligament avulsion injuries) are UNFIT due to the requirement to have full use of the hands

[41] See Annex B, Guidelines for the conduct of a pre-service medical assessment.
[42] See Annex B, Guidelines for the conduct of a pre-service medical assessment.

to perform usual military duties (e.g holding, grabbing, pulling, climbing, equipment and weapon handling).

82. **Other finger anatomical abnormality.** Candidates with any other anatomical abnormalities of the finger are FIT provided they meet all the following criteria:

a. Symptom-free with full function and have no foreseeable difficulty in weapon handling and putting on personal protective equipment (PPE) (including gloves),

b. Normal dynamic functional assessment.[43]

83. Candidates who do not meet all the above criteria are UNFIT due to the requirement to have full use of the hands to perform usual military duties (e.g holding, grabbing, pulling, climbing, equipment and weapon handling).

Spinal Conditions

84. **Vertebral fractures.** Candidates with a vertebral body fracture are FIT, provided they meet all the following criteria:

a. At least three months post injury with no pain or other symptoms,

b. The fracture has fully healed and there is no neurological deficit or significant anatomical abnormality (confirmed on post-recovery imaging),

c. Discharged from treatment and rehabilitation with normal spinal function,

d. Full function (at least three months activity comparable with military training, including load-carrying ability),

e. Clinical examination is normal,

f. Normal dynamic functional assessment.[44]

85. Candidates who do not meet all the above criteria are UNFIT as they are unlikely to achieve the required level of function required for military service and are at increased risk of foreseeable injury during training or service (the injuries predispose to accelerated degenerative change at the level of the deformity).

86. **Single transverse process fractures.** These are non-structural fractures that do not affect spinal stability. Candidates with a history of an isolated transverse process fracture are FIT, provided they meet all the following criteria:

a. At least three months post injury with no pain or other symptoms,

b. Discharged from treatment and rehabilitation with normal spinal function,

c. Full function (at least three months activity comparable with military training. including load-carrying ability),

[43] See Annex B, Guidelines for the conduct of a pre-service medical assessment.
[44] See Annex B, Guidelines for the conduct of a pre-service medical assessment.

d. Clinical examination is normal,

e. Normal dynamic functional assessment.[45]

87. **Multiple transverse process fractures** are often associated with muscle and nerve damage and candidates with this history are UNFIT due to the risk of deterioration during training and service requiring extended non-operative or surgical treatment.

88. **Single spinous process fractures.** Candidates with a history of an isolated spinous process fracture are FIT provided they meet all the following criteria:

a. At least three months post injury with no pain or other symptoms,

b. The fracture has healed with either bony union or symptom-free non-union and there is no neurological deficit or significant anatomical abnormality (confirmed on post-recovery imaging),

c. Discharged from treatment and rehabilitation with normal spinal function,

d. Full function (at least three months activity comparable with military training, including load-carrying ability),

e. Clinical examination is normal,

f. Normal dynamic functional assessment.[46]

89. **Multiple spinous process fractures** are often associated with ligamentous injury with an increased risk of biomechanical instability and persistent spinal pain. Candidates with this history are UNFIT as they are unlikely to achieve the required level of function required for military service and are at increased risk of foreseeable injury during training or service.

90. **Spondylolysis (pars fractures, stress fractures and defects).**

a. **Single vertebral level uncomplicated pars fracture**. Candidates with a single vertebral level uncomplicated (no spondylolisthesis, no pain, no neurological symptoms) pars fracture that has healed fully with conservative management are FIT provided they meet all the following criteria:

(1) At least 12 months post injury with no symptoms including pain, instability or other symptoms,

(2) Discharged from treatment and rehabilitation with normal spinal function,

(3) Full function (at least three months activity comparable with military training, including load-carrying ability),

(4) Clinical examination is normal,

[45] See Annex B, Guidelines for the conduct of a pre-service medical assessment.
[46] See Annex B, Guidelines for the conduct of a pre-service medical assessment.

(5) Normal dynamic functional assessment.[47]

b. Candidates who do not fulfil these criteria are UNFIT as they are unlikely to achieve the required level of function required for military service and are at increased risk of foreseeable injury during training or service.

c. **Fracture at multiple levels or a more complex history.** Candidates with more than one fracture or a more complex history (presence of spondylolisthesis, history of significant pain or neurological deficit) are FIT provided they meet all the following criteria:

(1) At least 12 months post injury with no symptoms including pain, instability or other symptoms,

(2) Discharged from treatment and rehabilitation with normal spinal function,

(3) Full function (at least twelve months activity comparable with military training, including load-carrying ability),

(4) Opinion provided by a military approved spinal surgeon in respect of recovery, function and prognosis,

(5) Clinical examination is normal,

(6) Normal dynamic functional assessment.[48]

d. Candidates who do not fulfil these criteria are UNFIT as they are unlikely to achieve the required level of function required for military service and are at increased risk of foreseeable injury during training or service. There is a risk of deterioration or re-injury during training and service requiring extended non-operative or surgical treatment. In addition, there is a moderate risk of developing disc degenerative disease and spondylolisthesis at the affected level.

91. **Fractured coccyx.** Those who have made a full functional recovery after 12 months and are symptom-free during activities comparable with military training for a minimum of three months are FIT.

92. **Isolated interspinous ligamentous injury.** Candidates with a history of isolated ligamentous injury are FIT provided they meet all the following criteria:

a. At least 12 months post injury with no symptoms including pain, instability or other symptoms,

b. Full function (at least three months activity comparable with military training, including load-carrying ability),

c. The candidate has been discharged from specialist follow-up,

d. Clinical examination is normal,

[47] See Annex B, Guidelines for the conduct of a pre-service medical assessment.
[48] See Annex B, Guidelines for the conduct of a pre-service medical assessment.

e. There is no neurological deficit,

93. Candidates who do not fulfil these criteria are UNFIT as they are unlikely to achieve the required level of function required for military service and are at increased risk of foreseeable injury during training or service.

94. **Cauda equina (spinal cord injury), spinal neurotrauma (spinal nerve root injury).** This includes, but is not limited to, spinal cord injuries, cauda equina syndrome and isolated nerve root injuries. Candidates who have had any spinal trauma with residual neurological deficit are UNFIT as they are unlikely to achieve the required level of function required for military service and are at increased risk of foreseeable injury during training or service.

95. **Spinal tumours.** Candidates should be assessed according to the criteria below:

a. **Benign tumours (non-cancerous growths).** These include aneurysmal bone cysts and chondroma. The following applies:

(1) Candidates with small tumours, confined to the vertebral body that are non-progressive are FIT.

(2) Candidates with other types of small non-progressive tumours without involvement of bone cortex may be FIT and should be referred to a military approved spinal surgery consultant for an opinion on prognosis.

(3) Candidates with large tumours which involve the cortex or tumours that involve the joints of the spine are UNFIT because they can predispose to vertebral body fractures. Fractures cause spinal pain, deformity and can cause spinal cord injury. Benign tumours involving a joint may affect the motion at a given segment of the spine and can alter spinal biomechanics increasing the risk of injury and could be exacerbated by the rigours of military training.

b. **Malignant tumours (cancerous growths).** Candidates are be FIT provided they meet all the following criteria:

(1) Discharged from treatment and rehabilitation with normal spinal function,

(2) There is no reasonably predictable risk of recurrence,

(3) There is no significant residual anatomical abnormality or impairment in function, movement, strength or pain,

(4) There was no joint or nerve involvement,

(5) The candidate has had no symptoms since with full symptom-free function (at least three months activity comparable with military training, including load-carrying ability),

(6) Those stated in Annex N Other Conditions under Oncology (cancers),

(7) Opinion provided by a military approved spinal surgeon and oncologist in respect of recovery, function and prognosis,

(8) Clinical examination is normal,

(9) Normal dynamic functional assessment.[49]

c. Candidates who do not fulfil these criteria are UNFIT as they are unlikely to achieve the required level of function required for military service and are at increased risk of foreseeable injury during training or service and would need access to routine specialist medical services.

Congenital Spinal Conditions

96. **Anatomical abnormalities of bone.** Guidance on specific conditions is provided below. Where there is another bony anatomical abnormality which does not affect spinal biomechanics and there is normal pain-free full range of movement, candidates are FIT.

97. **Hyperkyphosis of the spine, Scheuermann's disease (increased forward flexion of the spine).** Candidates are be FIT provided they meet all the following criteria:

a. Other causes including Chiari malformation, tethered cord and neural tube defect must have been excluded with appropriate radiological investigation,

b. No significant anatomical abnormality (up to 60° kyphosis is acceptable) and have achieved three months activity comparable with military training (especially load-carrying ability) without symptoms are FIT,

c. The candidate has had no symptoms since with full symptom-free function (at least three months activity comparable with military training, including load-carrying ability),

d. Clinical examination is normal,

e. Normal dynamic functional assessment.[50]

98. Candidates who are currently symptomatic with spinal pain or neuropathic pain are UNFIT due to the predisposition to biomechanical issues that would be incompatible with an austere military environment and the rigours of military life. Candidates who have had surgery to correct a hyperkyphosis are UNFIT due to very high chance of developing adjacent level disease or implant failure as a result of military duty.

99. **Scoliosis (lateral curvature of the spine)** Candidates should be assessed according to the criteria below:

a. **Adolescent idiopathic scoliosis.**

(1) Skeletally immature candidates with adolescent idiopathic scoliosis and a Cobb angle of less than or equal to 10° are FIT provided they are symptom-free and fully functional. Candidates with a Cobb angle greater than 10° are UNFIT

[49] See Annex B, Guidelines for the conduct of a pre-service medical assessment.
[50] See Annex B, Guidelines for the conduct of a pre-service medical assessment.

until skeletal maturity (described above) is achieved due to the possibility of progression and compromised function.

(2) Skeletally mature candidates with Adolescent Idiopathic Scoliosis should be assessed according to the criteria below:

(a) **Cobb angle of less than or equal to 20°.** Candidates are FIT if symptom-free and fully functional.

(b) **Cobb angle of 20-40°.** Candidates with a Cobb angle of 20-40° are FIT if symptom-free and fully functional and have conducted activity comparable to military training for three months (including load carrying ability). Appropriate radiological investigation must have been performed previously to rule out non-idiopathic causes.

(c) **Cobb angle greater than 40°.** Candidates with a Cobb angle greater than 40° are UNFIT due to the risk of deterioration of the scoliosis with arduous physical training.

b. **A new finding of scoliosis made during assessment.** Candidates with minimal abnormal scoliosis (determined by normal Adams' forward bend test, no scapula asymmetry, no paraspinal or rib prominence, a scoliometer measurement, where available, of less than 5° which equates to a Cobb angle less than 10°) with no associated back pain with full and free movement of all spinal segments are FIT. Candidates who do not fulfil these criteria require referral to a military approved spinal surgeon for imaging and an opinion on function and prognosis.

c. **Other causes of scoliosis.** Candidates with other causes of scoliosis are UNFIT due to a likely difficulty to perform physical tasks in an arduous environment and the increased risk of worsening symptoms.

d. **Scoliosis surgery.** Candidates who have had surgery to correct scoliosis are UNFIT due to very high chance of developing adjacent level disease or implant failure as a result of military duty.

100. **Vertebral anomalies including butterfly vertebra and hemivertebra.** Candidates with no associated anatomical abnormality or other symptoms are FIT provided they meet all the following criteria:

a. Discharged from treatment and rehabilitation with normal spinal function,

b. Full function (at least three months activity comparable with military training, including load-carrying ability),

c. Clinical examination is normal,

d. Normal dynamic functional assessment.[51]

[51] See Annex B, Guidelines for the conduct of a pre-service medical assessment.

101. Candidates who do not fulfil these criteria are UNFIT due to a likely difficulty to perform physical tasks in an arduous environment and the increased risk of worsening symptoms.

102. **Abnormal fusion of the spine (Klippel-Feil Syndrome).** Candidates with no associated anatomical abnormality or other symptoms are FIT provided they meet all the following criteria:

a. Discharged from treatment and rehabilitation with normal spinal function,

b. Full function (at least three months activity comparable with military training, including load-carrying ability),

c. Clinical examination is normal,

d. Normal dynamic functional assessment.[52]

103. Candidates who do not fulfil these criteria are UNFIT due to a likely difficulty to perform physical tasks in an arduous environment and the increased risk of worsening symptoms.

104. **Spina bifida occulta**. Candidates with an incidental finding, without history of symptoms and in the absence of other abnormality are FIT. Candidates with either present or previous symptoms are UNFIT due to a likely difficulty to perform physical tasks in an arduous environment and the increased risk of worsening symptoms.

105. **Other neural tube defects.** These include: spina bifida, lipomyelomeningocoele and myelomeningocoele. Candidates are UNFIT as they are unlikely to achieve the required level of function required for military service and are at increased risk of foreseeable injury during training or service and would need access to routine specialist medical services. These conditions can be associated with bladder, bowel, and lower limb dysfunction, as well as incomplete formation of the lumbar spinal column.

Movement abnormalities

106. **Torticollis (fixed flexion and rotation of the neck).** Candidates with a history of torticollis should be assessed according to the criteria below:

a. **Congenital torticollis.**

(1) **Non-surgical management.** Candidates who have been conservatively managed and have no residual symptoms are FIT.

(2) **Sternocleidomastoid surgery.** Candidates who have had sternocleidomastoid muscle lengthening surgery may be FIT provided they are symptom-free and there is no limitation to function. A should be referral to a military approved spinal surgeon for an opinion on recovery, function and prognosis.

[52] See Annex B, Guidelines for the conduct of a pre-service medical assessment.

(3) **Other surgical treatment.** Candidates with a history of other surgical treatment for their torticollis or who remain symptomatic are UNFIT as they are unlikely to achieve the required level of function required for military service and are at increased risk of foreseeable injury during training or service and would need access to routine specialist medical services. There is an increased risk of deterioration during training and service requiring extended non-operative or surgical treatment.

b. **Acquired Torticollis**. Candidates with a history of acquired torticollis with completely resolved symptoms without surgery are FIT. Candidates who have required surgical treatment to the vertebral column are UNFIT as they are unlikely to achieve the required level of function required for military service and are at increased risk of foreseeable injury during training or service and would need access to routine specialist medical services. The surgery increases the risk of accelerated spinal degenerative disease and cervical trauma.

107. **Dystonias (movement disorders), myoclonus (tremors, shock-like jerking movements and dyskinesias (abnormal movements).** Candidates with these conditions are UNFIT because of a likely difficulty to perform physical tasks in an arduous environment and the increased risk of worsening symptoms.

Neck and low back pain

108. **Short episodes of neck pain or low back pain (lasting less than two months).** Candidates with two or fewer episodes associated with injury or excessive training, that have fully resolved within two months with minimal clinical input (only GP and / or Physiotherapy) are FIT once fully functional.

109. **Longer episodes of pre-existing neck pain or low back pain (lasting less than three months).** Candidates with longer episodes of previous neck or low back pain, that required non-surgical clinical intervention are FIT provided they have been symptom-free for at least six months (where history includes exercise comparable with military training for three months).

110. **Persistent or recurrent neck or back pain (lasting three months or more).** Candidates with historic episodes (more than five years ago) which did not require invasive treatment, had fully resolved within a year, and where the candidate is both fully functional and has undertaken activity comparable to military training including load-carrying ability without pain or requirement for pain relief for three months should be referred to sSMES for a determination of FIT / UNFIT. Candidates with persistent or recurrent neck or back pain that has not responded to exercise, weight loss and physiotherapy are UNFIT as they are unlikely to achieve the required level of function required for military service and are at increased risk of foreseeable injury during training or service and would need access to routine specialist medical services. This may be associated with underlying structural disease (such as disc degenerative disease or facet hypertrophy) and the risk of exacerbation during training and service is unacceptably high.

111. **Sciatic pain with or without back pain.** Candidates with a history of sciatic pain[53] should be assessed according to the criteria below:

[53] Pain which arises in the back or buttock and can be felt down the front or back of the leg.

a. **Non surgical management.** Candidates who did not require surgical intervention, whose condition resolved fully and where the candidate is now fully functional and at least twelve months following successful treatment and have undertaken activity comparable to military training including load carriage for three months without pain or requirement for pain relief are FIT.

b. **Associated with disc prolapse.** Candidates with sciatic pain secondary to a disc prolapse, treated by a single level microdiscectomy are FIT provided they meet all the following criteria:

(1) 12 months post-surgery,

(2) No evidence of treatment or injury related secondary effects,

(3) Discharged from treatment and rehabilitation with normal spinal function and no evidence of degenerative disc disease at other spinal levels,

(4) Fully functional (at least three months activity comparable with military training, including load-carrying ability),

(5) Clinical examination is normal,

(6) Normal dynamic functional assessment.[54]

c. All other candidates, including those who have surgery at more than a single level are UNFIT as they are unlikely to achieve the required level of function required for military service and are at increased risk of foreseeable injury during training or service.

