



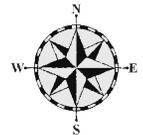
Fleet Public Health

Navy Environmental Health Center

Volume 6, No. 2

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NEPMU-2
Norfolk, VA



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From the OIC:

Fleet Health Promotion NEPMU-2 Experience

In August 1998, the Director of Health Promotion (HP) at the Navy Environmental Health Center (NEHC) made the decision to establish a pilot program at NEPMU-2 to evaluate the effectiveness of strengthening HP capabilities at the NEPMUs. A full time civilian Public Health Educator (and, as importantly, an experienced Health Promotion Manager) was transferred with startup funds from NEHC to NEPMU-2 to stand up the Unit's Health Promotion (HP) Department. Up to that point in time, HP at NEPMU-2 had been only the collateral duty responsibility of one of the other Preventive Medicine Specialists assigned to the Unit. This individual had little time and funding that could be dedicated solely to the purpose of enhancing HP products and services to the Fleet.

The mission of the new Department Head, Ms. Nancy Von Tersch, was clearly defined: "Provide direct Health Promotion Program support to the Atlantic Fleet and Force Marines." Her program objectives included defining her target population; defining the need for HP services; and providing HP program guidance, support, and assistance to the Fleet and the Marine Corps.

As a one-person Department, it was obvious that Ms. Von Tersch could not provide effective service to

the entire customer population in NEPMU-2's area of responsibility. Therefore, the target population was reduced to the active duty population in the Hampton Roads area belonging to the following operational commands:

Shore Staffs

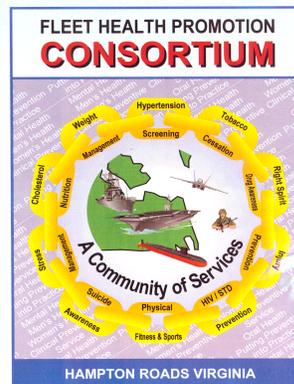
CINCLANTFLT
COMNAVAIRLANT
COMNAVSURFLANT
COMNAVSUBLANT

MARFORLANT
CONSECONDNCB
MSC
AMPHIBGROUPTWO
RSG

Afloat Commands

5 Aircraft Carriers
71 SURFLANT Ships
12 Submarines
13 ships of Military Sealift Command

Initially, Ms. Von Tersch was NEPMU-2's sole provider of HP products and services. But, over time, she has been able to train and utilize the personnel assigned to the Preventive Medicine Partnership at NEPMU-2 to assist her in taking HP services to the Fleet. And, she was able to coordinate the creation of a Fleet Health Promotion Consortium in the Hampton Roads area whose membership is engaged in trying to provide efficient distribution of HP resources to the operational customers.



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Navy Environmental and Preventive Medicine

Unit No. 2, Norfolk, VA – Unit No. 5, San Diego, CA – Unit No. 6, Pearl Harbor, HI – Unit No. 7, Sigonella, IT

From the S.E.L.



Greetings. Let me begin by saying I trust everyone is off to a successful start to 2001 and report it is great to be back at NEPMU-2! It was some fourteen years ago, after a short stint with NEHC that I first reported for duty here at the Unit. Ironically, the same recently occurred for the second time in my career, albeit a bit longer tour with NEHC this time and a much more challenging assignment. As many of you may know, I made the short drive down I-64 to assume the SEL duties here at NEPMU-2 in early October. My sincere thanks go out to the entire Plans and Ops Directorate. Captain Beddard and company treated me to ten outstanding and truly memorable months. Although my stay was short, it was an extremely educational and personally rewarding assignment, to say the least. I was provided the opportunity to see first hand the future of Operational Medicine is certainly alive and well. The collaborative efforts of BU-MED and worldwide NEHC dedicated to deliver an even more robust Preventive Medicine team, the Forward Deployable Preventive Medicine Unit (FD-PMU), will ensure we remain poised to meet all Force Health Protection challenges for many years to come.

I had the distinct privilege to participate in the Training Requirements Inventory (TRI) Validation Conference for Preventive Medicine Technicians held at the Naval School of Health Sciences in San Diego last summer with several other preventive medicine and disease vector professionals from around the world. This conference convenes every third year to conduct a thorough review of the existing PMT curriculum and to determine if changes should be incorporated into future classes. Several modifications are forthcoming and scheduled to be implemented in the June 2001 Preventive Medicine Technician (PMT) class. Although the school will remain six months in

length, the PMT School staff has worked extremely hard to realign the current curriculum and incorporate the following new topics:

- 12 hours of Chemical, Biological, Radiological, and Environmental (CBRE) Warfare training
- 10 hours of Shipboard Automated Medical Systems (SAMS) training using the latest version
- Introduction to "Putting Prevention into Practice (PPIP)"
- SHARP (Sexual Health and Responsibility Program) sponsored by NEHC will be introduced

A two-week field rotation will be re-introduced to the June 2001 class. This will mark the first time in several years a class will have completed a rotation to NEPMU-5, Naval Medical Center San Diego, and Marine Corps Base, Camp Pendleton. Shipboard preventive medicine indoctrinations are also on tap. Another distinct change is the assignment of two separate grade point averages (GPAs), the first upon completing the preventive medicine phase of the curriculum and the second upon completing the four-week disease vector rotation instructed by NDVECC Bangor. A heavier emphasis on epidemiology and mathematics can also be expected beginning in June.

With our current PMT inventory an unhealthy 80 percent, I think it is important to recognize the diligent efforts of the schoolhouse staff to improve the quality of formal training being offered to today's PMT. It is also important to recognize that the Force Master Chief's Office considers the 8432 NEC (Navy Enlisted Code) critical in the support of Navy Medicine and in particular, Operational Medicine. His Office endorses upward mobility for PMTs without setting caps on paygrade, which is not the case for all

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Please Note:

In the last issue, (Jan 01) the NEPMU-5 website was listed incorrectly. The listing above is correct.

From the OIC: Fleet Health Promotion – NEPMU-2 Experience

A summary of the particular services that NEPMU-2 has been directly able to provide over the past 2-1/2 years includes:

- Site Visits/Technical Assist Visits
- Consultations
- HP Briefings
- Health Fairs (6)
- Training
 - Pre-Executive Officer Briefs for COMNAV-SURFLANT and SWOMIC
 - Health Promotion Program Deckplate Training Course
 - Train-the-Trainer Courses
 - Public Health Education in the Nine Program Elements
- HP Program Development
- Delivery of Educational Resources
 - HP Program Resources
 - Health Education Resources
- Assistance on Shipboard Award Incentive Programs
 - Green H: Provided direct support to 14 of the 71 CY-99 winners
 - Blue M: Provided direct support to two Blue “M” winners in CY-99
- Assistance on Shipboard Health Risk Appraisal Programs
 - 12,000 processed by NEPMU-2 staff

In the future, the Unit will only see an increase in requests for HP products and services to the fleet. The HP Department is looking to expand its customer population to 200 afloat commands including 6 aircraft carriers, 122 COMNAVSURFLANT ships, 32 submarines, and 38 ships for Military Sealift Command. Per the request of the SURFLANT Fleet Surgeon, Ms. Von Tersch has visits scheduled to Pascagoula, MS (5 ships); Mayport, FL (18 ships); Earle, NJ (5 ships); and Ingleside, TX (22 ships) for the purpose of visiting the HP directors for the local MTFs, teaching SURFLANT’s one-day HP Deckplate Training Course, and conducting site and technical assist visits to the ships at these locations. Also, it is anticipated that the Unit’s participation in the Fleet Health Promotion Consortium will increase.

