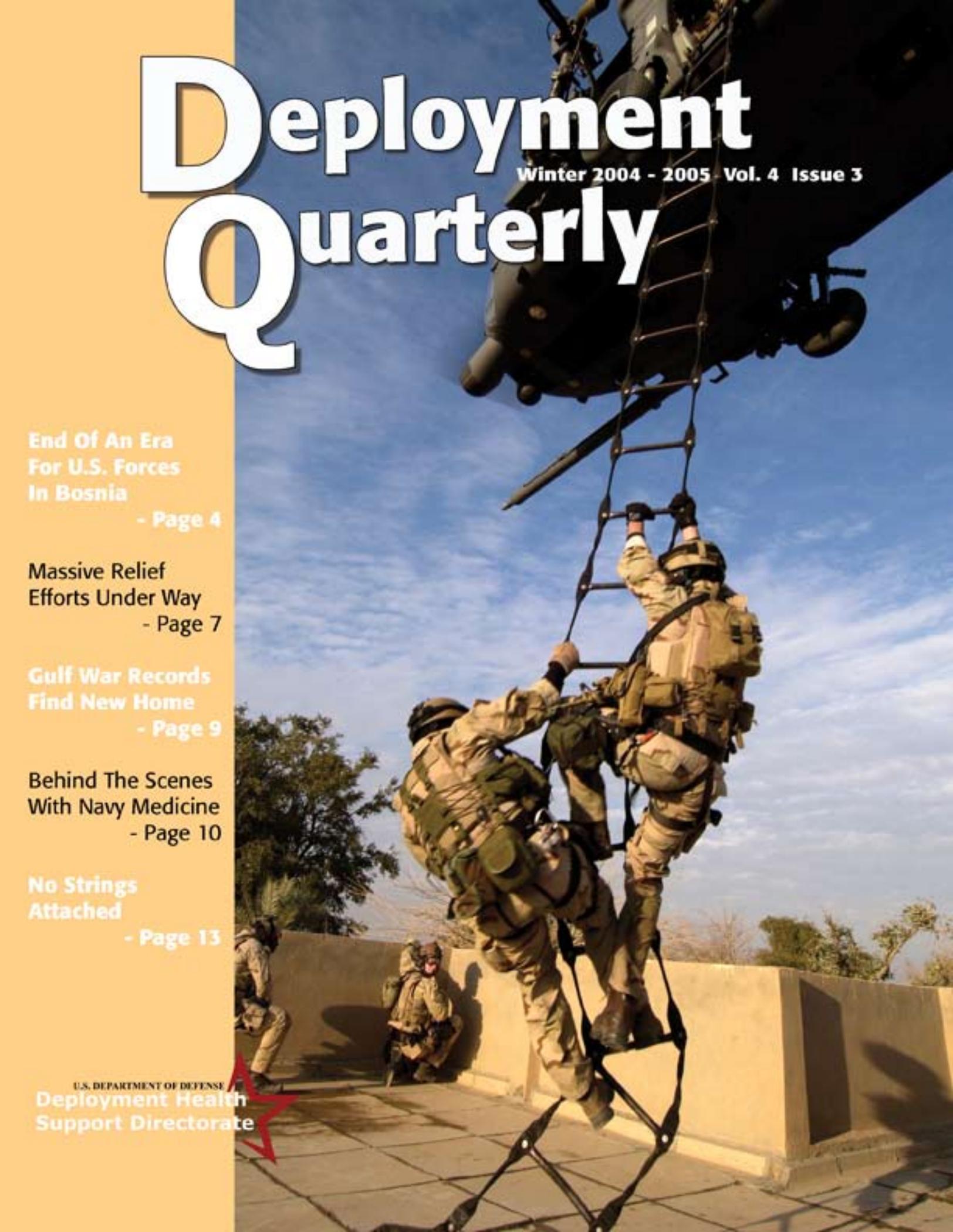


Deployment Quarterly

The background of the cover is a photograph of soldiers in camouflage gear rappelling down a rope ladder from the side of a helicopter. The helicopter is partially visible at the top, and the soldiers are in various stages of descent. The sky is blue with some light clouds. The ground below is a paved area with some trees and a wall in the distance.

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For U.S. Forces
In Bosnia**

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Efforts Under Way**

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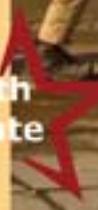
**Behind The Scenes
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U.S. DEPARTMENT OF DEFENSE
**Deployment Health
Support Directorate**

A red star logo is positioned to the right of the text, partially overlapping the yellow sidebar.

message

Dear Readers:

Today, more than 475,000 soldiers, sailors, airmen, Marines and Coast Guardsmen are deployed overseas and afloat. Many are fighting the war on terrorism and others are performing disaster relief duties. The members of Congress are elected to serve their constituents, which include members of the military and their families, and it is no surprise that Congress wants confirmation that the Department of Defense is doing all it can to protect the health of our deployed forces. As the deputy assistant secretary of defense for force health protection and readiness, I am often asked to keep Congress informed about what the Department of Defense is doing to protect the health of service members and how we are caring for those who become ill or injured.

Spring is the traditional time of the year when Congress calls upon DoD to brief various committees about a number of health related subjects. This is our opportunity to formally address Congressional concerns about the military health system, especially regarding medical care for the families of deployed service members, Reserve Component medical readiness and health care issues, deployment-related health threats and other subjects of interest. Key senior military and civilian DoD leaders testify and respond to questions during hearings held by the Senate and House Armed Services Committees, Defense Appropriation Committees and subcommittees, Veterans Affairs Committees and others who have legislative oversight on military health issues. While the committee members often ask tough questions, these hearings are a forum for the department to present its initiatives and program requirements to effectively implement our force health protection policies.

Additionally, we interact with Congress routinely throughout the year. We often respond to questions the legislators forward from their constituents. We also offer to provide periodic briefings to Congressional members and their staffs on various topics that relate to force health protection. Some recent topics of these briefings include the main recommendations of the depleted uranium capstone study and the pre-deployment and post-deployment health trends arising from assessments performed since the inception of Operations Enduring Freedom and Iraqi Freedom.

In the 2005 National Defense Authorization Act, Congress has enacted several of DoD's newest force health protection policies. These include the permanent extension of transitional health care benefits for Reserve Component members, additional requirement for pre-separation physical examinations, new requirements for medical record keeping and a single policy for meeting mobilization-related medical care needs at military installations. Annual reports to Congress were established to report the status of our medical readiness tracking, health surveillance and force health protection and readiness programs. When those reports are delivered to Congress, we will also post them on *DeploymentLINK* to also inform you about what has been accomplished.

We are making significant progress in delivering a world-class health system for our total force, and have laid the groundwork for even greater progress in the near future.

Sincerely,

Ellen P. Embrey
Director, Deployment Health
Support Directorate



Deployment Quarterly

The Deployment Health
Support Directorate

Volume 4 Issue 3

Director, Deployment Health
Support Directorate
Ellen P. Embrey

Deputy Director, Deployment Health
Support Directorate
Michael E. Kilpatrick, M.D.

Program Director, Deployment
Health Outreach
Barbara A. Goodno

Public Affairs Team Leader
Robert Dunlap

Editor
Lisa A. Gates

Staff Writers
Austin Camacho
Joan Kennedy
Rebecca Gattoni
Harrison Sarles

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Deployment Quarterly
5113 Leesburg Pike, Suite 901
Falls Church, Virginia 22041

Phone: (800) 497-6261
Fax: (703) 824-4229
E-mail: specialassistant@deploymenthealth.osd.mil

The editor reserves the right to edit all manuscripts for readability and good taste.

LETTERS: Letters to the editor must be signed and include the writer's full name, city and state (or city and country) and mailing address. Letters should be brief and are subject to editing.

AUTHORIZATION: *Deployment Quarterly* is an authorized publication for past and present members of the Department of Defense. Contents of *Deployment Quarterly* are not necessarily the official views of, or endorsed by, the U.S. Government, the Department of Defense or the Deployment Health Support Directorate.

winter 2005



Soldiers with the 30th Heavy Separate Brigade, North Carolina National Guard arrive at Pope Air Force Base, N.C., after a 10-month deployment to Iraq.

U.S. Air Force photo by Tech. Sgt. Brian Christiansen

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Behind The Scenes. Navy surgeons, nurses and corpsmen treat wounded Marines and Iraqis following December battles.

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On the Cover

BAGHDAD, Iraq — Air Force pararescuemen are extracted from an abandoned housing site by an HH-60G Pave Hawk helicopter. The airmen are assigned to the 64th Expeditionary Rescue Squadron.



U.S. Air Force photo by Staff Sgt. Shane A. Cuomo

Chief Master Sgt. of the Air Force Murray Shares Insight On Fitness

by tech. sgt. cindy dorfner
100th air refueling wing public affairs

Almost a year into the Air Force's new fitness program, the service's senior enlisted Airman said he is happy with some things, but said the program is "not where it needs to be yet." "[Air Force chief of staff Gen. John P. Jumper and I] are pleased, but we're not so naïve to think you can change a culture in one year," said Chief Master Sgt. of the Air Force Gerald R. Murray.