112. **Cervical radiculopathy due to foraminal stenosis or disc prolapse (nerve compression in the neck).** Candidates with a history of cervical radiculopathy should be assessed according to the criteria below:

a. **Non surgical management.** Candidates who did not require surgical intervention, whose condition resolved fully and where the candidate is now fully functional and at least twelve months following successful treatment, and have undertaken activity comparable to military training including load carriage for three months without pain or requirement for pain relief are FIT.

b. **Surgical management.** Candidates with cervical radiculopathy secondary to foraminal stenosis or disc prolapse, treated by neural foraminal widening (foraminotomy) or single level microdiscectomy are FIT provided they meet all the following criteria:

(1) 12 months post-surgery,

(2) No evidence of treatment or injury related secondary effects,

(3) Discharged from treatment and rehabilitation with normal spinal function and no evidence of degenerative disc disease at other spinal levels,

[54] See Annex B, Guidelines for the conduct of a pre-service medical assessment.

(4) Fully functional (at least three months activity comparable with military training, including load-carrying ability),

(5) Clinical examination is normal,

(6) Normal dynamic functional assessment.[55]

113. Candidates who do not meet all the above criteria are UNFIT due to the risk of deterioration during training and service requiring extended non-operative or surgical treatment.

114. **Thoracic back pain.** Candidates with two or fewer episodes associated with injury or excessive training are FIT provided they meet all the following criteria:

a. Resolved within three months with minimal clinical input (only GP and / or Physiotherapy),

b. Fully functional (at least three months activity comparable with military training, including load-carrying ability),

c. Clinical examination is normal,

d. Normal dynamic functional assessment.[56]

115. Candidates who do not meet all the above criteria are UNFIT due to the risk of deterioration during training and service requiring extended non-operative or surgical treatment. There may be significant underlying pathology.

116. **Spinal stenosis (narrowing of the spinal canal).** Candidates are UNFIT as they are unlikely to achieve the required level of function required for military service and are at increased risk of foreseeable injury during training or service and would need access to routine specialist medical services. There is a likelihood of neurological deterioration, including the onset of neuropathic pain.

117. **Spondylolisthesis (slipped vertebra).** Spondylolisthesis describes the slippage of a single vertebra relative to the one below. Fitness will be dependent on the cause and the extent of slippage.

a. Candidates with idiopathic Grade 1 (0-25% slippage) with no evidence of degenerative, post-traumatic (including pars fractures) and / or pathological causes who are symptom-free and able to carry out activities comparable with military training (including load carriage) for a minimum of three months are FIT.

b. Candidates with Grade 2 or higher (>25%) slippage and / or those with current symptoms are UNFIT as they are unlikely to achieve the required level of function required for military service and are at increased risk of foreseeable injury during training or service and would need access to routine specialist medical services. due to the risk of exacerbating their spondylolisthesis causing worsening back and neuropathic pain.

[55] See Annex B, Guidelines for the conduct of a pre-service medical assessment.
[56] See Annex B, Guidelines for the conduct of a pre-service medical assessment.

118. **Spinal Infection.** Candidates should be assessed according to the criteria below:

a. **Osteomyelitis and discitis (infection of the bones, intervertebral discs or soft tissues around the spine).** Candidates with a brief episode (up to three months) of uncomplicated infection who meet all the following criteria are FIT:

(1) Single episode which recovered more than 36 months ago (due to the risk of recurrence of infection and the time taken for full functional recovery),

(2) The candidate recovered with no complications,

(3) There was no joint or nerve involvement,

(4) Discharged from treatment and rehabilitation with normal spinal function,

(5) The candidate has had no symptoms since with full symptom-free function (at least three months activity comparable with military training, including load-carrying ability),

(6) There is no documentation of abnormal imaging post-recovery,

(7) Clinical examination is normal,

(8) Normal dynamic functional assessment.[57]

b. All other candidates are UNFIT due to the risk of deterioration during training and service requiring extended non-operative or surgical treatment.

Pelvis and Acetabulum Injuries

119. **Acetabular fractures.** Intra-articular fractures of the acetabulum represent a complex spectrum of injuries. Candidates with a history of acetabular fracture should be assessed according to the criteria below:

a. **Non surgical management.** Candidates are FIT provided they meet all the following criteria:

(1) Managed without surgical fixation,

(2) More than 24 months post injury,

(3) Discharged from treatment and rehabilitation with no neurological injury,

(4) Fully functional (at least three months activity comparable with military training, including load-carrying ability) without hip pain or stiffness,

(5) No significant joint changes on available imaging,

[57] See Annex B, Guidelines for the conduct of a pre-service medical assessment.

(6) Normal range of hip movement (at least 90° flexion, 25° abduction, 20° external rotation in 90° flexion, and 5° internal rotation in 90° flexion),

(7) Normal dynamic functional assessment.[58]

b. Candidates who do not meet these criteria are UNFIT as there is a significant risk of deterioration in their symptoms during training and service requiring extended non-operative or surgical treatment.

c. **Surgical management.** There is a high rate of post traumatic or early onset arthritis in people whose injury required surgical treatment. Candidates who have had surgical fixation of an acetabular fracture and who meet all the criteria stated above should be referred for a military orthopaedic consultant for an opinion on recovery, function and prognosis.

120. **Fractures of the pelvic ring.** Fractures of the pelvic ring represent a spectrum of injuries, which can range from plastic deformation in the skeletally immature to life threatening injury. Candidates should be assessed according to the criteria below:

a. **Non surgical management.** Candidates are FIT if they required neither surgery nor a period of reduced weightbearing for more than one month.

b. **Surgical management and / or prolonged protected weight-bearing.** Candidates who have had a period of protected weight bearing greater than one month and / or surgical fixation of pelvic fracture and who meet all the criteria stated below should be referred to a military orthopaedic consultant for an opinion on recovery, function and prognosis:

(1) More than 24 months post injury,

(2) Discharged from treatment and rehabilitation with no neurological injury,

(3) Fully functional (at least three months activity comparable with military training, including load-carrying ability) without hip pain or stiffness,

(4) No prior radiographic evidence of degenerative joint disease affecting the sacroiliac joint,

(5) Normal range of hip movement (at least 90° flexion, 25° abduction, 20° external rotation in 90° flexion, and 5° internal rotation in 90° flexion),

(6) Normal dynamic functional assessment.[59]

c. Candidates who do not meet these criteria are UNFIT as they will have a high risk of developing degenerative changes during training and service requiring extended non-operative or surgical treatment.

[58] See Annex B, Guidelines for the conduct of a pre-service medical assessment.
[59] See Annex B, Guidelines for the conduct of a pre-service medical assessment.

Conditions of the hip joint

121. **Fracture-dislocations of the hip.** These are high energy injuries involving severe damage to both the bony (acetabulum and / or femoral head) and soft tissue components of the hip joint. There is a high rate of post traumatic or early onset arthritis and therefore it is unlikely that candidates would be suitable for military service. Candidates who meet all the criteria below should be referred to a military orthopaedic consultant for an opinion on function and prognosis:

a. More than 24 months post injury,

b. Discharged from treatment and rehabilitation,

c. Fully functional (at least three months activity comparable with military training, including load-carrying ability) without hip pain or stiffness,

d. No prior radiographic evidence of degenerative joint disease,

e. Normal range of hip movement (at least 90° flexion, 25° abduction, 20° external rotation in 90° flexion, and 5° internal rotation in 90° flexion),

f. Normal dynamic functional assessment.[60]

122. Candidates who do not meet all these criteria are UNFIT as there is a significant risk of deterioration in their symptoms during training and service requiring extended non-operative or surgical treatment.

123. **Traumatic dislocation of the hip without fracture.** Candidates are FIT provided they meet all the following criteria:

a. More than 24 months post injury,

b. No evidence of sciatic nerve injury, avascular necrosis or post-traumatic arthritis,

c. Discharged from treatment and rehabilitation,

d. Fully functional (at least three months activity comparable with military training, including load-carrying ability) without hip pain or stiffness,

e. Normal range of hip movement (at least 90° flexion, 25° abduction, 20° external rotation in 90° flexion, and 5° internal rotation in 90° flexion),

f. Normal dynamic functional assessment.[61]

124. Candidates who do not fulfil these criteria are UNFIT as they will have a high risk of deterioration during training and service requiring extended non-operative or surgical treatment.

[60] See Annex B, Guidelines for the conduct of a pre-service medical assessment.
[61] See Annex B, Guidelines for the conduct of a pre-service medical assessment.

125. **Proximal femur fractures.** These are injuries with a high rate of delayed complications and recurrence due to the biomechanics and blood supply of the region. Candidates with traumatic proximal femur fractures are FIT provided they meet all the following criteria:

a. A period of at least 24 months must have elapsed as remodelling following fracture often takes up to 12 months and exclusion of avascular necrosis can take 24 months,

b. Fracture union is confirmed,

c. Discharged from treatment and rehabilitation,

d. Fully functional (at least three months activity comparable with military training, including load-carrying ability) without hip pain or stiffness,

e. Normal anatomy (length, rotation and alignment) has been restored through surgery,

f. There is no tenderness over the area of metalwork / fracture site. It is not necessary for metalwork to have been removed if the candidate is asymptomatic,

g. There is full function of the joints above and below the injury including a normal range of hip movement (at least 90° flexion, 25° abduction, 20° external rotation in 90° flexion, and 5° internal rotation in 90° flexion),

h. Normal dynamic functional assessment.[62]

126. **Stress fracture to the femur.** Candidates with a radiographically proven stress fracture of the femur (pending or complete) are UNFIT due to the likelihood or recurrence and the need for future prolonged treatment as a result of the rigours of military service.

127. **Developmental dysplasia of the hip (DDH) / Congenital Dislocation of the Hip, (CDH).** Candidates may have been treated non-surgically (splints, traction) to encourage the socket to grow deeper, or by surgery to realign the hip joint. Candidates who meet all the criteria below are FIT.

a. At least 24 months since any treatment,

b. Discharged from treatment and rehabilitation,

c. No pain at rest or with activity, including activity consistent with military training (including load carriage) for at least twelve months,

d. Normal range of pain free hip movement (at least 90° flexion, 25° abduction, 20° external rotation in 90° flexion, and 5° internal rotation in 90° flexion),

e. Normal dynamic functional assessment.[63]

[62] See Annex B, Guidelines for the conduct of a pre-service medical assessment.
[63] See Annex B, Guidelines for the conduct of a pre-service medical assessment.

128. Candidates with painful hips, or restricted movement are UNFIT because these limitations will prevent them from participating in military training and may deteriorate requiring extended non-operative or surgical treatment.

129. **Perthes disease (abnormal hip due to loss of blood supply in childhood).** In this condition there is abnormal growth of the top of the thigh bone. Candidates may have been treated non-surgically (reduced loading, splints, traction) or by surgery to encourage the ball to maintain a round shape. Candidates who meet all the criteria below are FIT:

a. At least 24 months since any treatment,

b. Discharged from treatment and rehabilitation,

c. No pain at rest or with activity, including activity consistent with military training (including load carriage) for at least twelve months,

d. Normal range of hip movement (at least 90° flexion, 25° abduction, 20° external rotation in 90° flexion, and 5° internal rotation in 90° flexion),

e. Normal dynamic functional assessment.[64]

130. Candidates with painful hips, or restricted movement are UNFIT because these limitations will prevent them from participating in military training and may deteriorate requiring extended non-operative or surgical treatment.

131. **Slipped Capital Femoral Epiphysis (SCFE) also called Slipped Upper Femoral Epiphysis (SUFE) (Abnormal hip due to damage to the growth plate).** In this condition the ball of the hip slides on the top of the thigh bone during growth. Candidates may have been treated non-surgically, or by surgery to stabilise the joint or to restore normal anatomy. Candidates who meet the criteria below are FIT:

a. At least 24 months since any treatment,

b. Discharged from treatment and rehabilitation,

c. No pain at rest or with activity, including activity consistent with military training (including load carriage) for at least 12 months,

d. Normal range of hip movement (at least 90° flexion, 25° abduction, 20° external rotation in 90° flexion, and 5° internal rotation in 90° flexion),

e. Normal dynamic functional assessment.[65]

132. Candidates with painful hips, or restricted movement are UNFIT because these limitations will prevent them from participating in military training and may deteriorate requiring extended non-operative or surgical treatment.

133. **Hip dysplasia (shallow hip socket).** Some people with shallow hip sockets and rotational abnormalities of the hip present as adults with painful hips. Those who have had

[64] See Annex B, Guidelines for the conduct of a pre-service medical assessment.
[65] See Annex B, Guidelines for the conduct of a pre-service medical assessment.

non-surgical treatment (usually physiotherapy), or surgery (pelvic or femoral osteotomy) are FIT provided they meet all the following criteria:

a. At least 24 months since any treatment,

b. Discharged from treatment and rehabilitation,

c. No pain at rest or with activity, including activity consistent with military training (including load carriage) for at least twelve months,

d. Normal range of hip movement (at least 90° flexion, 25° abduction, 20° external rotation in 90° flexion, and 5° internal rotation in 90° flexion),

e. Normal dynamic functional assessment.[66]

134. Candidates hip dysplasia and ongoing pain or treatment are UNFIT because these limitations will prevent them from participating in military training and may deteriorate requiring extended non-operative or surgical treatment.

135. **Femoroacetabular impingement (FAI) syndrome (restriction of the hip joint) and labral tears (tears of the hip socket rim).** In this condition the ball and socket of the hip do not precisely fit and may rub together damaging the hip cartilage or labrum. Many young people may have a reference to this condition in their records, (e.g. FAI, impingement, cam, pincer, labral tear) and these should not be used to determine fitness for entry because they are not determinants of function and may represent the normal range of anatomy. Candidates who had non-surgical (usually physiotherapy) or surgical (usually keyhole or arthroscopic surgery) treatment for an established diagnosis of hip impingement; they are FIT provided they meet all the following criteria:

a. At least 24 months since any treatment,

b. Discharged from treatment and rehabilitation,

c. No pain at rest or with activity, including activity consistent with military training (including load carriage) for at least twelve months,

d. Normal range of hip movement (at least 90° flexion, 25° abduction, 20° external rotation in 90° flexion, and 5° internal rotation in 90° flexion),

e. Normal dynamic functional assessment.[67]

136. Candidates with a diagnosis of hip impingement or labral tear who still have pain, or are undergoing treatment, are UNFIT because these limitations will prevent them from participating in military training and may deteriorate requiring extended non-operative or surgical treatment.

137. **Avascular necrosis (AVN) (Interrupted blood supply to the hip).** In this condition there is interrupted blood supply to the ball of the hip, which can lead to flattening of the top of the ball of the hip and osteoarthritis. Candidates are FIT provided they meet all the following criteria:

[66] See Annex B, Guidelines for the conduct of a pre-service medical assessment.
[67] See Annex B, Guidelines for the conduct of a pre-service medical assessment.

a. At least 24 months since any treatment,

b. Discharged from treatment and rehabilitation,

c. No evidence of secondary arthritis on available imaging,

d. No pain at rest or with activity, including activity consistent with military training (including load carriage) for at least twelve months,

e. Normal range of hip movement (at least 90° flexion, 25° abduction, 20° external rotation in 90° flexion, and 5° internal rotation in 90° flexion),

f. Normal dynamic functional assessment.[68]

138. Candidates not meeting these criteria are UNFIT because these limitations will prevent them from participating in military training and may deteriorate requiring extended non-operative or surgical treatment.

139. **Osteoarthritis (degenerative joint disease of the hip).** All candidates with a history of hip osteoarthritis are UNFIT as there is a significant risk of further deterioration in symptoms requiring extended non-operative and / or surgical treatment.

140. **Total hip replacement / resurfacing.** Candidates who have had a total hip replacement are UNFIT because of the risk of hip dislocation requiring urgent treatment. The need for complex revision surgery in the event of a fracture or infection is also significant and applies to both hip replacements and resurfacings.

141. **Muscle injuries around the hip.** These include adductor, hamstring, and quadriceps strains or tears, and lower abdominal wall tears (sometimes called 'sports hernia' or 'footballer's groin'). All of these may be treated by rehabilitation or surgery and candidates are FIT after successful treatment, provided they meet all the following criteria:

a. At least six months since any treatment,

b. Discharged from treatment and rehabilitation,

c. No pain at rest or with activity, including activity consistent with military training (including load carriage) for at least three months,

d. Normal dynamic functional assessment.[69]

142. Candidates who still have pain or are undergoing treatment, are UNFIT because there is a significant risk of deterioration in their symptoms during training and service requiring extended non-operative or surgical treatment.

Conditions affecting the Knee

143. **Meniscal tears (tears to the fibrocartilage of the knee).** Candidates should be assessed according to the criteria below.