The establishment of the Fleet Health Promotion Consortium (FHPC) in the Hampton Roads area was a major initiative for Ms. Von Tersch after her arrival to the Unit. The FHPC is an organization that brings the providers of HP services and the customers for these services together into a common forum where the customers can identify their needs and the service providers can determine the most effi-

cient means to fulfill those needs. The FHPC functions as a semi-official organization of organizations and has an established mission statement, bylaws and charters, a vision statement, functional goals, and 4 working groups. Membership has increased from 23 service provider organizations at the first meeting in May 1999 to 33 service provider organizations in the most recent meeting in November 2000. Marketing Briefs have been conducted for the TYCOM Surgeons; CINCLANTFLT Surgeon; CO, MIDATLANTIC Region; CO, Naval Medical Center Portsmouth; CO, NEHC; Director Community Health Services, Naval Hospital Portsmouth; and for the numerous stakeholders whose organizations are represented on the Consortium.

Advantages of the Consortium are that it encourages networking, cooperation, and collaboration among the service providers and that it allows for sharing of limited HP resources in the Hampton Roads area. The Consortium also minimizes duplication of efforts and improves trust and communication among all the HP service providers in the area. Benefits to the customer include “Health Promotion made easy” (one-stop shopping for HP services; “how to” direction on HP program development); proactive delivery of products and services pierside or onboard ship; and the potential for increased “political” clout to obtain resources to supplement programs (many voices speak louder than one voice).

It was the work of the membership from the FHPC that resulted in a needs assessment that successfully canvassed the ships in SURFLANT as to their HP needs. The FHPC is now working on the process by which these needs will be met and by which any interventions that are initiated can be tracked and outcome measures developed that will help determine the effectiveness of both the FHPC and its interventions.

The pilot program at NEPMU-2, at least anecdotally, demonstrates the value of having full time HP service assets at the waterfront. The customer receives HP services and expertise either directly from the NEPMU or indirectly through an organization such as the FHPC.

But, as always, this service comes at a cost. HP is not inexpensive. Personnel to stand up full time HP staffs at locations such as the NEPMUs, health education materials to support HP’s nine program elements, consumables to support health fairs and screenings, travel costs to support training at off-site locations are just some of the costs associated with this program. No one organization can be asked to “foot this bill”; all organizations in the Navy, medical or otherwise, must bear some of the responsibility for costs that can ensure the health and safety of those who work for them. Maintenance of the Navy’s human machines is as much an obligation of Commanding Officers as is maintenance of his/her inanimate machines. In the case of HP, even though the

From the OIC: Fleet Health Promotion - NEPMU-2 Experience

(Continued from page 3)

feedback on a particular “maintenance” intervention is not immediately evident in terms of return to the overall mission of the command, a Commanding Officer must not downplay its importance when determining what programs to support and what programs to put on the back burner. Otherwise, HP will never be placed in the position of importance that it deserves.

Individually, also, all of us have to contribute to “footing the bill” for Health Promotion. Sometimes, that means personally looking at our behaviors and making the necessary changes to improve our health outcomes. And other times, it means dedicating personal time and effort to support HP initiatives which may influence change in someone else’s unhealthy behaviors. As it affects a command, it is up to each individual to let leadership know what is important in terms of overall health and welfare, so that funding that focuses on maintenance of the human machines assumes

the same level of importance as that that focuses on maintenance of inanimate machines.

The pilot program at NEPMU-2 is an initiative that has been successful in enhancing Health Promotion efforts at the deckplate in support of the health and welfare of the Navy’s active duty personnel. As an offshoot to this initiative, the FHPC will hopefully provide a process that enables the equitable, targeted distribution of HP resources and services to operational commands in the Hampton Roads area. But, clearly, we in the medical community are instrumental in ensuring the success of HP initiatives within our commands by constantly reinforcing the need to focus and prioritize command initiatives and resources on preventing disease and injury in our military personnel now and in the future. Data collected as a result of these HP initiatives will better enable Navy Medicine to Manage the Health of Our Populations.

CAPT Dwight C. Fulton
OIC, NEPMU-2

From the S.E.L.

(Continued from page 2)

NECs. The Force and his staff understand the diversity and vital role Big Navy places on us as more is expected today than ever before. Just recently the FD-PMU Blue Team here at the Unit, as well as their three NDVECC Jax colleagues, were the first within Navy Medicine to complete a high-powered, three-week intensive course of instruction in familiarization and training on equipment that historically has been reserved for those with backgrounds in chemical detection and exposure, hazardous material spill response and damage control decontamination procedures. PMTs are now being asked to move into the Chem/Bio arena and become proficient in detecting and identifying chemical and biological

hazards, something never before considered or required. This initiative affords the young, hard-charging corpsman new opportunities and challenges in a relatively uncharted field of preventive medicine.

As we continue to develop this newest Navy Medicine capability, we should remember that although we do have the Force’s support, we cannot stop here. I too say, as has been the topic of several recent SEL articles, that we must continue to promote our specialty and do all we can to ensure every PMT school seat gets filled. New horizons await each of us so let’s reinforce the message to Stay Navy and “Accelerate Your Life”!

M. W. LAWRENCE
HMCS (SW/AW) USN
SEL

Eight Socialist Republic of Vietnam (SRV) senior military medical officers completed a comprehensive tour of the NEPMU-6 facilities...



