STANDARDS FOR ADJUDICATING CLAIMS PRESENTED BY VETERANS SUFFERING FROM HEPATITIS C, CEREBRAL MALARIA AND PERSIAN GULF ILLNESSES

HEARING

BEFORE THE

SUBCOMMITTEE ON BENEFITS

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIFTH CONGRESS

SECOND SESSION

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STANDARDS FOR ADJUDICATING CLAIMS PRESENTED BY VETERANS SUFFERING FROM HEPATITIS C, CEREBRAL MALARIA AND PERSIAN GULF ILLNESSES

THURSDAY, JULY 16, 1998

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON BENEFITS,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The committee met, pursuant to notice, at 10 a.m., in room 334, Cannon House Office Building, Hon. Jack Quinn (chairman of the subcommittee) presiding.

Present: Representatives Quinn, LaHood, Redmond, Filner, Mascara, Evans, Reyes, and Rodriquez.

OPENING STATEMENT OF HON. CHAIRMAN QUINN

Mr. QUINN (presiding). The Subcommittee on Benefits will come to order.

As we do that, instead of waiting until a little bit later this morning when possibly we lose some of our members or witnesses or members of the audience, I wanted to take a minute, Bob Filner and I, to mention to all of you who don't know that today's hearing—although we've sort of announced this before once or twice—is Michael Brinck's last hearing for this subcommittee. He was at the Full Committee I guess about 2 or 3 weeks ago before we broke, and a couple of people had nice things to say about him. I didn't step up and be counted that morning, but, Mike, from the subcommittee's point of view, and I know Bob and all of the members join me and the staff in saying thanks for the work that you've done here.

It's been a real delight since I've been the chairman to, first of all, have you close by here in Cannon just a few doors away from me, but, second of all, to take advantage of the great working relationship you've developed over the years with people in and outside of Government circles when it comes to veterans' activities. We also have a little present for you, and it fits within the ethics and how much you can accept and how much we can give you—as Filner's throwing candy bars at you—but this is just something, a little token oaf our appreciation from our side and all the members on the committee. Thank you so much.

Mr. BRINCK. Thank you. (Applause.)

Mr. QUINN. Ray LaHood thought that was for him when he walked in here this morning; little does he know.

Good morning, and thanks for joining us. We're here today, the subcommittee, to discuss several issues confronting the Department of Veterans Affairs and some, I might add, as I read through the testimony last night and this morning, are somewhat complicated, medically as well as, I think, from a layperson's point of view to discover what's in here and then even for us to pose some questions.

First on the list, though, if I may take a few minutes to review where we're going to try to be headed this morning. We want to see what progress the Department has made in ensuring consistent and fair processing of Persian Gulf veterans' compensation claims. We may mention a little bit later—unfortunately, we received that information late this morning, about 9:45 or 9:50—in recent history, we've seen the Department go from processing claims at regional offices to centralizing the processing at four regional centers and now back at the regional offices. Throughout all these moves we've been told that the latest decision would sort of clean up this processing problem. I'm not convinced it has.

In the past few months, the Department finally suggested that the data collection was a little bit faulty and began an effort to improve the data, and we received some of that data this morning--Bob Filner and I were just talking about it. However, after considerable efforts to sort of systemize the collection, the VA staff member who's responsible for it has now been assigned temporary duties away from the Department. To say the least, we're a little bit disappointed with that, and I hope the Department can inform the subcommittee this morning how you will continue to improve the data on Persian Gulf claims, and we may have a suggestion for you on how to go about that.

The issue, then, of exposure to depleted uranium which was widely used in various missions during the Gulf War has made the press recently; we've all read about it. It's my understanding that depleted uranium is a toxic heavy metal and potentially dangerous. I'd like to note this problem is not limited to those who fought in the Gulf War, because DU is still being used in firing ranges for our services, so our people are still exposed to it. For example, somebody has to clean the weapons after they've been fired and used. Therefore, I'm asking the Department to coordinate a VA/DOD briefing on the issues surrounding the exposure to depleted uranium within the next 30 days.

Second, we have asked the Department to discuss how it is handling claims involving hepatitis C. This a deadly disease that is also making front page news and magazines, and some scientists are saying this may be a bigger threat to national health than AIDS. I want to be sure. I think the subcommittee wants to be sure that if a veteran shows up at VA with hepatitis C and evidence of a possible infection opportunity while in the service, that veteran, first of all, will be taken care of. Initial VA data does not show that necessarily to be the case. So, my question to the Department, right up front, before we begin the hearing, do current laws and regulations inhibit a veteran's ability to be service connected for hepatitis C if he or she received a blood transfusion prior to the early 1990's or worked in the medical field?

And the final topic this morning concerns the possibility that veterans who are judged to be suffering from PTSD may actually be exhibiting the effects of cerebral malaria. We're looking forward to hearing the Department's views in the study done by Dr. Varney and others.

I also want to just finally spend a moment on what I see as a value and obligation of the VA Research Program. We've talked about research and the money we spend on research many times here at the subcommittee and, indeed, in the full committee. Today's hearing revolves around three examples of how VA research can contribute to a veteran's ability to be compensated for disabilities incurred in the service. While this subcommittee doesn't have jurisdiction over the Research Program—we understand that—we do want to make a point about how the VA chooses research topics.

I'm a little bit concerned that VA research has lost some of its focus on problems that, while not necessarily unique to veterans, occur with greater frequency than in the non-veteran population, and we will hear some testimony today reflecting that concern. To put in perspective, a research and development program focused on the relevant issues affecting large numbers of veterans is vital to any kind of fair compensation program.

Typically, these are problems that our troops encountered in the field or the workplace throughout this past century; things like tropical diseases, cold weather injuries, combat-related stress, exposure to radiation, or even hazardous materials. The question that comes naturally, I think, then, is what portion of the VA's $300 million budget for research and development is going directly to talk about these kinds of problems? We'd like to hear back from the Department, hopefully, by the end of next week.

And, also, finally, before I yield to Mr. Filner, without objection, I'd like to enter a letter from Chairman Stump to Secretary West into the record this morning—copies are available at the tables.

Mr. QUINN. In his letter, Chairman Stump has asked the Secretary to review implementation of compensation laws on undiagnosed illnesses to determine whether chronic fatigue syndrome and fibro myalgia should be considered equivalent to undiagnosed illnesses for compensation purposes. The chairman makes a point that two veterans with exactly the same symptoms could be diagnosed completely differently by VA physicians; one receiving a diagnosis of CFS or fibro myalgia and the other suffering from an undiagnosed illness. I believe that the Legion's prepared testimony and statement later this morning does a very good job in making the case in support of Chairman Stump's position. Therefore, I asked that it be included in the record. We look forward to hearing the Department's views on Mr. Stump's letter.

And, with that background, I'd like to yield to Mr. Filner for any opening remarks he has at this time.

[The information follows:]

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June 3, 1998

Honorable Togo D. West, Jr.
Secretary of Veterans Affairs
810 Vermont Avenue, N.W.
Washington, DC 20420

Dear Mr. Secretary:

As Congress continues to hear from Persian Gulf War veterans who believe their health care problems are of service origin, it has become increasingly apparent to us that the Department is too narrowly implementing the landmark legislation initiated in this Committee to provide compensation for these veterans.

The Persian Gulf War Veterans' Benefits Act (Public Law 103-446) in 1994, provided for the payment of compensation to Persian Gulf War veterans suffering from a chronic disability resulting from an undiagnosed illness (or combination of undiagnosed illnesses) which became manifest to a compensable degree within a period prescribed by regulation. VA regulations implementing that law, codified at 38 CFR section 3.317, effectively limit compensation to "illness...[which] by history, physical examination, and laboratory tests cannot be attributed to any known clinical diagnosis."

Neither the language of the law, nor its clear intent, compels so strict a limitation as that reflected above. I urge you to re-examine your authority under that law and amend this regulation in light of (1) the law's clear purpose, (2) what has been learned about Gulf War illnesses, and (3) the arbitrary and capricious results which flow from adjudications under this regulation. I believe such an analysis will lead you to conclude that the regulation should mandate compensation for illness manifested by symptoms which, after thorough examination, either (1) eludes diagnosis, or (2) if a diagnosis is rendered, attributes such symptoms to an ill-defined illness such as chronic fatigue syndrome or fibromyalgia.

Congress authorized compensation for certain chronic disabilities "resulting from an undiagnosed illness (or combination of undiagnosed illnesses)". One need not go beyond the face of the statute to question a regulation which in effect defines the term "undiagnosed illness" as one which cannot be attributed to any known clinical diagnosis. Literally, the regulation is so narrow as to rule out compensation even for an illness manifested by symptoms that could be attributed to a known diagnosis, even if no diagnosis is made. But to the extent that the Department reads the law as absolutely ruling out service-connection in any case in which a diagnosis has been made, it reads that law too narrowly.

Lest the intent of Congress in enacting the special compensation provision be thought in doubt, consider the congressional findings set forth in section 102 of the Act:

> "(2) Significant numbers of veterans of the Persian Gulf are suffering from illnesses, or are exhibiting symptoms of illness, that cannot now be diagnosed **or clearly defined**." (Emphasis added.)
>
> ***
>
> "(7) ...[V]eterans who are seriously ill as the result of such illnesses should be given the benefit of the doubt and be provided compensation benefits to offset the impairment in earnings capacities they may be experiencing."

As reflected in the above-quoted passages, and particularly the underscored phrase, Congress recognized that, because of the nature of the clusters of symptoms suffered by many Persian Gulf veterans, physicians were often either unable to identify and render a diagnosis, or faced an illness (or illnesses) which was not "clearly defined". Congress intended not only to provide a specific remedy, but signaled its intent that this new compensation policy be administered with the benefit of the doubt afforded the veteran. But in ruling out compensation under PL 103-446 in any case where the illness in question has been given a diagnosis is to ignore both the nature of the illnesses Congress sought to have VA compensate as well as the philosophy of benefits adjudication it sought to have the Department apply.

To illustrate, consider the case of two Persian Gulf War veterans who (1) have similar complaints (fatigue, difficulty in concentrating, musculo-skeletal pain, and gastro-intestinal problems); (2) first report these health care concerns three years after discharge from service; (3) provide similar in-theater histories as to Persian Gulf service; and (4) report "not feeling 100% after returning from the Gulf", suffering the above disabling

symptoms for more than a year, and being unable to work for the last six months. After similar workups, veteran #1, examined at VAMC X, is diagnosed with chronic fatigue syndrome and provided symptomatic treatment. Veteran #2, examined at VAMC Y, is not given a diagnosis, but is provided the same symptomatic treatment for an "illness of undefined nature". Both veterans file claims for compensation. Veteran #1 is denied service connection for chronic fatigue syndrome on the basis that there is no documentation of illness in service and insufficient continuity of symptoms after service; PL 103-446 is deemed not to apply because the veteran does not have an undiagnosed illness. Veteran #2 is granted service connection for his undiagnosed illness under PL 103-446.

While hypothetical in nature, this illustration represents an all-too-plausible snapshot of the arbitrary nature of adjudicative decision-making under the Department's regulation. As reflected in the above hypothetical, veterans become either beneficiaries or victims of a capricious system if they are awarded or denied service connection based on the happenstance of which VA physician happens to examine or treat them. Yet the regulation fosters such caprice when decisions turn on whether a physician, confronted by an ill-defined symptom complex, employs a diagnosis like chronic fatigue syndrome or fibromyalgia, or simply acknowledges his or her uncertainty regarding what is an ill-defined health problem.

What is clear with respect to such symptom complexes is that they are poorly understood. As described in expert testimony presented to our Subcommittee on Health from Dr. Daniel J. Clauw, Chief of Rheumatology, Immunology, and Allergy at Georgetown University Medical Center, at a June 19, 1997 hearing, quoted below, these are ill-defined illnesses, and the line between those cases which result in a diagnosis and those which do not is also a very fine one. It is also understandable that some physicians, untrained in the area, would not employ a diagnosis for a poorly understood symptom complex. Yet a diagnosis like fibromyalgia or chronic fatigue syndrome, as understood in the developing medical literature, identifies precisely the kind of symptoms which were reported by veterans after the Gulf War and which prompted the enactment of P.L 103-446. Dr. Clauw's comments highlight the point:

> "I have been involved in both research and the clinical care of persons afflicted with a number of ill-defined and poorly understood medical conditions, which include fibromyalgia and chronic fatigue syndrome...[A]lthough these symptom complexes go by a variety of semantic terms, most involved in the study

> of these conditions feel that these conditions are one large spectrum of illness. The symptoms and findings in individuals with the Persian Gulf Syndrome are the same as those of persons labeled with these other conditions, except that the Persian Gulf Syndrome patients developed these problems during or after deployment to the Gulf War. Why are these illnesses not recognized, and difficult to diagnose? One of the reasons for incomplete recognition of these conditions is that this symptom complex is given many different names, and many different attributions. Another reason is that there are no blood tests or other diagnostic studies that are predictably abnormal in persons with this illness. Because of this, these conditions are diagnosed on the basis of symptoms, and by excluding other medical problems which can cause the same type of symptoms. Another significant problem with the recognition and acceptance of fibromyalgia and related conditions is that these illnesses in general have become known as 'psychosomatic' conditions. *All of these conditions are either triggered or exacerbated by a variety of physical, immune, or emotional stressors, and there is likely a common underlying cause or causes for this entire spectrum of illness. Unfortunately, the root causes for this spectrum of illness are not presently known.*"

(The Institute of Medicine's discussion of difficult-to-diagnose and ill-defined conditions in its January 1998 report on the "Adequacy of the Comprehensive Clinical Evaluation Program" is also illuminating.)

Accordingly, for the Department to adjudicate cases on the basis of a rigid distinction between "diagnosed" and "undiagnosed" conditions is to ignore altogether what we have come to learn about chronic fatigue syndrome, fibromyalgia and related ill-defined conditions. Continued reliance on the current regulation ignores that medicine does not fully understand these ill-defined conditions and that physicians may or may not diagnose them. As is apparent from the literature on these illnesses, however, they present with many of the same symptoms which have been described in Persian Gulf veterans from the earliest reports and which were the subject of Congress' effort to service-connect veterans who suffer from symptoms of illness which cannot be clearly defined. Thus, for the regulation which implements PL 103-446 to effectively rule out service-connection under that law in any case in which a VA physician happens to assign a diagnostic label associated with an ill-defined illness is to frustrate the purposes of this law, and to raise a serious question of deprivation of due process.

I trust you will carefully consider these concerns in reviewing the applicable VA regulation.

Sincerely,

BOB STUMP
Chairman

OPENING STATEMENT OF HON. BOB FILNER

Mr. FILNER. Thank you, Mr. Chairman. Thank you for your comments. I'm pleased that we'll be able to learn more about the problems veterans are having in obtaining service connection for illnesses related to their service in the Persian Gulf as well as for hepatitis C and cerebral malaria.

It seems that every time we have an illness which is a little harder to identify and pin down than a clear cut obvious physical defect such as an amputated limb, we hear stories of veterans spending years trying to obtain the benefits that I think we agree are rightfully theirs.

The VA describes itself as an organization which grants claims when it can and denies them only when it must. Unfortunately, the cases I hear about, both here and back in my hometown of San Diego, suggest the opposite. For example, Persian Gulf veterans have had their symptoms dismissed as due to combat stress even when laboratory data suggest that a mycoplasma infection may be present. Veterans who are ill enough to qualify for placement on a liver transplant list are rated at only 60 percent or less for service-connected hepatitis C. Veterans who are treated by medics under combat conditions with no access to a military hospital or sophisticated laboratory testing have their claims of service connection for malaria dismissed, because their history of malaria cannot be verified by a medical diagnosis or appropriate laboratory test in their military medical records.

From the perspective of such veterans and members of the this committee, the VA policy is perceived as denying claims whenever it can. Only when the evidence is so overwhelming are benefits, seemingly grudgingly, granted at the lowest possible rating. This is especially true of our combat veterans who are supposed to be given special consideration taking into the account the time, place, and manner of their military service. I hope today's hearings will address these concerns as well as what actions can be taken under current law to solve these problems.

Let me add, also, that it seems—and I say this to the VA and anybody from DOD who's here—anytime a congressional committee gets into the area of the Persian Gulf illness, there is always the perception, somehow, that ends up being given, either unintentionally or by matter of policy, that there is something to hide and that we are stonewalling this and we refuse to look at it. Just at today's hearings, the hearing was on three subjects. The VA, Mr. Epley, gave us testimony on two and not until this morning, I guess, did we get anything on the Persian Gulf. Why does it always seem to be that we don't want to discuss this; that we're hiding something? That's always the impression, somehow, that's given.

And the two pages that you gave us are a collection of statistics which, if I have any time to go over with you today, seem to be intended to hide what is happening rather than to tell us what is happening. The average person looking at what you gave us will say they are trying to dismiss this as an issue. They are trying to hide the severity of the situation. We can't glean anything that the average person can understand from these statistics. It's just that every time we ask a question—every time we ask this subject to be looked at, the method that is used to give us information; the

timing of it; the kind of information; the stuff that is left out; the unanswered questions seem to say more about what this Government is trying to do and not do than get at source of the situation.

Now, I don't mean to say, Mr. Epley, that that's what you intentionally tried to do. I just say that everybody from every department that comes before us and other congressional committees gives us the sense that you don't really want to get into this issue; that the responsibility that this Government has to these veterans is not taken seriously, and, as I have said on other occasions, I think the medical facts that are out there that seem to be known to everybody but the VA and the DOD seem to indicate a much more serious health situation than anybody wants to admit or that you can glean from these statistics, and until somebody comes before this committee or any committee that says, "We have a problem, and we don't know—" be honest with us, then we're going to just think you're lying every time we get a set of statistics like this. I start looking at it and say what are they hiding instead of saying what are they trying to tell me? This Government, it seems to me, owes this country and our veterans the truth on this, and I don't think we're getting it yet. Thank you, Mr. Chairman.

Mr. QUINN. Thank you, Mr. Filner. I yield now to the ranking member of the Full Committee, Mr. Evans? Lane?

OPENING STATEMENT OF HON. LANE EVANS, RANKING DEMOCRATIC MEMBER, FULL COMMITTEE ON VETERANS' AFFAIRS

Mr. EVANS. Thank you, Mr. Chairman. Vietnam veterans, Gulf War veterans, atomic veterans, veterans with traumatic cold injuries, prisoners of war, veterans with malaria, Mr. Chairman, these veterans and others have two things in common: they have fought for their country, and they have been forced to fight again for their health care and other benefits that they deserve having served our country.

In the non-adversarial system of the VA benefits, too often the VA has been the adversary. For example, lay evidence submitted by veterans—sometimes the only credible evidence available for veterans disabled in combat—has not been properly considered by the Veterans Administration.

Mr. Chairman, veterans face unnecessary barriers at the VA as they seek the benefits that they have earned. These barriers must be broken down now. Veterans with these illnesses must not be forced to fight the same battles with their own Government for the benefits that they have earned that Vietnam and other veterans have been forced to fight for.

A recently completed analysis of VA claims data indicates Persian Gulf War veterans exposed to munitions depot destruction are 20 times more likely to be rated 10 percent or more for undiagnosed illnesses than other combat veterans of the theater who didn't serve actually in combat. This important finding was made by the committee's Democratic staff based on analysis of VA claims data.

Additionally, it must be noted that hepatitis infection among Vietnam veterans is increasing dramatically according to the VA data.

Mr. Chairman, thank you for scheduling this important hearing. It's timely, and I appreciate the opportunity to examine the standards by which the VA adjudicates claims. As a result of your efforts and the interest of other members, the standards by which the VA adjudicates claims, I believe, could be more veteran friendly.

Before I close, I'd also like to take a moment to welcome Dr. Varney, from the VA Medical Center in Iowa City. He has assisted many veterans in my congressional district, and I'm pleased that he is here to talk about his groundbreaking work on malaria. Thank you, doctor, for coming. Mr. Chairman, thank you for your time.

Mr. QUINN. Thank you, Mr. Evans. Other members who have opening statements? Mr. Mascara?

Mr. MASCARA. I'd like to ask unanimous consent to place an opening statement into the record.

Mr. QUINN. Without objection, so ordered.

[The prepared statement of Congressman Mascara appears on p. 118.]

Mr. QUINN. Mr. Rodriguez? Okay, and Mr. LaHood.

Mr. LAHOOD. Mr. Chairman, could I include in the record the democratic staff analysis?

Mr. QUINN. Without objection, the analysis is included in today's proceedings.

[The information follows:]

Democratic Staff Analysis of VA Data

The Department of Veterans Affairs (VA) provided the Committee on Veterans' Affairs with data from its "Gulf War Veteran Statistics" database. This database contains information from compensation and pension records and is cross-referenced with data from the Armed Services' Defense Manpower Data Center. Unique Social Security numbers are used to cross-reference the databases. This crosscheck is designed to prevent multiple counting of the same veteran and to verify the location of the veteran during military service.

The data used in this analysis are exclusively for veterans who served during the Persian Gulf Era – the time period beginning on August 2, 1990 and continuing to the present. The data reflects all information in the database as of March 31, 1998.

Separate information establishes the number of veterans who served in the Persian Gulf conflict, theatre and era. Information is also provided on the number of veterans in each of these cohorts who have been rated as service-connected for one or more conditions and the number of veterans in each cohort who were rated as having no service- connected conditions.[1] Additionally, VA provided data for veterans in each cohort who had filed claims for undiagnosed illnesses.[2]

Definitions

For purposes of this analysis, the cohorts are defined as follows:

1. **Era** veterans are veterans who served in the Armed Forces on or after August 2, 1990, but who **did not serve in the Southwest Asia** theatre of operation.

2. **Theatre** veterans served on or **after July 31, 1991** (the end of the fighting) in the Southwest Asia theatre of operations, but did not serve during the time of the conflict.

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[1] See page 4, "Gulf War Veteran Statistics: VA Compensation and Pension Stats."
[2] See page 5, "Gulf War Veteran Statistics: VA Undiagnosed Illness C&P Stats."

3. **Conflict** veterans served between August 2, 1990 and July 31, 1991 in the Southwest Asia theatre of operations, but were **not considered exposed to** the demolition of munitions at **Khamisiyah** in March and April of 1991.

4. **Khamisiyah** service members served on or after August 2, 1990 in the Southwest Asia theatre of operations **and** were potentially exposed to toxic substances in the munitions destruction at Khamisiyah.[3]

The Khamisiyah population includes all relevant service members – those at Khamisiyah who are now veterans and those service members who are still on active duty. Had VA been able to provide us with the number of *veterans* in the Khamisiyah population, the Khamisiyah percentages in our analysis would almost certainly have been higher because the denominator in our calculations would have been lower.

From the data which VA provided, the percentage of veterans in each category of each cohort (e.g. conflict veterans with one or more service connected condition) was calculated by dividing the number of veterans in each category by the total number of veterans in the cohort.[4] The number of veterans in each cohort who had filed claims was also calculated by adding the number of veterans who were granted service-connection for one or more conditions to the number of veterans who were rated as having no service connected conditions. We determined the percentage of veterans in each cohort who had filed claims by dividing the number who had filed claims by the total number of veterans in the cohort.[5]

Preliminary Findings

The percentage of Khamisiyah veterans who filed claims and were granted service connection was **one-third higher** than the analogous percentage of veterans who served in the Persian Gulf conflict (not including

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[3] See pages 6-7, "Gulf War Veteran Statistics: VA Khamisiyah Populations C&P Stats." The conflict veterans data which VA provided included the data for the Khamisiyah population. Therefore, we subtracted the Khamisiyah population data from the conflict veterans' data to determine the exclusive conflict veterans data which we used for our analysis.

[4] See chart on page 8. These percentages are also represented graphically on pages 11-16.

[5] See bottom of chart on page 8. These percentages are also represented graphically on page 10.

Khamisiyah veterans) and during the Persian Gulf era (not including veterans who served in the Persian Gulf theatre or conflict).[6]

Veterans who were potentially exposed to toxic substances in the Khamisiyah incident were **20 times** more likely to have been granted service connection with a rating of 10 percent or greater for **undiagnosed illnesses** than those who served in the Persian Gulf theatre (not including those who served in the Persian Gulf conflict).[7] The small size of this cohort must be noted however.

VA also provided information on the number of Persian Gulf veterans who have been examined at each VA medical center.[8] A preliminary review of the units which were potentially exposed to toxic substances in the Khamisiyah incident indicates that many of these units were **from Fort Bragg, NC and Fort Hood, TX, which are very close to Fayetteville, NC and Temple, TX (the two VA medical centers which had provided the most examinations of Persian Gulf veterans), respectively.**

The data analysis completed to date is a preliminary examination. Further study should examine the relationship between possible exposure to toxic substances at Khamisiyah and undiagnosed illnesses which may merit VA compensation. The Committee has requested information concerning the specific disabilities, in addition to undiagnosed illnesses, which have been service-connected for veterans exposed to Khamisiyah.

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[6] See graphs on pages 10-11.
[7] See page 9 for more detail on this.
[8] See page 18 for a listing of the top ten VA medical centers providing examinations to Persian Gulf veterans.

'Gulf War Veteran Statistics'

Report Date: 1998-04-15

Report Type: VA Compensation and Pension Stats.

Period Totals: Exclusive Report Totals

– Print –

– Close –

Veteran Group	ERA	THEATER	CONFLICT
Service Members	2,407,560	402,932	696,583
Estimated Veterans	2,242,242	222,086	563,742
Number of Veterans with 1 or More SC Conditions	341,547	29,100	118,584
Service Connected 10% or greater - Receiving Compensation or Pension.	227,803	18,752	76,460
Service Connected 0% - Receiving Compensation or Pension	11,153	986	3,835
Service Connected 10% - No Compensation	5,783	408	1,892
Service Connected 0% - No Compensation	96,808	8,954	36,397
Estimated Number of Claims Pending	53,211	9,160	30,924
Not Service Connected - Receiving Pension	714	33	230
Not Service Connected - No Pension	36,053	2,557	17,544

'Gulf War Veteran Statistics'

Report Date: 1998-04-15

Report Type: VA Undiagnosed Illness C&P Stats.

Period Totals: Exclusive Report Totals

-- Print --

-- Close --

[redacted]	ERA	THEATER	CONFLICT
Service Members	2,407,560	402,932	696,583
Estimated Veterans	2,242,242	222,086	563,742
Number of Veterans with 1 or More Undiagnosed SC Conditions	29	72	1,866
SC 10% Undiagnosed illness - Receiving Compensation or Pension	23	62	1,621
SC 0% Undiagnosed illness - Receiving Compensation or Pension	4	6	146
SC 10% Undiagnosed illness - No Compensation	0	0	7
SC 0% Undiagnosed illness - No Compensation	2	4	92
NSC Undiagnosed illness - Receiving Compensation or Pension	31	87	1,975
NSC Undiagnosed illness - No Compensation	106	126	3,884

'Gulf War Veteran Statistics'

Report Date: 1998-04-15

Report Type: VA Khamisiyah Population C&P Stats.

Period Totals: Inclusive Report Totals

-- Print --

-- Close --

Veteran Group	Era	Theater	Conflict
Service Members	3,507,075	1,099,515	696,583
Estimated Veterans	3,028,070	785,828	563,742
Khamisiyah Grid - POTENTIALLY Exposed Service Members	Not Applicable	Not Applicable	99,719
Number of Khamisiyah Veterans with 1 or More SC Conditions	Not Applicable	Not Applicable	21,113
Khamisiyah - SC 10% Receiving Compensation or Pension	Not Applicable	Not Applicable	13,420
Khamisiyah - SC 10% Undiagnosed illness - Receiving Compensation or Pension	Not Applicable	Not Applicable	311
Khamisiyah - SC 0% Receiving Compensation or Pension	Not Applicable	Not Applicable	610
Khamisiyah - SC 0% Undiagnosed illness - Receiving Compensation or Pension	Not Applicable	Not Applicable	21
Khamisiyah - SC 10% No Compensation	Not Applicable	Not Applicable	348
Khamisiyah - SC 10% Undiagnosed illness - No Compensation	Not Applicable	Not Applicable	1
Khamisiyah - SC 0% No Compensation	Not Applicable	Not Applicable	6,735

Khamisiyah - SC 0% Undiagnosed illness - No Compensation	Not Applicable	Not Applicable	26
Khamisiyah - NSC Receiving Pension	Not Applicable	Not Applicable	53
Khamisiyah - NSC Undiagnosed illness - Receiving Pension	Not Applicable	Not Applicable	439
Khamisiyah - NSC No Pension	Not Applicable	Not Applicable	3,375
Khamisiyah - NSC Undiagnosed illness - No Pension	Not Applicable	Not Applicable	800

Disposition of Claims Filed by Persian Gulf Veterans
Compiled by Democratic Staff
House Committee on Veterans' Affairs

Percentage of Persian Gulf Veterans

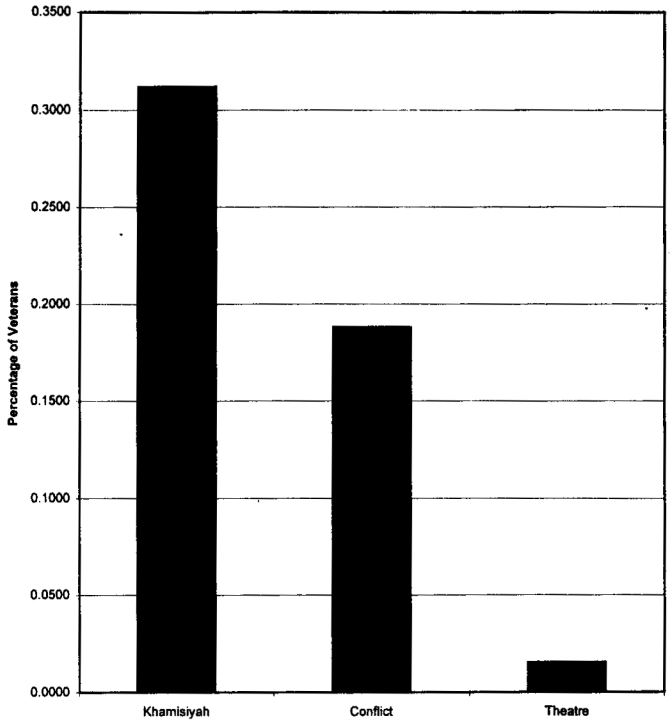
Veterans	# Khamisiyah	Conflict	Theatre	Era
1 or more SC conditions	21.1725	13.9927	7.2399	14.1876
SC 10% - receiving comp. or pension	13.4578	9.3178	4.6539	9.4620
SC 10% undiagnosed illness - receiving comp. or pension	0.3119	0.1881	0.0154	0.0010
SC 0% - receiving comp. or pension	0.6117	0.4630	0.2447	0.4632
SC 0% undiagnosed illness - receiving comp. or pension	0.0211	0.0179	0.0015	0.0002
SC 10% - no comp.	0.3490	0.2217	0.1013	0.2402
SC 10% undiagnosed illness - no comp.	0.0010	0.0009	0.0000	0.0000
SC 0% - no comp.	6.7540	4.2582	2.2222	4.0210
SC 0% undiagnosed illness - no comp.	0.0261	0.0095	0.0010	0.0001
NSC - receiving pension	0.0531	0.0254	0.0082	0.0297
* NSC undiagnosed illness - receiving comp. or pension	0.4402	0.2205	0.0216	0.0013
NSC - no pension	3.3845	2.0341	0.6346	1.4975
** NSC undiagnosed illness - no comp. or pension	0.8023	0.4140	0.0313	0.0044

Based upon the total veteran population in each cohort (not all veterans have filed claims with the Department of Veterans Affairs)

= Khamisiyah population includes veterans and service members still on active duty
* = receiving pension for Khamisiyah; receiving compensation or pension for conflict, theatre and era
** = no pension for Khamisiyah; no compensation for conflict, theater and era

The percentage of Persian Gulf veterans filling claims:	25.8526	16.6867	7.9356	15.7205

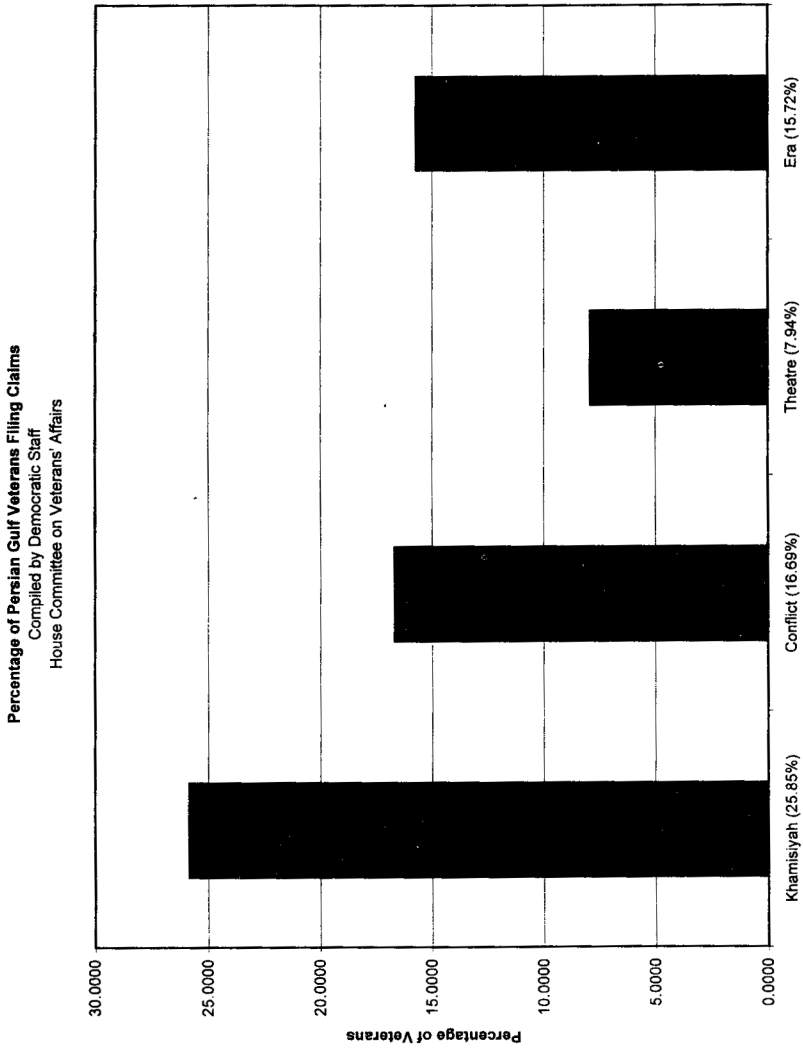
Percentage of Veterans with Undiagnosed Illnesses Service Connected at 10% or Greater Who Are Receiving Compensation or Pension
Compiled by Democratic Staff
House Committee on Veterans' Affairs

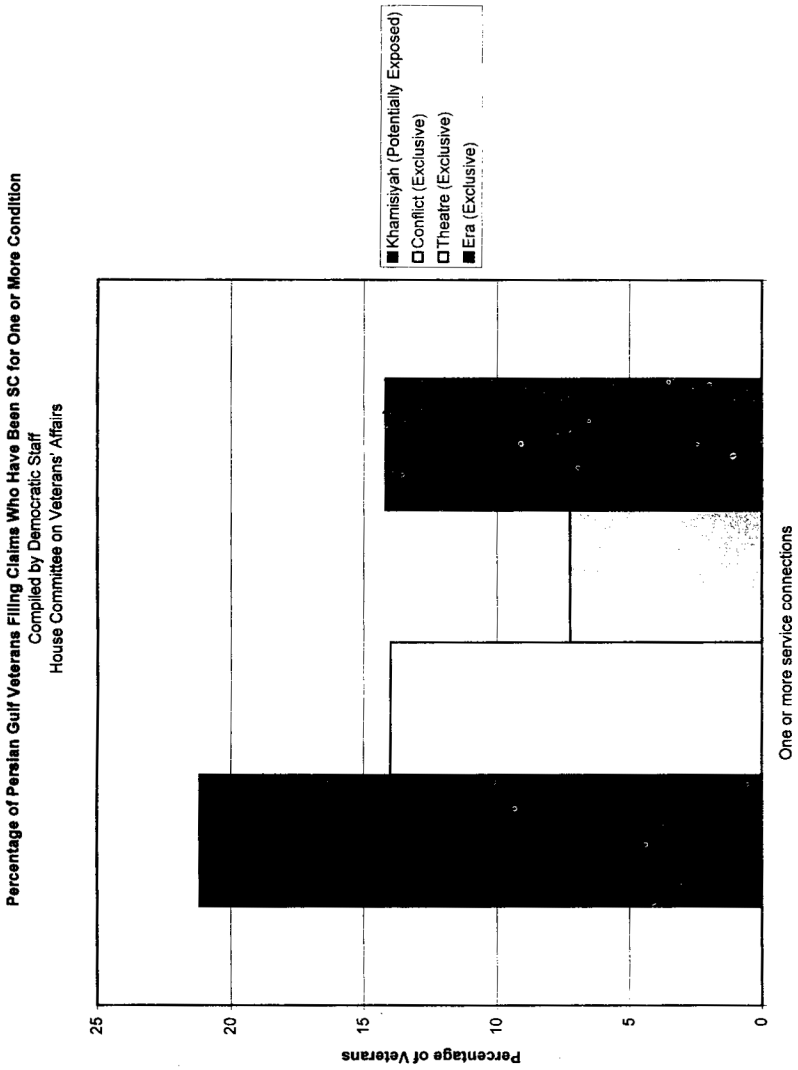


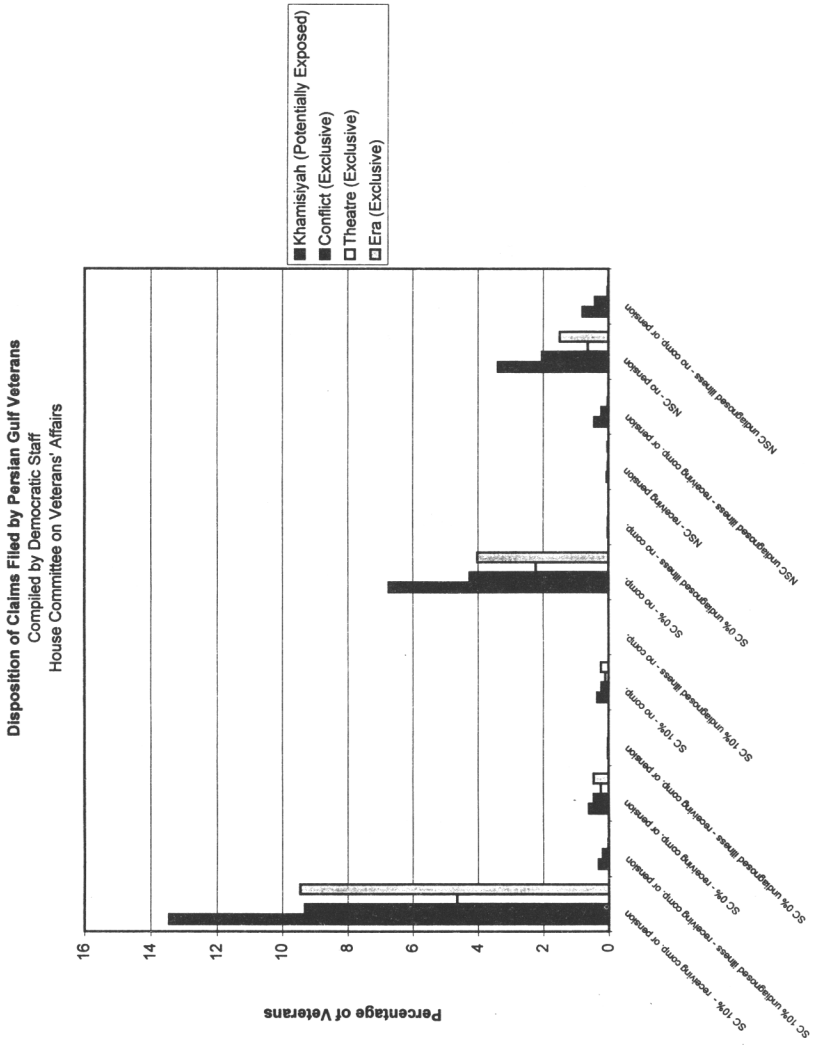
311 of the 99,719 veterans or active duty service members (0.312%) who were potentially exposed to toxic substances in the Khamisiyah incident have been granted service connection with a rating of 10% or more for an undiagnosed illness.

1,621 of the 696,583 veterans (0.188%) who were in the Gulf War Conflict but not identified as exposed to toxic substances in the Khamisiyah incident have been granted service connection with a rating of 10% or more for an undiagnosed illness.

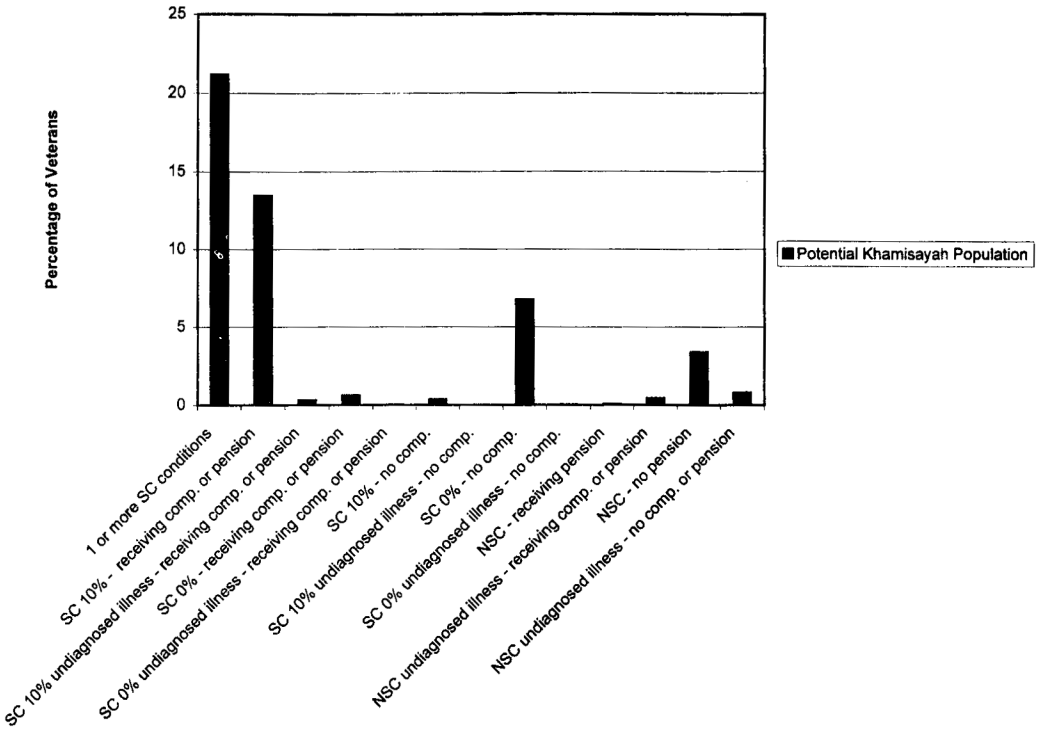
62 of the 402,932 veterans (0.015%) who served in the Persian Gulf Theatre but not during the Persian Gulf Conflict (after July 31, 1991) have been granted service connection with a rating of 10% or more for an undiagnosed illness.