[68] See Annex B, Guidelines for the conduct of a pre-service medical assessment.
[69] See Annex B, Guidelines for the conduct of a pre-service medical assessment.

a. **Non-surgically managed meniscal tears.** Candidates who meet all the following criteria are FIT:

(1) At least 12 months post injury for a radiologically confirmed meniscal tear,

(2) Fully functional after conservative management,

(3) Discharged from treatment and rehabilitation,

(4) No pain at rest or with activity, including activity consistent with military training (including load carriage) for at least three months,

(5) Normal dynamic functional assessment.[70]

(6) Candidates who do not meet these criteria are UNFIT as there is a significant risk that symptoms will deteriorate during training and service such that extended non-operative or surgical treatment is required.

b. **Arthroscopic partial meniscectomy.** If specified, this should be less than 50% of meniscal depth. Extensive meniscectomy is associated with greater risk of premature arthritis. Where not specified, partial meniscectomy should be interpreted to mean less than 50% of the meniscal depth has been resected. Candidates are FIT provided they meet all the following criteria:

(1) At least 12 months post-arthroscopic partial meniscectomy,

(2) Discharged from treatment and rehabilitation,

(3) No pain at rest or with activity, including activity consistent with military training (including load carriage) for at least three months,

(4) Normal dynamic functional assessment[71],

(5) Have undertaken activity comparable with military training for three months.

c. Candidates who do not meet these criteria, including those who had extensive, subtotal, complete meniscectomy, are UNFIT as there is a substantial risk that symptoms may worsen or recur during training and subsequent service.

144. **Meniscal repair.** Candidates are FIT provided they meet all the following criteria:

(1) Successful meniscal repair,

(2) At least 18 months from surgery because failed meniscal repairs may present late,

[70] See Annex B, Guidelines for the conduct of a pre-service medical assessment.
[71] See Annex B, Guidelines for the conduct of a pre-service medical assessment.

(3) No pain at rest or with activity, including activity consistent with military training (including load carriage) for at least three months,

(4) Normal dynamic functional assessment.[72]

b. Candidates who do not meet these criteria are UNFIT regardless of current symptoms / function as failure of meniscal repair may present late, be precipitated by military training and may require further surgical treatment.

c. **Complex meniscal injuries or if associated with other intra-articular injury.** Candidates who have had more complex meniscal injuries (co-existent medial and lateral meniscal tears, meniscal root repair or saucerisation of discoid meniscus) or if associated with other intra-articular injury may be referred to sSMES, unless the associated injuries independently make the candidate UNFIT, no sooner than 18 months after completion of treatment.

d. **Meniscal transplantation.** Candidates are UNFIT as there is a substantial risk that, despite meniscal transplant, symptoms may worsen or recur during training and service and that the transplanted meniscus does not offer equivalent protective function, substantially increasing the risk of developing knee arthritis.

Knee Ligament Injuries

145. **Anterior Cruciate Ligament (ACL)**. Candidates should be assessed according to the criteria below:

a. **Physiological laxity.** Candidates with slight laxity of the ACL without a history of injury and without any loss of function are FIT. Candidates with significant laxity of the ACL are UNFIT as there is a high likelihood of a missed ACL injury or connective tissue disorder. These factors substantially increase the risk of further knee injury or deterioration during training and service.

b. **Isolated partial or complete ACL rupture who have undergone ACL autograft reconstruction.** Candidates with history of isolated ACL rupture who have undergone ACL autograft reconstruction are FIT provided they meet all the following criteria:

(1) Isolated ACL injury[73],

(2) ACL autograft reconstruction (not ACL repair or alternative technique),

(3) Single surgical procedure to the affected knee only (no previous or revision surgery permitted),

(4) Minimum of twenty-four months since surgery to allow for ligament maturation,

(5) Pre-surgery MRI report and operation note available, confirming no significant meniscal or cartilage injury/lesion and no associated ligament injury

[72] See Annex B, Guidelines for the conduct of a pre-service medical assessment.
[73] No significant damage to the articular cartilage or menisci identified.

other than MCL sprain,

(6) Relevant outpatient clinic letter/s available, including confirmation of recovery and knee stability,

(7) Fully recovered with no chronic/recurrent knee symptoms,

(8) Completed a rehabilitation programme,

(9) Undertaken at least six months physical exercise, including weight carriage and sporting/military comparable activities,

(10) Objectively stable knee and no abnormal clinical signs.

c. Candidates who do not fulfil these criteria (including those who had ACL repair) are UNFIT due to the risk of re-rupture of the ligament, particularly if subjected to arduous training, and due to the risks of later progression to degenerative joint disease (arthritis) during training and service.

d. **Isolated partial tear of the ACL managed non-surgically.** Candidates with a history of isolated partial tear of the ACL, who have been managed conservatively are FIT provided they meet all the following criteria:

(1) At least 12 months from injury,

(2) No significant damage to the articular cartilage or menisci identified,

(3) Fully recovered with no chronic/recurrent knee symptoms,

(4) Completed a rehabilitation programme,

(5) Undertaken at least six months physical exercise, including weight carriage and sporting/military comparable activities,

(6) Objectively stable knee and no abnormal clinical signs.

e. **Complete ACL rupture managed non-surgically.** There may be candidates with a history of complete ACL rupture who have been managed conservatively and are FIT. This may be because an incorrect diagnosis has been made or adequate ligament healing has taken place. Candidates are FIT provided they meet all the following criteria:

(1) At least 24 months from injury,

(2) No significant damage to the articular cartilage or menisci identified,

(3) Fully recovered with no chronic/recurrent knee symptoms,

(4) Completed a rehabilitation programme,

(5) Undertaken at least six months physical exercise, including weight carriage and sporting/military comparable activities,

(6) Objectively stable knee and no abnormal clinical signs.

f. Candidates who have had complete ACL rupture managed non-surgically, but who do not meet the criteria above, are UNFIT as there is a significant risk that knee symptoms may worsen or recur during training and service requiring extended non-operative or surgical treatment.

146. **Posterior Cruciate Ligament (PCL).** Candidates should be assessed according to the criteria below.

a. **Isolated partial tear of the PCL managed non-surgically.** Candidates with a history of isolated partial tear of the PCL, and who have been managed conservatively are FIT provided they meet all the following criteria:

(1) At least 12 months from injury,

(2) No significant damage to the articular cartilage or menisci identified,

(3) Completed a rehabilitation programme,

(4) Fully recovered with no chronic/recurrent knee symptoms,

(5) Undertaken at least six months physical exercise, including weight carriage and sporting/military comparable activities,

(6) Objectively stable knee and no abnormal clinical signs.

b. Candidates who do not meet these criteria are UNFIT as there is a significant risk that knee symptoms may worsen or recur during training and service requiring extended non-operative or surgical treatment.

c. **Reconstruction surgery for partial PCL tears**. Candidates who have undergone reconstruction surgery (including surgical repair) for a partial tear are UNFIT as there is a substantial risk of re-rupture, particularly if subjected to arduous training before ligament maturation. In other situations, there is a significant risk that residual ligament laxity will result in knee symptoms worsening or recurring during training and service requiring extended non-operative or surgical treatment.

d. **Complete PCL rupture.** Candidates with any history of PCL rupture, whether managed conservatively or surgically are UNFIT as there is a substantial risk of re-rupture, particularly if subjected to arduous training. In other situations, there is a significant risk that residual ligament laxity will result in knee symptoms worsening or recurring during training and service requiring extended non-operative or surgical treatment.

147. **Medial Collateral Ligament (MCL).** Candidates should be assessed according to the criteria below:

a. **Physiological laxity.** Candidates with slight laxity of the MCL without a history of injury and without any loss of function are FIT. Candidates with more than mild laxity are UNFIT as there is a high likelihood of a missed MCL injury or connective tissue disorder. These factors substantially increase the risk of further knee injury and joint deterioration during training and service.

b. **Isolated partial rupture of the MCL managed non-surgically.** Candidates with a history of isolated partial rupture of the MCL, and who have been managed conservatively are FIT provided they meet all the following criteria:

(1) At least 12 months from injury,

(2) No significant damage to the articular cartilage or menisci identified,

(3) Completed a rehabilitation programme,

(4) Fully recovered with no chronic/recurrent knee symptoms,

(5) Undertaken at least six months physical exercise, including weight carriage and sporting/military comparable activities,

(6) Objectively stable knee and no abnormal clinical signs.

c. Candidates who do not meet these criteria are UNFIT as these factors substantially increase the risk of further knee injury and joint deterioration during training and service.

d. **Isolated complete rupture of the MCL.** Candidates who have had an isolated complete rupture of the MCL, whether managed non-surgically or surgically are FIT provided they meet all the following criteria:

(1) At least 12 months since date of injury or subsequent surgery,

(2) No significant damage to the articular cartilage or menisci identified,

(3) Fully recovered with no chronic/recurrent knee symptoms,

(4) Completed a rehabilitation programme,

(5) Undertaken at least six months physical exercise, including weight carriage and sporting/military comparable activities,

(6) Objectively stable knee and no abnormal clinical signs.

e. Candidates who do not meet these criteria are UNFIT as there is a substantial increase in the risk of further knee injury and joint deterioration during training and service.

148. **Lateral Collateral Ligament (LCL).** Candidates should be assessed according to the criteria below:

a. **Physiological laxity.** Candidates with slight laxity of the LCL without a history of injury and without any loss of function are FIT. Candidates with more than a slight laxity are UNFIT as there is a high likelihood of a missed LCL injury or connective tissue disorder. These factors substantially increase the risk of further knee injury and joint deterioration during training and service.

b. **Isolated partial rupture of LCL managed non-surgically.** Candidates with a history of isolated partial rupture of the LCL, managed conservatively, are FIT provided they meet all the following criteria:

(1) At least 12 months since injury,

(2) No significant damage to the articular cartilage or menisci identified,

(3) Completed a rehabilitation programme,

(4) Fully recovered with no chronic/recurrent knee symptoms,

(5) Undertaken at least six months physical exercise, including weight carriage and sporting/military comparable activities,

(6) Objectively stable knee and no abnormal clinical signs.

c. Candidates who do not meet these criteria are UNFIT as these factors substantially increase the risk of further knee injury and joint deterioration during training and service.

d. **Isolated complete rupture of the LCL or other posterolateral corner injuries.** Candidates who have had an isolated complete rupture of the LCL, whether managed conservatively or surgically, are FIT provided they meet all the following criteria:

(1) At least 12 months since surgery,

(2) No significant damage to the articular cartilage or menisci identified,

(3) Completed a rehabilitation programme,

(4) Fully recovered with no chronic/recurrent knee symptoms,

(5) Undertaken at least six months physical exercise, including weight carriage and sporting/military comparable activities,

(6) Objectively stable knee and no abnormal clinical signs.

e. Candidates who do not meet these criteria are UNFIT as there is a substantial increase in the risk of further knee injury and joint deterioration during training and service.

Multi-ligament knee injuries (MLKI)

149. Candidates who have had MLKI, other than partial or complete ACL rupture with MCL sprain (see Paras 145b and d), are UNFIT as there is a significant increase in the risk of further knee injury requiring extended non-operative or surgical treatment and a high risk of development of degenerative joint disease (arthritis) during training and service.

Conditions affecting the articular cartilage of the knee

150. **Osteochondritis dissecans (separation of a bone and cartilage fragment).** Candidates who have evidence of full resolution, both radiologically and clinically, whether managed conservatively, with medication or surgically, with no other lesion and no symptoms are FIT. Candidates with a residual defect, loose bodies or abnormal imaging (including any residual oedema or cystic change) are UNFIT as there is a significant increase in the risk of further knee injury requiring extended non-operative or surgical treatment and a high risk of development of degenerative joint disease (arthritis) during training and service.

151. **Osteochondral defects (Focal defects in Cartilage and Bone).** Candidates with small (no greater than than 1cm^2) focal defects in non-weight bearing regions of the knee are FIT provided they meet all the following criteria:

a. Are at least 12 months from injury,

b. Completed an adequate rehabilitation programme and been discharged from follow up,

c. Stable knee on examination,

d. No pain at rest or with activity, including activity consistent with military training (including load carriage) for at least six months,

e. Normal dynamic functional assessment.[74]

152. Candidates who do not meet these criteria are UNFIT as there is a significant increase in the risk of further knee injury requiring extended non-operative or surgical treatment and a high risk of development of degenerative joint disease (arthritis) during training and service.

153. **Larger defects (larger than 1cm^2) and / or in weight bearing regions of the knee.** Candidates are UNFIT as there is a significant increase in the risk of further knee injury requiring extended non-operative or surgical treatment and a high risk of development of degenerative joint disease (arthritis) during training and service.

154. **Osteoarthritis (degenerative joint disease).** Candidates who have developed radiologically apparent osteoarthritis of the knee, regardless of underlying cause, are UNFIT as there is a significant increase in the risk of further deterioration in symptoms requiring extended non-operative and / or surgical treatment.

[74] See Annex B, Guidelines for the conduct of a pre-service medical assessment.

155. **Knee joint replacement**. Candidates who have had partial or total knee joint prostheses (including articular resurfacing) are UNFIT. The physical demands of service life are such that they carry an increased risk of premature revision of their artificial joint. Revision surgery is associated with increased rates of complications and a lower level of function than the primary joint replacement.

Lesions of bone around the knee

156. **Bone cysts, chondroma, non-ossifying fibroma, intraosseous ganglion cysts (Fluid and soft tissue filled holes in bone).** Candidates should be assessed according to the criteria below:

a. **Spontaneous resolution without symptoms.** Candidates who have lesions which have spontaneously resolved with skeletal maturity (see Para K2a) are FIT.

b. **Unresolved conditions without symptoms.** Skeletally mature (see Para K2a) candidates who have lesions which have not resolved may be FIT if they meet all the criteria below. They should be referred to a military orthopaedic consultant for opinion on prognosis and future fracture risk.

(1) Symptom-free,

(2) No pain at rest or with activity, including activity consistent with military training (including load carriage) for at least six months,

(3) Normal dynamic functional assessment.[75]

c. **Symptomatic candidates or those who have not reached skeletal maturity and those with lesions at risk of progression or fracture.** These are UNFIT as there is a substantial increase in the risk of deterioration in symptoms during training and service and a moderate risk of fracture requiring extended non-operative or surgical treatment.

d. **Exostosis / osteochondroma (Isolated bony spurs).** Candidates with isolated single exostosis are FIT provided they meet all the following criteria:

(1) Symptom-free,

(2) Fully functional,

(3) No pain at rest or with activity, including activity consistent with military training (including load carriage) for at least three months,

(4) Normal dynamic functional assessment.[76]

e. Symptomatic candidates are UNFIT as there is a substantial increase in the risk of deterioration in symptoms during training and service and a moderate risk of this requiring surgical treatment.

[75] See Annex B, Guidelines for the conduct of a pre-service medical assessment.
[76] See Annex B, Guidelines for the conduct of a pre-service medical assessment.

f. **Hereditary multiple osteochondromas / hereditary multiple exostoses / diaphyseal aclasia (multiple bony spurs).** Candidates with these conditions are UNFIT as there is a substantial increase in the risk of deterioration in symptoms during training and service and a moderate risk of this requiring surgical treatment. There is also a low risk of progression to malignant disease requiring extensive treatment.

Conditions affecting the joint lining

157. **Pigmented villonodular synovitis (PVNS).**

a. **Focal PVNS.** Candidates who have had a single isolated focus of PVNS which has been removed and are symptom-free and fully functional are FIT provided they meet all the following criteria:

(1) At least three months from surgery,

(2) No pain at rest or with activity, including activity consistent with military training (including load carriage) for at least three months,

(3) Normal dynamic functional assessment.[77]

b. **Generalised PVNS.** Candidates with a history of generalised PVNS are UNFIT due to risk of recurrence, debilitating symptoms and progressive joint damage.

158. **Synovial chondromatosis and synovial osteochondromatosis.** Candidates are UNFIT due to high risk of recurrence, debilitating symptoms and progressive joint damage candidates with a history of synovial chondromatosis or synovial osteochondromatosis are UNFIT.

Other conditions affecting the knee

159. **Anterior knee pain (pain in the front of the knee).** Knee pain, often due to unidentified causes, accounts for a large proportion of the medical discharges that occur during recruit training.

160. **Isolated episodes of anterior knee pain, including patellar tendinitis.** Candidates with isolated episodes of knee pain who meet all the criteria below are FIT:

a. Knee pain is associated with injury or overtraining,

b. Pain resolved fully and quickly with minimal clinical input (only GP and / or Physiotherapy),

c. Fully functional for at least six months,

d. No pain at rest or with activity, including activity consistent with military training (including load carriage) for at least three months,

e. Normal dynamic functional assessment.[78]

[77] See Annex B, Guidelines for the conduct of a pre-service medical assessment.
[78] See Annex B, Guidelines for the conduct of a pre-service medical assessment.

161. All other candidates are UNFIT as there is a significant increase in the risk of further deterioration in symptoms requiring extended non-operative and / or surgical treatment. Candidates require a high level of function to work in challenging environments, in a physically demanding job, including in austere locations with limited medical support.

162. **Persistent or recurrent knee pain or patellar tendinopathy.** Candidates with a history of persistent (lasting three months or more) or recurrent knee pain with everyday activity are UNFIT as there is a significant risk of deterioration and recurrence during training and service which may require extended non-operative or surgical treatment.

