Research Advisory Committee on Gulf War Veterans' Illnesses

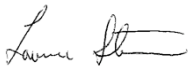
Committee Meeting Minutes
July 07, 2020

U.S. Department of Veterans Affairs
Washington, DC
Virtual meeting was held due to COVID-19 concerns

Research Advisory Committee on Gulf War Veterans' Illnesses

Committee Meeting Minutes

I hereby certify the following minutes as being an accurate record of what transpired at the July 07, 2020, meeting of the Research Advisory Committee on Gulf War Veterans' Illnesses.



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Lawrence Steinman, M.D.
Chair, Research Advisory Committee on Gulf War Veterans' Illnesses

Attendance Record

Members of the Committee present:

Dr. Lawrence Steinman, Chair
Ms. Kimberly Adams
Dr. James Baraniuk
Mr. Brent Casey
COL. Richard Gaard, USA, Ret.
Ms. Marilyn Harris
Dr. Stephen Hunt
Dr. Katherine McGlynn
Mr. Jeffrey Nast (no Adobe login, VANTS only)
Dr. Carey Pope
Dr. Mitchell Wallin
Mr. William Watts
Dr. James Woody, USN, Ret.

Members of the Committee absent:

Ms. Barbara Ward

Designated Federal Officer:

Dr. Karen Block

Committee Staff:

Mr. Stanley Corpus
Mr. John Rukkila
Ms. Marsha Turner

Invited Speakers:

Dr. Drew A. Helmer, VA IQuEST, Houston, TX
Dr. Steven Hunt, VA PDICI, Seattle, WA
Dr. Theresa Gleason, VA ORD, Washington, DC
Dr. Dawn Provenzale, VA CSP, Durham, NC
Dr. Victoria J. Davey, VA OR&D, Washington, DC
Dr. Melissa A McDiarmid, University of Maryland
Mr. Keith Hancock, Compensation Svc, VBA
Dr. Tobias Marton, San Francisco VA Hlth. Care
Dr. Paula P. Schnurr, VA National Ctr for PTSD

RAC-GWVI Subcommittee Members:

Dr. Lawrence Steinman, Chair
Dr. Karen Block, DFO
Ms. Kimberly Adams
Mr. Brent Casey
Ms. Marilyn Harris
Dr. Drew Helmer
Dr. Stephen Hunt
Mr. William “Bill” A. Watts

Data on Participant Logins:

68 VA National Teleconferencing System
107 Adobe Connect
13 Committee Member logins

Meeting of the Research Advisory Committee on Gulf War Veterans' Illnesses (RAC-GWVI)

U. S. Department of Veterans Affairs

Virtual Meeting

CALL-IN: (800) 767-1750; access code 56978#

WATCH ONLINE: http://va-eerc-ees.adobeconnect.com/racgwvi-july2020/

AGENDA

Tuesday, July 7, 2020

8:00am PT / 9:00am MT / 10:00am CT / 11:00am ET

**Opening Meeting Announcements—Karen Block, PhD, Designated Federal Officer

11:00–11:10	Welcome, Overview and Updates on RAC-GWVI	Lawrence Steinman, MD, Chair Res Adv Cmte on Gulf War Veterans' Illnesses
	VA Gulf War Research Program Updates	Karen Block, PhD Director, Gulf War Research VA Office of Research and Development
11:10–11:25	Report from Gulf War Veteran Listening Sessions	Drew A. Helmer, MD, MS Deputy Director, Center for Innovations in Quality, Effectiveness and Safety (IQuESt), Michael E DeBakey VA Medical Center, Houston TX
11:25–11:35	COVID-19—Perspectives from VA Medical Centers	Stephen Hunt, MD National Director, VA Post Deployment Integrated Care Initiative (PDICI), VA Puget Sound Healthcare, Seattle WA
11:35–11:45	Mental Health Research related to COVID-19 Early Projects	Theresa Gleason, PhD Director, Clinical Science Research and Development Service, Office of Research and Development, VA Central Office, Washington, DC
11:45–12:00	COVID-19—VA Cooperative Studies Program Research	Dawn Provenzale, MD, MS Director, VA Cooperative Studies Program Epidemiology Center, Durham NC; Director, GI Outcomes Research, Duke University; Professor of Medicine, Duke Univ Medical Center
12:00–12:15	National VA Research Efforts pertaining to SARS/CoV-2/ COVID-19	Victoria J. Davey, PhD, MPH Associate Chief Research & Development Officer for Epidemiology and Public Health, VHA Office of Research & Development

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Tuesday, July 7, 2020

8:00am PT / 9:00am MT / 10:00am CT / 11:00am ET

12:15–12:45	Overview of the VA Surveillance and Research Activities in the Depleted Uranium and Embedded Fragments Cohorts	Melissa A. McDiarmid, MD, MPH Medical Director, University of Maryland School of Medicine
12:45–1:15	Gulf War Veterans Benefits	Keith Hancock Policy Analyst, Compensation Service, Veterans Benefits Administration
1:15–1:30	Break	
1:30–2:00	Ketamine Therapy for Treatment of Refractory Depression: Current Evidence Care and Real-World Application in Veterans	Tobias Marton, MD, PhD Staff Psychiatrist, San Francisco VA Health System; Assistant Clinical Professor, UCSF Department of Psychiatry; Director, SFVAHCS Ketamine Clinic; Director, SFVAHCS rTMS Clinic
2:00–2:30	Pharmacology of Post Traumatic Stress Disorder	Paula P. Schnurr, PhD Executive Director, National Center for PTSD, Office of Mental Health and Suicide Prevention, Department of Veterans Affairs; Professor of Psychiatry, Geisel School of Medicine at Dartmouth
2:30–3:00	Committee Discussion	Lawrence Steinman, MD, Chair
3:00–3:30	Public Comment	
3:30	Adjourn	

Acronyms and Abbreviations

ACTIV Accelerated COVID-19 Therapeutic Interventions and Vaccines
ASPR Assistant Secretary for Preparedness and Response
BARDA Biomedical Advanced R & D Authority
CA California
CDC Centers for Disease Control and Prevention
CDMRP Congressionally directed medical research programs
CFR code of federal regulations
CFS chronic fatigue syndrome
CMI chronic multisymptom illness
Cmte Committee
COL. Colonel in the U.S. Military
COVID-19 Coronavirus Disease 2019: 'CO' corona, 'VI' virus, 'D' disease, and '-19' 2019
CPRS computerized patient record system
CSP Cooperative Study Program
CT Central Time (zone)
Ctr Center
DC District of Columbia
DFO Designate Federal Officer
DoD Department of Defense
Dr. Doctor
DU depleted uranium
EPIC3 Epidemiology, Immunology, and Clinical Characteristics of COVID-19
EPICOVID Epidemiology of Covid
ET Eastern Time (zone)
FDA Food and Drug Administration
GA Georgia
GI gastrointestinal
GW Gulf War
GWI Gulf War illness
HIV human immunodeficiency virus
Hlth. Health
HSR&D Health Services Research and Development (Service)
ICD International Classification of Diseases
IED improvised explosive device
INSIGHT International Network for Strategic Initiatives in Global HIV Trials
IQuESt (Center for) Innovations in Quality, Effectiveness and Safety
LGBTQIA lesbian, gay, bisexual, transgender, queer or questioning, intersex, and asexual or allied
MD Medical Doctor
MISSION Act "Based on fulfillment of President Lincoln's promise "To care for him who shall have borne the battle, and for his widow, and his orphan" by serving and honoring the men and women who are America's Veterans. 'VA MISSION Act of 2018'' was enacted "to establish a permanent community care program for veterans, to establish a commission for the purpose of making recommendations regarding the