The chief said Air Force fitness centers have seen a 30-percent increase in usage in the past year.

"As we go around bases today, we're seeing much more activity. People are out running, and they're in the gym," he said. "Airmen tell me they're in the best shape they've ever been, and they feel a lot better."

The chief said more emphasis is being placed on fitness resources, such as new and renovated fitness centers and getting the right equipment in the facilities.

"But," Murray said, "you don't need special equipment to go out and run, and do push ups and crunches. It does help to have weights and treadmills and those sorts of things available to use and increase fitness levels."

What will also help, he said, is for Airmen to incorporate this lifestyle change into their normal schedules.

"The program hasn't been fully embraced enough. Some have taken the test, and they've put too much emphasis on the test instead of making working out a part of the normal routine," the chief said.

"I asked a first sergeant about his squadron's fitness

program. He said, 'Well, we've just about got everyone tested.' I said, 'OK, but tell me about your physical fitness program. I want to know what you're doing to get people out there to work out.' He couldn't tell me," Murray said.

The program is more than just a test, the chief said. With the number of Airmen deployed to combat environments, it is about readiness and being able to function in austere conditions. He also said it is important for Airmen to maintain a good, healthy lifestyle to fend off disease and medical problems.

While Airmen adapt to the new lifestyle of being fit to fight, the fitness program has been under review during its inaugural year. Murray said there will be some changes, but not many.

"I can tell you what not to expect, and that is major changes. The test will not become easier than it is," he said. "This program is about what it takes to maintain a good fitness level."

One change Airmen can expect deals specifically with the Air Force instruction governing the program. The chief said the instruction will make clearer the actions commanders can take toward those not meeting the standards.

However, Murray said, Air Force leaders must make sure the instruction and standards are "right for our people." ■

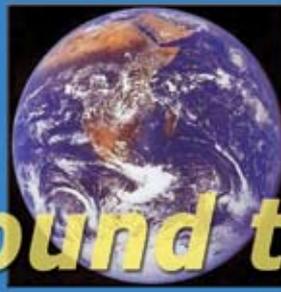
Editor's Note: Chief Master Sgt. of the Air Force Gerald R. Murray represents the highest enlisted level of leadership, and as such, provides direction for the enlisted corps and represents their interests, as appropriate, to the American public, and to those in all levels of government. Chief Murray is the 14th chief master sergeant appointed to the highest noncommissioned officer position.



Worth Repeating

"If you look at the front pages of many papers, you'll see pictures of U.S. military personnel rescuing people, delivering food and water, assisting with emergency medical types of assistance."

— Secretary of Defense Donald Rumsfeld about DoD's tsunami relief efforts in South Asia, the situation in Iraq, military transformation and Americans supporting the troops during radio interviews from the Pentagon on Jan. 4.



News from Around the World

Memo Improves Job Protections for Guardsmen, Reservists

Attorney General John Ashcroft and Labor Secretary Elaine L. Chao signed a memorandum of understanding in September 2004 to ensure that the employment rights of men and women returning from military service are vigorously protected.

The memorandum streamlines and strengthens enforcement of the Uniformed Services Employment and Reemployment Rights Act of 1994, commonly known as USERRA. Congress passed USERRA to safeguard the employment rights and benefits of service members upon their return to civilian life.

The memorandum deals exclusively with each department's role and responsibilities in the enforcement of USERRA. The attorney general has delegated his USERRA responsibilities to the Civil Rights Division of the Department of Justice and the U.S. Attorneys' offices.

The Department of Labor has delegated its USERRA responsibilities to the Veterans' Employment and Training Service and the Office of the Solicitor.

The memorandum will streamline the enforcement process, allowing the two agencies to work closely and effectively to ensure the protection of USERRA rights.

To read more about the memorandum, go to http://www.defenselink.mil/news/Sep2004/n09302004_2004093008.html.

More information about USERRA can also be obtained on the Internet at <http://www.osc.gov/userra.htm> or on the Department of Labor Veterans' Employment and Training Service Web site at <http://www.dol.gov/vets/>. ■ The Department of Veterans Affairs has

Enlisting Snowmen 'Soldiers'



Photo by Staff Sgt. Bradley Rhen

Soldiers from Battery B, 3rd Battalion, 7th Field Artillery Regiment, put the finishing touches on a snowman Dec. 29, 2004, at Forward Operating Base Orgun-E, Afghanistan, after a foot of snow fell on the base.

New Veterans ID Cards Help Battle Identity Theft

The VA designed a new identity card for veterans that will safeguard confidential information.

The card, formally known as the Veterans Identification Card, or VIC, will have veterans' photos on the front and identify them as enrollees in the VA's health care system. The card includes the words "service connected" under the photo if the veteran has a service-connected disability.

Identity theft is one of the fastest growing crimes in the nation. The Federal Trade Commission listed identity theft as the number one fraud reported by consumers in 2003. Requests from veterans and their congressional representatives were instrumental in bringing about these latest changes.

Veterans should request the new card at their local medical center. Processing will take five to seven days once eligibility is verified. The existing cards will remain valid until veterans receive their new cards. ■

Military W-2s Make it Easier to Determine Tax-Credit Eligibility

The 2004 W-2 forms for military members will now report pay earned while serving in combat zone tax-exclusion areas.

This information will allow members to better determine their eligibility for two credits to their federal income tax payments, the Earned Income Tax Credit and Child Tax Credit, officials said.

The combat zone pay information will be listed separately in Block 14 of the member's W-2 form and will not be included with taxable wage information.

The tax credit qualifications are based on gross income, which includes pay earned while in a tax-exclusion area. The addition of this information on 2004 W-2s will help determine whether a member meets the IRS requirements for Earned Income Tax Credit and Child Tax Credit and which method of computing taxes is most advantageous to each member's individual situation.

The 2004 W-2s will be available mid- to late-January. Visit "myPay" online at <https://mypay.dfas.mil/mypay.aspx> to check availability.

For more information on these or other tax issues, contact your unit tax adviser or finance office.

Information is also available in the Armed Forces Tax Guide 2004 online at <http://www.irs.gov/pub/irs-pdf/p3.pdf> and on the IRS Web site at <http://www.irs.gov>. ■

Defense Act Increases Pay, Provides Benefits

President Bush recently signed the \$420.6 billion National Defense Authorization Act. The act funds a 3.5 percent increase in pay for service members and raises the basic allowance for housing. It also makes permanent increases in hostile fire and imminent danger pay to \$225 per month, and in family separation pay to \$250 per month.

On the medical side, it provides for up to 90 days of TRICARE coverage for reservists and their families who are mobilized. It also authorizes 180 days of transitional TRICARE health benefits for Reservists, active

duty members and their families after separation from active duty. In addition, members of the selected Reserve earn a year's eligibility for TRICARE for each 90 days of service in a contingency.

For more information, go to the http://www.defenselink.mil/news/Nov2004/n11012004_2004110105.html.

Strategic Forces Authorized Service Medal for Troops

The commander of U.S. Strategic Command has authorized the Global War on Terrorism Service Medal for all service members assigned, attached or mobilized to the command for at least 30 consecutive days on or after Sept. 11, 2001.

The medal is awarded to people involved in supporting operations against terrorism anywhere in the world. It is worn after the Global War on Terrorism Expeditionary Medal. Both follow the Kosovo Campaign Medal. Only one award of this medal may be authorized for any individual; therefore, there are no service stars. ■

End of an Era

U.S. Peacekeepers Finish Bosnia Mission, Case Colors

by jim garamone
american forces press service

The last U.S. peacekeeping troops in Bosnia are gone, as NATO turned over control of operations in the country to the European Union.

A ceremony Nov. 24, 2004, officially marked "mission complete and mission accomplished," said Gen. B.B. Bell, commander of U.S. Army Europe. The NATO countries decided to end the peacekeeping mission during the Istanbul Summit in June 2004.

Task Force Eagle cased its colors during a ceremony at the American

headquarters in Tuzla, Bosnia.

More than 100,000 U.S. personnel served in Operation Joint Endeavor since U.S. troops first crossed the Sava River at the end of December 1995. Thousands more supported the servicemembers from bases in Italy, Germany and Hungary. The 1st Armored Division, which has recently returned from Iraq, was the lead in that operation.

In late 1995, more than 60,000 NATO troops poured into Bosnia following the signing of the Dayton Peace Accords on Dec. 14, 2004.

Since NATO moved into the country, the number of troops on duty there has steadily decreased. As the European Union Force takes charge, there are 7,000 NATO troops in the country — with only 700 Americans.

EUFOR, as the new group will be



known, will maintain the 7,000-member force level for the time being. ■

Q I've read in the news that there is now a surplus of flu vaccine. Is this true for DoD's flu vaccine supply as well? Who should be getting the flu shot, and when does the flu season end?

A When we learned of the shortage of the influenza vaccine last October, we had to balance military readiness requirements with protecting our most vulnerable beneficiaries from influenza. Since then, we have shipped vaccines to our deployed forces all over the world and have vaccinated service members who were deploying overseas in the Global War on Terrorism. We have also vaccinated many of our beneficiaries who fall into one of the high-risk categories specified by the CDC. However, many of our high-risk patients have chosen not to come in and get a flu shot this year, leaving military treatment facilities with surplus vaccine. Across the nation,

community health departments are finding that they also still have influenza vaccine available because people are not coming in to get immunized.