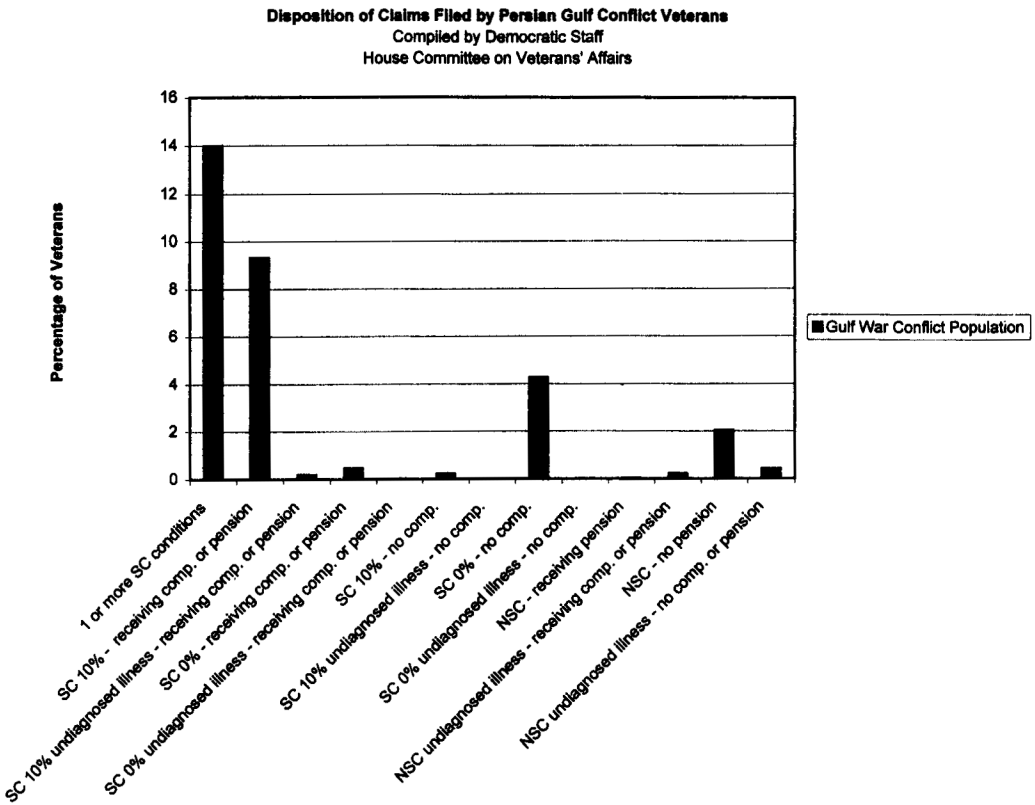

Percentage of Persian Gulf Veterans Filing Claims
Compiled by Democratic Staff
House Committee on Veterans' Affairs
30.0000
25.0000
20.0000
15.0000
10.0000
5.0000
0.0000
Percentage of Veterans
Khamisiyah (25.85%)
Conflict (16.69%)
Theatre (7.94%)
Era (15.72%)


Percentage of Persian Gulf Veterans Filing Claims Who Have Been SC for One or More Condition
Compiled by Democratic Staff
House Committee on Veterans' Affairs
Khamisiyah (Potentially Exposed)
Conflict (Exclusive)
Theatre (Exclusive)
Era (Exclusive)
Percentage of Veterans
25
20
15
10
5
0
One or more service connections

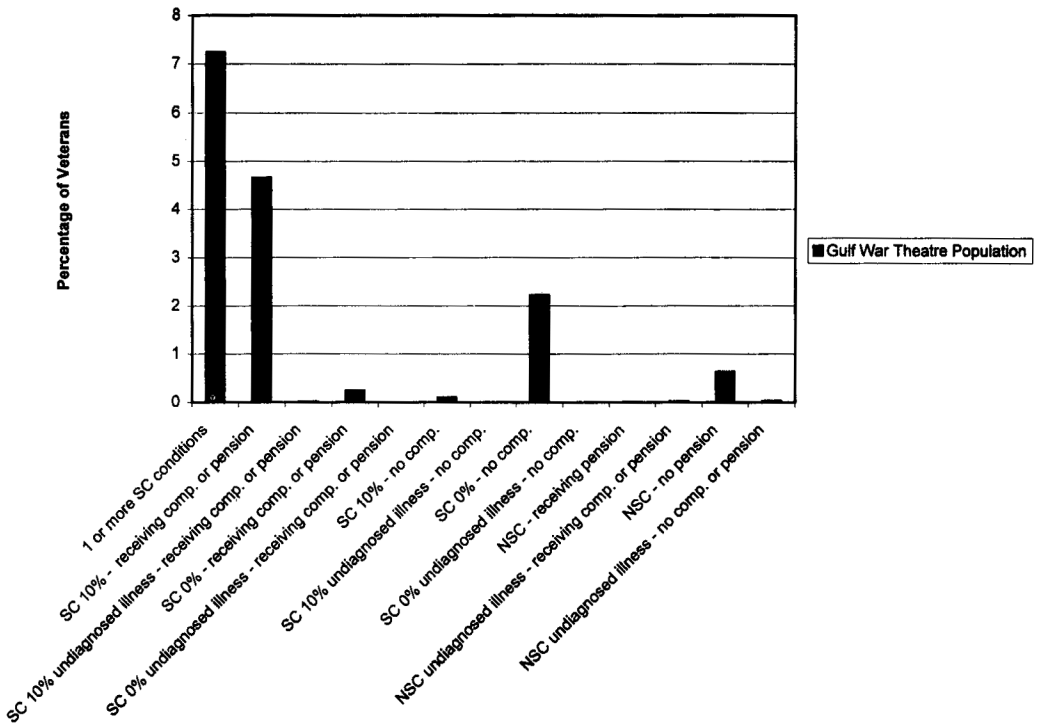

Disposition of Claims Filed by Persian Gulf Veterans
Compiled by Democratic Staff
House Committee on Veterans' Affairs
Khamisiyah (Potentially Exposed)
Conflict (Exclusive)
Theatre (Exclusive)
Era (Exclusive)
Percentage of Veterans
0
2
4
6
8
10
12
14
16
SC 10% - receiving comp. or pension
SC 10% undiagnosed illness - receiving comp. or pension
SC 0% - receiving comp. or pension
SC 0% undiagnosed illness - receiving comp. or pension
SC 10% - no comp.
SC 10% undiagnosed illness - no comp.
SC 0% - no comp.
SC 0% undiagnosed illness - no comp.
NSC - receiving pension
NSC undiagnosed illness - receiving comp. or pension
NSC - no pension
NSC undiagnosed illness - no comp. or pension

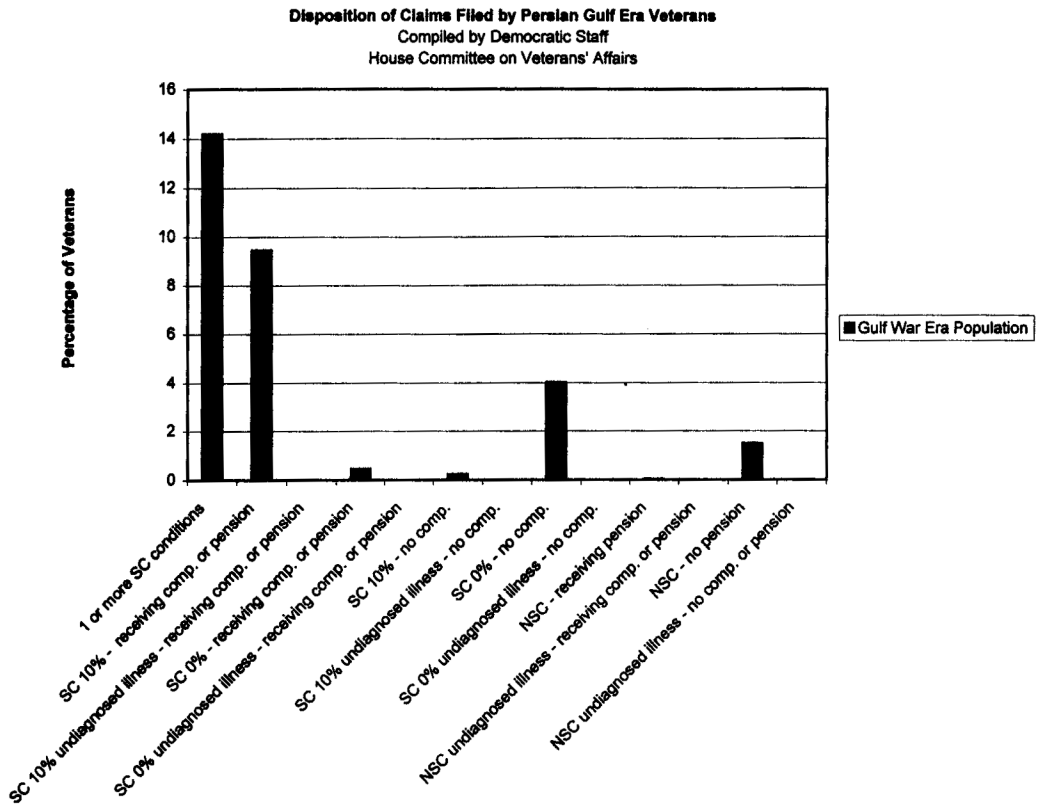
Disposition of Claims Filed by Persian Gulf Veterans Potentially Exposed to Khamisiyah
Compiled by Democratic Staff
House Committee on Veterans' Affairs

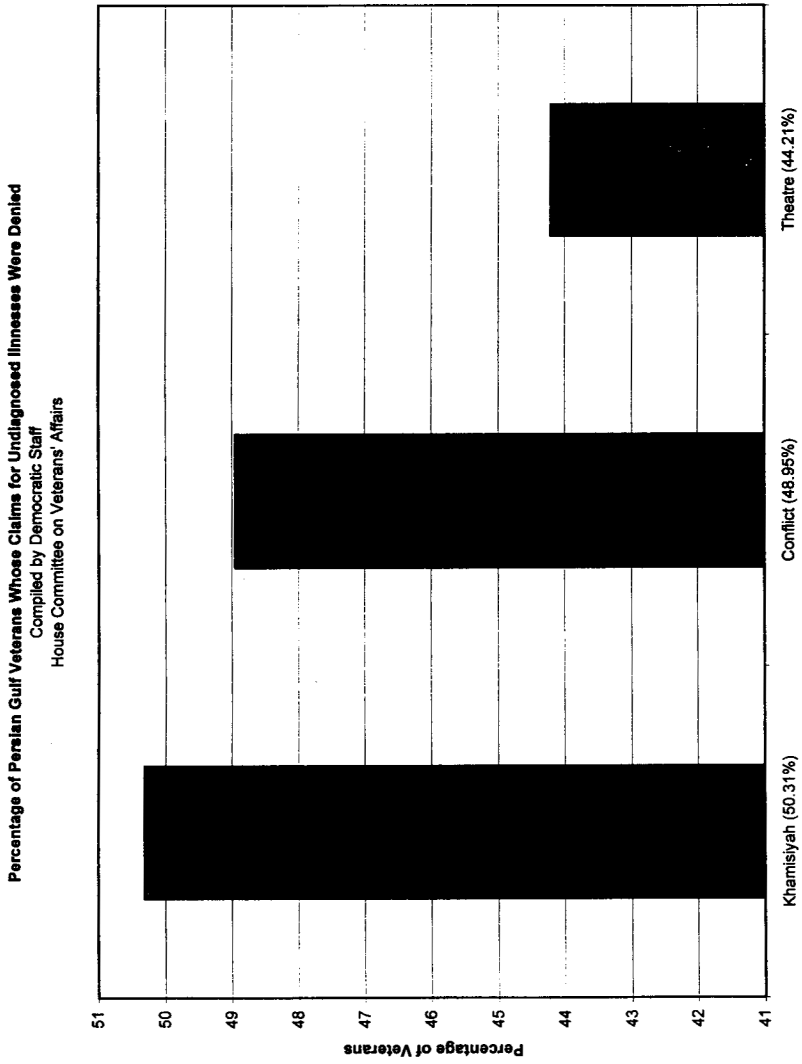



Disposition of Claims Filed by Persian Gulf Conflict Veterans
Compiled by Democratic Staff
House Committee on Veterans' Affairs
Percentage of Veterans
16
14
12
10
8
6
4
2
0
Gulf War Conflict Population
1 or more SC conditions
SC 10% - receiving comp. or pension
SC 10% undiagnosed illness - receiving comp. or pension
SC 0% - receiving comp. or pension
SC 0% undiagnosed illness - receiving comp. or pension
SC 10% - no comp.
SC 10% undiagnosed illness - no comp.
SC 0% - no comp.
SC 0% undiagnosed illness - no comp.
NSC - receiving pension
NSC undiagnosed illness - receiving comp. or pension
NSC - no pension
NSC undiagnosed illness - no comp. or pension

Disposition of Claims Filed by Persian Gulf Theatre Veterans
Compiled by Democratic Staff
House Committee on Veterans' Affairs




Disposition of Claims Filed by Persian Gulf Era Veterans
Compiled by Democratic Staff
House Committee on Veterans' Affairs
Percentage of Veterans
16
14
12
10
8
6
4
2
0
Gulf War Era Population
1 or more SC conditions
SC 10% - receiving comp. or pension
SC 10% undiagnosed illness - receiving comp. or pension
SC 0% - receiving comp. or pension
SC 0% undiagnosed illness - receiving comp. or pension
SC 10% - no comp.
SC 10% undiagnosed illness - no comp.
SC 0% - no comp.
SC 0% undiagnosed illness - no comp.
NSC - receiving pension
NSC undiagnosed illness - receiving comp. or pension
NSC - no pension
NSC undiagnosed illness - no comp. or pension


Percentage of Persian Gulf Veterans Whose Claims for Undiagnosed Illnesses Were Denied
Compiled by Democratic Staff
House Committee on Veterans' Affairs
Percentage of Veterans
51
50
49
48
47
46
45
44
43
42
41
Khamisiyah (50.31%)
Conflict (48.95%)
Theatre (44.21%)

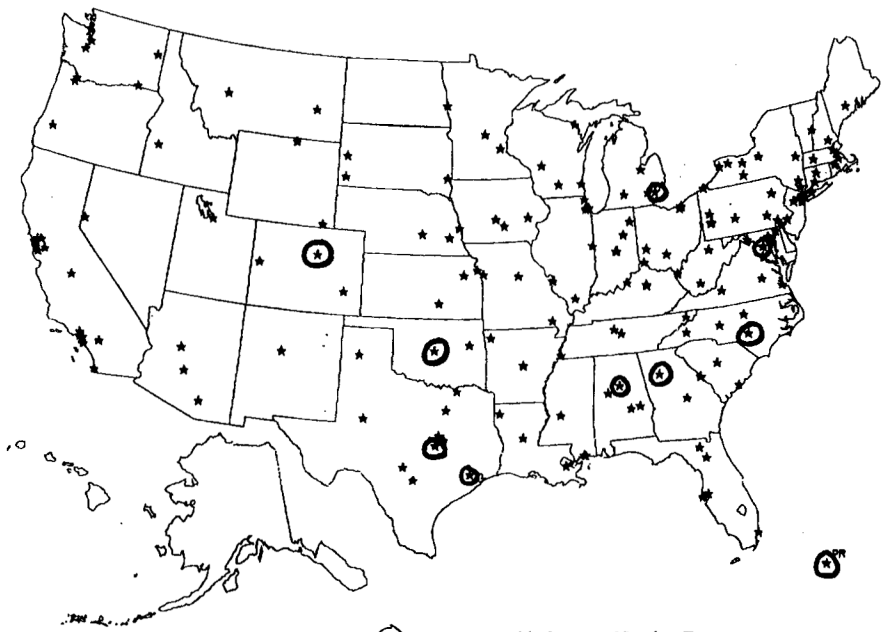
Examinations of Persian Gulf Veterans by Facility

Facility Name	Number of Veterans	Percentage
Fayetteville, NC	1,854	2.7
Temple, TX	1,668	2.4
San Juan	1,585	2.4
Denver	1,626	2.3
Decatur	1,614	2.3
Oklahoma City	1,263	1.8
Birmingham	1,257	1.8
Washington, DC	1,134	1.7
Houston	1,023	1.5
Allen Park, MI	1,017	1.5
San Antonio	809	1.2
El Paso	753	1.1
Iowa City	537	0.8
Hines, IL	505	0.7
Pittsburgh	453	0.7
San Diego	447	0.6
North Chicago	123	0.2
Chicago (WS)	121	0.2
Chicago (LS)	28	0.0
Kerrville, TX	2	0.0

Department of Veterans Affairs

Location of Medical Centers Conducting Persian Gulf Health Examinations

By Number of Examinations Conducted as of 06/25/98



Office of Policy and Planning - Information Management Team (008)

Mr. QUINN. Mr. Filner.

Mr. FILNER. Mr. Chairman, I would also like to ask unanimous consent that the record remain open for 3 weeks so additional written testimony that I anticipate will be submitted can be included in the record.

Mr. QUINN. Mr. Filner has asked that the record remain open for 3 weeks. I hear no objection. Hearing none, it is so ordered, Bob. Thanks, good idea; appreciate it.

So, thank you all, and we have our first panel, Mr. Epley, and Dr. Wright, Dr. Varney, and Dr. Booss. But before we—and we're going to start from you, Mr. Epley and work over—I'd like to—in your prepared testimony, you point out—and this is the kind of information I think Bob and I were talking about. We just want the information; we don't suspect it, but if we don't get it or we get it late then we have reason—but at one point in time one of the numbers in there is that 29 hepatitis claims were denied by the board—and we can cite the page number for you; I was looking at it earlier this morning. I'd just like to know on what grounds they were denied is all. We don't have to have a separate case-by-case, but in those 29, by the end of next week, we'd like to know—I would like to know why they were denied. Thank you. You may proceed, Mr. Epley.

[The information follows:]

DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON DC 20420

August 14, 1998

The Honorable Jack Quinn
Chairman, Subcommittee on Benefits
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

This is in response to the requests made by you and Congressman Filner in follow-up to your hearing on July 16, 1998, related to compensation claims for hepatitis C, cerebral malaria, and Gulf War (GW) veterans' illnesses.

As was arranged with Subcommittee staff, a coordinated VA and DoD briefing on depleted uranium took place on August 6. Copies of correspondence on depleted uranium and description of depleted uranium research have been provided under separate cover.

Second, enclosed is summary data from the Board of Veterans' Appeals related to 29 hepatitis C appeals that were denied. This document was previously provided to Subcommittee staff.

Third, enclosed is the information you requested on current VA research projects related to cold weather injuries, tropical diseases, combat-related stress, exposure to ionizing radiation, exposures to hazardous materials, and GW veterans' illnesses. This also has been provided to your staff.

Fourth, VA Congressional Affairs staff has contacted your staff to identify a date in August for VBA to provide a complete analysis of data related to GW veterans' compensation claims.

Fifth, we regret that testimony related to Gulf War veterans claims data was late. As you noted, this issue was added after your initial invitation. VA officials were initially under the impression that they only needed to be able to respond to oral questions and need not submit written testimony related to GW veterans' claims. Subcommittee staff notified us two days before the hearing of the need for a written statement addressing this issue. Because all testimony on GW veterans' issues requires OMB clearance, that portion of VA's testimony was sent to OMB for their review the day before the hearing. Clearance was subsequently obtained and testimony provided to Subcommittee staff early the next morning – the day of the hearing.

2.

The Honorable Jack Quinn

I hope this information meets your needs. We look forward to continuing to work with you on issues affecting our nations' veterans. A similar letter has been sent to Congressman Filner.

Sincerely,

Sheila Clarke McCready
Principal Deputy Assistant Secretary
for Congressional Affairs

Enclosures

"Well-grounded Claims"

The attached document summarizes 29 Board cases in which appeals were denied because the claims were found to be "not well-grounded."

The reason the term "well-grounded" exists and is important is because 38 U.S.C. § 5107(a) specifies that a claimant "shall have the burden of submitting evidence sufficient to justify a belief by a fair and impartial individual that the claim is 'well grounded.'" If the claim is not well-grounded, it must be denied.

The U.S. Court of Appeals for the Federal Circuit has adopted the following definition of a "well-grounded" claim for veterans benefits:

> [A] plausible claim, one which is meritorious on its own or capable of substantiation. Such a claim need not be conclusive but only possible to satisfy the burden of [38 U.S.C.] § 5107(a). For a claim to be well grounded, there must be (1) a medical diagnosis of a current disability; (2) medical, or in certain circumstances, lay evidence of in-service occurrence or aggravation of a disease or injury; and (3) medical evidence of a nexus between an in-service [disease or injury] and the current disability. Where the determinative issue involves medical causation, competent medical evidence to the effect that the claim is plausible is required.

Epps v. Gober, 126 F.3d 1464, 1468 (1997), *quoting Epps v. Brown,* 9 Vet. App. 341, 343-44 (1996).

Like a not well-grounded claim, a well-grounded claim can fall short of presenting enough evidence to justify a grant of benefits. There is, however, an important difference:

- If a claim is well-grounded, VA has a duty to assist the veteran in developing the facts pertinent to the claim.

- If a claim is not well-grounded, VA has no duty to develop facts pertinent to the claim. However, if VA is on notice that relevant evidence may have existed, or could have been obtained that, if true, would have made the claim well-grounded, VA must notify the veteran of the evidence needed. *McKnight v. Gober,* 131 F.3d 1483 (Fed. Cir. 1997) (per curiam).

In the summaries that follow, the Board found that the appellant's case lacked one (or more) of the three requirements for a well-grounded claim.

Prepared by the Office of the Chief Counsel
Board of Veterans' Appeals
July 27, 1998

Summaries of Appeals Relating to Hepatitis C Denied by the Board of Veterans' Appeals as "Not Well-Grounded," 1997

Source: **Board of Veterans' Appeals 1996-97 Decisions and Veterans Benefit Law Index (Government Printing Office 1998) (CD-ROM)**

1. Docket No. 94-05 110
   Issue: Entitlement to service connection for hepatitis.

The veteran had service from 1964 to 1968, and his service medical records show no complaints, treatment or diagnosis of hepatitis. He was treated for mortar wounds in service. While his medical records did not show that he received a transfusion in connection with that treatment, there are apparently medical records which show that his hematocrit (percentage of red blood cells in the blood) was 43 percent upon arrival and 46 percent following surgery. The first diagnosis of hepatitis is in 1978, 10 years after separation.

The veteran presented no medical evidence that (a) the increased hematocrit meant that he had had a transfusion, or (b) even assuming he had a transfusion, that the transfusion in service was the cause of his hepatitis. Accordingly, the Board concluded that there was no competent evidence of a nexus between a current diagnosis of hepatitis and any inservice disease or injury, found that the claim was not well-grounded, and denied the appeal.

Note: The form of hepatitis is not noted.

2. Docket No. 95-10 301
   Issue: Entitlement to service connection for residuals of hepatitis.

The veteran had active service from 1970-72. He was treated in service in 1970 for infectious hepatitis. Upon discharge from the hospital he was asymptomatic. The veteran claims that he is infected with hepatitis C.

There is, however, no diagnosis of hepatitis C—or any form of hepatitis—nor any symptomatology or residuals of hepatitis. Citing *LeShore v. Brown,* 8 Vet. App. 406, 408 (1995), the Board held that the veteran's opinion that he has hepatitis is not competent evidence. Because there was no medical evidence of a current disability, the Board concluded that the claim was not well-grounded and denied the appeal.

3. Docket No. 94-17 492
   Issue: Entitlement to service connection for hepatitis secondary to surgery for service-connected gallbladder disability.

The veteran had active service with the National Guard in 1976, and with the Army Reserves from November 1977 to February 1978. Service connection is in effect for

postoperative residuals of a cholecystectomy (surgical removal of the gall bladder) in a VA hospital in 1979. The appellant reported that she had had abnormal liver function tests in the past and that she had been told that she had non-A, non-B hepatitis.

A May 1993 test for the hepatitis C antibody was negative. The only evidence that the veteran has hepatitis was her statement. Because there was no competent evidence that the veteran had the claimed disability, the Board concluded that the claim was not well-grounded, and denied the appeal.

4. Docket No. 95-15 722
   Issue: Entitlement to service connection for chronic urinary tract infections as secondary to Hepatitis C.

The veteran served in Vietnam from December 1968 to December 1969. The report of 1992 VA Agent Orange examination concluded in a diagnosis of possible cirrhosis. Service records show one episode of genitourinary symptomatology in service, and no evidence of Hepatitis C.

The veteran presented no medical evidence that he has either a genitourinary disorder or hepatitis C. Because there was no competent evidence of the claimed disability, the Board concluded that the claim was not well-grounded and denied the appeal.

5. Docket No. 94-45 233
   Issue: Entitlement for service connection for hepatitis.

The veteran had active service from February 1992 to March 1993. The veteran gave plasma in March 1993 and was informed that she was positive for hepatitis C. She does not claim current symptoms, but that she was exposed to hepatitis during service. Service medical records do not show a diagnosis of hepatitis or evidence of any residuals from hepatitis exposure.

The veteran presented no medical evidence that she is infected with hepatitis C. (She said that the facility which informed her that she had hepatitis C would not release her medical records to her; VA tried, unsuccessfully, to get those same records.) Following a June 1995 review of her records, a VA health-care examiner concluded that the veteran had normal liver function and did not have hepatitis. Because there was no medical evidence that she currently has chronic hepatitis, the Board concluded that her claim was not well-grounded and denied the appeal.

6. Docket No. 95-05 561
   Issue: Entitlement to service connection for hepatic cirrhosis.

The veteran had service from 1967 to 1970, with service in Vietnam in 1967-68. He claims that he contracted Hepatitis C from a blood transfusion during treatment for shell fragment wounds. A filed medical card shows that the veteran was treated for shrapnel

wounds in January 1968. The card notes superficial wounds for which no tourniquet was applied and makes no mention of a blood transfusion.

The veteran submitted laboratory and pathology reports and treatment records concerning hepatitis C and its complications. The earliest of these is dated 1991 and several report a history of blood transfusions in service in Vietnam. At his hearing the veteran stated that he did not recall receiving a blood transfusion, but thought it was likely because he was unconscious for a period of time and remembered being soaked in his own blood. He reported intravenous drug use while in Vietnam, which he discontinued after his return to the United States.

The report of a current medical examination showed status post multiple shrapnel wounds and chronic hepatitis C with possible early cirrhosis. The examiner noted that the etiology of the hepatitis was unknown, that there was no evidence of a blood transfusion in the case and that often the cause of infection is unknown.

The Board found that the veteran had hepatitis C. However, there was no evidence of a blood transfusion in service other than the veteran's own supposition, and the medical records of shrapnel wounds in service did not indicate injury sufficient to warrant a blood transfusion. In any event, there was no medical opinion linking the veteran's service and his current diagnosis of hepatitis C. Accordingly, the Board concluded that the claim was not well-grounded and denied the appeal.

7. Docket No. 96-48 768A
   Issue: Entitlement to service connection for hepatitis C, secondary to transfusions for a gunshot wound.

The veteran had active duty from August 1975 to July 13, 1979. The veteran was shot on either July 23, or July 24, 1979 and treated at William Beaumont Army Hospital. Hospital records show that he underwent an exploratory laparotomy and several blood transfusions. In an April 1996 letter, a private physician expressed his belief that the veteran contracted hepatitis C from those blood transfusions.

Service connection is granted for disability resulting from disease or injury contracted in the line of duty while on active duty. 38 U.S.C.A. § 1131 (West 1991). Since the gunshot wound was incurred after the veteran was separated from service, and no evidence was presented linking either the wound or hepatitis C to service, the Board concluded that service connection was precluded and the claim was not well-grounded.

8. Docket No. 94-48 381
   Issue: Entitlement to service connection for hepatitis.

The veteran had active service from 1980 to 1986. He claims current hepatitis had its onset in service.

There is no reference to hepatitis in the veteran's service medical records, nor do they reveal any additional abnormalities or liver function studies.

Service medical records show that, in 1984, the veteran was found to have pneumothorax (an accumulation of air or gas in the cavity containing the lungs) in 1984 and underwent thoracotomy (a surgical incision of the chest wall). April 1984 treatment records show extremely mild elevation in liver function that was resolving itself. The increase in liver function was described as secondary to the thoracotomy. There was no indication in the service medical records that increase in liver function tests or pneumothorax was the result of hepatitis.

In 1990, the veteran was hospitalized for alcohol dependence, and tested positive for hepatitis B antibody. Studies of his liver function were reported to be consistent with past infection with hepatitis B. Diagnoses included alcohol hepatitis, mild. Subsequent treatment records make reference to hepatitis B and hepatitis C, as well as liver disease, largely by history. A 1993 VA compensation examination included diagnoses of elevated liver enzyme studies and probable cirrhosis of the liver.

The Board found no competent medical evidence—i.e., medical opinions—that the veteran's hepatitis had its onset in service, and that the only in-service evidence of liver pathology was attributed by treating physicians to a cause other than hepatitis. Accordingly, the Board concluded that the claim was not well-grounded and denied the appeal.

9. Docket No. 92-08 031
   Issue: Entitlement to service connection for hepatitis.

The veteran had active service from June 1968 to September 1970. He contends that he incurred hepatitis while serving in Vietnam as a result of exposure to Agent Orange. There is no record of treatment or diagnosis of hepatitis in his service medical records.

He first tested positive for hepatitis B and hepatitis C in 1990.

The veteran presented no medical evidence linking his diagnosis of hepatitis with his service. Accordingly, the Board concluded that his claim was not well-grounded and denied the appeal.

10. Docket No. 95-08 758
    Issue: Entitlement to service connection for cirrhosis of the liver.

The veteran had active service from August 1967 to May 1972. He claims that current cirrhosis of the liver is the result of malaria, the administration of inoculations, drinking contaminated water, or exposure to Agent Orange in Vietnam. He claims that he has suffered swelling of the lower legs and a skin rash since service, and that both these disorders are early manifestations of cirrhosis.

Medical records show that cirrhosis of the liver was first diagnosed in 1993. The contemporaneous VA hospital summary shows elevated liver function tests and a laboratory test positive for hepatitis C. The report of a VA orthopedic examination in June 1994 includes the comment that it is conceivable that swelling of the joints was connected to hepatitis C and liver cirrhosis.

Service medical records show no complaints, clinical findings or diagnoses of cirrhosis of the liver or hepatitis. A VA examination from October 1977, more than five years after separation from service, shows no complaints, clinical findings or diagnoses of cirrhosis of the liver.

The veteran has advanced four theories that place the onset of cirrhosis in service despite the absence of a diagnosis in service. He was hospitalized in July 1969 with an admission diagnosis of probable malaria. Smears taken during hospitalization demonstrated that malaria was not present. The medical records contain no further mention of malaria and therefore, there is no competent medical evidence of the presence of malaria in service.

Post service medical records show that liver concerns were first noted in 1979. A March 1979 notation indicates that the veteran was exposed to hepatitis six months earlier. Drinking binges were noted. Assessments were suspected alcoholic liver disease, probably transient; unable to rule out hepatitis. In 1982, the liver was enlarged, but testing showed no dysfunction. Hepatitis screening was negative in March 1982 and liver tests in 1987 showed no evidence of chronic liver disease. VA medical records first demonstrate the presence of hepatitis C and cirrhosis of the liver in 1993. There is no competent medical evidence to connect the manifestation of hepatitis C and cirrhosis of the liver in the early 1990's with service 20 years earlier.

The veteran contends that cirrhosis of the liver is related to inoculations or to drinking contaminated water in service. There is no competent medical evidence to make that connection and the assertion of a connection is beyond the veteran's competence, as a lay person, to make. *Espiritu v. Derwinski*, 2 Vet. App. 492 (1992); *Grottveit v. Brown*, 5 Vet. App. 91 (1993). The veteran's contention that cirrhosis is due to exposure to Agent Orange suffers from the same deficit. Cirrhosis is not among those disorders for which service connection will be presumed when exposure to Agent Orange is shown, and the veteran has offered no evidence other than his own lay assertion to show that there is a connection.

For a claim of service connection to be well grounded, there must be competent evidence of a current disability (a medical diagnosis), of incurrence or aggravation of a disease or injury in service (lay or medical evidence) and a nexus between the in service injury or disease and the current disability (medical evidence). *Caluza v. Brown*, 7 Vet. App. 498 (1995). Here, unequivocal medical evidence places the first manifestation of cirrhosis of the liver in 1993, many years after service. No competent medical evidence has been

presented to establish the onset of cirrhosis in service (*Caluza* requirement number two) or which would establish a medical nexus between cirrhosis and an disease or injury in service (Caluza requirement number three).

11. Docket No. 94-34 024
Issues: Entitlement to service connection for cirrhosis of the liver and for residuals of hepatitis C, as residual to Agent Orange exposure.

The veteran had active service from August 1968 to June 1970, including service in Vietnam from May to August 1969. He does not allege that cirrhosis of the liver or hepatitis C were present during active service, on service separation examination, during the initial postservice year, or for many years after separation from service. His sole contention is that those disabilities are residual to Agent Orange exposure while serving in Vietnam.

Cirrhosis of the liver and hepatitis C are not among the disorders listed at 38 C.F.R. § 3.309(e), for which service connection will be presumed when exposure to Agent Orange is shown.

No competent medical evidence was offered which would link the veteran's cirrhosis of the liver or residuals of hepatitis C to exposure to Agent Orange (or otherwise to his active service). The veteran is not qualified, as a lay person, to offer diagnoses or medical opinions as to the cause of a disability. Accordingly, the Board found the claims not well-grounded, and denied the appeal.

12. Docket No. 93-22 189
Issue: Entitlement to service connection for a liver disorder.

The veteran served on active duty from August 1969 to August 1971. He was hospitalized for serum hepatitis in September 1969. At that time it was noted that he admitted to intravenous drug use prior to enlistment and that the hepatitis was secondary thereto. He was treated for recurrent hepatitis in December 1969 and February 1970. It was noted that the latter recurrence was precipitated by drug and alcohol abuse. The remainder of his service medical record makes repeated reference to compulsive drug abuse.

Post-service diagnoses included hepatitis in 1987, persistent hepatic dysfunction, chronic active hepatitis and cirrhosis of the liver in 1990, and chronic hepatitis B with cirrhosis and liver failure in 1991. The veteran underwent a liver transplant in March 1991. A biopsy of the liver conducted in April 1991 showed cirrhosis compatible with hepatitis C.

The veteran now states that he reported drug use in service in order to be released from service, and that, in fact, he has never used intravenous drugs. Review of the record, however, led the Board to conclude that the veteran's hepatitis in service clearly was the result of intravenous drug use. Compensation for disability resulting from drug abuse is

precluded by statute. 38 U.S.C.A. § 1110 (West 1991). No evidence has been presented which otherwise tends to establish a relationship between the veteran's period of service and his post-service liver disease. The Board denied the claim as not well grounded.

13. Docket No. 95-03 736
Issue: Entitlement to service connection for hepatitis.

The veteran served on active duty from February 1973 to May 1974. Service medical records report no complaint, diagnosis or treatment of hepatitis.

On a VA general medical examination in 1994, the veteran reported a history of alcoholism and polysubstance abuse, but denied substance abuse for many years. The examiner noted a history of intravenous drug use and concluded that clinically determined changes in the liver function indicated positive hepatitis B surface antibody and hepatitis C core antibody. Diagnoses included abnormal liver tests consistent with hepatitis exposure.

The veteran submitted a statement asserting that he had had flu-like symptoms while in service in July 1973, and that he had been inoculated for influenza in March 1973 and January 1974. He stated that he believed that this indicated the onset of hepatitis while he was in service. He also stated that a VA physician had informed him in 1995 that his hepatitis virus was approximately 21 years old.

There was no medical opinion linking the veteran's hepatitis C with his active service. The assertion of the veteran as to what he was told by a physician is not sufficient to render a claim well-grounded. *Robinette v. Brown*, 8 Vet. App. 69, 77 (1994). Accordingly, the Board found the claim to be not well-grounded, and denied the appeal.

14. Docket No. 95-16 636
Issue: Entitlement to compensation under the provisions of 38 U.S.C. §1151 for hepatitis, claimed as due to treatment by the Department of Veterans Affairs (VA) during a hospitalization in June 1977.

The veteran had active duty from June 1971 to June 1973.

He claims that he has hepatitis C as the result of a platelet transfusion performed at a VA hospital in June 1977. The record shows that he did receive a transfusion of 10 units of platelets in 1977, and that he was given a diagnosis of anicteric (without jaundice) hepatitis in April 1982 and hepatitis C in 1988. A liver biopsy in 1992 revealed chronic active hepatitis (clinically hepatitis C). There was, however, no competent medical opinion of record that the transfusion caused his hepatitis.

Without such an opinion, the Board found the claim not well-grounded, and denied the appeal.

15. Docket No. 95-15 545
Issue: Entitlement to service connection for a liver disorder.

The veteran has verified service from 1978 to 1994, and unverified service from 1971 to 1977. While there was a suggestion of possible hepatitis C in service, a VA examination in November 1995 produced normal liver function tests and failed to find evidence of hepatitis C.

Because there was no evidence of a current liver disorder and the Board found that the claim was not well-grounded, and denied the appeal.

16. Docket No. 96-03 603
Issue: Entitlement to service connection for the cause of the veteran's death.

The veteran had active service from 1942 to 1945. He died in 1995 of cirrhosis of the liver, as a consequence of hepatitis C, which in turn was a consequence of a hepatoma. No other condition was identified as contributing to his death. Service connection for a psychiatric disorder was in effect at the time of his death. The appellant claims that hepatitis C was contracted while the veteran was in service.

The veteran's service medical records are devoid of any complaint, treatment or diagnosis of cirrhosis of the liver, hepatitis, hepatoma, or other liver disease. The appellant submitted three medical journal articles in support of the contention that the veteran contracted hepatitis C in service. The articles list various symptomatologies and characteristics of hepatitis, which the appellant attempts to correlate with notations in the veteran's medical records. However, lay reliance on medical treatises cannot, by itself, be competent medical evidence of a link between service and a disability. *Edenfield v. Brown*, 8 Vet. App. 384, 388 (1995). There is no evidence given by a competent medical practitioner that a relationship exists between the veteran's period of service and the liver disease that caused his death.

For a claim for service connection for the cause of death to be plausible, there must be competent medical evidence of a causal or etiological relationship between death and service or a service-connected disability. Absent such evidence, the Board found the claim for service connection for the cause of the veteran's death not well-grounded, and denied the appeal.

17. Docket No. 95-22 707
Issue: Entitlement to service connection for the cause of the veteran's death.

The veteran had active service from 1968 to 1970. He died in August 1994 of bacterial pneumonia due to endstage liver failure as a result of chronic active hepatitis C (of 6 years duration). He was service connected for post-traumatic stress disorder (PTSD) and necrobiosis lipoidicia at the time of his death. The appellant claims that the veteran's death was caused by alcohol and drug abuse secondary to service connected PTSD. She

also claims that he could have contracted hepatitis C through contaminated water or exposure to Agent Orange while in Vietnam.

With respect to hepatitis C, the appellant offered her observations, research and opinions on the possible sources of the veteran's exposure to the virus. No competent medical evidence was presented linking the veteran's active service with the incurrence of hepatitis C. The Board held that the appellant, while competent to testify to the symptoms she witnessed, was not competent to provide an opinion on the relationship between alleged exposure to contaminates and post-service diagnoses.

Because the Board found no competent medical evidence relating the veteran's post-service medical diagnosis of hepatitis C to his period of active service, it found that claim to be not well-grounded, and denied the appeal.

18. Docket No. 95-21 501
Issue: Entitlement to compensation under the provisions of 38 U.S.C.A. §1151 for hepatitis as a result of treatment by the Department of Veterans Affairs.

The veteran had active duty from March 1969 to April 1969.

He asserts that he contracted hepatitis C as a result of blood transfusions during VA oral surgery in 1984, and that, when he donated blood in June 1991, he was told that he had hepatitis. However, liver function tests at the VA medical center in 1993, 1995, and 1996 were normal. A physical examination was unremarkable and a diagnosis of no hepatitis was found.

The Board found on this record that there was no competent medical evidence that he currently had hepatitis or that he ever had hepatitis as the result of VA hospital, medical or surgical treatment. Absent evidence of a present disability, the claim was found to be not well-grounded, and the appeal was denied.

19. Docket No. 96-43 256
Issue: Entitlement to service connection for a liver disorder including as a result of exposure to herbicides.

The veteran had active service from 1965 to 1971. He contends that he is currently receiving treatment for chronic liver problems, which are the result of Agent Orange exposure in service.

Service records show no complaints of findings of liver problems. At a VA evaluation in January 1995, specific liver function related laboratory findings were well within normal limits.

In May 1996, an examiner gave a preliminary assessment of history of liver disease with no documentation and borderline elevation in urinary uroporphyrin excretion. On being

requested to review the findings and provide further clarification, the examiner reported in July 1996 that the veteran had a positive hepatitis C surface antibody. There was no evidence of significant liver disease.

The Board concluded that there was no evidence of a chronic liver disorder in service or for some years thereafter, and there was no evidence of current chronic liver disease or a medical opinion to link any abnormality to service. Therefore the claim was denied as not well-grounded.

20. Docket No. 96-09 715
Issue: Entitlement to service connection for the cause of the veteran's death.

The veteran had active service from 1967 to 1970 and from 1971 to 1973. At the time of his death, service connection was in effect for PTSD, rated 50 percent disabling. He died in 1995 due to hepatoma (a tumor of the liver, especially hepatocellular carcinoma). The approximate interval between the onset of the disability and the veteran's death was two months. No other significant conditions were recorded as contributing to his death.

The veteran's initial infection with hepatitis was thought to have occurred in 1976. The appellant presented no medical evidence linking the veteran's active service to either hepatitis or hepatoma. Accordingly, the Board found that the claim was not well-grounded, and denied the appeal.

21. Docket No. 95-35 690
Issue: Entitlement to service connection for hepatitis C.

The veteran had active service from 1968 to 1971.

Service medical records do not mention treatment for hepatitis. The veteran underwent a VA general medical examination in September 1972. There were no findings relating to hepatitis. He was diagnosed with hepatitis C in 1993. Nowhere in the record is medical evidence offered to establish a causal link between active service and hepatitis C.

Accordingly, the Board found the veteran's claim for service connection for hepatitis C to be not well-grounded, and denied the appeal.

22. Docket No. 95-31 842
Issue: Entitlement to service connection for the residuals of hepatitis C.

The veteran had active service from 1971 to 1993. He claims that he tested positive for hepatitis C in service.

Service medical records are negative for a diagnosis of hepatitis C. A 1993 separation examination is negative for hepatitis C. All blood testing conducted at this time was normal, and a medical history taken at the same time did not mention hepatitis C. The

veteran submitted a letter from "United Blood Services" indicating that an initial test for the presence of the hepatitis C antibody was positive. A supplemental test for anti-HCV was inconclusive. A test for inflammation of the liver (ALT) was normal. In a VA examination conducted in June 1994, the examiner concluded that the veteran had no symptoms relating to gastrointestinal disorders or hepatitis C. The diagnoses included a history of a positive test for hepatitis, with no impairment at that time.

The Board found that the veteran had not submitted evidence of a confirmed diagnosis of hepatitis C during service, or evidence of a current confirmed diagnosis of the disorder. Accordingly, the Board found the claim to be not well-grounded, and denied the appeal.

23. Docket No. 94-13 644
Issue: Entitlement to service connection for hepatitis.

The veteran had active service from 1987 to 1992. He contends that he has current residuals of hepatitis and that hepatitis was demonstrated in service.

Service medical records show treatment in 1991 for complaints of weakness and abdominal cramps. Specialized serology studies were not performed, but the examiner commented that the veteran had a history of hepatitis B exposure which increased the possibility of a latent hepatitis with current exacerbation. Serology studies conducted later that year were reactive for hepatitis B core antibody and hepatitis type B surface antigen. The same tests conducted a month later were negative. In a VA medical center discharge summary in 1992, his liver profile was within normal limits.

VA tests made in 1996 were negative for hepatitis B surface antigen and the hepatitis C antibody. The veteran's antibody to the hepatitis B surface antigen was positive. The examiner concluded that the veteran did not have chronic viral hepatitis of either type B or type C. The examiner stated that he may have had a hepatitis B virus infection in the past, however there was no evidence that the virus was present at the time of the examination. The examiner thought that the test for the antisurface antibody might be a false positive, or that the veteran was vaccinated against type B hepatitis in the past. The overall conclusion was no evidence of chronic hepatitis.

Because there was no competent current diagnosis of hepatitis or a competent medical opinion that he has residuals of the hepatitis demonstrated during service, the Board concluded that his claim was not well-grounded, and denied the appeal.

24. Docket No. 92-10 710
Issue: Entitlement to service connection for hepatitis.

The veteran had active service from 1972 to 1975. He contends that he had hepatitis that was treated in service, followed by a relapse treated by VA shortly after service, and present residuals from these infectious exacerbations.

A diagnosis of hepatitis was made on VA hospitalization in 1975. The diagnosis was viral hepatitis, probably infectious type. The hepatitis was treated and improved. Since then no physician or other medical specialist has diagnosed hepatitis or residuals of hepatitis. The veteran offered a form letter from a county health department to the effect that the addressee's blood had been found to be reactive for anti-HCV (hepatitis C antibody). The letter was unsigned, unaddressed and undated. It is insufficient to show a current disability.

The veteran declined to be examined by a VA specialist, but did have blood tests done at a VA facility. Liver function tests were normal and the hepatitis test was negative.

Because there was no competent evidence of current hepatitis or residuals, the Board found the claim to be not well-grounded, and denied the appeal.

25. Docket No. 96-23 361
Issue: Entitlement to service connection for a liver disorder.

The veteran had active service from 1971 to 1977, and a period of active duty for training in June 1985. The veteran currently suffers from a liver disorder which ultimately resulted in a liver transplant.

Service medical records from his period of service in the 1970s are negative for complaints for or treatment of hepatitis. On his separation examination no liver abnormalities were noted and he denied having had liver trouble, hepatitis or jaundice. A sick slip dated June 1985 shows treatment for low back pain which was incurred in the line of duty.

The post service medical record shows the development of liver disease beginning with a December 1985 study showing marked or moderate elevation of the levels of certain liver enzymes, and January 1986 hospital admission for a painless jaundice that he had noted one week earlier.

The veteran stated that he was injured in a parachute jump during his period of active duty for training in June 1985. He believes that his liver disease could have been caused or aggravated by that jump, and submitted a newspaper article on the topic of serious injuries and deaths inflicted on parachute jumpers who had made jumps in gusty wind conditions.

A current liver disorder is clearly shown by the record, but even assuming that all of the veterans statements are true, there is no medical opinion linking the current liver disorder to service generally, or to the residual effects of a traumatic parachute jump in 1985 specifically. Accordingly, the Board found the claim to be not well-grounded, and denied the appeal.

26. Docket No. 96-39 085

Issue: Entitlement to service connection for hepatitis.

The veteran had active duty from 1970 to 1974.

He has current liver disease, the onset of which is attributed to intravenous drug use while in service. The veteran claims he contracted the disease from drinking contaminated water. Although the veteran denies drug use in service, that usage is well documented and amounts to willful misconduct. The veteran presented no medical opinion that his hepatitis was the result of anything other than drug use. The Board concluded that the veteran's hepatitis was secondary to his drug abuse.

Where a disability is attributable to willful misconduct, compensation is precluded by statute. 38 U.S.C.A. § 1110; 38 C.F.R. § 3.301(a),(b)(1996). Accordingly, the Board found the claim not to be well-grounded, and denied the appeal.

27. Docket No. 94-25 120
Issue: Entitlement to service connection for residuals of hepatitis.

The veteran had active service from 1977 to 1980 and from 1981 to 1986. He contends that he contracted hepatitis in service, had a relapse in December 1989, and that he is entitled to service connection for hepatitis because he could have another relapse at any time.

The veteran had an acute episode of hepatitis in service in 1979. A VA examination report from February 1997 listed fatigue as the veteran's only current symptom and no indication of chronic liver disease was found. The examiner noted that laboratory tests done in December 1996 showed that the hepatitis B core antibody was reactive, the hepatitis B surface antibody was nonreactive, the hepatitis C core antibody was nonreactive and the hepatitis C surface antigen was nonreactive. In conclusion, the examiner noted that the findings were consistent with prior exposure to hepatitis B, however, there was no clinical or biochemical evidence of residuals of the disease at the time.

Because there was no medical evidence of a current disability, the Board found that the claim was not well-grounded, and denied the appeal.

28. Docket No. 96-02 532
Issue: Entitlement to service connection for hepatitis C.

The veteran had active service from 1971 to 1975, and from 1979 to 1986. Service medical records are entirely negative for any finding or diagnosis of hepatitis C infection or antibodies.

Hepatitis C antibodies were first noted in 1991. At that time the veteran stated that he suspected that the disorder was contracted when receiving a tattoo in 1981. He reported

bouts of fatigue in service beginning several months after acquiring the tattoo. A letter from the veteran's physician indicated that he had evaluated the veteran for chronic liver disease due to hepatitis C. The physician stated that it was impossible to ascertain exactly when the infection occurred and that he could neither verify nor deny the veteran's claim that hepatitis C was present in service.

Because there was no competent medical evidence linking hepatitis C with the veteran's active service, the Board found that the claim was not well-grounded and, accordingly, denied the appeal.

29. Docket No. 96-22 677
Issue: Entitlement to service connection for hepatitis C.

The veteran had active service from September 1970 to April 1972, and from August 1972 to December 1974. He claims that he contracted hepatitis C from blood transfusions for his service connected gunshot wounds.

Service medical records show treatment for gunshot wounds to the back in July 1974. Surgery required transfusion of two units of blood. The veteran was first diagnosed with hepatitis C in 1989, and his initial claim for service connection for hepatitis C was filed 17 years after his last period of service. At a 1996 hearing at the regional office, the veteran admitted to a very long history of polysubstance and alcohol abuse. He admitted to using heroin and cocaine, but denied ever having injected it.

There was no competent medical evidence linking the veteran's transfusion with his current diagnosis of hepatitis C. Accordingly, the Board found that the claim was not well-grounded and denied the appeal.

Prepared by the Office of the Chief Counsel
Board of Veterans' Appeals
July 27, 1998

REQUESTED INFORMATION

Introduction

This is the information provided in response to the request of Congressmen Filner and Quinn for lists of VA research in the following areas:

- Cold weather injuries;
- Tropical diseases
- Combat-related stress
- Exposure to ionizing radiation;
- Hazardous materials;
- Gulf War veterans' illnesses.

There are two principal sources of information in this response: the Office of Research and Development's Research and Development Information System (RDIS) and the Annual Report to Congress: Federally Sponsored Research on Gulf War Veterans' Illnesses for 1997. The largest source of information is RDIS containing literally thousands of VA research projects. For each of the projects in each of the areas listed above we have provided the name of the Principal Investigator, the amount of funding for the project, and an abstract of each project. Some projects are unfunded pilot projects that have no funding associated with them. Generally, these abstracts are technical in nature, but owing to the large number of projects it was not possible to convert each abstract into lay language. We will be happy to work with staff to identify those projects for which lay descriptions would be desirable. Particular features of the list for each area of this request are described below:

Cold Weather Injuries

There are 39 projects within the area of hypothermia and its physiological effects. All but two (listed in the attachment) are related to the utilization of induced hypothermia as a beneficial adjunct to cardiovascular surgery and neurosurgery.

Tropical Diseases

The RDIS list of research projects in tropical diseases includes some research on Leishmaniasis that is also listed under the area of Gulf War veterans' illnesses.

Combat Related Stress

Along with the RDIS list of projects on combat stress and PTSD, we have also included a list of projects recently funded under a VA/DoD initiative on the neurobiology of stress.