modernization or realignment of facilities of the Veterans Health Administration, to improve construction of the Department of Veterans Affairs, to make certain improvements in the laws administered by the Secretary of Veterans Affairs relating to the home loan program of the Department of Veterans Affairs, and for other purposes."

MPH Master of Public Health

MS Master of Science

Mr. Man regardless of professional title

Ms. Women regardless of professional status

MT Mountain Time (zone)

MVP Million Veteran Program

NC North Carolina

NJ New Jersey

OEF/OIF/OND Operation Enduring Freedom / Operation Iraqi Freedom / Operation New Dawn

ORD Office of Research and Development

PDHS Post-Deployment Health Services

PDICI Post Deployment Integrated Care Initiative

PT Pacific Time (zone)

PTSD post-traumatic stress disorder

RAC Research Advisory Committee

RAC-GWVI Research Advisory Committee on Gulf War Veterans' Illnesses

RECOVER Remission from Chronic Opioid Use-Studying Environmental and Socio-Economic Factors on Recovery

R & D Research and Development

Res. Research

Res Adv Cmte Research Advisory Committee

rTMS repetitive transcranial magnetic stimulation

SARS/CoV-2 Severe Acute Respiratory Syndrome Coronavirus 2

SFVAHCS San Francisco VA Health Care System

Svc Service

TX Texas

UCSF University of California, San Francisco

Univ University

U.S. United States

USA, Ret. U.S. Army, Retired

USN, Ret. U.S. Navy, Retired

VA Veterans Affairs

VA form 21-0960Q-1 chronic fatigue syndrome disability benefits online questionnaire

VANTS Veterans Affairs National Telecommunication System

VBA Veterans Benefits Administration

VHA Veterans Health Administration

VISN Veterans Integrated Service Networks

WA Washington state

WRIISC War Related Illness and Injury Study Center

Meeting of the Research Advisory Committee on Gulf War Veterans' Illnesses (RAC-GWVI)

U.S. Department of Veterans Affairs

Tuesday, July 7, 2020

Committee Meeting Minutes

Opening Meeting Announcements

Dr. Karen Block, VA Office of Research & Development and Designated Federal Officer, RAC-GWVI

Dr. Block announced the meeting as a virtual public meeting (due to COVID-19 pandemic) of the Research Advisory Committee on Gulf War Veterans' Illnesses. She noted a quorum for this committee was present on the phone and invited written comments to be sent to her as the Designated Federal Officer. She noted written and recorded proceedings of this meeting will be made public. Dr. Block welcomed Research Advisory Committee (RAC) members, alternative Dedicated Federal Officer Marsha Turner, and thanked RAC administrative staff Stan Corpus and John Rukkila for pulling the meeting together. She also noted that she is the Director of the Gulf War Research Program at the Office of Research and Development in Washington, DC.

Welcome, Overview and Updates on RAC-GWVI

Dr. Lawrence Steinman, MD, Chair, Research Advisory Committee on Gulf War Veterans' Illnesses

Dr. Steinman called the meeting to order; welcomed committee members, speakers, and guests; and gave a brief overview of the agenda for presentations to be held in the current meeting. He noted the planned follow-up committee discussion and public comment sessions. He introduced by roll call the committee members who each briefly described their backgrounds and RAC staff who described their supporting roles. He reviewed the Veteran Engagement Sessions held previously by the RAC that were formed as smaller subcommittee to go out and listen to our Gulf War Veterans firsthand. As the meeting sessions progressed, Dr. Steinman introduced speakers and guests.

Session 1: Report from Gulf War Veteran Listening Sessions

Dr. Drew A Helmer, MD, MS, Deputy Director, Center for Innovations in Quality, Effectiveness and Safety (IQuESt), Michael E DeBakey VA Medical Center, Houston, Texas

Dr. Helmer described how the Veteran Listening Session sub-committee went out to listen to Gulf War Veterans firsthand and provided broader and more diverse input from Veterans and caregivers. He described the talking points of the third Veteran Engagement Session in Atlanta, Georgia, that asked people about health concerns, quality of life, research issues, and what the VA Secretary needs to know. He said the content of responses varied depending on who was in the conversation and he noted specific key points raised: Primary health concerns included what rare and unusual conditions are more common and worrisome in Gulf War Veterans, particularly aging more rapidly and potential intergenerational health effects on their children and grandchildren. Concerns about quality of life included deficiencies in access to and provision of care as well as the lack of diagnosis codes, provider awareness, and specialized knowledge about Gulf War health issues. With launch of the MISSION Act and community care now a bigger part of VA's approach to care, Dr. Helmer noted concern about how do we coordinate that care for Gulf War Veterans? He said the need continues for greater outreach and marketing to dispel an undercurrent of lack of trust in the VA. He stated we need to make sure research findings are shared broadly to help promote awareness and change in practices that enhance Gulf War Veterans' engagement in all aspects of care with

more attention to women and homeless Veterans. Dr. Helmer stated the most-important message to the VA Secretary was that Gulf War Veterans need consistent, high-quality, proactive care with greater awareness among VA providers of Gulf War Veterans concerns and need for more specialists, clinical experts, and patient advocates. He said we need to enhance Gulf War Veteran engagement to promote all aspects of improving care and change in practices with research findings shared broadly and implemented in routine clinical practice. Dr. Helmer emphasized a "crosscutting theme was improving the system of care for Gulf War Veterans, needs to be more consistent, systematic, and proactive."

Committee member Kimberly Adams commented to not forget that more men will always access VA services, so we need to be very mindful to do more outreach for women Veterans and other disadvantaged Veterans in the community. She emphasized to include not just homeless Veterans, but black Veterans and Veterans of color as well as LGBTQIA Veterans. She noted all Gulf War Veterans deserve to have access and outreach if necessary so that they "are not just left off in this chasm that's already set for Veterans of the Persian Gulf War era."

Dr. Steinman responded, "if we don't address the audience in its broadest sense, we're going to be unsuccessful because our mission is to get out there and help people and allow them to know what is happening and how to get access."

