



GulfNEWS

A bimonthly newsletter serving the interests of Gulf War veterans

Lessons Learned Prompt Better Recordkeeping

By Lisa Gates
Public Affairs

The Office of the Special Assistant for Gulf War Illnesses recently released an information paper on medical recordkeeping during and after the Gulf War. This review of medical recordkeeping policies and practices was prompted by concerns voiced by veterans regarding the handling of medical records. Some veterans, for example, have commented

that some medical care and immunizations received during Operations Desert Shield and Storm were not recorded. Still others have expressed concerns that medical information is missing from their health records, or that the records themselves could not be located.

“The Gulf War taught us it’s not enough to simply care for casualties,” said Dr. Bernard Rostker, the special assistant for Gulf War illnesses. “We should more fully document health care, maybe even hazardous exposures, to better address post-deployment health concerns among servicemembers and veterans.”

With the release of this latest paper on medical recordkeeping, analysts anticipate veterans will gain a better understanding of how recordkeeping problems may have occurred during the war. The paper also addresses post-Gulf War records, as well as future initiatives for improved medical record management, especially during deployments.

“Many of the recordkeeping problems associated with the Gulf War resulted from not being prepared for such a rapid, large-scale, multi-service deployment,” said Tom Rupp, one of the paper’s authors. “DoD is now more focused on standardizing medical records and documenting the health of deployed forces.”

Medical records broadly fall into two categories: individual health records and inpatient hospital records. Individual health records typically include documentation of clinic visits, diagnostic tests, physical examinations, immunizations and inpatient care summaries. These records represent a history of a servicemember’s health care and accompany them throughout their military career. Upon a servicemember’s separation or retirement, the individual health records are sent to the Department of Veterans Affairs Records Management Center in St. Louis. Prior to the mid-1990s, individual health records were stored at the National Personnel Records Center, also located in St. Louis.

Inpatient records are created each time a servicemember is admitted to a medical treatment facility. These records document all treatments and procedures performed during hospitalization. Military service policies call for the inpatient records to be sent to the National Personnel Records Center, where they are stored under the name of the military hospital transferring the records. Inpatient records are not combined or archived with a servicemember’s individual health record, but are stored in separate groups based on the individual medical (See *Records*, page 3)



An F/A-18 "Hornet" breaks the sound barrier while deployed to the Gulf with the USS Constellation (CV 64) battle group. U.S. Navy photo by Ensign John Gay.

DoD Releases Iraqi Rocket Fuel Oxidizer Paper

By Bob Dunlap & Todd Stevens
Public Affairs

The Office of the Special Assistant for Gulf War Illnesses released recently an interim information paper on a missile fuel oxidizer used by the Iraqi military to propel its Scud, Guideline, Silkworm and Kyle missiles. This latest release from the DoD office is designed to provide a basic understanding of inhibited red fuming nitric acid – “IRFNA” – and identify where and how Gulf War veterans may have been exposed to the propellant.

Some Gulf War veterans have reported incidents involving colored clouds and mist during the Gulf War. These clouds were described as having strong odors, causing an immediate burning sensation to the eyes, skin, nose and throat as well as respiratory irritation, nausea and vomiting. While yet there is no evidence Iraq ever offensively deployed chemical or biological weapons against coalition troops, there is growing evidence of the possible exposure of veterans to industrial chemicals and other weapons-system components such as IRFNA.

“To date, the evidence we have indicates that weapons that used IRFNA did not carry biological or chemical warheads,” said Kelly

Niernberger, a chem-bio warfare analyst with the special assistant’s office. “If you were exposed to IRFNA, you’d know it. But it’s unlike anything most people reported from the experiences in the Gulf.”

During the Gulf War, Iraq used the oxidizer in combination with fuel to create the thrust needed to launch a rocket or missile. When a SCUD broke-up, impacted or was intercepted by coalition weapons, the missile fuel and IRFNA combination could have exposed some troops to the hazards of nitric acid and nitric dioxide which can be confused as a chemical or biological warfare agent attack.