Exposure to Ionizing Radiation

The approximately 450 VA research projects listed in RDIS as being in the area of ionizing radiation, are focused on the use of radiation for the treatment of cancer, as opposed to the topic of the health consequences of radiation exposure.

Hazardous Materials

The area of research on hazardous materials is broad, encompassing a vast array of chemicals, for which specific searches of RDIS cannot be easily or efficiently undertaken. Toxicology research is heavily focused on drug and pharmaceutical toxicology. However, VA has three Environmental Hazards Research Centers, established in FY'95, that are focused on issues of Gulf War veterans' illnesses and exposures to environmental toxins. These are located, respectively, at East Orange VAMC, Boston VAMC, and Portland VAMC. VA funds each of these centers at a level of $500 thousand per year. These Centers are more fully described in the list of VA projects on Gulf War veterans' illnesses. In addition, VA established another Environmental Hazards Center at the Louisville VAMC that is focused on reproductive toxicology and endocrine disrupters such as dioxin.

Gulf War Veterans Illnesses

The most comprehensive list of VA research projects on Gulf War veterans' illnesses can be found in the appendix of the Annual Report to Congress: Federally Sponsored Research on Gulf War Veterans' Illnesses for 1997. A copy of that portion of the appendix along with a table of funding is provided.

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[Additional enclosures retained in committee files.]

STATEMENT OF ROBERT J. EPLEY, DIRECTOR, COMPENSATION AND PENSION SERVICE, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY TERESA L. WRIGHT, M.D., CHIEF, GASTROENTEROLOGY SECTION, SAN FRANCISCO VETERANS' ADMINISTRATION MEDICAL CENTER; NILS R. VARNEY, Ph.D., DIRECTOR OF TRAINING, IOWA CITY VA MEDICAL CENTER, AND JOHN BOOSS, M.D., NATIONAL DIRECTOR OF NEUROLOGY, VA CONNECTICUT HEALTH CARE SYSTEM, DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF ROBERT J. EPLEY

Mr. EPLEY. Mr. Chairman and members of the subcommittee, I want to thank you for inviting here today to talk to give you testimony. This is my first opportunity before the committee. As you have already said, the primary focus of my written testimony and my verbal comments are with regards to hepatitis C and cerebral malaria. I want to apologize for the late submission of the testimony. It was not my intent to delay or withhold the information.

Mr. QUINN. If I may then, why was it submitted late. Is there a problem with staff? Are you short-staffed? Are the copy machines not working?

Mr. EPLEY. No, sir. When we were first advised of the hearing——

Mr. QUINN. Yes?

Mr. EPLEY (continuing). The two subjects that we were told to present testimony on were hepatitis C and malaria. We received a supplemental request, and it was written in addendum; it just didn't clear.

Mr. QUINN. Thanks.

Mr. FILNER. May I follow up? You said your last three words—"it didn't clear?"

Mr. EPLEY. We didn't receive approval of the addendum that we wrote up.

Mr. FILNER. What kind of approval do you have to go through for this?

Mr. EPLEY. In the Administration people above me review and authorize testimony.

Mr. FILNER. Explain that a little bit. Does it get approved just in VA or does it go to DOD? Does it go to the White House? Who has to approve any statement that you make here on Persian Gulf illness?

Mr. EPLEY. Sir, excuse me, I'm pretty new in Central Office, and I understand that the Secretary's office approves it. I believe that in the Administration it goes over for review, at least in some instances, by OMB, but I'm not familiar enough to give you an exact run-through of the process. I'm sorry. This is the first time I've done this.

Mr. FILNER. Well, it seems to me, if I were doing it for the first time, I'd like to know who is going to approve my testimony, but I don't mean to tell you how to do your job, I just have a different personality maybe. Could you get back to us by the next day or two? I want to know the route by which this testimony has to be

approved, and I want to know if the process is different for other subjects. Did everything that's being said today go through the same route? I suspect not, but I'd like to know.

(See Letter of August 14, 1998 on p. 32.)

Mr. FILNER. When you say something on Persian Gulf illness, does the Secretary of Defense have to approve that? Does the White House have to approve it? Again, I wish I didn't have to ask these questions. I've been sitting here, now, with my colleagues for a couple of years on this problem, and everything that happens seems to create suspicion, and we get something 10 minutes before the hearing—and it's not very interesting data I'll tell you—and then you tell me it has to be cleared. Then I'm saying well, who's clearing all this? Is it going to some mysterious czar of the Persian Gulf illness who's trying to keep information from us? I'd like to know, I mean, who has to approve? This data, it would seem to me, is objective data. Why would anybody have to clear it?

Mr. EPLEY. Sir, I was just told that the Administration is asked to clear any testimony regarding Gulf War and that maybe an unusual circumstance.

Mr. FILNER. Who in the administration? I mean, where?

Mr. EPLEY. We'll provide that information.

Mr. FILNER. I want to know who in DOD? I want to know who in the White House? I want to know who at NIH? I mean, who is clearing this testimony? Thank you.

Mr. QUINN. Thank you, Mr. Filner, and I think—and I interrupted your testimony when you began, Mr. Epley. I apologize for doing that, but I think you sense our frustration here on both sides with not necessarily with what you have to say or the truthfulness of what you're about to say, but it's the whole situation of how we receive it or don't receive it, and we're in that business as elected people that perception sometimes is as important as the facts, and it seems like we're always fighting this battle, and we appreciate your understanding of that, and, Bob, I appreciate your comments. We'll let you get back to your testimony now.

Mr. REYES. Mr. Chairman?

Mr. QUINN. Yes.

Mr. REYES. I just have a question. Will we be provided that information as well, because——

Mr. QUINN. Absolutely.

Mr. REYES (continuing). This is a very real issue across the country.

Mr. QUINN. Whenever we ask for information following even, for example, the question that I had on the 29 cases of hepatitis C that were denied, when we receive that written response, we'll make it available to the full subcommittee, and, indeed, to the ranking member and chairman of the Full Committee as well. Thank you. Sir?

Mr. EPLEY. Hepatitis C is a growing public health concern and an issue that concerns us because it affects our veteran population. Since we became aware of this health threat, VA has initiated several actions pertinent to hepatitis C disability claims. For example, in April 1998, we issued an information letter to our field stations about the incidence of the disease in the general population; the persons most at risk; how the infection spreads; its manifestations,

treatment, and prevention; and how our evaluators can address the disease under the current rating schedule. We asked all of our offices to prominently display posters published by the American Liver Foundation about the risks and symptoms of hepatitis C. We are revising our rating schedule criteria to be specific to hepatitis C and its complications. We're working with VHA, the Veterans Health Administration, to develop C&P exam guidelines so that physicians will be able to provide information sufficient for rating purposes.

In May of 1998, the Board of Veterans' Appeals held training for its Board members on hepatitis issues. They've scheduled similar training for attorneys this month. In June of 1998, the Veterans Health Administration (VHA) issued an information letter outlining standards for testing for an evaluation of hepatitis C.

The issues VA must consider to determine service connection for hepatitis C-related disabilities include when the infection was incurred; how the infection was incurred; and what current manifestations are present. We know that individuals can be at risk for hepatitis C for a number of reasons. Among these, three major risk factors are: for recreational drug use, especially with shared needles; blood transfusions before universal testing of hepatitis C; and accidental exposure to blood by health care workers.

People infected with the hepatitis C virus may have no symptoms. Many will not realize they've been infected. Nevertheless, they're at risk for developing serious complications such as cirrhosis of the liver or liver cancer. These complications may take up to 20 years to develop.

To evaluate claims based on hepatitis C, VA needs the same kinds of evidence we need to service connect any disability. These include medical evidence of a current disability; evidence that the disease or injury causing the disability is related to service; and medical evidence that links the in-service injury or disease to the current disability.

We will need to develop information that helps us to determine when and how the individual was infected. It's important to note that if hepatitis C infection is due to drug use, VA is prohibited by law from granting service connection or paying compensation. We will need to obtain a complete history from the veteran to include all risk factors to which the veteran was exposed before, during, and after service.

In the final analysis, a medical opinion as to the most likely etiology of the disease will be a key to our determination. Our rating schedule already allows us to evaluate all types of hepatitis including hepatitis C. The evaluations range from 0 percent for nonsymptomatic manifestations to 100 percent for severe manifestations.

In addition, the schedule contains provisions that allow us to rate late complications of hepatitis C such as cirrhosis and liver cancer. While the current rating provisions are adequate to evaluate hepatitis C, the revisions already in progress will specifically mention hepatitis C and explain possible complications of all types of hepatitis.

As to the second issue, cerebral malaria, there is less medical and scientific information available. I think you'll hear about that

from the other panel members. We do note from the literature and from discussions with the Veterans Health Administration that a diagnosis of malaria is not the same as a diagnosis of cerebral malaria. Cerebral malaria requires a diagnosis of falciparum malaria plus clear evidence of some neurologic disturbance.

To determine if cerebral malaria is service connected, we need the same type of evidence we need for any other claim for service connection, and I elaborated on that earlier. Current rating criteria provide a 100 percent evaluation for active malaria. Once the active process resolves, we evaluate any residual disabilities such as liver or spleen damage using the body's system effect.

We do not believe we're seeing a large number of claims based on either hepatitis C or cerebral malaria at the present time. A review of BVA decisions, which you alluded to earlier, for fiscal year 1997 shows that of 43,000 BVA decisions only 129 involved hepatitis C and only 3 involved cerebral malaria.

We believe that the rules and procedures we use for any claim for service connection, as supplemented by revisions already under development, will be adequate to determine whether hepatitis C and cerebral malaria are service connected.

We've begun with the Veterans Health Administration to determine if some change in law or regulation would be appropriate based on medical and scientific evidence, and we will of course initiate any changes we find necessary. Mr. Chairman, this concludes my verbal statement. I'll be happy to answer questions.

[The prepared statement of Mr. Epley, with addendum, appears on p. 119.]

Mr. QUINN. Thanks very much. I think, if it's okay with the rest of the members, Mr. Epley, we'll hear from our other witnesses first. Dr. Wright is scheduled to be next, and when everybody takes their 5 minutes, we'll come back with some questions. I do have one, but we'll let everybody have a break here and let you get a drink. Dr. Wright?

STATEMENT OF TERESA L. WRIGHT, M.D.

Dr. WRIGHT. Mr. Chairman and members of the subcommittee, I'm pleased to appear today to discuss the importance of hepatitis C infection in the VA health care system. I am chief of the gastroenterology section at the San Francisco VA. I've been treating veterans at the liver clinic there for more than 10 years. I'm also as associate professor of medicine at the University of California at San Francisco, and currently they hold research grants from the NIH, the VA, and from industry to study the epidemiology, pathogenesis, and treatment of hepatitis C.

Hepatitis C affects 3.9 million Americans with a prevalence of 1.84 percent in the population as a whole but with a higher prevalence in minority populations: 3.2 percent in blacks and 2.1 percent in Mexican-Americans. The highest seroprevelance is between the ages of 30 and 39 and 40 and 49 years. In these groups, the prevalence is three-fold greater than in the population as a whole, and it's these data in conjunction with the long duration of infection before life-threatening complications occur that has led to the concern that mortality for hepatitis C may triple in the coming decade.

The natural history of infection is highly variable with many being infected for 20 to 30 years without developing complications, yet some, albeit the minority, progress into cirrhosis and even liver failure within 10 to 20 years of onset. Nevertheless, hepatitis C is linked to 10,000 deaths annually in the U.S. and the development of liver cancer. HCV disease is also the most common indication for liver transplantation in U.S. transplant programs in general and VA transplant programs in particular.

There is limited information about factors which influence or accelerate the natural history of HCV disease, but three factors have been independently associated with the progressive disease in one large study. These were excess alcohol intake, male gender, and age greater than 40 years at the time of acquisition of infection. The first two factors are directly relevant to our veterans. Other factors which are believed to contribute to the progressive disease are HIV coinfection and immunosuppression following organ transplantation.

The prevalence of hepatitis C in veterans is unknown but would be predicted to be higher than in the U.S. population as a whole, because risk factors for infection are common in our veteran population. HCV is transmitted by parenteral routes, i.e. through contact with blood. Injection drug use is the most common risk factor for HCV in the general population, accounting for 40 to 60 percent of all infections. Transfusion is also associated but accounts for only 5 percent of infections historically and many fewer today. HCV infection has also been associated with increasing numbers of sexual partners and in minority populations with cocaine and marijuana use.

In the largest epidemiological study of HCV in the U.S., the NHANES III study, there was no association between HCV and education or military service for non-Hispanic whites. In Blacks and Mexican-Americans with military service, the prevalence was 3.3 and 1.9 percent respectively. What complicates determination of the mode or time of acquisition of HCV in an individual is that initial infection is typically silent and duration of disease must be inferred from presumed time of first exposure.

From our own experience at the San Francisco VA Medical Center, HCV disease is a common problem. In those who are tested as part of a city-wide needle-stick study, 10 percent of hospitalized veterans were seropositive for hepatitis C. This is substantially lower, however, than the experience of San Francisco General Hospital where the seroprevelance was 30 percent. Of 195 seropositive veterans attending the San Francisco VA Liver Clinic, 78 percent are between the ages of 40 and 59 years.

In a limited survey of 48 seropositive veterans, 24 percent had served in Vietnam; 2 percent had served in Korea; 4 percent has served in World War II, but more than 60 percent had never been to combat. A history of injection drug use was obtained in almost half of these veterans, but many had started using drugs after their military service. A history of transfusion was obtained in almost 20 percent. However, in this limited survey, prior use was also common in those without hepatitis C infection.

This study is too small in sample size to comment on the significance of these associations and is currently being extended to a

larger number of seropositive and seronegative individuals. The distribution of HCV genotypes in our veterans was similar to that in the U.S. population as a whole, a finding which supports prior observations by Dr. Seeff at the Washington DC VA. These results imply that HCV infection is being acquired in veterans from the U.S. rather than European or Asian sources.

Our study was not designed to assess the prevalence of hepatitis C in veterans as a whole or in subpopulations of veterans such as those who served in Vietnam. These questions are being addressed in a study which is currently getting underway at our VA and which is funded for the coming years.

In a recent mandated look-back program of transfusion recipients, there has been much discussion about the importance or otherwise of infected individuals knowing their serological status. While initially skeptical about the benefits of such knowledge, I've been convinced over the past year that from talking to many with infection the vast majority want to know. Individuals with hepatitis C should avoid alcohol; they should be immunized against other hepatitis viruses; they should be counseled regarding modes of transmission, and they should be considered for treatment.

There are three FDA approved formulations of interferon which has initial response rates of 40 percent but sustained response rates of only 20 percent. Interferon is not appropriate in those with significant psychiatric illness nor in those with ongoing substance abuse, problems which are frequently encountered in the patients we serve. Recently, the FDA approved an oral antiviral agent, ribavirin which in preliminary results would suggests you can get biological clearance in 40 percent of the time.

I'd like to thank the subcommittee for allowing me to testify. Hepatitis C is a global public health problem which has only recently begun to get the attention it deserves. There are many reasons to believe that hepatitis C is a greater problem in veterans than in the U.S. population as a whole, although the seroprevalence of veterans is currently unknown. We should not lose sight, however, of the fact that most individuals with hepatitis C will never develop life-threatening complications from their infection. Nevertheless, this virus is an important cause of morbidity and individuals need to know their serological status. There is insufficient information currently to know whether hepatitis C is linked to military service, but preliminary data would suggest that many veterans are acquiring hepatitis C by traditional, non-combat-related means. Thank you.

[The prepared statement of Dr. Wright appears on p. 130.]

Mr. QUINN. Thank you very much, and we appreciate your insight and statistics. I've written down all kinds of questions already, but, thanks, doctor, I appreciate it.

Dr. Varney, we appreciate your sharing the research on Vietnam veterans particularly, as Mr. Evans point out, and you may proceed.

STATEMENT OF NILS R. VARNEY

Mr. VARNEY. I appreciate the opportunity to speak. Malaria may have afflicted as many as 250,000 ground troops in Vietnam, making malaria nearly as common as gunshot wounds. The statistics

is relevant to Vietnam veterans today, because while they may have recovered from the malaria illness itself, a number of these veterans are left with neuropsychological and neuropsychiatric symptoms involving mood, temper, memory, and other symptoms that could be mistaken for PTSD.

Let me start with a bit of history. There is a consistent body of clinical literature dating from the 500 B.C. through the early 20th century which has reported that individuals who survive cerebral malaria frequently developed depression, memory loss, personality change, and temper problems. This constellation of neuropsychiatric deficits was observed often enough among survivors of cerebral malaria in the turn-of-the-century in British-occupied India that the syndrome was christened Tropical Neurasthenia, and it was a disability category back then for the British Army. Forrester, who is a leading expert of his day, reported that cerebral malaria was the leading cause of mental illness in the British-occupied malarial endemic zones.

Scores of papers were written about malaria and Tropical Neurasthenia during the 19th century. Many neurology books from that time contain long sections about cerebral malaria and its neuropsychiatric sequelae. It should be noted, in addition, that clinical observations about malaria leading to psychiatric-like symptoms were first recorded by Hypocrites and Galen 2,000 years before the experiences of the British in India or the Americans in Vietnam.

Among the acute brain-related complications of cerebral malaria are swelling of the brain with flattening of the gyri; brain and cell damage from high fever; small hemorrhages throughout the subcortical white matter; brain hemorrhages around large blood vessels; blockage of the capillaries with log jams of blood cells which in turn cause hypoxia; severe hypoglycemia, and, to top it off, it turns your brain blue-gray.

The key point from this abundant literature is that malaria in its severest form may cause brain damage, and this will persist after the malaria illness itself has been cured and could not identified on any biological tests.

In our research, the neurobehavioral status of 40 Vietnam veterans who reported being treated for malaria in Vietnam as compared with that of a group of combat veterans who sustained gunshot and shrapnel wounds but didn't have malaria. The purpose of requiring this comparison group was to control for exposure to combat and also to allow us to check for records of documentation. The results of the study suggested that cerebral malaria survivors have multiple neuropsychiatric symptoms that remain problematic years after the acute illness has been cured. As compared with the wounded combat Vietnam veterans, our study showed that people who contracted malaria manifested a variety of problems with depressed mood; feelings of subjective distress; memory problems; emotional liability; and neuropsychiatric symptoms very similar to small seizures such as memory gaps and staring spells. These findings are statistically and psychometrically more sophisticated and more reliable than the clinical observations over the last 2,500 years, and our study is just the most recent to show that cerebral

malaria has long-standing neuropsychiatric symptomatology in adults that survive the illness.

The message to be drawn from research is that there are some Vietnam veterans at risk for persistent neuropsychiatric syndrome which can produce a wealth of psychiatric, psychological, neuropsychological, neuropsychiatric, and neurological symptoms.

Findings suggest that further investigation and attempted replication by other groups may be appropriate. If additional studies confirm that malaria and, more important, post-malarial neuropsychiatric syndrome, which was called Tropical Neurasthenia is a problem nationwide, then we can look into treatments.

It is, by the way, not my intent to complain about the VA, the Army, or Vietnam veterans. Our findings offer good news for an undetermined number of Vietnam veterans in that they may have mental symptoms which are the result of a neurological disease which they and others have failed to appreciate. With the change in the perspective regarding their symptoms, it would logically follow that there would be changes and improvements, we hope, in treatment. In our experience, many of the Vietnam veterans who have this disorder can be found in PTSD clinics and their lives are substantially improved by treatment. Thank you very much.

[The prepared statement of Mr. Varney appears on p. 132.]

Mr. QUINN. Dr. John Booss from the DVA is here, and we'd like you to continue. Doctor?

STATEMENT OF JOHN BOOSS, M.D.

Dr. BOOSS. Mr. Chairman, members of the subcommittee, thank you very much. Malaria is a disease of antiquity, without question. However, it was not until the end of the last century, in the 1880's that it was, in fact, demonstrated to be due to parasites. Furthermore, although it was called malaria or bad air, it was not until the end of the last century that it was demonstrated to be transmitted by the mosquito. Thus, it's an infectious disease caused by a parasite and transmitted by the mosquito.

Now, if I could make a comment with respect to some of the preliminary remarks of the subcommittee, there's no question that the circumstances in Vietnam were awful. If you were a foot soldier under conflict circumstances which were terrible, and you developed a fever, there is no question about the horrible circumstances. However, even for troops treated in the field, they would then be taken to about—in the case of the Army—11 evacuation hospitals; get their acute treatment, and then go to a recovery hospital. This is well documented in the journal Military Medicine, for example. Thus, there was a fairly good procedure for how troops were treated in the field as I understand.

Now, with those preliminary remarks, let me get to my printed remarks which are rather long, and I may have to——

Mr. FILNER. I'm sorry to interrupt you, but are you suggesting that under those conditions there are standard tests and laboratory reports done, and the records would all be standard because there's this protocol that everybody's going through? Are you suggesting that?

Dr. BOOSS. I'm suggesting, sir, that the diagnosis would require an identification of the parasite in a blood smear; just seeing the

parasite in a blood smear. I can carry that further if you like, but the reason would be——

Mr. FILNER. But I can't imagine that under the circumstances of Vietnam and the situations of chaos and emergency and bloodshed that everybody had the same kind of standard test that you could then look back and rely on. As I understand it, many of the VA judgments are based on what's in those records, and if it's not in the records, tough, and, yet, I can't imagine that you could think that those records are either comprehensive enough or standardized enough that they're reliable enough for you to make all your judgments. That's what you seem to be suggesting unless I'm jumping to conclusions.

Dr. BOOSS. Point taken.

The office of research and development, Medical Research Service, reviewed a research proposal from Dr. Nils Varney from the IOWA City VA Medical Center in 1988 to carry out research on the neuropsychiatric consequences of cerebral malaria in Vietnam veterans. Following a competitive merit review process, funds were awarded to Dr. Varney for his proposed research from 1989 to 1992. A paper titled "Neuropsychiatric Sequelae of Cerebral Malaria in Vietnam Veterans" reporting on this research was published in 1997 in the Journal of Nervous and Mental Disease.

Much of the controversy surrounding this report involves four issues. The first is that there was no medical or laboratory confirmation that the majority of the patients were, in fact, infected with malaria. Second, there is a lack of documented medical evidence that supports the diagnosis of cerebral malaria. Thirdly, Dr. Varney's interpretation of his data is inconsistent with other interpretations from documented malaria cases. Fourthly, Dr. Varney has made unfortunate and insupportable extrapolations from a study of 40 veterans to the entire Vietnam experience. This is not to say, however, that Dr. Varney's hypothesis lacks value. Indeed, further investigation could refine our understanding of the long-term consequences of malaria infection. What we suggest is that an assessment of Dr. Varney's work reveals some methodological and interpretational problems that should be carefully considered before we make decisions that change health benefits policy. We must look at Dr. Varney's work in the larger context of scientific knowledge about malaria.

Before I go on to discuss Dr. Varney's work in more detail, I would like to consider some background regarding malaria itself. Malaria is caused by infection of the human with a parasite of the genus, Plasmodium. The diagnosis of malaria is made by examination of blood smears for the parasites. Humans are infected with Plasmodium through inoculation by the Anopheles mosquito carrying the organism which it received by biting an infected human. There are several species of Plasmodium, one of which is Plasmodium falciparum. Infection with Plasmodium falciparum leads to falciparum malaria which is the cause of cerebral malaria. Of all falciparum malaria cases, many published studies have estimated that approximately 2 percent are diagnosable as cerebral malaria. One study, in particular, examined 1,200 cases of falciparum malaria among the troops in Vietnam and found that 19 fit the cri-

teria for cerebral malaria. That paper was reported in the Journal of the American Medical Association in 1967.

With this background, I will now turn to Dr. Varney's work, and with the middle light on, I'd better advance a page or so in the written testimony. Thank you very much, Mr. Chairman. An earlier study of malaria from Dr. Varney's group was reported in the journal, VA Practitioner, in 1989. In that paper, 30 Vietnam veterans were studied who reported having had malaria accompanied by at least 12 hours of amnesia. Twelve of 17 medical records supported the diagnosis of malaria but the remainder were recorded as lost or destroyed.

There is no report of examination of blood smears for the malaria parasite nor was the diagnosis of cerebral malaria sought in the medical record. Hence, in the 1989 report, the diagnosis of cerebral malaria was not established medically. All subjects had coexisting medical conditions that could have contributed to the reported findings. Hence, there was ambiguity about the cause of the neuropsychological findings reported.

Unfortunately, the report of Dr. Varney and his group in the November, 1997 issue of the Journal of Nervous and Mental Disease does not resolve the ambiguities. There is, again, no requirement for laboratory verification of the malaria group. Of 40 veterans studied, service records were found for 37, of whom 14 had a diagnosis of malaria cited. A search for the diagnosis of cerebral malaria was not reported and no report of blood smears was made. This is, in fact, in contrast to medical reports on malaria at the time of the conflict in Vietnam in which microbiologic confirmation of actual infection was obtained—and we give a couple of citations for that in our written testimony. To reiterate, the most recent report did not require medical diagnosis in order for a subject to be included in the malaria group nor did inclusion require a medical record citation of cerebral malaria. This is a significantly lower standard than the wartime reports themselves. Mr. Chairman, I'd be happy to proceed if you like or I can stop here.

Mr. QUINN. If it's okay with you, in the interest of time, Doctor, why don't we have you end there. Your written testimony is part of the record. I've followed along with you here and we can get to some questions.

Dr. BOOSS. Thank you very much.

Mr. QUINN. Thank you.

[The prepared statement of Dr. Booss appears on p. 135.]

Mr. QUINN. I'm going to go back, Mr. Epley, if I may for a minute, and begin with at least one question and then give all the members an opportunity as long as you're all here.

At the end of your statement, you say that "In conclusion, we believe the rules and procedures we currently apply to any claim for service connection to be supplemented by revisions under development are adequate to determine whether hepatitis C or cerebral malaria are service connected." And then at the second-to-the-last sentence, "We do not believe that any legislative or regulatory changes are necessary at this time, and we're in the business of passing laws or regulatory changes unless they are necessary."

So, my question gets to the first sentence of your conclusion in which you say, "We currently—the rules and procedures we cur-

rently apply to any claim for service connection to be supplemented by revisions under development." I take that to mean that you're taking a look at some revisions possibly that might change the regulations that you use. Now, for those of us concerned about hearing the medical part of this, for laypeople, that's good news. So, my question is, do you expect some revisions—the ones that you mentioned that are under development—to happen and when might we hear back from you as to some kind of change?

Mr. EPLEY. We are actively writing a change to the rating schedule for hepatitis to make specific reference to the hepatitis C virus. The way the rating schedule is written right now, it relates to hepatitis——

Mr. QUINN. Right.

Mr. EPLEY (continuing). And we can rate hepatitis when it is present in the blood. We feel, with the information coming available to us, we need to specifically outline a reference to hepatitis C, and that revision has been drafted, and we'll be moving it forward as fast as we can.

Mr. QUINN. Assuming some of it needs to be checked by other people—we went through Mr. Filner's question—can you—I mean, will we be back here a year from now, 6 months, a month? Any idea?

Mr. EPLEY. We'll have that regulation draft or revision out of my service within the next 2 months. We'll move it along. The process after that, I'll do all I can to speed it up, sir.

Mr. QUINN. I understand. And let me also say that with all of these comments, questions, not only by myself or Mr. Filner or any of the members, we're here to help you do that. Believe me when I tell you that. We are here to help you move that through the process, if we can, through other members; through the administration. Anyway you think it helps you get that information, please let us know; we want to help you do that. That's what we're—one of our responsibilities. We want to work with you to do that, but we can't if you don't tell us you need the help. That's a fine answer, thank you. Mr. Filner?

Mr. FILNER. Mr. Chairman, the second panel has testimony with regard to the Persian Gulf illness. I was wondering whether I could postpone my questions for Mr. Epley. Can he wait for the second panel, and we can have those questions with that testimony just on the Persian Gulf.

Mr. EPLEY. I'd be happy to stay, sir.

Mr. QUINN. It's fine with me.

Mr. FILNER. I appreciate that. I'm almost tempted to say, I hope you don't need clearance for that, but I won't!

Mr. EPLEY. Thank you, Mr. Filner.

Mr. FILNER. I was interested in the disagreement here. I appreciate the history lesson from both. I studied the history of medicine at Yale, by the way.

Dr. BOOSS. A good education.

Mr. FILNER. Yes. I had the best of both to paraphrase President Kennedy. I went to Yale University but I got a degree from Cornell.

Dr. Varney, I'm sure you've heard these criticisms before. As I understand your research, your research was published in a peer review journal.

Mr. VARNEY. Yes.

Mr. FILNER. And I'm sure people who reviewed you—aware of such criticism. I don't want to get into a real debate here, but I was just wondering if you had any reaction to the criticisms?

Mr. VARNEY. There's one criticism I'd like to address which is the regular selection of subjects. None of the patients that we had that were diagnosed with cerebral malaria for our study had medical records that indicated that they had not had a serious tropical disease associated with a very high fever, et cetera, meeting all diagnostic criteria for cerebral malaria. One of the problems with cerebral malaria from blood smears is when the illness is in the brain it is not in the blood. You cannot diagnose with a blood smear when the patient is cerebral. So, that's an option that I don't have. It's not possible, so it's not available. Finally, the missing records in our study we found 70 percent confirmation and 30 percent nonconfirmation. It was the same as for gunshot wounds; 70 percent confirmation and 30 percent of the records didn't confirm gunshot wounds, but we were able to confirm from their DD214s. So, I think the selection of subjects is as good as can be expected under combat circumstances and with this disease as it is diagnosable.

Mr. FILNER. The thing that struck me by Dr. Booss' testimony is the general perception of the procedure under which the VA operates is that, number one, especially in a combat situation, the military records are seen as the bible, and much of your criticism came from "Oh, it wasn't in the military record."

As I said earlier, I just can't imagine under the conditions of Vietnam that that should be our only or even the best source of information. I would say testimony from folks, from the buddies who were there, testimony from the person who was involved would be as equally valid, and the VA ought to be looking at that and not just the bible of the medical file that may not have been complete. We just went through a Persian Gulf situation, and there's a claim made—I, frankly, don't believe it—but there's a claim made, that nobody kept any records of the inoculations and the vaccines that were given. We've asked for that material to even know what the soldiers under less than combat conditions received. I mean, these are soldiers being processed through in a civilian situation where supposedly the bureaucracy works and does everything in a standard way, and we're told "We don't have any records of what vaccinations were given to these men and women." So, I can't believe that you should rely just on that.

Second, knowledge changes; techniques improve. We may not have had at an earlier time what we have now. I know that there are some scientists—if I can get back to the Persian Gulf War—who claim that all veterans ought to be tested—and I'll ask this later—for the mycoplasmas—is it a bacteria? The infectious agent, mycoplasma.

Mr. VARNEY. Yes.

Mr. FILNER. Well, you could test the blood for that, but if the blood sample, as I understand it, is more than a few days old, you're not going to find it. So, we've had VA people say, "We've tested all the blood, and we can't find it." Well, they tested blood that was a week old or 2 weeks or 3 weeks old, and you're not going to find it. So, the reliability of tests; the reliability of records

just seems to me not to be at the level in which people are making judgments about their pension, their disabilities, their lives and whether we're going to get adequate treatment for them.

And, one more thing on the record, as I understand it—correct me if I'm wrong—that a discharge examination is not required, and so it's hard to prove by the records whether a condition existed at the time of service or not, because it's not in the records. Well, somebody was anxious to get out or missed an appointment so it's not in the records. It just seems to me that the Veterans' Administration is supposed to be for the veteran, not to find a way to deny them their lawful and just claims but to find a way to figure out if what they're saying is accurate, and it just seems, we're not doing that, and I could just hear it from the testimony.

Mr. QUINN. Okay, thank you, Mr. Filner. Mr. Rodriguez, a question at this point in time?

Mr. RODRIGUEZ. I guess, I have the same frustrations, and I just feel that maybe we need to look at the—and I don't know whether legislatively because it seems to—you know, if we don't have the documentation or we can't prove, we need to give—when in doubt, just provide them with the service. I think that's the only way we can—when in doubt, give them the benefit of the doubt instead of the reverse that they have to prove.

Mr. QUINN. How many times have we said that, sir?

Mr. RODRIGUEZ. Maybe we have to put it into legislation, unfortunately.

Mr. QUINN. Thank you. I do have a question, Dr. Wright—thank you, Mr. Rodriguez. You mentioned in your study and your remarks and I followed in the written testimony that the study is being extended because there's not a big enough sample and what you found is interesting enough to take the next step. Do you know if those extended studies are funded through NIH or the VA. You said, I think, at one time, in future years—how many years out are you funded?

Dr. WRIGHT. I'm funded for the coming 5 years. I started in April to start looking at the prevalence, the number of people in our hospital who have infections and the demographics of those people; whether they're Vietnam veterans; whether they have injections, transfusions——

Mr. QUINN. See, I think that would really be important information; you're right on target there. So, you're funded out 5 years?

Dr. WRIGHT. Correct, but, obviously, we need to extend it to other VAs, because we're an inner-city VA, and the other issue is we're not accessing veterans who don't come to our medical center which is a majority of veterans.

Mr. QUINN. Sure, like Buffalo, New York, for example.

Dr. WRIGHT. I don't know how we'd get out there and do it.

Mr. QUINN. I know how to get you out there, it's easy, but I don't know—yes, you'd never get back, that's the problem. And the funding is from——

Dr. WRIGHT. The funding is from the VA.

Mr. QUINN. VA, it is. Do you know how much?

Dr. WRIGHT. I have three-quarters of a million dollars.

Mr. QUINN. Okay, great. Thank you. Let's talk about that for just a second. Are we going to go outside San Francisco in the next 5

years? Can we look elsewhere? Do you need more money? What's the situation?

Dr. WRIGHT. I think the VA is going to have to look, actually, in conjunction with the CDC and the NIH to look at this is a broader epidemiological problem, because it's going to take multi-institutional collaborations. Also, the Department of Defense will be involved.

Mr. QUINN. Dr. Booss, can you comment on that at all? Or do you have an opinion from the VA?

Dr. BOOSS. May I defer to a colleague who is here, Dr. Paul Hoffman who is head of medical research for the VA.

Mr. QUINN. Absolutely, sure. Paul, would you please come to the microphone, so that we can—the end microphone on the last seat up there is active, if you turn the switch on.

So, my question was to Dr. Wright, with the funding that the VA has put in place for San Francisco's—the beginning of the work that was done in San Francisco, will we be able to get outside of that and expand it far enough to be helpful nationally?

Dr. HOFFMAN. Thank you. Yes, I think that the answer is that we do studies in single sites in the VA, and we do them in multiple sites. We have a program that's called the Cooperative Studies Program to do large-scale studies involving the multiple opportunities we have to do that in the VA, and, frequently, the studies that I'm responsible for funding which is the medical research single site studies such as this, would get translated into a cooperative study trial where we would look system-wide. It's one of the real advantages to a system like this for doing——

Mr. QUINN. Sure, and, after all, isn't that the idea? We find out something from a research point of view that interests us in one city and then we expand it.

Dr. HOFFMAN. Absolutely. So, we would welcome applications for research programs that would extend this and would use not only VA sites, but we've done this in conjunction with other agencies such as the NIH and——

Mr. QUINN. Now, how do you reach out to—excuse me—how do you reach out to make that known? You say you welcome applications. Unless someone is sitting in this room with us this morning that knows Dr. Wright's work, how would they even know enough to participate?

Dr. HOFFMAN. Well, the process is known through the VA, through investigators that they have the opportunity to submit these types of proposals to the Cooperative Studies Program. In addition, we frequently will let the field know that we have interests in particular areas, and then we welcome——

Mr. QUINN. Have you let them know that we have interest in this study?

Dr. HOFFMAN. We had a solicitation for, what we call, emerging pathogens for Agents that are becoming prevalent in not only the VA but in other populations and for agents that one might be exposed to in combat; that was a VA-DOD Cooperative Program, and that will be extended. We funded, I think, 12 programs initially on that.

Mr. QUINN. Excuse me just for one second. So, have you asked for outside involvement in this study that's begun in San Francisco?

Dr. HOFFMAN. Outside of the agency, are you saying?

Mr. QUINN. Outside of San Francisco.

Dr. HOFFMAN. No, we have not done that.

Mr. QUINN. Will you?

Dr. HOFFMAN. Yes.

Mr. QUINN. When?

Dr. HOFFMAN. I can't answer that.

Dr. WRIGHT. We've just begun.

Mr. QUINN. Pardon me?

Dr. WRIGHT. We've just began in April.

Mr. QUINN. Okay. Well, I—and, again——

Dr. HOFFMAN. In the written testimony that we'll provide for you, we can certainly make some estimate.

Mr. QUINN. I'd like for the subcommittee and the Full Committee to see that estimate.

(Subsequently, the Department of Veterans Affairs provided the following information:)

By September 30, 1998, we will convene experts from the VA, the National Institutes of Health, the Centers for Disease Control, and academic institutions to determine the feasibility of conducting a national epidemiology study on Hepatitis C. It requires approximately one year to plan such a study after it has been determined feasible. Therefore, we estimate that the project, if feasible, could begin in 12 to 18 months.

Mr. QUINN. And here, again, it's not that we don't think it's going to happen. I think it's great news there, and we need to expand it, but rather than keep it a secret, I'd be interested to know who else you are soliciting. That's a good answer.

Dr. WRIGHT. Mr. Quinn, to be fair to the VA, I think hepatitis C has been enormously underappreciated in general and that is changing. NIH has an RFP for $5 million that they're soliciting these kinds of studies, and we're planning to extend our study to Kaiser to look at a different population of patients for comparison.

Mr. QUINN. Great, good. And, Dr. Hoffman, I appreciate your coming to the microphone.

Mr. FILNER. Can he stay there for a second?

Mr. QUINN. Sure. Mr. Filner?

Mr. FILNER. Just a follow up on the follow up. How about Dr. Varney's research, is that going to be followed up at all?

Dr. HOFFMAN. Well, I think that there are problems that Dr. Booss had pointed out in terms of ascertainment that may not get any better by trying to do retrospective studies. As the length of time extends from the actual event, as you can see, it makes it harder to really determine that. We will extend studies in cerebral malaria as we do with all other emerging pathogens in terms of trying to get a better idea of how to treat these illnesses, and we do our supporting research in the area of malaria in terms of how organisms become resistant to treatment. Again, that was part of our endeavor in terms of——

Mr. FILNER. I will try to be calm; I don't know if he's right or wrong but he is saying that up to a quarter million troops may have had malaria. Dr. Booss said that's ridiculous. If Dr. Varney

is right, we have some real problems. I was struck by the neurological problems after the disease. For example, we have said again and again in this committee, we've heard the statistic; anywhere between a quarter and a half of homeless veterans are Vietnam vets. I'm only a layman here, but it seems if Dr. Varney is right—I don't know if you've gotten into this in your research—there seems to be some connection between some of these problems after malaria that might have great connection to why that homeless situation exists. That statistic, by the way, is incredible. I don't know if anybody has answered it besides saying, "Well, you know, there's drug and alcohol abuse." But I have talked to some of these folks on the streets of San Diego, and I will tell you, again as a layman, I see the problems that Dr. Varney describes as post-malaria neurological——

Mr. VARNEY. Neuropsychiatric.

Mr. FILNER. Thank you. Neuropsychiatric problems fit right into the folks I'm talking to. I don't know if you looked at that connection. But forget if he's right or wrong; he's saying something that seems to me is pretty important and just because a few guys say he's wrong who are his bosses, are we going to just throw this away and say no more, because, it just seems it has tremendous ramifications if he's right. Instead of proving him wrong, somebody should be asking, is he right? Do you have any comments on that, Dr. Varney? Would you like some of this stuff to be followed up?

Mr. VARNEY. Very much so.

Mr. FILNER. Is there any connection, the possibility, say, of the homeless situation and some of these neuropsychiatric disorders?

Mr. VARNEY. It's possible. With regard to follow up, I'd like to make a point where speed may be of the essence. This population of malaria-afflicted Vietnam veterans are the only malaria-afflicted population of note in the industrialized West. When they die, this research will become historical and have no relevance to anything in particular. I'd like to see things done as expeditiously as possible, because these people are getting older, and when they die, there won't be any reason to have done it.

Mr. FILNER. I hope we can, as a committee—again, I understand what the scientific method is. I understand peer review. I understand that if 20 people say he's wrong, you have a fiduciary responsibility, perhaps, to say it's not worth pursuing, but I will tell you, as a historian of science, that this is the kind of research that gets dismissed and is later found out to be accurate. This is the kind of research that, in hindsight, we wish we would have done. This is the kind of insight that people are not making that may provide an answer to things that we seem to be in the dark about, and there ought to be some little section of every bureaucracy that says we're going fund things that this bureaucracy is against.

Just as a check on the hubris of science and the hubris of expertise and the hubris of bureaucrats who run things. (Applause.)

I don't know whether he's right or wrong, but, I tell you, I studied for 30, 40 years the history of science, and everybody who said something that was said to be wrong, at some point, was later seen to be right and vice versa, and so if we sit here with our hubris about scientific knowledge and say he's wrong and don't pursue it, I think we're making a big mistake.

Mr. QUINN. Thank you, Bob. Mr. Reyes.

Mr. REYES. Mr. Chairman, if somebody will yield me a few minutes.

Mr. QUINN. You have your own time, sir.

Mr. REYES. Okay, thank you. Well, I get frustrated because this comes under the category of been there and done that, because I spent 13 months in Vietnam, and I was troubled by the fact that, oftentimes, we hear the textbook version of the United States military in terms of—you made mention of 11 evacuation hospitals and all of that—I happened to have been a helicopter crew chief; did some medi-vac and can tell you that at times things were bad enough to where guys that were sick—we were told to suck it up, because there was nobody else, and you don't want to let your buddy down, and you don't want to wimp out on an operation, and I'm not talking about myself, I'm talking GI Joe, in general, in Vietnam. And part of the difficulty and part of why we get—and I won't speak for we, I'll speak for me—I get frustrated is because I hear repeatedly the horror stories of today's veterans that are now in the fifties that are suffering and are suffering by maladies that, perhaps, research has ignored, and I would hate to think that we are abdicating our responsibility as a Nation and as a country and that I, in particular, to my brothers in combat and of—this is one man's opinion—that I think there's a lot more to this, and I've seen it, and I will tell you from personal experience that I went through in 1974. It's easy when you get shot and there's a wound and there's medical evidence and all of these other things, but it's much more difficult when you're dealing about things such as malaria and hepatitis and swelling of the joints and all of these other things that everyone in Vietnam, at some point or another, might have been exposed to the effects of Agent Orange and all of these other things, and I am troubled very much by a bureaucracy that—you know, in baseball, the tie goes to the runner; in the VA, you've got to make compelling, overwhelming, and sometimes even then case, and it's still—the bureaucracy stonewalls.

The fact that you made mention, Dr. Booss, about a system that keeps careful records and all of that, I can tell you they don't. In my personal case, records were lost; a simple thing like loss of hearing in my right ear. Now, I have the evidence, obviously, I don't hear out of my right ear, and in 1974 in pursuing, I finally gave up in frustration because there's a magic formula in the VA that says that if you have less than 10 percent disability, there is no compensation other than saying, "Thanks for doing a good job, folks." You were there in very terrible circumstances.

But I guess one of the things that I would ask, if a veteran qualifies for a liver transplant, under what circumstances would the VA rate them at less than 100 percent disability? Can anybody answer that? Because that's a very rapid concern and question that I think needs to be answered, and I think it strikes to what I tried to articulate, and, forgive me, but I get a little frustrated at times and especially when I hear the textbook version of what combats all about. And I am proud to have fought for this country and worn the uniform of the United States Army, but I can tell you, what is drawn up in battle plans and battle strategies is carried out by human beings and is influenced by things that we never think

about; things that happen either inadvertently or purposefully because you're fighting an enemy, and there are a lot of soldiers, veterans, that sucked it up at that time that are paying a terrible price today, and nothing is out there being done for them, and nothing was documented, and, in some cases, their anecdotal recollection of what happens is ignored and even revoked, and that, I think, should tell us a lot more about who we are as a society than anything else. And I think it's a condemnation of an attitude that needs to change.

So, anyway, my original question, liver transplant.

Mr. EPLEY. Sir, if a veteran came in with hepatitis and had marked liver damage, he would be rated at a 100 percent. If he underwent a liver transplant, he'd be rated after that fact based on his functional abilities. I can't say to you that they would be 100 percent or less at the moment, but we rate hepatitis based on degree of liver damage.

Mr. REYES. And, so, if they have a successful liver transplant, then it would depend—so, hypothetically, the veteran, once he gets a liver transplant, could be okay and would not——

Mr. EPLEY. It is conceivable that person would be less than 100 percent.

Mr. REYES. Any thoughts on some of my other observations, and I'll admit that I don't know what your backgrounds are, but I make those observations from having been there, and a lot of times, I hear people talk with a degree of certainty that weren't there and have heard or read and they're not correct, and that translates to people on the streets like Mr. Filner was talking about that are suffering and suffering because we have a very bad attitude about what happened to them during a tough time in their lives.

Mr. EPLEY. We acknowledge, sir, that it is difficult to always obtain the kind of records that would make it easier to rate claims. We know from the volume that we look at, it's not an even deck. They're not always cleanly available to us. Our obligation—and I hope we're fulfilling it—is to pursue as far as we can to get all the evidence available, and, indeed, when it's obtained, if that veteran has well grounded his claim, to give him the benefit of the doubt using all the evidence available at that time.

Dr. BOOSS. Thank you very much. I respect and admire that experience. I didn't have that experience. I was at the School of Aerospace Medicine in the Air Force in 1971 to 1973 when the human results were evident. So, I greatly respect what they went through.

The second thing I would say is that your colleagues were sick, there's no question of that. It might not all have been malaria. There was Japanese B encephalitis; and there was Dengue; they were sick. My point is just that if they were sick, it might have been something else.

The third thing to say is that I actually talked to a colleague who was at an evacuation hospital, who examined the troops, and asked him to review the material at hand. What I have said is compatible with his response to me.

Mr. REYES. But your colleague was at the evacuation hospital.

Dr. BOOSS. That's correct.

Mr. REYES. My point is not everybody made it to those evacuation hospitals.

Dr. BOOSS. I accept that.

Mr. REYES. Thank you.

Mr. QUINN. I appreciate the comments from the gentleman from Texas which is evidence of why he's such a valuable member of the subcommittee and the Full Committee. We appreciate that, Mr. Reyes, very much.

Dr. Hoffman, thanks for joining the panel. I think you sort of get our drift here, ladies and gentleman, and we appreciate your patience with us, and I'd like to thank you for being with us this morning and release you and ask for our second panel, Mr. Paul Sullivan, a single-person panel.

Mr. Sullivan how are you?

Mr. SULLIVAN. I'm doing fine.

Mr. QUINN. Good, good. We're going to ask you, Mr. Sullivan, as the morning proceeds here, to—we know we've received your written testimony; we appreciate that a great deal—ask that you maybe give us about a 5-minute summary of those remarks. Your written remarks become part of today's record. We are scheduled to be called to a vote shortly, but I think we'll have more than enough time to have your oral comments on the record now, and then we'll see if we'll have to take a break then.

The National Gulf War Resource Center, we're very, very pleased to have you with us today and look forward to a long working relationship with you in the future. You may begin.

STATEMENT OF PAUL SULLIVAN, EXECUTIVE DIRECTOR, NATIONAL GULF WAR RESOURCE CENTER

Mr. SULLIVAN. Thank you, Mr. Chairman, members of the subcommittee. On behalf of the 51-member organizations of the National Gulf War Resource Center, I appreciate the opportunity to testify today regarding disability claims and other matters important to Gulf War veterans. The National Gulf War Resource Center is the first Washington-based veterans organization dedicated solely to Gulf War illnesses.