Session 2: COVID-19—Perspectives from VA Medical Centers

Dr. Steven Hunt, MD, National Director, VA Post Deployment Integrated Care Initiative (PDICI), VA Puget Sound Healthcare, Seattle, Washington

Dr. Hunt presented perspectives on how the VA responded to the COVID-19 pandemic and how that has affected post-deployment care in the VA. He stated we don't know for sure, but it certainly is a possibility that Gulf War Veterans are at higher risk because of the action of coronavirus and how it works in inflammatory systems to contribute to dysfunction and pathology. He said it is important to keep Gulf War Veterans informed and to be sure they do everything they can to take care of themselves and optimize health. He emphasized that the VA does have an easily accessible standardized system to systematically approach COVID Veterans across the nation. He noted that what we did in response to COVID was to approach Veterans' healthcare in the same way we approached post-deployment and integrative care, staying connected and working to integrate their care. He said our major challenge in the VA is to make sure that we have a standardized, systematic, easily accessible approach to care for Gulf War Veterans. Dr. Hunt said in his opinion one of our biggest failures with Gulf War Veterans wasn't in not understanding the cause of Gulf War illness, but that we didn't really connect Veterans with an integrated comprehensive system of care to get back on their feet and do well after deployment. He revealed that Veterans found it very favorable when virtual care increased from being about 10 percent of all clinical contacts in early March to over 90 percent by the middle or end of April, with an 800 percent increase in both video and telephone care. He pointed out that this increase in access to telehealth strengthened regional clinical resource hubs of service and standardization of what is available to Veterans throughout the system. Additionally, he noted veteran-oriented healthcare resources are strengthened with the new electronic health record to ensure seamless and expeditious connection to Veterans and how military service and deployments have affected their health. He said we have learned a lot from our experiences with Gulf War Veterans about how to continue providing Veteran-centered, team-based, integrated, whole-health oriented care supported by these technologies to both improve access and bring are to the Veteran. Dr. Hunt further emphasized the what is most challenging is that it is not easier and not quicker but takes some time for providers to learn virtual care and to cultivate a sense of commitment, dedication, empathy, caring, transparency, and openness. Whether we're talking about COVID, pandemics, national disasters, or post-deployment care in the VA, he said we've learned from Gulf War Veterans' experience sessions that it is essential to build a system of care to provide the necessary integration, sense of trust, empathy, and teamwork.

Session 3: Mental Health Research related to COVID-19 Early Projects

Dr. Theresa Gleason, PhD, Director, Clinical Science Research & Development Service, Office of Research and Development, VA Central Office, Washington, DC

Dr. Gleason reviewed mental health research related to the COVID-19 pandemic. She noted mental health care in the VA is very high and the factors related to COVID are also related to patients with mental health disorders and healthcare needs. She said there is high concern for the impact of COVID on mental health services that still require in-person care. She described how clinical and health services are moving as quickly as possible to implement research. Dr. Gleason reviewed and described rapidly funded early research applications to include prevention of suicide with risks involving social distancing and isolation, self-help programs for major depressive and post-traumatic stress disorders in rural Veterans, provision of residential healthcare and treatment programs, tracking impact of daily activity and social distancing factors in an aging population, expansion of the Caring Contacts Program to patients at risk from isolation during COVID, and tracking changes in inflammatory factors in association with mental health. Dr. Gleason moved on to focus on the broader impact of health services research to advance knowledge of the consequences of the pandemic on patients with mental health disorders. She noted an expanding focus on other subpopulations adversely impacted and how to organize overall investment for greatest impact and understanding of COVID-related effects. She said supplemental funding was considered for rehabilitation research projects to turn findings into generalizable information as quickly as possible. She pointed out projects related to COVID for PTSD and alcohol use disorder impacts in homeless Veterans as well as tele-mental health services added onto a funded cohort study. Dr. Gleason explained that future steps for mental health projects include that funded mental health investigators virtually meet and share information to develop a consistent case definition for work being done that impacts COVID-19.

Session 4: COVID-19—Perspectives from VA Medical Centers

Dawn Provenzale, MD, MS, Director, VA Cooperative Studies Program Epidemiology Center, Durham NC; Director, GI Outcomes Research, Duke University; Professor of Medicine, Duke University Medical Center

Dr. Provenzale presented studies of COVID-19 effects in Veterans and focused within the Office of Research and Development on Epidemiology Studies in the Cooperative Studies Program. She reviewed five current VA epidemiology program COVID-19 studies: EPIC^3–CSP 2028, Million Veteran Program (MVP) sub-study CSP 2006, Convalescent Plasma, RECOVER, and EPICOVID: The EPIC^3 study in consultation with a Department of Defense protocol cohort of SARS-CoV-2 infected and uninfected Veterans provides information about viral shedding, immunity development, re-infection, risk factors, clinical course, and transmission. The MVP national research program, she explained, is one of the world's largest programs on genetics and health to learn how genes, lifestyle, and military exposures affect health and illness with 110,000 Gulf War 1 Veterans and 829,000 total Veteran participants to date. Dr. Provenzale noted the CSP-2006 sub-study in MVP is pertinent to 1990–1991 Gulf War Veterans in studying the genomics of Gulf War illness, effects of aging, coordination and opportunities for care, and specifically looking at COVID-19 impact and response. She reviewed the MVP online enrollment option as well as a current online survey and activities being tested such as home blood collection that present an opportunity for Gulf War 1 Veterans to contribute to knowledge of both COVID-19 and other health conditions in Gulf War 1 Veterans. Dr. Provenzale briefly described the program for convalescent plasma administered for treatment of Veterans with severe or life-threatening COVID-19 to help improve their outcomes. For the RECOVER initiative population-based research on the epidemiology of coronavirus among VISN-6 Veterans, Dr. Provenzale reviewed the regional collaboration of four medical centers in North Carolina and two in southern Virginia. She described how this phased approach study looks at the prevalence of COVID-19 with self-collected symptoms surveys and rapid PCR testing of nasal swabs to establish the prevalence of population immunity to SARS-CoV-2. She noted self-obtained serum sampling is conducted for serology to understand population impacts as well as breadth, depth, and mitigation

strategies of COVID infection in Veterans over time. Dr. Provenzale explained that RECOVER is a pilot study for a much larger VA approach to COVID-19 infection through the EPICOVID cooperative epidemiologic population-based and bio-repository cohort study of Veterans and infectious disease in partnership with MVP. She said this is a comprehensive VA-learning healthcare system model for COVID-19 clinical scalable research integration that will be a VA-wide rapid response platform to track future acute and chronic pandemic infections and non-infectious high-priority disorders. Dr. Provenzale summarized that RECOVER is going to provide valuable information about how we actually conduct the process of mailing, self-collection, tracking, and repository development. She said in RECOVER we have specific focus to identify Gulf War 1 Veterans' service, deployment to the Gulf, and potential military exposures that occurred during the Gulf War. She followed up to note this focus in RECOVER will inform the larger EPICOVID study with key testing of similar processes in an already-enrolled cohort of about 829,000 Veterans.