Most likely this is because of the relatively mild influenza season so far, along with concerns that there would not be enough vaccine for everyone.

The Centers for Disease Control and Prevention report that only 34 percent of people in the high-risk groups have been vaccinated. This is raising concern among health care professionals – both military and civilian – that some of the vaccine may go unused this year despite the shortage at the beginning of the season. For this reason, we are aggressively continuing to seek to vaccinate our medically high-risk beneficiaries, who rely on military medical treat-



Lt. Col. (Dr) Stephen Phillips, D.O., MPH

ment facilities for their care. The CDC guidelines for who should still be vaccinated are as follows:

- All children aged six to 23 months.
- Adults aged 50 and older.
- Persons aged two to 49 years with underlying chronic medical conditions.
- All women who will be pregnant during the

- influenza season.
- Children aged 6 months-18 years on chronic aspirin therapy.
- Out of home caregivers and household contacts of infants less than six months of age
- Anyone who has regular contact with a person in one of the other risk categories.

The most common time for the flu to peak is in February, but the flu season runs through April. Vaccination now will still protect you from influenza. DoD strongly encourages

— Continued on Page 6

vaccines DRUGS & HERBS

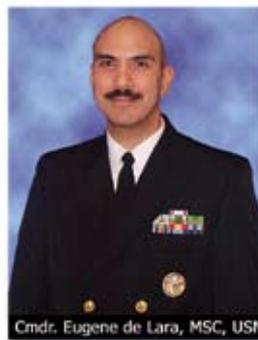
Q I am deploying to an area that does not have robust medical assets and I am particularly concerned about the medications my civilian doctor prescribed before my anticipated deployment. What options do I have to ensure I can continue my medications?

A question is not uncommon. You may be surprised that many of our service members — active duty and Reserves Component members — are on a variety of medications to control chronic conditions, such as high blood pressure, high cholesterol, and arthritis to name a few. While the costs of medications continues to rise annually, it is still significantly

more cost effective to treat medical conditions with medications, rather than the consequences of not treating those conditions.

Today the Department of Defense has a comprehensive program that gives you options for getting your prescription medications. They are:

- 1) The Medical Treatment Facility pharmacy, which typically will give you a three month supply of your medications.
- 2) The TRICARE Retail Pharmacy, or TRRX, program, which include a network of major retail pharmacies such as CVS, Rite-Aid, Giant, Wal-Greens, etc.,.
- 3) The TRICARE



Cmdr. Eugene de Lara, MSC, USN

Mail-Order Pharmacy which is operated by Express Scripts, Inc.

For your situation, I would suggest using a combination of the above list. You could have your provider give you a prescription for a three-month supply and have it filled at the military treatment facility, and then register with Express Scripts to have your refills mailed to you under the TRICARE Mail-Order Pharmacy program.

Naturally, some medications would have restrictions. However, you probably wouldn't be deploying if you couldn't

— Continued on Page 6

Policy Changes Help Wounded Troops Stay in Service

by rudi williams
american forces press service

Fundamental changes have taken place in the Defense Department's disability policy, a top Pentagon official told attendees at the 17th DoD Disability Forum held in Bethesda, Md., last December. John M. Molino, acting deputy undersecretary of defense for equal opportunity, cited a December 2003 visit by President Bush to Walter Reed Army Medical Center in Washington, when the president noted advancements in medical treatment and recovery allow many

more wounded service members to resume their careers.

"Today, if wounded service members want to remain in uniform and can do the job, the military tries to help them stay," Molino recalled the president telling the patients.

"This statement, this attitude," Molino continued, "has implications for everything from accessibility policy on military installations to the long-standing expectation that every active duty service member must be able to deploy to combat anywhere in the world. We're re-examining our basic assumptions, and basic changes are on the way."

The department is committed to doing all it can to bring those changes about, Molino told the group. "We're moving aggressively to help service members remain on active duty if they wish to do so," he said. "This is the news in DoD disability policy today."

Noting that with Defense Secretary Donald H. Rumsfeld wholeheartedly supporting keeping capable service members in the DoD fold, Molino said defense personnel officials also are looking for ways to improve opportunities for veterans with disabilities in DoD's civilian work force. ■

Ask the Doc

— Continued from Page 5
those in one of the risk categories who have not gotten their flu shot yet, to do so now.

Additionally, the department has opened up influenza vaccines to persons not in the high-risk category who desire to avoid influenza this year. Vaccine sitting on a refrigerator shelf will do no public health good, so we are making every attempt to fully utilize the limited vaccine that we have this year.

Both colds and flu can be passed from person to person through coughing, sneezing and touching surfaces such as doorknobs and telephones and keyboards. So, wash your hands often.

The CDC recommends regular

scrubbing of your hands with warm, soapy water for about 15 seconds. Touching your nose, mouth, and eyes with contaminated hands makes it easy for cold and flu viruses to enter the body.

Also, remember to cover your cough, but not with your hands. Muffling coughs and sneezes with your hands allow germs and viruses to cling which results in passing along your germs to others. When you feel a sneeze or cough coming, use a tissue, then throw it away immediately. If you don't have a tissue, turn your head away from people near you and cough into the air.

Also, don't touch your face. Cold and flu viruses can enter your body through the eyes, nose, or mouth. Touching their faces is the major way children catch colds, and a key way

they pass colds on to their parents.

Another way to prevent colds and the flu is to practice healthy habits. Get plenty of rest, eat a balanced diet, drink plenty of fluids and exercise.

These simple measures, along with vaccination, will help keep you healthy this influenza season. ■

***Editor's Note:** Army Lt. Col. (Dr.) Stephen C. Phillips, D.O., M.P.H., is an Army family practice physician who is currently serving as the director of deployment medicine for force health protection and readiness in the office of the assistant secretary of defense for health affairs.*

Mail Order

— Continued from Page 5
condition required drugs in these categories. Since you have been recalled to active duty, there are no costs for you to use the mail order program. They have done an outstanding job making the mail order pharmacy program convenient for those of you that will be on deployment. You can order your refills by phone, mail, or online and your prescriptions will be mailed to any U.S. postal address, including temporary

addresses, APO and FPO. If you are assigned to an embassy with no APO/FPO address, just use the official Washington, D.C., address.

For more information about the Department of Defense TRICARE Mail-Order Pharmacy program, go to <http://www.express-scripts.com>. There is an excellent frequently asked questions section at this Web site that will probably answer all the questions you may have about this program.

And finally, I always recommend staying in close contact with your

unit's medical assets. Who knows, maybe they have the medicine that you need or can get it easily. ■

***Editor's Note:** U.S. Navy Cmdr. Eugene de Lara is the Assistant Head in the Pharmacy Department at the National Naval Medical Center in Bethesda, Md. Prior to this assignment, he was deployed to Iraq for six months.*



Banda Aceh, Sumatra — Sailors from the USS Abraham Lincoln (CVN 72) Carrier Strike Group carry off injury civilians from a U.S. Navy helicopter at Muda Air Base. The Lincoln Strike Group is providing sealift and airlift capabilities as well as vast numbers of volunteers and supplies to the relief effort.

U.S. Navy Photo by Photographer's Mate 1st Class Alan D. Monyelle

Massive Relief Mission Supports Tsunami Victims

by donna miles
american forces press service

The largest humanitarian relief effort since the Berlin Airlift in 1947 is providing desperately needed water, food and medical supplies to victims of the tsunami in the Indian Ocean, the general coordinating air support for the operation told reporters.

U.S. Air Force Brig. Gen. Jan-Marc Jouas, director of the Combined Support Force Air Component Coordination Element based in Utapao, Thailand, called the relief effort "a monumental task" but said he is impressed by the extent of the international response and the speed with which it has come together.

Tremendous distances between the affected nations and destruction at many airfields following the devastating Dec. 26, 2004, tsunami have challenged the relief effort, Jouas said. However, C-130 transport aircraft are currently able to land at one site in Sri Lanka, three in Thailand and three in Indonesia. From these sites, as well as airfields in Kuala Lumpur, Malaysia, and Singapore, rotary-wing aircraft and trucks are then ferrying relief supplies to tsunami victims.

In addition, the U.S. Navy is playing a big role in

delivering supplies in ship-to-shore operations that eliminate the need to use damaged or overcrowded airfields.

Jouas said the search continues for more runways to expand the airlift support to the region.

During Sunday morning talk shows, Secretary of State Colin Powell stressed that the United States must plan to give long-term support to the region during the long recovery period ahead.

"This is a long-term prospect," Powell said on ABC's "This Week" following his visit to the region in January. He told President Bush during a Jan. 10 meeting at the White House that the United States must help fund not just "immediate humanitarian relief, ... but also infrastructure development."

Powell also told CNN's "Late Edition" he is confident the president will be willing to increase the United States' current \$350 million pledge for disaster relief to the region, if deemed necessary over time. However, he said it's important to continue assessing need to avoid flooding the area too quickly with more supplies and more financial assets than are yet needed for rebuilding.