I've shortened my remarks at your request, Mr. Chairman. I would appreciate being able to place two things into the record: the National Gulf War Resource Center's "Government Relations Working Paper"——

Mr. QUINN. Without objection, so ordered.

Mr. SULLIVAN. Thank you. And the National Gulf War Resource Center, Swords to Plowshares, and Military Toxics Project, "Depleted Uranium Exposures Case Narrative."

Mr. QUINN. Hearing no objection, again, it's so ordered. Thank you, Paul.

Mr. SULLIVAN. Thank you, Mr. Chairman. You asked us to provide you with updated statistics on Gulf War veterans and that detailed information was provided to you, and we even have some newer information that the VA sent to us, and I wanted to thank them, because we asked for it and they sent it to us right away. So, we wanted to thank their policy——

Mr. QUINN. Maybe what we should do is funnel our requests through you. (Laughter.)

Mr. SULLIVAN. Well, there are cases—we do work together with the VA sometimes, and we get along.

Mr. QUINN. I'm sure you do. Thank you.

Mr. SULLIVAN. You also, Mr. Chairman, wanted us to comment on VA's problems involving undiagnosed illness claims as well as diagnosed claims. We note an alarming rate of at least 78.5 percent of the Gulf War veterans who had their claims adjudicated for undiagnosed illnesses were denied. This rate does not address pending claims; the rate does not address the granting of one or more undiagnosed conditions along with the denial of one or more undiagnosed condition.

The National Gulf War Resource Center in reviewing this complicated problem finds there are five sometimes conflicting points of view resulting in various interpretations of the law and widely varying out comes to frequently ill-served Gulf War veterans seeking benefits.

The first point of view is that of the Gulf War veteran who is sick from a Gulf War toxic exposure and who wants to help restore their health. Veterans are interested in a timely, accurate adjudication of their claims, so evaluation and treatment can begin promptly. Gulf War veterans are not simply out for a check as the VA and DOD and independent medical practitioners have unanimously concluded that Gulf War veterans are ill and that they are ill in greater numbers than civilians in other groups. Gulf War veterans simply want health care, and they apply for benefits in order to obtain care. The National Gulf War Resource Center has distributed 10,000 self-help guides toward that end to make sure Gulf War veterans know about the process, and we have a special section on undiagnosed illness. We also note the American Legion is doing the same thing. So, the veterans' organizations are trying to help out the veterans.

The Pentagon is another point of view. We're in this mess mainly because of the Pentagon. The Pentagon has failed to follow their own regulations and to train soldiers about toxic exposures, specifically, depleted uranium, to monitor toxins in the air, soil, and water. And Pentagon failures to note medical records and conduct required screenings, there is an absence of information regarding the toxic exposures. The Department of Defense has also failed to develop a case definition as required by Public Law 103–337.

Another point of view is the Department of Veterans Affairs. According to the GAO, there were significant problems with the adjudication of Gulf War veterans' claims, especially under the undiagnosed provisions. The important problems cited by the GAO were the underdevelopment of claims such as a failure to get lay statements and failure to review independent medical records. The VA should have taken such actions under their duty to assist.

We have no new information to determine whether or not the corrections made by the VA and noted by the GAO have resulted in significant changes. We also note that the VA's reliance upon the DOD for exposure information and medical research delayed the research and treatment that could have provided answers in relief to tens of thousands of Gulf War veterans, especially those filing claims.

Chairman Stump of the House Veterans' Affairs Committee also voiced his concerns in a recent letter to VA Secretary Togo West on June 3. The National Gulf War Resource Center agrees with the

concerns of Mr. Stump. What he asserts in his letter is that a Gulf War veteran's claim under the undiagnosed provision could be very narrowly interpreted or widely interpreted, thus, causing serious problems. The Resource Center believes that if additional training was provided to VA adjudicators, we may be able to resolve this, and I understand some of that is being done.

One thing that's new that we want to bring to the subcommittee's attention is VA physicians performing compensation and pension exams. Training of VA physicians places a heavy emphasis on stress as a major cause of the illness, according to the new Gulf War Illness Guide. The absence of toxic exposure data and training and an overreliance on stress as the cause may tilt the C&P exam in favor of the VA and against the veteran.

Another point of view is veteran service organizations who are doing the best job possible to try to help veterans out. There isn't blame with the veterans' service organizations. We're trying to do the best we can in a difficult situation, but some veteran service organizations are pushing an undiagnosed claim, and some want to ignore the undiagnosed claim field all together. Thus, possibly skewing the data.

Another point of view is Congress. Congress acted wisely in passing these new laws, and they acted in the best interest of Gulf War veterans. We believe Congress should address the problems cited by us—and more extensively detailed in our written testimony—with new hearings, with getting better data, and with holding some investigation using the General Accounting Office to find out exactly what's going on. We do want to note, specifically, that we thank very much Congress for extending the 2-year limitation presumptive period to 10 years. That was a very helpful thing in helping resolve a lot of the undiagnosed illness claims.

The National Gulf War Resource Center wanted to propose some solutions regarding this matter, and, as you noted earlier today, the first is the development of better data. Specifically, how many veterans have major types of illnesses, especially cancers? There's been significant discussion over that of whether or not the VA can or cannot do that well, determining the total number of different undiagnosed conditions claimed by veterans, because some veterans are claiming four or five, being granted on one, being denied on four. But the veterans is being counted as granted service connection for an undiagnosed condition. We don't have the data to sort out who's being denied on what, and we believe that that may provide some answers on this issue.

Better DOD recordkeeping is essential; it's very much needed, and, today, the DOD has not yet begun noting medical records of Gulf War veterans known or suspected to have been exposed to radiotoxic waste in the form of depleted uranium, thereby continuing and perpetuating this problem. The DOD has not yet begun any screenings or medical research into the effects of inhaled or ingested depleted uranium, again, further complicating this problem and continuing it. The DOD has not yet completed or released any report on depleted uranium even after repeated public announcements to do so. In a related manner, DOD lacks firm data on as many as 908 Iraqi ammunition dump demolition incidents, 35 of which may have contained chemicals according to the Pentagon.

Again, we're waiting for more data to come from the DOD to find out what exactly the soldiers were exposed to.

So, what we conclude is because of the serious nature of the illnesses, the National Gulf War Resource Center believes Congress should pass legislation that presumes exposure to toxins including allowing for the addition of new toxins yet to be revealed as well as combinations of toxins; funds the establishment of an independent oversight panel, because, clearly, the Department of Defense isn't doing anything, so someone needs to step in and do something; funds independent research; funds the provision of Public Law 103–446 that calls for evaluating spouses and children. This is because we believe this is important in a manner similar to Agent Orange, which now service connects the children who may have spina bifida. We need to be developing some data on the children of Gulf War veterans, and, as the GAO pointed out, the VA may or may or not be doing a good job on that, because it was delayed in setting it up.

With those specific suggestions in mind, the National Gulf War Resource Center strongly supports the prompt passage of H.R. 4036 and or a combination of bills meeting our suggestions. We specifically thank you for agreeing to hold hearings on depleted uranium. We think that you will learn a lot about that, and it will be very good for everyone involved, and we also thank the members of this subcommittee who have co-sponsored H.R. 4036. We think that those members are definitely doing the right thing for Gulf War veterans.

[The prepared statement of Mr. Sullivan appears on p. 140.]

[The document entitled "Depleted Uranium Exposures Case Narrative" has been retained in committee record.]

[The information on the Government Relations Working Paper follows:]

National Gulf War Resource Center
1224 M Street, NW
Washington, DC 20005
(202) 628-2700, ext. 162
(202) 628-6997 fax
www.gulfweb.org/ngwrc
ngwrc@vva.org

1998 Government Relations Working Paper

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National Gulf War Resource Center 1998 Government Relations Working Paper

I. Mission Statement of the National Gulf War Resource Center

Formed in 1995 to assist grassroots Gulf War veteran support groups, the National Gulf War Resource Center has a clear mission statement advocating the concerns of ill Gulf War veterans:

> **The National Gulf War Resource Center is an international coalition of advocates and organizations providing a resource for information, support, and referrals for all those concerned with the complexities of Persian Gulf War issues, especially Gulf War illnesses.**

II. Executive Summary

Due to the serious nature of this health care crisis and due to the missing and/or poorly defined medical research, Gulf War veterans have a short list of four government relations goals:

* Obtaining the best and most prompt medical care and medical research for those ill as a possible result of Gulf War service, including family members and deployed civilians

* Determining the causes of the illnesses so proper treatment may be provided and so we may be able to use science to understand the relationship between multiple toxic exposures and illnesses, especially undiagnosed illnesses. This includes the formulation of a case definition for Gulf War illnesses and handing the lead investigative role to an outside agency, preferably one outside of the executive branch.

* Using the knowledge gained by research to address military doctrine and training shortfalls with an eye toward reducing or preventing further toxic exposures and illnesses.

* Repealing the FDA Interim Rule that allows the use of experimental drugs on our service men and women without informed consent.

Toward that end, the NGWRC has endorsed the report prepared by Representative Christopher Shays and approved unanimously on November 7, 1997 by the House Government Reform and Oversight Committee ("Gulf War Veterans' Illnesses: VA, DoD Continue to Resist Strong Evidence Linking Toxic Causes to Chronic Health Effects," House Report 105-388).

The NGWRC supports HR 3279 (introduced by Representative Lane Evans), and HR 3661 (introduced by Representative Joe Kennedy), as they both address the medical benefits and health care needs of Gulf War veterans.

The NGWRC also supports HR 3484 (introduced by Representative Lloyd Doggett), which allows for the fair distribution of former frozen Iraqi assets now owned by the US Government.

III. Brief History

Service in the Gulf War can best be described as living in a "toxic soup" of various chemicals, heavy metals, and pollutants. In the seven years since the start of the Gulf War, 249,508 (or approximately 44%) Desert Shield and Desert Storm veterans, out of a veteran population of 563,742, have sought medical care from the Department of Veterans Affairs (VA). Tens of thousands more have sought help from the Department of Defense (DoD) or from the private sector.

Combined, the Gulf War illness registries of both the VA and DoD exceed 111,000. According to the VA and DoD, twenty-five percent or more (some DoD reports show as high as forty percent) of those on the registries cannot be properly diagnosed.

An unknown number of ill Gulf War veterans have sought assistance from the private sector and are not counted in official reports. According to press reports, Gulf War veterans from Canada, England, the Czech Republic, Australia, and other nations in the Coalition serving in the Gulf War are also ill, some with illnesses that cannot be diagnosed.

Dozens of grassroots Gulf War veteran support groups formed around the globe in order to address this issue. These groups include not only veterans, but families of ill or deceased veterans desperately seeking accurate and timely information they can share. The National Gulf War Resource Center (NGWRC) was formed by these grassroots groups to serve their growing needs at the national and international level.

The number of ill Gulf War veterans, especially the high number of undiagnosed veterans seven years into the war, indicates a very serious health crisis exists among Gulf War veterans. The NGWRC believes this demands the prompt, active involvement of Congress to investigate the matter and to modify laws and policies, as needed.

IV. Formation of the of NGWRC

Founded on June 28, 1995 in Washington, DC, the National Gulf War Resource Center, Inc. is the leading international organization providing advocacy and self-help assistance to Gulf War veterans. The NGWRC remains the first and only non-profit organization with a full-time office and staff in Washington dedicated solely to Gulf War veterans' health concerns.

The NGWRC maintains offices inside those of the Vietnam Veterans of America (VVA), our patron organization. The VVA does not participate in or control NGWRC policy development or implementation. The importance of our close relationship with fellow war veterans at VVA and their assistance enables the NGWRC to attempt to shorten the time line it takes the government to address complex issues such as Gulf War illnesses.

The NGWRC was incorporated in the District of Columbia on November 21, 1995, and we received our certification as a non-profit 501(c)(3) from the Internal Revenue Service on March 31,

1997. We began as seventeen organizations, and today we have almost tripled our size to forty-eight groups. Our organization represents a consensus view within the Gulf War veteran community. Our resolutions and Board of Directors are voted upon during public meetings in a democratic fashion.

The NGWRC currently represents the interests Gulf War veteran organizations in the United States, the United Kingdom, and Denmark. Our three dozen member groups include:

Alaska Gulf War Syndrome Referrals; Eagle River, Alaska
Augusta Gulf War Veterans, Inc.; Augusta, Georgia
Bill Motto Veterans of Foreign Wars Post 5888; Santa Cruz, California
California Association of Persian Gulf Veterans; Santa Cruz, California
Citizen Soldier, Inc.; New York, New York
Crisis in the Homeland; Mitchell, Indiana
Danish Gulf War Veterans Information Team; Fredericia, Denmark
Desert Storm Justice Foundation, Inc.; Guthrie, Oklahoma
Desert Storm Veterans of Florida; Titusville, Florida
Desert Storm Veterans of North Carolina, Inc.; Greensboro, North Carolina
Desert Storm Veterans of the Rocky Mountains; Wheat Ridge, Colorado
Gulf War Veterans of Arkansas; Little Rock, Arkansas
Gulf War Veterans of Delaware; Wilmington, Delaware
Gulf War Veterans of Georgia, Inc.; Marietta, Georgia
Gulf War Veterans of Western Pennsylvania, West Virginia, and Northeastern Ohio; East Palestine, Ohio
Gulf War Veterans of Wisconsin; Madison, Wisconsin
GulfWatch, I.N.S.; Hannibal, Missouri
Gulf Veterans Association; Clackmannanshire, Scotland, United Kingdom
Idaho Desert Storm Foundation; Lewiston, Idaho
The Last Patrol; Saint Cloud, Florida
The Military Justice Clinic, Inc.; Atlanta, Georgia
Northern California Association of Persian Gulf Veterans; Valley Springs, California
Northwest Veterans for Peace, Inc.; Portland, Oregon
Persian Gulf Information Network, Inc.; Clarksville, Tennessee
Persian Gulf Veterans of America; Fort Huachuca, Arizona
Persian Gulf Veterans, Inc.; East Rochester, New York
Persian Gulf War Veterans Association of America, Inc.; Oakland, California
Staten Island Desert Storm Veterans; Staten Island, New York
Swords to Plowshares, Inc.; San Francisco, California
Trauma After Care Trust; Withington, United Kingdom
Unified Veterans of America, Inc.; Dunn, North Carolina
Veterans Family Health Services, Inc.; Darien, Connecticut
Veterans for Peace, Inc.; Washington, District of Columbia
Veterans of Foreign Wars Rainbow Post 2681; Marietta, Georgia
Veterans Speakers Alliance; San Francisco, California
VietNow, Inc.; Rockford, Illinois

Our one dozen associate groups include:

Americans for Truth; Kuckville, New York
The CFIDS Association of America; Charlotte, North Carolina
Chemical Weapons Working Group; Berea, Kentucky
Georgia Vietnam Veterans Alliance, Inc;, Doraville, Georgia
Gulf War Research Foundation, Inc.; Washington, District of Columbia
Military Toxic Project; Lewiston, Maine
National Organization of Veterans Advocates; Topeka, Kansas
National Veterans Legal Services Program, Inc.; Washington, District of Columbia
New York State POW/MIA Action Group; Utica, New York
North Shore Veterans Counseling Services, Inc.; Beverly, Massachusetts
Tres Pueblos Auxiliary, VFW Post 7263; Santa Cruz, California
927th Family Network.; Saint Clair, Michigan

The NGWRC wrote and distributed the first-ever Gulf War Syndrome Self Help Guide for those who wanted the best available independent information. The Guide was so successful, a second printing was needed in 1997. To date, we have given away 10,000 free copies of our guide and are preparing a third edition for 1998. The Guide has a well-established reputation as an invaluable tool for veterans, veterans service officers, and others interested in the issue.

The NGWRC provides veterans with information before and as they seek help, so that the proper questions may be asked and the best services provided, making everyone better off in the long run. The Guide helps to ensure there are more well-informed Gulf War veteran consumers aware of the health care system and of veterans benefits. The Gulf War Syndrome Self Help Guide would not have been possible without the generous assistance of the VVA and the Eastern Paralyzed Veterans of America.

The NGWRC, using volunteers and donated server space, operates the largest and most active web site for Gulf War veterans. It received more than 200,000 visits last year. Our web site address is www.gulfweb.org/ngwrc. We actively utilize the Internet to obtain information from veterans, the government, and the press, and then we instantly distribute it to our advocates and organizations around the globe. Our Self Help Guide, a listing of support groups, and our Depleted Uranium Case Narrative are available at the site.

The NGWRC has held two Gulf War Veterans' Illnesses Conferences. The first was in Tampa in 1996, and the second was in Atlanta in 1997. Presentations were made by leading independent researchers investigating the causes of Gulf War illnesses. Presentations were also made about research projects investigating chemical, biological, and depleted uranium exposures. The conferences serve as the annual meeting of NGWRC groups. During the conferences, member organizations elect the Board of Directors and vote upon various policy resolutions. The 1998 Gulf

War Veterans' Illnesses Conference will be held in Washington, DC, from September 18 - 21.

V. History of Gulf War Illnesses

On August 2, 1990, Iraq invaded neighboring Kuwait, and the Gulf War began. American troops arrived in Saudi Arabia shortly thereafter as part of Operation Desert Shield.

On January 14, 1991, Congress passed a joint resolution (Public Law 102-1) authorizing the use of force in accordance with United Nations resolutions and guidelines if Iraq did not withdraw from Kuwait. Iraq refused to comply with U.N. Resolution 678 and others. Thus, on January 17, 1991, Operation Desert Storm began as American and Coalition forces began bombing Iraq.

According to the Department of Defense, as part of the air war, chemical and biological warfare agent manufacturing sites were targeted. Many stockpiles were destroyed, releasing tons of toxic agents into the atmosphere. By January 20, 1991, the Iraqi army began igniting more than 700 massive oil well fires, resulting in tremendous amounts of toxic pollution being released into the air, ground, and water in the region. Gulf War veterans, Congress, and the public now know that the DoD was well aware before the war of the risks involved in bombing these sites.

In an attempt to protect troops in the region against known Iraqi chemical and biological warfare agents, the Department of Defense received a waiver, referred to as the "Interim Rule," from the Food and Drug Administration (FDA) in December 1990. The FDA waiver allows the DoD to inject and administer, under order, experimental (often called "investigational new drugs") vaccines and anti-nerve agent pre-treatment pills.

As part of the special, one-time waiver, the DoD agreed to note the medical records of those who received the anti-botulinum toxoid (BT) vaccine and the pyridostigmine bromide (PB) pill. The DoD also agreed to conduct follow-up studies to determine the side effects, if any, of the drugs.

There are also reports that pesticides were used extensively in and around troop locations. Diesel and other fuels were used to keep down blowing sand on and near roadways. Both of these have been widely implicated in illnesses among other exposed populations.

Starting on February 24, 1991, one of the largest armored assaults in military history took place as American and Coalition troops invaded both Iraq and Kuwait in order to expel Iraqi troops from the area. During the ground war, a new ammunition called depleted uranium (DU) was used for the first time in combat by M-1 tanks and A-10 attack planes. According to the Department of Defense, as much as 300 tons of radioactive toxic waste, much of it in the form of respirable dust, continue to pollute the firing ranges and battlefields in the region.

The toxic dust, which is easily inhaled and has a half-life of several billion years, may be found at target ranges in Saudi Arabia, such as those near King Khalid Military City, and in Kuwait. Low-level radioactive waste may be near Doha, Kuwait, the site of a major American base and site of a dramatic explosion and fire involving tons of DU in July 1991. There may be dust along the highways

and tank battlefields along the Saudi Arabian border, around Kuwait, and deep inside southern Iraq.

By February 28, 1991, Kuwait was liberated, with fewer than 150 American combat casualties. Former President George Bush ordered a cease fire, effective February 28, 1991. After the cease fire was signed by American and Iraqi military officials on April 6, 1991, most of the troops involved in the fighting returned promptly home to either the United States or to bases in Europe.

Contrary to most press reports, the Gulf War is not over. There is no treaty. There is no official declaration by either the executive or legislative branch of our government to end the conflict. Thus, PL 102-1 remains in effect today.

As many as 40,000 American troops and their equipment stand ready to enforce the sanctions blockade of Iraq and resume armed conflict immediately. This includes policing the "No-Fly Zones" in southern and northern Iraq and closely monitoring the shipping lanes in the Persian Gulf. Ironically, according to United Nations weapons inspectors, Iraq is still believed to retain biological and chemical warfare agent capabilities.

The fact that the war continues may explain the many different definitions of Gulf War veterans in use today by the VA and DoD. For example, according to the VA:

696,583 served in the conflict from August 2, 1990 through July 31, 1991
1,099,515 served in the theater from August 2, 1990 through April 1998
3,507,075 served in the armed forces from August 2, 1990 through April 1998

We note that Congress (or the VA and DoD) in cooperation with veterans' organizations, may wish to define exactly what is a "Gulf War veteran," a "Gulf War-era veteran," or a "potential toxic exposure Gulf War-era veteran." This may be critical in determining how medical research is conducted, health care is provided, and benefits are distributed. The NGWRC understands the VA and DoD are working toward a resolution of this matter, and we await the final details of their definitions.

For example, some military units that arrived in May and June 1991 may be considered "conflict" veterans, even though they did not participate in Desert Storm, the air war, or the ground invasion.

In addition, it may be important to consider non-deployed veterans who received pre-deployment vaccines among those to be studied to determine the effects, if any, of multiple vaccines. It may also be relevant to include those with known non-combat depleted uranium exposure among those studied for the long-term effects of DU. It may also prevent abuse by the Pentagon in using non-exposure groups to study the effect of certain toxic exposures (please see our discussion regarding oil well fire pollution studies undertaken by the military).

However, in an otherwise victorious and brief battle of less than two months, several things went wrong that affected the long-term health of American veterans. The first mistake, admitted by

the Pentagon, was that they did not listen to the health complaints and exposure reports made by veterans. The second mistake was to not investigate the matter with vigor and honesty. A comprehensive review by the military began in late 1996, and we await the reports scheduled to be released soon by the Office of the Special Assistant for Gulf War Illnesses (OSAGWI) at DoD.

Between March 4 and March 11, 1991, U.S. Army soldiers demolished several tons of chemical agents at an Iraqi arms depot called Khamisaya. The Central Intelligence Agency and the Pentagon would not admit to their roles in this, possibly the world's largest friendly fire incident in military history, until June 1996.

Veterans, Congress, and the press made the full role of those two agencies public only after applying intense pressure. Today, the number possibly exposed to chemical warfare agents has climbed to near 100,000. There may also have been biological agent exposures.

Several other things went wrong, too. As was reported by the Presidential Advisory Committee on Gulf War Veterans' Illnesses (PAC), few accurate records were kept on who received the experimental BT shots and PB pills. There was little or no follow-up to determine the side effects, if any, of the experimental drugs, according to the PAC. It became clear by 1996 that the Pentagon was an excellent war fighting agency and a rather sloppy (if not negligent) record keeper.

The Pentagon, in a belated effort to determine the effects of the massive oil well fire pollution, began monitoring pollution levels near, but not inside, oil well fire areas in the late Spring and Summer of 1991. Some areas, either inside Iraq or near the Kuwait-Iraq border where American troops remained for weeks after the cease fire, were never monitored for pollution levels and exposure. Most monitoring began well after the troops who had fought in the ground war had returned to their home bases or were discharged.

The DoD drew lab samples from soldiers serving with the Army's 11th Armored Cavalry Regiment (11th ACR) in the Summer and Fall of 1991 to determine health effects of exposure to oil well fire pollutants. In a case of research used for questionable political ends, veterans discovered that the 11th ACR did not serve in the ground war and the unit was not present during Operation Desert Storm. In fact, the lead elements of the 11th ACR arrived in Kuwait in May 1991 and subsequently departed as late as December 1991, well after a significant number of the oil well fires were extinguished.

Again, the departure of the 11th ACR from Kuwait was well after the ground war. The 11th ACR was not stationed inside the oil well fire areas, as were some units, including the Army's 1st Armored Division, for more than two months. Under pressure from the NGWRC, the military retreated from using this discredited study as a basis for claiming there is no relationship between the oil well fires and Gulf War illnesses.

In another matter, the depleted uranium ammunition used in the Gulf War, although excellent for piercing armor and destroying enemy tanks, is made from low-level radioactive toxic waste. Guidelines established before the Gulf War to monitor DU contamination and exposure were not

followed.

Based on the best available information, the NGWRC concludes that as many as 400,000 of the 1.1 million Americans who have deployed to the Kuwait Theater of Operation since August 1990 may have been exposed to some level of depleted uranium. This does not mean those soldiers are ill or will fall ill.

The Pentagon recently confirmed that more than 250,000 American troops were at or near the front lines in 1991 alone, out of the approximately 697,000 in the region. By following existing military and Nuclear Regulatory Commission guidelines, inhalation or ingestion of only one one-hundredth of a gram of DU constitutes an "exposure." The NGWRC conclusion about the number of possible exposures is made using common sense, and it is our conservative estimate in light of Pentagon failures to survey DU exposures.

To our understanding, as of today, no measurements and surveys of actual battlefield exposure among service members have been released or are even underway. There is no health screening for inhaled or ingested DU available from DoD, although there is a limited follow-up on those with imbedded DU fragments.

Furthermore, there is no service-wide training plan in place to warn our troops about the hazards and harmful effects of DU, even though several orders have been issued by the Pentagon to implement DU training -- some of the warnings regarding DU date to the 1970s. Medics deployed with troops may not have the equipment needed to assess possible DU contamination of wounds.

When Congress began investigating Gulf War illnesses in 1993, the Pentagon repeatedly stated there were no chemical detection reports. In a letter to then-Senator Donald Riegle, the Department of Defense denied the existence of a chemical incident log. Gulf War veterans, using the Freedom of Information Act, obtained copies of Central Command's Nuclear Biological, and Chemical Desk Officer's Log (CENTCOM NBC Log) in January 1995. The CENTCOM NBC Log was replete with chemical incidents and injuries, contrary to repeated Pentagon assertions that there was no information that indicated there were any chemical warfare agent incidents..

The use of FOIA and subsequent releases of information by the DoD eventually paved the way for a partial admission in June 1996 that a few hundred Gulf War veterans may have been exposed to chemicals. By July 1997, the military admitted as many as 100,000 American troops may have been exposed to low-level chemical warfare agents, including sarin.

The Gulf War veteran community does not believe stress is the sole factor, and we do not believe it is a leading factor, for Gulf War illnesses. We note with disapproval the overemphasis on psychological diagnoses by the Institutes of Medicine (IOM), the DoD, the VA, and the PAC. Given the large number of serious toxic exposures among veterans, the overemphasis by the government on stress needlessly strained relations between veterans and the government.

Several things did go right, however. Congress passed legislation allowing for priority care

and for a free health screening, such as those available as part of the Persian Gulf Registry at the VA. Congress also passed a bill that requires the Department of Defense to develop a case definition for Gulf War Illnesses (Public Law 103-337). However, the DoD has not yet fulfilled their obligation under the law. The formulation of a case definition should expedite the provision of medical care and compensation issues.

Congress also passed landmark legislation regarding undiagnosed illnesses (Public Law 103-446). Gulf War veterans appreciate the dedicated work of Congress, especially the House and Senate Veterans Affairs Committees, on this issue for several years. This session, Congress extended the period of time for filing a claim under the undiagnosed illnesses provision (PL 105-114). We also recognize the tremendous effort put forth by Representative Christopher Shays and the Human Resources Subcommittee of the Government Reform and Oversight Committee. Rep. Shays has held more than eleven hearings on Gulf War illnesses in the past two years.

We look forward to the report scheduled for release soon by the Special Investigative Unit of the Senate Veterans Affairs Committee. Their report should shed some new light on this issue, especially since they received new, previously unreleased documents regarding widespread depleted uranium exposures.

VI. 1998 Legislative Priorities

The government relations and legislative priorities of the National Gulf War Resource Center can be summed up in four points:

* Obtaining the best and most prompt medical care and medical research for those ill as a possible result of Gulf War service, including family members and deployed civilians
* Determining the causes of the illnesses so proper treatment may be provided and so we may be able to use science to understand the relationship between multiple toxic exposures and illnesses, especially undiagnosed illnesses. This includes the formulation of a case definition for Gulf War illnesses and handing the lead investigative role to an outside agency, perferably one outside of the executive branch.
* Using the knowledge gained by research to address military doctrine and training shortfalls with an eye toward reducing or preventing further toxic exposures and illnesses.
* Repealing the FDA Interim Rule that allows the use of experimental drugs on our service men and women without informed consent.

In light of the number of ill who need medical care, and because of the missing records and lack of relevant, recent research data, and after careful deliberation, the Board of Directors of the National Gulf War Resource Center adopts the following legislative priorities:

1. Endorsement of Shays Report

The NGWRC endorses the report approved unanimously on November 7, 1997 by the House Government Reform and Oversight Committee ("Gulf War Veterans' Illnesses: VA, DoD Continue

to Resist Strong Evidence Linking Toxic Causes to Chronic Health Effects," House Report 105-388).

This bipartisan report, prepared by Representative Christopher Shays, forms the core of our legislative agenda. The report remains the most comprehensive investigation into Gulf War illnesses to date by Congress. We hope the investigation expands, looking into all possible areas related to the illnesses, including recent disclosures regarding the toxic effects of depleted uranium. We strongly urge a thorough review of the report.

2. Presumptive Exposure & Need for Independent Medical Research

Because of the reluctance of the military to act with vigor and thoroughly investigate many of the toxic exposures present in the Kuwait Theater of Operations since 1990, the NGWRC believes Congress should pass legislation presuming exposure to toxins during the Gulf War. Such a presumption should expedite research and treatment.

The exposures include, but are not limited to, oil well fire pollution, chemical and biological warfare agents, depleted uranium, experimental shots and pills, pesticides, fumes from diesel fuel, and combinations of these and other factors.

A presumption of exposure, in legislation, may force the DoD and VA to begin medical research and treatment programs – two of our major goals. The Presidential Advisory Committee on Gulf War Veterans' Illnesses, in their December 1996 Final Report, wrote that, "The evidence of CW [chemical warfare agent] release at Khamisiyah is overwhelming. The Committee concludes exposure should be presumed for nearby troops, although the exact levels are unknown."

As mentioned above, after admitting some chemical exposures at Khamisiyah in June 1996, the DoD subsequently announced in July 1997 that as many as 100,000 may have been exposed at or near Khamisiyah. If nothing else, this represents widespread exposure in a manner similar to the 400,000 possibly exposed to radioactive and toxic depleted uranium dust.

The Department of Defense and the Department of Veterans Affairs have lost credibility and objectivity in the eyes of many Gulf War veterans, especially many of those who are ill. The NGWRC view is supported by reports prepared by the Presidential Advisory Committee on Gulf War Veterans' Illnesses as well as the Subcommittee on Human Resources (Government Reform and Oversight Committee). We hope that credibility can be restored, as it is in the best interests of our country and veterans that we have strong faith in our institutions of government.

In an effort to restore the strained relationship between Gulf War veterans and the VA and DoD, the NGWRC supports independent medical research funded by Congress into the exposures known to be present in the Gulf region, including experimental drugs.

Our position should not be construed as a suggestion that VA and DoD be relieved of all research. Rather, an outside body should carefully review the vigor, the integrity, and the spectrum of VA and DoD research and report their findings promptly to Congress, especially in the newly

discovered toxic exposure areas of low-level chemical warfare agents and depleted uranium.

Medical research should be expanded to include comprehensive investigations into increased levels of birth defects, miscarriages, and other reproductive issues. We are awaiting the results of studies on spouses and children as called for in PL 103-446. We are awaiting the development of a case definition of Gulf War illnesses, as required under PL 103-337.

Given the lessons of Agent Orange and the effect it had on children of Vietnam War veterans, studies should be undertaken on family members of Gulf War veterans. The NGWRC defines family members as those with a close living relationship with a veteran. This includes, but is not limited to, spouses, children, siblings, and significant others living with the veteran.

It is important to note that we strongly support the development of a case definition of Gulf War illnesses so this may be shared with care givers at the VA, DoD and the private sector. It is equally important to know why veterans are ill so that the correct treatment is provided and so that our government policies can be reviewed and corrected with an eye toward preventing further mistakes and illnesses.

The NGWRC appreciates the funding Congress appropriated to study the effects of low-level chemical warfare agent exposure passed last year. Research efforts should be expanded to include depleted uranium in light of recent revelations regarding widespread exposures to DU.

3. Presumption of Service Connection for Toxic Exposures

The NGWRC, the only international Gulf War veterans' organization based in Washington, supports HR 3279, the Persian Gulf Veterans Act of 1998, introduced by Representative Lane Evans, the Ranking Member of the House Veterans Affairs' Committee. The Vietnam Veterans of America and the Veterans of Foreign Wars also support this comprehensive legislation. The Evans bill is the best legislation introduced to date on this complex issue, and it addresses many of the key points contained within the Shays Report.

Most importantly, the Evans bill requires the VA to give the benefit of the doubt to ill veterans when reviewing benefits claims. It is imperative, seven years into this health crisis, that veterans not be penalized for the poor record keeping, the lack of medical research, and other mistakes made by the Pentagon. We support the Evans bill with the stated intent that a provision for a presumption of exposure to various toxins, heavy metals, pollutants, and drugs be added.

Again, it is important to note that the Pentagon has lost or misplaced chemical detection reports critical to determining the type, amount, and duration of many toxic exposures. The military did not monitor oil well fire pollution in the areas where large concentrations of troops actually served. The Pentagon did not monitor radioactive toxic waste exposure (depleted uranium). The DoD and VA have not launched a broad epidemiological study to determine the causes of the illnesses.

Specifically, the Evans bill, for the first time, defines and lists specific toxic exposures. It allows

for the use of animal studies to determine the effects of some toxic compounds that cannot otherwise be tested. It has strong reporting requirements for the VA and DoD. It requires additional outreach. This benefits all concerned.

4. Revocation of FDA "Interim Rule"

As mentioned above, the Food and Drug Administration (FDA) granted a special waiver, or "Interim Rule" to the DoD in 1990 allowing the military to use troops as experimental test subjects without informed consent. American service men and women were given experimental drugs, sometimes called "investigational new drugs." This included pyridostigmine bromide (PB) and anti-botulinum toxoid (BT). There was no existing FDA approval for the use of these drugs.

As documented by the Presidential Advisory Committee on Gulf War Veterans' Illnesses, the Pentagon failed in most aspects of the implementation and follow-up of the Interim Rule during the Gulf War. In addition, the military continues to be negligent in maintaining adequate records for the experimental anti-tick virus vaccine (TBE) now in use in our current deployment to Bosnia.

The NGWRC believes a better method should be discussed and approved by Congress before troops receive experimental drugs again. Other veterans' groups, including the Veterans of Foreign Wars, are on record calling for a change in the way experimental drugs are administered.

The NGWRC believes soldiers should be provided with adequate informed consent and protection against chemical biological warfare agents. But we must also note strongly our belief that soldiers do have human rights, and one of those is to be free from possible violations of the Nuremberg Code, no matter how well intentioned.

5. Continued Independent Oversight

The NGWRC also believes there needs to be close oversight of the medical research conducted by the VA and DoD. We support handing the lead role of investigating Gulf War illnesses to an outside agency. This should restore the severely tarnished reputations of both the VA and the Pentagon for failing to address this issue sooner and with more vigor and honesty. Toward that end, the NGWRC supports HR 3661, the bipartisan legislation introduced by Representative Joseph P. Kennedy, II last month.

Currently, the VA and the DoD have no case definition for Gulf War illnesses. The VA and DoD have no treatment programs developed (or under development) to provide to care givers at hospitals. After seven years of illnesses, this is unconscionable. The NGWRC notes, with dismay, that the DoD's only so-called "comprehensive" program to treat ill Gulf War veterans at Walter Reed Army Medical Center (WRAMC) addresses only psychiatric diagnoses and provides only mental health care. While the WRAMC program may be beneficial for developing coping skills, and those enrolled in the program find the counseling useful, the WRAMC program does not address the core issues of Gulf War illnesses, and thus it is too narrow and too short-sighted.

Even though the military is aware of serious toxic exposures, and even though the most difficult veterans to diagnose are seen at WRAMC, veterans are not asked about toxic exposures as part of the program. We believe this is short-sighted and demonstrates the clear bias of the military toward psychological causes and not toxicological causes.

While we have no official position regarding the recently announced formation of an oversight panel by President Bill Clinton, we support the concept of a permanent oversight review process of on-going VA and DoD research and treatment programs. We await further details of the scope, mission, and staffing of the newly formed panel headed by former Senator Warren Rudman.

We note there were severe limitations imposed on the now-disbanded Presidential Advisory Committee on Gulf War Veterans' Illnesses. For instance, there was limited access to classified data by the majority of panelists and staff. There was no subpoena power to compel the production of various reports and documents or statements under oath. Finally, there were no chemical, biological, or depleted uranium medical experts on the panel. Any new panel should have more access to classified data, subpoena power, and independent medical experts from selected, highly specialized fields related to the exposures unique to the Gulf War, including chemical agents and DU.

We do believe that any future on-going review of VA and DoD research should be conducted by an organization outside of the government. Gulf War veterans and veterans' service organizations, because of our first-hand experience, should play a significant and active role. This specifically means veterans do not want a passive role merely receiving information after a policy decision has been made.

The NGWRC, in 1995, was the first Gulf War organization to call for an independent investigation into the possible misplacement, concealment, or destruction of chemical detection reports. Our concerns were validated by a recent DoD Inspector General Report confirming an on-going criminal investigation into the missing logs.

The evidence obtained by Gulf War veteran organizations using FOIA shows some chemical detection reports were either improperly destroyed, are missing, are concealed, or are so mismanaged that a proper review of possible chemical exposures remains difficult, if not impossible.

The NGWRC remains deeply concerned that official information supplied by the VA to Congress and to veterans regarding the health of Gulf War veterans was incomplete and/or misleading. According to a General Accounting Office report issued in April 1998, the VA may have deflated cancer deaths by failing to include data on illnesses from the private sector.

Furthermore, the VA may have improperly used information taken from its incomplete and inaccurate Gulf War illness registry to claim Gulf War veterans have similar illnesses as the general population. Again, this behavior by the VA further demonstrates the need for an independent investigation of Gulf War illnesses, especially veterans with various cancers and deaths related to cancers. Clearly, a far more detailed study of Gulf War veterans, including a review of cancers, should be launched immediately.

6. Need For New Statistical Research:
Homelessness, Drug Abuse, Domestic Violence, Broken Families, Alcoholism, Chronic Unemployment, and Incarceration

The National Gulf War Resource Center strongly suggests that independent statistical research be undertaken as soon as possible to determine what role, if any, Gulf War service may have with disproportionate rates of homelessness, suicides, homicides, drug abuse, alcoholism, divorce and family strife, chronic unemployment, and incarceration among Gulf War veterans. The NGWRC believes our request may break new ground in understanding the full effects of military service, especially upon the current generation of war veterans.

Recent press reports show unacceptably high levels of homelessness among Gulf War veterans. In a news article, "Who Are America's Homeless Veterans?" (Associated Press, January 13, 1998), the International Union of Gospel Missions stated that thirty-two percent of the homeless population claimed they were veterans, and that Gulf War veterans account for ten percent of that subgroup. This study, conducted in October 1997 by the Missouri-based non-profit, may mean that as many as three percent of the homeless population in the United States served in the Gulf War.

If true, this is alarming and tragic, given that all Gulf War theater veterans (approximately 1.1 million Americans and rising) make up less than one-half of one percent of the American population of more than 268 million. Gulf War veterans who served in theater represent an even smaller group (less than one-fourth of one percent of the American population). Given the complex nature of homelessness, it is imperative that the status as well as the suspected causes of this situation be thoroughly examined as quickly as possible.

The sooner we focus on this issue, the better we will be able to understand it and attempt to reverse and to resolve it. We also should be cognizant of any possible relationship between Gulf War illnesses and these issues, especially since twenty-five percent or more of ill Gulf War veterans remain undiagnosed, according to the VA and DoD. This is why the NGWRC calls for an independent, unbiased review of this matter by an outside group not associated with the VA, DoD, or the Department of Health and Human Services (HHS).

As mentioned above, the NGWRC supports surveys that also consider family members and addresses the needs of frequently overlooked subgroups of veterans, including female veterans and minority veterans. In light of recent press reports claiming increased domestic violence, rape, and spouse abuse in military families, we believe thrse frequently under-explored issues should be researched. The NGWRC supports medical research into the relationship between service in the Kuwait Theater of Operations and illnesses reported among civilian contractors and others deployed to the region in support of Desert Storm.

7. Support of Vet Centers (VA Readjustment Counseling Services)

The NGWRC believes one of the most effective outreach and assistance tools used by the Department of Veterans Affairs is its highly successful Vet Centers. The Readjustment Counseling

Service (RCS), established in 1979 (Public Law 96-22), now provides the same benefits available to Vietnam War veterans to the growing population of Gulf War veterans (Public Law 102-25).

The NGWRC believes Congress acted wisely in opening up Vet Centers to Gulf War combat veterans. According to the VA, as many as 80,000 Gulf War veterans have utilized this important benefit. Stress may explain some of the illnesses among some Gulf War veterans, but stress is not the leading cause of the illnesses, nor should it be emphasized as such.

Vet Centers, usually located off-site from VA medical centers, provide a broad array of services, including assessment and counseling for post traumatic stress disorder (PTSD), employment and educational counseling, family counseling, and, in some locations, medical clinics.

This service rightly belongs in community settings, as this remains the easiest and most successful method of providing direct service to combat veterans in need. This provides the Vet Centers with substantial credibility among veterans and veterans organizations. Their independence and funding must at a minimum be maintained. The NGWRC asks that they be expanded and strengthened.

The NGWRC notes that the Presidential Advisory Committee on Gulf War Veterans' Illnesses (PAC) praised the Vet Centers for their work with Gulf War veterans in their report issued in January 1997. The NGWRC believes a survey should be undertaken to determine the use of Vet Centers by Gulf War veterans and the effectiveness of RCS in addressing Gulf War veterans' concerns. We believe an independent evaluation by Congress (such as the General Accounting Office) or an outside organization would support our position and the position of the PAC.

The NGWRC recognizes the role stress may have in some veterans' mental and physical health. Combat, along with the threatened and actual exposure to chemical weapons, remains one of the most stressful events imaginable to humans. Veterans with those concerns do receive superb assistance from Vet Centers, and we applaud the efforts of the VA to care for those veterans with such war-related mental injuries.

8. Force Protection

One of the main goals of the National Gulf War Resource Center focuses on lessons learned from the Gulf War. The NGWRC believes our service men and women deserve the best doctrine, the best training, the best equipment, and the best follow-up medical care possible. To do so for those who serve and protect our way of life is both a legal and moral obligation this great nation must uphold.

Toward that end, the NGWRC has made note of contradictory statements made by some military officials with regard to the effectiveness, availability, and reliability (or lack thereof) of certain equipment used in Desert Storm. To our understanding, some of this equipment may still be in use today by our armed forces. We recognize and share the same concerns contained in the letter sent last month by members of the Senate Veterans Affairs Committee to Secretary of Defense William Cohen.

Since some of these matters, including possible flaws with our chemical protection masks, chemical protection suits, chemical detection alarms, and chemical injury awareness and reporting doctrine remain classified, we ask that Congress make an appropriate review of these matters with a view toward resolving them as quickly as possible.

The NGWRC supports recent measures undertaken by the Pentagon to protect our troops against weapons of mass destruction, including anthrax. We strongly believe, in light of past shortcomings, that Congress should carefully monitor the implementation of these immunization programs.

Even though the anti-anthrax vaccine is FDA approved, it presents a very complex and time-sensitive immunization schedule that requires intense follow-up. In addition, many studies regarding the effectiveness and safety of the anthrax vaccine date from the 1950s and the 1970s. More recent medical research data is desperately needed. We note there are serious concerns among those on active duty regarding the administration of the anti-anthrax vaccine, including reports where service members may not be receiving information regarding the need for the vaccine and potential side-effects.

The overall administration of vaccines and other drugs, including record keeping and medical follow-up, are also key concerns of veterans. When using experimental or investigational new drugs, Congress and the military should recognize that force protection should be balanced against the rights guaranteed soldiers by our Constitution as well as human rights as described in the Nuremberg Code.

We also recognize and support recent DoD initiatives, including spending several hundred million dollars, to develop and distribute new masks, new alarms, and other equipment to soldiers currently deployed to the Gulf region. The NGWRC also notes the recent appropriation of twelve million dollars by Congress to study the effects of low-level chemical warfare agents.

It is with great concern that the DoD remains unable to determine the source of the chemical detections reported by Czech troops inside Saudi Arabia starting on January 19, 1991. The Pentagon calls the Czech reports "credible" and "reliable." However, the military remains unable to pinpoint a source, even though Iraqi storage areas to the North are the most suspect, given satellite data and other available evidence, including comments taken from Central Command's Nuclear, Biological, and Chemical Desk Officer's log.

A review of doctrine surrounding the Czech's "immaculate detection" should be undertaken, given the classified and sensitive nature of the issue. The inability of the Pentagon to explain of the loss of the missing Central Command Nuclear, Biological, and Chemical detection logs as well as the source of the Czech detection events are inexcusable. Congress should continue to review biological and chemical defense issues for the benefit of future generations of soldiers and veterans.

As described in further detail later in this report, the NGWRC has serious concerns about the proliferation of weapons systems using or containing depleted uranium. Those serving in or near battlefields where DU is used (or may be used), should have the best available radiation detection devices so our service men and women may avoid contaminated areas (when possible) and so medic

and other health care providers are able to evaluate and treat contaminated wounds. According to recent reports issued by the DoD, more than one dozen nations now possess DU weapons, thus making any future battlefield more likely to contain even higher amounts of toxic depleted uranium dust contamination.

9. Need for Outreach to Gulf War veteran community

The National Gulf War Resource Center strongly supports the goal of increased outreach and risk communication by the VA and DoD regarding Gulf War illnesses. The VA and DoD clearly state that one of their major mistakes in dealing with the issue of Gulf War illnesses revolved around not listening to soldiers and veterans who served in the Gulf War and who are clearly ill, many with undiagnosed illnesses.

This problem was most severe in the years immediately after Desert Storm in 1991. While many veterans organizations would argue the situation has not improved, the NGWRC does note that the DoD and VA have taken some constructive steps toward resolving their poor record of outreach. We hope the DoD and VA continue improving risk communication with service members and veterans.

The VA and DoD, in the past year, each held a series of town hall meeting to address Gulf War illnesses. We laud this approach – this is a clear step in the right direction. However, we believe there were serious problems with the implementation of the programs.

First, there was very little public notice given by the DoD for their meetings, especially at military installations located near town hall meeting sites. We note that the Pentagon recently addressed our concern, with several town hall meetings scheduled near military bases in 1998. Since early 1997, the NGWRC has called for additional town hall meetings at military installations.

What publicity there was for prior town hall meetings usually came from veterans' organizations, often those associated with the National Gulf War Resource Center. Lack of DoD vigor may have reduced attendance, especially among active duty personnel. The VA and DoD should work more closely with Gulf War veteran groups to determine what Gulf War veterans need to know and to publicize the meetings sooner.

Second, there was no early coordination between the VA and DoD. Relations between VA and DoD have not been complete, as many top VA leaders were kept in the dark regarding chemical exposures, the dangers of depleted uranium, and other classified matters. The issue of Gulf War illnesses overlaps the mission of these two agencies.