Session 5: National VA Research Efforts pertaining to SARS/CoV-2/COVID-19

Victoria J Davey, PhD, MPH, Associate Chief Research and Development Officer for Epidemiology and Public Health, VHA Office of Research and Development, Washington, DC

Dr. Davey reviewed VA interagency collaborations for national and international partnerships in research efforts to combat the coronavirus pandemic. She emphasized the Office of Research and Development support goals in contributing to COVID-19 research efforts to develop a vaccine start with keeping research staff and participants safe. She said additional goals include access to investigational therapies only available through research and collecting and evaluating scientific literature and real-world evidence to support operational decision-making. Dr. Davey discussed the very valuable efforts of the VA to coordinate research and promote collective national and international research efforts among collaborative participants that include the National Security Council, Biomedical Advanced R & D Authority (BARDA), Accelerated COVID-19 Therapeutic Interventions and Vaccines (ACTIV), Operation Warp Speed, and NIH/NIAID/INSIGHT. She described the collaborative real-world big-data approach through the National Security Council's COVID Insights Task Force to look at aspects of the epidemic that bring together DoD, VA, Health and Human Services, and other data through supercomputing analysis at the Department of Energy's Oak Ridge National Laboratory. She explained how the Assistant Secretary for Preparedness and Response (ASPR), an arm of Health and Human Services, initially began collaboration with BARDA that operates to develop and procure innovative medical countermeasures for expected threats of all kinds, including biologic. She noted BARDA served as the organizer of U.S. Government COVID-19 activity across the clinical environment with working groups that included VA representation. Next, Dr. Davey explained how collaborative organization of clinical research and therapeutics moved from BARDA to the ACTIV program to coordinate, secure, and streamline processes and collaborate with academia and industry through five master protocols designed to evolve with evolution of the epidemic and the therapies that become available. Dr. Davey briefly reviewed Operation Warp Speed, a new federal-wide collaboration with industry pharmaceutical companies co-led by Health and Human Services to enable rapid development and distribution of novel diagnostics, therapeutics, and vaccines. The final collaboration described by Dr. Davey was the INSIGHT network (International Network for Strategic Initiatives in Global HIV Trials) that has been instrumental in studies in HIV and influenza and has now pivoted to COVID-19. She described that the INSIGHT trial is developing a human hyper-immune gamma globulin extraction of human plasma containing measured antibodies to SARS-CoV-2 and will be a next-generation convalescent plasma with specific standardized antibodies. Dr. Davey pointed out that these international and collaboration efforts she described are in addition to the VA investigators proposed studies getting funded. She finished with the statement, "that in the absence of proven treatment, clinical trials are a part of clinical care."

Session 6: Overview of the VA Surveillance and Research Activities in the Depleted Uranium and Embedded Fragments Cohorts

Melissa A McDiarmid, MD, MPH, Medical Director, University of Maryland School of Medicine

Dr. McDiarmid presented an overview of two programs involving embedded fragments in Veterans: The first program covers Veterans exposures to depleted uranium (DU) fragments as well as inhaled uranium from depleted uranium artillery rounds. The second program covers Veteran metal exposures related to fragments from improvised explosive devices (IED). Dr. McDiarmid described the first clinical surveillance program that began at the Baltimore VA in 1993 for 80 Gulf War 1 Veteran casualties of desert combat friendly fire events involving depleted uranium rounds. In the initial stages of the program, she said, patch testing and whole-body radiation counting was done for markers of genotoxic effects, but abnormalities were not found as a function of uranium exposure or other unmeasured non-DU exposure. When fragments could not be removed, she said, the testing turned into a medical surveillance program using uranium bio-monitoring measurement of total concentration of uranium in the urine. Sustained elevated urine uranium secretion was found in Veterans with DU fragments 20 years after time of injury. Although no clinically significant differences were detected between low- and high-uranium exposure groups, subtle signals were observed for kidney proximal tubule effects and abnormal bone marrow density as a function of uranium level. Uranium mobilized from fragments in soft tissue, she explained, and made its way into systemic circulation to be ultimately absorbed into bone so that later a decline in bone mineral density was seen in the high- compared to the low-uranium group. Because of comorbidities of aging and ongoing accrual of the uranium increasing body burden over time, she noted ongoing follow up continues in this cohort. In a larger group, Dr. McDiarmid described exposure to uranium through inhalation when Veterans passed within 15 meters of a burning tank or were involved in decontamination after recovery of contaminated vehicles. She explained that in response to this additional potential exposure, a program was started in 1998 for any Veteran concerned to obtain mail-in biomonitoring of urine uranium and about 6,000 mailed-in samples were received as of a year ago. The second clinical surveillance program Dr. McDiarmid described was a new mission to track, monitor, provide follow-up care, develop a registry, and continue active surveillance for Veterans with embedded fragments resulting from improvised explosive devices. A long time ago, she said, it was taught that a fragment in soft tissue was well-behaved and inert, but we know now that these embedded fragments are not inert. She explained that embedded fragments posed potential local effects from foreign body reaction and systemic health effects because metal ions dissociate from the fragment into the peripheral circulation and travel widely throughout the body to encounter organ systems all over the body. She reviewed how currently the VA identifies at-risk populations through the clinical reminder system and characterizes metal exposure related to the fragment through urine testing. She explained how potential health effects are anticipated by mapping target organs for surveillance to 14 metal toxicants of concern and when elevations are seen, making recommendations to local VAs for further evaluation. The major findings to date, she said, are the majority of urine results were within established reference ranges and will serve as the baseline for future measures. Urine biomonitoring performed at intervals over a long term is a non-invasive method to help better identify and characterize the fragment-related exposures and associated systemic metal body burden, she said. Almost 17,000 veterans, she noted, have completed the clinical reminder questions in CPRS with their care providers and were enrolled in bio-monitoring and medical surveillance by mail that includes a questionnaire and specialized urine kit. Dr. McDiarmid added that a complication of unusual lab results in the urine surveillance process may be caused not only by diet but also by supplements, piercings, and tattooing that can also shed metal into the systemic circulation. She noted smokers have chromium in their urine, zinc is commonly found in a lot of supplements, tungsten level varies significantly across the country in what is normal, and arsenic requires very fancy methodology to tell the difference between inorganic toxic elevations and organic non-hurtful levels.