...on Tuesday, February 13, 2001. The Vietnamese delegation was sponsored by CINCPACFLT, as part of the US and SRV Bilateral Humanitarian Medical Assistance Conference. The visit to NEPMU6 served as an opportunity for information sharing and team building as a precursor to future MED/DEN Civic Action Programs. NEPMU6 and the Vietnamese delegation presented each other with mementos to commemorate the visit. Commander Ken Ockermann, MSC (center) and HMC(AW/SW/FMF) Schloegl (left, back row) gave each SRV delegation member a Hawaiian flower lei and an NEPMU6 Unit Coin, and the Vietnamese delegation presented NEPMU6 with a long-stitch needlework depicting a flower. Subsequently, the Unit Brief was presented to the SRV representatives at a multi-service briefing/discussion session at CINCPACFLT. (US Navy photo)

Military Tropical Medicine Field Mission to the Dominican Republic

A class of 12 students taking the Military Tropical Medicine course, that is offered annually by the Naval School of Health Sciences (NSHS), deployed to the Dominican Republic July 29 to August 11, 2000. They were led by NSHS instructors CAPT Michael Crutcher, MC, USNR, and LCOL Glenn Wortmann, MC, USA, Walter Reed Army Institute of Research. Students and staff represented the US Navy, Air Force, and Army. Similar teams deployed to Brazil, Belize, and Peru, among other locations. The course is open to Medical Corps Officers and my role as the NEPMU-2 Microbiologist, was to serve as lab officer during the field mission providing specimen-processing capability. In addition, I supplied the need for Spanish interpretation during the course, especially during clinical case presentations by local physicians and in the interactions of US medical personnel with patients and other



An NSHS student welcomes and interviews, with the help of a translator, a patient along with her two children.

locals.

The schedule consisted of three days in the historic capital city of Santo Domingo visiting military and public hospitals, where students listened to clinical case presentations by local medical professionals. In the middle of the course, the team moved to the town of San Juan de la Maguana for five days to set up a temporary acute care facility. Three villages in the San Juan province were visited, one per

day, where a total of approximately 800 patients were seen. All children were given presumptive treatment for intestinal parasites and received vitamins and medications for common upper respiratory illnesses, as needed. The set-up consisted of a patient interview area, patient examination area, laboratory, and pharmacy. Dental services were also provided, which consisted mainly of tooth extractions. The local Dominican team consisted of a team leader, COL Ramon Rojas, ten translators (some with medical degrees), two dental officers, one dental technician, one pharmacy technician, and two drivers. The trip to San Juan was followed by another three days of hospital visits in Santo Domingo. In all, the team visited six hospitals, two of which were military and four were public. Two of the public hospitals were exclusively pediatric and one was dedicated only to dermatology. The visits also included the Pan-American Health Organization (PAHO) where students heard lectures about zoonotic diseases, nutrition, epidemiology, environmental challenges, tropical diseases, and the Dominican Public Health Service. At the Tropical Medicine Center, the team visited the Malaria unit, under the direction of Dr Guillermo Gonzalve, and heard expositions on several parasitic diseases. Among the clinical syndromes examined during the week were tuberculosis (pulmonary and extra pulmonary), dengue and dengue hemorrhagic fever, leprosy (tuberculoid and lepromatous), filariasis, pertussis, tetanus, AIDS, bacterial meningitis, and meningococemia.



Microbiologist interprets for the NSHS students at the Tropical Medicine Center in Santo Domingo.

**Eduardo Gomez Saladin, Ph.D.
LT MSC USNR**

Remembering...

We would like to acknowledge the passing of CAPT Louis R. Kaufman, MSC, USN (Ret), 16 February 2001.

He was a contributing factor for much of the historical information received for the Preventive Medicine Unit's 50th anniversary. He retired in 1979 after 30 years working in the Navy Preventive Medicine community. Eight of those years were spent as a staff member of the U. S. Navy Preventive Medicine Unit No. 2 during the 1950's and 1960's. He was a member of the original Unit established in 1949.



NEPMU-2 and NDVECC JAX Train for FD-PMU Platform

Historically, Navy preventive medicine professionals have been extremely successful in delivering traditional preventive medicine services such as disease surveillance, vector control and field sanitation, in an array of military settings. Navy Medicine has recognized the need for more robust deployment medical surveillance capabilities and has tasked the Navy Environmental Health Center (NEHC) to design a light, rapid response team that would be capable of deploying within a matter of hours to support preventive medicine operations worldwide.

The Forward Deployable Preventive Medicine Unit (FD-PMU) platform was designed to enhance Force Health Protection by identifying and evaluating environmental health hazards, assessing the risk of adverse health outcomes, monitoring the health of deployed forces, and advising the operational commander concerning significant risks and recommending appropriate preventive medicine interventions. This platform includes all microbiology capabilities of the Navy Forward Deployed Laboratory (FDL) plus many additional capabilities including Chemical, Biological, Radiological and Environmental (CBRE) threat detection and identification.

Navy Environmental and Preventive Medicine Unit No. 2 (NEPMU-2) and Disease Vector Ecology and Control Center (DVECC), Jacksonville, FL recently joined forces in Norfolk, VA, to complete three weeks of intensive chemical detection and identification capability training as a first step toward the formation of the East Coast FD-PMU. This element, under NEHC's direction and the first within Navy Medicine, spent many classroom hours learning the theory and operation of portable Gas Chromatograph/Mass Spectrometry devices, "four gas" analyzers, photo ionization detectors and other sophisticated detection instruments. Classroom and field training were conducted at the old AMC terminal on board the Norfolk



Preventive medicine personnel operate the Inficon Hapsite – a field portable Gas Chromatograph/Mass Spectrometer (GC/MS) for on-site analysis of volatile organic compounds.

Naval Air Station where students learned a variety of collection and detection techniques for chemical warfare agents and toxic industrial chemicals, and chemical protective equipment, including civilian level A and Self-Contained Breathing Apparatus (SCBA). This training and equipment will enhance existing preventive medicine skills and increase capabilities of the NEPMUs and DVECCs to meet the challenges of 21st century hazards and threats in a CBRE threat



Team personnel decontaminate a fellow team member at the portable decontamination facility.

environment.

NEPMU-2 was chosen as the testing and evaluation platform for transition from the Medical Mobilization Augmentation Readiness Team

(MMART) to the FD-PMU platform concept.

This exercise included training by the Inficon Company and Battelle Memorial Institute. Selection of equipment, concepts of operation and standard operating procedures have been the result of a combined effort by a team of component managers from NEHC, the NEPMUs, and DVECCs with expertise in Logistics, Preventive Medicine, Industrial Hygiene, Environmental Health, Entomology, Microbiology, and Radiation Protection.

LTJG Jacqueline Piotrowski and Ms. Martha Murray at NEPMU-2 were selected to coordinate the first detailed training schedule that took weeks of intense work to organize. Personnel who completed training were LT Stancil, HM1 Phillips and HM1 Dean from DVECC, Jacksonville and LCDR Haissig, LCDR Blankenship, LT Garland, LT Gomez, HMC Caldwell, HMC Szczepanski, HM1 Chamberlain, HM2 Yett, and HM3 Snider from NEPMU-2, Norfolk.

In successive weeks to follow, NEPMU-6 in Pearl Harbor, NEPMU-5 in San Diego, in cooperation with DVECC in Bangor, and NEPMU-7 in Sigonella will also complete this same training schedule. The FD-PMU concept has been under development for approximately four years and is to become a reality in FY-04. The program manager for this capability is CAPT Diana Novak, Deputy Director for the Plans and Operations Directorate at NEHC.