163. **Osgood-Schlatter's Disease and Sinding Larsen Johansen Syndrome (Inflammation of the patella tendon at its origin or insertion).** These are chronic fatigue injuries due to repeated microtrauma of the patellar tendon at its origin at the patella or its insertion at the tibial tuberosity, usually affecting boys between ages 10-15 years. Candidates who have been symptom-free for at least 12 months, can kneel without difficulty / pain and have been able to undertake activity comparable with military training for three months are FIT. Candidates not meeting these criteria are UNFIT as there is a significant risk of deterioration and recurrence during training and service, which may require extended non-operative and occasionally surgical treatment.

164. **Chondromalacia Patellae (softening and fragmentation of articular cartilage of patella).** Candidates should be assessed according to the criteria below.

a. **Non-confirmed diagnosis.** Candidates who have a possible diagnosis which has not required imaging, should be assessed as per the para "Isolated episodes of anterior knee pain associated with injury or training, including patellar tendinitis" above.

b. **Confirmed diagnosis.** Candidates with current evidence of chondromalacia patella on cross sectional imaging are UNFIT due to the high risk of recurrence, debilitating symptoms and progression of joint damage during training and service which may require extended non-operative or surgical treatment.

165. **Patella dislocation (dislocated kneecap).** Patella dislocations are potentially complex injuries, and all candidates will require careful assessment before their fitness can be confirmed. All candidates should have had imaging (at the time of injury or after). If not, this may be required for an opinion to be formed. Candidates should be assessed according to the criteria below.

a. **Isolated acute traumatic patella dislocation in an anatomically normal knee.** Candidates who have suffered an isolated acute traumatic patella dislocation in an anatomically normal knee are FIT provided they meet all the following criteria:

(1) At least 12 months post injury,

(2) Successfully completed all rehabilitation and discharged from follow up,

(3) No pain at rest or with activity, including activity consistent with military training (including load carriage) for at least three months,

(4) No evidence of osteochondral damage on available imaging,

(5) Normal dynamic functional assessment.[79]

b. All other candidates are UNFIT as there is a significant increase in the risk of further deterioration in symptoms requiring extended non-operative and / or surgical treatment.

c. **Recurrent dislocations.** Candidates who had recurrent dislocations during childhood are FIT, provided they meet all the below criteria:

(1) They are skeletally mature and have had no recurrence for the past 36 months.

(2) No evidence of degenerative joint disease or osteochondral damage.

(3) Successfully completed all rehabilitation and discharged from follow up.

(4) No pain at rest or with activity, including activity consistent with military training (including load carriage) for at least three months.

(5) No evidence of osteochondral damage on available imaging.

(6) Normal dynamic functional assessment.[80]

d. All other candidates are UNFIT due to the significant risk of recurrence and further knee injury requiring extended non-operative or surgical treatment.

e. **Single or recurrent dislocation secondary to anatomical anomaly.** Candidates who have suffered from single or recurrent dislocation secondary to anatomical anomaly (e.g. femoral trochlear dysplasia, patella alta, abnormal rotational profile) and have had corrective surgery are FIT, provided they fulfil all the criteria listed below:

(1) No evidence of degenerative joint disease or osteochondral damage,

(2) At least 12 months following successful corrective surgery,

(3) Successfully completed all rehabilitation and discharged from follow up,

(4) No pain at rest or with activity, including activity consistent with military training (including load carriage) for at least six months,

(5) Normal dynamic functional assessment.[81]

f. Candidates who do not meet these criteria are UNFIT regardless of whether corrective surgery such as trochleopasty, tibial tuberosity transfer or rotational osteotomy of the femur has been undertaken as there is a significant risk of recurrent

[79] See Annex B, Guidelines for the conduct of a pre-service medical assessment.
[80] See Annex B, Guidelines for the conduct of a pre-service medical assessment.
[81] See Annex B, Guidelines for the conduct of a pre-service medical assessment.

instability, persistent symptoms and progression to degenerative joint disease in these patients.

166. **Medial patello-femoral ligament (MPFL) reconstruction.** Candidates are FIT provided they meet all the following criteria:

a. At least 12 months post MPFL reconstruction,

b. No evidence of previous anatomical abnormality,

c. Successfully completed all rehabilitation and discharged from follow up,

d. No pain at rest or with activity, including activity consistent with military training (including load carriage) for at least three months,

e. No evidence of osteochondral damage on available imaging,

f. Normal dynamic functional assessment.[82]

167. All other candidates are UNFIT as there is a significant increase in the risk of further deterioration in symptoms requiring extended non-operative and / or surgical treatment.

Conditions causing exercise related leg pain

168. **Medial Tibial Stress Syndrome (shin splints).** Candidates are FIT**,** provided they meet all the following criteria:

a. Successfully treated without surgery (physiotherapy, orthotics),

b. Symptom-free for 12 months,

c. Have undertaken activity comparable with military training for three months including wearing military type footwear over extended distances, uneven ground and variable inclines,

d. Normal dynamic functional assessment.[83]

169. Other candidates who have had medial tibial stress syndrome and do not fulfil these criteria are UNFIT due to the high risk of recurrence during training and service requiring extended non-operative treatment.

170. **Tibial stress response or fracture.** Candidates who have had a radiological proven stress response or stress fracture of the tibia are UNFIT due to the high risk of recurrence during training and service requiring extended non-operative or surgical treatment.

171. **Chronic Exertional Compartment Syndrome (CECS).** Candidates are FIT, provided they meet all the following criteria:

a. Condition correctly diagnosed and successfully treated by surgical fasciotomy or fasciectomy,

[82] See Annex B, Guidelines for the conduct of a pre-service medical assessment.
[83] See Annex B, Guidelines for the conduct of a pre-service medical assessment.

b. Symptom-free for 12 months,

c. Have undertaken activity comparable with military training for three months including wearing military type footwear over extended distances, uneven ground and variable inclines,

d. Normal dynamic functional assessment.[84]

172. All other candidates are UNFIT due to the high risk of recurrence during training and service requiring extended non-operative treatment.

173. **Popliteal artery entrapment syndrome (PAES).** Candidates who meet all the criteria below should be referred to sSMES, who may request a military orthopaedic consultant's opinion on recovery, function and prognosis:

a. Successfully treated by surgical release,

b. Symptom-free for 12 months,

c. Fully functional,

d. No underlying vessel injury,

e. Have undertaken activity comparable with military training for three months including wearing military type footwear over extended distances, uneven ground and variable inclines,

f. Normal dynamic functional assessment.[85]

174. Other candidates who do not fulfil all the above criteria or have functional PAES, are UNFIT due to significant risk of recurrence during training and service requiring extended non-operative and / or surgical treatment.

175. **Quadriceps or patellar tendon ruptures.** Candidates are FIT, provided they meet all the following criteria:

a. Rupture surgically repaired within three weeks of injury (delayed repair is associated with a poorer outcome),

b. At least one year from surgery,

c. Symptom-free and fully functional,

d. Stable knee on examination, with full range of movement and no weakness / lag on straight leg raise,

e. Completed an adequate rehabilitation programme and discharged from follow up,

[84] See Annex B, Guidelines for the conduct of a pre-service medical assessment.
[85] See Annex B, Guidelines for the conduct of a pre-service medical assessment.

f. Have undertaken activity comparable with military training for three months,

g. Normal dynamic functional assessment.[86]

176. All other candidates are UNFIT, including those who underwent delayed repair or reconstruction as there is a higher risk of failure of delayed repair / reconstruction. This is a particular risk during training and service and may require extended non-operative or surgical treatment.

Fractures around the knee

177. **Femoral shaft fracture or extra-articular distal femoral fracture (broken thigh bone).** Candidates are FIT, provided they meet all the following criteria:

a. A period of at least twelve months must have elapsed as remodelling following fracture often takes up to 12 months,

b. Normal anatomy (length, rotation and alignment) has been restored through treatment,

c. Full function of the joints above and below the injury,

d. No pain at rest or with activity, including activity consistent with military training (including load carriage) for at least three months,

e. Union is confirmed with no deformity,

f. No tenderness over the area of metalwork / fracture site. It is not necessary for metalwork to have been removed if the candidate is symptom-free,

g. Normal dynamic functional assessment.[87]

178. All other candidates are UNFIT as there is a significant increase in the risk of further deterioration in symptoms requiring extended non-operative and / or surgical treatment.

179. **Intra-articular distal femoral fracture (fracture involving the joint).** Candidates are FIT, provided they meet all the following criteria:

a. A period of at least twelve months must have elapsed as remodelling following fracture often takes up to twelve months,

b. Simple fracture pattern,

c. Fully united,

d. No reported steps / gaps on the articular surface,

e. No evidence of post-traumatic arthritis,

[86] See Annex B, Guidelines for the conduct of a pre-service medical assessment.
[87] See Annex B, Guidelines for the conduct of a pre-service medical assessment.

f. Has completed a rehabilitation programme and is discharged from follow up,

g. No pain at rest or with activity, including activity consistent with military training (including load carriage) for at least six months,

h. Normal knee examination (normal range of movement and no instability),

i. Normal dynamic functional assessment.[88]

180. Candidates not meeting the criteria above are UNFIT due to risk of progression to post-traumatic arthritis.

181. **Avulsion fractures around the knee (broken fragment of bone around the knee).**

a. **Avulsion fractures of the medial and lateral collateral ligaments** (b**roken fragment of bone around the knee involving the medial and lateral collateral ligaments).** Candidates with a history of avulsion fractures of the medial and lateral collateral ligaments are FIT, provided they meet all the following criteria:

(1) They are at least twelve months from surgery,

(2) Discharged from treatment and rehabilitation,

(3) No pain at rest or with activity, including activity consistent with military training (including load carriage) for at least three months,

(4) Stable knee on examination,

(5) Normal dynamic functional assessment.[89]

b. Candidates not meeting the criteria above are UNFIT due to risk of re-injury and ongoing instability during training, or progression to post-traumatic arthritis in service, any of which may require extended non-operative or surgical treatment.

c. **ACL (tibial spine) or PCL avulsion fractures (broken fragment of bone around the knee involving the ACL or PCL ligaments).** Candidates with a history of ACL (tibial spine) or PCL avulsion fractures who meet all the below criteria may be FIT and should be referred to sSMES, who may request a military orthopaedic consultant's opinion on recovery, function and prognosis:

(1) They are at least twelve months from surgery,

(2) Discharged from treatment and rehabilitation,

(3) No pain at rest or with activity, including activity consistent with military training (including load carriage) for at least three months,

(4) Stable knee on examination,

[88] See Annex B, Guidelines for the conduct of a pre-service medical assessment.
[89] See Annex B, Guidelines for the conduct of a pre-service medical assessment.

(5) Normal dynamic functional assessment.[90]

d. Candidates not meeting the criteria above are UNFIT due to risk of re-injury and ongoing instability during training, or progression to post-traumatic arthritis in service, any of which may require extended non-operative or surgical treatment.

182. **Salter-Harris / physeal fractures (Fracture involving the growth plates around the knee during childhood).** Candidates are FIT, provided they meet all the following criteria:

a. A period of at least 12 months must have elapsed as remodelling following fracture often takes up to 12 months,

b. Normal anatomy (length, rotation and alignment) has been restored through surgery,

c. Union is confirmed,

d. There is no deformity or growth disturbance,

e. No symptomatic or significant (greater than 2cm) limb length inequality,

f. Discharged from treatment and rehabilitation,

g. There is no tenderness over the area of metalwork / fracture site. It is not necessary for metalwork to have been removed if the candidate is symptom-free,

h. There is full function of the joints above and below the injury,

i. No pain at rest or with activity, including activity consistent with military training (including load carriage) for at least three months,

j. Normal dynamic functional assessment.[91]

183. Candidates not meeting the criteria above are UNFIT due to risk of re-injury and ongoing instability during training, or progression to post-traumatic arthritis in service, any of which may require extended non-operative or surgical treatment.

184. **Patella fracture (fracture of the kneecap).** Candidates are FIT, provided they meet all the following criteria:

a. They are at least twelve months from injury,

b. Stable knee on examination,

c. No pain at rest or with activity, including activity consistent with military training (including load carriage) for at least three months,

d. Normal dynamic functional assessment.[92]

[90] See Annex B, Guidelines for the conduct of a pre-service medical assessment.
[91] See Annex B, Guidelines for the conduct of a pre-service medical assessment.
[92] See Annex B, Guidelines for the conduct of a pre-service medical assessment.

185. Candidates with evidence of failure of union, malunion, degenerative joint disease or metalwork irritation are UNFIT due to increased risk of worsening symptoms during training, or progression to post-traumatic arthritis in service, either of which may require extended non-operative or surgical treatment.

Tibia and / or fibula fractures (broken lower leg bone)

186. **Extra-articular tibial shaft fracture or proximal tibial fracture (not involving the joint).** Candidates are FIT, provided they meet all the following criteria:

a. A period of at least 12 months must have elapsed as remodelling following fracture often takes up to 12 months,

b. Discharged from treatment and rehabilitation,

c. Normal anatomy (length, rotation and alignment) has been restored through treatment,

d. Union is confirmed and there is no deformity,

e. There is no tenderness over the area of metalwork / fracture site. It is not necessary for metalwork to have been removed if the candidate is symptom-free,

f. There is full function of the joints above and below the injury,

g. No pain at rest or with activity, including activity consistent with military training (including load carriage) for at least three months,

h. Normal dynamic functional assessment.[93]

187. Candidates not meeting the criteria above are UNFIT due to risk of re-injury and ongoing instability during training or in service, either of which may require extended non-operative or surgical treatment.

188. **Proximal intra-articular tibial fracture (involving the joint).** A candidate is FIT, provided they meet all the following criteria:

a. A period of at least 12 months must have elapsed as remodelling following fracture often takes up to 12 months,

b. Simple fracture pattern,

c. Fully united,

d. No reported steps / gaps on the articular surface,

e. Discharged from treatment and rehabilitation,

f. No evidence of post-traumatic arthritis,

[93] See Annex B, Guidelines for the conduct of a pre-service medical assessment.

g. Normal knee examination (normal range of movement and no instability)

h. No pain at rest or with activity, including activity consistent with military training (including load carriage) for at least six months,

i. Normal dynamic functional assessment.[94]

189. Candidates not meeting the criteria above are UNFIT due to risk of re-injury and ongoing instability during training, or progression to post-traumatic arthritis in service, any of which may require extended non-operative or surgical treatment.

190. **Proximal fibula fracture.** Candidates are FIT, provided they meet all the following criteria:

a. A period of at least 12 months must have elapsed as remodelling following fracture often takes up to 12 months,

b. Discharged from treatment and rehabilitation,

c. There is no tenderness over the area of metalwork / fracture site,

d. There is full function of the joints above and below the injury.

e. No pain at rest or with activity, including activity consistent with military training (including load carriage) for at least six months,

f. Normal dynamic functional assessment.[95]

191. Candidates not meeting the criteria above are UNFIT due to risk of re-injury and ongoing instability during training, or progression to post-traumatic arthritis in service, any of which may require extended non-operative or surgical treatment.

Conditions of the ankle joint

192. **Ankle ligament injuries (ankle sprain).** Candidates with previous ankle sprain are FIT if they have made a full recovery, have no limitation of movement, and are symptom-free during activity comparable with military training for three months. Candidates with persistent symptoms are UNFIT as these symptoms are likely to be exacerbated by the arduous nature of military service (e.g. movement over broken or undulating ground).

193. **Ankle stiffness or recurrent instability.** Candidates with a stiff or unstable ankle (recurrent ankle injuries experienced during day-to-day activities, especially when walking over uneven ground) are UNFIT. Military service places high demands on the foot and ankle including weight carriage across rough ground and adopting fire positions. Symptomatic candidates are unlikely to be able to reach or sustain the required activity levels. There is a significant risk of further injury.

[94] See Annex B, Guidelines for the conduct of a pre-service medical assessment.
[95] See Annex B, Guidelines for the conduct of a pre-service medical assessment.

194. **Ankle stabilisation surgery.** Candidates who have had a ligamentous repair (e.g. Brostrom Gould Repair) or ligamentous replacement / reconstruction (e.g. Evans Tenodesis) are FIT, provided they meet all the following criteria:

a. At least 12 months post-surgery,

b. Discharged from treatment and rehabilitation,

c. No pain at rest or with activity, including activity consistent with military training (including load carriage) for at least six months,

d. Normal dynamic functional assessment.[96]

195. Candidates not meeting these criteria are UNFIT as the reconstruction / repair is unproven and may fail during training or later in military service.

196. **Ankle cartilage damage.** Candidates with diagnosed ankle cartilage injury including those who have undergone microfracture or cartilage grafting are UNFIT. These operations do not restore a normal joint surface. Candidates therefore have a high risk of recurrence of symptoms or early joint degeneration as military service places high demands on the foot and ankle including weight carriage across rough ground.

197. **Fusion or replacement of ankle.** Candidates with previous ankle fusion or ankle replacement are UNFIT. Military service places high demands on the ankle including weight carriage across rough ground and adopting fire positions. Candidates are unlikely to be able to reach or sustain the required activity levels. There is also a high risk of further injury, further joint degeneration or need for revision surgery.