Rebuilding timetables will vary
— Continued on Page 8



Researchers Say Screenings Needed Four Months After Redeployment

by karen fleming-michael
fort detrick, md.

Asking most soldiers who have just returned home from a deployment if they're feeling "downhearted and blue" is

probably from a month later, though, seems to be the ticket to getting warfighters the help they need for combat-related depression, said Army Lt. Col. Paul Bliese, commander of the U.S. Army Medical Research Unit-Europe in Heidelberg, Germany. The research unit screened returning troops in Italy first at reintegration and again at 120 days and found that more soldiers needed help after they had been home for a while.

"They spent a year in Iraq, they're back, they're alive, there's a huge celebration. Then, three months into it, life intervenes. All of a sudden, they're having to deal with going to work every day and having to deal with the responsibilities of being a parent, spouse and a soldier," he said. "I think that's when these problems really start to come out."

A study reported in the "New England Journal of Medicine" in July 2004 said that 15.6 to 17.1 percent of military members who served in Iraq or Afghanistan typically screened pos-

itive for a mental disorder when they were surveyed three or four months after they got back to their home installation. The study was conducted by researchers at the Walter Reed Army Institute of Research, parent organization to the U.S. Army Medical Research Unit-Europe.

While conducting research on a psychological screening tool, the research team from Heidelberg, led by Dr. Kathleen Wright, surveyed troops within their first two weeks of returning to Italy after serving in Iraq. They came up with a 6.5 percent positive rate for mental disorders for the 1,604 soldiers they screened.

Warfighting commanders — most notably Army Col. William Mayville, commander of the 173rd Brigade, and Army Maj. Gen. Thomas Turner II, Southern European Task Force commander — noted that something just wasn't right with those numbers, said Army Col. Richard F Trotta, commander of the clinic at Vicenza, Italy.

So Trotta asked the research unit to screen the soldiers again 120 days after their return.

"We did that and, not surprisingly, those rates went back up to something closer to what was published" in the "New England Journal of Medicine", Trotta said.

In fact, the rates were exactly 15

percent, Bliese said, adding that to be fair some of the increase might reflect the fact that different procedures were used at the latter time. The best indication of how soldiers' responses changed came from 509 soldiers who provided data both times.

"I think it is remarkable that these warfighters [Mayville and Turner] completely understood the significance of the evaluation and were concerned enough to fully support the follow-up evaluation at 120 days," Trotta said. "Without their support, it would never have happened."

The responses from these soldiers showed marked increases in psychological symptoms.

"Overall, 80 to 85 percent of the people do fine, but 15 to 20 percent of people fairly consistently seem to be showing some problems at 90 to 120 days," he said. "These are resolvable, so in no way do we think we're going to lose 15 to 20 percent of our population on redeployment. But these 15 to 20 percent are saying 'My relationship with my spouse has really gone to hell since I've been back; I've started to drink too much, and I need to dry out.'"

To quickly screen hundreds of soldiers, the Heidelberg researchers used their psychological screening tool that

— Continued on Page 18



U.S. Navy photo by Photographer's Mate 2nd Class Seth C. Peterson

Flight deck personnel fill water jugs on the flight deck of USS Abraham Lincoln (CVN 72) for tsunami survivors on Jan. 9, 2005. The Lincoln's distilling plant can produce 400,000 gallons of water a day.

Relief Efforts

— Continued from Page 7 throughout the region, Powell said. Banda Aceh, Indonesia, one of the hardest-hit areas, will take "years" to rebuild after much of it "was scraped to the ground," the secretary said. Other areas will return to relative normalcy much more quickly, he said.

In addition to delivering water, food and medical supplies, the relief effort is also focused on providing sanitation and shelter for

some 1.5 million people left homeless following the Dec. 26 disaster, according to Tom Fry from the U.S. Agency for International Development.

Fry, who leads U.S. Agency for International Development's disaster assistance response teams, said the relief effort will soon become a rehabilitation effort. Rebuilding people's livelihoods is as important to their long-term survival as rebuilding homes, he said. ■



Capstone Report Concludes Little Health Risk From Depleted

by austin camacho

Five years ago, the Department of Defense set out to determine the depleted uranium exposure levels for those service members in, on, or near an armored vehicle when it is perforated by a depleted uranium munition. On Oct. 18, 2004, DoD released the report, "Depleted Uranium Aerosol Doses and Risks: Summary of U.S. Assessments," detailing the results of the testing conducted, and the health risk assessment.

The conclusions of the Capstone Depleted Uranium Aerosol

Characterization and Risk Assessment Program indicate that the chemical and radiological risks to human health of inhaling depleted uranium aerosols in a perforated vehicle are low. If the onboard vehicle ventilation system is operating during or soon after a depleted uranium perforation, exposure received by the crew-members is virtually eliminated.

The director of the Capstone Depleted Uranium Program, U.S. Army Lt. Col. Mark Melanson, Ph.D., briefed representatives of several military and veterans service organizations on the study conclusions. Melanson is the Program Manager

for Health Physics at the U.S. Army Center for Health Promotion and Preventive Medicine.

Sponsored by the Army and the Defense Department's Deployment Health Support Directorate, the program was designed to provide a peer-reviewed, rigorous scientific estimate of the health risks to military personnel in and around armored vehicles penetrated by large caliber depleted uranium munitions. The conclusions of the program indicate that the chemical and radiological risks to human health from inhaling depleted

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Thousands Of Gulf War Medical Records Find New Home In St. Louis

story and photo by austin camacho

After the 1991 Gulf War, veterans expressed concerns about possible health effects related to their service. In response to those concerns, the Department of Defense initiated the Comprehensive Clinical Evaluation Program. The program provided in-depth medical examinations to approximately

40,000 service members and family members before a broader program replaced it. In September 2004, DoD moved the archived records of the CCEP from the National Archives and Records Administration in Washington, D.C., to the National Personnel Records Center in St. Louis, Mo.

"We are the personnel data center for military records," said Eric Voelz of the National Personnel Records Center. "We are working to get other record collections here: military personnel files, military medical records, and now the CCEP records."

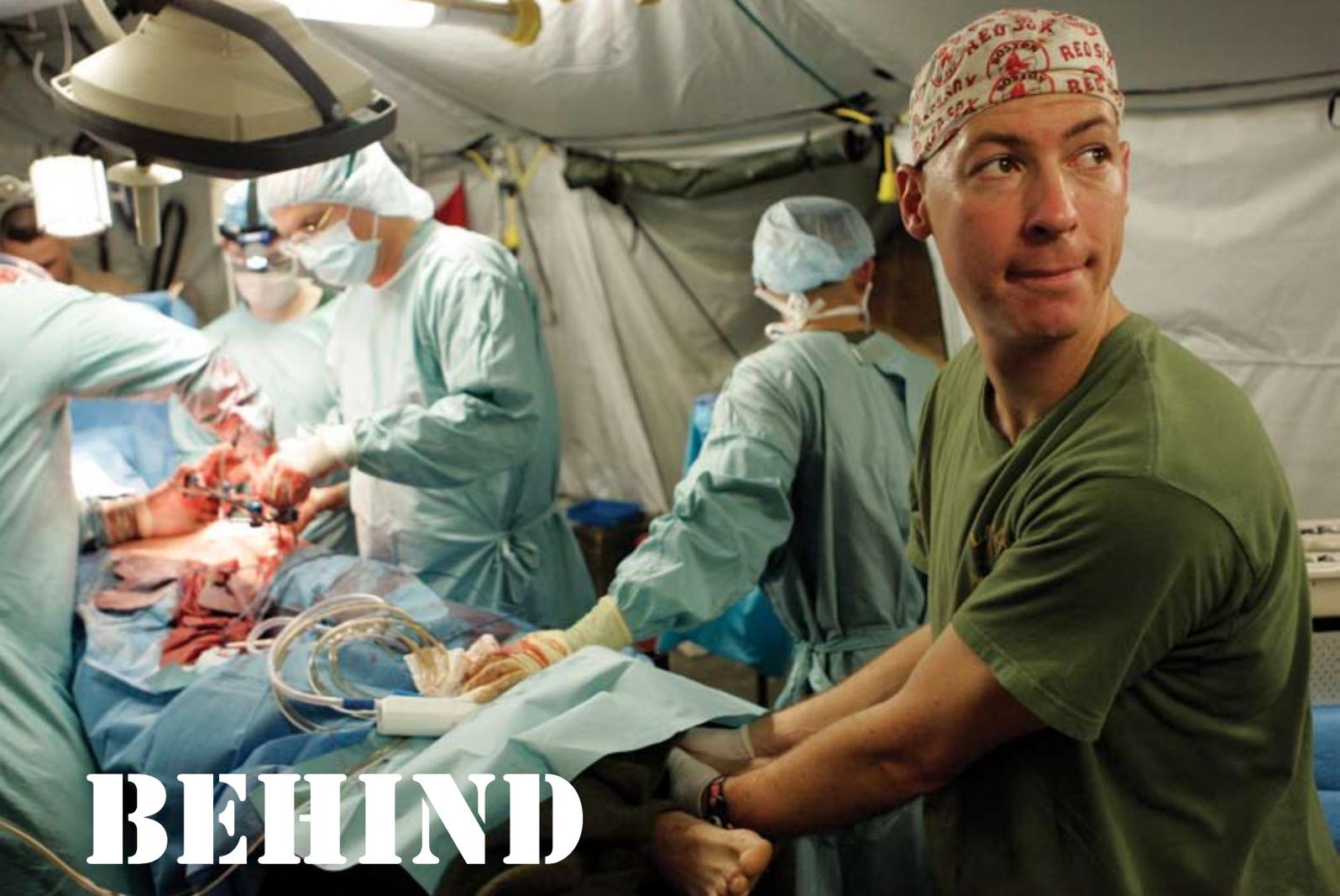
The Comprehensive Clinical Evaluation Program offered medical exams to any Gulf War veteran who wanted them, but participation in the program was voluntary. Some service members were concerned that illnesses revealed during these medical examinations might

damage their military careers. In order to encourage Gulf War veterans to participate in the program, exam results were kept separate from mainstream medical records unless the service member requested otherwise.