**CDR Gregory A. Harris, MSC, USN
Director, Deployment Medical Surveillance**

Outbreak of West Nile Virus United States 1999-2000

West Nile Virus (WNV) is a flavivirus in the Japanese encephalitis complex, which also includes St. Louis Encephalitis. According to the Centers for Disease Control and Prevention (CDC), it was first isolated in 1937 in the West Nile district of Uganda and has been involved in outbreaks in Romania in 1997, Russia in 1999, and Israel in 2000. The outbreak in New York City in September 1999 was centered in the borough of Queens and resulted in 62 cases with seven deaths occurring in people over 50 years old. The disease was first thought to be St. Louis Encephalitis, but was later confirmed as WNV during an analysis of dead exotic birds from the Bronx Zoo. WNV is spread by house mosquitoes like *Culex pipiens* and flood-water mosquitoes like *Aedes vexans*. Also, mosquitoes that breed in artificial containers around the home such as the Asian Tiger Mosquito (*Aedes albopictus*) and the newly introduced *Ochlerotatus japonicus* have been shown to be excellent vectors for WNV in the laboratory.

The CDC provided funding for public health agencies along the Eastern Seaboard to conduct surveillance to track the disease's progression, and they detected the virus in mosquitoes, dead wild birds, and horses. Cages of domestic sentinel chickens were also used to monitor for the presence of WNV, and NEPMU-2 used one in the local Norfolk area (Fig. 1). In 2000, there were 21 human cases and two deaths. The cases were from Connecticut (1 case), New York (14 cases) and New Jersey (6 cases). Deaths occurred in September, in an 82-year-old New Jersey man, and in December, in an 87 year-old New York woman, who had been hospitalized in a coma since August.

Results of the surveillance program showed that the disease had extended its reach, with numerous wild birds found positive in New Hampshire, Massachusetts, Rhode Island, Connecticut, New York, New Jersey, Pennsylvania and Maryland. Single positive wild birds were found in a few counties in Vermont, Virginia, and North Carolina. Infected mosquitoes were found in Massachusetts, Connecticut, New York, New Jersey and Pennsylvania, with infected horses found in Massachusetts, Rhode Island, Connecticut,



Fig. 1: Staff member performs blood draw on sentinel chicken.

New York, New Jersey, Pennsylvania and Delaware. WNV infections were detected during biweekly bleedings of sentinel chickens in New York, but only after human and animal cases were reported.

The surveillance data show that WNV is slowly migrating in wild bird populations south along the eastern seaboard, with westward migration in New York and Pennsylvania. WNV has been found in many species of wild and migratory birds from gulls to red-tailed hawks, but is most common in American Crows (Fig. 2) and Blue Jays. The chance for cases here in Norfolk and surrounding areas will increase next Summer and Fall. Local medical departments should be on the lookout for the disease. If you find dead birds (especially crows or jays) near your home, please call your local health department and find out if they have a protocol for picking them up for analysis, since guidelines vary from state to state.

Young children and people over 55 years old are most susceptible to developing encephalitis from the virus. In the young active-duty population most infections will be asymptomatic or present with mild fever, headache and body aches. Severe cases of WNV encephalitis are characterized by high fever, mental status changes, nausea, vomiting, a flat or slightly raised rash and swollen lymph nodes. Treatment is supportive, and may include mechanical ventilation. Patients who recover from WNV infection generally do not have any long-term complications. The overall mortality rate is 3% to 15%.

WNV is only transmitted by the bite of an infected mosquito, so protect yourself from being bitten. Use personal protective measures during mosquito season (April to October) in the peak biting times of dusk and dawn. Wear loose fitting shirts with long sleeves, long pants, and cover all exposed skin with insect repellent containing 30% DEET. Be careful applying DEET to areas around the face and eyes and sparingly apply repellent to small children. Mosquitoes breed in as little as a few teaspoons of water, so eliminate standing water in birdbaths, flower pots, gutters, old tires, and children's toys to get rid of these pests!



Fig. 2: American Crow, *Corvus brachyrhynchos*.

CDR James E. LaMar
Threat Assessment

LT Frederick M. Stell
Entomology

TB Prevention and Control: 1999 Results, NEPMU-2 AOR

Recent Tuberculosis (TB) outbreaks among Marines and Sailors demonstrate that our personnel remain vulnerable to this disease, especially because of the close working and living quarters aboard ship. The goal of the Navy's TB control program is to detect and treat TB as early as possible, reducing illness and death and decreasing the spread of TB. A short review of the Navy's TB Control program with 1999 data reported to NEPMU-2 is presented.

The Navy's TB Control Program consists of periodic Tuberculin Skin Testing (TST), treatment of newly identified reactors – designated by the new BUMED instruction, to be published this year, as Latent Tuberculosis Infections (LTBI), treatment of active TB cases and performing contact investigations. TST should be done annually for personnel in operational units and in units with a high risk for TB exposure or outbreaks. This includes all shipboard personnel (active duty and civil service), all members of deployable Navy and Marine Corps units, all health care workers and all inmates and staff of Naval Brigs. If shipboard personnel have not had a TST done within 12 months, a TST

must be administered and read within one week of embarking or reporting in high risk areas. Also, if personnel do not have a current TST when reporting to a new duty station, a TST must be administered and read. The forthcoming BUMED TB instruction has an important change: Newly identified reactors, (LTBI cases), are required to receive 9 months of INH (Isoniazid), not 6 months, as required by the 1993 instruction.

Triennial TST is required for all other active duty and reserve personnel in low risk areas. This can be conducted during Physical examinations, receipt of Permanent Change of Station (PCS) orders, review of medical records by a Medical Department Representative (MDR), or on reporting for active duty for training. If the rate of newly identified LTBI cases is greater than 2.5% among any group tested, then medical department personnel must search for an active case of tuberculosis disease among individuals from common berthing, work and social/recreational areas.

The Navy TB instruction requires commands to prepare and submit an "Annual Summary of Tuberculosis Screening of Active Duty and Civilian Mariners" by 15 February of each year to the area Navy Environmental and Preventive Medicine Unit. The 1999 screening results reported to NEPMU-2 are shown in the accompanying table.

Table 1. 1999 Annual Summary of Tuberculosis Screening of Navy and USMC active duty personnel and Civilian Mariners reported to NEPMU-2

SHIP/Station	Total Personnel	Number Tested	LTBI	LTBI		Old Reactors	Active TB Cases	New LTBI Rate
				Treated	Not treated			
Submarines	7,081	6,350	31	21	2	180	0	0.49%
Surface Fleet	21,281	19,976	134	152	4	1,335	2	0.67%
Carriers (CVs)	21,114	17,114	53	92	11	834	0	0.31%
Marines	45,639	43,606	484	480	6	762	0	1.11%
Shore Commands, Clinics, Hospitals	92,590	52,033	639	543	47	1,896	5	1.23%
Miscellaneous*	6,624	3,514	31	26	1	135	0	0.88%
Totals	194,329	142,593	1,372	1,314	71	5,142	7	0.96%

*Seabees, EOD, Seals, etc.