Many veterans showed up at the DoD town hall meetings only to find there was no one able to address veterans' health care issues. The NGWRC suggests that the VA and DoD use their tremendous assets to work together at joint VA/DoD town hall meetings.

Third, the VA and DoD work mainly with veterans' organizations with missions that only partly

address Gulf War illnesses. While this is critical and good, it has limitations. The NGWRC, an organization with a mission statement dedicated to Gulf War veterans and Gulf War illnesses, believes the VA and DoD should expand their work with grassroots Gulf War veteran organizations, including the National Gulf War Resource Center, in an effort to more widely distribute information.

The NGWRC remains the only national or international Gulf War veteran organization cooperating with the Pentagon by distributing information and meeting with officials in the Office of the Special Assistant for Gulf War Illnesses (OSAGWI).

Fourth, the Veterans of Foreign Wars, in a self-selected survey conducted in 1994, found that approximately one-half of those claiming to be ill had not sought care from the VA or DoD. This may mean, that in addition to a large pool of undiagnosed veterans currently on VA and DoD Gulf illness registries, there may be tens of thousands of additional Gulf War veterans not participating in those same registries. More research and outreach are needed, so that veterans are aware of all of their health care options and benefits.

We commend the VFW for their efforts to conduct surveys important to understanding this issue. Outreach by our government and others should be designed to define this group and determine methods to advise them of health concerns and their benefits. The VFW's work demonstrates the need for developing more and better risk communication plans.

Toward that end, the NGWRC provided lists of grassroots groups (both those associated with the NGWRC and those independent of the NGWRC) to the VA and the DoD. The DoD, starting in January 1998, began sending information directly to grassroots groups via fax and mail.

Over the past year, in cooperation with the OSAGWI, the NGWRC distributed DoD-generated news articles on Gulf War illnesses to our member organizations via surface mail and via the Internet. The NGWRC also provides research on various exposures and other matters directly to the VA and DoD. The NGWRC also sent out information on GulfNEWS and GulfLINK, the print and electronic news prepared by the OSAGWI, to the Gulf War veteran community.

The NGWRC wants to work with the VA and DoD in providing outreach. Unfortunately, there are some small Gulf War veteran organizations bent on conspiracy theories. The NGWRC does not subscribe to those theories and we attempt to disassociate ourselves from such organizations.

Although we may disagree with the VA and DoD on many important matters surrounding Gulf War illnesses, the NGWRC still wishes to establish working relationships with the VA and DoD. We share common goals of finding out what may have caused the illnesses, making sure health care is provided, and preventing repeat mistakes.

This principle of cooperation between citizens and government remains a critical part of our enduring democracy. This cooperation should be expanded to include Gulf War veteran organizations.

10. Support for Fair Distribution of Former Frozen Iraqi Assets

The NGWRC expresses our strong support for legislation allowing Gulf War veterans equal and fair access to frozen former Iraqi assets, estimated at more than $1.3 billion, now under the control of the U.S. Treasury Department. If any group deserves the opportunity to file a claim against Iraq for injuries caused by Iraq, it should include those who served during Desert Shield and Desert Storm and returned home with medical problems possibly associated with chemical warfare agent exposure.

When Iraq invaded Kuwait in August 1990, the United States government froze and then subsequently seized Iraqi assets in the United States. These assets are now the property of our government and are awaiting the development of a distribution plan by Congress.

Many veterans claim they were exposed to chemical warfare agents. The Pentagon, by July 1997, acknowledged as many as 100,000 may have been exposed to low-levels of the poisonous agents. The gases were used by Iraq during and after Desert Storm. Agents were released during the air war bombardment of Iraq manufacturing and storage facilities. Agents were released during post-ground war demolitions. And, more agents may have been used by the Iraqi army as they crushed the uprising among civilians in Iraq in the Spring of 1991.

There is precedent for distributing the former Iraqi assets to American Gulf War veterans. America has a long history of providing direct monetary and other relief for war veterans dating back to the Revolutionary War, when former Royalist land was seized and then given to war veterans as compensation for their services.

Iraq does not own these funds. Our government owns the funds. There is no reliance upon a foreign government to provide new or additional aid to our veterans. The question here is how to distribute assets seized from Iraq. We are not aware of any further action planned or needed by the United States to collect additional assets from Iraq (excluding reparations to the United Nations and to Kuwait).

Many veterans claim that American companies may have sold chemical agents to Iraq. Medical studies conducted at the University of Texas Southwestern in Dallas (Dr. Robert Haley) show there may be a link between chemical warfare agent exposures and some of the illnesses among some of veterans. Thus, there are grounds upon which Gulf War veterans should be able to have their claims reviewed and granted.

For that reason, the NGWRC is the first organization to publicly support HR 3484, introduced by Representative Lloyd Doggett, and S 1794, introduced by Senator Tom Harkin. The Veterans of Foreign Wars also supports the legislation.

These companion bills provide for a fair and equal treatment of claims against the former frozen Iraqi assets now owned by our government. We urge prompt passage of this legislation so we may close this chapter of this issue. Many veterans are very ill or have died while waiting for Congress to develop a plan to distribute the assets.

11. Depleted Uranium Health Monitoring, Record Keeping, Training, and Poliferation

The National Gulf War Resource Center, Swords to Plowshares, and the Military Toxics Project (both NGWRC member groups) have thoroughly investigated the health controversies surrounding the use of depleted uranium (DU) as anti-tank ammunition and tank protective armor. This is the only comprehensive report on the subject given to Congress and to medical professionals, including those at the VA and DoD.

The joint STP/MTP/NGWRC Depleted Uranium Case Narrative conservatively estimated as many as 400,000 exposures to DU since 1990. This is based on two independent surveys. Using the VA's statistics from the Revised Gulf War Registry (December 1997), between 100,000 and 156,000 may have been exposed (the survey used self-reported exposures at the rate of 14.2 percent). In contrast, the Department of Defense, in late 1997 listed only a few dozen exposures. By January 1998, the DoD dramatically increased the number of exposures from a few dozen to "thousands," with out elaboration. Thus, the need to accurately determine the number, severity, and length of DU exposure remains very important.

Depleted uranium is a low-level radioactive toxic waste. In a manner similar to a work-place exposure, one one-hundredth of one gram (.01 gram, or .000365 ounce) is enough, according to Federal guidelines (Nuclear Regulatory Commission [Title 10], Standards for Protection Against Radiation, Subpart C – Occupational Dose Limits; 1997) to warrant a notation in medical records that a service member or veteran was exposed to depleted uranium.

Those in DU contaminated areas and believed exposed should then be tested and monitored, according to military rules (Army Regulation 40-5, dated 15 October 1990). Health consequences known to be associated with DU exposure should then, the NGWRC contends, be deemed service connected for purposes of health care and other benefits.

However, although these rules are in place, there is no training for those soldiers who handle or who may be exposed to DU in battle, those visiting battlefield areas, or those at or near test firing ranges. It is our understanding that there are no radiation detection devices given to medical personnel to evaluate wounds possibly contaminated by DU. And there are no medical studies planned or underway to address the most widespread form of DU exposure – inhalation and ingestion. The NGWRC finds the lack of inhalation and ingestion research unconscionable in light of the serious nature of the exposures. We understand current VA regulations do not address DU as a separate exposure in a manner similar to ionizing radiation exposures suffered by atomic veterans who participated in or witnessed atomic bomb blasts.

Therefore, the National Gulf War Resource Center, as outlined in our Depleted Uranium Case Narrative, calls for the immediate implementation of DU training for all members of the armed services. We also ask Congress to review the failure of the military to follow existing guidelines and note medical records with possible DU exposures and to implement adequate screening and medical care. Congress should also investigate the proliferation of DU in the world's arsenals, and the impact

this will have on the health and safety of American troops.

The NGWRC requests that veterans be presumed exposed to DU, given the missing monitoring data, the lack of any health screening, the lack of exposure avoidance training, and the lack of post-conflict exposure surveys that should have been completed according to regulation and were not. This, we argue, will expedite research and treatment for Gulf War veterans while we are still young enough to benefit from such aid.

Unfortunately, due to Pentagon and VA inaction, scientists may never, with exact scientific certainty, know who was exposed to how much depleted uranium (or many other toxins cited here), both in the Kuwait Theater of Operations and in other locations where DU is used. Thus, any benefit of the doubt must be weighed in favor of veterans, especially those dead or ill.

We cannot understate our concern regarding this very important health threat to our service members and veterans. In addition to widespread troop exposures to low levels of chemical warfare agents, the recently disclosed widespread exposures to DU may well represent important keys as to why so many Gulf War veterans are ill today. Immediate medical research is desperately needed because DU is implicated in increased lung, kidney, liver, and other medical problems when inhaled or ingested.

The NGWRC is deeply troubled by the continued DoD advocacy for and use of DU weapons systems while at the same time failing to provide training regarding the known hazards of DU to our soldiers. This is disturbing because Bernard Rostker, in a speech on March 23, 1998, stated those who "entered Iraqi equipment, or who were down wind from vehicles that burned after being struck by a DU round ... received minimal exposure." This contrasts sharply with previous statements by the military, and cited in our DU Case Narrative, that the Most Exposed Individuals (MEIs) are those who visit the battlefield immediately after a conflict -- especially those who climb upon or enter armored vehicles destroyed by DU rounds.

Continuing his speech, Rostker then stated, as official Administration policy, that "we have no plans to provide special screening...." No one is asking for a "special screening." Rather, the NGWRC believes current rules and regulations should be enforced.

Furthermore, in his March 23 presentation, Dr. Rostker claimed, "to date, DU exposure has not produced any medically detectable effects." The Pentagon and VA have conducted only limited follow-up on only 33 people, and even the DoD does not characterize this as "research." Out of possibly hundreds of thousands exposed, it is very misleading and disturbing for the DoD to claim no one is ill based on a very small sample. Again, because of the lack of research and monitoring, the DoD is making baseless statements based on their advocacy of DU weaponry. Such wild speculation by the military is not in the best interests of the long-term health of American fighting men and women.

Rostker's comments are a very serious matter, in light of the large number of undiagnosed Gulf War veterans. The inability of the DoD to consider long-term consequences of DU use is yet another

clear example of why the investigation into Gulf War illnesses must be handled by an outside agency.

We strongly suggest a review of our more detailed recommendations contained in our DU Case Narrative. Copies of the Case Narrative were delivered to the Chairman of the Senate Veterans' Affairs Committee and to the Ranking Member of the House Veterans Affairs' Committee on March 4, 1998.

12. Employment, Retraining, and Transition

Since the Gulf War is not over, and because large numbers of Americans continue to be deployed to the Gulf region, the number of Gulf War veterans and Gulf War-era veterans will rise. This, and recent military reductions in force, lead the NGWRC to endorse employment, retraining, and transition programs.

Currently, it takes fifteen weeks or longer to train some military occupational specialties. Thus, the military, as a federal employer, should continue with their basic obligation to provide transition services to separating veterans so they may resume normal civilian activities both quickly and well-adjusted.

The NGWRC supports the active participation of disabled veterans outreach program specialists (DVOPs) and local veterans employment representatives (LVERs) in the reemployment process. In the long term, this program saves tax dollars, in many cases, by reducing the amount of unemployment compensation paid to unemployed veterans. The program also raises revenue by having workers contribute to unemployment funds, pay income taxes, and participate in various retirement programs, including Social Security. The program also trains qualified and concerned individuals to deal specifically with issues unique to veterans, including disabled veterans.

The NGWRC believes that there is more to transition than the preparation of a resume. In order to address the concerns we have for unemployment, homelessness, drug addiction, family break ups, spouse abuse, and others, we believe a comprehensive approach should be used by those agencies assisting veterans. Given the unique situation with undiagnosed illnesses among Gulf War veterans, health care during transition is also very critical. Congress should use their oversight powers to make sure that service men and women are properly examined before discharge and informed of their health benefits.

The NGWRC is aware of the work of the Transition Commission, and we are looking forward to reviewing the details of their forthcoming report. The NGWRC supports the concept of case management, as this best serves the interests of veterans.

13. Bosnia Deployment Insurance Payments

The NGWRC believes that those called to active duty for deployment should have some level of protection of their civilian income while they are defending America or her interests, either at home or abroad. The NGWRC is on record as calling for insurance plans that will supplement income of

service members that is eliminated or reduced due to deployment. We ask that Congress review these insurance programs to make sure they are adequately funded and operated, and that insurance benefits owed under these programs are paid promptly to those serving. Americans in uniform should not be penalized for their call to active duty.

14. Chemical Weapons Convention

The National Gulf War Resource Center was honored to be among a select group of three veterans' organizations supporting the Chemical Weapons Convention (CWC) in 1997. The NGWRC joined the Veterans of Foreign Wars and the Vietnam Veterans of America in calling upon the Senate to ratify the CWC. The NGWRC supports the prompt destruction of the world's chemical weapons stockpiles with the assurance of the maximum possible health, safety, and environmental protections. The NGWRC also supports the development and funding of alternatives to incineration.

Except for some surviving World War One veterans, there are no combat veterans in large numbers with first-hand experience dealing with chemical weapons other than Desert Storm veterans. Gulf War veterans take the issue of chemical weapons proliferation very seriously, especially in light of recent United Nations weapons inspectors' disclosures that Iraq may still possess these deadly agents as well as the technology and equipment needed to deliver them.

In response to our member groups' direction, the NGWRC actively urged veterans nationwide to support ratification of this important treaty that works toward the eventual elimination of these dreaded weapons of mass destruction. The Senate ratified the treaty in 1997, and this represents a major victory for everyone in the world, but most important, it may reduce the likelihood of chemical warfare agent usage during this war and future conflicts. These weapons must be destroyed quickly as well as in a safe and effective manner.

We hope Congress will continue to support efforts that reduce the manufacturing, use, and proliferation of weapons of mass destruction, and this includes chemical and biological weapons, nuclear weapons, land mines, and depleted uranium.

VII. Conclusion

The National Gulf War Resource Center's Government Relations Working Paper is designed to share the most pressing issues of the Gulf War veteran community with the legislative and executive branches of the U.S. Government.

By effectively communicating our concerns, it is our intent that Congress, the VA, and the DoD address this health crisis as quickly as possible. The views expressed here represent consensus goals of the member and associate groups of the NGWRC, as reflected by resolutions adopted by the NGWRC at our 1997 National Conference and as reflected by positions taken by the NGWRC Board of Directors in the interim.

We emphasize that this is a working paper, and our positions may be modified as developments

(such as previous announcements of widespread chemical and depleted uranium exposures) warrant. Questions about this working paper should be directed to our national office in Washington, DC.

(Revised 5/18/98)

Mr. QUINN. Thank you, Paul. Thanks very much. Is this your first trip to testify before the subcommittee? I think it is, is it not?

Mr. SULLIVAN. Yes, Mr. Chairman.

Mr. QUINN. Yes, it is. Well, thank you. We appreciate—I'm sure we'll see you again.

Mr. Filner asked earlier, Mr. Epley, if you could be here for this questioning. I'd ask you to join us at the table just for a minute, please. Even though Mr. Filner said he was going to yield his time then for now, we gave him some time back then too, so I'm going to yield to you now, Bob, to get to those questions. All right?

Mr. FILNER. Thank you, Mr. Sullivan, and I appreciate your testimony and your research. The fact that you have to be here is a statement in itself; I mean, that the National Gulf War Resource Center has to be here. That's what the VA and DOD ought to be, the National Gulf War Resource Center, but we have not been able to rely on them, and the statistics are an example of how we indicate whether we're taking this seriously or not. Just for example, Mr. Sullivan in almost his first statement gave a statistic. He said 78.5 percent of claims were denied. Mr. Epley, do you accept that figure?

Mr. EPLEY. Congressman Filner, the numbers that we have indicate that about 13 percent of the veterans who were in the Gulf War conflict are getting benefits; approximately 76,000 of them. That includes receipt of service-connected benefits other than undiagnosed illness.

Mr. FILNER. I didn't get an answer to the question, I don't think. Are 78.5 percent of claims for undiagnosed illness rejected?

Mr. EPLEY. I can't refute that information. I know that a significant majority of claims that are filed are rejected for undiagnosed illness.

Mr. FILNER. It seems to me that when we pass a law that says that there's a presumption that there is need for treatment, it would seem to me that people would be treated and compensated for this undiagnosed illness. But let me say that how you present your statistics, Mr. Epley—which we just got—seems, in itself, to say something. I look at your first group of statistics. It says number of veterans with one or more undiagnosed service-connected conditions, 1,967 out of the biggest, and out of the smallest group, 1,866. I assume they're the same 1,866 as in the other one or included in 1967. This looks to me—anybody who looks at that says, "Filner or anybody that's yelling about this Persian Gulf War illness and Sullivan, you're crazy. There's no problem here. We've looked at this—and out of 3 million people in my category or 785,000 in the theater or 560,000 members, only 1,808 have undiagnosed conditions. That seems to me that you're saying it's not a problem. Do you think this is a problem, by the way, the Persian Gulf War illness, beyond the statistics?

Mr. EPLEY. Yes, sir, I do.

Mr. FILNER. But look at what your first data—your first line of data says. It says to everybody who is an expert and everybody who reads this and everybody in the bureaucracy, it's no problem. I mean, I don't know where this figure comes from. We need to really sit down and go over this data table, because that many people in my district have come to me and said they have problems.

You also have figured out a way to hide the data. Tell me, if somebody comes with—says I have these conditions which don't seem to have a diagnosis, and I have a loss of hearing, let's say, or a bad knee, wouldn't they then get a rating or a service connection based on the diagnosed situation?

Mr. EPLEY. Yes, sir.

Mr. FILNER. So, those people who may have undiagnosed but also something else that is diagnosed are not even considered in this data of undiagnosed conditions, right?

Mr. EPLEY. That's correct, sir. I tried to allude to that earlier.

Mr. FILNER. Well, I'm looking at the table and the average person in the press who says, "I'll ask the VA for data, because Filner's saying there's all this problem, and the data seems to say there's no problem here," because you have systematically—and there's about five other ways which I'd like to sit down when we have the time—you have systematically hidden the problem here. Now, I think that's intentional. You don't want to say that there's a major problem going on, because if you did, you would start off by saying how many claims have been filed? Is that in here somewhere?

Mr. SULLIVAN. We've determined that, Mr. Chairman, to be approximately 212,000, but we're waiting for further clarification of that. (As of April 15, 1998, the number was 203,679).

Mr. FILNER. All right. You say 212,000. I get this data from the official source, the source that should be the National Gulf War's Resource Center, and I don't see anything near that figure—let's assume you're right for a second—there's nothing on here that says there were 212,000 claims, is there?

Mr. EPLEY. No, I don't believe there is, Congressman.

Mr. FILNER. Well, what good is this data if I can't figure out how many people came in and said they had illnesses; how many folks did have the illness. This data systematically lies. The data is lying to me, sir, because I don't know—I cannot read from this—and this is the answer you gave us to official response—I cannot tell you any of that data that Mr. Sullivan says, I can't confirm it or deny it, and you can't either from this chart, and if he's wrong, I want to know; if he's right, I want to know, and the data you have here is basically worthless, because it hides what we should know.

Mr. EPLEY. Congressman, the data that we have been gathering for Gulf War veterans has been a subject for previous committee hearings and there have been problems. There are continuing problems. We are working continuously to try to improve the situation since the last hearing before this committee——

Mr. FILNER. Can you just tell me how many people applied for benefits for undiagnosed illness?

Mr. EPLEY. Approximately 76,000.

[The information follows:]

Approximately, 76,000 veterans of the conflict have been evaluated as service-connected—10 percent or more. Over 17,000 veterans have been identified as claiming "undiagnosed Illness."

Mr. FILNER. All right. You said 212,000?

Mr. SULLIVAN. The information, Congressman Filner, that was sent to us from the Department of Veterans Affairs does not specifically state Gulf War illness of undiagnosed illness. We have

asked for that information, because we don't know. It's one of the points in our testimony, but what we need is more information.

Mr. FILNER. Mr. Chairman, you can see that we have a very reliable person who has devoted his present life to this; we have the official statistics, and they're different. We need to sit down and understand this in some seminar kind of fashion where we can discuss it. I hope we can do that.

Mr. QUINN. Well, I think, Bob, one of the things that we've talked about—and, gentleman, I appreciate your candor in answering Bob's questions or any of the members here and, believe me, there are some questions on this issue outside of this committee and subcommittee in terms of Members of Congress too. I suggested to Bob this morning when we came in and looked over the testimony—some of it we had beforehand—that, likely, I think what needs to take place is some kind of a meeting or meetings here on the Hill with members of this subcommittee who are interested to get us to a point where we can at least be talking about apples and apples and oranges and oranges, because any of these statistics anybody can use to their advantage or disadvantage.

If we operate under the assumption that we're all here to help veterans—and I think we start from that premise—then there ought to be a way for us to do that, and I've suggested to Mr. Filner that we, as a subcommittee, draw up and prepare for you a list of areas that we're interested in just like the questions that Bob asked this morning in laymen's terms. Get those to both of you and others, and we don't have to do it, in my opinion, in a formal hearing session, because everything goes on the record, and we don't have a chance to work it through. I would suggest a seminar, some kind of a meeting here on the Hill; maybe one or two or three of those right after the August recess in early September where we don't have to be worried about official hearings and official documentation and on the record and off the record and who can help us and who can't, and Mr. Filner and I will put that to writing these next couple of days while we're here in Washington and share that with others. But, clearly, Bob, I think you and I are on the same wavelength that that's what needs to happen next.

Mr. FILNER. Thank you, Mr. Chairman.

Mr. QUINN. Are there any other questions for Mr. Sullivan who's here? Mr. Mascara?

Mr. MASCARA. Thank you, and I would just like to say that I was involved with two young ladies—one from my district in Pennsylvania and another——

Mr. QUINN. I think you better be careful how you say that, Mr. Mascara. (Laughter.)

So far, you said you've been involved with two young ladies.

Mr. MASCARA. Oh, yes, yes. I need an attorney.

Mr. QUINN. I think you need an attorney. You need an attorney or an understanding wife, one of the two. (Laughter.)

Mr. MASCARA. Or both. (Laughter.)

Mr. QUINN. Or both, yes.

Mr. MASCARA. Well, after 44 years of marriage, I think I'm on safe ground. These ladies came to my office asking for help, both of whom had an illness; both of whom served in the Gulf War, one of whom was in the barracks that killed a number of people from

my district. I also had the opportunity to introduce her to the President's Commission studying the Gulf War illnesses. Both my constituent and the constituent from Florida, received 100 percent disability. These were the sickest people I have ever met, and for us to have to push and prod to get the correct information from Veterans Affairs and this Government really frustrates me, and I'm sure all of my colleagues are frustrated here; that somehow everybody seems to be so defensive. Aren't we about trying to help veterans, and while I would admit there are those who might try to take advantage of the situation, but we've got to get this program on track, Mr. Chairman, even if it means—and, Bob, I want to associate myself with your remarks—having to question those people in the government who are supposed to be forthright with this country and its veterans. I'm just entirely frustrated. Thank you.

Mr. QUINN. Mr. Reyes.

Mr. REYES. Mr. Chairman, I don't have any questions other than just to express my gratitude for the work that your organization is doing on behalf of the Gulf veterans.

Mr. QUINN. Thank you, Mr. Reyes. Mr. Epley, we appreciate your returning to the witness stand.

Mr. FILNER. Just one quick question.

Mr. QUINN. Yes, go ahead.

Mr. FILNER. Just one question, do you know, Mr. Epley, if veterans who come in with undiagnosed illness or anybody who comes in from the theater are tested for this mycoplasma?

Mr. EPLEY. I don't know that, sir.

Mr. FILNER. As far as I know, the answer is no. Now, it's a similar situation as we had with Dr. Varney and Dr. Booss. There are scientists, reputable scientists, who say that this is, perhaps, one of the indicators of Gulf War illness of one type. Other people say he's full of baloney. On the chance that he's right—and I have seen hundreds of patients, by the way, like yours, Congressman Mascara, who because of the protocol that has been figured out for antibiotic treatment for this, people who I've seen almost dying are now recovering but not from the VA treatment because the VA refused to accept it—so, in the chance that Dr. Varney is right—this is a test that's not difficult to administer—why not administer the test to do it for 1,000 people; do it for 5,000—to see if they have this "mycoplasma incognitos" on the chance that this may be part of an answer. Why should we not invest a few bucks when some portion of reputable scientists say this is one key? Just because the VA's experts say no, I want that little section that says, let's find somebody who they disagree with. I don't understand why we can't do that.

Mr. QUINN. Well, I think, Bob, one of the things that Mr. Reyes said a little bit earlier was that if we don't get the cooperation that we're asking for, that it may be legislatively where we need to step up and either find that kind of money and designate to whom it goes and for what reason and do it through the subcommittee; through the Full Committee, and through our 435 Members on the floor.

Mr. FILNER. That's what they're asking.

Mr. QUINN. Yes, I think so. I'm going to thank the members for their questions and their comments and Mr. Sullivan and Mr.

Epley. We've been called to a series of votes right now, and we're going to recess for probably what amounts to at least a half hour.

Our final panel, Bill Russo, with Vietnam Veterans of America; Bill Frasure, Phil Ridley, who will represent the VBA, the Legion, the VFW, the DAV, respectively, will be on our third panel, but for all those interested, I'm going to recess for at least a half hour, and when we come back we'll hear from our third panel.

[Recess.]

Mr. REDMOND (presiding). The committee will come to order.

Our final panel is composed of representatives from veterans' service organizations. Bill Russo, Matt Puglisi, Bill Frasure, and Phil Ridley will represent the VA, the Legion, the VFW, and the DAV, respectively. Gentlemen, please begin.

STATEMENT OF WILLIAM F. RUSSO, ESQUIRE, DIRECTOR, VETERANS BENEFIT PROGRAM, VIETNAM VETERANS OF AMERICA; WILLIAM T. FRASURE, SPECIAL ASSISTANT, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES; MATTHEW L. PUGLISI, ASSISTANT DIRECTOR, NATIONAL VETERANS' AFFAIRS AND REHABILITATION, THE AMERICAN LEGION; PHIL RIDLEY, LEGISLATIVE ASSISTANT, DISABLED AMERICAN VETERANS, AND DICK WANNEMACHER, ASSOCIATE NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

STATEMENT OF WILLIAM F. RUSSO

Mr. RUSSO. Mr. Chairman and members of the subcommittee, on behalf of Vietnam Veterans of America, I am pleased to have this opportunity to present our views on the issues here today.

The issues surrounding VA processing of Gulf War Illness claims are constantly evolving, as is the state of scientific knowledge about these illnesses. It may be the relative newness of these types of benefits that is causing the VA so much problem in accurately and promptly processing these claims. We believe that the VA regional offices and Board of Veterans' Appeals staff are still improperly trained to handle Gulf War Illness claims.

By way of illustration, our organization has filed a lawsuit in the U.S. Court of Veterans Appeals, on behalf of a Persian Gulf veteran, an appeal of a Board of Veterans' Appeals decision. In that decision, the Board of Veterans' Appeals did not even address or apply the Persian Gulf Illness—the undiagnosed illness statute or the regulations, simply ignored that whole structure and that whole process, and denied every one of this man's claims. I'm pleased to say that the VA General Counsel has agreed to settle this case to the extent that they will remand the case back to the Board of Veterans' Appeals for them to correct this error and, at least, process his claim under the proper regulations.

But that's just one case and this veteran was fortunate enough to have attorneys representing him. Many veterans don't get representation and they get denied by the VA this way, and they simply go away.

VVA supports the premise contained in legislation offered by Senator Rockefeller, Congressman Evans, and Congressman Shays which would have an independent scientific body evaluate which

medical conditions VA ought to allow service connection for. Our experience with the National Academy of Sciences with respect to Agent Orange has been very, very positive. NAS has done an outstanding job of evaluating what illnesses are caused by Agent Orange, and the VA has, frankly, been forced to begin paying service connection for those diseases as well as the birth defect, Spina bifida. So we urge Congress to follow that successful model that was contained in the Agent Orange Act of 1991 and use the National Academy of Sciences to work on Persian Gulf illnesses as well.

VVA also agrees with the views expressed by the committee's Chairman Stump with respect to VA regulations being so strictly applied. We are heartened that VA is considering changing its regulations or, at least, instructing its staff to not apply the undiagnosed illness requirement so strictly. We applaud the Chairman for that letter.

With respect to hepatitis C, Chairman Quinn asked about Board of Veterans' Appeals decisions. As part of my testimony, I've cited to a number of Board of Veterans' Appeals cases, the full text of which is available to you on CD-Rom which I know your staff has. These Board of Veterans' Appeals decisions—they're all from fiscal year 1997—they show that the Board of Veterans' Appeals and, I think, the regional offices are, frankly, very ignorant of hepatitis C.

Now, I don't blame them necessarily. Until February, I'd never heard of it myself. But now we know about hepatitis C. It's been on U.S. News and World Report, it's been on Nightline, and we know that veterans have it at a much higher rate than the general population.

The major areas where VA is ignorant in processing these hepatitis C claims are as follows:

The VA doesn't understand how the disease is transmitted, that it comes through a variety of sources, mainly through blood transfusions and other medical procedures or any veteran who is exposed to blood or blood products, whether in a combat or noncombat situation.

Another area that the BVA doesn't seem to understand is that hepatitis C has a long latency period of up to 30 years. The BVA has been denying claims because they're saying, well too much time has elapsed between the veterans' service and his claim that he has filed. Well, scientists now know that there can be 10, 20, 30 years or more between when you're initially infected with this disease and when you develop the symptoms. So that's not a valid basis to deny the claims.

Another thing we found in reviewing these BVA decisions is that they say, well, the veteran did not test positive for hepatitis C while in service or until the early 1990's. Well, there was no test for hepatitis C until 1991. So it's an impossibility for the veteran to have been tested for this. Again, it just reflects ignorance and this ignorance is resulting in unfair denials of service connection.

What we're proposing is that Congress pass a statute allowing for a presumption of service connection. Mr. Epley stated this morning that VA is going to revise its rating regulations for hepatitis C. But that won't address the problem of getting the veteran service connected to begin with. What we need is a statute that

will allow for presumptive service connection. For example, any veteran who was exposed to blood or blood products in service and now has hepatitis C, that they are presumed to have acquired that in service. Thank you.

[The prepared statement of Mr. Russo appears on p. 150.]

STATEMENT OF WILLIAM T. FRASURE

Mr. FRASURE. Good morning, and thank you for this opportunity to present the views of the Veterans of Foreign Wars regarding the adjudication of VA compensation claims for Gulf War related undiagnosed illnesses. The VFW has been actively and extensively involved on issues involving claims processing for Gulf War related disabilities for over the past 6 years.

Despite the intent of Congress, many Gulf War veterans with disabling illnesses that may be associated with service in the Gulf are being denied compensation. Currently, Gulf War veterans suffering from undiagnosed illnesses are eligible to receive compensation under Public Law 103–446. Unfortunately, too many of these veterans who file for compensation for an undiagnosed illness are subsequently diagnosed by the VA with a known condition that is similar to the signs or symptoms of an undiagnosed illness as prescribed by 38 C.F.R., section 3.317.

It is all too common for a Gulf War veteran to be prematurely diagnosed with chronic fatigue syndrome or some other condition which bears resemblance to Gulf War undiagnosed illnesses. This usually results in the service connection being denied. Section 3.317 of 38 C.F.R. contains a list of 13 signs or symptoms which may be manifestations of, but do not define undiagnosed illnesses in Gulf War veterans.

If a veteran is prematurely diagnosed with chronic fatigue syndrome or some other multi symptom condition, the veteran is thus not considered under Section 3.317 of 38 C.F.R. This is not keeping with the intent of Public Law 103–446 and, in our view, is patently unfair. Representative Stump, in his pointed letter to the VA Secretary, raised these concerns. We thank Representative Stump for this excellent letter and hope that Secretary West takes heed of it and amends the current regulation.

The second area of concern for the VFW may be addressed by amending another aspect of 38 C.F.R., section 3.317. The current presumptive period for undiagnosed illnesses is mandated to expire in the year 2001. As of today, the medical community has yet to determine a date as to when symptoms associated with service in the Gulf War will manifest. In light of this lack of finite medical knowledge, any date that limits the time for when symptoms may appear is rather arbitrary and may be detrimental to Gulf War veterans.

The VFW has long held that any presumptive period should be based on available, credible medical and scientific evidence. There should be no limitation on a presumptive period in the absence of such evidence. We believe that the only appropriate presumptive period at this point is one that is temporarily open-ended.

Two pieces of pending legislation aim to correct many of the problems associated with the adjudication of claims for undiagnosed illnesses. We thank Congressmen Stearns, Evans and

Joe Kennedy for bringing about the Persian Gulf War Veterans' Health Care and Research Act of 1998. Additionally, we thank Representative Chris Shays for his subcommittee's investigation into Gulf War related problems that has resulted in H.R. 4036, the Persian Gulf War Veterans' Health Act of 1998. The VFW asks that the Committee on Veterans' Affairs work closely with Congressman Shays toward the passage of this legislation.

This concludes my statement. John Mucklebar, a VFW Claims Consultant, is here today to answer any questions you may have. Thank you.

[The prepared statement of Mr. Frasure appears on p. 159.]

STATEMENT OF MATTHEW L. PUGLISI

Mr. PUGLISI. Good afternoon, Mr. Chairman. The American Legion appreciates the opportunity to offer testimony today regarding the Department of Veterans Affairs' standards for adjudicating claims presented by veterans suffering from hepatitis C, Cerebral Malaria, and Gulf War illnesses. Your leadership and the leadership of Chairman Quinn on the issue of Persian Gulf undiagnosed illness claims last year, led directly to a significant decrease in the backlog of those claims. Your continued concern and oversight of this process has kept the pressure on VA to adjudicate these claims as well as possible.

Before I go further and before I forget, we'd like to wish a fond farewell to Mike Brinck, the counsel of the subcommittee. We wish him best of luck in his future pursuits.

Yet, in spite of the committee's oversight and the oversight of The American Legion and the GAO, 9 out of 10 Gulf War veterans who file a disability claim for undiagnosed conditions are denied service connection and compensation from VA. This is also in spite of the fact that VA adjudicated most Persian Gulf undiagnosed illness claims twice, and overhauled the undiagnosed illness claims process. VA is failing to compensate disabled veterans with Gulf War Illnesses because its regulations implementing Public Law 103–446, the Veterans Benefits Improvements Act of 1994, were written too narrowly.

The American Legion therefore has three recommendations for the committee:

First, encourage VA to change its regulations regarding Persian Gulf undiagnosed illness compensation in order to bring them more in line with the letter and spirit of Public Law 103–446.

Second, support legislation that closes the gap in the government's service to Gulf War veterans with Gulf War Illness. A number of bills were mentioned by my colleagues, H.R. 3980, H.R. 4036, and there are others as well and we encourage the committee to support those bills.

And lastly, we encourage the Veterans Health Administration and the Veterans Benefits Administration to develop a more cooperative approach to Gulf War veterans health care and compensation.

The Gulf War, as we now know well, was like all of our Nation's past wars in that it left thousands of disabled veterans in its wake. And like our past wars, thousands of deployed Gulf War veterans report with the what the Institute of Medicine calls Medically Un-

explained Symptoms Syndromes, now known collectively as Gulf War Illnesses. Although some of the risk factors troops were exposed to in the Persian Gulf were the same as those found in past wars, some were different: low levels of chemical nerve agents, pyridostigmine bromide, and depleted uranium, just to name several.

As Gulf War veterans began reporting these hard to define illnesses, VA was confronted with compensating these disabled veterans. VA, however, did nothing. Faced with disabled war veterans, VA pointed to public laws and blamed them for its failure to act. Congress rose to the challenge, and passed historic legislation in 1994 that would help veterans suffering from Gulf War Illnesses.

Congress' intent in this historic law was plain and simple. Aware of VA's claim that thousands of disabled Gulf War veterans were ineligible for disability compensation because Gulf War Illnesses remained ill defined and poorly understood, Congress passed a law that would permit VA to compensate these veterans. Yet, 90 percent of them who file a claim for undiagnosed illness compensation are denied compensation for those conditions. Why? VA regulations implementing the law codified in 38 C.F.R., section 3.317 strictly limit eligibility for this unique type of disability compensation.

Mr. Chairman, a comparison of the language contained in the public law and VA's regulations, and a detailed analysis is provided in our written testimony, explain why many sick Gulf War veterans are denied compensation. VA wanted—Congress wanted VA to compensate veterans with Gulf War Illnesses, but VA wrote regulations that ensure it will not compensate most of these veterans.

Mr. Chairman, Congress listened to sick Gulf War veterans in 1994 and acted by passing historic legislation granting VA the authority to compensate those with difficult to diagnose and ill-defined illnesses. VA has failed to implement the law, and thousands of Gulf War veterans would remain without compensation for these service-connected conditions. The American Legion is encouraged by your continued interest in this matter and we look forward to you taking action in the near future that would resolve this issue once and for all.

Mr. Chairman, that concludes my statement. I'll be happy to answer any questions.

[The prepared statement of Mr. Puglisi appears on p. 162.]

Mr. REDMOND. Mr. Ridley.

Mr. WANNEMACHER. Mr. Chairman, I'm Dick Wannemacher, Disabled American Veterans. It's a Disabled American Veterans' tradition to introduce to the committee members our professional staff when they testify here for the first time.

The Disabled American Veterans, with a membership of over 1 million members—wartime service-connected disabled veterans, employs veterans as national service officers throughout the country. The DAV is proud that, to this day, we have 160 veterans of the Persian Gulf War, Granada, Panama, Somolian and Bosnia conflicts. We are most proud to be able to state that these men and women corp compromises 60 percent of our entire national service officer corp.

Mr. Ridley joined the DAV's professional national service office staff as a trainee and participated in our academy in Denver, CO

in October 1995. He graduated from the academy in February 1996 as a spokesman for the academy class number 3. A native of North Carolina, he served in the Army, was disabled, and he stands before you or sits before you today to give the views of the Disabled American Veterans. Thank you very much for the opportunity.

Mr. REDMOND. Welcome, Mr. Ridley.

STATEMENT OF PHIL RIDLEY

Mr. RIDLEY. Thank you very much, Dick, and thank you Mr. Chairman for this opportunity, on behalf of the 1.1 million members of the Disabled American Veterans and its auxiliary, to present our views on the adjudication of Persian Gulf War claims, and also on those veterans who are suffering from hepatitis C and Cerebral Malaria. I would first like to briefly address the issues of service connection for certain veterans suffering from the relatively new and highly infectious hepatitis C virus and related liver diseases.

Recently, the Centers for Disease Control and Prevention have determined that hepatitis C is the most widespread among the hepatitis C viruses, and for generations have plagued our armed forces serving in foreign countries. Research has also shown that while hepatitis C appears as an acute illness at the time of infection, it often shows significant symptoms only after 10 or 20 years of latency.

In the case of many Vietnam veterans, particularly those who were wounded or underwent blood transfusions and worked in the medical care field, they are at risk and may be unaware of it. I certainly appreciate the comments of Congressman Reyes, giving his own personal experiences as to the difficulties of individuals who are in combat and as it relates to their inability to substantiate their possible exposures to blood transfusions or documentation of their having been exposed to the malaria. It really helps the committee and the group in general to understand how unique the circumstances were and how an individual may not be able to substantiate—or their medical records may not be able to substantiate their claim for service connection.

In light of the many still unknowns regarding screening and treatment for hepatitis C, the DAV strongly asks that Congress allocates additional funding to the VA medical care account in order to provide additional research, as well as additional health care providers to address this issue.

Our full comments regarding Cerebral Malaria have been submitted for the record as well as our full comments regarding hepatitis C. If you have any specific questions regarding our position, I'll be more than happy to provide you with a timely response.

Mr. Chairman, there is no doubt that the adjudication of Persian Gulf War veterans' claims is complicated and made even more difficult by the increasing inability of rating board members to obtain and decipher the appropriate evidence needed to develop a veteran's claim for service connection. Comparatively speaking, when one considers the number of issues found and the complexity of Gulf War examinations, the timeliness of adjudication of Gulf War veterans' claims for service connection is virtually the same as non-

Gulf War veterans' claims for service connection and this is due to a number of reasons.

This is due in part to the recent efforts by VA to better train its adjudicators to sift through the vast symptomatology and complex medical examinations, and other evidence of record to better evaluate Gulf War veterans' degree of disability. This is not to say the VA has done nothing to try to help their system and their personnel to address the needs of Gulf War veterans.

Earlier this year, the VA Under Secretary for Benefits and Under Secretary for Health released a joint memorandum which stressed the need for VBA and the Veterans Health Administration personnel to take the initiative to pursue additional expert medical opinions to assist in determining the exact nature of a veterans' disability. And this was also a part of a continuing training project by VBA and VHA to ensure that their personnel were able to address the needs of Gulf War veterans in rating their claims. But we know that the system still lacks in being able to address the Gulf War veteran's claim.

Our primary concern lies in the current guidelines for rating claims for undiagnosed illness. As stated by my colleagues from the Vietnam Veterans and VFW and American Legion, under the current guidelines if all issues claimed are not granted or cannot be granted under direct service connection, presumptive service connection, or service connection due to aggravation then it is to be considered under claim for undiagnosed illness. So if a veteran has filed a claim for undiagnosed illness and he has filed that claim more than 1 year from his date of discharge after the 1 year presumptive period therefore not qualifying for direct service connection and he is given a diagnosis, he is then denied service connection based on the fact that it is an undiagnosed condition, but he is not qualified for direct service connection. Therefore, thousands of Gulf War veterans are falling through the cracks, being diagnosed with unexplained conditions or being diagnosed with conditions and being unable to associate it to their military service because of poor documentation either in-service or post-service.

It is based on this scenario that the DAV strongly advocates that this subcommittee carefully consider legislation such as H.R. 4036, introduced by Representative Chris Shays, or similar legislation that would provide presumptive exposures to certain hazardous and chemical toxins such as low-level mustard gases and solvents, several environmental pollutants such as hydrogen sulfide and oil fire by products, ionizing radiation such as depleted uranium, and disease endemic to the region such as leishmaniasis, sand fly fever, and malaria to name a few.

This type of legislation would allow the Secretary of Veterans Affairs to enter into contract with appropriate scientific medical bodies to review medical and scientific data to determine if there is an association between diseases and illnesses suffered by Persian Gulf War veterans and their exposures to these hazardous toxins. Based on these findings, such diseases that become manifest in Persian Gulf War veterans would then be presumed to be service connected.

While the language in H.R. 4036 would cut off the date defining service in the Persian Gulf War as of December 31, 1991, the DAV

would advocate for an extension of this date to the end of the Persian Gulf War which is yet to be determined by the President. In light of continued discoveries of Iraq's chemical capabilities and the use of chemical weapons, we must ensure that those members of our armed forces currently serving in the Persian Gulf theater are adequately cared for.

Mr. Chairman, there are many uncertainties associated with Persian Gulf War veterans undiagnosed illnesses. The DAV believes that H.R. 4036 or similar previously introduced legislation would provide with a reasonable degree of certainty a viable resolution to the PGW veterans compensation nightmare. H.R. 4036 or other similar legislation, such as H.R. 3279 and S. 1320, would bridge the gap for those veterans who are suffering from either a diagnosed illness or an array of diagnosed and undiagnosed conditions associated with their service in the Persian Gulf, and possibly associated with their exposure to an array chemical, biological, or environmental toxins. This type of legislation would give veterans who served in the Persian Gulf the benefit of the doubt regarding their exposure to hazardous toxins.

Mr. Chairman, I would again like to thank your subcommittee and urge you to act quickly to correct the flaws in the adjudication of Persian Gulf War claims. We believe that the language contained in current and pending legislation provides a solution to many of the problems Gulf War veterans are currently facing in the—our Nation's veterans' benefits system. Your kind attention to this legislation is greatly appreciated.

Thank you again, and I'm willing to answer any questions you may have.

[The prepared statement of Mr. Ridley appears on p. 168.]

Mr. REDMOND. Thank you. I do have one question for Matt. Matt, would you elaborate on your work—on your excellent work in the comparison of Public Law 103–446 and the VA's regulations?

Mr. PUGLISI. Yes, Mr. Chairman. As a matter of fact, I think the easiest way to do it—and the way the U.S. Marines like to do things is simply—is when holding up the public law and the regulations and literally holding them side-by-side, one is struck that the language and the descriptions used in each are vastly different. If I could just read some exerts from each, I think I could make clear to yourself and those present the differences.

Reading from the public law, "the purposes of this title are to provide compensation to Persian Gulf War veterans who suffer from disabilities resulting from illnesses that cannot be diagnosed or defined and for which other causes cannot be identified." Reading from the regulations VA has written, "VA shall pay compensation to a Persian Gulf veteran who exhibits objective indications of chronic disability resulting from an illness or combination of illnesses manifested by one or more signs or symptoms."

And throughout the regulations you see phrases like "objective indications of chronic disabilities," "signs, in the medical sense, of objective evidence perceptible to an examining physician," and "independent verification." These phrases and this criteria are found nowhere in the public law.

And what we found is that when claims are submitted to VA, the adjudicators given the criteria and the regulations just cannot

grant service connection or compensation to these veterans. Things like headaches, fatigue, joint muscle pain can't be seen by a physician. They can't be measured by a physician unless they do a very elaborate workup regarding the measurement of disability and functionality. Physicians don't have time to do that, especially in some VA medical centers that are short-handed. And so—although we commend our colleague from the VBA and the lawsuit they've brought and the case they've got before the Court of Veterans Appeals, we feel that the regulations as they are today make it impossible, in any way, to really win these claims in other than rare cases. And so that's why we recommend that the regulations be rewritten as Mr. Stump did in his letter to Togo West, and that we also recommend that pending legislation be considered by the committee because it would do more than just change the regs. VA would have to sit down and rewrite everything from scratch.

Mr. REDMOND. Thank you, Matt. I appreciate that.

I'm going to read a script from Gone With The Wind cause because we can't find anything else here. (Laughter.)

Here it is. Thank you.

I want to thank everybody for coming today, the witnesses especially. But most importantly, I'd like to thank the Department. I would like the Department to understand that they're still deficient in their data collection and I believe they need to do whatever it takes to get the data question straightened out.

The hearing stands adjourned.

[Whereupon, 1:05 p.m., the subcommittee adjourned subject to the call of the chair.]

APPENDIX

Honorable Jack Quinn
Remarks
Oversight Hearing on Persian Gulf Claims Processing,
Hepatitis C and Cerebral Malaria
July 16, 1998

Good Morning. The Subcommittee will come to order.

We are here today to discuss several issues confronting the Department of Veterans Affairs. First, what progress has the Department made in ensuring consistent and fair processing of Persian Gulf War veterans' compensation claims. We have seen the Department go from processing claims at the Regional Offices to centralizing processing at four regional centers and now back to the RO's. Throughout each of those moves, we have been told that the latest decision would clean up the processing problem. Unfortunately, I am not convinced. In the past few months, the Department finally admitted that its data collection scheme was faulty and began an effort to improve its data. However, after considerable efforts to systematize data collection, the staff member responsible has now been assigned temporary duties away from the Department. I am very disappointed to see that and I hope the Department will inform the Subcommittee how it will continue to improve its data on Persian Gulf claims.

The issue of exposure to depleted uranium, which was widely used in various munitions during the Gulf War, has made the press recently. My understanding is that depleted uranium is a toxic heavy metal and potentially dangerous. I would note this problem is not limited to those who fought in the Gulf War because DU is still being used on firing ranges by all the services, so our people are still being exposed to DU. For example, somebody has to clean the weapons after they have been fired. Therefore, I am asking the Department to coordinate a VA-DoD briefing on the issues surrounding the exposure to depleted uranium within the next 30 days .