Session 7: Gulf War Veterans Benefits

Keith Hancock, Policy Analyst, Compensation Service, Veterans Benefits Administration

Mr. Hancock presented a brief overview of Gulf War Veteran benefits for disability, compensation, and service-connected claims. He explained the online application process to apply for VA disability benefits. In describing specifics on compensation for disabilities in Gulf War Veterans, he reviewed the basis for compensation, the schedule for rating disabilities, the authority regulations for Gulf War claims processing, and the Gulf War regulation on presumptive symptoms, illness, and diseases based on various circumstances in service. He noted the authority for Gulf War claims processing was established in 1994 by the Persian Gulf War Veterans Benefits Act that promoted research on disability patterns and provided compensation for undiagnosed illness. He discussed how service connection for claims based on Gulf War service are determined and reviewed Gulf War claims data based on the wartime period established from August 2, 1990, until now. He noted the additional amount of compensation paid by the special compensation program for severe disabilities such as amputations and loss of use of extremities as well as the aid-and-attendance program payment when another person is needed to support daily activities of life. Mr. Hancock described details and examples for establishment of service connection and said the schedule for rating disabilities is the bible for evaluating all disabilities in the compensation program. He noted that per regulation 38 CFR 3.317 the VA presumes certain chronic, unexplained symptoms, that have existed for six months or more after August 2, 1990, are in fact related to Gulf War service. Categories, he noted, included in that provision are first undiagnosed illness and second the chronic multisymptom illnesses (CMIs) such as fibromyalgia, chronic fatigue syndrome (CFS), functional gastrointestinal (GI) disorder, and infectious diseases such as malaria. He presented data on key Gulf War 1 conflict statistics and a recent court case of significance that changed the focus on medically unexplained chronic multisymptom illness to have either an inconclusive etiology or pathophysiology. He reported that the disability benefits questionnaire for Gulf War examinations is being changed to clarify some of the other issues and concerns that have been raised over the last several years. One of the issues he noted is that sometimes during the examination, the examiner will provide an unsolicited opinion that a CMI is not related to service, which would prevent that veteran from getting service connected. He said language is being clarified and guidance put out to the field that any CMI that shows up is in fact a presumptive. He added that the only medical opinion needed in that regard is whether or not it is in fact a CMI.

In follow-up questions, Marilyn Harris noted Mr. Hancock presented the definition of Gulf War Veterans as people that went to the Gulf from August 2, 1990, to the present. Mr. Hancock replied this was a big-picture to show the magnitude of the program being administered. Ms. Harris said this is also part of the confusion in the Veteran community regarding being addressed as a Gulf War Veteran.

Dr. Block asked whether the presentation slide data for Gulf War era included OEF/OIF as well as Operation Desert Shield/Desert Storm? Mr. Hancock stated yes and added the data would also include Veterans who served stateside, were never deployed, and had claims similar to deployed Gulf War Veterans.

Kimberly Adams reviewed the presented numbers for era and deployed Veterans that applied for benefits and stated that that only a quarter were approved because the clinicians are not adequately educated to find the symptomatology. She noted that's a problem and not progress to have a drop off of a quarter of the applicants for benefits. She concluded this is one of the reasons why Persian Gulf War Veterans, Gulf War 1 Veterans, have issues with getting their claims approved. She pointed out regarding the drop off that, "one of the other reasons that could be occurring is that if you go to the doctor enough, and nobody is paying attention, you stop going" and "at the end of the day, that drop off is horrific." Ms. Adams emphasized in summary that clinicians need to be educated to understand and discern the health issues and "my fellow Veterans that are going to end up being the Vietnam Veterans of the Gulf War era if we're not careful."

Mr. Hancock replied that the Veterans Benefits Administration is working to clarify the disability benefits questionnaire. He said if a Gulf War Veteran comes in and has a CMI, that should be presumptively service connected, period, just like for Vietnam Veterans.

Dr. Block asked what definition is being used for the CMI, is it the CDC or the Kansas case definition? Mr. Hancock replied we have examples of the most-common conditions that we see. He questioned whether Dr. Block was saying standards that could lead to a diagnosis of those conditions, or just CMI in general? Dr. Block replied it sounds like it's just kind of general CMI conditions versus that you have to have so many within a certain amount of time of leaving the Gulf. Mr. Hancock summarized that one category is the CMIs and then you have the undiagnosed illness category and the single-case definition group trying to come to a better understanding and definition of Gulf War illness, undiagnosed illness.

Dr. Baraniuk noted the chronic fatigue syndrome (CFS) disability benefits online questionnaire is the most-common form he fills out for disabled Gulf War illness Veterans. He inquired why CFS doesn't appear to be one of the most-common illnesses awarded and whether the disability branch is not accepting the CFS definition? Mr. Hancock replied we certainly accept it and have granted service connection for that condition. Dr. Baraniuk replied it's not commonly awarded but is common in the Veterans he has seen. He requested that Mr. Hancock provide him a yearly summary of applications and awards granted for CFS using VA's form 21-0960Q-1 of March 2011 to answer the question as to why CFS is the overwhelming syndrome he sees but doesn't appear to be commonly awarded. Mr. Hancock said we can look into that and Dr. Block clarified that the questions will be provided in writing to Mr. Hancock.

Session 8: Ketamine Therapy for Treatment of Refractory Depression: Current Evidence and Real-World Application in Veterans

Tobias Marton, MD, PhD, Staff Psychiatrist, San Francisco VA Health Care System; Assistant Clinical Professor, UCSF Department of Psychiatry; Director, SFVAHCS Ketamine Clinic; Director, SFVAHCS rTMS Clinic

Dr. Marton presented a review of the use of ketamine for treatment-refractory depression, the mechanisms and controversies of ketamine therapy, and an overview of the ketamine therapy program for Veterans at the San Francisco VA Health Care System. He pointed out a need for more rapid-acting therapies for treatment of a large population of Veterans with major depression, comorbid PTSD, and very impaired quality of life who are not getting better with psychotherapy and medication support and are at a chronically elevated risk for suicide. He explained how the anesthetic agent ketamine developed in the 1970s has been found to have profound impacts on chronic and severe depression within hours to days. He described the pharmacology of ketamine and the important synaptic plasticity phenomenon of long-term potentiation of ketamine as a medication with rapid antidepressant effectiveness despite a side effect of disassociation experiences. He noted a different phenomenology whereby the acute psychoactive effects of ketamine are temporally dissociated from the antidepressant effects and as a ketamine infusion wears off depression starts to lift with potential dramatic drop in the depression rating scale. He said with six infusions over either two or three weeks you get 70 percent efficacy and three weeks of remission of depression including anti-suicidality properties and an equally large effect on PTSD. Dr. Marton added that despite concerns about potential neurotoxicity, cognitive deficits have not cropped up in people getting ketamine and delivering ketamine at the medical center greatly reduces the risk of diversion, dependence, and abuse issues. He noted continued work on leveraging dosage to moderate the correlation between extent of dissociation and efficacy of inducing some kind of psychotherapy, like a psychedelic-assistive therapy, that leads to a durable effect. Dr. Marton reviewed his treatment at the SFVAHCS ketamine clinic of 75 Veterans over the last three years doing 25 infusions a week five days a week with positive outcomes in a PTSD cohort and reduction from the average of 36 to 17 in the Beck Depression Inventory scale. He noted the treatment population really shifts from very depressed to minimally depressed, there is a 50 percent remission rate and 72 percent response rate, and none of the cognitive side effects or other risks that occur with general anesthesia. He said the VA is well-poised to be in a position to contribute to research and understanding of how to use ketamine appropriately. Dr. Marton summarized that "this is really the biggest advance we've seen in psychopharmacology or treatment for depression in 20 years."

