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Prisoner of War (POW) Protocol Examination
Comprehensive Version

Name: SSN:

Date of Exam: C-number:

Place of Exam:

Narrative: This is the protocol for conducting initial examinations on former POWs. Approach these veterans with the greatest sensitivity because the POW experience likely resulted in a great deal of psychological and physical trauma. Details about beatings, torture, forced marches, forced labor, diet, disease, brainwashing, extremes of hot and cold, and anxiety may be significant parts of the veteran's history; eliciting these details requires that one establish a trusting relationship with the veteran. Examine veteran for each disability/ disease/ condition veteran is claiming as a consequence of the POW experience. A former POW may be entitled to service connection for presumptive POW diseases; the worksheet contains a list of these presumptive diseases. Based on veteran's claim(s) and your findings, please refer to and follow additional worksheets to assure the examination provides information adequate for rating purposes.

Presumptive POW disabilities: If a veteran is a former prisoner of war, the following diseases shall be service connected if manifest to a degree of disability of 10 percent or more at any time after service:

- Psychosis.
- Any of the anxiety states.
- Dysthymic disorder (or depressive neurosis).
- Organic residuals of frostbite, if it is determined that the veteran was interned in climatic conditions consistent with the occurrence of frostbite.
- Post-traumatic osteoarthritis.
- Atherosclerotic heart disease or hypertensive vascular disease (including hypertensive heart disease) and their complications (including myocardial infarction, congestive heart failure, arrhythmia).
- Stroke and its complications.
- On or after October 10, 2008, Osteoporosis, if the Secretary determines that the veteran has posttraumatic stress disorder (PTSD).

If a veteran is a former prisoner of war and was interned or detained for not less than 30 days, the following diseases shall be service connected if manifest to a degree of 10 percent or more at any time after service:

- Avitaminosis.
- Beriberi (including beriberi heart disease).
- Chronic dysentery.

- Helminthiasis.
- Malnutrition (including optic atrophy associated with malnutrition).
- Pellagra.
- Any other nutritional deficiency.
- Irritable bowel syndrome.
- Peptic ulcer disease.
- Peripheral neuropathy except where directly related to infectious causes.
- Cirrhosis of the liver
- On or after September 28, 2009, Osteoporosis.

A. Review of Medical Records:

1. Include a review of VA Form 10-0048, *Former POW Medical History*, which the veteran should have completed, prior to conducting the examination.
2. Review the Social Survey.

B. Medical History (Subjective Complaints):

NOTE: If the veteran has had a previous protocol examination, only an interval history is required.

Comment on:

1. Past medical history, including childhood and adult illnesses. History of hospitalizations or surgery, reason or type of surgery, location and dates, if known. History of trauma, with type and date of injury and cause.
2. Family history.
3. Social history - state civilian and military occupations, including dates and locations. Describe use of alcohol, tobacco, and drugs.
4. Indicate the dominant hand and how determined (i.e., writes, eats, combs hair, etc.).
5. Symptoms of fever/chills, night sweats, malaise.
6. If there are flare-ups of any joint (including of spine, hands, and feet) or muscle disease, state the frequency, duration, precipitating factors, alleviating factors, and the extent, if any, per veteran, they result in additional limitation of motion or other functional impairment during the flare-up.
7. Comment on amount of weight lost as a prisoner. Record initial and release weights.
8. Describe initial symptoms, time of onset, course, and current symptoms of all presumptive POW disabilities found.
9. Describe current and relevant past treatments (specify type, frequency, duration, response, side effects).
10. If a neoplasm is or was present, state whether benign or malignant and provide:
    a. Exact diagnosis and date of confirmed diagnosis.
    b. Location of neoplasm
    c. Types and dates of treatment

d. For malignant neoplasm, also state exact date of the last surgical, X-ray, antineoplastic chemotherapy, radiation, or other therapeutic procedure. If treatment is already completed, provide date of last treatment and fully describe residuals. If not completed, state expected date of completion.

11. Conduct a complete system review, with a focus on symptoms related to the presumptive conditions, and comment on all positive symptoms.

C. Physical Examination (Objective Findings):

Address each of the following and fully describe current findings. Report any other significant physical abnormalities. The examiner should incorporate all ancillary study results into the final diagnoses.