Some blister chemical warfare agents have a “pleasant” or no odor and the onset of respiratory problems is not immediate. Conversely and according to the information paper, IRFNA has a distinctive, recognizable color, a suffocating, acrid or pungent odor, and in high concentrations causes immediate respiratory distress.

“We know of no one that got that far. There are reports of coughing, shortness of breath or difficulty breathing, but only a few people that we know of were hospitalized during the war,” said Niernberger. “Even of those hospitalized, we could only guess that they had been exposed to IRFNA because we know so little about one-time, short-term exposure to nitric acid.” (See *IRFNA*, page 2)

(IRFNA from page 1)

While the possibility exists that IRFNA caused these reported symptoms, troops observing them did not have monitoring devices designed to detect the oxidizer's presence. They had no way to confirm whether these exposures involved IRFNA. Additionally, immediate signs, not the delayed symptoms expected from a chemical warfare agent attack, lead investigators to believe IRFNA to be a likely explanation in some reported cases.

The CIA also confirmed the likelihood of IRFNA exposure in an August 1996 report on intelligence related to Gulf War illnesses citing that, "Although we know of no long-term illnesses related to these chemicals, we assess that [IRFNA] is a likely cause of some burning sensations reported by veterans near SCUD impacts."

Some of the other symptoms reported are immediate headache, dizziness, lethargy, anxiety and difficulty breathing. According to the report, there are no indications that most symptoms are persistent following short-term exposure, but contact can cause serious chemical burns to the eyes and skin or permanent lung damage at moderate or high levels of exposure.

The information paper recommends improved Fox vehicle detection capabilities, improved monitoring and detection equipment, and improved doctrine, training and awareness of troops who may encounter IRFNA on the battlefield.

This report can be accessed through *GulfLINK*.

Recently the President's Special Oversight Board that monitors this office completed their "Interim Report." They commented that, "Perhaps most noteworthy is the Office of the Special Assistant for Gulf War Illnesses' sustained effort to provide veterans and the public with as much information as possible through the Internet, a telephone hotline and town hall meetings. In addition, [they have] increasingly used veterans' and military service organizations to provide information to Gulf War veterans."

When we established the Office of the Special Assistant, one of the first things we did was to expand the toll-free phone line for veterans to call with their questions and concerns. To date, our contact managers have talked with more than 11,000 veterans across the globe. We also established an outreach program that includes our award-winning interactive website, GulfLINK, and a free, bi-monthly newsletter, GulfNEWS. We also frequently meet with Veterans Service Organizations and Military Service Organizations to discuss topics of interest to them in an effort to remain responsive to the needs and concerns of those we serve.

Last year we began sending teams out to brief the total force on our efforts and deliver the message of "force protection" to today's soldiers, both veterans of the Gulf War and those who have joined since 1991. We

*From the desk of
Bernard D. Rostker
Special Assistant for
Gulf War Illnesses*



wanted to listen to their concerns firsthand, including new concerns about anthrax. To date, we have met with almost 50,000 service members.

Although this is not a traditional function of the Defense Department, it is showing a clear benefit to us all. First, it's the right thing to do. Service members, veterans and families have questions and need information. Our office is here to fulfill those needs.

Today, we live in an age where we are inundated with information; where we get our news in sound bites; and where anonymous rumors abound. Perhaps that's why our person-to-person approach is working so well.

For our efforts to be meaningful, we have to learn from our experiences. Specifically, we work to better account for what happened on the battlefield, and in the future, to better protect our troops from nontraditional risks. To that end, we reassigned several analysts to the newly established Lesson Learned Directorate.

We agree with the Board when they said, "identifying lessons learned ranks among OSAGWI's most important work." We must develop a "formal integration of the OSAGWI lessons learned team into the existing Military Service and Joint Staff lessons learned infrastructure."



Veteran Spotlight: David Windmiller

By Lisa Gates

Although no longer running seven-minute miles, David Windmiller is making strides of his own after battling back from a baffling illness that left him partially paralyzed nearly four years ago. Now, Windmiller jogs and lifts weights five days a week.