198. **Intra articular distal tibial fractures (Fractures involving the joint).** Intra-articular fractures involving the weight bearing part of the distal tibia i.e. the plafond are sometimes referred to as Pilon fractures. These injures have a high rate of early degenerative changes and poor function which would likely be worsened with by the rigours of military service. Candidates who have previously sustained a fracture of this type are UNFIT.

199. **Ankle fractures not requiring surgical management.** These are intra-articular fractures of the ankle joint NOT involving the weightbearing surface of the distal tibia. The candidate is FIT, provided they meet all the following criteria:

a. At least six months post injury,

b. Completed rehabilitation and discharged from follow up,

c. Pain free with a normal range of movement and no evidence of syndesmotic instability,

d. No pain at rest or with activity, including activity consistent with military training (including load carriage) for at least six months,

e. Normal dynamic functional assessment.[97]

[96] See Annex B, Guidelines for the conduct of a pre-service medical assessment.
[97] See Annex B, Guidelines for the conduct of a pre-service medical assessment.

200. Candidates not meeting the above criteria are UNFIT as persisting symptoms are highly likely to be worsened by the arduous nature of military service and may require extended non-operative or surgical treatment.

201. **Ankle fractures requiring surgical management.** These are intra-articular fractures of the ankle joint NOT involving the weightbearing surface of the distal tibia. The candidate is FIT, provided they meet all the following criteria:

a. At least 12 months post injury,

b. Completed rehabilitation and discharged from follow up (it is acceptable to have remaining metalwork, provided it does not cause symptoms),

c. No pain at rest or with activity, including activity consistent with military training (including load carriage) for at least twelve months,

d. Normal dynamic functional assessment.[98]

202. Candidates not meeting the above criteria are UNFIT as persisting symptoms are highly likely to be worsened by the arduous nature of military service and may require extended non-operative or surgical treatment.

203. **Ankle arthritis (degenerative change or articular damage of the ankle).** Candidates with any signs of degenerative change or articular damage after any ankle fracture or other injury are UNFIT as this is likely to be exacerbated by the arduous nature of military service particularly movement over rough ground bearing weight.

Ankle tendon pathology

204. **Tendinitis / tendinosis.** Candidates with a single episode of tendinitis / tendinosis who meet all the following criteria are FIT:

a. Single episode per side more than 12 months ago,

b. Discharged from follow up,

c. Fully recovered with no residual weakness,

d. No deformity,

e. No pain at rest or with activity, including activity consistent with military training (including load carriage) for at least three months,

f. Normal dynamic functional assessment.[99]

205. All other candidates are UNFIT as military training is likely to worsen symptoms and / or lead to long term functional deficit.

[98] See Annex B, Guidelines for the conduct of a pre-service medical assessment.
[99] See Annex B, Guidelines for the conduct of a pre-service medical assessment.

206. **Tendon rupture.**

a. **Achilles tendon.** Candidates are FIT, provided they meet all the following criteria:

(1) At least 12 months post injury,

(2) Successfully completed rehabilitation and discharged from follow up,

(3) No clinically demonstrable weakness,

(4) No pain at rest or with activity, including activity consistent with military training (including load carriage) for at least three months,

(5) Normal dynamic functional assessment.[100]

b. Candidates are UNFIT if any of the criteria above are not met as candidates would be at high risk of deterioration during training or service with increased risk of subsequent injuries, including re-rupture.

c. **Toe flexor / extensor tendons.** Candidates are FIT if there are no persisting symptoms six months after the injury. Candidates who are symptomatic are UNFIT as symptoms will likely worsen during training and service.

d. **Other foot / ankle tendons rupture (including tibialis anterior, tibialis posterior, peroneal tendons).** Candidates are UNFIT as persisting tendon weakness or impaired strength following either repair or rupture places the candidate at a greatly elevated risk of reinjury, exacerbation of existing symptoms or a fall occasioning further injury.

Conditions of the foot

207. **Foot deformities (including hallux valgus).**

a. **Minor deformities where normal footwear without orthotics is worn.** Candidates with minor conditions, that allow the use of normal footwear are FIT provided there is no pain at rest or with activity, including activity consistent with military training (including load carriage) for at least three months.

b. **Minor deformities where normal footwear with over-the-counter or custom-made orthotics is worn.** Candidates with minor conditions, that allow the use of normal footwear with over the counter or custom-made orthotics are FIT provided they provided there is no pain at rest or with activity, including activity consistent with military training (including load carriage) for at least three months.

c. **Deformities requiring custom-made footwear.** Candidates who use custom-made footwear (excluding custom-made orthotics and issued off-the-shelf footwear normally available through the military supply chain) are UNFIT. The supply chain when deployed cannot reliably provide or replace such footwear. The requirement for such footwear is a marker of the severity of the condition.

[100] See Annex B, Guidelines for the conduct of a pre-service medical assessment.

208. **Flat feet.** Candidates with mobile flat feet causing no symptoms, or symptoms controlled with orthotics alone are FIT. Candidates with mobile flat feet causing symptoms, or with rigid flat feet, are UNFIT. Military service places high demands on the foot and ankle including weight carriage across rough ground. When a candidate already has symptoms, these are highly likely to worsen in military training.

209. **Talipes equinovarus (club foot).** The following candidates are FIT:

a. Confirmed positional talipes or metatarsus adductus which has resolved with physiotherapy.

b. Club foot, corrected or otherwise, who can use military footwear without any problems.

210. All other candidates with clubfoot, corrected or otherwise are UNFIT.

211. **Abnormal hindfoot morphology (shape of the back of the foot).** Candidates with abnormal hindfoot morphology requiring surgical correction are UNFIT. An abnormal hindfoot markedly increases the risk of injury as it cannot accommodate as well to uneven surfaces. Military service places high demands on the foot and ankle including weight carriage across rough ground.

212. **Pes cavus / cavo varus foot (rigid high arched foot).** Candidates are FIT, provided they meet all the following criteria:

a. Symptom-free,

b. Foot is mobile without pressure areas or fixed clawing,

c. Candidate is foreseeably able to use issued military footwear with / without over the counter or custom-made orthotics.

d. No associated neurological disorder (such as peroneal muscular dystrophy, etc),

e. No pain at rest or with activity, including activity consistent with military training (including load carriage) for at least three months,

f. Normal dynamic functional assessment.[101]

213. Candidates who do not meet the above criteria are UNFIT. Military service places high demands on the foot and ankle including weight carriage across rough ground. Typically, a rigid high arched foot / cavo varus foot places the candidate at increased risk of injury because their feet cannot accommodate as well to uneven surfaces. They may also represent an underlying neurological abnormality. Typically, their feet then worsen with time.

214. **Plantar Fasciitis (inflammation of the plantar fascia of the foot).** Candidates with a prior history of plantar fasciitis who meet all the following criteria are FIT:

[101] See Annex B, Guidelines for the conduct of a pre-service medical assessment.

a. Symptom-free for six months,

b. Single episode lasting no more than one year,

c. Have required no more than one corticosteroid injection, not required surgery or cast immobilisation,

d. No pain at rest or with activity, including activity consistent with military training (including load carriage) for at least three months,

e. Normal dynamic functional assessment.[102]

215. Candidates who do not meet the above criteria are UNFIT due to the risk of further episodes exacerbated by load carriage, covering distances on foot or issued footwear.

216. **Sever's disease (inflammation of the achilles tendon at its insertion).** Candidates who have been symptom-free for at least 12 months and have been able to undertake activity comparable with military training (including weight carriage) for three months are FIT. Candidates not meeting these criteria are UNFIT as there is a significant risk of deterioration and recurrence during training and service, which may require extended non-operative and occasionally surgical treatment.

217. **Foot joint fusions.** Candidates who have undergone fusion surgery of any large joint of the hindfoot or midfoot are UNFIT. Military service places high demands on the foot including weight carriage across rough ground and adopting fire positions. The ability of the foot to accommodate to rough and the increased strain on adjacent joints places the candidate both at higher risk of injury during training and of further joint problems in the future.

Foot fractures (broken bones of the foot)

218. **Fractures of the talus, calcaneum, navicular, cuboid or cuneiform bones.**

a. **Flake avulsion fractures of navicular, calcaneum and / or navicular.** These fractures may be treated as severe ankle sprains. Candidates are FIT if they have made a full recovery, have no limitation of movement, and are symptom-free during activity comparable with military training for three months. Candidates with persistent symptoms are UNFIT as the symptoms are likely to be exacerbated by military employment.

b. **Fracture of the bones of the hind or midfoot, including osteochondral lesions of the talus.** Candidates known to have an additional or accessory bone in the hind or midfoot and who are symptom-free are FIT. Candidates who have had a cuboid fracture or isolated extra-articular calcaneal fracture and meet all the below criteria are FIT:

(1) Twenty-four months post injury,

(2) Discharged from follow up,

[102] See Annex B, Guidelines for the conduct of a pre-service medical assessment.

(3) Symptom-free with a full range of subtalar joint motion and a normal heel pad,

(4) No pain at rest or with activity, including activity consistent with military training (including load carriage over uneven ground) for at least three months,

(5) Normal dynamic functional assessment.[103]

c. Candidates who have any other fracture of the bones of the hind or midfoot, including osteochondral lesions of the talus, are UNFIT due to the likelihood of degenerative change causing persisting or worsening symptoms, and stiffness or instability causing further injuries.

d. **Lisfranc fracture-dislocations (Lisfranc injuries).** The most common type of dislocation involving the foot, these involve dislocation of the articulation of the tarsus with the metatarsal bases. Candidates are FIT, provided they meet all the following criteria:

(1) Discharged from treatment follow up,

(2) Symptom-free with a full range of subtalar joint motion and a normal heel pad,

(3) No pain at rest or with activity, including activity consistent with military training (including load carriage over uneven ground) for at least three months,

(4) Normal dynamic functional assessment.[104]

e. Candidates not meeting these criteria are UNFIT due to a significant increased risk of developing symptomatic joint damage with military activity, which will need extended non-operative or even surgical treatment.

f. **Metatarsal fracture, including stress fracture.** Candidates who meet all the following criteria are FIT:

(1) At least six months since injury,

(2) Discharged from follow up,

(3) Fully rehabilitated,

(4) No pain at rest or with activity, including activity consistent with military training (including load carriage over uneven ground) for at least three months,

(5) Normal dynamic functional assessment[105],

(6) For stress fractures, no more than one episode overall.

[103] See Annex B, Guidelines for the conduct of a pre-service medical assessment.
[104] See Annex B, Guidelines for the conduct of a pre-service medical assessment.
[105] See Annex B, Guidelines for the conduct of a pre-service medical assessment.

g. Candidates who do not meet these criteria are UNFIT due to a significant increased risk of deterioration during training which will need extended non-operative or even surgical treatment.

Conditions of the toes

219. **Hallux rigidus (arthritis of the big toe).** Candidates with hallux rigidus due to joint degeneration or fusion are UNFIT. The rigid position of the toe affects safe adoption of a range of firing positions, running and weight carriage and surgical treatment will not improve this. There is also an increased risk of degeneration of adjacent joints.

220. **Hallux valgus (bunion).** Candidates should be assessed according to the criteria below.

a. **Symptom-free without treatment.** Candidates who are symptom-free with no over-riding or callosity of the second toe and no foreseeable issues with military footwear are FIT.

b. **Symptom-free after treatment by corrective osteotomy.** Candidates who meet all the following criteria are FIT:

(1) At least 12 months post corrective osteotomy,

(2) Fully rehabilitated and discharged from follow up,

(3) Pain free with normal range of movement,

(4) No foreseeable issues with military footwear,

(5) No pain at rest or with activity, including activity consistent with military training (including load carriage over uneven ground) for at least three months,

(6) Normal dynamic functional assessment.[106]

c. Candidates who do not meet the criteria above are UNFIT due to the likelihood that symptoms will be exacerbated by military service and the requirement for specialist footwear.

221. **Symptomatic or loss of motion in the 1st MTP joint.** Candidates with symptomatic hallux valgus or loss of motion in the 1st MTP joint due to surgery are UNFIT as any symptoms are likely to be exacerbated by military training and service.

222. **Hammer, mallet and clawed toes.** Candidates with mild abnormalities without a history of symptoms are FIT. Candidates with lesser toe anatomical abnormalities who have undergone corrective surgery and meet all the following criteria are FIT:

a. At least 12 months post-surgery,

b. Fully rehabilitated and discharged from follow up,

[106] See Annex B, Guidelines for the conduct of a pre-service medical assessment.

c. Pain free with normal range of movement,

d. Have undertaken at least three months activities comparable to military training,

e. No foreseeable issues with military footwear,

f. No pain at rest or with activity, including activity consistent with military training (including load carriage over uneven ground) for at least three months,

g. Normal dynamic functional assessment.[107]

223. Candidates with symptomatic clawed, hammer or mallet toes, or toes that cannot be accommodated in standard military footwear, are UNFIT. Military service places high demands on the foot including weight carriage across rough ground and adopting fire positions. Custom footwear cannot be reliably provided when deployed.

224. **Toe fractures (broken toes).** Candidates who are symptom-free and meet all the following criteria are FIT:

a. Pain free with normal range of movement,

b. No pain at rest or with activity, including activity consistent with military training (including load carriage over uneven ground) for at least three months,

c. Normal dynamic functional assessment.[108]

225. Candidates with symptoms are UNFIT as these conditions are likely to be worsened by prolonged standing, marching and / or load carrying whilst wearing military footwear.

226. **Loss of toes.** Candidates should be assessed according to both the functional impact of amputation of the toe and the cause of the loss. Candidates with the loss of more than one toe at, or distal to the metatarsophalangeal joint (MTPJ) or loss of the great toe distal to the interphalangeal joint (IPJ) are FIT. Candidates with loss of more than one toe, or loss of the great toe at or proximal to the IPJ who meet all the following criteria are FIT:

a. At least 12 months post-surgery, if undertaken,

b. Fully rehabilitated and discharged from follow up,

c. No pain at rest or with activity, including activity consistent with military training (including load carriage over uneven ground) for at least three months,

d. Normal dynamic functional assessment.[109]

227. Candidates who do not meet the above criteria are UNFIT due to the likelihood that symptoms will be exacerbated during service or training and require operative or non-operative treatment.

[107] See Annex B, Guidelines for the conduct of a pre-service medical assessment.
[108] See Annex B, Guidelines for the conduct of a pre-service medical assessment.
[109] See Annex B, Guidelines for the conduct of a pre-service medical assessment.

Other conditions affecting the lower limb

228. **Leg length discrepancy.** The following applies:

a. **Discrepancy of 2.0cm or less.** Candidates with a discrepancy of 2.0cm or less are FIT provided the functional assessment is normal, they are symptom-free and can achieve activity comparable with military training for a minimum of three months. Candidates may use an in-shoe orthotic but should not require bespoke footwear.

b. **Discrepancy of greater than 2.0cm.** Candidates with a discrepancy of greater than 2.0cm, are UNFIT. This degree of discrepancy is likely to cause a reduction in function and require the use of bespoke footwear.

Annex L

PSYCHIATRY PRE-ENTRY

1. **General principles for assessing candidates against this Annex.** The general principles against which a candidate is assessed as FIT for entry are:

a. Function. A candidate must have the cognitive function, in all military environments, to safely and effectively perform their military role,[1] which involves safety critical tasks including weapon handling, operating vehicle and machinery, decision making and managing sensitive information. This may be affected by any of the following aspects of mental capacity and emotional stability:

(1) Emotional regulation (managing negative feelings).

(2) Motivation.

(3) Thought Disorder (disorganised thinking).

(4) Abnormal perceptions (seeing / hearing things that are not there).

(5) Cognition (understanding & learning).

(6) Concentration (focusing attention).

(7) Insight (self-awareness).

(8) Judgement.

(9) Impulsivity (acting without thinking).

(10) Fatigue (tiredness).

(11) Resilience (the ability to cope / adapt).

(12) Executive function (planning and organisation).

b. **Prognosis**. For many mental health disorders, a previous episode increases the likelihood of further episodes and persisting or severe stress acts as an independent risk factor. In general, consideration should be given to the likelihood of recurrence in the context of military service, the implications of recurrence for the candidate and others, and operational effectiveness.

c. **Medical support requirements.** Where a candidate is at increased risk of a mental health condition, the condition should be manageable within resources readily available in the deployed environment.

2. **Exceptional considerations.** Criteria within each condition have been outlined to determine candidates FIT or UNFIT. Where there is any doubt, advice should be sought

[1] This includes but is not limited to: acceptance of hierarchy and discipline; maintaining physical fitness; living and working in close proximity to others; short notice taskings with potential separation from family and / or support structures; safety critical tasks including the use of weapons and handling sensitive information; exposure to austere environments and demands of operational deployment.

from the single Service Medical Entry Staff (sSMES) [2]. Additionally, for each condition which requires service-approved specialist opinion, the resultant FIT or UNFIT outcome will be determined by sSMES.

3. **Mental health in adolescence.** Mental health symptoms in adolescence should be carefully assessed to distinguish between proportionate reactions to life stressors and diagnosable mental health disorders. If a candidate has recovered to demonstrate a significant period (12 months or more) of good mental health and stability in socio-occupational function, in the absence of co-morbidities (such as anxiety, sleep disorders, addiction, violence, self-harm and physical health conditions), candidates may be referred for single Service Medical Entry Staff (sSMES) opinion.

