**ABSTRACT**

The Combined Joint Special Operations Task Force-Afghanistan (CJSOTF-A) Surgeon partnered with the Afghan National Army Special Operations Command (ANASOC) Surgeon to complete medical screening of a repatriated ANASOC soldier following a 2019 combined raid on a Taliban prison that freed 35 prisoners of war (POWs). This article discusses the presentation and management of the ANASOC POW while also providing a literature review of common pathologies within the POW population. The purpose of this document is to address a unique aspect of military medicine in the expectation that future military providers are prepared to receive repatriated soldiers and prepared to care for fellow prisoners should they themselves become captured.

**Keywords:** Afghanistan; Afghan Campaign 2001–; military medicine; warfare; war wounds; military personnel; prisoners; veterans; prisons; terrorism

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**Introduction**

Elements from US Army Special Forces and ANASOC conducted a raid on a Taliban prison in southeastern Afghanistan in early 2019. The operation resulted in the repatriation of 35 POWs that included an assortment of Afghan defense forces and civilians who were captive for as long as 11 months. While the captives described moving between different locations during their captivity, the area of the raid was characterized by elevations greater than 2000 m above sea level with average winter temperatures between –10°C and 0°C and summer temperatures between 15°C and 30°C. Soldiers on the raid documented that the captives wore chains around their ankles and wrists. The prisoners described having inconsistent shelter and a meager diet of beans, bread, and water. In separate interviews, they commented on physical abuse at the hands of their captors, which included frequent blunt trauma with fan belts, sticks, and metal rods.

The ANASOC POWs were returned to their corps headquarters for repatriation. The corps headquarters is the ranking command of Afghan Special Operations and the partner element of the CJSOTF-A. The ANASOC Surgeon (ANASOC SGN) did not have a protocol for the receipt of repatriated prisoners, prompting the CJSOTF-A Surgeon (CJSOTF-A SGN) to mentor proper medical screening and subsequent medical management of the freed soldiers. The purpose of this article is to describe this experience as a unique part of Special Operations medicine and provide a brief review of the literature to prepare battlefield providers for similar repatriations. The authors also seek to reinforce one of the common community values within Special Operations that derives from formal instruction on the principles of Survival, Evasion, Resistance, and Escape (SERE)—simply, you are not forgotten.

**Case Presentation**

The unanticipated arrival of a repatriated POW to ANASOC corps headquarters presented the CJSOTF-A SGN with a unique and challenging opportunity: conduct a medical screening for a patient who had spent months in captivity at the hands of the Taliban with very little time to prepare. The CJSOTF-A SGN immediately coordinated with the ANASOC SGN and communicated the importance of welcoming repatriated POWs back to the unit by addressing their physical and mental health. Mentorship of this process included brainstorming questions for a thorough medical history and discussion of potential management decisions. After introductions with the soldier, all personnel vacated the room except for the repatriated POW, the CJSOTF-A SGN, the ANASOC SGN, and two Dari linguists. The CJSOTF-A SGN asked the ANASOC SGN to proceed with his examination but in a change of plans he deferred to the CJSOTF-A SGN. The CJSOTF-A SGN immediately began a complete review of systems while considering further questioning. Following initial responses from the soldier, the CJSOTF-A SGN concentrated questioning on psychological, physical, and sexual abuse while in captivity; exposure to animal bites or scratches; diet; personal faith traditions; and social history.

The patient endorsed being fed very little during his incarceration. He denied physical, psychological, or sexual abuse at this time but later admitted to being persistently beaten with a fan belt. He noted having very itchy skin. The patient endorsed strong religious beliefs. A brief physical examination...
revealed a healthy appearing young man with no obvious signs of trauma. The ANASOC SGN believed the patient appeared depressed, but the linguists and CJSOTF-A SGN did not observe this finding. This disparity in clinical assessment was most likely due to unspoken communication and subtle signals and was not due to the language barrier. The CJSOTF-A SGN and ANASOC SGN ordered laboratory tests as available at the local clinic. These laboratory tests included urine, complete blood count, basic metabolic panel, malaria screening, and typhoid screening.

**Literature Review**

Reflecting on the haphazard nature of the experience, the authors sought to better understand the medical literature to enable evidence-based screening and management of future POWs. The majority of US medical research on war prisoners originates from the roughly 116,000 repatriated prisoners from World War II, 4500 from the Korean Conflict, and less than 600 from the Vietnam Conflict. The experiences from these conflicts are varied with one study articulating differences in outcomes even between the European and Pacific theaters of World War II. Additionally, individual characteristics of prisoners including age, education, and length of service have been shown to affect health outcomes. One prisoner of war and surgeon wrote about his experiences in a German camp and described how different diseases resulted from different “psychological and physical humiliations,” a division that serves as a suitable means for categorizing the spectrum of unique experiences. A different author stratifies physical stressors into four subcategories: weight change, nutrition, injuries at time of capture, and captivity injuries and illnesses. These divisions help frame how military medical personnel could approach screening recently repatriated prisoners.