"Most of my coworkers now don't know that I have a problem or even what I went through back three years ago," said the 53-year-old Virginia resident and military analyst at the Pentagon.

Exercising and eating a low-fat diet were a way of life for Windmiller even before he fell ill. In the 1980s, he traded his diet of red meat and fatty foods for low-fat, low-cholesterol choices.

"Even during the Gulf War, I managed to work out on a regular basis, running around the airfield where I was stationed," he said.

Now a retired U.S. Army Reserve colonel, he served with the 354th Civil Affairs Brigade supporting the Army's VII Corps during the Gulf War. Following Iraqi surrender, his unit moved to northern Iraq to assist the Kurds during Joint Task Force Provide Comfort.

Almost a year-and-a-half after his five-month deployment to Southwest Asia, Windmiller saw changes in his health. An avid runner averaging six mile-a-day workouts, he began experiencing difficulty in breathing, joint pain, fatigue and memory loss.

Concerned about his worsening health problems, Windmiller sought medical care through the Comprehensive Clinical Evaluation Program at Walter Reed Army Hospital in Washington. The doctors who listened to his concerns investigated his illness.

"I had a number of tests run on me over a fairly lengthy time at Walter Reed," said Windmiller.

At the end of it all, the CCEP doctors, unable to link this to his Gulf War experiences, diagnosed him with exercise-induced asthma. Windmiller, with no prior history of asthma, tried not to let his deteriorating health get the best of him.

"That still didn't stop me from exercising. Slowed me down, maybe, but didn't stop me," Windmiller said.

In December 1995, nine months after initial diagnosis, his health took a turn for the worse following a seven-day ski trip.

"I wasn't feeling well, but made it into work on that Monday. Throughout the day, I noticed my vision was getting blurry and my speech was starting to slur. I still made it through an entire day. Until then, I had never missed a day out of work for illness."

By the next morning, he couldn't get out of bed. He had lost feeling in his arms and legs. He also experienced chest pains and his vision was blurred and breathing labored – classic symptoms of someone suffering a stroke. After seeing his personal physician, he went to the Fairfax County emergency room where doctors checked his heart and ordered a CT scan. When the report came back, there were no indications of a stroke. Knowing something was definitely wrong, he returned to his personal doctor who ordered an MRI.

"The doctor figured there could be one of three things wrong with me. One, it could have been an infection. Two, it could have been a tumor. Or three it could be multiple sclerosis."

The MRI showed that Windmiller had a small growth, possibly a tumor or infection inside the brainstem.

(See *Windmiller*, page 4)

(Records from page 1)

facility and the year in which the hospitalization occurred.

Medical recordkeeping policies prior to the Gulf War generally focused on peacetime health services and did not fully address the special requirements of maintaining a health record during deployments. Some deployed with abbreviated health records while others deployed with their complete individual health record. And although detailed guidance on routine immunizations existed, investigators found policy on the use of investigational drugs and vaccine documentation requiring operational security was problematic.

The rapid deployment of a large and diverse military force, including Reserves, may have contributed to problems with medical recordkeeping during the Gulf War. Concerns included adequacy of medical records for pre-deployment screening, deployment of abbreviated medical records, documentation of immunizations, transfer of deployment medical information to permanent individual health records, and availability and access of medical records after the Gulf War.

For Operations Desert Shield and Storm, the Army and Air Force directed that one-page health summary forms be prepared during

mobilization. These “abbreviated health records” were sent with deploying troops in place of full individual health records. Sailors and Marines, however, deployed with complete health records. Information contained in after-action reports and obtained from veterans indicated that health records – full or abbreviated – and medical record forms were not always available at the time care was given.

There was also confusion during the Gulf War about how, where, and even whether vaccines such as anthrax and botulinum toxoid, and drugs like pyridostigmine bromide, would be recorded in medical records. Operational security surrounded the administration of both vaccines. In addition, botulinum toxoid was an investigational product, which created more documentation

questions. Little specific guidance was provided for the documentation of pyridostigmine bromide, which was widely distributed to servicemembers and self-administered under the direction of operational commanders. Following the war, some veterans experienced difficulty locating their medical records or finding documentation of all care received in the Gulf.