The overall new reactor rate or identification of new LTBI cases among commands reporting to NEPMU-2 is close to 1%. The greatest rate of new LTBI cases was in hospitals, Branch Medical Clinics and shore commands. The rates are higher in hospitals and clinics because personnel there are at increased risk of coming in contact with an active TB case. Also, if the Navy's TB control program is administered correctly - as statistics for 1999 indicate, very

few active cases should ever be aboard ship to spread infection. The reason many LTBI cases were not treated is because they may have left military service, transferred from the reporting command or in very rare episodes, had an adverse reaction to medication.

CDR James E. LaMar
Threat Assessment

NEPMU-2

Medical Event Reports, 2000

NEPMU-2 received 2,733 Medical event reports (MERs) for calendar year (CY) 2000. Of those, 62% (1684/2733) reported were for active duty members. Table 1 on the next page displays the MERs received at NEPMU-2 for active duty for CY 2000. Rates are reported as number of cases per 100,000 and derived by dividing the total number of each disease by the estimated mid-year strength of 223,000 Atlantic Fleet DON personnel (180,000 USN, 43,000 USMC), and multiplying by 100,000. Following are some highlights.

Sexually Transmitted Diseases. Ninety-one percent (1535/1684) of the reports were sexually transmitted diseases (STDs). The top three were chlamydia, gonorrhea, and non-gonococcal urethritis. These high numbers most likely reflect the continued expansion of STD screening programs in the Navy/Marine Corps and the increased used of more sensitive diagnostic tests. Screening and subsequent treatment of STDs are important as they can lead to chronic pelvic pain and infertility in females. In addition, many STDs, including chlamydia, can facilitate the transmission of an incurable disease-HIV. Education and counseling emphasizing healthy sexual practices is vital to decreasing this cause of morbidity in Navy and USMC personnel.

Animal Bites. Approximately 3% (46/1654) of the reports were of animal bites. Most of these reported were caused by known pets and Human Rabies Immune Globulin (HRIG) was not considered necessary. Although animal bite reports are required if HRIG is given to the patient, valuable information is gained from reporting of all animal bites. Although rabies in humans in the US is rare, there were over 7,000 reports of rabid animals in 1998. These were mostly wild animals such as raccoons, bats and skunks. In developing countries, where US military personnel deploy, domestic dogs remain the principal reservoir of rabies virus. Military personnel need to be aware of this risk and avoid stray or unknown animals when outside the US. Education on wound cleaning and the importance of seeking immediate medical assistance should be taught to all military members and their families.

Hepatitis (all types). There were 25 reports of hepatitis in active duty personnel for CY 2000. Of those, 84% (21/25) were Hepatitis B and C. Hepatitis B accounted for 67% (14/21) of these cases. The majority of infected patients were identified when donating blood and gave no known history of sexual or blood exposure. The Hepatitis B vaccination program among US children is expected to steadily decrease disease rates since new recruits will most likely have

been immunized as adolescents. Hepatitis C is the most common chronic blood borne infection in the US. Blood screening will continue to identify those already infected and help prevent further infection.

Vector-borne Diseases. Only 1% (19/1684) of reported events were vector-borne diseases that include dengue, malaria, Lyme disease, and Rocky Mountain Spotted Fever (RMSF). The Lyme disease rate was 6.5 cases/100,000 among Navy and Marine Corps personnel, which is similar to the overall US rate of 6.39/100,000 population. Personal Protective Measures (PPM), which include correct uniform wear and DEET application, should be emphasized when preparing deploying forces as the primary means of preventing exposure to these diseases. Also crucial is the use of buddy checks to search for ticks that may have attached to the body, an important measure in preventing tick-borne diseases such as Lyme and RMSF. Also, taking chemoprophylaxis to prevent malaria is important when traveling to malaria-endemic areas.

Enteric Diseases. Interestingly, only 9 cases of enteric diseases were reported for CY 2000 and no food-borne outbreak was described. Causative organisms reported were Campylobacter, Giardia, and Salmonella.

Varicella (Chicken pox). The number of cases of varicella in active duty Navy and Marine Corps was 4 and 1, respectively. An acute systemic viral disease diagnosed by its characteristic rash, varicella is usually a mild childhood infection. However, in adults the fever and rash may be severe. The overall case fatality rate in the United States is 2/100,000; but rises to 30/100,000 in adults. Even with minimal complications, this disease is highly infectious and requires patients to be isolated from the general public for at least five days after the skin rash first appears. Patients who have had varicella have a lifetime risk of herpes zoster, a very painful local reactivation of latent varicella infection. The potential of varicella to cause death and severe disease in military personnel never exposed to it requires its continued surveillance in the active duty population. A live attenuated varicella vaccine has been available in the United States for approximately 6 years. Current Navy/Marine Corps standards require personnel to receive the 2-dose varicella series or have a past history of chicken pox. Some commands have decided to screen for antibodies to varicella as many individuals cannot give a reliable history.

Heat Injuries. Although not an infectious disease, heat injuries can cause significant morbidity in military personnel, especially in the tropics and southern areas of the United States in summertime. There were 7 heat injuries reported to NEPMU-2 in CY 2000. The wet bulb globe temperature ranged from 66 to 84 degrees Fahrenheit. All patients re-

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NEPMU-2 Medical Event Reports 2000

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ceived supportive therapy and fully recovered. Preventive measures include leadership enforcement of rest/work cycles guided by heat condition flags. Also necessary is educating individuals to acclimate to new environments before exertion, to remain adequately hydrated and to consume no alcoholic beverages at least 48 hours prior to increased physical work or exercise.

Summary. Medical event reporting is a continuing challenge to the Navy medical community. Recent computerization of the process using the Navy Disease Reporting System (NDRS), soon to be part of SAMS, will aid in the proc-

ess of monitoring closely for mission-degrading diseases and conditions. Acting on this information, the Navy-Marine Corps can quickly employ preventive measures when medical event rates begin to rise. Timely and complete reporting is critical to identify emerging or reemerging infectious disease and to protect our personnel strength from these threats. However, letting you the reporting commands, know what diseases are increasing and may pose threats to your personnel is crucial in completing the cycle of surveillance.