Those separate records — some 760 boxes, each holding about 50 records — now reside with other military records at the National Personnel Records Center. Unlike most other records, this set won't grow. In February 2002, new enrollments into Comprehensive Clinical Evaluation Program ceased, when the Deployment Health Clinical Center became responsible for coordinating evaluations of veterans seeking care for post-deployment health concerns.

These 15 pallets of personal medical
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BEHIND

THE SCENES

Surgical Unit Treats Fallujah's Casualties

by staff sgt. jim goodwin
1st force service support group

As Marines stamp out remaining pockets of insurgents in Fallujah, a different battle is being fought at Camp Taqaddum in Iraq — the battle to save lives.

In the first six days of the December 2004 offensive, the 63 surgeons, nurses, corpsmen and other personnel of the Surgical Shock Trauma Platoon treated 157 patients, including 29 Iraqis and performed 73 operations.

By comparison, the Surgical Shock Trauma Platoon treated 63 patients in September, and 122 patients in October. During the first week of November, the Surgical Shock Trauma Platoon treated 132 casualties.

The Surgical Shock Trauma Platoon is one of three major immediate surgical and trauma care teams assigned to Marine forces operating in Iraq. The other two are Alpha and

Bravo Surgical Companies, located in Al Asad and Camp Fallujah, Iraq, respectively.

All three facilities fall under the 1st Force Service Support Group, which provides all logistical support to the 31,000 Marines, sailors and soldiers operating in the Al Anbar Province of Iraq.

In the days leading up to combat operations in Fallujah, the staff began preparing for the expected ad-



ditional casualties.

They staged "push packs" — large containers of medical supplies needed for surgery. Additional medical personnel were brought in from other units in Iraq. The blood supply was increased by 50 percent, courtesy of Marine donors. Medical equipment was repaired and serviced. Extra tents were available to house extra patients.

The stage was set, and the Marines' medical personnel were ready.

"We can do 'damage controlling, death cheating' surgery here," said Navy Lt. Charles L. Cather, one of Surgical Shock Trauma Platoon's operating room nurses.

"Damage Controllin', Death Cheatin'" is the unit's catch-phrase for their medical mission: control the damage, which often times translates into stopping further blood loss; stabilize the patient, and prepare them for movement to a larger medical facility for further treatment via aircraft.

As the Marines began the assault through the "City of Mosques," the expected increase in casualties arrived. Marines and soldiers from the frontlines transported their wounded on High Mobility Multi-purpose Vehicles and helicopters.

At one point, the Surgical Shock Trauma Platoon had so many casualties coming in, the gravel road in front of its tents were jammed packed with a "chain of ambulances, dropping off patients," said Cather, a 32-year-old native of Voluntown, Conn.

Despite the increased number of casualties the Surgical Shock Trauma Platoon received during the height of Fallujah operations, most were able to be saved, due in large to the modern body armor issued and worn by Marines, said Cather.

"If they weren't wearing their flak [vest] and Kevlar [helmet], they'd have all this damaged," said Cather, pointing to his head and chest.

Cpl. Howard A. Antonio, 32, a fire team leader with Lima Company, 3rd Battalion, 1st Marine Regiment, was treated for a broken wrist sustained when an explosion went off near the building he and his Marines had just secured in Fallujah.

"The people who want to kill us are still there," said Antonio, speaking while sitting upright on a cot, his arm in a sling, his face unshaven and covered in dirt. He spent eight days in Fallujah.

"I wish I was back out there," said the Chicago native. "Here, I'm safe. But my Marines aren't. My job as an NCO is to be out there with them. I'd be back there now if I could."

Several other Marines from Antonio's unit were also admitted to the Surgical Shock Trauma Platoon that day, with much more severe wounds — shrapnel from improvised explosive devices and bullet wounds.

They were rushed into the operating room for immediate surgery.

When patients arrive at Surgical Shock Trauma Platoon, they are immediately off-loaded from the ambulance. Physicians and corpsmen assess the severity of the wounds. Patients with life-threatening injuries are rushed directly into the operating room so doctors can "control the damage."

Time is of the essence when it comes to treating severe, traumatic wounds, said Navy Cdr. Steven L. Banks, Surgical Shock Trauma Platoon's assistant officer in charge. A few minutes can mean the difference between life and death.

As Banks spoke, other members of the medical staff are positioned outside the Surgical Shock Trauma Platoon's tents donning scrub caps and gloves. Looking down a gravel road, they are awaiting an incoming

There's a lot of work. Everyone here supports each other. We just have to get it done. ”

ambulance carrying a soldier who has been shot.

While waiting for the inbound patient, Banks reflects on the 150 plus patients he and the rest of the staff treated during the initial week of Operation Al Fajr.

"That's a lot of work," said Banks, a 48-year-old native of San Diego, Calif. "But everyone here supports each other. We just have to get it done."

Several minutes later, another radio call comes through - two more patients are inbound via helicopter.

Then another call comes over the radio — "D.O.W.," screams Navy Lt. Guadalupe L. Lopez, Surgical Shock Trauma Platoon's personnel officer, repeating the information she just received over the radio.

The inbound soldier with the gunshot wound is "D.O.W." — dead of wounds.

"Sometimes they just don't get to us fast enough," said Banks, a 48-year-old San Diego native.

Most casualties do make it to the Surgical Shock Trauma Platoon in time and most survive their injuries, although some may end up losing an arm, leg, or both, due to their injuries.

Mental recovery from wounds sustained in combat can be just as traumatic as physical recovery. That's where Navy Lt. Cdr. Eric E. Cunha's mission begins.

Cunha, 42, is a clinical psychologist with the 1st Force Service Support Group, and is charged with helping recovering patients deal with combat stress.

"My job is to help them get through this moment," said Cunha, a native of San Jose, Calif.

The mental fatigue associated with combat can be devastating to battle weary Marines. Cunha tries to reunite patients with their units when possible to prevent separation anxiety associated with being a casualty.

"When they [Marines] come out here, they're young. They're units are their families," said Cunha, who adds that "three hots and a cot" also helps

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On Page 10: Navy Lt. Charles L. Cather, an operating room nurse at the Surgical Shock Trauma Platoon at Camp Taqaddum, Iraq, pulls on a patient's leg during surgery to prevent the leg muscle from retracting.

Left: Chief Petty Officer Suzette Dugger helps off-load a patient from an ambulance.

U.S. Marine Corps Photos by Staff Sgt. Jim Goodwin



Jessica R. Ross, a Navy corpsman with the Surgical, Shock Trauma Platoon at Camp Taqaddum, Iraq, guides Cpl. Howard A. Antonio to an awaiting ambulance for transportation to the SSTP. Antonio, a 32-year-old Chicago, Ill., native and fire team leader with Lima Company, 3rd Battalion, 1st Marines, sustained injuries while he and his team were clearing buildings in Fallujah. Ross, a 22-year-old native of Nashua, N.H., volunteered to deploy to Iraq from Okinawa, Japan, where she was stationed.

Behind the Scenes

— Continued from Page 11
reduce combat stress.

"They're closer to some of their buddies out here than to their immediate family members," he said.

But Cunha is also available to help the Surgical Shock Trauma Platoon's staff deal with their own personal demons serving in a combat environment brings — treating severe combat wounds.

"I get them to a point where they can cope," said Cunha.

When a patient doesn't survive, Cather reminds his corpsmen that it's not their fault — sometimes people just die.

"If a patient doesn't make it, I tell them it's not because the [operating room] tables weren't ready, or they didn't anticipate what was needed, it's because he [patient] was shot," said Cather. "This is war."

Hospital Corpsman Joey E. Aguilar has seen his fair share of combat

casualties over the past month, just as his fellow corpsmen serving throughout Iraq.

"There's been some days where I say, 'Man, this is too much,'" said Aguilar, pausing from playing a hand-held video game during some down time.

The 22-year-old Redlands, Calif., native extended for an additional seven months of duty here. Aguilar could have returned to Marine Corps Base Camp Pendleton, Calif., in November, where he is stationed in the U.S. He recalls working well beyond his scheduled 12 hours at a nearly non-stop rate during the height of Fallujah operations. Still, he doesn't regret his decision to stay.

"This is what I've been trained to do. Save lives," said Aguilar.