Second, we have asked the Department to discuss how it is handling claims involving Hepatitis C. This is a deadly disease that has been making the front pages of news magazines and some scientists are saying a bigger threat to the national health than AIDS. I want to be sure that if a vet shows up at the VA with Hep C and evidence of a possible infection opportunity while in the service, the vet will be taken care of. Initial VA data does not show that necessarily to be the case. So, my question to the Department right up front is do current laws and regulations inhibit a veteran's ability to be service-connected for Hepatitis C if he or she received a blood transfusion prior to the early 1990's or worked in the medical field?

Our final topic concerns the possibility that veterans who are judged to be suffering from PTSD may actually be exhibiting the effects of cerebral malaria. I am looking forward to hearing the Department's views on the study done by Dr. Varny and others.

Finally, I want to spend just a moment on what I see as the value and obligation of the VA research program. Today's hearing revolves around three examples of how VA research can contribute to a veterans ability to be compensated for disabilities incurred in service. While this subcommittee does not have jurisdiction over VA's research program, I want to make a point about how VA chooses research topics. I am concerned that VA research has lost its focus on problems, that while not necessarily unique to veterans, occur with greater frequency than in the non-veteran population, and we will hear testimony today reflecting my concern. To put it in perspective, an R&D program focused on the relevant issues affecting large numbers of veterans is vital to a fair compensation program. Typically, these are problems that our troops encountered in the field or the workplace throughout this century - things like tropical diseases, cold weather injuries, combat-related stress, exposure to radiation or hazardous materials. My question is, what portion of the VA's $300 million R&D appropriation is

going to directly address these types of problems? I would appreciate an answer from the Department by next Wednesday.

Before we begin, without objection, I would like to enter a letter from Chairman Stump to Secretary West into the record. Copies are available on the table. In his letter, Chairman Stump has asked the Secretary to review implementation of compensation laws on undiagnosed illnesses to determine whether chronic fatigue syndrome and fibro myalgia should be considered equivalent to undiagnosed illness for compensation purposes. The Chairman makes the point that two veterans with exactly the same symptoms could be diagnosed completely differently by VA physicians, with one receiving a diagnosis of CFS or fibro myalgia and the other suffering from undiagnosed illness. I believe the Legion's prepared statement does a very good job of making the case in support of the Chairman's position. I look forward to hearing the Department's views on the Chairman Stump's letter.

I now yield to the Ranking Member of the Subcommittee, Bob Filner for any opening remarks he may have.

Do any other members have opening remarks?

Could we have the first panel, please. Today, we have with us Mr. Bob Epply, Director of the Compensation and Pension Service and Dr. Teresa Wright, Dr. Nils Varny, and Dr. John Booss (BOOZE). Before you start, I would like to request an explanation of each of the 29 Hepatitis claims denied by the Board on the grounds of being not well grounded by the end of next week. Please proceed.

Thank you. I have a couple questions for this panel.

I now yield to the Ranking Member for any questions he may have.

Do any of the other Members have questions for this panel?

Could we have our second panel, please. We are delighted to have Paul Sullivan from The National Gulf War Resource Center. Paul, I am impressed with the quality of your written testimony and I look forward to a long and positive working relationship with the Resource Center. Your full testimony will be entered into the record, so if you would, please begin with your summary.

Mascara

OPENING STATEMENT FOR 7/16/98 BENEFITS SUBCOMMITTEE HEARING ON CLAIMS FOR GULF WAR ILLNESS AND HEPATITIS C

Thank you Mr. Chairman for holding this hearing. I am glad to be here to discuss the standards on which claims of these disabilities are considered.

I am dumbfounded by the inconsistency of the claims process. To base a decision on whether a veteran is disabled should not depend upon record keeping at the front. These soldiers are in combat. It is controlled chaos. When people are fighting for their lives, the last thing they worry about is whether all the paperwork is together.

What is unconscionable is that the process set up to help these veterans, those who have served our country in the most spectacular way, are not given the benefit of the doubt in their claims. It seems as though the claim of the veteran is useless unless his or her medical record is filled out in triplicate at the front.

The claims process should not be adversarial, it is supposed to help veterans get through the bureaucratic maze. People who are injured and cannot function at 100 percent, are even more vulnerable because they do not have the strength to fight the government as hard as they fought the enemy.

The government- Congress, the Department of Veterans Affairs, the Administration- is here to serve the people and not the other way around. I am continually amazed, but not surprised, by the stories of the people who have problems getting legitimate claims approved. We must do better. We must stop stonewalling legitimate claims.

The real question is why the Department of Veterans Affairs continues to be dragging its feet in rectifying this situation.

STATEMENT OF

ROBERT J. EPLEY

DIRECTOR, COMPENSATION AND PENSION SERVICE

DEPARTMENT OF VETERANS AFFAIRS

BEFORE THE

SUBCOMMITTEE ON BENEFITS

COMMITTEE ON VETERANS'AFFAIRS

HOUSE OF REPRESENTATIVES

JULY 16, 1998

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Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to provide information about how the Department of Veterans Affairs develops and evaluates claims for service connection for disabilities resulting from hepatitis C infection or cerebral malaria.

HEPATITIS C

Since we recently became aware that Hepatitis C is not only a growing public health concern, but an issue that affects our veteran population, VA has initiated several actions to increase field station awareness of the issue and to

ensure consistent handling of claims based on disabilities resulting from this disease.

For example:

- On April 8, 1998, we issued an information letter to all of our field stations. That letter provided current information about the incidence of hepatitis C, the persons most at risk for chronic infection, the way the infection spreads, its manifestations, treatment and prevention, and the ways the disease can be addressed under current rating schedule provisions.

- We sent copies of a poster published by the American Liver Foundation to all regional offices and centers. We asked them to prominently display the posters to help make employees and visitors to the offices aware of hepatitis C, its risk factors, and signs or symptoms that might indicate the infection.

- We are in the process of revising the Schedule for Rating Disabilities so that the rating criteria will specifically mention hepatitis C and discuss the possible complications that may result from various types of hepatitis.

- We are working with VHA to develop an examination protocol that will guide examining physicians to provide information that is sufficient for rating purposes.

- In May 1998, the Board of Veterans' Appeals provided a comprehensive medical lecture for Board members on the forensic issues presented by hepatitis claims, with particular emphasis on hepatitis C. A similar lecture for Board counsel is scheduled for this month.

- On June 11, 1998, the Under Secretary for Health issued an information letter, "Hepatitis C: Standards for Provider Evaluation and Testing."

There are a number of facts about hepatitis C that VA will have to consider when determining whether hepatitis C-related disabilities are service-connected. These include when the infection was incurred, how it was incurred, and what current manifestations are present.

Hepatitis C is an infection that is carried in the blood and there are a number of factors that place an individual at risk for hepatitis C. In order of prevalence, these include:

- IV drug use, especially with shared needles;
- Blood transfusions, especially if they occurred before 1990;
- Accidental exposure in healthcare workers;
- Hemodialysis;
- Other illegal drug use, such as nasal cocaine;

- High risk sexual activity;
- Other exposure through the skin, such as tattoos, body piercing or acupuncture with non-sterile needles;
- Shared toothbrushes or razor blades.

People infected with the hepatitis C virus in its acute stage may have minimal symptoms, such as mild intermittent fatigue, or no symptoms at all. Many will not realize that they have been infected. Half or more of those with an acute infection will develop chronic hepatitis C. The chronic infection progresses over a period of 10 to 40 years with few, if any symptoms, and its course is variable. Approximately 20 percent of individuals with a chronic hepatitis C infection will develop cirrhosis of the liver within 20 years; alcohol intake increases that risk. One to five percent of individuals with chronic hepatitis C will develop liver cancer after 20 years.

In order to award compensation for any disability, VA must have certain evidence. This includes:

- medical evidence of a current disability;
- evidence – usually medical -- that the disease or injury causing the disability was incurred or aggravated in service; and
- medical evidence that establishes a link between the in-service injury or disease and the current disability.

We need the same general type of evidence to determine whether disabilities resulting from hepatitis C infection are service-connected. Given that most individuals are unaware that they were infected with the hepatitis C virus until a later complication develops, a major focus will be developing information that will help us determine when and how an individual was infected.

It is important to note that if we determine that hepatitis C infection is due to drug abuse, we are prohibited by law from granting service connection or paying compensation under the provisions of 38 U.S.C.§§ 105, 1110, and 1131.

In order to process claims for service connection based on disability resulting from hepatitis C infection, it will be very important that we obtain a complete history from the veteran to include all risk factors to which the veteran was exposed--before, during and after service. In the final analysis, a medical opinion as to the most likely etiology of the disease will play an important role in our determination.

Our Schedule for Rating Disabilities (38 CFR Part 4) currently contains provisions for evaluating claims for hepatitis. All types of viral hepatitis, including hepatitis C, can be rated under diagnostic code 7345 (the code for infectious hepatitis). The Schedule supports evaluations ranging from zero percent for non-symptomatic manifestations to 100% for severe manifestations,

such as marked liver damage, with gastrointestinal symptoms. Late complications of chronic hepatitis C may be also be rated under diagnostic codes 7312 (cirrhosis of liver); or 7343 (malignant new growths of digestive system), as appropriate.

While the current rating schedule provisions are adequate to evaluate claims for hepatitis C, we are revising those criteria to specifically explain possible complications that may result from various types of hepatitis, including hepatitis C.

CEREBRAL MALARIA

There is less medical and scientific information available about cerebral malaria. We do know from the literature and from discussions with VHA, however, that a diagnosis of malaria is not the same as a diagnosis of cerebral malaria. A diagnosis of cerebral malaria requires a diagnosis of falciparum malaria plus clear evidence of neurologic dysfunction, such as coma or seizures.

We believe that we would need the same type of evidence to determine that cerebral malaria is service-connected that we need in any claim for service connection. We would need:

- evidence that malaria was contracted while on active duty;

- medical evidence that the veteran currently has cerebral malaria, or residuals of cerebral malaria; and
- a medical opinion that links the current disorder to the malarial episode in service.

Under criteria in the Schedule for Rating Disabilities, the diagnosis of any kind of malaria depends on the identification of the malarial parasites in blood smears. If the veteran served in an endemic area and presents signs and symptoms compatible with malaria, the diagnosis may be based on clinical grounds alone without the confirming identification of malarial parasites in blood smears.

Current rating criteria for malaria provide that the active disease process will be rated under diagnostic code 6304 (malaria), with an evaluation of 100 percent. Following the active process, any residual disabilities will be evaluated under the appropriate body system. We believe these criteria are adequate to evaluate any cases of cerebral malaria or its residuals that we determine are service-connected.

CONCLUSION

It does not appear that we are seeing, at least at this time, a large number of claims for benefits based on either hepatitis C or cerebral malaria. Neither

disease is specifically tracked within VBA. However, based on a review of Board of Veterans' Appeals decisions for fiscal year 1997, it appears that of the 43,000 decisions completed, only 129 involved hepatitis C and only 3 involved cerebral malaria.

In conclusion, we believe that the rules and procedures we currently apply to any claim for service connection, to be supplemented by revisions under development, are adequate to determine whether hepatitis C and cerebral malaria are service-connected. Nevertheless, we are working closely with VHA to determine whether some change in law or regulation would be appropriate with regard to the adjudication of claims for service connection for hepatitis C. We will continue to look at medical and scientific information on these conditions as it becomes available and consult with VHA as necessary. We will, of course, revise our rules and procedures if we determine that would be appropriate. We do not believe that any legislative or regulatory changes, other than those to the rating schedule, are necessary at this time.

Mr. Chairman, this completes my testimony. I will be happy to answer any questions at this time.

ADDENDUM TO THE

STATEMENT OF

ROBERT J. EPLEY

DIRECTOR, COMPENSATION AND PENSION SERVICE

DEPARTMENT OF VETERANS AFFAIRS

BEFORE THE

SUBCOMMITTEE ON BENEFITS

COMMITTEE ON VETERANS' AFFAIRS

HOUSE OF REPRESENTATIVES

JULY 16, 1998

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GULF WAR STATISTICS

On February 15, 1998, the Under Secretary for Benefits advised the Committee that VA is committed to providing the most accurate and complete data possible regarding Gulf War veterans. He reported that VA's Office of Policy and Planning had been designated as the focal point for coordinating all information pertaining to the Gulf War. He also reported that VA had begun to assess and evaluate all of its Gulf War data sources in an attempt to identify and correct discrepancies. We have made progress and continue our efforts to clean up the data. I am submitting statistics from the April 15, 1998 Gulf War Management Information System report for the Subcommittee's review.

Gulf War Veteran Statistics'

Report Date: 1998-04-15
Report Type: VA Undiagnosed Illness C&P Stats.
Period Totals:Inclusive Report Totals

Veteran Group	Era	Theater	Conflict
Service Members	3,507,075	1,099,515	696,583
Estimated Veterans	3,028,070	785,828	563,742
Number of Veterans with 1 or More Undiagnosed SC Conditions	1,967	1,938	1,866
SC 10% Undiagnosed illness - Receiving Compensation or Pension	1,706	1,683	1,621
SC 0% Undiagnosed illness - Receiving Compensation or Pension	156	152	146
SC 10% Undiagnosed illness - No Compensation	156	152	7
SC 0% Undiagnosed illness - No Compensation	98	96	92
NSC Undiagnosed illness - Receiving Compensation or Pension	2,093	2,062	1,975
NSC Undiagnosed illness - No Compensation	3,916	3,810	3,684

Period:Gulf Era - Inclusive Period TotalsDescription:Active duty military service beginning on or after August 2, 1990 and continuing to the present. Any individual serving on active duty regardless of location and who has been discharged since August 1, 1990 is a potential veteran of the Gulf War Era. This includes any individual activated from "Reserve" or "National Guard" status and subsequently separated from active duty.Source:38 U.S.C.

Period:Gulf Theater - Inclusive Period TotalsDescription:A period of active duty military service beginning on or after August 2, 1990 and continuing to the present, occuring in the Southwest Asia theater of operations as defined by 38 CFR 3.317. It includes Iraq, Kuwait, Saudi Arabia, Bahrain, Qatar, the United Arab Emirates, Oman, the Gulf of Aden, the Gulf of Oman, the Persian Gulf, the Arabian Sea, the Red Sea, and the airspace above all of these locations.Source:38 CFR sec 3.317

Period:Gulf ConflictDescription:Active duty military service in the Southwest Asia theater of operations beginning on or after August 2, 1990 through July 31, 1991.Source:DoD- Defense Manpower Data Center

'Gulf War Veteran Statistics'

Report Date: 1998-04-15
Report Type:
Period Totals: Inclusive Report Totals

Veteran Group	[illegible]	[illegible]	[illegible]
Service Members	3,507,075	1,099,515	696,583
Estimated Veterans	3,028,070	785,828	563,742
Service Connected 10% or greater - Receiving Compensation or Pension.	323,015	95,212	76,460
Service Connected 0% - Receiving Compensation or Pension	15,974	4,821	3,835
Service Connected 10% - No Compensation	8,083	2,300	1,892
Service Connected 0% - No Compensation	142,159	45,351	36,397
Estimated Number of Claims Pending	93,295	40,084	30,924
Not Service Connected - Receiving Pension	977	263	230
Not Service Connected - No Pension	56,154	20,101	17,544

Statement of

Teresa L. Wright MD
Chief, Gastroenterology Section,
San Francisco Veterans Administration Medical Center
Before the House Veterans' Affairs Committee
Subcommittee on Benefits
July 16, 1998

Mr. Chairman and Committee Members,

I am pleased to appear today to discuss the importance of Hepatitis C infection in the V.A. Healthcare system.

I am Chief of the Gastroenterology Section at the San Francisco VA and have been treating veterans at the liver clinic there for more than ten years. I am also an Associate Professor of Medicine at the University of California, San Francisco and currently hold research grants from the National Institutes of Health, the VA and from industry to study the epidemiology, pathogenesis and treatment of hepatitis C virus (HCV).

HCV affects 3.9 million Americans with a prevalence of 1.84% in the population as a whole, but with a higher prevalence in minority populations - 3.2% in blacks and 2.1% in Mexican Americans. The highest seroprevalence is in those between the ages of 30 and 39, and 40 and 49 years. In these groups, the prevalence is 3 fold greater than in the population as a whole, and it is these data, in conjunction with the long duration of infection before life threatening complications occur, that has led to the concern that mortality from HCV may triple in the coming decade. The natural history of infection is highly variable, with many being infected for 20-30 years without developing complications, yet some, albeit the minority, progressing to cirrhosis and even liver failure within 10-20 years. Nevertheless, HCV disease is linked to 10,000 deaths annually in the U.S. and the development of liver cancer. HCV disease is also the most common indication for liver transplantation in US transplant programs in general and VA transplant programs in particular.

There is limited information about factors which influence or accelerate the natural history of HCV disease, but three factors have been independently associated with progressive disease in one large epidemiological study were excess alcohol intake, male gender and age greater than 40 years at the time of acquisition of infection. The first two factors are directly relevant to our veterans. Other factors which are believed to contribute to progressive disease are HIV coinfection and immunosuppression following organ transplantation.

The prevalence of HCV infection in Veterans is unknown, but would be predicted to be higher than in the U.S. population as a whole because risk factors for infection are common in our Veteran population. HCV is transmitted by parenteral routes, i.e. through contact with blood. Injection drug use is the most common risk factor for HCV in the general population accounting for 40-60 per cent of all infections. Transfusion is also associated, but accounted for only 5 per cent of infections historically and many fewer today. HCV infection has also been associated with increasing number of sexual partners, and in minority populations with cocaine and marijuana use. In the largest epidemiological survey of HCV in the US, the NHANES III study, there was no association between HCV and education or military service for non-Hispanic whites. In Blacks and Mexican Americans with military service, the prevalence of infection was 3.3 and 1.9 per cent respectively. What complicates determination of the mode or time of acquisition of HCV in an individual is that initial infection is typically silent and duration of disease must be infered from presumed time of first exposure.

From our own experience at the San Francisco VA Medical Center, HCV disease is a common problem. In those who were tested as part of a city-wide needle-stick study, 10 per cent of hospitalized veterans were seropositive for HCV. This is substantially lower however than the experience at San Francisco General hospital where the seroprevalence is 30 per cent. Of 195 seropositive veterans attending the San Francisco VA liver clinic, 78% are between the ages of

40 and 59 years. In a limited survey of 48 seropositive veterans, 24% had served in Vietnam, 2% had served in Korea, 4% had served in World War II, but more than 60% had never been in combat. A history of injection drug use was obtained in almost half of these veterans, but many had started using drugs after their military service. A history of transfusion was obtained in almost 20%. However, in this limited survey, prior transfusion was also common in those without HCV infection. This study is too small in sample size to comment on the significance of these associations, and is currently being extended to a larger number of seropositive and seronegative individuals. The distribution of HCV genotypes in our veterans was similar to that in the U.S. population as a whole, a finding which supports prior observations by Dr. Leonard Seeff at the Washington DC VA. These results imply that HCV infection is being acquired in Veterans from U.S. rather than European or Asian sources. Our study was not designed to assess the prevalence of HCV infection in veterans as a whole nor in subpopulations of veterans such as those who served in Vietnam. These questions are being addressed in a study which is just getting underway at our VA and which is funded for the coming five years.

With the recently mandated 3look-back2 program in blood transfusion recipients, there has been much discussion about the importance or otherwise of infected individuals knowing their serological status. While initially skeptical about the benefits of such knowledge, I have been convinced over the past year from talking to many with infection that the vast majority want to know. Individuals with HCV should avoid alcohol, they should be immunized against other hepatitis viruses such as hepatitis A and B, they should be counseled regarding modes of transmission of this virus and they should be considered for treatment. At the San Francisco VA we have been involved in numerous studies of HCV therapies in the past decade. Interferon, a recombinant protein, remains the mainstay of treatment. There are three FDA-approved formulations of interferon which result in initial response rates of approximately 40 per cent but long-term response rates of only about 20 per cent. Interferon therapy is not appropriate in those with significant psychiatric illness nor in those with ongoing substance abuse, problems which are frequently encountered in the patients we serve. Recently the FDA approved an oral antiviral agent, ribavirin, to be given in combination with interferon in HCV-infected patients who had previously responded to interferon but then had subsequently relapsed off therapy. This combination therapy is not yet approved in patients who are treatment naive, but results from Europe suggest that sustained viral clearance is achievable with treatment in almost 40 per cent. Results of large-scale U.S. studies will be available by the end of this calendar year.

I would like to thank the committee for allowing me to testify. Hepatitis C is a global public health problem which has only recently begun to get the attention it deserves. There are many reasons to believe that HCV infection is a greater problem in Veterans than in the U.S. population as a whole, although the prevalence of infection in Veterans is currently unknown. We should not lose sight however, of the fact that most individuals which HCV will never develop life-threatening complications from their infection. Nevertheless, this virus is an important cause of morbidity, and individuals with infection need to know their serological status. There is currently insufficient information to know whether HCV infection is linked to military service, but preliminary data would suggest that many veterans are acquiring infection by traditional, non-combat-related means.

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Statement of
Nils R. Varney, Ph.D.
Director of Training
Iowa City VA Medical Center
before the
Subcommittee on Benefits,
House Committee on Veterans' Affairs
July 16, 1998
*

Mr. Chairman I appreciate the opportunity to talk about my research on cerebral malaria in Vietnam Veterans.

Malaria may have afflicted as many as 250,000 ground troops in Vietnam, making malaria nearly as common as gunshot wounds. This statistic is relevant to Vietnam veterans today, because while they may have recovered from the malaria illness itself, a number of these veterans developed cerebral malaria and may have been left with neuropsychological and neuropsychiatric symptoms involving problems with mood, temper and memory which could be mistaken for PTSD.

Let me start with a bit of history. A consistent body of clinical literature dating from 500 BC through the early 20th century has reported that individuals who survive cerebral malaria frequently developed depression, memory loss, personality change, and temper problems as long-term secondary effects of the disease. This constellation of neuropsychiatric deficits was observed often enough among survivors of cerebral malaria in turn-of-the-century, British-occupied India that the syndrome was christened *Tropical Neurasthenia*. Forrester, a leading expert of his day, reported that cerebral malaria was the single most important cause of mental illness in British-occupied malarial endemic zones. Scores of papers were written about malaria and tropical neurasthenia during the 19th century, and most neurology books of the time contained long sections about cerebral malaria and its neuropsychiatric sequelae. It should be noted in addition that clinical observations about cerebral malaria leading to psychiatric-

like symptoms were first recorded in the writings of Hypocrites and Galen, which is 2,000 years before the colonial British experience or the war in Vietnam.

Among the acute brain related complications of cerebral malaria are swelling of the brain with flattening of the cerebral gyri, brain injury from high fever, multiple small hemorrhages throughout subcortical white matter, ring hemorrhages around large blood vessels, blockage of capillaries by "log jams" of blood cells (causing hypoxia in watershed zones of cortex), severe hypoglycemia, and permanent discoloration of the brain to a blue-gray .

The key point from this abundant literature is that malaria, in its severest form, may cause brain damage which may persist after the malarial illness itself has been cured.

In our research, the neurobehavioral status of 40 Vietnam veterans who reported being treated for malaria while in Vietnam was compared with that of a group of combat veterans who sustained gunshot/shrapnel wounds in Vietnam, but did not contract malaria. The purpose of requiring veterans in the comparison group to have been wounded was to control for medical treatment of a non-lethal condition and to ensure that both groups had been exposed to similar levels of combat experience.

The results of the study suggest that cerebral malaria survivors may have multiple neuropsychiatric symptoms which could be problematic years after the acute illness had been "cured." As compared with wounded combat veterans who did not have cerebral malaria, the 40 Vietnam veterans who participated in my study who contracted malaria manifested substantial problems with depressive mood, "personality change," feelings of subjective distress, memory problems, emotional lability, and neuropsychiatric symptoms very similar to small seizures, such as memory gaps and staring spells. Although these findings are statistically and psychometrically more sophisticated and reliable than the clinical observations reported over the previous 2,500 years, our study

is only the most recent to suggest that cerebral malaria is a cause of long-standing neuropsychiatric symptomatology in adults who survive the illness.

The message to be drawn from this research is that there may be some Vietnam veterans at risk for suffering from a persistent neuropsychiatric syndrome which can produce a wealth of psychiatric, psychological, neuropsychological, neuropsychiatric and neurological symptoms.

In summary, these findings suggest that further investigation and attempted replication by other groups of independent investigators may be appropriate. If additional studies can confirm that Malaria, or more importantly, the post malaria neuropsychiatric syndrome is a cause of mental problems in Vietnam veterans, then improved treatments could be developed.

It is not my intention to complain about the VA, the Army or Vietnam veterans. Our findings may offer good news for an undetermined number of Vietnam veterans in that they may have mental symptoms which are the result of a neurological disease. With that change in perspective regarding their symptoms, it would logically follow that there would be changes, improvements we hope, in their treatment. In our experience, many of the malaria veterans can be found in PTSD clinics and their lives are substantially improved with neurological treatment.

This concludes my remarks. I would be happy to answer the Committee's questions.

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STATEMENT
John Booss, MD
Department of Veterans Affairs
National Director of Neurology at
VA Connecticut Healthcare System,
West Haven, CT
Before the
Subcommittee on Benefits
House Committee on Veterans' Affairs

July 16, 1998

Thank you Mr. Chairman and members of the Subcommittee on Benefits for this opportunity to discuss the matter of potential long-term neuropsychological outcomes associated with malaria and in particular, cerebral malaria. My name is John Booss and I am the Director of Neurology for the Department of Veterans Affairs based at VA Connecticut Healthcare System in West Haven, Connecticut, and Professor of Neurology and Laboratory Medicine at the Yale University School of Medicine. I am testifying before you today as one of the Department of Veterans Affairs experts on neurological conditions and their potential association with the combat experience. I am one of thousands of clinician/researchers in the VA system who provide clinical care for veterans and who conduct research relevant to some of the unique health problems, combat-related and non-combat-related, posed by participation in military service. The issue that we are discussing today is complex and controversial and is an example of why VA supports clinician/researchers.

VA has long been concerned about infectious diseases and their outcomes among veteran populations. Our research programs in infectious disease range from endemic infectious agents (such as malaria) in areas to which service members have been deployed, to emerging pathogens (such as multiple drug resistant TB) that pose new threats and concerns about the health of the veteran community.

The Office of Research and Development Medical Research Service reviewed a research proposal from Dr. Nils Varney from the Iowa City VA Medical Center in 1988 to carry out research on the neuropsychiatric consequences of cerebral malaria in Vietnam veterans. Following a competitive merit review process, funds were awarded to Dr. Varney for his proposed research from 1989 - 1992. A paper titled

"Neuropsychiatric Sequelae of Cerebral Malaria in Vietnam Veterans" reporting on this research was published in 1997 in the Journal of Nervous and Mental Disease (185:695-703). Much of the controversy surrounding this report involve four issues:

1. There is no medical or laboratory confirmation that the majority of the 40 patients were infected with malaria;
2. There is a lack of documented medical evidence that supports a diagnosis of cerebral malaria;
3. Dr. Varney's interpretation of his data is inconsistent with other interpretations from documented malaria cases;
4. Dr. Varney has made unfortunate and unsupportable extrapolations from a study of 40 veterans to the entire Vietnam experience.

This is not to say, however, that Dr. Varney's hypothesis lacks value. Indeed, further investigation could refine our understanding of the long-term consequences of malaria infection. What we suggest is that an assessment of Dr. Varney's work reveals some methodological and interpretational problems, that should be carefully considered before we make decisions that change health benefits policy. We must look at Dr. Varney's work in the larger context of our scientific knowledge about malaria.

Before I go on to discuss Dr. Varney's work in more detail, I want to consider some background regarding malaria itself. Malaria is caused by infection of the human with a parasite of the genus *Plasmodium*. The diagnosis of malaria is made by examination of blood smears for the parasite. Humans are infected with *Plasmodium* through inoculation by the *Anopheles* mosquito carrying the organism, which it received by biting an infected human. There are several species of *Plasmodium*, one of which is *Plasmodium falciparum*. Infection with *Plasmodium falciparum* leads to falciparum malaria, and is the cause of "cerebral malaria". Of all falciparum malaria cases, many published studies have estimated that approximately 2% are diagnosable as "cerebral malaria" which causes loss of consciousness and other neurological, psychological, and neuropsychological signs and symptoms. One study in particular examined 1,200 cases of falciparum malaria among troops deployed to Vietnam and found 19 who fit criteria

for cerebral malaria. The paper reporting these findings was published in the Journal of the American Medical Association in 1967 (JAMA, 202:679-682).

With this background, I will now turn to Dr. Varney's work.

An earlier study of malaria from Dr. Varney's group was reported in VA Practitioner in February 1989. In that paper, 30 Vietnam veterans were studied who reported having had malaria, accompanied by at least 12 hours of amnesia. Twelve of 17 medical records supported a diagnosis of malaria, but the remainder were reported as lost or destroyed. There was no report of examination of blood smears for the malarial parasite, nor was the diagnosis of "cerebral malaria" reported from the available medical documents. Hence in the 1989 report the diagnoses of cerebral malaria were not established medically. All subjects had co-existing medical conditions that could have contributed to the reported findings. Hence there is ambiguity about the cause of the neuropsychologic findings reported.

Unfortunately, the report of Dr. Varney and his group in the November 1997 issue of The Journal of Nervous and Mental Disease does not resolve the ambiguities. There is again no requirement for laboratory verification of the "malaria group". Of 40 veterans studied, service records were found for 37, of which 14 had a diagnosis of malaria cited. A search for the diagnosis of cerebral malaria was not reported, and no report of blood smears for the parasite was made. This is in contrast to medical reports on malaria at the time of the conflict in Vietnam in which microbiologic confirmation of actual infection was obtained [JAMA, 202:679-682, 1967; Military Medicine, 138:795-802, 1973]. To reiterate, the most recent report from Dr. Varney's study did not require medical diagnosis of malaria in order for a subject to be included in the malaria group, nor did inclusion require a medical record citation of cerebral malaria. This is a significantly lower diagnostic standard than the wartime reports.

Other researchers have examined the long-term effects of malaria infection on brain function. In 1998 Anthony Dugbartey and colleagues reported in the Journal of Nervous and Mental Disease (186:183-186, 1998) on their follow-up study of 142 individuals in Ghana with medically documented uncomplicated falciparum malaria (i.e. not cerebral malaria). They evaluated these individuals' psychiatric and cognitive status

using self-report questionnaires and compared their results with a similar group of 30 individuals with no life-history of malaria. These researchers found comparisons between the malaria and control groups showed small differences on scales of anxiety and depression with no observed differences in higher level brain functions such as thinking clearly or remembering. They suggest that falciparim malaria may cause a long-term, subclinical or subtle mixed depression-anxiety syndrome.

Dr. Varney's paper presents certain issues as factual that diminish the validity of his conclusions. First, he states that "it is estimated that about 250,000 Vietnam veterans were hospitalized for falciparum malaria during the course of the war." The basis for that estimate is unclear, as the reference for this figure cited by Dr. Varney (Connor, et.al., 1976) does not contain that figure. A compilation of military cases from another source (Clinical Infectious Diseases, 16:320-329, 1993) is considerably lower. He further states that "those who were hospitalized were at high risk for cerebral malaria." This latter statement is true only if one accepts a rate of 2% among all falciparum malaria cases as constituting a high risk.

To summarize, whether the 40 veterans studied by Dr. Varney ever had cerebral malaria has not been medically demonstrated and the extrapolation of the number of veterans with cerebral malaria appears to be in error. Evidence from other researchers indicates that uncomplicated falciparum malaria results in, at worst, mild psychiatric sequelae. What about veterans who actually had cerebral malaria in Vietnam? Could they have neuropsychological effects to this day? I don't think we have a conclusive answer to that question, but given the serious acute nature of cerebral malaria, the possibility certainly exists. Were a veteran with a history of falciparim malaria with or without documented acute cerebral symptoms to complain of symptoms suggesting complex partial seizures, anxiety, and/or depression, careful clinical evaluation of those symptoms and appropriate therapy would be warranted. This would constitute accepted practices and standard of care in any VA hospital.

The Department of Veterans Affairs is particularly mindful of the disease burden, both combat and non-combat, carried by those who have served in deployments around the world. Research such as Dr. Varney's, despite our reservations, reminds us that

diseases are complex. For this and other reasons, the Department of Veterans Affairs will continue to fund scientifically sound research that explores disease associations that might affect the health of our veteran patients, either acutely or in the long term.

Thank you Mr. Chairman. I will be happy to take any questions you may have.

National Gulf War Resource Center
1224 M Street, NW
Washington, DC 20005
(202) 628-2700, ext. 162
(202) 628-6997 fax
www.gulfweb.org/ngwrc
ngwrc@vva.org

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Testimony
of
Paul Sullivan
Executive Director

House Veterans' Affairs Committee
Subcommittee on Benefits
July 16, 1998

National Gulf War Resource Center

Chairman, members of the Subcommittee, on behalf of the fifty-one member organizations of the National Gulf War Resource Center, I appreciate this opportunity to testify today regarding disability claims and other matters important to the Gulf War veteran community. The NGWRC is the first Washington-based veterans' organization dedicated solely to Gulf War veterans' issues, and our primary focus continues to be on Gulf War illnesses.

Before I begin, I would appreciate being able to introduce two important documents into the record of this hearing. The first document is the National Gulf War Resource Center's 1998 Government Relations Working Paper (GRWP). In it are our positions on many issues important to the Gulf War veteran community and the work of this Subcommittee. Our GRWP also contains greater descriptions of our answers to the questions answered here today.

The second document we wish to submit for the record is our Depleted Uranium Exposure Case Narrative, Second Edition, July 2, 1998. The DU Case Narrative contains detailed and new information regarding the scope and nature of radioactive toxic waste exposures since the start of the Gulf War in 1990. The DU Case Narrative is a joint project of Swords to Plowshares and the Military Toxics Projects, and both organizations are affiliated with the NGWRC.

Chairman, you asked the National Gulf War Resource Center to provide you with updated statistics on Gulf War veterans, with information regarding "VA's problems involving undiagnosed illness claims as well as diagnosed illness claims," and with our positions on other compensation issues important to the Gulf War veteran community.

The first subject you asked us to comment on was recent statistics regarding Gulf War veterans. Unfortunately, the NGWRC can only provide you with a few statistics, and the numbers are not encouraging. Here are the latest statistics, according to the VA, as of April 15, 1998. We thank the VA's office of Policy and Planning for supplying us with this data.

"Gulf War-Era Veterans" from August 2, 1990 until April 15, 1998	3,507,075
"Theater Veterans" who served in the Kuwait Theater since August 2, 1990	1,099,515
"Conflict Veterans" who served in Operations Desert Shield and Desert Storm	696,583
"Conflict Veterans" released from military service	568,442
"Conflict Veterans" seeking medical care from the VA	242,000+
"Conflict Veterans" with One or More Service-Connected Conditions	118,584
Number of Gulf War veterans (not defined) seen in VA Vet Centers	80,000+
"Conflict Veterans" who have applied for Undiagnosed Illness Benefits	UNKNOWN
"Conflict Veterans" claims adjudicated for Undiagnosed Illness Benefits	7,525
"Conflict Veterans" receiving 10% or more Compensation	1,621

As shown by the numbers, we are not able to obtain the total number of veterans who have applied for undiagnosed illness claims made possible by Public Law 103-446.

National Gulf War Resource Center

These numbers speak for themselves. An alarming rate of at least 78.5% of the Gulf War veterans who had their claims adjudicated for undiagnosed illnesses were denied. This rate does not address pending claims. This rate does not address the granting of one or more undiagnosed condition along with the denial of one or more diagnosed condition by the VA.

The second subject you wanted the NGWRC to comment upon was "VA's problems involving undiagnosed illness claims as well as diagnosed illness claims." The NGWRC, in our review of the administration of PL 103-446, determines there are five sometimes conflicting points of view on this subject, resulting in various interpretations of the law and widely varying outcomes. These sometimes conflicting views ill serve Gulf War veterans seeking benefits by further complicating an already complex claims system.

Veterans. One point of view is that of the Gulf War veteran who is sick from Gulf War toxic exposures and who wants his or her health restored. In many cases, the best avenue of approach, which is most often advocated by veterans' organizations, is for the veteran to file a claim for benefits, to include health care and compensation.

The veteran is most interested in a timely, accurate adjudication of the claim so evaluation and treatment, if available, can begin promptly. In essence, delays in filing, reviewing, and adjudicating claims are killing time, and therefore, an unknown number of ill Gulf War veterans may be denied care and are left in limbo while seriously or terminally ill.

Rest assured, Gulf War veterans are not just out for a check, as some may imply. These veterans, as verified by the Department of Defense, the Department of Veterans Affairs, and the Department of Health and Human Services as well as independent medical practitioners and researchers, unanimously conclude that Gulf War veterans are ill and that they are ill in greater numbers than civilians and other groups. These veterans simply want health care, and they apply for benefits in order to obtain care.

Pentagon. Another point of view is the Department of Defense. Due to Pentagon failures to follow their own regulations and to train soldiers about toxic exposures (notably depleted uranium), to monitor toxins in the air, soil, and water, and Pentagon failures to note medical records and conduct required screening, there is an absence of information regarding toxic exposures.

As the GAO has described in a recent report, the blame for this claims adjudication problem rests squarely with the Department of Defense ("Gulf War Illnesses: Federal Research Strategy Needs Reexamination," February 24, 1998).

The failure of the Pentagon to follow the law and develop a case definition as required under PL 103-337 unduly hinders the veteran by placing an unreasonable burden upon the veteran to show toxic exposure(s) in the Gulf War, to demonstrate the onset of medical conditions, and then claim a

link between the exposure(s) and current illnesses, even when the condition(s) claimed is undiagnosed.

The DoD has not, to our understanding, initiated or completed any medical research into many types of toxic exposures before, during, and after Desert Storm, including oil well fire pollution, depleted uranium, and combinations of these and the many other combinations unique to the Gulf region. After almost eight years since the start of Operation Desert Shield, such inaction is unconscionable.

Such outrageous behavior by the Pentagon demands an independent inquiry and independent oversight. To do less is to ignore what the House Committee on Government Reform and Oversight concluded in November 1997, that the DoD and VA's investigation into Gulf War illnesses is "irreparably flawed," "hobbled by institutional inertia," and plagued by arrogant incuriosity and pervasive myopia."

The VA. According to VSOs, and confirmed by a February GAO study ("Veterans' Benefits: Improvements Made to Persian Gulf Claims Processing"), there were significant problems with the adjudication of Gulf War veterans' claims under PL 103-446.

The most important problem noted by GAO was the under-development of claims by the VA, such as obtaining lay statements, obtaining private medical records, and other actions the VA could have taken under their duty to assist. We have no new information to determine if the improvements made by the VA and noted by the GAO have been successful, had no effect, or were detrimental.

One of the major problems with the law was the extremely limiting two-year presumptive period. The NGWRC thanks Congress for passing PL 105-114, and changing the presumptive period to ten years, with an expiration date of 2001.

Another significant problem is the VA's over-reliance upon the DoD for information regarding toxic exposures and their effects, as VA representative acknowledged before the first hearing of the Subcommittee on Human Resources' investigation into Gulf War illnesses. This, in effect, delayed the research and treatment that could have provided answers and relief to tens of thousands of stricken veterans.

For example, a study regarding oil well fire pollution conducted by the DoD and relied upon by the VA was found to be seriously flawed. The DoD had drawn lab samples from troops not involved in Desert Storm, not adjacent to oil well fire pollution, and, in some cases, the DoD drew samples after the oil well fires were extinguished. VA reliance upon questionable research (or lack of research) by the DoD unduly hinders Gulf War veterans making claims.

Chairman Stump also voiced his concerns in a recent letter to VA Secretary Togo D. West,

National Gulf War Resource Center

Jr., dated June 3, 1998. The NGWRC agrees with the concerns of Mr. Stump. What he asserts in his letter is that a Gulf War veteran's claim under the undiagnosed provision of PL 103-446 could be widely interpreted, with very different possible outcomes for two similar claims.

The VA is using, in most cases, a very strict interpretation of the law. Thus, in many instances, it is difficult to provide benefits to veterans in the absence of evidence that could have and should have been collected by the VA and DoD as a matter of regulation and routine business. The NGWRC believes additional training for VA employees handling Gulf War veterans' undiagnosed illness claims may correct many problems at the VA.

Another problem with the VA is the absence of data regarding the number of claims for each type of undiagnosed illness under this unique law. For example, a veteran may claim several undiagnosed issues, be rated favorably on one or more, and rated unfavorably on others.

There is no existing database that we are aware of that can determine this. Congress may wish to have the GAO investigate the numbers as well as the types of claims and outcomes made by Gulf War veterans. The NGWRC has also received reports that some VA adjudicators may lump several symptoms into a diagnosis (not otherwise determined by a physician), and then deny the claim stating there is no evidence of that "new" diagnosis in service. This may violate the spirit and intent of PL 103-446.

Another serious problem deals with VA physicians performing Compensation and Pension examinations (C&P Exams) to determine the current status of a claimants's health. In March 1998, in an effort to better train VA doctors about Gulf War illnesses, Dr. Kenneth Kizer, VA Undersecretary for Health, sent out a new training booklet that is required reading for all VA physicians, "A Guide to Gulf War Veterans' Health."

The Guide has fatal flaws. Instead of containing complete and accurate information, the Guide is replete with incomplete and false information. For example, the Guide sites information taken from the Persian Gulf Registry through 1995 regarding "Ten Most Frequent Complaints" self-reported by Gulf War veterans, such as fatigue, skin rash, and headaches.

The Guide also places a heavy emphasis on stress as a major cause of the illnesses (5 of the 15 studies cited). Although peer-reviewed, published research exists on low-level chemical warfare agent exposures, none is included in the Guide.

The VA could have included information it has available from the Persian Gulf Registry showing the types of toxic exposures faced by veterans, including chemical warfare agents, depleted uranium, oil well fire pollution, and other very serious poisons.

The absence of the toxic exposure information, and the VA's over-reliance upon stress as the

sole or leading cause, may cause a strong bias in training VA doctors to look for stress and not for toxic exposure-related illnesses. As a result, when a Gulf War veteran is examined by a VA doctor, the physician may be predisposed, as a result of VA training, to look for stress and not be aware of the serious, multiple toxic exposures documented by VA data. This bias complicates the VA adjudication process by tilting the C&P exam in favor of the VA and not in favor of the veteran, as required by law.

We also note the absence of information regarding illnesses among family members of Gulf War veterans. Under PL 103-446, the VA was directed to evaluate spouses and children of Gulf War veterans. The was designed to provide the VA, the DoD, veterans, and independent researchers critical data as to the number and types of illnesses affecting Gulf War veterans' families. Learning from Agent Orange exposures, where benefits are now available to the descendants of Vietnam War veterans exposed to toxins, it is wise and prudent to maintain, if not expand, this program.

Veterans' Service Organizations: Some Veterans' Service Organizations (VSOs) have service representatives with unwritten policies, developed with the best intent for the veteran in mind, to either attempt to strongly follow-up with an undiagnosed illness claim when the merits of the case suggest otherwise, or, the VSO may attempt to avoid the well-known and well-documented quagmire of the undiagnosed illness route by placing a difficult claim into the regular (diagnosed) claim adjudication process.

The VSOs are strong, forceful, and much-needed advocates for veterans, and veterans want and deserve the assistance of VSOs. Due to existing and perceived problems with 38 CFR 3.317, some will attempt to service-connect veterans any way possible within the law. This may muddle an already complicated system by giving the VA and VSOs an inaccurate count of the number of claims filed under this law passed in 1994.

This dichotomy of representation tactics, although well intended by VSOs, may further complicate the undiagnosed illness compensation adjudication by possibly deflating the number of claims that could have been made and or approved under the undiagnosed illness provisions.

It has also come to the attention of the NGWRC that some VSOs may not fully inform veterans about the difficult nature of filing an undiagnosed claim, or, worse, may not inform the veteran that an undiagnosed illness claim was filed. This speaks to the need to better inform veterans and VSOs regarding this new, complicated addition to the claims process.

Congress: By passing PL 103-446 and PL 103-337, Congress acted in the best interests of Gulf War veterans who are ill and who are facing severe difficulty obtaining medical care and compensation for their illnesses resulting from military service during the Gulf War. Congress should now address the problems associated with both PL 103-446 and 104-337. The NGWRC believes that additional hearings, new investigations, better data, and new laws may begin to resolve this

complicated issue.

Solutions Proposed by the National Gulf War Resource Center: The Gulf War veteran community recognizes the difficulty with sorting out five different points of view and how this effects Gulf War veterans' undiagnosed illnesses claims. The number one suggestion by the NGWRC is the development of better data.

For example, according to the GAO, the VA may not be able to determine how many veterans have cancers or tumors. Not knowing this critical data, in the midst of a health crisis, is inexcusable, as the need for accurate information on the types and courses of the illnesses faced by Gulf War veterans is a very real concern. Congress can either ask the VA to determine this, or Congress can ask the GAO to investigate.

For example, since there may be more than one condition claimed for each veteran, the VA may not be able to determine the total number of different undiagnosed conditions claimed by those veterans, including those granted, those pending, and those denied. In a similar fashion, the VA and the VSOs do not know if those veterans with service-connected disabilities have conditions possibly related to Gulf War illnesses. Again, Congress can ask the VA to provide the data, or Congress can ask the GAO to investigate.

For example, the DoD and VA have not yet developed a case definition. With no sets of symptoms or diagnoses for doctors to be aware of, the doctors are without the tools needed to properly examine veterans (for both health care and for C&P exams), and veterans are denied valuable assistance that could and should be provided by the VA. Since Congress passed a law requiring a case definition, Congress and veterans have the right to know who is responsible for the failure of the DoD to comply with the law. Hearings could also be held to determine why the VA's "Guide to Gulf War Veterans' Health" is so seriously flawed, and then suggest possible measures to correct the Guide.

For example, the DoD has not yet begun, to our knowledge, noting medical records of Gulf War veterans known or suspected to have been exposed to radioactive toxic waste in the form of depleted uranium, in possible violation of military regulations. The DoD has not yet begun, to our understanding, any screenings or medical research into the effects of inhaled or ingested depleted uranium dust, a type of toxic exposures extensively detailed in pre-Gulf War medical reports prepared by the Pentagon.

For example, the DoD has not yet completed or released any report on depleted uranium, even after repeated public announcements to do so since 1995. To our understanding, DoD lacks data on as many as 908 Iraqi ammunition dump demolition incidents, 35 of which may have contained chemicals, according to the Pentagon. For these concerns regarding chemical warfare agents and depleted uranium, Congress should consider holding hearings and questioning those responsible at

National Gulf War Resource Center

the DoD.

In addition to hearings, and because of the serious nature of the illnesses, the National Gulf War Resource Center believes Congress should immediately pass legislation that:

1. Presumes exposures to toxins, such as those listed by Representative Shays in HR 4036, including allowing for the addition of new toxins yet to be revealed as well as combinations of toxins.

2. Funds the establishment of an independent oversight panel looking into past, present, and future government research into the toxins presumed to be on the battlefield.
3. Funds independent resarch into the toxins presumed to be on the battlefield.

4. Funds the provision of PL 103-446 that calls for evaluating spouses and children of Gulf War veterans.

5. Includes deployed soldiers as well as undeployed for purposes of presumption of exposure, given the possible receipt of experimental shots and pills prior to deployment as well as poss exposure to depleted uranium on test-firing ranges and clean-up operations at military installations located outside of Southwest Asia.