Medical recordkeeping after the Gulf War emphasized the documentation of deployment health-related activities and the development of automated information systems.

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**-Tom Rupp,
Medical Issues Team**

Increasingly, the health of servicemembers is being addressed as an important element of military doctrine, plans and directives. The Army and the Air Force have continued their policies of deploying personnel with abbreviated health records, while full health records continue to accompany Navy and Marine Corps personnel on deployments.

“One of the most encouraging results of the Gulf War – from a medical recordkeeping perspective – is greater cooperation between the DoD, the VA and the NPRC. It has made medical records more accessible for the veteran, and it needs to continue,” said Rupp.

Expectations of the medical recordkeeping component of force health protection remain high as military personnel continue to deploy overseas in support of operational missions. The services now use standardized pre- and post-deployment health assessments and automated immunization tracking systems. Additionally, efforts are underway to uniformly manage records and develop disposition policies for deployments.

Accessibility to medical records has improved thanks to closer cooperation between DoD, the VA and the National Archives and Records Administration. As part of an initiative to identify and facilitate veterans’ access to their Gulf War inpatient records, staff from the special assistant’s office searched through records at the National Personnel Records Center in St. Louis – permanent storage site for all records of hospitalizations (See *Records*, page 4)

DoD Critiques Agent Detector Kit

By Todd Stevens
Public Affairs

The Office of the Special Assistant for Gulf War Illnesses recently released an information paper on the M256-series chemical agent detector kit. This latest release from the DoD office is designed to provide a basic understanding of chemical detection equipment relevant to several case narratives currently under investigation by this office. This paper also provides information on the kit’s strengths and limitations related to its use during the Gulf War.

The M256 Chemical Agent Detector Kit, which consists of a vapor-sampler and a litmus paper-like test, is used to identify hazardous concentrations of blood, nerve and blister agents that could possibly harm troops in a combat situation. It is manually operated and used to determine whether it is safe to remove protective gear following a chemical warfare attack, or as a confirmatory test after a chemical warfare agent alarm has sounded.

The paper details the sensitivity of the M256-series chemical agent detector kit, which detects chemical warfare agents at much lower concentrations than other detectors U.S. forces had during the war. To prevent injury and death, the detector had to be able to detect chemical agents in concentrations lower than those that would injure service members. Those levels were established from laboratory research, from observing workers who were accidentally exposed and from other real-life examples, such as in the case of American doctors who treated Iranian soldiers after chemical agents were used against them in the Iran-Iraq war.



An NBC investigation team aboard the USS George Washington searches for “contamination” using M8 paper and an M256 kit during a recent drill.
U.S. Navy photo by PH2 Sammy Dallal.

This paper, as well as four other information papers, 14 case narratives and two environmental exposure reports, all relating to the Gulf War, are posted on the GulfLINK website (<http://www.gulflink.osd.mil>).

Resources for Veterans

Your ticket to the information highway — visit our GulfLINK web site at:
<http://www.gulfink.osd.mil>

Are you a Gulf War veteran (or know of one) with health concerns? Call the CCEP at:
1-800-796-9699

Anyone with information on Gulf War incidents should call the DoD Incident Reporting Line at:
1-800-472-6719

Gulf War veterans seeking information on VA benefits of all types should call the Persian Gulf Helpline at:
1-800-749-8387

(*Windmill* from page 2)

Windmill was immediately admitted to Georgetown University Medical Center, noted for its outstanding neurosurgery department.

At Georgetown, more testing revealed the growth had doubled in size and an elevated whiteblood cell count led to the suspicion he had a bacteriological infection. Physicians determined surgery was needed to extract the infection.

For five months, nurses treated him at home to kill what remained of the infection. Caregivers came and went, administering medication and therapy, helping him relearn all the things he said he had taken for granted, including walking and talking.