Session 9: Pharmacology of Post Traumatic Stress Disorder

Paula P. Schnurr, PhD, Executive Director, National Center for PTSD, Office of Mental Health and Suicide Prevention, Department of Veterans Affairs; Professor of Psychiatry, Geisel School of Medicine at Dartmouth

Dr. Schnurr presented a review of medication in the treatment of PTSD beginning with an overview, findings on treatment, practice guidelines, and ongoing research for PTSD. She reviewed PTSD diagnostic criteria and the high prevalence in Gulf War and OEF/OIF/OND Veterans. For treatment of PTSD she noted some types of medication as well as psychotherapy and somatic treatments are effective; however, psychotherapy is more effective than medications used, which have a lot of room for improvement. She discussed joint VA/DoD practice guidelines, called GRADE, for physical and mental disorders designed to facilitate decision-making and provide information, but not to define or mandate standard of care. The VA/DoD guideline, she stated, recommends trauma-focused psychotherapy as the primary choice of treatment for PTSD. Medication or individual non-trauma-focused psychotherapy is recommended when trauma-focused psychotherapy is not available or preferred, with insufficient evidence to recommend one over the other. Dr. Schnurr emphasized that the best medications for treatment of PTSD symptoms (sertraline, paroxetine, fluoxetine, and venlafaxine) are moderately effective and not as effective as the best psychotherapies. For primary treatment of PTSD, she said the widely used sleep and nightmares medication prazosin showed no benefit in a large VA trial, and widely used benzodiazepine has no evidence of efficacy and substantial evidence of harm especially for older Veterans. She also pointed out the recommendation against use of ketamine as a treatment outside of research, stating more research is needed, such as ketamine for treatment of PTSD in military Veterans who have comorbid depression. She warned that there is concern about polypharmacy and over-medication, with evidence of high use of primary medications that have questionable or no evidence of efficacy. Dr. Schnurr said there is less research on medication than psychotherapy, noting we need to increase medication research and innovation especially with industry partners, for example as in the novel National Adaptive Trial to do interim analysis and drop medications not showing promise of efficacy. Another area of great interest, she explained, is medication-enhanced psychotherapy using medications such as ketamine, cannabidiol, and oxytocin to boost evidence-based psychotherapy aiming to help people learn to forget the extreme paralyzing distress associated with trauma-related memories and reactions. She summarized the current state of evidence on medication for PTSD, indicating medications that are effective are less effective than the best psychotherapies. Dr. Schnurr finished with the comment that for "the tried-and-true antidepressants, I think we've gotten as much juice as we're going to get from them, and we have to look elsewhere."

Committee Discussion

Lawrence Steinman, MD, Chair, Research Advisory Committee on Gulf War Veterans' Illnesses

Dr. Steinman made strategic decisions throughout this virtual meeting to use his prerogative as Chair to advance presentations without discussions including canceling the break in order to make up time and move forward with the agenda. He also cancelled this scheduled committee discussion in deference to ensuring time for public comment. He requested that questions and discussions take place after scheduled presentations only as time permits.

Public Comment

Moderated by Bill Watts and Marsha Turner.

Mr. Bunker, Gulf War Veteran and Veteran advocate, said he will write up questions to send to the RAC-GWVI. *(attached)*

Mr. Chrisman, Gulf War Veteran, had two questions:

1. Dr. Martin: Is ketamine a lifetime treatment or will it eventually come to an end?
    - Dr. Martin signed off and was not available.
    - Dr Schnurr answered that right now we don't know the answer, but it seems durability is not the long-time solution of lifetime treatment. We are still trying to learn how long benefits last or how to dose it to get longer-term retention of benefits. We are also enthused about using it to boost an effective treatment. The effects of things like how long the exposure and cognitive processing can be very durable. One follow-up study in civilians who had prolonged exposure and cognitive processing showed about 7 years later that 80% were still in remission. So right now, the ketamine can help us get some very long-term benefits.
2. Dr. Schnurr: What are the differences between ketamine and cannabidiol treatments?
    - Cannabidiol is used in a pill form and ketamine is being explored as an intravenous infusion. Right now, we are not studying cannabidiol as a treatment for PTSD. We are studying it very specifically as a tool to get more effectiveness out of something that we already know to be effective.

Ms. Nichols, Gulf War Veteran advocate, had several comments and questions about various needs:

1. A follow-up report on COVID in Gulf War Veterans, in particular Desert Storm Veterans who got COVID. What symptoms occurred to include hypercoagulation, ground-glass appearance in the lungs, neurological symptoms, and any complicating factors?
2. The Pre-911 data for that we used to get as updates on disabilities—would be very helpful to talk about.
3. Follow-up for education on Gulf War illness for providers who do not know about the WRIISC or about Gulf War illness and presumptives. We lose trust and that has been an ongoing problem.
4. Follow-up on the NIH study that Dr. Klimas was getting VA funding on for chronic fatigue.
5. Follow-up on funding of research studies for Gulf War illness going on at VA.
6. Is there a VA advisory committee on PTSD? Although PTSD diagnosis is a smaller percentage for Gulf War Veterans than for OEF/OIF Veterans, CDMRP studies were funded because the RAC identified a concentration of stress and PTSD, and we needed more concentration on the inflammatory and immune problems.
7. The anthrax vaccine problem has not been addressed in a long time. It is particularly important to get that addressed because Gulf War Veterans who had the anthrax vaccine are very hesitant to either take part in research for a possible COVID vaccine or to take the vaccine.

Ms. Johnson, whose Desert Storm husband was exposed to depleted uranium during service:

1. She said her husband has calcified particles in his body and he had calcified body parts removed that doctors say should not be calcified. She asked if studies are being done on exposure from dust and not just the uranium fragments?
    - Dr. McDiarmid replied that there is concern about inhalation exposure of particles. She said we have looked at this in the friendly fire cohort with imaging and x-rays looking at hot spots in the lungs, but we haven't found them in our group. This might not be the same as in your husband. Make sure there isn't something else explainable that can be offered to your husband before we blame it on something we are not going to be able to measure this many years later. She said she could review the husband's urine but would probably not see anything for such a long exposure.