When they don't have patients in their facilities, the medical staff relax by reading books, movies, socializing with peers — anything to take their minds off their work, even if only for a brief period.



"An empty ward is good," said Aguilar. "I'd rather be bored than have patients."

Shortly after, another call comes over the radio — three more patients are inbound: two with shrapnel wounds from an improvised explosive device, another has been shot in the leg. ■

No Strings

Wireless Electronic Information Carrier Frees Up Providers' Hands While Ensuring Care Is Documented

by karen fleming-michael
standard staff writer

Getting medical charts from the battlefield to a combat support hospital to a bricks-and-mortar hospital has long been a challenge for health care providers. “Paper goes thousands of miles and through dozens of hands, and it doesn’t always make it,” said U.S. Army Col. John Holcomb, the Army Surgeon General’s trauma consultant at a conference on combat casualty care in August 2004. “In Operation Iraqi Freedom, I’ve seen doctors resort to writing notes on patients’ dressings

to let the next care provider know what was done. My personal opinion is they need to wear their record on their neck.”

Soldiers who deployed with the Stryker Brigade out of Fort Lewis, Wash., did just that.

On the chain they wear their dog tags, they also wore their medical records on a device called a PIC, which stands for Personal Information Carrier. The record can be updated after any medical encounter, if the provider had a PCMCIA adapter on a personal digital assistant or a laptop.

Getting rid of the need for an adapter — and getting rid of the need to touch the information carrier during a medical encounter — is what developers are now aiming for by developing a new wireless Electronic Information Carrier, or EIC.

The PIC “pretty much requires that we predict where all our evacuation routes are going to be and to have pre-positioned adapters everywhere, because if a patient shows up with a PIC and there’s no adapter, they’re not going to have the emergency data,” said Maj. Tim Rapp, the project manager for the Electronic Information Carrier who works in the Army Surgeon General’s Office. “The EIC [Electronic Information Carrier] provides a patient-centered data flow so as the patient moves from node to node within the network, the EIC will have the latest information, so if a node fails or isn’t gathering data as fast, the EIC will be reliable source of patient encounter information.”

Location, location

Having a wireless Electronic Information Carrier will also solve one of the troubling problems medics have encountered with the Personal Infor-

In Operation Iraqi Freedom, I’ve seen doctors resort to writing notes on patients’ dressings to let the next care provider know what was done. ”

mation Carrier.

“On 95 percent of the soldiers, they’re wearing the PIC next to the regulation dog tag so the medic needs to dig down to get it,” Rapp said. “Other soldiers take it off and put it in their cargo pocket, so now the challenge becomes a full-blown POW search trying to figure out where the PIC is. Or, more likely, the medic just forgets it and goes back to pen and paper or chooses not to record the data out to the PIC.

Not recording a medical encounter is precisely what the Army is trying to avoid. After learning of the military’s sporadic medical recordkeeping during the 1991 Gulf War, Congress mandated the services improve their process.

The PIC was one answer to that requirement, and the Battlefield Medical Information System-Telemedicine that electronically records every medical encounter on the PIC was another.

“It’s our responsibility to take that a step further, and if we have the capability to take care of the soldiers and collect this information at the point of injury, then we should do it,” said Tommy Morris, the program manager for the BMIS-T at the Telemedicine and Advanced



File photo

The Personal Information Carrier provides the service member with a physical, portable, electronic mechanism for storing and transporting personal medical information. It also allows this data to be accessed and updated by medical personnel. With the PIC, treatment data can be captured in a deployment situation, regardless of the communications infrastructure or patient evacuation route. The PIC is the size of a military dog tag, with a storage capacity of up to 128 megabytes. It is currently in limited use.

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No Strings

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Technology Research Center. “Not just because it’s public law, but because we have a responsibility to the soldiers from boot camp to the end of their military careers.”

A wireless EIC, Rapp said, will let a medic record what care was provided via Battlefield Medical Information System - Telemedicine, sign the document and save it wirelessly to a soldier’s Electronic Information Carrier, no matter where the soldier is wearing it.

“We’ve always had a need and a desire to capture what we do on the battlefield, disease and non-battle injuries, medical surveillance, and providing data to support medical command and control on the battlefield,” Rapp said. “What the technology will do is it will actually help meet those requirements of data capture that are seamless to the user. It won’t be asking physicians to ‘Oh by the way, in between treating patients, we’d like you to fill out spreadsheet X, Y and Z.’”

Storing medical encounters digitally also stems the logistics burden involved in moving 90 tons of medical records in the field, Morris said.

“And that doesn’t include the reams of paper that you have to have to document the new encounters,” he said. “You’re talking about a whole line of logistics just to move medical records. These types of devices with the interoperability have the potential to save millions of dollars on a deployment just in logistics alone in addition to providing service to the patients.”

Connections

Adding wireless capability as well as a universally available adapter were just two requirements the military wanted for the EIC.

“The new EIC will have a ubiquitous physical interface [like a USB port], meaning you will no longer need a proprietary PCMCIA adapter,” Rapp said. “If you don’t have wireless communication or for some reason there’s interference, the handheld will have a port for you to simply plug it in. You’re tethered to an 8 to 12-inch chain [if the Electronic Information Carrier is around the neck with the dog tag] but at least you have that as a back-up

and there’s no adapter.”

Inter-operability of the Electronic Information Carrier is important to the U.S. military as well as its NATO allies. “When we start talking about them [NATO] providing care to U.S. soldiers, the provider can actually capture information on the USB-type device with a wireless device Morris said.

“So if the wireless connectivity is there, they can use that. If not, they can use the USB interface.”

Rapp, the wireless EIC program manager since 2001, said the new EIC will also offer automatic encryption as well as more memory than the PIC. The EIC should be able to offer anywhere from 16 megabytes to two to four gigabytes of data.

We’ve always had a need and a desire to capture what we do on the battlefield, disease and non-battle injuries, medical surveillance . . . ”

“That will allow us to store not only the encounters that take place in theater, but we also can store 20-year medical records, digital radiographic images, ultrasounds, you name it,” he said. “It essentially can become a personal health care longitudinal record that could be taken to a VA [Veterans Affairs] hospital so they don’t start a new record with an empty file folder.”

Developers

Four companies were each given \$100,000 in 2004 through the small business innovative research program to come up with prototypes of the wireless Electronic Information Carrier. After the Department of Defense reviewed the designs in July 2004, two companies were given \$750,000 to continue their work.

These Electronic Information Car-



rier creators, Rapp said, balanced tough requirements to come up with their versions of the EIC.

“It’s a tradeoff between the device throughput, security, device life, ruggedization, signature issues and power management,” he said. “As you increase one, it has a detrimental effect on the other ones.

For example, if designers increase the capacity of the device to four gigabytes, the device has memory sectors to scan to find data, which has a detrimental effect on power. And, if they increase the wireless range from four inches to two yards, the device leaves a larger electronic signature.

“The challenge for all the vendors is we set out a set of standards and requirements that are pretty much in conflict with each other,” Rapp said. “We want it all and we’re asking them to figure out how to give it to us.”

The Electronic Information Carrier is one piece of a larger vision for hands-free battlefield health care.

“When you tie this EIC project with the BMIST project, a speech-capable PDA [portable data assistant], visual input devices and a noise-canceling microphone, what you get out the other end is a medic who will be able to go about treating patients the way he did 30 years ago, grabbing an aid bag and going,” Rapp said. “He can literally be hands free and capture the medical care he’s providing.”

Rapp hopes to see prototypes of the first wireless EICs on soldiers in late 2005. ■

CCEP Records

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information have provided insight into the nature of symptoms and diagnoses in the self-selected group of individuals who enrolled in the program. The participants represented a cross-section of Gulf War veterans as a group. Symptoms and diagnoses seen in Comprehensive Clinical Evaluation Program participants resembled those seen in the general population and in patients seeking primary care.

Today, they are important to the individual participants as evidence of health problems that may not appear anywhere else. It makes sense that they be stored near the other military health records. The basic health record is filed with each veteran's official military personnel file, but separated from it when he or she leaves the military.

"Those health records don't come here when the personnel record does," Voelz said. "They go directly to the [Department of Veterans Affairs] records management center. That is outpatient stuff that happens while a service member is on active duty, including dental work."

The Department of Veterans Affairs records management center that gets those health records is also in St. Louis.

Clinical records, those from care that veterans received while admitted to a hospital, are stored at the National Personnel Records Center, filed by the name of the hospital and the year. However, Comprehensive Clinical Evaluation Program records are neither inpatient records nor are they health records, and this closed set of records is quite small compared to other collections.

"We have about 700 cubic feet of CCEP records," Voelz said. "We probably have 600,000 cubic feet of other medical records here and a 1.6 million cubic feet of OMPFs [official military personnel files]."

A cubic foot of records takes up about the same amount of space as a carton of copier paper.

Clinical Comprehensive Evaluation Program records will not automatically be called up when veterans request medical records. Because these records are not identified by hospital or date, they will be annotated in a separate database.

"When the requestor tells us CCEP, then we know to look in that. I don't believe we're going to routinely look in that for every request we get," said Voelz.