LCDR T. Blankenship, MC, USNR

Table 1. MERs reported to NEPMU-2, Active Duty Navy and Marine Corps, 2000

Disease	USN	USMC	TOTAL	Rate/ 100,000
Animal Bites	36	10	46	20.6
Bacterial Meningitis NOS	1	0	1	0.4
Botulism	1	0	1	0.4
Campylobacteriosis	2	0	2	0.9
Chlamydia	481	421	902	404.5
Condyloma Acuminatum	2	0	2	0.9
Dengue Fever (Specify Type)	1	0	1	0.4
E. Coli 0157:h7 Infection	1	0	1	0.4
Giardiasis	2	0	2	0.9
Gonorrhea	218	110	328	147.1
Hantavirus Infection	1	0	1	0.4
Heat Injuries	1	6	7	3.1
Hepatitis (All Types)	13	12	25	11.2
Lyme Disease	4	3	7	3.1
Lymphogranuloma Venereum	0	1	1	0.4
Malaria	4	3	7	3.1
Meningitis (All Types)	7	5	12	5.4
Meningococemia	1	0	1	0.4
Occupational Blood Exposure	15	0	15	6.7
Pneumonia	1	0	1	0.4
Rocky Mountain Spotted Fever	3	1	4	1.3
Salmonellosis	1	2	3	1.3
Streptococcal Disease, GRP A, Invasive	2	1	3	1.3
Syphilis	12	5	17	7.6
Tuberculosis— Pulmonary, Active	4	0	4	1.8
Urethritis (Non-gonococcal)	54	231	285	127.8
Varicella (Chicken Pox, Active Duty Only)	4	1	5	2.2
TOTAL	872	812	1684	755.2

NOTE: A reportable disease not listed indicates zero reports for that disease.

The Fluoride Debate *OR*

How to Beat a Dead Gift Horse Without Looking it in the Mouth

About sixty years ago, it was determined that fluoride occurring naturally in drinking water prevented cavities, and communities began to add it to their water (with dramatic improvements in dental health). Some people were immediately opposed to it for a variety of reasons. After all these years, there is still spirited debate from the opposition. But the response from the public health community consists mostly of rolling eyes and a few snickers punctuated by an occasional yawn. The main thrust of the anti-fluoridation argument has gone through many changes over the years, always involving a vast conspiracy with many layers, and always with murderous intent at the core. One of the more interesting theories offered by the anti-fluoridation leadership was that it was a communist plot to take over the U.S. (this was in favor during the 50s and 60s). The current theory has the conspiracy being led by the aluminum industry (or possibly the fertilizer industry – depending on who you ask). Joining these industrial leaders are the U.S. Public Health Service, the American Medical Association, the American Dental Association, the entire scientific community and a host of government and non-government organizations, groups and individuals (see endorsements for fluoridation for a complete list). The conspiracy goes something like this: the aluminum (or fertilizer) industry has all this waste fluoride they don't know what to do with, so they fake a bunch of research to make it look like fluoride is beneficial (even though everyone knows it's poison). Once they create a need, they begin selling the stuff to water suppliers at a profit. All the co-conspirators go along with this for unknown reasons (there isn't enough money involved to give everyone a cut), but they are all connected by elaborate "six degrees of Kevin Bacon" evidence trails. I am not doing the whole thing justice. I recommend doing a web search, key word: fluoride, to get the "real" story.

Here's the thing: I was recently asked to do a few presentations at public forums on fluoridation for the Molokai Dental Health Coalition. They are trying to get fluoridation on the island, but are running into problems dealing with outrageous claims made by opposition groups. I agreed to provide some guidelines for helping the public differentiate opinions from evidence (although those aren't the exact words I used...). I had no idea what I was getting in to.

My first clue was finding out one of the local newspapers is owned and operated by a fiercely anti-fluoridation activist whose idea of responsible journalism is insuring his

name is spelled right on the byline. The majority of the information that had been available to the public was biased, to say the least. Claims made by the anti-fluoridation groups included: "...fatalities have occurred when fluoride saturation levels ran too high..."; "All the recent large-scale studies on fluoridation and tooth decay show that fluoridation does NOT reduce decay in permanent teeth..."; and my personal favorite, "The U.S. EPA Assistant Administrator Mr. Fox clarified in statements Sep 5, 2000 that 52-million Americans are at Risk of Adverse Health Affects from Community Water Fluoridation" (sic). Accurate information was being put out, but it wasn't having as much impact as the negative information.

At the public forums, it was easy to see that all of the people on both sides of the issue had the best interests of the community at heart, and that all concerns had to be taken seriously. I put on my best "risk communication" hat, and walked through the differences between opinion and evidence, and that opinions should be based on evidence, not mistaken for it. I used many examples from the local paper. (One man re-stated the "fatalities," saying there had been six deaths from fluoride accidents. When pressed, he conceded that these deaths were from hydrogen fluoride gas in industrial accidents, but – "it's still fluoride".) I went over "dose makes the poison" and the real toxicity data on fluoride. I produced numerous studies about the effectiveness of fluoride. I implored the audiences to look at the evidence and form their own opinions, to pin down those who make claims – for or against fluoridation. But in the end, I'm not sure I had any effect at all. The race goes to the quickest, and inaccurate information was quickest.

On Molokai, and throughout Hawaii, where a bill is pending for statewide fluoridation, no one is yawning anymore. The battle has been joined, and all of the wonderful public health benefits of fluoridation look pretty small next to the inaccurate, but very scary, warnings of doom.

And this, friends, brings us to the question that is really the point of this story: who is responsible for providing timely, accurate health information to the public? The media? Please! The media are responsible for selling their products, and scary stuff about chemicals makes a better selling front page than preventing cavities. How 'bout the civil leadership? Not hardly, politicians only tell the public what they think the public wants to hear. I submit that it is the responsibility of the health professionals to provide this kind of information to the public, particularly when there is controversy. We shouldn't assume everyone will agree with our assessments and wait until the last minute to begin providing information. And we should work with the same levels of passion and dedication as those putting out the less

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accurate information. But we should never use their tactics.

A quick refresher on the rules (in no particular order):

1. Never assume you know what motivates groups or individuals (very few anti-fluoridation activists are actually kooks, so we should not refer to them that way).
2. Never make blanket statements that cannot be (immediately) supported with irrefutable evidence. Do not say things like, "Fluoridation is absolutely safe".
3. If there is pertinent or related evidence that does not support your position, provide it anyway. If you don't, someone will eventually dig it up and have evidence of a cover-up as well.
4. If you are stating an opinion, identify it as such. It is usually okay to say something like, "In my opinion, fluoridation does not cause cancer in humans".
5. Do not make allusions to evidence you can't (immediately) produce.
6. Never tell the public what they should think. Besides being presumptuous and annoying, it's probably not in your job description. Provide evidence and let the public form their own opinions.
7. If you have the evidence, it is okay to directly challenge inaccurate information in a respectful way ("You are mistaken ma'am, the human body does not retain every last bit of fluoride consumed").
8. It is okay to challenge tactics that are obviously deceptive ("Sir, do you think it is responsible for you to present deaths from hydrogen fluoride gas accidents as evidence that water fluoridation isn't safe?").
9. Never make personal attacks (even when they are obviously warranted).
10. Answer questions openly and honestly. "I don't know" is a perfectly acceptable answer (as long as it's the truth).

