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STATEMENT BEFORE THE SUBCOMMITTEE ON MEDICAL FACILITIES AND BENEFITS
OF THE VETERANS AFFAIRS COMMITTEE OF THE HOUSE OF REPRESENTATIVES

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July 22, 1980

I wish to thank the committee for the opportunity to present testimony today. As we are all aware, recent years have seen a rapid growth of concern among Veterans, their families and the organizations to which they belong about the possible health effects of Agent Orange. As in any other population, many of the Veterans are now developing cancer, are suffering from ailments such as neuromuscular or psychological disease, and are experiencing reproductive dysfunction in the forms of infertility, miscarriages in their spouses and birth defects among their offspring. Many Veterans are suspicious that their ill health patterns are different than those of their peers who have not served in Vietnam and may indeed be related to Agent Orange. Dr. Steven Stellman and I are collaborating on research which provides highly suggestive, although not definitive, data on atypical health outcomes among Vietnam Veterans with symptoms of dioxin exposure. Dr. Steven Stellman will present some of our findings in his testimony. I would like to take this opportunity to discuss the health needs of the Veterans as I perceive them from health questionnaires I have received from thousands of them, from my perspective as advisor to various groups, and from my position as Associate Professor of Public Health at Columbia University.

TCDD, or dioxin, a contaminant of Agent Orange, is among the most potent toxic substances ever produced and tested. It is a carcinogen, a teratogen and systemic toxin at extremely low doses in animals. Thousands of United States troops were inad-

vertently exposed to TCDD during their tour of duty in Southeast Asia. Despite the seemingly obvious need for medical surveillance and reserach into the human health effects of TCDD/Agent Orange exposure, a Vietnam Veteran today has no identifiable means for seeking medical assistance for health effects which he believes to be related to Agent Orange, nor are there programs and protocols in place for the systematic discovery of the true health effects of Agent Orange exposure on our troops. I would like to explore these issues now.

In order to carry out epidemiological or clinical research it is essential that a mechanism for identification of veterans be developed for use by health planners, State and Federal Agencies and by epidemiologists who wish to construct an unbiased morbidity and or mortality study. (Such studies should of course comply with provisions of the Privacy Act in order to preserve the medical confidentiality of the Veterans.) Without a mechanism for Veteran identification, a cohort cannot be constructed and calculations of relative risk carried out.

It is esstial that a mechanism be established for characterization of exposure to Agent Orange of Veterans. In our current research we have developed and tested a questionnaire for solicitation of information on location of tour or duty and on personal recollection of spraying, a method which is clearly a less satisfactory substitute for troop movement information which can then be matched to spray

mission data. Each soldier who served in Southeast Asia should now know whether he was stationed in a spray zone and how close in time and space to spraying he was. While it is true that at this time it may be impossible to reconstruct highly accurate exposure data, surely some attempt at exposure characterization is both necessary and timely.

There are alternative methods for characterization of exposure. One is biological monitoring of the Veterans for evidence of TCDD residues. It has been reported that fat biopsies for TCDD content have been taken from several Veterans by the Veterans Administration. Such sampling requires large quantities of tissue, administration of anesthesia and risk and pain to the patient. I would like to suggest that other bioassay methods be developed and that basic data on the half-life of TCDD storage in fat be investigated to determine the utility of the tests. It is conceivable that a radioimmunoassay (RIA) for specific TCDD-Tissue adduct could be developed. The RIA technique, for which its developer Dr. Yalow justifiably was awarded a Nobel prize, was pioneered at the Bronx Veterans Administration Hospital, though not for the direct benefit of Veterans, would be extremely sensitive and far less invasive. It would seem appropriate to attempt its use in this case. Other fine assays could also be adapted.

It is essential that a mortality study of Vietnam Veterans be carried out to determine whether there are indeed excess mortality rates among the Veterans. It may be too early to compile definitive

results because of the long latent period of the disease but certainly, by this time, the protocol and the inception of data collection processes should have begun.

Similarly, since the question of the teratogenicity of TCDD looms so large before us, there should be a systematic approach to data collection on the reproductive outcome and histories of the Veterans. Unlike cancer, congenital anomalies, if they are occurring at an unusual rate or with an unusual distribution, would be obvious at this time, although latent functional defects in the offspring may still require more time to become apparent. Again, no programs or protocols are in place and hence there is no answer at hand for the very pressing question of the effect of Agent Orange exposure on reproductive functioning of the Veterans.