2. She noted years ago there was a depleted uranium questionnaire for her husband's unit that dealt with the friendly fire materials. Only 27 contaminated members, and not all the 200 to 300 members of the unit, were studied and tested in Boston.
    - Dr. McDiarmid said they were not tested by us and she is unable to speak to that review, but she would be happy to check the husband's urine again now.
    - Karen Block said she could give Tracy information.

Mr. Ortis, Gulf War Veteran, noted getting the brush off when he visits a VA clinic:

1. He noted his inability to get the VA to even look at Gulf War illnesses. He noted they blow it off and try to blame it on something else. He can't get anybody to get him on track with a registry despite having fought under the oil fires in the Gulf War and was exposed to burn pits. He has the issue that no one will take time to help us speak with doctors and specialists noted here, and no one tells us where to go to find the references cited today for Gulf War Veterans.
    - Kim Adams, RAC-GWVI committee member, noted the schedule of ratings can be found online. Anyone can look at the schedule of ratings for VA disabilities. She said to email her, and she will provide the link to the documents.
    - Mr. Bunker, Gulf War Veteran and Veteran advocate, said to google what you are looking for in the VA ratings.
    - Karen Block noted regarding the burn pit registry to email her the specific question and she can make sure to follow up to get you what you need. Registry information is also available at VA.gov.

Ms. Johnson described having problems with family generational issues with both her daughter and son.

1. She asked whether there are any studies about effects on DNA that are passed on to Gulf War Veteran children who are now adults and showing signs of aging in their late 20s.
    - Karen Block noted some studies have looked at major and minor birth effects and have not found any association with Gulf War 1 Veterans; however, a generational effects and exposure work group is looking at the issue, has no specific research right now, but information may be coming out in 6 to 8 months.
2. She said her husband came home in the early 1990s and there was a questionnaire on children and spouses of Desert Storm Veterans that they filled out several times, but it all disappeared. Where are those records? Where are those studies that were supposed to be done?
    - Dr. Rumm said he believes it was a Department of Defense study. He said as a Director of the Registry Programs as far as he knows this was not a Registry or VA study, but he will research this for Tracy and email a reply.
    - Ms. Nichols clarified this was not a specific registry but a VA questionnaire for spouses and children and it went into medical history records. She said that after previous inquiries about this over 30 years she was told it was all lost.
    - Mr. Bunker said he sent an email to Dr. Rumm.
    - Dr. Steinman added comments about research in general and how the RAC-GWVI is trying to be sure any individual participating in a study receives feedback on study results. He noted it is not acceptable not to know what happened.

Mr. Ortis, Gulf War Veteran, asked for previous stated information to be repeated so he could write it down.

- Dr. Rumm repeated his email address at Peter.Rumm@va.gov.
- Ms. Nichols noted the VA Public Health has a website and she has a Facebook group to help guide people to the right sites for information.

Mr. Pauls asked whether a registry will be created for generational follow-up?

- Karen Block noted there will be a response to a public law, but no information is available yet; however, keep in touch and information will be put out publicly.

Special Thanks

Dr. Steinman, Chair for the RAC-GWVI, gave special thanks for outstanding service to those committee members rotating off the committee: Kim Adams, Marilyn Harris, Stephen Hunt, Katherine McGlynn, Jeffrey Nast, and Mitch Wallin.

Dr. Steinman expressed confidence in the expertise and enthusiasm of departing committee members and hoped to reach out to them to share ideas and rely on them as resources and future speakers.

Adjourn

Dr. Steinman, Chair for the RAC-GWVI, thanked everyone for their participation, the speakers for their presentations, and the public who attended. He adjourned the Committee meeting at 4:00 pm.

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Emailed Supplementary Questions and Replies for the July 07, 2020, RAC-GWVI Virtual Meeting.

Mr. Bunker Question—Mon 7/6/2020 12:54 PM

I do not know why the committee is stepping outside of their charter and spending so much time on the COVID-19 virus. This is an illness affecting everyone I understand that; but it is not something we are sick form due to our service in the Gulf war and is not covered in the charter and the time spent (money) is not covered. The outcome of the subcommittees and the decussations from what was hopeful learned has became a back stage with very little time spent on how to fix any problems veterans face.

The problems with the claims is a one side thing too.

Dr. Karen Block Reply—Mon 7/6/2020 1:10 PM

Hope you are doing well. Dr. Larry Steinman, Chair of the RACGWVI, wanted COVID discussions in the Agenda for important reasons. We have received several questions/concerns from Gulf War Veterans regarding their illness in the background of COVID-19. Instead of just looking backwards, we need to consider Gulf War Illness prospectively in the context of aging and now in the landscape of a viral pandemic.

Hope this makes sense. I have CC'd Dr. Steinman here if he would like to add anything.

Dr. Steinman Reply—Mon 7/6/2020 1:58 PM

I felt the RAC GWI would be remiss if we did not address the matter of COVID-19 in the context of Gulf War Illness. There is much to learn. If there is no connection at all between GWI and COVID-19, it would be good to know that and to establish that conjecture- "no connection of GWI and COVID-19" as "proven correct". If there is a connection, it would also be good to know that and to establish that conjecture- "there is a connection of GWI and COVID-19" -which would then be "proven correct".

I contend that we are "within the charter" in discussing this. From our website:

"According to its charter, the guiding principle for the work of the Committee shall be the premise that the fundamental goal of Gulf War-related government research is to improve the health of ill Gulf War veterans."

Our statement of Mission: "The Research Advisory Committee on Gulf War Veterans' Illnesses (the RAC) provides advice and makes recommendations to the Secretary of Veterans Affairs on proposed research studies, plans, and strategies related to understanding and treating the health consequences of military service in the Southwest Asia theater of operations during the 1990 - 1991 Gulf War."

What if, there are consequences related to COVID-19 of military service in the Southwest Asia theater of operations during the 1990-1991 Gulf War?

I actually applaud your email and appreciate the question you raise. You wrote, "This is an illness affecting everyone I understand that; but it is not something we are sick form due to our service in the Gulf war". There are some key co-morbidities related to COVID-19. What if there is either increased or decreased susceptibility to COVID-19 from serving in the Gulf War theater of operation. It would be good to know. Your opinion, if I understand it, is that the outcome of studying this would be there is "no effect". That would be good to prove.

Hoping you do call in to the meeting to express your important opinion. I would look forward from hearing you "live" during the meeting.

Keep Going with your criticisms of the RAC GWI. We take the criticism very seriously.

Mr. Bunker Reply—Mon 7/6/2020 2:31 PM

The charter is for the study of the illnesses raising from our service in the Gulf War and COVID is a new virus and did not start in the gulf war. While many veterans of the Gulf war have raspatory issues due to the sand, oil vapers, and other PM as well as the smoke. The committee should be looking at those issues to help veterans.

To many of the veterans do not get the care they need as their doctors do not know how to treat their illnesses and the committee has yet to really handle this issue. While some doctors know what a CMI is many doctors other types of PCP's that a veteran have do not. This is one of the biggest roadblock to better care.