These are just my rules, make your own. But get the information out. There is no shortage of controversial health issues out there. If fluoride isn't an issue, look into immunizations (varicella and anthrax are hot), herbal remedies, over-the-counter diet pills, or something more benign like sports drinks. Whenever you see less than accurate health information, don't just roll your eyes, go to work.

**LT Loren P. Locke, MSC, USN
Environmental Health Officer**

NEPMU-5 DFT Exercise to Antigua, West Indies

The rapid deployment of the NEPMU-5 Mobile Medical Augmentation Readiness Team (MMART) to Honduras following Hurricane Mitch made us realize the importance of conducting a Deployment For Training (DFT) every year to maintain readiness. For 2000, we had the opportunity to integrate with an annual U.S. Southern Command (USSOUTHCOM) exercise to get as much realistic field experience as possible, and to demonstrate the broader capabilities being developed for the future Forward Deployed Preventive Medicine Unit (FD-PMU) concept.

The major SOUTHCOM exercise is Operation New Horizons (NH), conducted each year in many parts of Central and South America and the Caribbean. We were informed that Sea Bees from Naval Mobile Construction Battalion Five were deploying to several islands in the Caribbean for NH 2000. They were to be joined by Marine Engineers from Marine Wing Support Squadron 274. We chose to go to Antigua, a small island in the Northeast Caribbean.

Antigua is known for having 365 beaches and the gorgeous harbor once commanded by Lord Nelson. Ads for the exclusive Sandals Resort run every day in the newspaper and on TV. We found out quickly that the real side of Antigua was that of a clearly less-developed nation, highly reliant on tourism, and with many public health problems that threaten the image of a Caribbean paradise. Antigua and Barbuda has been independent of the United Kingdom only since 1981, with a total population of about 80,000 and the capital (and only city) at St. John's.

LCDR Mike Medina, our MMART coordinator, was in charge of the pre-deployment planning and participated in a site visit on the island during a hurricane in October 1999. In March 2000, we collected pre-deployment sera from Sea Bees going to Trinidad, Puerto Rico, Jamaica, as well as Antigua.

The NEPMU-5 MMART consisted of CAPT Pat Olson, Preventive Medicine Officer (Team Leader); LCDR Mike Medina, Entomologist; LCDR Scott Thornton, Microbiologist; LT Allan Lumanog, Industrial Hygiene Officer; LT Diane Kelsch, Environmental Health Officer; HM1 Deborah Doggett, Medical Laboratory Technician (LPO); and Preventive Medicine Technicians HM1 Sonji Bucannon, HM1 Ernard Ongsioco, and HM2 Josie Miller. An advance party flew to Antigua on 5 July 2000 and the major gear shipment departed the Unit the same day. The rest of the personnel arrived on 9 July. Our new home was at Camp Blizard on the old U.S. Navy base, now the Antigua-

NEPMU-5 DFT Exercise to Antigua, West Indies

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Barbuda Defense Force camp. The Sea Bees had set up a camp on the old baseball field, with chow hall, laundry, and shower tents. Our admin/laboratory shared a GP Medium tent with the male MMART sleeping area. One minor glitch was that our gear did not arrive until 18 July 2000.

JTF-Antigua was composed of about 40 each of Sea Bees and Marines. Their main purpose was to build a new operations center for the Antiguan Coast Guard and also refurbish a medical clinic and a charity house. We used JTF support for food, electricity, and transportation. Since we expected few if any JTF personnel to become ill while we were there, we were interested in working with the Antiguan Ministry of Health (MOH) on several projects. Each day, we rode to the St. John's Health Clinic and then departed to different work sites, usually with a counterpart from the MOH. The big upcoming event was the summer Carnival, and the Ministry wanted the MMART to help inspect restaurants, screen and train food vendors, and eliminate the rodent problem.

CAPT Olson, LCDR Thornton, and HMC Doggett led the infectious disease surveillance effort. In Antigua, local diseases include dengue fever, diarrheal agents, leptospirosis, and typhoid fever.



A microbiologist collects Amblyomma ticks off an animal carcass.

One new disease of interest was African spotted fever (ASF), which is caused by *Rickettsia africae* and vectored by the tropical bont tick (*Amblyomma variegatum*). Although the only known New World ASF case occurred on Guadeloupe, the tick is well-known in the Caribbean. We collected over 100 *Amblyomma* ticks off (mostly) just-killed cattle at the St. John's slaughterhouse. The ticks were extracted onto paper strips and sent to the Centers for Disease Control for rickettsial PCR detection. Results are still pending at this time.

Other laboratory support included culturing cistern and bottled water, and fecal specimens from food service workers and live poultry. A rapid dipstick IgM assay detected two cases of leptospirosis in Antiguan, while other

dipsticks could not be tested due to lack of patients. There was evidence that a small outbreak of viral gastroenteritis occurred among the JTF personnel prior to our arrival. We collected sera from several Sea Bees who already had given a pre-deployment specimen. These were tested back at NEPMU-5, but were negative for human calicivirus.

LT Kelsch conducted numerous sanitation inspections on restaurants and hotels. You may be guaranteed a safe meal if you're paying \$500 a night at the very best hotels, but even some of those establishments would fail inspection in the United States. Common discrepancies included: lack of adequate refrigeration, improper storage of prepared foods, cockroach and rodent infestations, and use of untreated water directly out of cisterns.

LT Luma-nog conducted noise level, particulate, welding fumes and paint hazard surveillance for both JTF personnel and Antiguan at various commercial work sites, including a desalination



A PMT measures noise levels at a Sea Bee worksite.

plant, quarry, asphalt factory, and the airport. Indoor air quality was assessed in various locations. Soil and surface water samples were collected for comprehensive pesticide testing back in the U.S.

At Camp Blizard, LCDR Medina set live rat and mouse traps to determine species and parasites. Dozens of rodents were collected, along with land crabs, giant centipedes and fire ants. They repeated the work in the alleys of downtown St. John's, where the Oriental rat flea was found on some of the Norway rats. Ovitrap and light traps were sent up around Camp Blizard. Both *Anopheles* and *Aedes aegypti* larva were identified from tires, water cans, and standing water. A Global Positioning System receiver was used to denote sites of rodent and mosquito capture.

Besides assisting in all the above evolutions, our PMTs also provided general preventive medicine support to the camp. They inspected food storage and trash locations, and promoted hand washing. A PM checklist was created to help non-PMT corpsmen in future deployments. All of the MMART components provided training sessions for their MOH colleagues and food service workers.