In addition to the research needs of protocol development and data availability and collection, there is a pressing need for development of clinical protocols for examination of Veterans with possible exposure to Agent Orange. I have appended a medical examination form of one Veteran examined at the Veterans facility at Fort Snelling, Minnesota. It is clear that this form was designed without regard to centralization and computerization of results. It is an open form, allowing each examining physician discretion for even the most basic and routine blood and urine tests. It provides no guidance to the examining physician who must treat a patient with possibly a quite complex array of symptoms. It

seeks no systematic reproductive history. It requests that the Veteran describe his exposure to Agent Orange, rather than provide the physician with an independent mechanism for determining exposure. There is no attempt at records linkage between the Veteran's medical record and his service history. It is not unreasonable to ask that when a Veteran seeks medical attention, an attempt be made to ascertain whether his unit was indeed in an exposure area. Instead the form places the burden of exposure history reconstruction on the Veteran and leaves his physician to piece together the exposure as best he can, with no guidelines for doing so.

What is needed? First, a precoded, computerizable form for each Veteran examined so that data can be centralized, and is comparable between centers. There should be a minimum examination required of each Veteran. If such a form had been developed, by this time enough data could have been collected so that norms would be available, and unusual patterns would already be known. The past is lost, but the future lies before us.

The absence of guidelines which can aid the physician in her or his care of the Veteran, is just one aspect of the Agent Orange information vacuum that exists. There is already a data base on the toxicology of dioxin. This should be made available. The armed services do know when and where Agent Orange was used. Such infor-

mation should be compiled and made available. Some of the symptoms, such as chloracne, of Agent Orange exposure are already known. They should be described and made available. Simple availability is not enough. Information should be available in the form of public information oriented toward both the lay public and the professional health community. It should be aggressively disseminated. This would serve to relieve anxiety and to help those currently seeking or providing health care. One need only look toward the efforts of the National Cancer Institute, and its Asbestos Information Program, or the American Cancer Society and its information on smoking, or the diethylstilbesterol programs that exist nationwide, to see what can be done if the national will, energy, and commitment are present. Surely our Veterans and their service organizations, the people who served our nation at the peril of their lives, they and their families deserve the finest effort in research, in outreach, in information, in medical care that our country can put forth. Only minimal effort has thus far been forthcoming.

MEDICAL RECORD	PROGRESS NOTES
DATE	<u>INITIAL DATA BASE - POSSIBLE EXPOSURE TO TOXIC CHEMICALS - PART I</u>
A. Date	Current Status of Veteran: <input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient
B. Branch of Service: Military or Civilian Unit Designation:	
C. How many exposures does the veteran allege?	
D. What was the nature of each exposure?	
E. When and where did these exposures occur? (Specify dates, military field bases, and length of exposure.)	
F. Define severity of the exposure - circle or check, as appropriate.	
Severe Direct Repeated Prolonged Short Mild Indirect	
G. At time of exposure - what was the veteran's job in service? (Field participation, rear echelon, administration, etc.)	
H. How directly was the veteran brought in contact with chemicals? (Check one)	
<input type="checkbox"/> Veteran was member of headquarters personnel and far removed from site of chemical exposure.	
<input type="checkbox"/> Veteran was in field.	
<input type="checkbox"/> Veteran operated apparatus used for chemical spraying or handled bulk chemicals in such a manner that gross exposure was possible.	
I. If, in field, was veteran undercover (building, trench, foxhole, etc.) or out in open? Was he in a vehicle at the time?	
(Continue on reverse side) (SEE OTHER SIDE)	

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle, grade, rank, rate, hospital or medical facility)

REGISTER NO

WARD NO.

PROGRESS NOTES **INITIAL DATA**
 STANDARD FORM 509 (Rev 11-77) **BASE-POSSIBLE**
 Prescribed by DVA/CMR **EXPOSURE TO TOXIC**
 (FORM 41 (CR) 1-11-71) 509-8 **CHEMICALS - PART I**
 509-110

PROGRESS NOTES

DATE	INITIAL DATA BASE - POSSIBLE EXPOSURE TO TOXIC CHEMICALS - PART I
J.	How long was veteran present at site of chemical exposure?
K.	Was veteran issued protective gear? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes" - did veteran wear this gear? <input type="checkbox"/> Yes <input type="checkbox"/> No Describe gear:
L.	Did veteran enter areas where chemicals previously had been sprayed or spilled - or did veteran eat from utensils or drink water contaminated by chemicals? Does veteran remember chemical names? Describe in detail.
M.	What steps were taken to remove chemicals from veteran or the environment?
N.	Has veteran been exposed to other potentially toxic chemicals: (1) Prior to military service: <input type="checkbox"/> Yes <input type="checkbox"/> No (2) During military service: <input type="checkbox"/> Yes <input type="checkbox"/> No (3) After military service: <input type="checkbox"/> Yes <input type="checkbox"/> No IF "YES" DESCRIBE:
O.	(1) What is veteran's military occupation code number? _____ (2) Veteran possesses a copy of DD 214, Report of Separation-Active Duty? <input type="checkbox"/> Yes <input type="checkbox"/> No IF "YES" ENCOURAGE VETERAN TO BRING A COPY. (3) Veteran possesses a copy of Service health/medical record? <input type="checkbox"/> Yes <input type="checkbox"/> No IF "YES" ENCOURAGE VETERAN TO BRING IN A COPY. (4) Has veteran received VA Care? <input type="checkbox"/> Yes <input type="checkbox"/> No IF "YES", STATE LOCATION.