So, if a veteran wants his CCEP records he or she should specifically ask for them. Copies of these records are easy to request, as are copies of personnel and medical records. The easiest way is to order them on line through the veterans records or VET-RECS Web site.

Military veterans, or the next of kin of a deceased military member, or a former member of the military can initiate the request by clicking on the "Request Military Records" button. They will have to enter some basic information, then print, sign and date the signature verification area of a customized form. The final step is to mail or fax the signature verification form to the records center.

Veterans should be prepared for

their requests to take a little time, perhaps as long as a month. The National Personnel Records Center receives as many as 6,000 pieces of mail per day, and generally requests are handled on a first-come, first-served basis. However, Voelz says, that there are

For More Information

To obtain a copy of your CCEP record, you may write to the National Personnel Records Center, Military Personnel Records, 9700 Page Avenue, St. Louis, MO 63132 - 5100

You may also send a fax to: (314) 801- 9195 or call their customer service number at (314) 801 - 0800.

Visit the site on line at: http://www.archives.gov/facilities/mo/st_louis/military_personnel_records.html

Request records on line at: http://www.archives.gov/research_room/vetrecs

exceptions.

"If someone writes for information for a medical emergency, or if they need to bury someone in a VA cemetery, or if they're a homeless veteran, they could get an answer within a day," Voelz said, adding that if someone requesting documents is facing any kind of deadline, they should make that very clear in their letter. That will change where their request will fit in their priorities.

The important thing, Voelz said, is to make sure that veterans have access to their important medical records. Moving the Comprehensive Clinical Evaluation Program records to the National Personnel Records Center further centralizes veterans' official records, making the search for them less of a quest and more like

AMC Aircraft, People Support Tsunami-Relief Operations

Staff Sgt. Billy Lucas, an Air Transportation Craftsman with the 733 Air Mobility Squadron, guides a pallet of relief supplies on to a C-130 aircraft from Kadena Air Base, Japan, on Jan. 4, 2005, at the Bangkok International Airport. Sergeant Lucas is in Thailand in support of the international Tsunami relief efforts in Asia.

U.S. Air Force photo by Tech. Sgt. John M. Foster



Capstone Report

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uranium aerosols in a perforated vehicle are low.

The Capstone project is the logical conclusion of studies that DoD has conducted on the health and safety of depleted uranium munitions and armor over the last 30 years. During Operation Desert Storm friendly fire survivors in both Abrams tanks and the Bradley Fighting Vehicles were exposed to depleted uranium. In addition to getting a clear picture of the amount of exposure to these service, DoD wanted to be prepared for future conflict, when enemies might be firing depleted uranium rounds at our vehicles.

The 2000 study of military depleted uranium exposures and risks by U.S. Army Center for Health Promotion and Preventive Medicine, identified a big data gap in knowing what the aerosols were inside the armored vehicles at the time they were penetrated. The \$6 million depleted uranium capstone study was aimed at filling that gap.

"It was rigorous science conducted by some of the best and brightest scientists and engineers, measuring aerosols and doing military testing," Melanson said. "There was external peer review throughout the process, and the testers worked to make their process transparent."

That means that anyone interested in seeing how the tests were done or viewing the data collected and examining how that data was interpreted in terms of health risk can just look at the more than 1,000-page report. The report specifies what models were used, what doses were calculated and the risk of those doses put in proper context with other combat risks.

Melanson said that the depleted uranium capstone program had two major components. The capstone aerosol study characterized the aerosols created when a large-caliber depleted uranium penetrator cuts through an Abrams tank or a Bradley Fighting Vehicle. The tests required aerosol-sampling systems rugged enough to survive perforation of the crew compartment and complex enough to collect depleted uranium particles in the air. The second component of the report — the Human Health Risk Assessment — used that data to estimate risk, using internationally recognized models.

Before stating conclusions, Melanson reminded the veteran service organization representatives that the Human Health Risk

Assessment used established, internationally-recognized models for intake, distribution of uranium within the body, and dose. It addressed both radiological and chemical risks and puts them in context with other combat risks. He added that the data from this report is useful for addressing retrospective exposure scenarios from Operation Desert Storm, and because some tests were of DU armor penetrated by DU munitions, it looked prospectively as well. Then he explained what the tests have shown.

"The radiological and chemical risks to human health from the DU aerosol generated in both the Bradley and the Abrams are relatively low when compared with many other combat risks," he said. "And the predicted radiation doses from the study were less than peacetime safety standards for all the scenarios considered."

He added that the uranium concentrations in the kidney for most of the scenarios were below levels expected to have any health effects. However, when a DU round penetrated an unventilated Abrams with conventional armor, there was the potential for an intake that might cause subtle, transient effects on the kidneys. These effects would not lead to any long lasting health effects.

Because the ventilation system in the Abrams significantly reduced depleted uranium concentrations inside the vehicle, the report recommends that the crews keep the ventilation system running. The depleted uranium capstone report also recommends that training be provided to vehicle crews and those whose jobs might require them to be in or near damaged vehicles, to ensure that they know how to minimize any intake of depleted uranium. These groups should also be monitored for potential intake of depleted uranium,

usually done through urinalysis. The report also says that all other troops on the battlefield should receive general awareness training.

"That is to make them aware that DU is out there," Melanson said, "that vehicles struck with DU are a potential source of exposure or intake of DU, and also to show them that the risks are very low compared to other risks on the battlefield."

After showing a video of the interior view of depleted uranium rounds penetrating armored vehicles, Melanson recapped the important conclusions of the capstone study.

"Exposure levels to depleted uranium in military scenarios are safe," he stressed. "Troops in, on, or near armored vehicles when they are struck with DU munitions have the highest potential for intake and exposure, and we've seen that the intake and doses they receive are below U.S. peacetime standards for radiation and not high enough to cause lasting effects on individuals from their heavy metal toxicity."

The capstone report and the Human Health Risk Assessment can be viewed on the Web at http://www.deploymentlink.osd.mil/du_library/du_capstone/index.pdf. ■



Be Prepared for The Flu Season

by al eakle
88th medical group public affairs
wright-patterson air force base, ohio

Colder temperatures signal the start of the flu season, which runs primarily between now and April. With a nationwide shortage of vaccine this year, health officials say it is important to know the symptoms of this contagious respiratory illness, and what to do if a person is infected.

The flu usually starts suddenly, said Maj. (Dr.) Molinda Chartrand, a staff pediatrician, and Capt. (Dr.) Eric Halsey, an infectious disease physician, assigned to the 88th Medical Group here. Symptoms may include fever, headache, runny or stuffy nose, body aches, tiredness, cough and sore throat.

Diarrhea and vomiting also can occur but are

more common in children, Chartrand said. Although the phrase “stomach flu” is often used to describe an illness involving nausea, diarrhea and vomiting, Halsey said the flu virus does not classically cause gastrointestinal disease.

The flu spreads from person to person in respiratory droplets from coughing and sneezing. Occasionally people may become infected by touching something with virus on it, and then touching their mouth or nose.

Adults may be able to infect others



one day before getting symptoms Chartrand said.

People with the flu need plenty of rest and a lot of liquids. They should
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Blood Pressure: Silent Killer Lurks

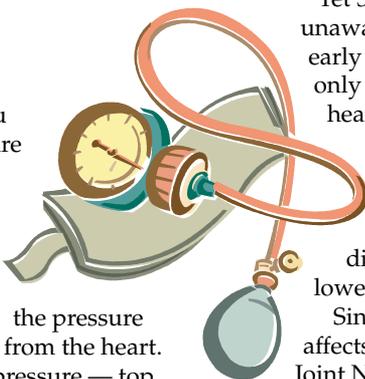
by u.s. air force maj. (dr.) richard capling
81st medical operations squadron
keesler air force base, miss.

When is the last time you had your blood pressure checked? It's a simple procedure that could help prevent serious medical problems and save your life.

A blood pressure check measures the pressure within the arteries that carry blood away from the heart.

When the heart contracts, the systolic pressure — top number — increases, and when the heart relaxes, the diastolic pressure — bottom number — decreases, providing the two measured values when blood pressure is taken.

When numbers are within a range that may cause damage to the vessel wall, a person is considered to have hypertension, or high blood pressure. Elevations in either the systolic or diastolic values can have harmful health effects.



High blood pressure is very common, with about 50 million Americans diagnosed. According to a 2002 National Ambulatory Medical Care Survey, it's the most common primary medical diagnosis, accounting for more than 35 million annual trips to the doctor's office.

Yet 30 percent of people with this disorder are unaware of it because of the non-specific nature of early warning signs. Commonly, the diagnosis is only made after “cardiovascular events” such as heart attack, stroke, loss of vision and kidney failure.

The classic threshold values for diagnosis of high blood pressure is a reading of 140/90. However, many people have other diseases that may place them at risk at a much lower reading.

Since different blood pressures may have varying effects on people with other health conditions, the Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure developed a classification system to help doctors decide when treatment should start and how aggressive it should be.

A systolic blood pressure less than 120 and a diastolic value less than 80 define normal. Prehypertension is when

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Flu Season

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avoid using alcohol and tobacco. They should also take medications to relieve the symptoms of the flu.

The doctors said parents should never give aspirin to children or teenagers who have flu-like symptoms, particularly fever.