We also did community support work at a local shelter for children. We tilled their garden and cleaned up a mosquito-laden ditch, while Sea Bees repainted the buildings.

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Chief Medical Officer of the Republic of Singapore Navy Visits NEPMU-6

The Chief Naval Medical Officer of the Republic of Singapore Navy (RSN), COL Edwin Low, visited the Navy Environmental and Preventive Medicine Unit 6 (NEPMU6), Pearl Harbor, HI from 5-9 February 2001. COL Low is the RSN equivalent of the U.S. Navy Surgeon General. He was accompanied by the RSN Head Naval Inspectorate, Lieutenant Colonel Foon Wai Yim, and the Prospective Head of the Naval Medicine and Hyperbaric Center, Major Michael Ong. The RSN Officers were visiting NEPMU6 to in order to learn more about the United States Navy's Occupational Health and Industrial Hygiene programs. In addition, COL Low and his colleagues were interested in learning more about the day-to-day activities and training of the Navy Industrial Hygiene Officers.

LCDR(sel) Paul Brochu of the NEPMU6 Industrial Hygiene Department, organized and executed this highly successful visit. COL Low and LCDR(sel) Brochu met in 2000 while both were completing a master's program at the Harvard School of Public Health.

While there, they found that they shared a common interest in occupational health and safety and developed a very good working relationship that eventually led to this visit to NEPMU6.

CDR Kim Taylor, CDR Jerry Formisano, LCDR Jean Williams, LCDR(sel) Brochu, and LTJG Jason Longwell, all of whom are Navy Industrial Hygiene Officers based at



A microbiologist discusses the microbiological capabilities at NEPMU6 with representatives of the Republic of Singapore Navy.

Pearl Harbor commands, provided several briefs to the RSN Officers on various aspects of the Navy Occupational Safety and Health (NAVOSH) Program. COL Low and his colleagues also visited senior Navy and Army Medical Department Officers at area commands and made tours of the Occupational Health Clinics at Pearl Harbor Naval Shipyard and Tripler Army Medical Center.

During this visit, COL Low was also kind enough to serve as guest speaker at a luncheon attended by Oahu Navy Medical Department Officers. COL Low discussed the mission, vision, and organization of the Republic of Singapore Navy. LCDR (sel) Brochu commented that "it was really enjoyable to see my friend and colleague COL Low

again and to build on the good working relationship that we developed in graduate school. I feel that this visit has been a great first step in fostering a spirit of cooperation between the Occupational Safety and Health Organizations of the United States Navy and the Republic of Singapore Navy."



A PhD, chemist briefs Republic of Singapore Navy Officers on the capabilities of the NEPMU-6 Consolidated Industrial Hygiene Laboratory. (CIHL).

LT Deidra Ramos

NEPMU-5 MMART DFT Exercise to Antigua, West Indies

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Our DFT ended on 29 July 2000, as we flew back to San Diego. It had been a rewarding experience for all members of our MMART and predicted what a future FD-PMU force health protection and humanitarian assistance deployment would be like. "Carnival" came and went the week after we left. The JTF completed their work and departed in mid-August. A hurricane slammed the island a week later.

Dengue cases were on the rise with the commencement of the rainy season.

LCDR Scott Thornton
and all the members of the
Antigua DFT MMART

Hail & Farewell

Welcome Aboard!

NEPMU-2:

NEPMU-5:

NEPMU-6:

NEPMU-7:

Fair Winds & Following Seas!

NEPMU-2:

NEPMU-5:

NEPMU-6:

NEPMU-7:

NEPMU-6: Then and Now

Navy Environmental and Preventive Medicine Unit 6 has been home based in Pearl Harbor for over fifty years, since its inception in March 1949. December 17 marked twenty-five years of service to the Fleet from its location at Building 1535, at the corner of North Road and Makalapa Road, one half block inside the Makalapa Gate. (Pictured below.)

Throughout the years the mission has remained the same, to "maximize the combat readiness of operational forces within the Pacific region by providing specialized environmental and preventive medicine support."

People have always been the number one asset in carrying out our mission. This is illustrated in a statement from



an Officer in Charge (OIC) in 1975, Commander Gene Jenkins, "I have under my roof some of the finest instructors and people... in the military or civilian community." Today, that same sentiment is expressed by OIC Captain Jim Beecham: "Our number one priority is mission accomplishment. That means training and retaining the best people. Our product is a preventive health service that serves as a force multiplier, and that service is delivered by our people. That is the way our customers experience us...through our people. That is why our people--from our receptionist to the Officer and Hospital Corpsman in the field or shipboard--ARE the critical links in the chain." Here are some of the contributions made by the NEPMU6 staff over the last 25 years:

- 1979 – NEPMU-6 assists Bishop Museum (Honolulu) with first major survey of Island of Kahoolawe.
- 1985 – Established the Disease Risk Assessment Profile (DISRAP) to communicate and monitor medical threats to military units in Pacific Area of Responsibility (AOR).
- 1991-Launched first Navy Preventive Medicine Officer (LCDR Kevin Hansen), as well as Forward

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NEPMU-6 Then and Now

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Deployable Lab, to Operation Desert Shield/
Storm.

- 1992 - Provided disaster relief on island of Kauai in the aftermath of Hurricane Iniki.
- 1996 - Supported Operation Southern Watch in Saudi Arabia following deadly terrorist bombing of the US Military's Khobar Towers.
- 1996 - Initiated infectious disease surveillance project, targeting members of Joint Task Force Full Accounting who deploy to remote areas of Laos, Cambodia, and Vietnam in search of remains of American servicemembers designated as Missing In Action (MIA).
- 1999 - Participated in Commander, US Pacific Command (PACOM) Humanitarian Assist Ecology Project Russia-Far East (Vladivostok and surrounding area), collecting data to quantify the exposure of kindergarten children to lead and to support a health risk assessment for such exposures.
- 2000 - Response to emergent request from the State of Hawaii Department of Health (DOH) to analyze alleged anthrax specimens delivered in a

threatening manner to both a local business and a state government agency.

Navy Environmental and Preventive Medicine Unit 6 stands ready to provide assistance and expertise to the Fleet Navy and Marine Corps Forces in several areas of Preventive Medicine, including shipboard pest control, environmental health (food service sanitation and shipboard water sanitation), disease surveillance (malaria, sexually transmitted diseases, tuberculosis, hepatitis, etc), occupational and industrial health (asbestos training, spirometry, heat stress afloat), Chemical, Biological, Radiological, and Environmental (CBRE) training, and microbiology laboratory training and assistance. Visit our website at <http://nepmu6.med.navy.mil> or email us at nepmu6@nepmu6.med.navy.mil. Our phone number is (808) 473-0555, DSN 473-0555.

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Your April issue!