4. **Mental health in pregnancy, childbirth, or the puerperium.** Candidates who experience a mental health disorder during pregnancy, childbirth or the puerperium should be assessed against the standards for the diagnosed disorder.

Additional considerations for psychiatric conditions

5. **Current psychological illness**. Candidates with current mental disorder or dysfunctional behaviour (with or without formal diagnosis) are UNFIT. Such candidates are unlikely to be able to perform in training and the condition is likely to be exacerbated by military service.

6. **Multiple diagnoses (comorbidity).** Where a history of multiple common mental health disorder (CMHD) diagnoses exist, this needs consideration of the possibility of an underlying diagnosis that makes the candidate UNFIT. Candidates with a history of multiple conditions can be raised to sSMES for further consideration. The resultant FIT or UNFIT outcome will be determined by sSMES. A specialist assessment by a consultant psychiatrist may be required.

7. **Diagnostic criteria.** The diagnostic criteria used in this document are based on the International Classification of Diseases and Disorders Index 11 (ICD-11) [accessed 13 Jan 26] under '06 Mental, behavioural or neurodevelopmental disorders'[3]. Prognostic information is based on the relevant National Institute for Clinical Excellence (NICE) [accessed 13 Jan 26] guidelines, where available. Diagnoses must be made by clinicians with the appropriate level of skills, qualifications, and experience to make the diagnoses in question. Consideration should be given as to whether previous diagnoses meet the current diagnostic thresholds, against which the current fitness standards are set.

The impact of specific psychiatric conditions

Neurodevelopmental disorders

8. Candidates with a history of neurodiverse traits who have not received a clinical diagnosis and have evidence of acceptable social functioning are FIT, provided there is no increased risk that expression of the traits could impair military performance. Where there is doubt the candidate should be referred to sSMES for determination of fitness.

9. **Autism spectrum disorder (ASD) 6A02.** ASD symptoms can cause significant functional impairment in a wide range of military settings. This includes impaired ability in social interaction, communication and difficulty adapting to unpredictable situations.

[2] Delegated Authority arrangements may apply.
[3] ICD-11 for Mortality and Morbidity Statistics [accessed 12 Jan 26]

Difficulties may become more marked with the increased social demands and responsibility that come with promotion and may impact career progression. Individuals with certain autistic traits are more vulnerable to common mental health disorder (CMHD). Candidates diagnosed with ASD whose symptoms have no significant impact on academic, occupational or social function and who need no ongoing specialist support should be referred to sSMES to determine if they are FIT. Candidates needing support from a specialist autism service or who have symptoms impacting on their academic, occupational or social function are UNFIT[4] because military employment and / or deployment is likely to exacerbate symptoms and result in the candidate being unable to carry out their duties. If an ASD diagnosis is revised in later life by a specialist autism service, the candidate should be referred to sSMES for determination of fitness.

10. **Attention deficit hyperactivity disorder (ADHD) 6A05.** ADHD symptoms include inattention, hyperactivity and impulsivity which can negatively impact function in the military environment, including ability to perform safety critical tasks. Candidates with ADHD who meet all the following criteria are FIT:

a. No evidence of past psychiatric co-morbidities, including substance abuse.

b. Not used medication for the preceding 12 months without adverse impact on function.

c. Demonstrate evidence of function compatible with military employment for at least 12 months.

11. Other candidates are UNFIT due to the risk of poor decision making, risky behaviour and inability to safely conduct their military role, as well as medical support requirements.

12. **Disruptive behaviour or dissocial disorders; personality disorders and related traits; paraphilic disorders; factitious disorders.** These conditions indicate enduring patterns of interpersonal behaviour. Candidates with a diagnosis in this group are UNFIT due to the importance of effective interpersonal functioning and their negative impact on others, particularly regarding operational effectiveness and close-quarter living.

Psychotic disorders

13. **Schizophrenia or other primary psychotic disorders[5].** Psychotic disorders involve symptoms (such as delusions, hallucinations and thought disorder) that cause severe behavioural disturbance with little or no warning and involve either high risk of recurrence or persistence, even with treatment, rendering the candidate unsuitable for service. All candidates with a current or past history of psychotic disorder are UNFIT.

14. **Other psychotic disorders.** Candidates who develop a psychiatric disorder associated with pregnancy, childbirth, or the puerperium, with psychotic symptoms, are UNFIT due to the risk of recurrence. Candidates experiencing psychotic symptoms secondary to general medical and brain conditions are assessed against the underlying medical condition (as per Delirium and substance use paragraphs).

[4] Tri Service consultant psychiatrist consensus
[5] ICD-11 differentiates 'primary psychotic' disorders excluding identified organic causes. General medical and brain conditions producing psychotic symptoms are coded '6E61 Secondary psychotic syndrome', and those related to psychoactive effects of substances including medication are coded under 'Substance-induced psychotic disorders.

Mood disorders

15. **Single episode depressive disorder, mild / moderate (**ICD 11 Mild [accessed 12 Jan 26])(ICD 11 Moderate [accessed 12 Jan 26]) **without psychotic symptoms 6A70.0-6A70.1**. Candidates whose episode has lasted for less than two years and remained asymptomatic without relapse following the completion of all treatment for at least one year, are FIT.[6]

16. **Single episode depressive disorder, severe** (ICD 11 Severe [accessed 12 Jan 26]) **without psychotic symptoms 6A70.3.** Candidates whose episode has lasted for less than two years and who have remained asymptomatic without relapse following the completion of all treatment for at least two years, are FIT.[7]

17. All other diagnosed mood disorders, including **Recurrent Depressive Disorder 6A71**, and bipolar and related disorders are UNFIT because of the high risk of relapse and significant impact on military employability.

Anxiety or fear-related disorders

18. **Generalised anxiety disorder 6B00, Panic disorder 6B01, Agoraphobia 6B02, Specific phobia 6B03 and Social anxiety disorder 6B04.** These disorders are characterised by excessive fear, anxiety and related behavioural disturbances, with symptoms that are severe enough to result in significant distress or significant impairment in personal, family, social, educational, occupational, or other important areas of functioning. Individuals who develop these disorders early in life have a worse prognosis, which if left untreated may persist for many years. Candidates who experience symptoms for two years or less and are fully recovered without relapse following the completion of all treatment (including medication) for at least one year are FIT.[8] Candidates presenting with a history of two or more episodes are UNFIT, because anxiety disorders have a high risk of relapse and significantly impair military employability.

Obsessive-compulsive (F42) or related disorders

19. Candidates with a diagnosis of obsessive-compulsive or related disorders (including hypochondriasis) are UNFIT as these disorders have a high risk of relapse and are likely to impact on military employability. For transient tic disorders see Annex G Neurology.

Stress-related disorders

20. **Post-traumatic stress disorder (PTSD) 6B40.** Candidates with a single episode of non-complex PTSD lasting less than two years with a cause unlikely to be triggered by military employment, with complete resolution of symptoms and without relapse for a period of at least two years are FIT.[9] Candidates with recurrent episodes of PTSD are UNFIT due to the risk of developing a further stress-related disorder affecting fitness for service.

21. **Complex post traumatic stress disorder (complex PTSD) 6B41.** Candidates with a history of complex PTSD are UNFIT due to the risk of severe problems with emotional

[6] Tri Service consultant psychiatrist consensus.
[7] Tri Service consultant psychiatrist consensus.
[8] Tri Service consultant psychiatrist consensus.
[9] Tri Service consultant psychiatrist consensus.

regulation such as violent outbursts, reckless or self-destructive behaviour, dissociative symptoms when under stress, and emotional numbing.

22. **Adjustment disorder 6B43.** (ICD 11 Adjustment disorder [accessed 13 Jan 26]) If symptoms of adjustment disorder persist for longer than six months after the identified stressor has ended, other diagnoses should be considered. Candidates with a single episode, with an identified precipitating stressor who remain fully recovered for at least one year[10] are FIT. Candidates with more than one episode are UNFIT as they are more likely to develop a stress related disorder in military employment.

Dissociative disorders

23. Dissociative states are characterised by 'functional' neurological symptoms (not consistent with a recognised disease), multiple identities, amnesia, and trance states. Candidates with dissociative disorders are UNFIT because the individual will be unable to function reliably and perform their military role safely and effectively.

Eating disorders

24. **Anorexia nervosa 6B80.** Candidates with a current or previous diagnosis are UNFIT because it has a poor prognosis[11] and military life is likely to exacerbate the symptoms and the physical risks associated with malnourishment, including the risk of musculoskeletal injury.

25. **Bulimia nervosa and 6B82 Binge eating disorder 6B81.** Candidates with a single episode, who have made a full recovery for one year, are FIT. Candidates with two or more discrete episodes are UNFIT due to the risk of relapse and impact on military employability.

Disorders of bodily distress or bodily experience

26. Candidates with a history of bodily distress disorders (previously categorised under somatisation) are UNFIT because the individual will be unable to reliably function and perform their military role safely and effectively.

Disorders due to substance use (including alcohol)[12]

27. **Harmful substance use.** Candidates with a history of harmful use[13] of substances (including alcohol[14]), not amounting to dependence, with evidence of continued abstinence for at least two years (including normalisation of abnormal blood parameters) and without evidence of comorbid mental disorder are FIT.

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[10] Tri Service consultant psychiatrist consensus.
[11] Although 20% make a full recovery and do not relapse in the future, it is not currently possible to reliably distinguish this group from those relapse and remit or who remain severely ill.
[12] Examiners are not obliged to inform recruiting staff of a history of illicit substance use.
[13] Harmful use refers to one or more of the following: (1) behaviour related to intoxication; (2) direct or secondary toxic effects on body organs and systems; (3) a harmful route of administration; (4) harm to the health of others.
[14] The prognosis of those who have been diagnosed with harmful use of alcohol not amounting to dependence is variable and the risk of dependence remains.

28. **Substance dependence.** Candidates with a previous diagnosis of substance dependence (including alcohol), with evidence from an addiction service of absolutely no substance[15] use for at least three years[16] prior to application are FIT.[17]

29. **Substance-induced psychotic disorder.** Candidates with a history of a single episode of psychotic symptoms related to substance use are FIT provided they meet all the following criteria:

a. The episode was a brief episode of psychosis and fully resolved once the effect of the substance had worn off,

b. There is no evidence of substance use since and for at least three years to ensure there is no substance dependence,

c. The episode was at least three years ago to ensure there is no underlying or subsequent mental disorder.

Disorders due to addictive behaviours (unrelated to substance use)

30. **Addictive behaviours.** Candidates with a history of hazardous addictive behaviours, (such as gambling or gaming behaviours), without impairment in socio-occupational functioning, or criminality and evidence of remission for three years or more[18] are FIT. If these conditions are not met then the candidate is UNFIT because of the potential risks for associated behavioural disturbance.

31. **Addictive behaviour disorders.** Candidates previously diagnosed with an addictive behaviour disorder by a specialist service are UNFIT because of the high relapse rate.

Impulse control disorders (ICD 11 code 6C70)

32. **Candidates** previously diagnosed with an impulse control disorder are UNFIT because of the uncontrollable nature of these behaviours and their negative impact on others.

Neurocognitive disorders

33. **Delirium 6D70.** Candidates with a history of delirium due to an underlying medical condition that has fully resolved are FIT.

34. **Amnestic disorder (acquired memory loss) 6D72.** Candidates with this diagnosis are UNFIT because the individual would be unable to reliably function and perform their role safely and effectively.

Intentional self-harm

35. Candidates with a single episode of intentional self-harm (by any specified means; most commonly cutting, scraping, burning, biting, hitting or exposure to harmful effects of

[15] This includes Candidates who are prescribed methadone, naltrexone or buprenorphine as part of maintenance or detoxification therapy.
[16] Tri Service consultant psychiatrist consensus
[17] Those who have been alcohol dependent have a 70% chance of relapse, with only 30% remaining abstinent or being able to drink in a controlled way.
[18] Tri Service consultant psychiatrist consensus

substances e.g. medicines or poisons) in the absence of underlying psychiatric disorder are FIT provided they meet all the following criteria:

a. Symptoms lasted no more than three months,

b. The episode was more than two years ago,

c. Only minor physical harm was caused.

36. All other cases of intentional self-harm in adulthood, including interrupted, aborted or unsuccessful suicide attempts, are UNFIT due to the increased risk of repetition and death by suicide.

Annex M

DENTAL AND ORO-MAXILLOFACIAL PRE-ENTRY

1. **General Principles for assessing candidates against this annex.** The general principles against which a candidate is assessed as FIT for entry, with respect to oral health are:

    a. **Function.** A candidate must have the oral function and stability (speech and chewing function) to:

        (1) Perform their role safely and efficiently in all military environments.

    b. **Prognosis.** Where a candidate is found to have a has pre-existing oral health condition(s) or is at increased risk of oral health morbidity, the following general criteria should be met in addition to the relevant specific paragraph in policy, it should not:

        (1) Place a significant foreseeable demand on military primary dental care resources.

        (2) Be foreseeably exacerbated by military service.

        (3) Pose a significant risk of future temporary or permanent loss of function.

        (4) Pose a risk of sudden deterioration / incapacitation without reasonable warning.

    c. **Medical support requirements.** Where a candidate has a pre-existing or increased risk of a dental condition, there must be no reasonably foreseeable requirement for medical / dental care within the deployed location beyond deployed Primary Healthcare (or equivalent). The medical / dental condition must be stable with treatment. Should loss of medication occur for ≤ one week this should not lead to clinical deterioration in the condition or functional degradation during that time. In the deployed environment the condition should not foreseeably impact military medical resource.[1]

2. **Exceptional circumstances.** Criteria within each condition has been outlined to grade a candidate as FIT or UNFIT. Where there is any doubt, advice should be sought from the Single Service Medical Entry Staff (sSMES).[2]

Uncontrolled / untreated oral disease

3. Candidates with mild / moderate dental disease(s) or other oral conditions that are treatable by a general dental practitioner, are FIT. These candidates should have:

    a. An acceptable and functional occlusion of either natural teeth or well-fitting standard removable or fixed prostheses.

[1] Assessing clinicians should be aware of pericoronitis (impacted Wisdom Teeth).
[2] Delegated Authority arrangements may apply.

b. Healthy gums (pink and stippled gingivae with an absence of swellings, discharge, acute bleeding or tooth mobility), and oral mucosa, with no obvious soft tissue disease or deformity.

4. Candidates with gross oral neglect are UNFIT.[3] This is because these candidates would place a significant foreseeable demand on military primary dental care resources.

5. In cases of doubt, the candidate should be referred to sSMES, who may refer to a sS or HQ DPHC Dental Officer for further assessment of oral disease.[4]

Dental phobia

6. Candidates who cannot tolerate routine primary care dentistry under local anaesthetic and require conscious sedation or general anaesthesia are UNFIT. This is because anaesthesia requirements cannot be supported within an operational environment or routinely within primary care. In cases of doubt, the candidate may be referred to sSMES, who may refer to a sS or HQ DPHC Dental Officer.

Dental genetic disorders

7. **Amelogenesis imperfecta (condition affecting enamel) and dentinogenesis imperfecta (condition affecting dentine).** Candidates with a history of hypocalcified amelogenesis imperfecta (AI) or dentinogenesis imperfecta (DI) must be referred to sSMES, who should refer to a sS or HQ DPHC Dental Officer for further assessment to determine if the candidate is FIT. This is because candidates with these specific genetic conditions often have wide-ranging, multi-disciplinary treatment needs. Whilst the dentition may be treated or remediable,[5] the possibility of osteogenesis imperfecta[6] must be considered in candidates presenting with DI.

Dental and facial abnormalities

8. **Candidates with corrected cleft-lip and / or hard / soft palate.** See Annex B – ENT Para 23.

Facial fracture and orthognathic surgery

9. Candidates with retained metalwork are FIT provided they are symptom-free, with confirmation of fracture healing, and no residual deformity. Candidates with a history of facial fractures, including those who have undergone orthognathic surgery and who continue to have symptoms, are UNFIT until these have resolved. This is because candidates undergoing bone healing are at a high risk of fracture for up to six months following surgery. Where there is doubt, cases may be referred to sSMES, who may refer to a sS or HQ DPHC Dental Officer.

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[3] This is defined as a patient with multiple open carious teeth (it should be noted by non-dental assessor that anterior incisor and canine teeth are usually the last teeth to be affected and is an indicator of high levels of disease), uncontrolled severe periodontal disease (2017 Periodontal disease classification), severe non-carious tooth surface loss (6 or more teeth with loss of enamel and extensive dentine exposure), periradicular disease (affecting more than 2 teeth), atypical facial pain or unstable temporomandibular joint disorder.
[4] Service Dental Officers asked for opinion, should determine TN (Treatment Need) by visual examination only, radiographs are not to be taken. Utilising the DPHC(Dental) Project Molar agreement of 2 hours of dentistry per recruit, if the opinion is that disease cannot be **stabilised** within 2 hours i.e. >TN4, the candidate is to be determined UNFIT.
[5] Further advice / assessment by a Service Restorative Dentistry specialist may be required.
[6] Including musculoskeletal and ophthalmological abnormalities.