With those specific suggestions is mind, the National Gulf War Resource Center strongly supports the prompt passage of HR 4036, HR 3279, HR 3661, and/or a combination of those bills meeting the suggestions we have listed above. We believe the passage of presumptive exposure legislation may be the natural evolution of the intent of Congress expressed in PL 103-446.

We believe the House Veterans' Affairs Committee could play a pivotal role in shaping comprehensive legislation on this issue this year. The National Gulf War Resource Center stands ready to assist the Committee in any way.

Again, thank you for the opportunity to speak with you today. I will be happy to answer any of your questions.

National Gulf War Resource Center
1224 M Street, NW
Washington, DC 20005
Phone: (202) 628-2700 ext. 162
Fax: (202) 628-6997

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Statement as to Registration and Federal Assistance

The National Gulf War Resource Center, Inc. has not received any Federal grant or contract during the current or previous two fiscal years.

The National Gulf War Resource Center, Inc. is registered with the Secretary of the Senate and the Clerk of the House of Representatives.

The National Gulf War Resource Center, Inc. was formed on June 28, 1995 in the District of Columbia, and was incorporated on November 21, 1995 in the District of Columbia.

The National Gulf War Resource Center, Inc., received our certification for non-profit status as a 501(c)(3) from the Internal Revenue Service on March 31, 1997.

Further information regarding these subjects should be addressed to our Washington, DC office.

NATIONAL GULF WAR RESOURCE CENTER

1224 M Street, NW
Washington, DC 20005
(202) 628-2700, ext. 162

PAUL SULLIVAN
Executive Director

After serving more than two years on the Board of Directors, Paul Sullivan was appointed Executive Director of the National Gulf War Resource Center in August 1997. Reporting to the NGWRC Board of Directors, Mr. Sullivan serves as the chief executive officer and principal spokesperson for the NGWRC, a coalition of fifty-one grassroots organizations involved with the Gulf War illnesses issue.

The National Gulf War Resource Center is the first organization based in Washington, D.C. dedicated solely to Gulf War veterans' issues. The NGWRC maintains a national presence in our nation's capital advocating Gulf War veterans' concerns through a grant from Vietnam Veterans of America (VVA). NGWRC offices are located on the premises of the VVA.

Starting in 1993, Mr. Sullivan conducted research and then publicized documents (most notably Central Command's Nuclear, Biological, and Chemical incident reporting log) that assisted in forcing the Department of Defense to disclose that as many as 100,000 American soldiers may have been exposed to low-levels of chemical warfare agents during the Gulf War.

He previously served as the President of the Gulf War Veterans of Georgia, an organization he helped form, from 1994 to 1996. He also helped organize the National Unity Conference in Dallas, Texas, in March 1995, the genesis for the formation of the NGWRC.

Elected to the NGWRC Board in 1995 and subsequently re-elected, Mr. Sullivan has served as the spokesperson for the Board since the formation of the NGWRC. He subsequently organized and managed the highly successful 1997 Gulf War Veterans' Illnesses Conference in Atlanta.

Mr. Sullivan provided assistance with preparing the first outline and draft of a Gulf War Syndrome Self Help Guide. More than 10,000 free NGWRC Self Help Guides have been distributed to veterans, veterans service organizations and the general public.

During the Gulf War, he served in the U.S. Army as a Cavalry Scout (Armored Reconnaissance Specialist) with the 1st Armored Division. After leaving the service, he earned a Bachelor of Arts degree in Political Science from the State University of West Georgia.

Mr. Sullivan and his wife Danielle live in Alexandria, Virginia with their two-year old daughter, Erin.

Vietnam Veterans of America, Inc.

1224 M Street, NW, Washington, DC 20005-5183 • Telephone (202) 628-2700

Faxes: Main (202) 628-5880 • Advocacy (202) 628-6997 • Communications (202) 783-4942 • Finance (202) 628-5881

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A Not-For-Profit Veterans Service Organization Chartered by the United States Congress

Statement of

VIETNAM VETERANS OF AMERICA

Presented By

WILLIAM F. RUSSO, ESQ.
DIRECTOR, VETERANS BENEFITS PROGRAM

Before The

House Veterans' Affairs Subcommittee on Benefits

Regarding

VA Benefits Claims for Service Connection for
Hepatitis C and Gulf War Illnesses

July 16, 1998

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Funding Statement – July 16, 1998

Introduction

Chairman Quinn and members of the subcommittee, on behalf of Vietnam Veterans of America (VVA), I am pleased to have this opportunity to present our views on Gulf War veterans benefits and hepatitis C claims.

Gulf War Veterans Benefits

The issues surrounding VA processing of Gulf War illness claims are constantly evolving, as is the state of scientific knowledge about these illnesses. It may be the newness of this type of benefit that has caused VA so much difficulty in the accurate and timely processing these claims. (See GAO Testimony, February 5, 1998, "Veterans' Benefits: Improvements Made to Persian Gulf Claims Processing.") VVA does believe that VA Regional Office and Board of Veterans' Appeals staff need additional training in the handling of Gulf War claims. For example, we are now representing a veteran at the U.S. Court of Veterans Appeals whose claim was denied as not well grounded because he does not have a diagnosed illness. This is ironic since the whole purpose behind Pub. L. No. 103-446 was to entitle such sick veterans to receive compensation. More than 90% of undiagnosed illness claims are still being denied.

VVA supports the premise, contained in legislation offered by Senator John D. Rockefeller, IV, Congressman Lane Evans and Congressman Christopher Shays, which would have an independent scientific body evaluate for what medical conditions VA should allow service connection. VVA was an early and forceful advocate of such a process for Agent Orange-related conditions, and as a result of the Agent Orange Act of 1991, this process has become much fairer. The National Academy of Sciences (NAS) has now conducted two comprehensive, objective reviews of the scientific literature on Agent Orange. As a direct result, VA now pays compensation for eight Agent Orange-related diseases, and for the children of Vietnam veterans with the birth defect spina bifida.[1]

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[1]VVA has been disappointed with NAS' tardiness in issuing its reports. The 1996 NAS' Agent Orange report was issued eight months late. NAS's current report was due out last March, and is not expected until September. VVA met with NAS officials last week to convey our concern

Based on the very positive outcome of this process, we urge that a similar process be used for Gulf War illnesses.

VVA also agrees with the views expressed by Chairman Stump in his June 3, 1998 letter to VA Secretary Togo D. West, Jr. We have observed that many veterans are being denied service connection due to VA's overly strict interpretation of the law, as reflected in its regulations. Under Secretary for Benefits Joseph Thompson has announced the formation of a task force (comprised of his staff and VA General Counsel staff) to revise VA regulations. We urge them to make the changes suggested by Chairman Stump.

Another serious problem is VA physicians performing Compensation and Pension examinations (C&P Exams). We share the concerns of the Gulf War Resource Center about the March 1998, Veterans Health Administration training booklet for all VA physicians, "A Guide to Gulf War Veterans' Health." We agree that the booklet places too much emphasis on stress as a cause of Gulf War illness. It and other training material should place less emphasis on this, and more on the possible toxic causes of the illness.

Presumptive Service Connection for Hepatitis C

In an effort to determine how well VA is adjudicating hepatitis C claims, we reviewed selected FY1997 Board of Veterans' Appeals (BVA) decisions denying service connection for hepatitis C. (Full text available on CD-ROM from BVA). What we discovered strongly supports the recent calls for a statute allowing presumptive service connection for hepatitis C. As reflected by the attached nine BVA decisions, the VA Regional Offices and BVA, and apparently some VA doctors conducting C & P exams, are very uninformed about hepatitis C. This has lead to wrongful denials, some of which are quite unfair to the sick veteran claimant.

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about this problem, and we are hopeful that they are taking appropriate action.

Ignorance about How Hepatitis C is Transmitted

According to the recent Congressional testimony of the current Surgeon General and former Surgeon General Koop, and several recent articles in the popular press, hepatitis C is most often transmitted through blood, including transfusions and other medical procedures. VA adjudicators do not seem to recognize this medical fact.

In Docket 95-35 690, the veteran had abscesses incised and drained in Vietnam in 1969. He also reported having sex with local women in Vietnam. Since the veteran had no medical evidence to support his assertion that he likely was infected in Vietnam, his claim was denied. In Docket No. 96-02 532, the veteran got a tattoo in Hong Kong in 1981, while in service, and began having fatigue several months later. He was diagnosed with hepatitis C in 1991. Because his doctor did not render an opinion on whether he was infected in service, the claim was denied. In Docket No. 96-22 677, the veteran received 2 units of blood during surgery in service in 1974. He was not diagnosed with hepatitis C until 1992, according to Board Member Lyon, "a period too distant from service to be related in any injury or event in service." In Docket No. 96-34 751, the veteran was a medic in service, who testified she was stuck with needles 4-5 times while drawing blood. From her discharge until her diagnosis with hepatitis C, she was treated often for abdominal pain, which was never diagnosed. Despite her medical training and experience, Board Member Sherman denied the claim, noting that the veteran did not qualify to testify as to medical causation.

Ignorance about Hepatitis C's Latency Period

According to the recent Congressional testimony of the current Surgeon General and former Surgeon General Koop, and several recent articles in the popular press, hepatitis C has been found to have a latency period of at least 30 years, during which it may show no symptoms at all. VA adjudicators do not seem to recognize this medical fact.

In Docket No. 95-15 143, Board Member Senyk cited the fact that hepatitis C "was first diagnosed in January 1994, more than 20 years after the veteran's discharge from service," as one basis for his denial of the claim. In 96-45 233, the veteran testified that a corpsman used an unclean needle to close his hand wound in Vietnam. Board Member Dannaher relied on a VA exam which found "the length of time between active service and the diagnosis of hepatitis C [and] lack of history

of hepatitis C-like illnesses indicated the disorder was acquired during service in Vietnam", to deny the claim. In Docket No. 96-22 677, the veteran received 2 units of blood during surgery in service in 1974. He was not diagnosed with hepatitis C until 1992, according to Board Member Lyon, "a period too distant from service to be related in any injury or event in service."

Ignorance About The Recent Discovery of Hepatitis C

According to the recent Congressional testimony of the current Surgeon General and former Surgeon General Koop, and several recent articles in the popular press, hepatitis C was not identified until the 1980's. A reliable test for hepatitis C was not available until 1991. VA adjudicators do not seem to recognize this medical fact. In Docket No. 95-32 722, the veteran wrote on his separation exam questionnaire, that he was hospitalized for three days in Vietnam due to hepatitis C. Despite this, Board Member Callaway denied the claim, noting "there is no indication in any of the service medical records that there was any diagnosis of hepatitis C made by a physician based on laboratory testing." This logic is flawed for several reasons. First, she does not cite any authority for this requirement that certain diagnoses be confirmed by "laboratory testing." Second, there was no test for hepatitis C during the Vietnam War. Third, it is not unusual for service medical records to omit records of treatment, especially in a war zone, where scrupulous record keeping is of little concern. In Docket 95-35 690, discussed above, the Board Member cited as significant the fact that there were no findings regarding hepatitis C on a 1972 VA exam, a year after the veteran's discharge.
In Docket 96-51 676, Board Member Ferner cited the fact that a 1949 blood test failed to show hepatitis C, as a basis for a denial of a WWII veteran's claim for service connection. (This was despite the fact that records show he received 500 cc of blood for treatment of multiple wounds.)

Veterans Are Not Getting Medical Opinions

In addition to being ignorant about the medical aspects of hepatitis C, VA will offer no assistance to a veteran who is not sufficiently educated and wealthy, to obtain a medical opinion supporting his claim. In Docket No. 94-12 200, the veteran's doctor stated, "it is entirely possible, indeed probable, that [hepatitis C] was acquired during his time [during military service] in Korea, possibly through sexual exposure." Despite this, Board Member Blasingame found this opinion

"address[ed] only the possibility of a link between the veteran's hepatitis C and events in service, without positive medical evidence that the veteran's hepatitis C began during service." Since he found the claim not well grounded, no VA medical opinion was sought and the claim was simply denied.

A similar conclusion was reached by Board Member Frank in Docket No. 96-00 585. In that case, the veteran was a laboratory technician in service, clearly a job with an increased risk for blood-borne diseases. He testified under oath that he tested positive for hepatitis C when he attempted to donate blood in 1990, but there was no record of this. Despite the fact that in service "liver function studies reportedly show high ALT's and abnormal liver functioning, there was no clinical evidence of liver disease," so the claim was denied without obtaining a medical opinion.

Need for Legislation

The premise behind presumptive service connection is that in certain claims, often involving complex, technical scientific issues (such as radiation or dioxin exposure), or certain types of service (such as prisoner of war service), it would be unfair to burden the sick veteran with proving all the elements of service connection. Our analysis of the above cases is that they show the need for a statute allowing presumptive service connection for hepatitis C. Veterans are being wrongfully denied service connection—and therefore health care—because they lack the funds or the knowledge to obtain a doctor's opinion as to the etiology of their hepatitis C. Congress should help these sick veterans by passing appropriate legislation.

Conclusion

VVA is very pleased to serve as a resource to you and your staff as the Committee considers the issues surrounding hepatitis C and Gulf War claims. Thank you for the opportunity to present VVA's views. This concludes our statement. We would be pleased to respond to any questions.

Vietnam Veterans of America, Inc.

1224 M Street, NW, Washington, DC 20005-5183 • Telephone (202) 628-2700

Faxes: Main (202) 628-5880 • Advocacy (202) 628-6997 • Communications (202) 783-4942 • Finance (202) 628-5881

World Wide Web: http://www.vva.org • *E-mail 71154.702@compuserve.com*

A Not-For-Profit Veterans Service Organization Chartered by the United States Congress

FUNDING STATEMENT
July 16, 1998

The national organization Vietnam Veterans of America (VVA) is a non-profit veterans membership organization registered as a 501(c)(19) with the Internal Revenue Service. VVA is also appropriately registered with the Secretary of the Senate and the Clerk of the House of Representatives in compliance with the Lobbying Disclosure Act of 1995.

VVA is not currently in receipt of any federal grant or contract, other than the routine allocation of office space and associated resources in VA Regional Offices for outreach and direct services through its Veterans Benefits Program (Service Representatives). This is also true of the previous two fiscal years.

For Further Information, Contact:
Director of Government Relations
Vietnam Veterans of America
(202) 628-2700, extension 127

Vietnam Veterans of America, Inc.

1224 M Street, NW, Washington, DC 20005-5183 • Telephone (202) 628-2700

Faxes: Main (202) 628-5880 • Advocacy (202) 628-6997 • Communications (202) 783-4942 • Finance (202) 628-5881

World Wide Web: http://www.vva.org • *E-mail 71154.702@compuserve.com*

A Not-For-Profit Veterans Service Organization Chartered by the United States Congress

WILLIAM F. RUSSO, Esq.
Director, Veterans Benefits Program

Since 1994, Bill Russo has served as Director of the Veterans Benefits Program of Vietnam Veterans of America (VVA). In this position, he is responsible for the training and management of more than 300 accredited Service Representatives nationwide, and supervises VVA's representation at the Board of Veterans' Appeals, the U.S. Court of Veterans Appeals and military discharge review boards. In addition, Mr. Russo oversees VVA's production of publications on VA benefits which are provided to veterans and their representatives.

Previously, Mr. Russo worked from 1987 to 1990 for VVA Legal Services/National Veterans Legal Services Project, advising VVA Service Representatives and representing claimants at the BVA. From 1990 to 1991, he then served as a staff attorney with the U.S. Court of Veterans Appeals Central Legal Staff, analyzing veterans' cases for the Court's judges. From 1991 to 1994, he practiced civil litigation for a private law firm and spent his spare time successfully representing a number of veterans *pro bono*.

In 1991, Mr. Russo received a Special Service Award from the U.S. Court of Veterans Appeals, for his work on the American Bar Association's study on *pro se* appellants at the Court. In 1994, he was selected by the American Bar Association's Young Lawyers Division for the "Profiles of the Profession" issue of *Barrister* magazine, for his *pro bono* work on behalf of veterans. In 1997, he was presented with the VVA Government Affairs Distinguished Service Award for his legal advocacy work for veterans. During his career, Mr. Russo has testified to the U.S. Senate and House of Representatives Committees on Veterans Affairs, published numerous articles regarding veterans law, and trained hundreds of attorney and non-attorney veterans advocates around the country.

Mr. Russo is a 1985 graduate of the University of Maryland and a 1989 graduate of The George Washington University Law School. He is admitted to practice law in the District of Columbia, Maryland and Pennsylvania.

STATEMENT OF

WILLIAM T. FRASURE, SPECIAL ASSISTANT
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

SUBCOMMITTEE ON BENEFITS
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

ADJUDICATION OF VA COMPENSATION CLAIMS FOR HEPATITUS C, CEREBRAL MALARIA, AND GULF WAR UNDIAGNOSED ILLNESSES

WASHINGTON, D.C. JULY 16, 1998

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

Thank you for the opportunity to present the views of the Veterans of Foreign Wars of the United States with respect to adjudication of VA compensation claims for Hepatitis C, cerebral malaria, and Gulf War undiagnosed illnesses.

On the first subject, the annual incidence of new cases of Hepatitis C in the United States is estimated between 135,000 and 180,000, and there are 8,000 to 10,000 deaths annually. It is now the most common cause of liver transplantation in the U.S.

Fifty to 70 percent of those who get Hepatitis C develop chronic HCV infection but they may have no symptoms or only mild, intermittent fatigue as the infection progresses over a period of ten to 40 years. The risk of cirrhosis of the liver in those with chronic HCV infection is 20 percent within 20 years, and the risk of liver cancer after 20 years of HCV infection is estimated as one to five percent.

Like many here, we received the letter from Dr. C. Everett Koop wherein he shares his concerns on Hepatitis C and, of significant interest to us, its direct ramification on veterans. We share Doctor Koop's specific concerns that veterans, who are suffering with this disease, will find it difficult to establish service-connection because, in most cases, there will be no contemporaneous evidence showing that the disease's etiology manifested during service.

What really grabbed our attention was Dr. Koop's reference to VA studies that "indicate as many as one in five veterans may be infected with HCV..." and the possible association of this blood-borne virus with military service. Because of the espoused latency, we are very concerned whether there is sufficient guidance and procedures readily available in the Department of Veterans Affairs on adjudicating present and future claims for HCV service-connection. This concern was recently transmitted in a letter to the Under Secretary for Benefits, Joe Thompson.

Currently, the only approved treatment for Hepatitis C is Alpha interferon. It improves serum aminotransferase levels in 50 percent of patients during treatment, and many of these patients also become negative for HCV RNA during therapy. We are additionally concerned that there are no mechanisms in place for routine blood testing of veterans, many of who now seem to be at increased risk for contracting Hepatitis C.

Mr. Chairman, we have very little knowledge on cerebral malaria and must apologize that we cannot comment adequately on it.

That is not the case for the third topic. The Veterans of Foreign Wars has dedicated extensive resources and much effort over the past six years working on issues involving claims processing for Gulf War related disabilities. Specific to the discussion today, we feel one of the current issues of greatest urgency regarding benefits for Gulf War veterans is that claims based on symptoms for which no known cause is established are being improperly denied. Concurrently, we believe it is now time to again consider extending the presumptive period for which symptoms associated with service in the Gulf War may appear.

Despite the intent of Congress, many Gulf War veterans with disabling illnesses that may be associated with service in the Persian Gulf are being denied compensation. While it seems reasonable, in general, that claims submitted by veterans will be considered based on the claimed conditions and symptomatology, such methods of adjudication may not adequately capture the unique aspect of Gulf War Undiagnosed Illnesses claims. It was the extraordinary nature of Gulf War illness claims that resulted in the enactment of the "Persian Gulf War Veterans' Benefits Act of 1994" (Public Law 103-446).

Gulf War veterans, suffering from undiagnosed illnesses, are eligible to receive compensation under P.L. 103-446. Pursuant to this law, the VA was to provide a description of the illnesses and the relevant characteristics -- such as latency periods -- associated with each or all of the illnesses. The VA did this only to the extent of implementing regulation, 38 C.F.R. § 3.317, a list of 13 signs or symptoms which may be manifestations of, but do not define, undiagnosed illnesses in Gulf War veterans.

The signs and symptoms presented in the regulation closely correspond to those that can be found in other diseases. Dr. Daniel J. Clauw, Chief of Rheumatology and Allergy at Georgetown University Medical Center, most recently presented this information on June 19, 1998, to the Persian Gulf Veterans Coordination Board. Dr. Clauw states that there is often an overlap between systemic multi-symptom illnesses such as Chronic Fatigue Syndrome, Fibromyalgia, and what has been called Gulf War Syndrome. Thus, it is difficult, if not impossible, to differentiate between such illnesses.

From the perspective of treatment, the close association between multi-symptom illnesses may not be entirely detrimental. Effective treatment regiments for Chronic Fatigue Syndrome have been shown to be effective against Fibromyalgia. However, the close association between multi-symptom conditions may be very detrimental for Gulf War veterans seeking disability compensation. A serious problem that many veterans face is, although they present evidence of some of the symptoms listed in 38 C.F.R. § 3.317, they may be actually and prematurely diagnosed with Chronic Fatigue Syndrome, Fibromyalgia, or some other multi-symptom condition. Because of this inadvertent specific diagnosis, the veteran is thus not considered under § 3.317. If evidence of a disability is not shown in service or within the limited presumptive period ascribed to the diagnosed condition, service connection must be denied.

This is not in keeping with the intent of P.L. 103-446, which makes these stipulations patently unfair. The problems associated with the mislabeling of conditions affecting Gulf War veterans for which no known etiology exists, and not otherwise specified, are very possibly a result of Gulf War service. The purpose of P.L. 103-446, as it pertains to Gulf War veterans, was to "provide compensation to Persian Gulf veterans who suffer from disabilities...that cannot now be diagnosed or defined, and for which other causes cannot be identified." 38 U.S.C.A. § 1117, note 1 (1994) (Congressional Statement of Purpose Respecting Persian Gulf War Veterans). The intent of the law has been inadvertently diminished through the promulgation of 38 C.F.R. § 3.317. This must be changed.

This is why the VFW adamantly supports Representative Stump's excellent and erudite letter dated June 3, 1998, to Secretary of Veterans Affairs West in which he discusses these very points. We appreciate Congressman Stump's interest and are looking forward to reviewing Secretary West's response and hope that it will indicate intent to amend the current regulation.

A second area of concern for the VFW may be addressed by amending another aspect of 38 C.F.R. § 3.317. As early as September 1996, we formally petitioned the VA to extend the presumptive period for which veterans may receive compensation for undiagnosed disabilities resulting from service in the Gulf War. The original presumptive period annotated in 38 C.F.R. § 3.317 was then a restrictive two years. After months of dialogue with the VA, the President announced, on March 7, 1997, an extension of the presumptive period to December 31, 2001.

The amendment to the regulation was finalized and published on April 29, 1997. These dates are significant in order to demonstrate that it took 20 months from our first formal inquiry to the VA before action was finalized. The VA is still trying to undo the damage caused by the limited two-year period.

This is brought out today because the extension that is reflected in the April 29, 1997, amendment to 38 C.F.R. § 3.317 is only temporary. As just stated, the amendment extended the presumptive period through the year 2001 which is now just over two years away. The medical community still cannot determine a date as to when symptoms associated with service in the Gulf War will manifest. Therefore, any date limiting the time for when symptoms may appear is arbitrary and may be detrimental to Gulf War veterans. We should not force Gulf War veterans to once again bear the burden of an arbitrary presumptive period.

The VFW has long-held the view that any presumptive period should, pursuant to P.L. 103-446, be based on available credible medical and scientific evidence. There should be no limitation on a presumptive period in the absence of evidence establishing a date as to when the symptoms will appear. We feel the only appropriate presumptive period at this point is one that is temporarily open-ended.

It is clear that the medical community is not yet ready to make a determination as to when illnesses associated with Gulf War service will appear. Additionally, the VA does not anticipate in the near future any final determination as to when such will appear. The VA has contracted with National Academy of Sciences to provide two reports intended to provide insight into the health outcomes and treatment of Gulf War veterans based on available literature and research. We applaud the VA in initiating the contracts with the NAS. It is time to start this review to hopefully draw some conclusions as to what is causing the illnesses. That can then only help toward prescribing effective treatment. The problem now is that such a review takes time. The contract with the NAS calls for an initial two reviews over 36 months at 18-month intervals. This, of course, goes beyond the year 2001.

While we are encouraged that the VA has voluntarily taken steps to work with the NAS on Gulf War illnesses, we feel it is essential that there be a law reflecting they must continue to do so. There must also be simultaneous funding adequate to ensure the comprehensive fulfillment of the NAS contract. Because of this and related factors, we support both the "Persian Gulf Veterans' Health Care and Research Act of 1998" (H.R. 3980) and the "Persian Gulf War Veterans' Health Act of 1998" (H.R. 4036). We feel these bills are much needed and deserve our support. We particularly appreciate the hard work undertaken by Representative Stearns and his fellow members of the Committee on Veterans' Affairs in bringing about H.R. 3980.

Additionally, we thank Representative Shays for his subcommittee's investigation into Gulf War related problems that has resulted in H.R. 4036. The VFW believes H.R. 4036 is an excellent bill which can be made even better with language which clearly points out to the VA that all existing laws applicable to the adjudication of Gulf War veterans claims must be fully considered. We also believe H.R. 4036 should rely upon existing language in 38 United States Code § 1117(e) in its definition of a "Persian Gulf veteran". We have relayed our suggestions directly to Congressman Shays' staff.

Representative Shays' investigation into Gulf War illnesses has resulted in another bill, the "Drug and Informed Consent Armed Forces Protection Act of 1998" (H.R. 4035), aimed at protecting the health of our troops. The Senate has included an amendment in the National Defense Authorization Bill that echoes the language of H.R. 4035. There can be no understatement on the importance of such an issue and we ask that the Committee on Veterans' Affairs work closely with Congressman Shays toward the passage of this legislation.

Mr. Chairman, this concludes my testimony and I will be happy to respond to questions you may have.

MATTHEW L. PUGLISI
ASSISTANT DIRECTOR, PERSIAN GULF TASK FORCE
THE AMERICAN LEGION
BEFORE THE
SUBCOMMITTEE ON BENEFITS
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
THE STANDARDS FOR ADJUDICATING CLAIMS PRESENTED BY VETERANS SUFFERING FROM HEPATITIS C, CEREBRAL MALARIA AND PERSIAN GULF WAR ILLNESSES

JULY 16, 1998

Mr. Chairman and distinguished members of the Subcommittee:

The American Legion appreciates the opportunity to offer testimony regarding the Department of Veterans Affairs' (VA) standards for adjudicating claims presented by veterans suffering from hepatitis C, cerebral malaria and Gulf War illnesses. Your leadership on the issue of Persian Gulf undiagnosed illness claims last year led directly to a significant decrease in the backlog of those claims (Department of Veterans Affairs, 1997-98). Your continued concern and oversight of this process has kept the pressure on VA to adjudicate these claims as well as possible.

Yet, in spite of your oversight, and the oversight of The American Legion and the United States General Accounting Office (GAO), nine out of ten Gulf War veterans who file a disability claim for undiagnosed conditions are denied service connection and compensation from VA (Department of Veterans Affairs, 1998). This is also in spite of the fact that VA adjudicated most Persian Gulf undiagnosed illness claims twice, and overhauled the undiagnosed illness claims process. VA is failing to compensate disabled veterans with Gulf War Illnesses because its regulations implementing Public Law 103-446, the "Veterans Benefits Improvements Act of 1994," were written too narrowly.

The American Legion therefore has three recommendations for the Committee:

1. Encourage VA to change its regulations regarding Persian Gulf undiagnosed illness compensation in order to bring them more in line with the spirit of PL 103-446.

2. Support legislation that closes the gap in the government's service to Gulf War veterans with Gulf War Illnesses.

3. Encourage the Veterans Health Administration (VHA) and the Veterans Benefits Administration (VBA) to develop a more cooperative approach to Gulf War veterans health care and compensation.

Background

The Gulf War, as we now know well, was like all of our nation's past wars in that it left thousands of disabled veterans in its wake. And like our past wars, thousands of deployed Gulf War veterans report Medically Unexplained Symptom Syndromes (Institute of Medicine, 1998), known collectively as Gulf War Illnesses (Iowa Persian Gulf Study Group, 1997; Hyams, 1996). Although some of the risk factors troops were exposed to in the Persian Gulf were the same as those found in past wars, some were different: low levels of chemical nerve agents, pyridostigmine bromide, and depleted uranium. As Gulf War veterans began reporting these hard to define illnesses, VA was confronted with compensating these disabled veterans. VA, however, did nothing. Faced with disabled war veterans, VA pointed to public laws and blamed them for its

failure to act. Congress rose to the challenge, and passed historic legislation in 1994 that would help veterans suffering from Gulf War illnesses.

Public Law 103-446: The "Veterans Benefits Improvements Act of 1994"

Congress' intent in this historic law was plain and simple. Aware of VA's claim that thousands of disabled Gulf War veterans were ineligible for disability compensation because Gulf War illnesses remained ill defined and poorly understood, Congress passed a law that would permit VA to compensate these veterans. Yet 90 percent of those veterans who file a claim for undiagnosed illness compensation are denied compensation for those conditions. Why? VA regulations implementing the law, codified in 38 C.F.R., section 3.317, strictly limit eligibility for this unique type of disability compensation.

Comparison of PL 103-446 and 38 C.F.R., Section 3.317

Public Law 103-446	**38 C.F.R., Section 3.317**
"The purposes of this title are-- (1) to provide compensation to Persian Gulf War veterans who suffer disabilities resulting from illnesses that cannot now be diagnosed *or defined*, and for which other causes cannot be identified;" [Emphasis added]	"VA shall pay compensation...to a Persian Gulf veteran who exhibits *objective* indications of chronic disability resulting from an illness or combination of illnesses manifested by one or more signs or symptoms..." [Emphasis added]
"Significant numbers of veterans of the Persian Gulf War are suffering from illnesses, or are exhibiting symptoms of illness, that cannot be diagnosed or *clearly defined*. As a result, many of these conditions or illnesses are not considered to be service connected under current law for purposes of benefits administered by the Department of Veterans Affairs." [Emphasis added]	"By history, physical examination, and laboratory tests cannot be attributed to any known clinical diagnosis."
"Further research and studies must be undertaken to determine the underlying causes of the illnesses suffered by Persian Gulf veterans and, pending the outcome of such research, *veterans who are seriously ill as the result of such illnesses should be given the benefit of the doubt and be provided compensation benefits to offset the impairment in earnings capacities they may be experiencing.*" [Emphasis added]	"For purposes of this section, 'objective indications of chronic disability' include both *'signs,' in the medical sense of objective evidence perceptible to an examining physician*, and other, non-medical indicators that are capable of *independent verification.*" [Emphasis added]

Mr. Chairman, a comparison of the language contained in PL 103-446 and VA's regulations implementing the law explain why many sick Gulf War veterans are denied compensation. Congress wanted VA to compensate veterans with Gulf War Illnesses, but VA wrote regulations that ensure it will not compensate most of these veterans.

Phrases like "objective indications of chronic disability," "signs' in the medical sense of objective evidence perceptible to an examining physician," and "independent verification" are not found in PL 103-446. Yet they are found guiding VA adjudicators on how to carry out Congress' will.

Mr. Chairman, can you imagine a physician who can objectively "perceive" a headache, or "independently verify" muscle pain? Are you aware of any medical training program that produces doctors who do not diagnose disease in patients? It is little wonder then that VA's employees, regardless of their intentions, cannot grant service connection for "undiagnosed" illnesses. Regulations written by VA make it almost impossible.

VA's regulations lowered the hurdle for sick Gulf War veterans by only a hair, when Congress' clear intent was to lower it completely.

Medically Unexplained Symptom Syndromes

The Institute of Medicine (IOM) published a report in January of this year regarding the Department of Defense's (DoD) Comprehensive Clinical Evaluation Program (CCEP). The CCEP is DoD's identical version of VA's Persian Gulf Health Registry, and it is available for Gulf War veterans on active duty. IOM's report provides us with an insightful description of the illnesses that Gulf War veterans exhibit. It was clear to IOM, and it is clear to many researchers investigating Gulf War Illnesses, that the pattern of symptoms reported by these veterans overlap with some recognized or controversial illnesses: chronic fatigue syndrome (CFS), fibromyalgia (FM), and multiple chemical sensitivity (MCS). In order to create some consistency in describing these illnesses the phrase Medically Unexplained Symptom Syndromes, coined by IOM, becomes helpful. It is not a case definition, so it cannot be diagnosed, per se. But it describes what is happening to these sick veterans.

There is a growing body of evidence found in the medical literature which suggests that the symptoms of CFS, FM, and MCS so overlap with each other that these illnesses are sometimes indistinguishable to physicians.

CFS, FM and MCS are diagnoses that physicians arrive at after they have excluded other diseases. Patients with these illnesses do not test positive on any available medical tests. One does not test positive on a blood test for fatigue, for instance. Physicians diagnose them after spending a great deal of time with a patient. Different treating physicians of the same patient can diagnose one or the other or none in the same patient.

Deployed Gulf War veterans suffer from significantly worse health than non-deployed veterans (Iowa). The causes of Gulf War Illnesses remain controversial, but even the Presidential Advisory Committee on Gulf War Veterans' Illnesses found that these diffuse illnesses were likely service connected (PAC, 1996). Some investigators have argued that these illnesses were found after all our wars since at least the Civil War. Although the explanations for this phenomenon are controversial, it remains that the occurrence of ill defined syndromes in combat veterans is fact.

CFS, FM and MCS are not well understood by the medical community. Their exact causes remain unknown. Since epidemiological studies completed to date show that Gulf War veterans report significantly more health symptoms consistent with these illnesses than non-deployed veterans; and since Congress intended for such disabled veterans to be compensated by VA; then it is VA's obligation to amend its regulations in order to incorporate what's been learned in Gulf War research since 1994, and to implement the will of Congress as it clearly failed to do in 1994.

Recommendations

Mr. Chairman, The American Legion would like to provide the Committee with three recommendations that we think would address the problems with Persian Gulf undiagnosed illness claims.

1. Encourage VA to change its regulations regarding Persian Gulf undiagnosed illness compensation in order to bring them more in line with the spirit of PL 103-446.

2. Support legislation that closes the gap in the government's service to veterans with Gulf War Illnesses. Representative Lane Evans' bill, H.R. 3279, and Representative Chris Shays' H.R. 4036, both address the issue of granting service connection to disabled Gulf War veterans who may not otherwise be service connected under current law or regulations.

3. The Veterans Health Administration (VHA) and the Veterans Benefits Administration (VBA) must develop a more cooperative approach to Gulf War veterans health care and compensation. The American Legion, through site visits to VA Medical Centers and Regional Offices, and through reports from our service officers in the field, has learned that VHA and VBA are "not on the same page of music" when it comes to Gulf War veterans. We have found VA physicians conducting Compensation and Pension examinations who were unaware that Gulf War veterans with undiagnosed illnesses could be compensated by VA. In meetings with officials of both organizations from VA's Central Office each group blames the other for the inability of VA to compensate disabled Gulf War veterans. It's time for these agencies to be encouraged (or forced, as the armed services were with the Goldwater-Nichols Act of 1986) to serve Gulf War veterans, and all veterans, in a more seamless and cooperative manner.

Conclusion

Mr. Chairman, Congress listened to sick Gulf War veterans in 1994 and acted by passing historic legislation granting VA the authority to compensate those with difficult to diagnose and ill defined illnesses. VA has failed to implement the law, and thousands of Gulf War veterans remain without compensation for these service connected conditions. The American Legion is encouraged by your continued interest in this matter, and we look forward to you taking action in the near future that would resolve this issue once and for all.

Hepatitis C and Cerebral Malaria

Mr. Chairman, The American Legion is in the midst of questioning our service officers regarding their experience with any claims for hepatitis C and cerebral malaria. The results of our investigation will be reported to the committee as soon as it is completed.

Mr. Chairman, that concludes my statement. I would be happy to answer any questions.

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STATEMENT OF
PHILLIP A. RIDLEY
LEGISLATIVE ASSISTANT
FOR THE
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
SUBCOMMITTEE ON BENEFITS
JULY 16, 1998

MISTER CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the more than one million members of the Disabled American Veterans (DAV) and its Auxiliary, I thank you for this opportunity to present the subcommittee with the DAV's assessment of the adjudication of Persian Gulf War (PGW) veterans' claims.

You also asked that we provide our views for the record on the issues of service connection for hepatitis C and cerebral malaria in Vietnam veterans. We have provided our comments for the record on these issues for your review.

Mr. Chairman, over the last 18 months, in an effort to decrease the processing time of PGW veterans' claims, the VA has reorganized its processing of those claims from four VA regional offices to each of the 69 regional offices of original jurisdiction. In talking with DAV supervisory National Service Officers in Detroit, Michigan; Louisville, Kentucky; Oakland, California; Philadelphia, Pennsylvania; Phoenix, Arizona; and Washington, D.C., they have stated that reorganization has improved the overall timeliness of the processing of PGW veterans' claims. A review of the Work in Progress status lists from these regional offices indicates that there is an average pending time of 370 days for PGW veterans' claims. While this time frame remains unacceptable, it is an improvement over past performance by the VA adjudication division.

While there is marked improvement in the timeliness of the VA's decision making, there are still numerous difficulties facing the VA as to the accuracy of rating decisions and adequacy of compensation examinations. Examination results and medical assessments regarding veterans' complaints for undiagnosed illnesses are often vague or non-descriptive compared to the examination report of a diagnosed illness. Interpreting examination results becomes more difficult and time consuming because of the complexity brought on by not having a diagnosis and the need to evaluate specific symptoms and apply them to the VA Schedule for Rating Disabilities. Because of the complexity of these claims, many examinations are insufficient and must be returned for reexamination.

The DAV recognizes that the VA has made genuine efforts to address this problem. On February 6, 1998, in an effort to assist adjudicators in sifting through the cornucopia of symptoms, medical examinations, and other evidence of record, the VA Under Secretary for Benefits and Under Secretary for Health released new guidelines for disability examinations involving PGW veterans. In a joint memorandum, the Under Secretaries first identified the unique nature of PGW veterans' claims and most importantly lay the groundwork for more thorough and extensive compensation examinations. This memorandum was also the basis for additional training for both Veterans Health Administration (VHA) personnel and Veterans Benefits Administration (VBA) personnel on PGW disability examinations.

The joint memorandum also stressed the need for VHA and VBA personnel to take the initiative to pursue additional expert medical opinions to assist in determining the exact nature of a veteran's disability. The memo stated:

> An undiagnosed illness is established when findings are present that cannot be attributed to a known, clearly defined diagnosis, after all likely diagnostic possibilities for such abnormalities have been ruled out. Examiners...**will also need to request more laboratory tests and specialists' examinations than average in these cases.** (Emphasis added.)

Mr. Chairman, the DAV believes that the guidelines, if properly followed and diligently executed as set forth in the Under Secretaries' instructions, can result in substantial improvement in the examination process.

There is no doubt that the adjudication of PGW veterans' claims is complicated and made even more difficult by the increasing inability of rating board members to obtain and decipher the appropriate evidence needed to develop a veteran's claim for service connection. Many of our supervisory National Service Officers have told us that there is some confusion regarding the VA determination of a "Gulf War claim" and a "claim for undiagnosed illnesses." In many cases, a veteran who files a claim for service connection for an undiagnosed illness is granted service connection for a diagnosed condition based on the symptomatology suffered or analogous to the condition the symptomatology most closely resembles. Hence, the veteran's condition is no longer considered an undiagnosed illness. Service connection is denied because the veteran does not meet the criteria for an undiagnosed illness.

Under the current guidelines for rating claims for undiagnosed illnesses, if all issues cannot be granted under 38 U.S.C. § 1110 (direct casual basis), 38 U.S.C. § 1112 (presumptions), or 38 U.S.C. § 1153 (aggravation), then it is considered under Public Law 103-446 for undiagnosed illnesses. Under this current rating criteria, far too many PGW veterans are denied service connection and are left to suffer with their disabilities. These veterans fall through the cracks of the veterans' disability compensation system, because they have poor service medical records to document symptomatology while in service or were unable to support their claim with adequate post-service medical records within the one-year presumptive period for service connection, hence they cannot establish a claim for direct service connection.

Mr. Chairman, this is the main reason the DAV believes the subcommittee should carefully consider legislation such as H.R. 4036, introduced by Representative Christopher Shays (R-CT). This bill would amend title 38, United States Code, to establish presumptive exposure to certain hazardous chemical, biological and environmental toxins. The bill would then provide presumptive service connection for diseases and other maladies determined to be associated with these toxins for veterans who served in the Persian Gulf War.

H.R. 4036 would provide presumptive exposure to certain chemical toxins such as low-level mustard gas agents, red fluming nitric acid, solvents, hydrazine and uranium, several environmental pollutants such as hydrogen sulfide, oil fire byproducts, diesel heater fumes, sand micro-particles, and ionizing radiation such as depleted uranium, microwave radiation, and diseases endemic to the Persian Gulf region such as leishmaniasis, sandfly fever, pathogenic escherechia coli, chigellosis and malaria.

H.R. 4036 would give the Secretary of Veterans Affairs the authority to enter into contract with an appropriate medical scientific body to establish a panel which would review the medical and scientific literature to identify those diseases and illness epidemiologically, medically or scientifically associated with humans or animals to any of the presumptive hazardous toxins. Based on these findings, each disease or illness that becomes manifest in a PGW veteran would be presumed to be service connected.

While this bill would cut off the date defining service in the Persian Gulf War as of December 31, 1991, the DAV would advocate for the extension of this date through the end of the Persian Gulf War which is yet to be determined by the President. In light of continued discoveries of Iraq's chemical capabilities and use of chemical weapons, we must ensure that those members of our Armed Forces currently serving in the Persian Gulf theater are adequately cared for.

There are many uncertainties associated with PGW veterans' undiagnosed illnesses. H.R. 4036 would provide, with a reasonable degree of certainty, a viable resolution to the PGW veterans' compensation nightmare. H.R. 4036, or other similar legislation such as H.R. 3279 or S. 1320, would bridge the gap for those veterans who are suffering from either a diagnosed illness or an array of diagnosed and undiagnosed maladies associated with their service in the Persian Gulf theater and possibly associated with their exposure to an array of chemical, biological or environmental toxins.

This type of legislation would give veterans who served in the Persian Gulf theater the benefit of the doubt regarding their exposure to hazardous toxins. This is reminiscent of the horrifying dilemma suffered by Vietnam veterans who were exposed to the toxic defoliant Agent Orange. Many Vietnam veterans have succumbed to a wide variety of diseases and ailments which now, 25 to 30 years later, have been determined to have been caused by their exposure to Agent Orange.

The DAV has long mandated that PGW veterans should be compensated for illnesses circumstantially associated with their service in the Persian Gulf. Delegates to our last annual National Convention, held in Las Vegas, Nevada, August 17-21, 1997, passed DAV Resolution No. 214, calling for fair and just compensation for PGW veterans.

Mr. Chairman, your subcommittee must act quickly to correct the flaws in the adjudication of PGW veterans' claims. We believe that current pending legislation, such as H.R. 3279, H.R. 4036, and S. 1320 provides a solution to many of the problems PGW veterans are currently facing in the veterans' benefits system. Your kind attention to this legislation is greatly appreciated.

HEPATITIS C VIRUS

Hepatitis C virus (HCV) has only recently become visible as a significant blood borne infection. The Centers for Disease Control and Prevention (CDC), in Atlanta, Georgia, estimates that HCV affects over four million Americans—2% of the population—and causes liver disease, liver failure, and death. It is also reported to be the most widespread of the various forms of hepatitis, and for generations it plagued our Armed Forces serving in foreign theaters.

Unlike other forms of hepatitis, HCV rarely appears as an acute illness at the time of infection and often shows significant symptoms only after 10 to 20 years following infection. Due to the long latency period, many veterans who contracted this disease during the Vietnam War would only now be appearing with symptoms of the disease.

Veterans with HCV and related liver disease contracted during their military service are experiencing difficulty in establishing service connection. VA requires that a veteran demonstrate onset during service or within requisite presumptive periods with chronic residuals of a disease or injury that had its onset during active military service. Because this disease appears in acute form, most veterans do not exhibit chronic symptoms during military service or the requisite presumptive periods and thus their claims are routinely denied.

Prior to 1990, HCV had not been distinguished and diagnostic tests had not been developed. Even after tests were developed, the military does not include hepatitis C tests as part of the comprehensive discharge physical examination.

HCV attacks the liver and is the leading cause of liver transplants in the United States, according to the latest National Health and Nutrition Examination Survey. Also, according to the survey, about 85% of those infected develop chronic liver disease, which often leads to severe scarring of the liver and, eventually, liver failure and death.

HCV can be spread through contact with infected blood. It was not until 1992 that a reliable test was available to detect this tiny virus in blood transfusions or blood byproducts. The risk of contracting the infection from transfusion has dropped from one in every 100 pints of blood transfused in the late 1960s to one in 100,000 pints today. According to the CDC, the incidence of HCV has declined by over 80% since the 1980s because of the close testing and monitoring of blood.

End-stage liver disease due to HCV is the most common indication for liver transplantation in American veterans. In a study of 47 veterans who underwent transplant, 66% were infected with HCV genotype 1a, the predominant genotype. Type 1b was found in 25% of

the patients.[1] Interestingly, this distribution of genotype is more suggestive of the genotype distribution found in Southeast Asia, rather than in the United States where the numbers are basically reversed.

The VA must develop clear guidelines for HCV screening and treatment of veterans receiving health care. The guidelines should incorporate the most recent diagnostic tools and treatment advances.

Currently, all types of viral hepatitis are rated by the VA under diagnostic code (DC) 7345 (infectious hepatitis), from zero to 100%. The late complications of chronic HCV can be rated under DC 7345 or DC 7312 (cirrhosis of the liver), DC 7343 (malignant new growths) or, if liver transplantation is required, DC 7531, analogous to kidney transplantation based on the disabling symptoms.

The incidence of infections from HCV has risen dramatically over the last few years and is likely to place a significant burden on the VA health care system. The incidence of claims for compensation or pension based on HCV is unclear, but the potential for confusion and wrongful denial of these claims is great given the long period between contact with the disease and the development of chronic symptoms.

HCV infection is on the rise, and it is a major cause of liver failure. In fact, cirrhosis related to HCV has become the most predominant disease requiring liver transplants. VHA is planning a study that will examine a treatment called alpha-interferon to determine if it can prevent the development of liver failure in patients with HCV. Vietnam veterans, particularly those who were wounded and underwent blood transfusions and those who worked in the medical care field, are at risk and may be unaware of it. Unlike hepatitis A, from which a person can suffer flu-like symptoms, persons with HCV generally do not have recognizable symptoms, and approximately 85% of them are developing liver diseases such as cirrhosis and liver cancer.

The DAV has been made aware that clinical practice guidelines are being prepared for dissemination to VA health care providers, instructing them to ask questions about risk factors for HCV among patients. We ask that these guidelines for HCV screening and treatment include the most recent diagnostic and treatment advances.

We further ask that Congress allocate additional funding to the VA's medical care account in order to provide additional research as well as health care providers in addressing the issue.

CEREBRAL MALARIA

Studies have been conducted to explore the causal relationship between malaria and the onset of neuropsychiatric sequelae. These studies reportedly show that cerebral malaria survivors have multiple neuropsychiatric symptoms that are problematic years after the acute illness occurred. Additionally, the study raises the issue of a link between cerebral malaria and the development of epileptiform symptoms or frank seizures.