“I had to learn how to use crutches and walk first to let alone be able to run,” said Windmill.

He has maintained a positive attitude with the help and support of family who were there through every step.

“It doesn’t do any good to dwell on the negatives. You have to look on the positive side and make the best of it. No matter what your handicap is, you can always find something good in life.”

As for exercising, it has become an even greater priority in his life. Windmill said the doctors attributed excellent physical and mental condition as critical to his survival and successful recovery.

“Exercise and a supportive family are

what saved my life and what keeps me going. There are days when I am almost too tired — and I’m tired most of the time — to exercise, but I do it anyway.”

After hard recovery and a six-month absence, Windmill returned to his job. Keeping with his promise, he continues with that regimen of jogging and weightlifting nearly two hours a day, five days a week.

How or why did this happen? Windmill says doctors are still asking but still cannot find a direct link to his Gulf War experiences.

“I still have problems,” said Windmill. “But I don’t let them get in the way.”

(*Records* from page 3)

in military medical facilities. The team located more than 25,000 inpatient records of deployed Gulf War servicemembers and entered the information into a database. Veterans can call OSAGWI at (800) 497-6261 for a database search and assistance in obtaining copies of their records. Since this service was offered in August 1998, nearly 200 veterans have retrieved copies of inpatient health records.

DoD is currently looking to technology for meeting many of its medical record-keeping challenges. The computerized patient record and personal information carrier — a dog tag-like, computer chip device that holds medical data — are two major cornerstones of future military recordkeeping. Each of these technologies, however, require substantial time and effort to acquire, deploy and integrate.

“Computerized medical recording is clearly the way to go,” said Rupp. “At the same time, DoD should continue improving its paper records as a foundation for, and bridge to the future.”

We can no longer rely solely on a traditional peacetime system of paper-based medical records, Rupp said. New recordkeeping initiatives and total force protection programs are essential to the health and effectiveness of our armed forces.

“Uniformity of medical recordkeeping among the military services is both achievable and desirable. It is also timely, since deployments increasingly involve closely integrated forces from all branches of the armed services and all components — active duty, National Guard and Reserve,” said Rupp.



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Agencies assisting Gulf War veterans:

<http://www.afa.org/>
Air Force Association
1501 Lee Highway
Arlington, VA 22209-1198

<http://www.legion.org/building.htm>
American Legion
1608 K St., NW
Washington, DC 20006

<http://www.amvets.org/>
AMVETS
4647 Forbes Blvd.
Lanham, MD 20706

<http://www.ausa.org/>
Association of the U.S. Army
2425 Wilson Blvd.
Arlington, VA 22201

<http://www.dav.org/index.html>
Disabled American Veterans
807 Maine St., SW
Washington, DC

<http://www.eangus.org/>
Enlisted Association of the National Guard
1219 Prince St.
Alexandria, VA 22314

<http://www.fra.org/>
Fleet Reserve Association
125 N. West St.
Alexandria, VA 22314-2754

<http://www.mcleague.org/>
Marine Corps League
8626 Lee Highway, #201
Merrifield, VA 22031

<http://www.ngaus.org/>
National Guard Assn of the US
1 Massachusetts Ave., NW
Washington, DC 20001

<http://www.navy-reserve.org/index.html>
Naval Reserve Association
1619 King St.
Alexandria, VA 22314-2793

<http://www.navyleague.org/>
Navy League
2300 Wilson Blvd.
Arlington, VA 22201

<http://www.ncoausa.org/>
Non Commissioned Officers Association
225 N. Washington St.
Alexandria, VA 22314

<http://www.roa.org/>
Reserve Officers Association
1 Constitution Ave., NE
Washington, DC 20002

<http://www.troa.org/>
Retired Officers Association
201 N. Washington St.
Alexandria, VA 22314

<http://www.vfw.org/>
Veterans of Foreign Wars
200 Maryland Ave., NE
Washington, DC 20002

<http://www.vva.org/>
Vietnam Veterans of America
1224 M St., NW
Washington, DC 20005