Orthodontic treatment

10. Active orthodontic treatment involves the use of both fixed and removable appliances. On completion of active treatment, the use of fixed or removable retention devices is frequently required for enduring stability.

11. **Active orthodontic treatment.** Candidates who are undergoing active orthodontic treatment are UNFIT until treatment is complete, as confirmed by a report from the treating practitioner.[7,8] This is because of the difficulties of continuing with orthodontic treatment during military service.

12. **Active appliances.** The removal of active appliances simply to facilitate Service entry is not advised. Where a treatment course has not been completed cases may be referred to sSMES, who may refer to a sS or HQ DPHC Dental Officer.

    a. **Removable orthodontic aligners.** Candidates who are undergoing removable orthodontic aligner treatment are FIT. However, the duty of care for this treatment must be preserved by the original dental provider (NHS / private).

    b. **Fixed and removable retention devices.** Fixed and removable retention devices required for enduring stability on completion of active treatment, must continue to be worn and are FIT.

Orthodontic Treatment for HM Forces sponsored students and members of University Military Units[9]

13. Entry to these establishments is generally constrained by age. Recruits to these establishments are FIT if treatment can be managed within the constraints of the training timetable.[10] Individuals applying must make arrangements to continue orthodontic treatment with their civilian orthodontist / dental practitioner for the duration of their training and treatment should be scheduled to be completed by the end of Phase one training.

Elective aesthetic treatment

14. Candidates who have had elective aesthetic treatment to five or fewer teeth are FIT. Candidates who have had elective aesthetic treatments to six or more teeth are to be referred to the sSMES, who may refer to a sS or HQ DPHC Dental Officer for further assessment to determine if the candidate is FIT.[11] This is because elective aesthetic dental treatment conducted to a poor standard is complex and resource intensive to manage, therefore cannot be addressed within military primary dental care resources.

[7] Further advice / assessment by a DPHC Orthodontist may be required.
[8] An acceptable end point to treatment may be considered as the position of teeth being beneath the NHS criteria for treatment (Index of Orthodontic Treatment Need (IOTN) 3 and below, aesthetic component under 6.
[9] Including but not limited to Army Foundation College (Harrogate), URNU, UOTC, UAS, Sixth Form and University Scholars and Bursars.
[10] Further advice / assessment by a DPHC Orthodontist may be required.
[11] Service Dental Officers asked for opinion, should determine TN (Treatment Need), endodontic status and the overall maintenance of restored teeth where complex elective treatment has been undertaken. Utilising the DPHC(Dental) Project Molar agreement of 2 hours of dentistry per recruit, if the opinion is that disease cannot be **stabilised** within 2 hours i.e. >TN4, the candidate is to be determined UNFIT.

Dental implants

15. Candidates wishing to enlist who have had implant treatment are FIT.[12] Any implanted prosthetic structure should have healthy associated mucosa.

[12] It should be noted that Defence Primary Healthcare only supports Dentsply-Astra, Straumann, Nobel and 3i BioMet implants systems. Therefore, those individuals who have had implant treatment using alternative systems would have to have to seek private treatment in the event of replacement / repair.

Annex N

OTHER CONDITIONS PRE-ENTRY

1. **General principles for assessing candidates against this Annex.** The general principles against which a candidate is assessed as FIT for entry are:

    a. **Function.** A candidate must have the physical and cognitive function, in all military environments, to safely and effectively:

        (1) Perform their military role.

        (2) Operate their personal weapon.

    b. **Prognosis.** Where a candidate has a pre-existing or is at increased risk of a medical or surgical condition, it should not:

        (1) Be foreseeably exacerbated by military service (physically demanding activities, blunt / penetrating trauma, extremes of heat / cold, atmospheric pressure, UV light or environmental conditions).

        (2) Pose a significant risk of future temporary or permanent loss of function.

        (3) Pose a risk of sudden deterioration / incapacitation without reasonable warning

        (4) Pose an unacceptable employment risk to self and / or others.

    c. **Medical support requirements.** Where a candidate has a pre-existing or increased risk of a condition, there must be no reasonably foreseeable requirement for medical care within the deployed location beyond deployed Primary Healthcare (or equivalent). The medical condition must be stable with treatment. Should loss of medication ≤ one week this should not lead to clinical deterioration in the condition or functional degradation during that time. In the deployed environment the condition should not foreseeably impact military medical resource.

2. **Exceptional considerations.** Criteria within each condition have been outlined to grade a candidate as FIT or UNFIT. Where there is any doubt, advice should be sought from single Service Medical Entry Staff (sSMES)[1]. The resultant FIT or UNFIT outcome will be determined by sSMES.

Haematology (blood diseases and conditions)

3. **Chronic (long-standing) blood diseases.** These conditions may be exacerbated by military service (in particular, physically demanding activities, blunt / penetrating trauma, extremes of heat / cold, atmospheric pressure) and pose an increased demand on military medical care. Candidates with the following conditions are UNFIT:

    a. G6PD deficiency.

[1] Delegated Authority arrangements may apply.

b. Hereditary spherocytosis.

c. Homozygous (sickle cell anaemia) or compound heterozygous sickle cell disease.

d. Alpha (α) or Beta (β) thalassaemia (for trait, see below).

e. Inherited or irreversible acquired platelet or clotting disorder resulting in defective coagulation.

4. **Sickle cell trait (Hb A / S).** Candidates with sickle cell trait (SCT) have a higher risk of exertional rhabdomyolysis (muscle damage) and other conditions such as hyposthenuria (reduced ability to concentrate urine), and blood clots (including deep vein thrombosis and pulmonary embolism). A rare complication of SCT is exertional collapse associated with sickle cell trait (ECAST). This can result in serious illness and death. The following applies to all candidates:

a. All candidates must be screened for SCT using an appropriate questionnaire and, where required, diagnostic test.

b. Candidates who have SCT are FIT with a permanent E2 marker (to reflect the risks described above and the requirement for appropriate mitigation and communication to the single Service employer), provided they meet all the following criteria:

(1) There must be no history of ECAST. Candidates with a history of ECAST are UNFIT as the condition is foreseeably exacerbated by military service (physically demanding activities and extremes of heat) and there is a risk of recurrent ECAST which may be life-threatening,

(2) There must be no history of exertional rhabdomyolysis or other significant complication related to SCT. Candidates with a history of exertional rhabdomyolysis (including history of passing black urine (likened to ‘flat cola’) after exercise) or other significant complication related to SCT are UNFIT as the condition is foreseeably exacerbated by military service (physically demanding activities and extremes of heat) and there is a risk of recurrence which may be life-threatening,

(3) There must be no history of heat illness with concurrent SCT. Candidates with a history of heat illness with concurrent SCT are UNFIT due to the elevated risk of recurrent heat illness which may be life-threatening.

5. **Alpha (α) or Beta (β) thalassaemia trait.** The following applies:

a. Candidates with heterozygous α or β thalassaemia traits are asymptomatic with an altered blood picture (hypochromic – low MCH, microcytic – low MCV) and little or no anaemia. Candidates with asymptomatic, isolated α or β trait conditions are FIT.

b. Candidates with any thalassaemia trait in combination with sickle cell trait (for example, Hb S / C or Hb S / D) have disease varying in clinical severity and require a service-approved Haematology opinion and referral to sSMES for a determination of FIT / UNFIT.

6. **Thromboembolic disease (formation of blood clots in blood vessels).** A previous history of blood clots (including deep vein thrombosis (DVT) or pulmonary embolus (PE)) is the strongest predictor for a future clot event[2].

a. Candidates with a clear history of provoked DVT or PE, who no longer require treatment or clinical review are FIT, subject to sSMES reviewing the likelihood of the provoking event recurring during military service.

b. Candidates with a previous history of other thromboembolic events (including unprovoked DVT or PE), whether on treatment or not, are UNFIT as risk of recurrence is increased by military service (in particular dehydration and prolonged travel times on deployment). For stroke and cardiac conditions refer to Annex C Cardiology.

7. **Thrombophilia (tendency to form blood clots in the blood vessels).** Testing should not be initiated for the purposes of employment screening. The following applies:

a. Candidates with antiphospholipid antibodies who do not require anticoagulation are FIT.

b. Candidates with antiphospholipid syndrome (APS / APLS) are UNFIT due to the high risk of future thrombotic events which would require significant medical support.

c. Candidates with Factor V Leiden and / or Prothrombin 20210A expressed in heterozygote form, who have not had a thrombotic event (e.g. DVT or PE) and who do not require anticoagulation are FIT.

d. Candidates with Factor V Leiden and / or Prothrombin 20210A expressed in heterozygote form, who have had a thrombotic event (e.g. DVT or PE) or who require anticoagulation are UNFIT as they are at higher risk of future thrombotic events which would require significant medical support.

e. Candidates with Factor V Leiden and Prothrombin 20210A expressed in homozygote form and present individually or in combination are UNFIT as they are at higher risk of future thrombotic events which would require significant medical support.

8. **Anti-coagulation therapy (blood-thinning medication).**

a. Candidates who previously required anti-coagulation are FIT provided the underlying reason for the anti-coagulation is not disqualifying.

b. Candidates who require any anti-coagulation therapy[3] (including warfarin and direct oral anti-coagulants[4]), are UNFIT. This is due to the risk of suffering a clot should they be prevented from taking their medication due to loss of re-supply when deployed on operations, and the additional / higher levels of medical care required in the event of injury.

[2] Arachchillage DJ, Mackillop L, Chandratheva A, Motawani J, MacCallum P, Laffan M. Thrombophilia testing: A British Society for Haematology guideline. Br J Haematol. 2022 Aug;198(3):443-458. https://doi.org/10.1111/bjh.18239 [accessed 13 Jan 26].
[3] Including where advised for long distance travelling prophylaxis
[4] This excludes anti-platelet medication (such as aspirin or clopidogrel)

9. **Idiopathic thrombocytopenic purpura (ITP) (low platelet disorder of unknown origin).** Candidates with resolved ITP are FIT E2 (to reflect the need for extra vigilance in the event of possible recurrence) provided they meet all the following criteria:

a. In remission for more than two years,

b. Symptom-free (no excessive or easy bruising),

c. Platelet count is between 100 and 150x10^9 / l. Evidence of three platelet measurements spanning a period of at least six months is required,

d. Intact spleen.

10. Where the above criteria are not met, candidates are UNFIT. Severe thrombocytopenia may result in sudden blood loss and even moderate thrombocytopenia may be associated with excessive bleeding if injured. They may require additional / higher levels of medical care.

11. **Leukaemia.** The following applies:

a. **Acute lymphoblastic leukaemia (ALL) and acute myeloid leukaemia (AML).** Candidates with a history of ALL / AML who have remained free of recurrence for a period of five years from the completion of treatment and fulfil the requirements of the paragraphs relating to Oncology should be referred to sSMES for a determination on FIT E2[5] / UNFIT.

b. **Chronic myeloid leukaemia (CML).** Candidates with a history of CML who have been off treatment for two years[6] and fulfil the requirement of the paragraphs 12 and 13 which relate to Oncology should be referred to sSMES for a determination on FIT E2[6] / UNFIT.

c. **Other leukaemias.** This includes chronic lymphocytic leukaemia (CLL), chronic myelomonocytic leukaemia (CMML) and myeloproliferative neoplasms (MPNs)[7]. Candidates with these forms of leukaemia are UNFIT. This is due to the risk of relapse, and increased need for ongoing specialist medical care and surveillance.

12. **Irradiated blood components.** Candidates who require irradiated blood components[8] are UNFIT. Irradiated blood components cannot be provided routinely whilst deployed. There is a risk of potentially fatal complications should they receive non-irradiated blood components. This risk is further increased with transfusion of non-leucodepleted blood components, such as whole blood collected in emergencies from an emergency donor panel.

a. The following candidates are likely to require irradiated blood:

(1) Those who have been treated with the following drugs:

[5] The purpose of the E2 marker is to highlight a need for ongoing surveillance. MedLim 1100 may apply.
[6] For some individuals, discontinuation of treatment after 3-5 years in deep remission can be successful and renders the disease cured.
[7] Including: chronic eosinophilic leukaemia, chronic myelogenous leukaemia, chronic neutrophilic leukaemia, essential. thrombocythaemia, polycythaemia vera, primary myelofibrosis or chronic idiopathic myelofibrosis.
[8] British Society for Haematology. Guidelines on the use of irradiated blood components. Available from: Guidelines on the use of irradiated blood components [accessed 12 Jan 26]

(a) Fludarabine.

(b) Cladribine.

(c) Pentostatin.

(d) Alemtuzumab.

(e) Other novel purine analogues and related agents until evidence of safety emerges.

(f) Anti-thymocyte globulin.

(2) Those with Hodgkin's lymphoma (lifelong following diagnosis).

(3) Those with Immunoglobulin A (IgA) deficiency.

(4) Where the treating specialist has recommended the requirement for irradiated blood components.

Oncology (cancers)

13. Candidates with a history of cancer who meet all the criteria stated below should be referred to sSMES with a clinical report outlining diagnosis, treatment provided, risks of recurrence, risks of present or future complications from treatment given:

a. Treatment completed and discharged from secondary care follow up, (excluding surveillance conducted annually or less frequently).[9]

b. No ongoing side-effects or functional deficit from the underlying disease or treatment.[10]

c. No requirement for irradiated blood products.

d. Requirements outlined in relevant Annexes are met.

sSMES will consider the risk of recurrence, the impact of medical surveillance requirements and determine FIT E2[11] / UNFIT.

14. Candidates who are undergoing active treatment for cancer are UNFIT because:

a. They may not have the functional level required for worldwide service due to side effects of the treatments such as tiredness (fatigue).

b. The effects of some treatments may also make them more susceptible to infections (immunocompromised).

[9] Candidates who are being followed-up for the purposes of clinical trials, long-term studies into treatment or disease effects or for long-term holistic or psycho-social issues (where no active treatment or investigations are undertaken) may be considered to meet this criterion.
[10] Certain types of chemo- and radio-therapy may cause long-term impairment to the heart and or lungs. Anthracylines, Bleomycin and trans-thoracic radiotherapy are therapies of interest.
[11] The purpose of the E2 marker is to highlight a need for ongoing surveillance. MedLim 1100 may apply.

c. Continuity of clinical care may be compromised by military service, resulting in adverse health outcomes for the candidate.

Human Immunodeficiency Virus (HIV) and hepatitis viruses

15. Routine pre-employment screening for these conditions is not required.

16. **Human Immunodeficiency Virus (HIV).** For those who declare a relevant history the following applies:

a. Candidates living with HIV who are prescribed and taking antiretroviral therapy (ART) are FIT E2 provided they meet all of the following criteria and subject to sSMES review:

(1) Have been taking ART for at least 6 months

(2) Are on a stable, robust and effective treatment regimen

(3) Have an undetectable viral load of less than 50 copies / mL[12]

(4) Have a CD4 count of at least 200 cells / mm^3 [13]

(5) Approval has been given by a military recommended specialist in HIV

(6) Specific guidance applies to certain employment groups, such as healthcare workers[14], who may be UNFIT due to the need to comply with national patient safety guidance[15].

b. Aircrew and controller candidates: should be graded in accordance with AP1269A Lft 5-10.

c. All other candidates living with HIV are UNFIT due to the increased risk of significant illness including infection and / or cancer, decompensation on military operations, and risk of transmission to others when deployed.

17. **HIV Pre-Exposure Prophylaxis (PrEP).** Candidates who are prescribed and using HIV PrEP are FIT E2 for the duration of PrEP use, to reflect the need for regular blood testing. Specific guidance applies to certain employment groups such as aircrew.[16]

18. **Human T-cell lymphotrophic virus (HTLV) 1 & 2.** Candidates with a diagnosis of HTLV are UNFIT due to the risk of immunocompromise, leading to parasitic infection, and potential neurological deterioration.

19. **Viral hepatitis.**

[12] A single viral load of 50 – 200 copies / mL preceded and followed by an undetectable viral load is considered a 'blip' and is acceptable. Para 7.2 Blips BHIVA-guidelines-on-antiretroviral-treatment-for-adults-living-with-HIV-1-2022.pdf [accessed 12 Jan 26]
[13] Consensus expert opinion – BHIVA and DMS meeting 29 Jul 25
[14] JSP 950 Lft 6-8-1: Defence Medical Services Uniformed and Civilian Healthcare Wokers: Tuberculosis and Blood-Borne Viruses Screening and Management [accessed 12 Jan 26]
[15] Integrated guidance on health clearance of healthcare workers and the management of healthcare workers living with bloodborne viruses (hepatitis B, hepatitis C and HIV) [accessed 12 Jan 26]
[16] PrEP policy for aircrew and controller recruits is detailed in AP1269A Lft 5-10 [accessed 13 Jan 26].

a. **Hepatitis A or E.** Candidates with resolved hepatitis A or E are FIT. Candidates with a current acute or chronic viral hepatitis (abnormal liver function test (LFT)), or persistence of symptoms after 6 months, or objective evidence of impairment of liver function are UNFIT due to the risk of transmission to others, and risk of long-term liver disease.

b. **Hepatitis B.** Candidates with previous hepatitis B who are hepatitis B surface antigen negative, and with no chronic liver disease are FIT. Candidates who are hepatitis B surface antigen positive more than 6 months after infection are UNFIT due to the risk of transmission to others and risk of long-term liver disease.

c. **Hepatitis C.** Candidates with previous hepatitis C who are polymerase chain reaction (PCR) negative for hepatitis C at least 6 months after completing antiviral therapy or following spontaneous clearance of infection and who have no chronic liver disease are FIT. Candidates with a current acute or chronic viral hepatitis C are UNFIT due to the risk of transmission to others, and risk of long-term liver disease.