They also advised people who are at high risk from complications of the flu to consult their health care provider if they develop flu-like symptoms. Doctors, they said, may recommend use of an anti-viral medication to help treat the flu.

There are also some “emergency warning signs” that require urgent medical attention, they said.

In children, emergency warning signs that need urgent medical attention include:

- Fast breathing or trouble breathing.
- Bluish skin color.
- Not drinking enough fluids.
- Not waking up or not interacting.
- Being so irritable that the child does not want to be held.
- Flu-like symptoms improve but then return with fever and worse cough.

In adults, emergency warning signs that need urgent medical attention include:

- Difficulty breathing or shortness of breath.
- Pain or pressure in the chest or abdomen.
- Sudden dizziness.
- Confusion.

Silent Killer

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the systolic value ranges from 120 to 139 or the diastolic reading is 80 to 89.

Stage 1 hypertension has a systolic blood pressure between 140 to 159 or diastolic value from 90 to 99, and Stage 2 is blood pressure greater than 160 over 100.

Treatment depends on how high the blood pressure is and whether there are other medical conditions, such as diabetes, heart failure, previous heart attack or stroke, chronic kidney disease or the existence of multiple risk factors for a future heart attack.

The best way to determine if a person has hypertension is to monitor blood pressure regularly. Take blood pressure at different times of the day while performing various activities and record readings for future review by a doctor.

Many stores have free blood pressure stations and others sell home machines that are fairly precise, but should be checked regularly for accuracy. ■

- Severe or persistent vomiting.

People need to seek medical care immediately if they are experiencing any of these signs, the doctors said. At the hospital, they should tell the reception staff that they think they have the flu. ■

Screenings

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could be completed and scored quickly before and after deployments.

The team started with research scales that had been tested and validated



in the civilian world, and then put together a two-page questionnaire that hit the topics of traumatic stress, depression and problems with relationships, anger and alcohol.

“We’re sensitive to the fact that soldiers don’t like filling out page after page after page of surveys,” said Capt. Jeffrey Thomas, who worked at the Heidelberg unit before moving to Walter Reed Army Institute of Research. “We’re going with ... the least number of items that we can have to tap into the areas of stress. That’s where a lot of the number crunching has been done to make it as efficient and as lean as it can be.”

Soldiers can complete the “short screen” in 10 minutes or less, and mental health personnel can score it in a tenth of that time.

“I like to think of it as a triage filter, because the Army ... does not have the resources to give every single soldier a clinical interview,” Thomas said. “But short of doing that, what we can do is develop a very lean, efficient stubby-pencil version of the screening triage survey to help direct resources that

are pretty limited to begin with.”

If soldiers test “hot” for either the suicide or homicide question on the short screen, they’re immediately referred to a mental health professional. Others whose scores indicate they should get help can be contacted confidentially by mental health professionals on post.

A soldier can also ask for help as well.

“One item we like on the screen is essentially: Do you want to see a counselor? They say yep, and we get them in,” Bliese said. “By somebody showing up at the unit and basically letting the person self refer for any problem, it’s a very easy way to get into the health care system.”

He likens this approach to mental health to the way the military now delivers fuel.

“They used to wait for a unit to request fuel and then [suppliers] would send it out to them. Now the idea is you push the fuel to them,” Bliese said. ■

Air Force Association
1501 Lee Highway
Arlington, VA 22209-1198
Phone: (800) 727 - 3337
<http://www.afa.org>

American Legion
1608 K St., NW
Washington, DC 20006
Phone: (202) 861 - 2700
<http://www.legion.org>

American Red Cross
17th & D Streets, NW
Washington, DC 20006
Phone: (202) 639 - 5520
<http://www.redcross.org>

AMVETS
4647 Forbes Blvd.
Lanham, MD 20706
Phone: (877) 726 - 8387
<http://www.amvets.org>

Association of the U.S. Army
2425 Wilson Blvd.
Arlington, VA 22201
Phone: (800) 336 - 4570
<http://www.ausa.org>

Department of Veterans Affairs
810 Vermont Ave., NW
Washington, DC 20400
Phone: (202) 273 - 4300
<http://www.va.gov>

EIELSON AIR FORCE BASE, Alaska—KC-135 Stratotankers from Kadena Air Base, Japan, and the Alaska Air National Guard sit on the flightline in December 2004. The Alaskan tankers belong to the 168th Air Refueling Wing, the only Arctic-region refueling unit for all of Pacific Air Forces.

Disabled American Veterans
807 Maine St., SW
Washington, DC 20024
Phone: (202) 554 - 3501
<http://www.dav.org>

Enlisted Association of
the National Guard
3133 Mount Vernon Ave.
Alexandria, VA 22305
Phone: (800) 234 - 3264
<http://www.eangus.org>

Fleet Reserve Association
125 N. West St.
Alexandria, VA 22314-2754
Phone: (703) 683 - 1400
<http://www.fra.org>

Marine Corps Association
715 Broadway St.
Quantico, VA 22134
Phone: (866) 622 - 1775
<http://www.mca-marines.org>

Marine Corps League
8626 Lee Highway, Suite 201
Merrifield, VA 22031
Phone: (800) 625 - 1775
<http://www.mcleague.org>

Military Officers Association
201 N. Washington St.
Alexandria, VA 22314
Phone: (800) 234 - 6622
<http://www.moaa.org>

Military Order of the Purple Heart
5413-B Backlick Road
Springfield, VA 22151-3960
Phone: (703) 642 - 5360
<http://www.purpleheart.org>

National Association for
Uniformed Services
5535 Hempstead Way
Springfield, VA 22151
Phone: (800) 842 - 3451
<http://www.naus.org>

National Committee for Employer Support
of the Guard and Reserve
1555 Wilson Blvd., Suite 200
Arlington, VA 22209-2405
Phone: (800) 336 - 4590
<http://www.esgr.org>

National Guard Association
of the United States
1 Massachusetts Ave., NW
Washington, DC 20001
Phone: (202) 789 - 0031
<http://www.ngaus.org>

National Military Family Association
2500 North Van Dorn St., Suite 102
Alexandria, VA 22302
Phone: (800) 260 - 0218
<http://www.nmfa.org>

Naval Reserve Association
1619 King St.
Alexandria, VA 22314-2793
Phone: (703) 548 - 5800
<http://www.navy-reserve.org>

Navy League
2300 Wilson Blvd.
Arlington, VA 22201
Phone: (800) 356 - 5760
<http://www.navyleague.org>

U.S. Air Force photo by Senior Airman Joshua Strang

Non-Commissioned
Officers Association
610 Madison St.
Alexandria, VA 22314
Phone: (703) 549 - 0311
<http://www.ncoausa.org>

Paralyzed Veterans Association
801 Eighteenth St., NW
Washington, DC 20006-3517
Phone: (800) 424 - 8200
<http://www.pva.org>

Reserve Officers Association
1 Constitution Ave., NE
Washington, DC 20002
Phone: (800) 809 - 9448
<http://www.roa.org>

Veterans of Foreign Wars
200 Maryland Ave., NE
Washington, DC 20002
Phone: (202) 543 - 2239
<http://www.vfw.org>

Vietnam Veterans of America
8605 Cameron Street, Suite 400
Silver Spring, MD 20910-3710
Phone: (301) 585 - 4000
<http://www.vva.org>

OTHER RESOURCES

By Phone

Direct Helpline for Service
Members, Veterans and Families
(800) 497 - 6261

Deployment Health
Clinical Care Center
(800) 769 - 9699
or from Europe
00 - 800 - 8666 - 8666

TRICARE Active Duty Programs
(active duty and family members)
(888) DOD - CARE
or (888) 363 - 2273

TRICARE Mail Order
Pharmacy - Express Scripts
(866) 363 - 8667

TRICARE Dental Program
(TDP) - United Concordia
(800) 866 - 8499

TRICARE Pharmacy Program
(877) DOD - MEDS
or (877) 363 - 6337

TRICARE For Life
(888) DOD - LIFE
or (888) 363 - 5433

TRICARE Retiree Dental
Plan - Delta Dental
(888) 838 - 8737

Defense Enrollment Eligibility Reporting
Systems (DEERS)
(800) 538 - 9552

TRICARE Online
(866) DOD - EWEB
or (866) 363 - 3932

Health Insurance Portability
and Accountability Act (HIPAA)
(888) DOD - HIPA
or (888) 363 - 4472

Department of Veterans Affairs
(800) 827 - 1000

VA Gulf War Registry
(800) 749 - 8387

VA Benefits and Services
(877) 222 - VETS
or (877) 222 - 8387

Web Links

Department of Defense
<http://www.defenselink.mil>

DeploymentLINK
<http://deploymentlink.osd.mil>

GulfLINK
<http://www.gulflink.osd.mil>

MedSearch
<http://www.gulflink.osd.mil/medsearch>

DeployMed
<http://deploymentlink.osd.mil/deploymed/>

PDhealth
<http://www.pdhealth.mil>

Hooah 4 Health
<http://www.hooah4health.com/>

TRICARE
<http://www.tricare.osd.mil/>

Department of Veterans Affairs
<http://www.va.gov/>