The psychological ramifications of war imprisonment are significant. One author articulates the major sources of stress for POWs that can lead to psychological change: cycles of anxiety and relief, starvation and inadequate shelter, and indoctrination. These stressors have immediate and enduring health effects. Researchers have noted an immediate presentation of apathy that can begin to lessen within days of repatriation. Often more enduring, POWs experience greater symptoms of posttraumatic stress disorder (PTSD), and these symptoms are dose related to the severity of experienced trauma. Finally, there is a lifelong increased risk of suicidal ideation decades after imprisonment.

The descriptions of physical stress on POWs are harrowing: 60-mile death marches from Bataan, diets consisting of less than 750 calories a day, and extreme cases of physical torture including repeated blunt trauma to a prisoner’s stomach after artificial distention with water and forcing the eyelids of a prisoner open while staring at the sun for hours. These examples demonstrate the need for careful attention to diet, changes in weight, and incurred injuries. In cases of malnutrition, historical accounts demonstrate the potential of avitaminosis including pellagra, ariboflavinosis, and beri-beri with symptoms including scrotal and exfoliative dermatitis, ankle edema, ascites, atrophic glossitis, absence of deep tendon reflexes, optic atrophy, sensorineural deafness, and peripheral neuropathy. In evaluating the severity of these symptoms, long-term measures of morbidity associated with nutrition correlate to overall weight loss during captivity. Injuries during and after capture can derive from the environment or from torture. Malaria, dysentery, cholera, typhoid and parasites are common in captivity, and studies have demonstrated an increased risk of peptic ulcers, purportedly from stress and an increased incidence of H pylori infection. Imprisonment often includes physical restraints that can place repetitive constrictive pressure on extremities, and POWs have been found to have an increased incidence of long-term peripheral nervous system disorders. Other methods of confinement paired with disruptive articular trauma may contribute to the increased incidence of arthropathies and dorsopathies (Figures 1 and 2).

**Management**

In the case of this repatriated ANASOC soldier, the CJSOTF-A SGN provided recommendations for vaccinations and advised a referral for specialty and subspecialty evaluation at the national Army hospital in Kabul: infectious disease for endemic conditions, orthopedics for occult musculoskeletal injuries, and dermatology for pruritus within the context of long-term confinement. The ANASOC religious cultural advisor met...
with the soldier and provided religious counsel and tended to his spiritual needs. The CJSOTF-A SGN pressed the importance of a hasty connection with the Afghan medical system given the documented increased mortality of former POWs in the early postwar period. However, the resources available in the Afghan medical system significantly limit overall management. Another limitation is the lack of experience by ANASOC medical personnel in the evaluation and treatment of POWs. The CJSOTF-A SGN sought to address this limitation by mentoring the ANASOC SGN to provide guidance through formal policy. The ANASOC SGN indicated that no formal policy to guide medical providers in the repatriation of prisoners currently exists within any portion of the Afghan National Army Medical Command (ANA MEDCOM). The CJSOTF-A SGN has begun development of a policy framework for the ANASOC SGN that describes the importance of proper repatriation, the authorities of the medical examination, the appropriateness of a fitness for duty examination, and a checklist for a medical officer tasked to examine a repatriated POW.

Conclusion

Military medical providers face unique problems. Medically welcoming repatriated soldiers back into the force remains an important part of military operations despite their relatively rare incidences in the recent US conflicts. Additionally, the need for medical providers to consider the health consequences of captivity goes beyond repatriation. Literature from World War II demonstrates the possibility of captured medical providers being the sole source of medical care for fellow prisoners. Dunlop’s account of “Medical Experiences in Japanese Captivity” describes some of the 773 surgical interventions he oversaw while in captivity, often using the “cleanest nail that could be found” for a traction pin, hand-made catgut from the peritoneum of pigs and cattle, and intrathecal solutions of cocaine for lower extremity amputations. The ingenuity and dedication of captured physicians demonstrate why military medical providers must consider and understand POW medicine. Isolated from all support, military medical providers must be prepared to alleviate the suffering of their comrades. Providing good medical care will strengthen resolve and help soldiers keep faith in their fellow prisoners so they may come home alive and with honor.

Author Contributions

JF and MH conceived of the case report concept. MH oversaw the medical screening. JF conducted the literature review. JF and MH wrote and approved the final manuscript.

Disclosures

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Disclaimer

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References