CLINICAL RECORD

DOCTOR'S PROGRESS NOTES

(Sign all notes)

DATE

INITIAL DATA BASE - POSSIBLE EXPOSURE TO TOXIC CHEMICALS - PART 11

REVIEW DATA ON PART 1

2-20-80

A. Pertinent Medical History - include symptoms at time of exposure, or later - attributed by the veteran to exposure.

1970 - 1979 Skin rash, diarrhea, abd. pain, brown urine, joint pain & stiffness, tingling, numbness, headaches, fatigue, & ^{low} irritability, depression, loss of concentration, back & neck injuries & hearing loss

B. Pertinent Physical Examinations (PE) - (check one).

Physical examination to be done (Use SF 506 or VAF 10-7978i)
"Initial Data Base - Chemical Exposure, Part 111.

Repeat physical examination is indicated (a prior PE has been done within six months and has been reviewed).

Repeat PE is not indicated (a prior PE has been done within six months and has been reviewed).

Check if following examination ordered:

C. Yes No

Complete blood count including differential

Chest x-ray (if no chest x-ray within six months)

Liver Function Profile

Renal Function Profile

Sperm Count

Referral to a Dermatologist

D. Other Comments:

1. Evidence of Neoplasia: Present Absent

Family History of: brother - lymphoma & breast

Neoplasia related factors (e.g., cigarette smoking, radiation exposure, etc.)

no smoking by

no known radiation exposure

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries Give: Name—last, first, middle; grade; date; hospital or medical facility)

REGISTER NO.

WARD NO.

CLINICAL RECORD

DOCTOR'S PROGRESS NOTES

(Sign all notes)

DATE

INITIAL DATA BASE - POSSIBLE EXPOSURE TO TOXIC CHEMICALS - PART 11

2. Evidence of - Veteran and/or Family:

Infertility: Present ___ Absent X

Abortions: Yes X No ___ ? Spont AB x 1

Teratogenesis: Yes. ___ No X

If, "YES", Describe:

3. Were veteran's spouse or children in Vietnam? Yes X No ___
If "YES", give details.

Wife i us, visited southeast
Asia i 1970.

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name-last, first, middle; grade; date; hospital or medical facility)

REGISTER NO.

WARD NO.

VA Outpatient Service
Ft. Snelling
St. Paul, Minn. 55111

DOCTOR'S PROGRESS NOTES
Standard Form 509
509-106

CLINICAL RECORD

PHYSICAL EXAMINATION

DATE OF EXAM.	HEIGHT	WEIGHT			TEMPERATURE	PULSE	BLOOD PRESSURE
		AVERAGE	MAXIMUM	PRESENT			
2.20.78	6'1"	266	287	266	98.4	80	140/90

INSTRUCTIONS.—Describe (1) General Appearance and Mental Status; (2) Head and Neck (General); (3) Eyes; (4) Ears; (5) Nose; (6) Mouth; (7) Throat; (8) Teeth; (9) Chest (General); (10) Lungs; (11) Cardiovascular; (12) Abdomen; (13) Hernia; (14) Genitalia; (15) Rectum; (16) Prostate; (17) Anus; (18) Extremities; (19) Urological; (20) Skin; (21) Lymphatics.

INITIAL DATA BASE - POSSIBLE EXPOSURE TO TOXIC CHEMICALS - PART III

Vague diffuse skin rash after returning from South Pacific 1970 - handled herbicides, unknown types.

ROS - general - negative
 skin - by now, rash as outlined above.
 HEENT - ↓ hearing
 resp - neg
 CV - neg - ? by rheumatic fever 1967
 GI - neg
 GU - neg
 neuro - neg

BM 140/50 Aphakic.

skin - clear
 lymph - 5 palp nodes
 HEENT - normocephalic. fundi benign - mouth clear
 chest - clear
 CV - brt SEM LCM
 abd - soft, 5 masses re organomegaly
 ext - 5 edema
 joint - ul male
 neuro - 5 focal deficit

(Continue on reverse side)

PATIENT'S IDENTIFICATION (Not typed or written on this page. Name, last, first, middle, grade, date, hospital or medical facility)

DATE OF EXAM.	WARD NO.
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INITIAL DATA BASE - PHYSICAL EXAMINATION
 POSSIBLE EXPOSURE TO TOXIC
 CHEMICALS -
 PART III