1. **General**: Pulse, respirations, height, weight, maximum weight in past year, percentage of weight change in past year compared to baseline (average weight in the 2 years preceding onset of disease), body build, and state of nutrition.
2. **Blood Pressure:** (Per the rating schedule, hypertension means that the diastolic blood pressure is predominantly 90mm. or greater, and isolated systolic hypertension means that the systolic blood pressure is predominantly 160mm. or greater with a diastolic blood pressure of less than 90mm.)
    a. If the diagnosis of hypertension has not been previously established, and it is a claimed issue, B.P. readings must be taken two or more times on each of at least three different days.
    b. If hypertension has been previously diagnosed and is claimed, but the claimant is not on treatment, B.P. readings must be taken two or more times on at least three different days.
    c. If hypertension has been previously diagnosed, and the claimant is on treatment, take three blood pressure readings on the day of the examination.
    d. If hypertension has not been claimed, take three blood pressure readings on the day of the examination. If they are suggestive of hypertension or are borderline, readings must be taken two or more times on at least two additional days to rule hypertension in or out.
    e. In the diagnostic summary, state whether hypertension is ruled in or out after completing these B.P. measurements. If hypertensive heart disease is suspected or found, follow worksheet for Heart.

3. **Posture and gait**: Describe if abnormal.
4. **Skin:** If abnormal, describe appearance, location, extent of rash or lesions. If there are scars, including burn scars, describe the location, measurements (cm. x cm.), shape, depression, type of tissue loss, adherence, color difference, and whether there is tenderness, skin breakdown, or functional limitation of activity or motion due to the scarring. If there are scars, including burn scars, or other disfigurement of the head, face, or neck, follow the Scars worksheet. **(NOTE:** If

there are disfiguring scars of the head, face, or neck, obtain and submit **color photographs** of the affected area(s). Report nail abnormalities.

5. **Hemic and Lymphatic:** (Describe local or generalized adenopathy, tenderness, edema, suppuration, etc., as well as splenomegaly, hepatomegaly, signs of anemia or bleeding tendency, etc.).

6. **Head and neck**: Describe cervical adenopathy, carotid bruit, deformities, etc.

7. **Eyes**: Report corrected visual acuity, pupil reactions, gross visual fields**,** and retinopathy or other abnormality of fundus, eyelids, eyebrows, conjunctivae, etc. Eye abnormalities found or eye complaints require an examination by an Eye specialist.

8. **Ears**: Describe hearing loss, tinnitus, vertigo, status of tympanic membrane, pain, discharge, etc. Refer for an examination by a specialist as indicated.

9. **Nose, sinuses, mouth and throat**: Describe nasal vestibule, turbinates, polyps, signs of obstruction, position of septum. Describe mouth and tongue, gums, tonsils, uvula and palate, gross dental findings. For sinuses, describe any tenderness, purulent discharge, crusting, etc.

10. **Endocrine**: Describe neck mass or nodule, lid lag, exophthalmos, abnormality of hair or skin, effects of any endocrine condition on other body systems.
11. **Pulmonary**: Inspection, palpation, percussion, auscultation. Report abnormal breath sounds, pleural rub, prolonged expiration, etc.
12. **Cardiac**: Record heart sounds, including any extra heart sounds, rhythm, PMI. Indicate if there is evidence of congestive heart failure or pulmonary hypertension. **(NOTE**: A determination of METs by exercise testing may be required for certain cardiovascular conditions, and an estimation of METs may be required if exercise testing cannot be conducted for medical reasons. If there is evidence of a cardiovascular condition, or one is claimed, refer to appropriate worksheet(s).)
13. **Abdomen/gastrointestinal**: Report abnormal bowel sounds, ascites, mass, tenderness, guarding, hepatomegaly, splenomegaly, etc. If there is a hernia, describe type, location, size, whether complete, reducible, recurrent, supported by truss or belt, and whether or not operable. If there are hemorrhoids, state whether they are internal or external, whether bleeding or prolapse (state whether reducible) is present, and whether thrombosis or fissure is present. If there are periods of incapacitation due to a gastrointestinal condition, state total number of days of incapacitation (requiring bedrest and treatment by a physician) during the past 12-month period.
14. **Genitourinary**: For males, report abnormality of penis, testicles, epididymis, seminal vesicles, spermatic cord, and prostate gland. Include rectal examination. For both males and females, if there is a urinary fistula, describe extent of leakage and need for catheter or number of absorbent pads required per day.

15. **Gynecologic:** Report abnormality on pelvic examination of labia, introitus, vagina, cervix, uterus, adnexa, and ovaries. Include rectal examination. Perform Pap smear (if none within past year). If unable to conduct an examination and Pap smear, or if there is a severe or complex problem, refer to a specialist.
16. **Musculoskeletal**: If there is limitation of motion of one or more joints, a detailed assessment of each affected joint is required. Using a goniometer, measure the active range of motion in degrees. State whether there is objective evidence of pain on motion. After at least 3 repetitions of the range of motion, state whether there are additional limitations of range of motion and whether there is objective evidence of pain on motion. Also state the most important factor (pain, weakness, fatigue, lack of endurance, incoordination) for any additional loss of motion after repetitive motion. Report the range of motion after the repetitions. (See the appropriate musculoskeletal worksheet (feet, spine, etc.) for more details.)