There needs to be an honest effort to update the caregivers understanding about what the veterans illnesses are and how to best treat the symptoms. To many veterans are over medicated causing added symptoms.

I do understand that many of us GWV are in a higher risk bracket for COVID due to our problems, as I have problems with my lungs since the war.

Dr. Steinman Reply—Mon 7/6/2020 3:06 PM

I think all your points are made well, and I agree. I concur most strongly with your comment that "There needs to be an honest effort to update the caregivers understanding about what the veterans illnesses are and how to best treat the symptoms."

However, ***if*** Gulf War veterans are actually at increased risk for COVID-19 due to their service, then we MUST know that. I contend that we would be remiss NOT to address this matter. We can respectfully disagree about how we should prioritize the many issues facing Gulf War veterans.

The agenda shows we cover COVID-19 issues from 11:25 to 12:15 (50 minutes) with 4 speakers. The remainder of the meeting until the public session ends at 330 is about other matters outside COVID-19. The agenda for the public meeting from 11 to 330 thus has 50 minutes devoted to COVID-19 and the remainder to other topics. If we subtract the 15 min break we have 50 min out of the 255 min program devoted to COVID-19. That is less than 20% of the public time (19.6%). I had not made these calculations until you raised the issue.

Therefore, I think the time allotted is appropriate for discussion of COVID-19. We may learn something important related to Gulf War veterans and their (your) health.

I hope you see what I mean when I say that I take your criticism quite seriously. And I mostly agree with you Jim on what you wrote.

Dr. Rumm Reply—Mon 7/7/2020 3:34 AM

Good am – FYI this article and a YouTube video by Dr. Klimas (GWI and potential > risk Covid) led to a lot of interest in topic from Veterans and Congress has also raised interest of Covid-19 and health of Veterans, especially potentially related to burn pits exposures.

https://connectingvets.radio.com/articles/gulf-war-veterans-could-be-at-higher-risk-for-coronavirus

https://www.youtube.com/watch?v=zvBfGLjsUvc

VA has had this box on the GWR site:

Registry health exam.

Coronavirus (COVID-19) and your risk. We recognize that everyone is concerned about the risk of contracting Coronavirus (COVID-19), including Veterans. Veterans have the same risk for Coronavirus infection and illness severity as the general population, based on the current understanding of this virus. According to the Centers for Disease Control and Prevention (CDC), COVID-19 is a new disease and there is limited information regarding risk factors for severe disease. Those who may be at higher risk for more severe complications from COVID-19 include adults age 65 or over; smokers; those who reside in a nursing

home or long-term care facility; and those who have an underlying health condition such as chronic lung disease, asthma, a serious heart condition, breathing problems, diabetes, severe obesity, chronic kidney disease, liver disease, or are immunocompromised. ..you have specific health concerns, please discuss them with your primary health care team. All individuals should adhere to recommended precautions regarding the virus such as frequent hand washing for at least 20 seconds, avoiding touching your face, and keeping six feet of space between yourself and others. For Veterans' health and safety, environmental health registry evaluations are deferred or offered via telehealth, depending on the location https://www.publichealth.va.gov/exposures/gulfwar/benefits/registry-exam.asp

Mr. Bunker Comment—Mon 7/7/2020 12:11 PM

I have been on the phone most of the day. I would like to share about the claims and the DBQ.

1. Why some CFS claims get denied
2. the problem with IBS DBQ

Mr. Bunker Comment Regarding: Information on the child study 4 years ago—Mon 7/7/2020 2:23 PM

I do not have the Email I sent to Victor.
I did find this link to a study. https://www.latimes.com/archives/la-xpm-1994-10-21-mn-53035-story.html

Then a second one from the CDC
https://www.researchgate.net/publication/316718168_Increased_Risk_of_Chronic_Multisymptom_Illness_in_Spouses_of_Gulf_War_Era_Veterans

Both do cover the time frame of the caller on the phone today. I know I send Victor a copy of a survey and some other information but that emails of 2015 is not on my server anymore.

Dr. Block Reply—Mon 7/7/2020 2:40 PM

Thanks Jim. I have never heard of The Banking Committee study. I was aware of the other. It seems like there were so many studies going on then, some grassroots, some operational, and some research. I'll wait and see what Peter Rumm adds to this discussion. He was going to look into it as well.

Dr. Rumm Reply—Mon 7/7/2020 5:42 PM

From what I can tell the Banking Committee ordered a study but the results are not available. A study on about 900 spouses led to two papers (one you sent and one about ten years earlier). I am going to emphasize with her the recent law and the fact more research is needed (being actively looked into by federal agencies now) and share one of the spousal papers with her. I will send her a link to the executive summary of the NASEM report as well.

Dr. Block Reply—Mon 7/7/2020 7:19 PM

OK, Thanks Peter. Can you send me the other paper (the ten years earlier one) if it isn't too much trouble. I think I read a few papers suggesting that spouses and family members of Veterans with PTSD do have poor health conditions compared to those families of Veterans without PTSD. However, the generational effects and physiological effects are what I think the community is talking about. Two different things….. One is secondary and indirect stress-mediated and whereas the other would be a direct biological change leading to a health outcome respectively.

Dr. Rumm Reply—Mon 7/8/2020 3:04 AM

Here is the first study (2006) I mentioned did not find significant issues in spouses of GW Veterans. I am also attaching the 2017 study which stated: *There was not a statistically significant difference in the prevalence of CMI among spouses of DV compared with spouses of NDV [non-deployed]*. I am researching to try to find the "Banking Committee study" today.

[Note: Following are two PubMed linked references provided in lieu of two article PDFs that were attached with Dr. Rumm's email reply.]

Increased Risk of Chronic Multisymptom Illness in Spouses of Gulf War Era Veterans.

Blanchard M, Toomey R, Karlinsky J, Reda D, Alpern R, Xue L.

Mil Med. 2017 May;182(5):e1648-e1656. doi: 10.7205/MILMED-D-16-00194.PMID: 29087907

Spouses of Persian Gulf War I veterans: medical evaluation of a U.S. cohort.

Eisen SA, Karlinsky J, Jackson LW, Blanchard M, Kang HK, Murphy FM, Alpern R, Reda DJ, Toomey R, Battistone MJ, Parks BJ, Klimas N, Pak HS, Hunter J, Lyons MJ, Henderson WG; Gulf War Study Partcipating Investigators.

Mil Med. 2006 Jul;171(7):613-8. doi: 10.7205/milmed.171.7.613.PMID: 16895127

Mr. Bunker Reply—Mon 7/8/2020 7:39 AM

Dr. Rumm Thank you, and as we did address on the phone there was some problems in keeping research going when 9-11 happened.

I think moving forward and conducting more research that is well thought out is best.

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