Chronic fatigue syndrome and associated conditions

20. **Infectious mononucleosis (glandular fever / Epstein-Barr Virus).** Candidates are FIT provided they meet all the following criteria:

a. The condition lasted no longer than twelve months,

b. There are no ongoing symptoms (including breathlessness, muscle aches, enduring tiredness, chest pain),

c. There have been no serious complications,

d. They are undertaking activities compatible with military training and service for more than three months.

21. Where Candidates do not meet the above criteria, a referral should be made to sSMES.

22. **Other chronic fatigue syndrome and associated conditions.** This includes the following conditions: chronic fatigue syndrome, fibromyalgia (FM), myalgic encephalomyelitis (ME), long-COVID, or post-viral fatigue syndrome (PVFS). Candidates are FIT provided they meet all the following criteria:

a. The condition lasted no longer than twelve months and symptoms have resolved for at least two years,

b. There are no ongoing symptoms (including breathlessness, muscle aches, enduring tiredness, chest pain),

c. They are undertaking activities compatible with military training and service for more than three months.

23. All other candidates with active chronic fatigue syndrome or the group of associated disorders stated above are UNFIT. High levels of physical and / or psychological demand

are associated with relapse or recurrence of symptoms. A candidate must have the physical function, in all military environments, to safely and effectively perform their military role.

Conditions affected by climate

24. **Heat illness.** Candidates who have experienced a diagnosed episode of heat illness (with or without physical exertion) are FIT provided they have been shown to thermoregulate normally during an exercise-in-heat stress test.[17] All others with a history of diagnosed heat illness are UNFIT, because this condition is foreseeably exacerbated by military service (in particular physical exercise) and the condition poses a risk of sudden deterioration / incapacitation. This presents a risk to life.

25. **Hypohidrosis or anhidrosis (disorders of sweating).** This is an inherited condition affecting sweating characterised by a decrease in or complete loss of sweat production in response to an appropriate thermal or pharmacological stimulus. Candidates should be referred to sSMES who will consider the extent of the condition and whether an exercise-in-heat stress test is required. An inability to sweat increases a candidate's risk of heat injury and death.

26. **Cold injury.** The following applies:

a. Candidates with a history of Freezing Cold Injury (FCI) (including frostbite), Non-Freezing Cold Injury (NFCI) or Cold Sensitivity whose symptoms are fully resolved should be referred to sSMES for a determination on FIT E2 / UNFIT. E2 reflects the requirement for clinical vigilance.

b. Candidates with symptomatic FCI, NFCI, or Cold Sensitivity are UNFIT. These conditions pose a significant risk of future, temporary or permanent loss of function.

27. **Raynaud's disease or phenomenon (primary or secondary), acrocyanosis, vasospasticity, or similar conditions.** These conditions result in a tendency for extremities to change colour and / or lose sensation and / or become painful in moderately cold conditions or when experiencing stress. Candidates with a confirmed diagnosis of these conditions are UNFIT because of cold sensitivity and an increased risk of temporary or permanent loss of function.

Congenital, chromosomal and genetic conditions

28. The spectrum of congenital, chromosomal and genetic conditions is broad and the impact on military service is variable. In all cases, the general requirements stated at the start of this Annex should be considered. Genetic testing should not be initiated solely for the purposes of recruitment.

29. **Specified congenital, chromosomal and genetic conditions.** The following applies:

a. **Phenylketonuria.** Candidates with this condition are UNFIT. Although there is no clear evidence which provides overwhelming support for the need for lifelong dietary treatment, regular annual clinical review remains essential. This condition

[17] Such as those available at the Institute of Naval Medicine.

poses a significant risk of future temporary or permanent loss of function. Candidates require specialist lifelong medical support and follow up. Dietary restrictions are generally necessary with protein supplements normally required and the military cannot guarantee that specialist diet (lower protein) will be available[18].

b. **Malignant hyperpyrexia.**

(1) Candidates known to have the gene / s associated with this condition[19] are UNFIT due to the elevated risk of heat injury and adverse reaction to anaesthetic medicines. This condition is foreseeably exacerbated by military service (in particular, physical exercise). This condition poses a risk of sudden deterioration / incapacitation without reasonable warning. Safe delivery of anaesthetic on operations cannot be guaranteed for these conditions and poses a foreseeable risk to life.

(2) Candidates with a family history, but who have not been tested are UNFIT for the reasons stated above.

(3) Candidates with a positive family history but a negative test should be referred to sSMES for a determination on fitness.

c. **Suxamethonium sensitivity.** The following applies:

(1) Candidates who are homozygous for the atypical cholinesterase gene and have been identified as requiring special anaesthetic precautions are UNFIT as the safe delivery of anaesthetic on operations cannot be guaranteed for this condition and may pose a risk to life.

(2) Candidates who are heterozygous of the atypical cholinesterase gene should be referred to sSMES for a determination on fitness.

d. **Neurofibromatosis Types 1 and 2.** Candidates known to be carriers of either of the genes associated with these conditions are UNFIT as there are associated consequences of unpredictable onset, including intra-cerebral tumours (most commonly optic nerve gliomas), renal artery stenosis and thyroid carcinoma. The risk of seizures is approximately 20 times higher than that of the general population[20]. The condition poses a risk of sudden deterioration / incapacitation without reasonable warning. It may prevent the wearing of operational Personal Protective Equipment (such as helmet or combat body armour).

e. **Hereditary cardiac conditions** See Annex C Cardiology Paras 13 and 22.

f. **Hereditary gastro-intestinal cancer syndromes.** See Annex E Gastroenterology Para 22.

g. **Breast cancer (BRCA) gene carriers and equivalent risks.** See Annex J Gender Para 8.

[18] From National Society for PKU 'Management of PKU' Feb 2004.
[19] Including RYR1 and mutations of CACNA1S.
[20] Adams & Victor: Principles of Neurology.

h. **Hereditary musculoskeletal conditions.** See Annex K Musculoskeletal Para 127(e).

30. **Family history of congenital, chromosomal and genetic conditions – Candidate confirmed to not carry gene.** Where there is a known family history, but the Candidate does not exhibit the condition and has a documented negative test, they are FIT.

31. **Family history of other congenital, chromosomal and genetic conditions – Candidate not undergone genetic testing.** Where there is a known family history, but the Candidate does not exhibit the condition and has not been tested, they are to be referred to sSMES to determine FIT E2 / UNFIT. Genetic testing should not be initiated solely for the purposes of recruitment. sSMES will apply the following general considerations:

a. The probability of the Candidate having the relevant gene / being susceptible to the condition.

b. The probability of developing the disease if the gene is present.

c. The likely onset time / age of the condition.

d. The likely rate of progression of the condition.

e. Whether screening or surveillance is available for the condition, the frequency of such screening and Candidate participation.

f. Whether appropriate mitigations are available (e.g. medical, surgical intervention). This includes whether the condition is compatible with / supportable on deployments.

g. Whether the condition poses a risk to life or of sudden incapacitation.

h. The short, medium and long-term prognosis of the condition once present.

i. Whether the condition onset or severity is likely to be accelerated by service.

j. What impact the condition may have on the Candidate's physical and mental function and ability to undertake military duties.

32. **Candidates with a documented positive test result for a congenital, chromosomal or genetic condition.** The following applies:

a. Where a Candidate has a documented positive test, they are to be referred to sSMES for an opinion on fitness. The general considerations stated in Para 29 apply.

b. Where a Candidate has already developed an associated condition, they should be considered under the relevant part of Section 4 or, where there is doubt, be referred to sSMES.

Systemic Conditions

33. **Sarcoidosis.** See Annex D Respiratory Paras 16 and 17.

34. **Tuberculosis.** See Annex D Respiratory Para 19.

Immune system disorders

35. **Anaphylaxis (severe allergy).** Anaphylaxis is a severe life-threatening allergic reaction, typically to foods, insect stings / bites or medications. Dermal and systemic signs and symptoms manifest which may include urticaria, angioedema, hypotension and bronchospasm. It may require urgent treatment with adrenaline or hospitalisation. The following applies:

a. **Adrenaline auto-injector.** Any candidate who has to have access to an adrenaline auto-injector is UNFIT as this is a marker for anaphylaxis risk. Rapid access to life-saving treatment cannot be guaranteed.

b. **Medication anaphylaxis.** Candidates with a history of anaphylaxis to drugs should have a careful history taken, including whether anaphylaxis has been formally diagnosed.

(1) **Operationally essential medications and latex.** The operationally essential medications include:

(a) Neuromuscular blocking agents (NMBAs).

(b) Intravenous (i.v.) anaesthetics.

(c) Antibiotics.

(d) Opioid analgesics (such as morphine, codeine).

(e) Non-steroidal anti-inflammatory drugs (NSAIDs) (such as ibuprofen, diclofenac).

(f) Local anaesthetics (such as lidocaine).

(g) Colloids (a type of intravenous fluid).

(h) Other agents likely to be used on operations.

(i) Latex.

(2) Candidates with anaphylaxis to any of the above are UNFIT due to the inability to guarantee avoidance of the allergen when deployed and the potential risk to life.

(3) **Chemical, Biological, Radiation & Nuclear (CBRN) medications.** Candidates with an anaphylaxis to drugs used in prophylaxis or treatment in a CBRN[21] environment are UNFIT due to the inability to guarantee avoidance of the allergen when deployed and the potential risk to life.

[21] Including: atropine, pralidoxime, benzodiazepines including midazolam, pyridostigmine, naloxone.

(4) Candidates with anaphylaxis to other medications, which are readily avoidable are FIT E2 with a requirement for a NATO Medical Warning Tag subject to sSMES opinion on suitability.

c. **Food anaphylaxis.** Candidates with anaphylaxis to foodstuffs are UNFIT. This is due to the inability to guarantee avoidance of allergen cross-contamination in operational rations and / or catering when deployed. Where an adrenaline auto-injector has been prescribed to manage food allergy, the Candidate is UNFIT.

d. **Insect bite / sting anaphylaxis.** Candidates with a history of anaphylaxis to insect bites / stings are UNFIT due to the inability to guarantee avoidance of the allergen when deployed and the potential risk to life.

(1) **Venom Immunotherapy (VIT).** Candidates who have completed a programme of VIT at a British Society for Allergy and Clinical Immunology (BSACI) clinic and are no longer required to carry an adrenaline autoinjector are UNFIT due to the risk of the effectiveness of the therapy deteriorating over time and the risk of an anaphylactic event occurring.

36. **Seasonal allergic rhinitis (hayfever).** Candidates with hayfever are FIT provided they meet all the following criteria:

a. symptoms are controlled with over-the-counter non-sedating oral[22,23], nasal and / or ocular medicine,

b. the deliberate avoidance of allergen is not required,

c. symptoms are not functionally disabling (in particular, vision),

d. symptoms do not cause wheeze or require an inhaler.

37. **Birch Pollen Food Syndrome (Oral Allergy Syndrome).** This is a hypersensitivity reaction to fruits, vegetables and nuts (often referred to as plant-based foods). The following applies:

a. **Where the trigger is a raw plant food (not including nuts).** Candidates with mild symptoms (including: itching and swelling of the lips, tongue, inside of the mouth, ears and throat, usually within five to ten minutes of eating the allergic food and these settle within an hour, often without any medical intervention) are FIT. In these cases, there must be no evidence of any airway compromise or wheeze. Risk of incapacitation is assessed as being very low.

b. **Where the trigger is cooked fruit / vegetables, any nuts (including pine nuts and seeds), wheats, cereals, composite meal / snacks.** Candidates should have been investigated in accordance with British Society for Allergy and Clinical Immunology (BSACI) guidance[24] for confirmation of diagnosis. Candidates should be referred to sSMES for a determination on FIT / UNFIT.

[22] Including: acrivastine, cetirizine, fexofenadine and loratadine.
[23] Where montelukast is prescribed, referral should made to sSMES to evaluate impact of disease and to assess whether there are asthma-like symptoms. In the UK, oral montelukast is only licensed for the symptomatic relief of seasonal allergic rhinitis in people with asthma (Source: BNF, BNFC, 2023). A possible uncommon adverse effect is a neuro-psychiatric reaction.
[24] The British Society for Allergy and Clinical Immunology (BSACI) [accessed 12 Jan 26]

c. **Where symptoms have included throat closure, itching or swelling of extremities, hives and / or angioedema, wheeze or difficulty in breathing, tachycardia or hypotension, fainting or dizziness.** Candidates should have been investigated in accordance with British Society for Allergy and Clinical Immunology (BSACI) guidance[24] for confirmation of diagnosis. Candidate should be referred to sSMES for a determination on FIT / UNFIT.

38. **Other mild and moderate allergy.** Candidates with mild allergic symptoms are FIT provided they meet all the following criteria:

a. symptoms are controlled with over-the-counter non-sedating oral[21] [22] , nasal and / or ocular medicine,

b. the deliberate avoidance of allergen is not required,

c. symptoms are not functionally disabling,

d. symptoms do not cause wheeze, require an inhaler or adrenaline autoinjector,

e. not foreseeably exacerbated by military service.

All other Candidates, including those with severe symptoms are UNFIT due to the foreseeable impact on military employment.

39. **Immuno-suppressive conditions.** Candidates with immuno-suppressive conditions which make them more vulnerable to developing infections are UNFIT due to the risks of worldwide deployed service.

40. **Sleep disorders.** See Annex B ENT Para 22 and Annex G Neurology Paras 26 –35.

Miscellaneous and unspecified conditions

41. **Malaria.** Candidates who have lived overseas in endemic areas may have an incomplete medical record. These candidates are encouraged to provide as much information as they can to verify treatment received. Candidates should not have experienced symptoms or any restriction to exercise tolerance within the previous three months.

a. Candidates with past history of malaria who have received an appropriate course of treatment and have been discharged from appropriate specialist follow-up, including Plasmodium ovale or P. vivax that has had a radical cure[25] are FIT.

b. Candidates who are known to have been infected with the Plasmodium ovale or P. vivax strains of malaria, and have not received a radical cure[24], are FIT E2. The E2 marker is required for the first two years of service, to reflect the potential for malaria reactivation which would require early treatment.

[25] A course of treatment targeting the hypnozoite phase, typically primaquine.

c. All others, including those with active disease are UNFIT due to the impact on function and requirement for medical treatment.

42. **Other tropical diseases.** Candidates with a history of tropical disease who have made a full recovery, who are considered cured and have no functional impairment are FIT. Where there is uncertainty surrounding diagnosis and treatment, referral should be made to sSMES. Conditions of concern include, but are not limited to:

a. Schistosomiaisis.

b. Lymphatic filariasis.

c. Onchocerciasis.

d. Chagas disease.

e. African trypanosomiasis.

f. Leishmaniasis.

g. Leprosy.

h. Strongyloidiasis.

i. Dengue fever.

43. **Splenectomy and reduced splenic function.** Candidates who have reduced splenic function (for example, partial splenectomy or splenunculus) who do not require regular prophylactic antibiotics or specific immunisations are FIT. Candidates who have had a splenectomy or have reduced splenic function for any reason who require regular prophylactic antibiotics or specific immunisations are UNFIT. This is due to the increased susceptibility to several potentially life-threatening infections which may be encountered during service life, such as Haemophilus influenzae, Neisseria meningitidis, malaria, Capnocytophaga canimorsus and babesiosis.

44. **Transplantation of organs**. Candidates in receipt of a transplanted organ[26] are UNFIT. This is due to the long-term risk of life-threatening infection, organ failure and / or transplant rejection. The condition poses a risk of sudden deterioration / incapacitation.

45. **Organ donors.** The following applies:

a. **Kidney.** Candidates who have donated a single kidney and have no other complications are FIT six months post-surgery, provided they meet the requirements of Annex F Renal and Urological Para 19.

b. **Bone marrow and peripheral blood stem cells.** Candidates who have donated bone marrow and / or peripheral blood stem cells and have no other complications are FIT one month post-surgery.

[26] Excluding blood transfusions

c. Candidates who have donated all or part of any other organ are to be referred to sSMES.

46. **Congenital lymphoedema.** All candidates with congenital lymphoedema are UNFIT due to functional limitation and risk of infection.

47. **Medically unexplained conditions and symptoms.** Candidates with medically unexplained conditions and symptoms that were functionally limiting, and which have been fully investigated are FIT provided they have been symptom free for two years and undertaken activities comparable with military service.