In 1980, the American Psychiatric Association added Post Traumatic Stress Disorder (PTSD) to the third edition of its Diagnostic and Statistical Manual of Mental Disorders (DSM-III). Although a controversial diagnosis when first introduced, PTSD has filled an important gap in psychiatric theory and practice. From an historical perspective, the significant change ushered in by the PTSD concept was the stipulation that the etiological agent was outside the individual. In other words, the traumatic event, rather than an inherent individual weakness, caused a traumatic neurosis. The key to understanding the scientific basis and clinical expression of PTSD is the concept of "trauma."

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[1] Gayowski, T., Singh, N., Marino, I.R., Vargus, H., Wagner, M., Wannstedt, C., Morelli, F., Laskus, T., Fung, J.J., Rakela, J., Starzel, T.E. Hepatitis C Virus Genotypes in Liver Transplant Recipients: Impact on Posttransplant Recurrence, Infections, Response to Interferon-Alpha Therapy and Outcome. *Transplantation*, 1997; 64(3): 422-6.

In its initial DSM-III formulation, a traumatic event was conceptualized as a catastrophic stressor that was outside the range of usual human experience. The framers of the original PTSD diagnosis had in mind events such as war, torture, rape, the Nazi Holocaust, the atomic bombings of Hiroshima and Nagasaki, natural disasters (earthquakes, hurricanes, and volcanic eruptions), and other disasters (such as factory explosions, airplane crashes, and automobile accidents). They considered traumatic events as clearly different from the very painful stressors that constitute the normal unpredictable changes of life such as divorce, failure, rejection, serious illness, financial reverses and the like. By this logic, adverse psychological responses to such "ordinary stressors" would, in DSM-III terms, be characterized as Adjustment Disorders, rather than PTSD. This distinction between traumatic and other stressors was based on the assumption that although most individuals have the ability to cope with ordinary stress, their adaptive capacities are likely to be overwhelmed when confronted by a traumatic stressor.

PTSD is unique among other psychiatric diagnoses because of the great importance placed upon the etiological agent, the traumatic stressor. In fact, one cannot make a PTSD diagnosis unless the patient has actually met the "stressor criterion," meaning that he or she has been exposed to an historical event that is considered traumatic. Clinical experience with the PTSD diagnosis has shown, however, that there are individual differences regarding the capacity to cope with catastrophic stress so that, while some people exposed to traumatic events do not develop PTSD, others go on to develop the full-blown syndrome. Such observations have prompted a recognition that trauma, like pain, is not an external phenomenon that can be completely objectified. Like pain, the traumatic experience is filtered through cognitive and emotional processes before it can be appraised as an extreme threat. Because of individual differences in this appraisal process, different people appear to have different trauma thresholds, some more protected and some more vulnerable to developing clinical symptoms after exposure to extremely stressful situations. Although there is a renewed interest in subjective aspects of traumatic exposure, it must be emphasized that exposure to events such as rape, torture, genocide, and severe war zone stress, are experienced as traumatic events by nearly everyone.

Although recent studies show the onset of psychiatric symptoms in combat veterans, we support the identification of veterans who have suffered febrile illness during the medical history portion of health care assessment. By obtaining a complete medical history, to include past febrile illness, health care providers will be able to develop a treatment plan through the use of appropriate pharmacological agents (antiepileptic medication), rather than relying solely on psychotropic medications.

Additionally, we ask that further studies be undertaken in order to provide linkage between the onset of malaria and the subsequent development of neuropsychiatric sequelae. We believe that further research should be explored with veterans not exposed to catastrophic events and with a history of cerebral malaria. These studies should determine whether the onset of malaria alone causes neuropsychiatric sequelae.

Mr. Chairman, that ends my written testimony. I would be happy to answer any questions.

Non Commissioned Officers Association of the United States of America

225 N. Washington Street • Alexandria, Virginia 22314 • Telephone (703) 549-0311

STATEMENT OF

LARRY D. RHEA
DEPUTY DIRECTOR OF LEGISLATIVE AFFAIRS

BEFORE THE

SUBCOMMITTEE ON BENEFITS

COMMITTEE ON VETERANS AFFAIRS

U. S. HOUSE OF REPRESENTATIVES

ON

OVERSIGHT FOR ADJUDICATING

PERSIAN GULF VETERANS'

DISABILITY CLAIMS

JULY 16, 1998

Chartered by the United States Congress

Good morning Mr. Chairman, Mr. Filner and Distinguished Members of the Subcommittee. The Non Commissioned Officers Association of the USA (NCOA) welcomes this opportunity to appear and present to the Subcommittee the Association's thoughts on veterans claims processing, specifically for veterans claims relating to Persian Gulf War illnesses. Since the topic of today's hearing ranks in such importance with Association members, NCOA congratulates the distinguished Chairman for holding this hearing.

It has been about one year since the last hearing on the processing of Persian Gulf claims was held. At that time, the processing of claims for Persian Gulf War veterans was fraught with inefficiencies and errors. At that time also, VA was in the midst of decentralizing the processing of these claims because of the dismal result of centralized processing. In view of these factors, NCOA considers today's hearing most suitable and particularly timely. The Association is hopeful that our comments will prove useful to the Subcommittee as you review the important area of claims processing for Persian Gulf War illnesses.

Processing of Persian Gulf Claims

NCOA's volume of activity in assisting veterans' with processing their claims for Persian Gulf War illnesses has not been dramatic. Our modest level of activity in this area is attributable to the fact that many of NCOA's members are still serving on active duty in the Armed Forces. In this regard, the Subcommittee needs to know that many members still on active duty are reporting and receiving treatment for conditions and symptoms identical to those that other veterans have reported to VA under the general classification of Persian Gulf Syndrome.

The Subcommittee should also be made aware of the reluctance, on the part of an active duty member, to attach any potential link between their medical conditions and their service in the Persian Gulf Theatre, despite the DOD's urgings for these members to voluntarily identify themselves. That reluctance, among these veterans who are still on active duty Mr. Chairman, stems from the belief that an association of their medical conditions to Persian Gulf Syndrome will result in their discharge or release from active duty. It is NCOA's impression that this reluctance is particularly great among those

members aspiring to career military service. While NCOA does not have any evidence that suggests active duty members identified as having Persian Gulf Syndrome are being prematurely separated from active service, the Association is nonetheless concerned because these veterans will rely on VA to fairly and expeditiously adjudicate their claims at some future point. Also, while NCOA does not have any recommendations on this situation to offer to the Subcommittee, the Association believes it is important to make the Distinguished Members aware of the situation and its potential adverse implications for these future veterans.

At this point in the Association's testimony, NCOA believes a word of thanks is in order to this Subcommittee, indeed the entire Congress, for the attention and concern that has been shown for Persian Gulf Veterans. NCOA knows of no one who would express complete satisfaction with what is known at this point, there are still too many unanswered questions. But it is appropriate that NCOA salute all of you for the attention you have given to these veterans and their conditions. You have done and are continuing to do the right things, particularly in the areas of research, presumptive findings for compensation, priority for health care for these veterans and in holding DOD and VA accountable. The Association is equally grateful for the priority and attention you have demanded in the processing of disability claims for Persian Gulf veterans. Without the Subcommittee's aggressive oversight in all of these areas, NCOA shutters to think of where we would probably be today. The Association is sincerely appreciative for what you have done and for that, which we believe, you will continue to do.

Overall, NCOA is pleased with the progress that has been made during the past year in the processing of disability claims for Persian Gulf veterans. It is our impression that VA has made a concerted effort to inform veterans and service organizations on what is needed to ensure proper development of a claim. Certainly, the confusion that existed in claims development last year seems to have settled down and VA communications with veterans and VSO's has improved considerably. The comprehensive guidance, that NCOA suggested was needed as a part of VA outreach, was promulgated by VA and made

available to veterans and VSO's. That alone has helped to clear up much of the confusion and lack-of-information that hampered veterans and service organizations in the past.

NCOA is aware of a few cases wherein the veteran claimant believes his or her claim was not adjudicated properly or that the rating assigned was lower than what the veteran believed the claim deserved. The Association, however, has no evidence to suggest that complaints of this nature are any more or less frequent among Persian Gulf veterans than the general veteran population. Nonetheless, these few complaints illustrate a persistent concern that NCOA has with claims processing for all veterans. That concern, Mr. Chairman, is accuracy and getting the job done right the first time.

This Association has never agreed with VA's stated goal of a 92% accuracy rate for claims. If you are a veteran who is among the 92% fortunate enough to have a claim adjudicated properly, then VA's goal is probably OK. If, however, you are one of the veterans comprising the other 8%, NCOA believes your outlook would be quite different. If 92% accuracy is the goal, it does not speak well of where we are today nor does it speak well of where we're going in the future. An error rate of nearly one in every ten claims is unacceptable to this Association. The goal must be accuracy at every level, on every action, by every employee and to get it done right the first time. The path to achieve that goal is simple in NCOA's view – its called accountability.

Effectiveness of the claims process is more though than just the criteria to determine accuracy in the adjudication process. Effectiveness of the claims process for Persian Gulf Veterans, indeed all veterans, includes other factors such as remands, appeals and the number of physical examinations required to support a case. Satisfaction of veterans is also a factor and this includes promptness in the decision and an explanation of the decision in terms that the veteran can understand and accept as fair and impartial, regardless of whether the claim is approved or denied. In this regard, NCOA believes there is ample room for improvement, not just for veterans presenting claims for Persian Gulf illnesses but for all veteran claimants.

Much of what NCOA is experiencing now with Persian Gulf claims is not necessarily unique to those particular claims. What this Association is now seeing on Persian Gulf claims is the same systemic VA problem that has existed for many years. The only difference is that the public spotlight is shining directly on Persian Gulf veterans. NCOA is still waiting for "accountability" to be brought to the entire claims process and at all levels of VA within that process. While the Association is encouraged by the progress that has been made in the past year, the "lack of accountability" problem is still with us.

Veterans and Hepatitis C

Probably like most other veteran service organizations, NCOA has only recently come to fully appreciate the extent of the threat to the public health, in particular to veterans, that hepatitis C represents. As you are aware, hepatitis C is a blood-borne virus that can lead to liver disease and death. Studies of veterans in VA hospitals estimate that as many as one in five veterans may be infected with the hepatitis C virus. Onset of the virus may take 10 to 20 years and, absent active symptoms, it is impossible to diagnose the infection without a blood test.

Although the hepatitis C virus was isolated only recently, the scientific community now seems to agree that it has existed in the blood supply for a long time. Consequently, some veterans could have been exposed to the virus through transfusions, blood contact, and needle-sticks during military service. Immunizations administered by the production line "air gun" could have transmitted the disease. As a result, some veterans who possibly contracted the disease during their military service are just now starting to experience symptoms of hepatitis C and liver disease.

As the Subcommittee knows, this situation now presents a complex problem for veterans because there is no way for a veteran to establish connection between the disease and their military service. Twenty years ago, hepatitis C was not distinguished from other forms of hepatitis and therefore could not be diagnosed and documented in the veterans medical records. But today we know that veterans as a group suffer one of the highest infection rates.

NCOA is not prepared, however, to suggest that a presumptive finding be enacted for service-connection for veterans with hepatitis C. The Association does believe though that more research is needed and that VA should embark on an aggressive testing program for all veterans. With additional research and the accumulation of scientific data, NCOA believes VA would be in a better position to provide guidance and procedures on adjudicating claims for hepatitis C service-connection.

Conclusion

In closing Mr. Chairman, NCOA again salutes the Subcommittee for the care and concern you have shown to Persian Gulf veterans. The Association believes you have pursued the proper course and we urge you to remain steady on that course as answers to the perplexing questions are sought. NCOA asks that the Subcommittee continue to support aggressive research efforts, outreach and medical care and disability compensation for these veterans. As the Association has maintained from the onset, NCOA believes that reliable scientific research and evidence must dictate the final outcome on the myriad of questions on Persian Gulf illnesses. In the meantime and as you have done, we should continue to give the "benefit of the doubt" to the veteran. NCOA believes if the Subcommittee continues to focus on the systemic problems in claims processing overall, we will then simultaneously solve any lingering problems for veterans presenting Persian Gulf claims. In the end, we will have better served all veterans.

Thank you.

DISCLOSURE OF FEDERAL GRANTS OR CONTRACTS

The Non Commissioned Officers Association of the USA (NCOA) does not currently receive, nor has the Association ever received, any federal money for grants or contracts. All of the Association's activities and services are accomplished completely free of any federal funding.

Statement of

Leonard B. Seeff, M.D.

Senior Scientist for Hepatitis C Research

National Institutes of Diabetes, Digestive, and Kidney Diseases

National Institutes of Health

and

Former Chief, Gastroenterology & Hepatology

Veterans Affairs Medical Center, Washington, D.C.

for House Committee on Veterans' Affairs

Subcommittee on Benefits

July 16, 1998

Mr. Chairman and Members of the Subcommittee,

I am honored to be invited to appear before this committee to comment on the issue of hepatitis C as it affects veterans who are cared for in Veterans Affairs Medical Centers. I regret deeply that I was unable to appear in person, and I proffer my sincerest apologies. As you may be aware, the Centers for Disease Control and Prevention (CDC) is holding a meeting in Atlanta, Georgia on July 15-18,1988, to discuss the issue of hepatitis C virus infection. The aim of this meeting is to develop updated guidelines and recommendations for the identification, counseling, testing, and referral of persons at risk for hepatitis C virus infection. I have been asked to attend the meeting as one of the consultants and to address the issue for the panel of the natural history of the infection. I

believe that the information that derives from the CDC meeting will have much relevance to the future deliberations of this Subcommittee.

The request to me from this Subcommittee, I believe, was to address the issue of hepatitis C in general terms and, in particular, to review the problem as it affects veterans attending VA facilities. Let me begin then with a very short and general overview of the topic.

As you are aware, hepatitis C virus infection has been recognized recently as a common and potentially serious medical problem that is responsible for a major proportion of liver disease-related morbidity and mortality in the United States. Although identified as early as 1974 as transfusion-associated non-A, non-B hepatitis, it was only after discovery of the actual hepatitis C virus in late 1989, permitting the development of specific diagnostic tests which reached a high level of sensitivity by 1992, that the true extent of the problem began to emerge. In fact, these tests were essential to the recognition of the true magnitude of the infection because the vast majority of acutely infected persons - as many as 85% to 90% - are unaware that they have been infected. Indeed, both acute and chronic hepatitis C are characterized by a paucity of symptoms and hence infected persons are most commonly identified for the first time only when they are tested at the time that they donate blood for transfusion purposes, when they undergo a routine physical examination for insurance or employment purposes, or when they are being evaluated for other medical conditions.

The major concern regarding hepatitis C, as you are aware, is that almost all persons who develop the infection remain infected (the current evidence is that chronic infection evolves in about 80-85% of those who develop acute hepatitis), that the infection persists for life in almost all such persons, and that the persisting virus infection sets the stage for progression to cirrhosis and, occasionally, to liver cancer. The currently held view is that cirrhosis will develop in about 20% of chronically-infected individuals, and liver cancer in about 1%. Since liver cancer related to hepatitis C virus infection almost never occurs in the absence of cirrhosis, outcomes have been examined specifically in persons who have compensated or stable hepatitis C-related cirrhosis. Such studies suggest that the risk of development of liver cancer in this subgroup is about 1-5% per year. If one now adds to these statistics the emerging evidence that hepatitis C virus infection appears to be a very common problem (4 million people in this country are believed to be infected), that many formerly undefinable causes for cirrhosis and liver cancer can now be attributed to hepatitis C virus infection, and that this infection is currently the most common basis for liver transplantation, it is easy to see why there is presently such great distress regarding this infection. Indeed, it is these issues that have been, and continue to be, blazoned in the popular press, not always appropriately, in my opinion, and that has helped to raise the level of anxiety about hepatitis C.

There is no question that chronic infection with the hepatitis C virus is a potentially serious, uncomfortable, and life-threatening problem. But the news about the disease is not necessarily all bad. One of the most difficult issues facing researchers is how to determine the frequency of progressive liver disease among those infected. This

is not a simple task. The problems are that disease onset remains undefined in most instances because of lack of symptoms, that symptoms are generally absent also during most of the course of the chronic infection, and that serious end-stage liver disease, should it occur, usually emerges 20 to 30 years after the initial infection. Therefore, much of the information derives from studying persons with already clearly-established chronic liver disease, which tends to bias interpretation since infected persons without symptoms may not be identified and included in such analyses. Only through long-term studies that begin at the time of onset or early in the course of the infection is it possible to accurately determine the frequency and rate of progression to severe liver disease. I can state that in a couple of such studies that I have conducted together with a large number of colleagues, as well as in studies reported by others, it would appear that progressive disease is far from inevitable. Indeed, results of these studies indicate that close to 80% of persons initially infected have a relatively benign course, at least over a period of 25 years, with minimal liver disease-related morbidity and mortality. The remaining approximately 20%, predominantly those with clear-cut cirrhosis, do have a potentially serious medical problem. The total number who fall into this last category will depend, of course, on the total size of the infected population – the larger the number of infected persons, the larger the number of persons with serious liver-related illness. Based on the current CDC data that 4 million persons in this country are infected, one can anticipate that three-quarter to one million persons are at risk of developing serious chronic liver disease because of hepatitis C virus infection. More research is needed to confirm these data, to define why only a limited number of infected persons have progressive disease, and to establish means of accurately determining early in the course

of the infection who is destined to develop serious disease. One item that is believed to play an important role in enhancing progressive liver disease is chronic alcoholism, but other factors that could have an additive or permissive effect also need to be sought.

Another positive note is the fact that treatment of the chronic infection which, until now, has been only modestly successful, at best, is beginning to show real improvement. Unfortunately, treatment outcomes are still far from ideal, and much more research in this area is needed and, indeed, is in progress.

Now, with that somewhat abbreviated preliminary overview, what is known about the issue among veterans who attend Veterans Affairs Medical Centers? Based on the knowledge of risk factors for acquisition and progression of hepatitis C virus infection, it might be anticipated that the problem should be relatively common among such individuals. Certainly, previous studies have identified large outbreaks of hepatitis B virus infection among military personnel, attributable to parenteral drug abuse. The most important risk factors for HCV transmission include blood transfusions prior to 1992, parenteral drug abuse, the recently recognized item of snorting of cocaine and, perhaps, but far from proven, tattooing and body piercing. Such risk factors would seem to be more common among veteran than non-veteran groups, a higher rate of transfusions being anticipated particularly among those who go into combat. Other risk factors, such as the controversial one of sexual transmission, also are relevant although it is unclear, at least to me, whether promiscuity (believed to be the salient feature), is any greater among veterans than among non-veterans. A surrogate item identified by CDC investigators is

the fact of belonging to lower socioeconomic groups, currently the bulk of veterans attending VA facilities. Added to the potentially greater likelihood of acquisition of the virus is the fact that chronic alcoholism remains an important and common concern among veteran patients and hence, there may also be a greater likelihood of progressive chronic liver disease among veteran patients. Clearly, the issue of chronic liver disease in the VA is one that will continue to require careful surveillance and appropriate attention.

Now what about the frequency of HCV infection among VA medical center patients? Routine screening for HCV has not, to my knowledge, been undertaken in VA Medical Centers, no more than it has among non-VA medical institutions. That HCV infection is common in the VA setting seems unquestioned. In my liver clinic, as seems to be the case in virtually all other liver clinics, both VA and non-VA located, patients with hepatitis C represent by far the bulk of patients seen. I would estimate that fully 80% of persons that attend the Liver Clinic at the VA Medical Center in Washington DC are there for evaluation because of the problem of hepatitis C. I am not aware of any large-scale, multicenter studies that have been undertaken in VA Medical Centers. Dr. Gary Roselle and others, from the VA Medical Center in Cincinnati, conducted a four-year survey between 1991 and 1994 of all VA Medical Center laboratories that do HCV screening to determine the rates of positive results over these time periods. A dramatic increase was noted each year, the increase being more than 285% over the entire 4-year period, occurring in all geographic regions, while the increase in the total number of patients seen was just 4.9%. Impressive though these data are, they cannot inform

accurately as to whether the actual number of infected cases increased. The likelihood is that over this time period, there was greater awareness of the problem, prompting increasing requests by house staff for hepatitis serologic testing. Furthermore, test procedures were changing during this period and the data did not take into account the important issue, at that time, of false-positive results.

The only large, population-based screening study in the VA of which I am aware is one that was conducted at my VA Medical Center here in Washington, DC over a 6-week period at the beginning of 1994. The intent of our study was to screen 1,000 consecutive patients who were admitted to the facility, regardless of which section they entered, for the presence of hepatitis B and hepatitis C markers. We accomplished our aim in 839 patients and were astonished to find that, whereas 3% were infected with hepatitis B, 21% had markers of hepatitis C virus infection. Half of these individuals had normal liver function. The frequency was significantly higher in African-American than white patients, and risk factors that correlated with a positive result include illicit drug use (injection and snorting), multiple sexual partners, and a history of sexually-transmitted disease. Strikingly, over 90% were not aware of their positive status and about the same percentage had never had a known bout of acute hepatitis. When we later studied the positive group for the viral genotypes in order to determine whether those who belonged to the Vietnam era had the genotype characteristic for that country, we found that, in fact, they all bore the genotype seen in the American-based infection.

Although we were surprised by these results, we noted that they were similar to those of a screening study that had been performed a little earlier among persons seen in the emergency room at Johns Hopkins University, in which a prevalence figure of 18.5% was noted. The populations studied in these two screening surveys both derived from the "inner city" and both identified parenteral drug abuse as the apparently most common risk factor. Similar data, I believe, have been noted at the VA Medical Center in San Francisco as may be mentioned to you by Dr. Theresa Wright in her testimony before you. Obviously, these results cannot be applied to other VA Medical Centers that have not conducted similar surveys, particularly facilities located in more rural areas. Aditional surveys are therefore needed, and indeed are in process or are being planned. Dr. Wright has received funds, I believe, to conduct a large survey at her institution. She will probably inform you of this. In collaboration with investigators from the Department of Defense, I am planning to conduct a survey, with approval, of patients attending several geographically diverse VA facilities in order to obtain broader-based information. Finally, the recently submitted letter by Dr. Kizer to all VA institutions requiring that all attending veterans who fit specifically-defined risk categories be screened for hepatitis C will provide vast and critically-needed information on the VA-wide prevalence of HCV infection, and will permit categorization according to the period of military service.

I am not aware of any specific data relating HCV prevalence according to time of service, in particular, among Vietnam era veterans. Using age as a surrogate for time of service, there appears to be a higher frequency of hepatitis C positivity in the age group that would coincide with the Vietnam era veteran in some studies, including the one

conducted at our Medical Center. However, in comparing these data with those of the general population, as described in the NHANES III survey by CDC investigators, there appears to be little difference between veterans and non-veterans in this regard. These data can possibly be interpreted as indicating that parenteral drug use flourished in the 1960's and 1970's among all segments of society.

I sincerely hope that I have responded appropriately and informatively to the questions posed by the staff of the Subcommittee. Hepatitis C infection is clearly a problem for the Nation as well as for veterans at Veterans Affairs Medical Centers. I am most pleased that the issue is being considered of importance and that efforts to respond to the problem are underway. It is clear that more research is needed both to identify the true scope of the problem, to devise ways to prevent the infection and to curb progression once infection has occurred, to learn about factors that promote disease progression, to understand the mechanisms involved in viral retention and disease production, and to improve markedly the treatment armamenterium. Equally important is the need to educate both patients and physicians about this viral infection, and to embark on a campaign to limit the intense anxiety that is presently being engendered about this infection without denying or underplaying its potentially serious manifestations and consequences.

Thank you for listening to my comments.

WRITTEN TESTIMONY OF
Dr. Garth L. Nicolson
COMMITTEE ON VETERANS' AFFAIRS
Subcommittee on Benefits
UNITED STATES HOUSE OF REPRESENTATIVES
July 16, 1998

Dr. Garth Nicolson is currently the Chief Scientific Officer and Research Professor at the Institute for Molecular Medicine in Huntington Beach, California. He was formally the David Bruton Jr. Chair in Cancer Research and Professor at the University of Texas M. D. Anderson Cancer Center in Houston, and Professor of Internal Medicine and Professor of Pathology and Laboratory Medicine at the University of Texas Medical School at Houston. He was also Adjunct Professor of Comparative Medicine at Texas A & M University. Among the most cited scientists in the world, having published over 475 medical and scientific papers, edited 13 books, served on the Editorial Boards of 12 medical and scientific journals and currently serving as Editor of two (*Clinical & Experimental Metastasis* and the *Journal of Cellular Biochemistry*), Professor Nicolson has active peer-reviewed research grants from the U.S. Army, National Cancer Institute, National Institutes of Health, American Cancer Society and the National Foundation for Cancer Research. In 1998 he received the Stephen Paget Award from the Cancer Metastasis Research Society and the Albert Schweitzer Award in Lisbon, Portugal.

We have been engaged in studying Gulf War Illnesses (GWI) since 1993 as researchers but also as a family that has suffered from GWI. Our step-daughter returned from service in Desert Storm in 1991 as a Crew Chief of a Blackhawk helicopter in the US Army's 101st Airborne Division (Air Assault) and developed the unusual, multiple signs and symptoms of GWI that prevented her from finishing pilot training. Much of our information on the problems within the VA benefits system has come from this source as well as others. Our entire family has suffered from GWI, but this is not unusual for Desert Storm veterans' families as will be discussed below.

The most troubling problems that veterans of Desert Storm face in trying to find adequate care for their illnesses are obtaining appropriate diagnoses and then adequate treatments for their conditions. Most of the emphasis in diagnosing and treating GWI within the military and VA has been on stress-related conditions, such as Post Traumatic Stress Disorder (PTSD) [1]. Since many patients do not fit this category, but cannot be diagnosed within existing ICD-9-coded diagnosis categories, they usually receive an 'unknown illness' diagnosis. This, unfortunately, results in their receiving reduced disability assessments and reduced benefits. It's not that they are any less sick than their compatriots who have ICD-9 diagnoses used by the VA, they just don't fit within the military's or VA's diagnosis systems.

Gulf War Illnesses (GWI) present as complex, multi-organ chronic signs and symptoms that overlap with other chronic illnesses like Chronic Fatigue Syndrome (CFS), Fibromyalgia Syndrome (FMS) and Multiple Chemical Sensitivity Syndrome (MCS). These include chronic fatigue, headaches, memory loss, muscle pain, nausea, gastrointestinal problems, joint pain, lymph node pain, memory loss, chemical sensitivities and other signs and symptoms [2-4]. Often included in this complex clinical picture are increased sensitivities to various environmental agents and enhanced allergic responses. Although these syndromes have been known for several years, until recently most patients with CFS, FMS and GWI have had few options for obtaining effective treatments. This may have been due to the imprecise nature of their diagnoses, which are usually based on clinical observations rather than laboratory tests. Unfortunately, within the VA system medical treatments appear to be more easily administered on the basis of laboratory tests than on clinical observations, and the lack of clear-cut laboratory results in GWI cases tends to lend support for psychological or psychiatric diagnoses for complex chronic illness like GWI.

Since the signs and symptoms of FMS and CFS overlap with those found in GWI, we suggested that these are not a separate syndromes, they are all CFS-like disorders [3]. In the case of GWI, over 100,000 veterans of the Persian Gulf War in 1991, not including immediate family members, have been found to have this disorder. According to one government study, GWI has spread to family members

[5], and it is likely that it has also spread in the workplace. The fact that many immediate family members have also presented with similar signs and symptoms indicates that diagnoses biased on PTSD may be a gross oversimplification of GWI [9]. The variable incubation time of GWI, ranging from months to years after presumed exposure, the cyclic nature of the relapsing fevers and other signs and symptoms, and the types of signs and symptoms are consistent with diseases caused by combinations of biological and/or chemical or radiological agent(s) (Figure 1) [8-10]. Although this US Senate committee study was incomplete, investigators found after surveying approximately 1,200 GWI families that 77% of spouses and a majority of children born after the war had the signs and symptoms of GWI [5]. Although the official position of Department of Defense is that family members have not contracted GWI, this US Senate study indicates that at least a subset of GWI patients have a transmittable illness. We can lend our support to the Senate study, as we have found GWI in Desert Storm veterans' family members. In fact, clinical tests reveal that GWI family members have the same chronic infections as the veterans.

Relationship of Stress to Chronic Illnesses, Including GWI, CFS and FMS

Patients with CFS, FMS and GWI often have cognitive problems, such as short term memory loss, problems concentrating and other psychological problems. In fact, psychologists or psychiatrists who examine CFS, FMS or GWI patients usually find psychological or psychiatric problems in these patients and decide in the absence of contrary laboratory findings that these conditions are somatoform disorders. That means that these practitioners decide that the illnesses are caused solely or predominantly by psychological or psychiatric problems, not organic or medical problems that can be treated with medicines or treatments that are not specific for the Central Nervous System. Stress is often mentioned as an important factor or *the* important factor in these disorders. As mentioned above, GWI patients are often diagnosed with Post Traumatic Stress Disorder (PTSD) in VA and military hospitals. The evidence that physicians have offered as proof that stress or PTSD is the source of most GWI sickness is the assumption that most veterans must have suffered from stress by virtue of the stressful environment in which they found themselves during the Gulf War [6]. In fact, most veterans themselves do not feel that stress-related diagnoses are an accurate portrayal of their illnesses. Testimony to the US House of Representatives Committee on Government Reform and Oversight studying the origins of GWI refutes the notion that stress is the major cause of GWI [6]. The General Accounting Office (GAO) after studying government and civilian data on the subject concluded that while stress can induce some physical illness, the statement that stress is the causes of GWI has not been established [7].

Of course, stress can exacerbate chronic illnesses and suppress immune systems. But most military personnel that we interviewed, including highly disciplined US Special Forces and Navy SEALS, indicated that the Gulf War was not a particularly stressful war, and they strongly disagreed that stress was the origin of their illnesses [8]. However, in the absence of physical or laboratory tests that can identify possible origins of GWI or FMS and CFS, many military and VA physicians accept that stress is the cause of these chronic illnesses. It was only recently that other causes have been seriously considered, including chemical and biological exposures (Figure 1).

Chronic Illnesses Caused by Environmental (Chemical/Biological) Exposures

We have assumed that chemical and biological exposures occurred during the Gulf War, and many civilian patients may have also been exposed to chemical and biological substances that could be the underlying cause of their illnesses [9]. The complex signs and symptoms found in CFS, FMS and GWI, the variable incubation time, ranging from months to years after presumed exposure, the cyclic nature of the relapsing fevers and other signs and symptoms, and the types of signs and symptoms are consistent with diseases caused by combinations of biological and/or chemical or radiological agent(s) (Figure 1) [7-10]. In at least some of the GWI may be due to system-wide or systemic chronic infections and/or chemical insults that can penetrate various tissues and organs, including the Central and Peripheral Nervous Systems [9, 10]. When such infections occur, they can cause the complex signs and symptoms seen in CFS, FMS and GWI, including immune dysfunction. Changes in environmental responses as well as increased titers to various endogenous viruses that are commonly found to be expressed in these patients have been seen in CFS, FMS and GWI. If infectious agents are involved, few can produce the complex chronic signs and symptoms found in CFS, FMS and GWI patients. One type of airborne

infection that has received renewed interest of late as an important element in these disorders is represented by the class Mollicutes [11]. These microorganisms, principally mycoplasmas and other rather primitive bacteria, although not well known agents in causing disease, are now considered important emerging pathogens in causing chronic diseases and may also be important cofactors in some illnesses, including AIDS [11].

Interestingly, as chronic illnesses such as GWI (and in some cases CFS and FMS) progress, there are a number of accompanying clinical problems, particularly autoimmune problems. These include in some patients the signs and symptoms of Multiple Sclerosis (MS), Amyotrophic Lateral Sclerosis (ALS or Lew Gehrig's Disease), Lupus, Graves' Disease, Arthritis and other complex autoimmune diseases. Such usually rare autoimmune responses are consistent with certain chronic infections, such as mycoplasmal infections that penetrate into nerve cells, synovial cells and other cell types. It is proposed that these autoimmune signs and symptoms are caused when intracellular pathogens, such as mycoplasmas, escape from cellular compartments and stimulate the host's immune system. Microorganisms like mycoplasmas can incorporate into their own structures pieces of host cell membranes that contain important host membrane antigens that can trigger autoimmune responses or their surface antigens may be similar to normal cell surface antigens. Thus patients with such infections may be responding to microorganism antigens as well as their own membrane antigens, producing unusual autoimmune signs and symptoms in the organs where the infectious agents are located.

Microorganisms as Important Agents or Cofactors in CFS, FMS and GWI

Most microorganisms like mycoplasmas are not considered as important human pathogens, but some species, such as *M. fermentans, M. penetrans, M. pneumoniae, M. genitalium, M. pirum* and *M. hominis*, among others, have been closely associated with various human diseases [11]. Do these agents cause CFS, FMS or GWI? Not necessarily on their own, but they appear to be important in causing the major signs and symptoms or the morbidity seen in patients with chronic illnesses [12]. If such microorganisms can cause chronic illnesses, is there any evidence for mycoplasmal infections in CFS, FMS or GWI patients? In a majority of FMS, CFS and GWI patients examined we and others, principally Dr. Daryl See of the University of California College of Medicine, Irvine, are finding strong evidence for mycoplasmal blood infections that can explain much if not most of their chronic signs and symptoms [13]. In our studies on GWI, we have found mycoplasmal infections in the blood of about one-half of patients (91/200), and these patients were found to have predominantly one infectious species of mycoplasma, *M. fermentans* [14, 15]. Moreover, in over one-half of the 150 civilians with CFS, FMS or arthritis that we have examined we are finding a variety of pathogenic mycoplasma species, such as those listed above, in their white blood cell fractions [13]. The tests that we use to identify mycoplasmal infections, polymerase chain reaction and nucleoprotein gene tracking [14, 15], are very sensitive and highly specific for mycoplasmas. These tests are a dramatic improvement over the relatively insensitive serum antibody tests that are currently used to assay for systemic mycoplasmal infections. We recently received a Department of Defense contract to train scientists and physicians to perform these tests, including the training of staff from the Armed Forces Institute of Pathology and Walter Reed Army Medical Center in Washington DC.

Possible Origins of GWI, CFS and FMS

Our hypothesis (Figure 1) is that most GWI is not caused by stress, although it can be exacerbated by stress. It is primarily caused by multiple exposures to environmental, chemical, radiological and/or biological agents that cause chronic multisystem signs and symptoms that for the most part can be diagnosed as existing diseases [2, 3, 10]. We have been particularly interested in veterans with GWI whose family members are now also sick with similar signs and symptoms, suggesting that many GWI patients owe their illness due to biological not solely chemical or radiological exposures. Illnesses caused by chemical or radiological exposures should not be transmitted to family members. Unfortunately, GWI in immediate family members is still officially being denied by the DoD and Veterans' Affairs (DVA). Although some family members could have developed their illnesses by contact with war souvenirs, packs or uniforms, only biological causes of GWI can account for the overwhelming fraction of family members contracting the same illness in this important subset of GWI

patients. Our research into GWI and the laboratory tests for GWI-associated pathogens that we developedwere done completely without compensation or funding from the US Government. Since the Institute for Molecular Medicine is a nonprofit private research institute dedicated to discovering new diagnostic and therapeutic solutions for chronic human diseases, we do not charge veterans or their family members for our assistance and services. We do, however, solicit donations for our services. We are also assisting Desert Storm veterans from other Coalition countries that have GWI casualties.

The DoD previously claimed from their clinical evaluation program that Gulf War veterans do not show higher rates of health problems than the US population as a whole. They failed to mention, however, that all personnel that served in the Gulf received health clearances before they were deployed, and yet many returned with illnesses or later developed illnesses that cannot be explained. Four National Guard and Air Force Reserve units were studied by the Center for Disease Control (CDC) in Atlanta for evidence of chronic health problems associated with deployment to the Persian Gulf, and it is clear from this CDC study that the Persian Gulf deployed soldiers have much higher frequencies (from 2.5-times to 13.5-times higher) of chronic health problems (> 6 months duration) than those who were not deployed to the Persian Gulf Theater of Operations [16].

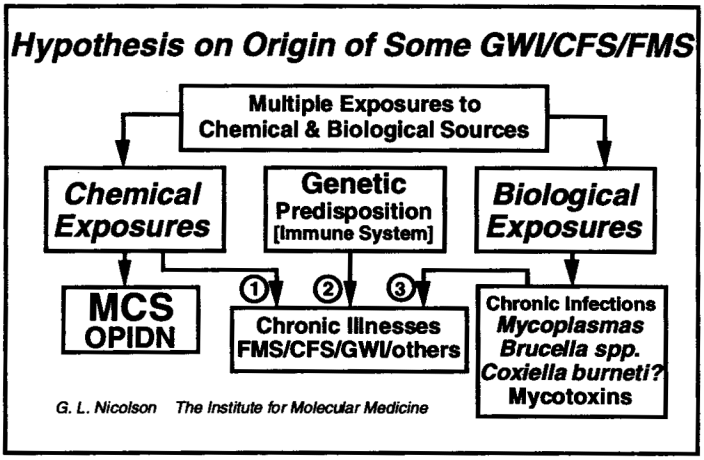

Figure 1. Multiple exposures (chemical, radiological, biological) or multifactorial causes may have resulted in GWI in susceptible individuals (modified from reference 9).

The Responses of the DoD and DVA to GWI

In response to our published studies and formal lectures at the DoD (in 1994 and 1996) and DVA (in 1995), Dr. Steven Joseph, then Assistant Secretary of Defense for Health Affairs, and Dr. Kenneth Kizer, Undersecretary for Health, DVA, stated in letters to various members of Congress and to the press that this type of infection is commonly found, not dangerous and not even a human pathogen, and our results have not been duplicated by other laboratories. These statements could not be further from the truth. The Uniformed Services University of the Health Sciences, the US military's medical school, has been teaching its medical students for years that this type of infection, although uncommon in the US population, is very dangerous and can progress to system-wide organ failure and death [17]. In addition, the Armed Forces Institute of Pathology (AFIP) has been publishing for years that this type of infection can result in death in nonhuman primates [18] and in man [17]. The AFIP has also suggested

treating patients with this type of infection with doxycycline [19], which is one of the antibiotics that we have recommended [20, 21]. Then why has the DVA issued guidelines stating that GWI patients should not be treated with antibiotics like doxycycline, even though in a significant number of patients it has been shown to be beneficial [14, 15]? In response to the comments that our tests have not been duplicated, certified diagnostic clinical laboratories, Immunosciences Laboratories of CA and Medical Diagnostic Laboratories of NJ and have been conducting diagnostic tests on mycoplasmal infections in blood of GWI and CFS patients, and they are obtaining essentially the same results as we have found. Thus our results have been replicated by certified commercial laboratories. The DoD and DVA have also stated that we have not cooperated with them or the CDC in studying this problem. This is not true. We have done everything possible to cooperate with the DoD, DVA and CDC on this problem, and we even published a letter in the Washington Post on 25 January 1997 indicating that we have done everything possible to cooperate with government agencies on GWI issues. We formally invited DoD and DVA scientists and physicians to the Institute for Molecular Medicine to learn our diagnostic procedures on 23 December 1996 at a meeting convened at Walter Reed Army Medical Center by Major General Leslie Burger at the request of Congressman Norman Dicks (D-WA). We have been and are fully prepared to share our data and procedures with government scientists and physicians. Although government laboratories can test for mycoplasmal infections and have been conducting their own examination of mycoplasmal infections in GWI patients, they are using relatively insensitive, outdated antibody tests or conventional molecular biological tests, and we would not expect them to detect the infection by these procedures. To correct this situation we received a small training contract from the DoD to train DoD scientists in our new techniques, and the training was completed on January 30, 1998.

Successful Treatment of GWI using Private Funds

In GWI patients that tested positive for mycoplasmal infections in their blood, we have found that this type of infection can be successfully treated with multiple courses of specific antibiotics, such as doxycycline, ciprofloxacin, azithromycin, clarithromycin or minocycline [13-15, 20-21], along with other nutritional recommendations. Multiple treatment cycles are required, and patients relapse often after the first few cycles, but subsequent relapses are milder and most patients eventually recover [14, 15]. In contrast, in nondeployed, healthy adults the incidence of mycoplasma-positive tests were <6% [15]. We found that 87 mycoplasma-positive GWI patients on antibiotic therapy relapsed within weeks after the first 6-week cycle of therapy, but 69/87 recovered after up to six cycles of therapy and 18/87 are still undergoing therapy. GWI patients who recovered from their illness after several (3-7) 6-week cycles of antibiotic therapy were retested for mycoplasmal infection and were found to have reverted to a mycoplasma-negative phenotype [14, 15]. We hypothesize that the therapy takes a long time because of the microorganisms involved are slow-growing and are localized deep inside cells in tissues, where it is more difficult to achieve proper antibiotic therapeutic concentrations. As stated above, multiple cycles of therapy result in eventual recovery in a high percentage of mycoplasma-positive GWI patients. Although anti-inflammatory drugs can alleviate some of the signs and symptoms of GWI, the signs and symptoms appear to quickly return after discontinuing drug use. If the effect was due to an anti-inflammatory action of the antibiotics, then the antibiotics would have to be continuously applied and they would be expected to eliminate only some of the signs and symptoms of GWI. In addition, not all antibiotics, even those that have anti-inflammatory effects, appear to work. Only the types of antibiotics that are known to be effective against mycoplasmas are effective; most have no effect at all on the signs and symptoms of GWI/CFS/FMS, and some antibiotics make the condition worse. Thus the antibiotic therapy does not appear to be a placebo effect, because only a few types of antibiotics are effective and some, like penicillin, make the condition worse. We also believe that this type of infection is immune-suppressing and can lead to other opportunistic infections by viruses and other microorganisms or increases in endogenous virus titers. The percentage of mycoplasma-positive GWI patients overall is likely to be lower than found in our studies (~45%). This is reasonable, since GWI patients that have come to us for assistance are probably more advanced patients (with more progressed disease) than the average GWI patient. Although we have been criticized for not conducting double-blinded, controlled clinical studies on large numbers of patients, such studies are quite labor intensive and expensive, and all of our studies were conducted without any government support or help whatsoever. Although our studies do not involve controlled patient populations, such as all veterans that served in a single unit compared to similar numbers of nondeployed personnel from the same unit, such controlled populations can only be studied

only with the help and financial assistance of the DoD and DVA. Recently the DVA has agreed to initiate a controlled clinical trial (CSP#475) involving 18 VA institutions that will test the usefulness of antibiotic treatment of GWI patients. This clinical trial is based completely on our research and publications on the diagnosis and treatment of chronic infections in GWI patients [10, 13-15].

Potential Sources of Exposures That Could Have Caused GWI

We consider it quite likely that many of the Desert Storm veterans suffering from the GWI signs and symptoms may have been exposed to chemical/biological toxins (exogenous or endogenous sources of these agents) containing slowly proliferating microorganisms, such as pathogenic mycoplasmas and quite possibly other bacteria and viruses, and such infections, although not usually fatal, can produce various chronic signs and symptoms long after exposure. This would account for the illnesses being passed to immediate family members. The DoD has maintained that Iraqi offensive Chemical and Biological Weapons (CBW) were not released during or after the Gulf War, but over 14,000 Chemical Weapons alarms sounded during but not before the conflict and we did not have detection equipment forward deployed to be able to determine whether Biological Weapons were present. The Iraqi armed forces were operating under Soviet War Doctrine, which stresses offensive use of combinations of Chemical and Biological Weapons together with conventional weapons. Evidence presented to Congress [6] indicated that it was extremely likely that Chemical Weapons were released during and certainly after the conflict when bunkers containing CBW were destroyed. Although chemical and/or radiological exposure(s) can result in somewhat similar signs and symptoms to those found in GWI, this does not explain the apparent contagious nature of GWI and the delayed appearance of similar signs and symptoms in immediate family members. Fortunately, the types of slow-growing, chronic infections found in GWI patients can be diagnosed and successfully treated with multiple cycles of specific antibiotics.

There were several potential sources of chronic biological agents in the Persian Gulf Theater [9, 22]. First, deployed soldiers were given multiple inoculations, in some cases with experimental vaccines in unproved immunization schemes, such as vaccines that were given all at once instead of using an appropriate schedule of inoculations over months or years. Multiple vaccinations given simultaneously can result in immunosuppression and leave an individual susceptible to opportunistic infections. Some of these experimental vaccines could also have been contaminated with small amounts of slow-growing microorganisms. Next, the Iraqis were known to have extensive stockpiles of Biological Weapons and the potential to deliver these weapons offensively, at short range in modified Italian-made biological sprayers that deliver Biological Weapons onto the sand to create exclusionary zones or 'biological minefields' and at long range in modified SCUD-B (SS-1) missiles with 'airburst' warheads or sprayers carried by aircraft. As mentioned above, many of the storage and factory facilities where Chemical and Biological Weapons were stored were destroyed immediately up to, during and after the Desert Storm ground offensive, releasing plumes containing these agents high in the atmosphere where they could be carried downwind ('blow-back' exposures) to our lines. These and other possible mechanisms of potential exposure must be carefully examined, not categorically dismissed by DoD personnel in Washington DC with little first-hand knowledge of the conditions on the ground [22]. A number of possible reasons exist that could explain why the DoD and DVA deny that our forces were exposed to CBW agents during the Gulf War, but this does not rationalize the poor responses to GWI casualties [22].

Conclusions and Suggestions

Seven years after the Gulf War, it seems counterproductive to continue the contentious battle over whether or not our forces were exposed to toxic agents in the Gulf. It is time to put this war behind us, and treat the casualties and claims appropriately. We previously stated that "the lack of response to possible CBW use during the Persian Gulf War has actually increased our risk and future vulnerability to CBW attack. Aggressor countries and terrorists groups may have concluded that the US and UK are vulnerable to CBW, because they may assume from the Gulf War that we will not acknowledge CBW use and we will not treat our casualties. Thus a very bad precedent has been set by our policies during the Gulf War. Unfortunately, the steps that we take to health crises such as GWI/CFS/FM may dictate how our weaknesses are assessed and exploited in the future" [23].

Finally, the following suggestions are advanced to the Subcommittee:

1. Benefits and claims from the Persian Gulf War must be expanded to include immediate family members who have suffered and who continue to suffer because of veterans' illnesses that were transmitted to family members after the war. Denial that this has occurred has only angered veterans and their families and created a serious public health problem, including contamination of our blood supply.

2. Serious consideration must be made to overhaul the ICD-9-coded diagnosis system used by the VA to determine illnesses. The categories in this system have not kept pace with new medical discoveries in the diagnosis and treatment of chronic illnesses. This has resulted in large numbers of patients from the Gulf War with 'undiagnosed' illnesses who cannot obtain treatment or benefits for their medical conditions.

3. The efforts at denying claims and benefits by giving small, partial % disabilities due to PTSD should not be continued in patients that have organic (medical) causes for their illnesses.

4. Research efforts must be increased in the area of chronic illnesses. Traditionally this area has not received much attention or financial support. It is estimated that over 3% of the adult US population suffers from chronic illnesses, such as those mentioned in this report; however, there are few federal dollars available for research on the diagnosis and treatment of chronic illnesses.

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Under penalty of perjury, I swear that the statements above are true and correct to the best of my knowledge, information and belief.

Garth L. Nicolson
Chief Scientific Officer
The Institute for Molecular Medicine
and
Professor of Internal Medicine

Address:
The Institute for Molecular Medicine
15162 Triton Lane
Huntington Beach, CA 92649
Tel (714) 903-2900 Fax (714) 379-2082

Institute for Molecular Medicine Website: www.immed.org

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