    Describe spasm, atrophy, or other muscle abnormalities. For atrophy, report measurements bilaterally. Report any loss of muscle strength using the standard muscle strength grading system (0 = absent. No muscle movement felt; 1 = trace. Muscle can be felt to tighten, but no movement produced; 2 = poor. Muscle movement produced only with gravity eliminated; 3 = fair. Muscle movement produced against gravity but cannot overcome resistance; 4 = good. Muscle movement produced against some resistance, but not against "normal" resistance; 5 = normal. Muscle movement can overcome "normal" resistance.

    If there has been a fracture, describe location and any residuals, such as malunion, deformity, ankylosis, etc. If there has been an amputation, follow the Residuals of Amputation worksheet.
17. **Extremities:** Describe abnormalities such as ulcers, cyanosis, clubbing, stasis dermatitis, gangrene, trophic changes, varicose veins, calf tenderness, edema, and decreased or absent pulses. If there is edema, is it relieved by elevation of extremities?

    If foot problems exist, also report painful motion, swelling, callus, tenderness, instability, weakness, spasm, rigidity, and circulatory disturbance. Report foot or toe deformities such as pes cavus, hammertoes, or hallux valgus. If there if flatfoot: report whether there is pronation; the status of the arch; whether the weight bearing line is over or medial to the great toe; the Achilles, forefoot, and midfoot alignment; whether there is pain at rest or on manipulation; and whether a malalignment is correctable by manipulation.
18. **Endocrine**: Describe neck mass or nodule, lid lag or exophthalmos, abnormalities of hair or skin, or abnormalities of other body systems due to endocrine disease.
19. **Neurological**: Assess orientation and memory, gait, stance, and coordination, speech, cranial nerve functions. Assess deep tendon reflexes, pain, touch, temperature, vibration, and position, motor and sensory status of peripheral nerves. If neurological abnormalities are found on examination, or there is a history of seizures, refer to appropriate worksheet.

20. **Psychiatric**: Describe affect, mood, judgment, behavior, comprehension of commands, hallucinations or delusions, and intelligence. This is meant to be a brief screening examination. If a mental disorder is claimed, or suspected based on the screening examination, request a mental disorder or PTSD examination conducted by a specialist.
21. **Breasts**: Describe mass or diffuse nodularity, nipple abnormalities, gynecomastia, residuals of surgery, axillary lymphadenopathy, and skin abnormalities. Report whether there is a significant difference in size or contour between the breasts.

D. Diagnostic and Clinical Tests:

1. Include results of all diagnostic and clinical tests conducted in the examination report.
2. Review all test results before providing the summary and diagnosis.
3. Follow additional worksheets, as appropriate.
4. Request tests as indicated - e.g., parasite studies, X-rays of joints, pulmonary function tests, metabolic blood tests, ECG, etc. The diagnosis of degenerative or traumatic arthritis of any joint requires X-ray confirmation, but once confirmed by X-ray, either in service or after service, no further X-rays of that joint are required for disability evaluation purposes.

E. Diagnosis:

1. All laboratory and diagnostic tests should be completed and reviewed prior to completing the summary of findings.
2. The POW Physician Coordinator should complete summary of findings, diagnoses, and recommendations. The Coordinator should also express an opinion, with supporting reasons, concerning the relationship between the veteran's experiences as a POW and each current medical condition. If osteoarthritis is diagnosed, it should be clarified whether this is post-traumatic osteoarthritis, and, if so, whether it is related to the period of confinement.
3. State whether any specialist examinations are indicated and whether any have been requested.
4. For each condition diagnosed, describe its effect on the veteran's usual occupation and daily activities.
5. **Capacity to Manage Financial Affairs:** Mental competency, for VA benefits purposes, refers only to the ability of the veteran to manage VA benefit payments in his or her own best interest, and not to any other subject. Mental incompetency, for VA benefits purposes, means that the veteran, because of injury or disease, is not capable of managing benefit payments in his or her best interest. In order to assist raters in making a legal determination as to competency, please address the following:

   What is the impact of injury or disease on the veteran's ability to manage his or her financial affairs, including consideration of such things as knowing the

amount of his or her VA benefit payment, knowing the amounts and types of bills owed monthly, and handling the payment prudently? Does the veteran handle the money and pay the bills himself or herself?

Based on your examination, do you believe that the veteran is capable of managing his or her financial affairs? Please provide examples to support your conclusion.

If you believe a Social Work Service assessment is needed before you can give your opinion on the veteran's ability to manage his or her financial affairs, please explain why.

Signature: Date: