

UNITED STATES OF AMERICA

+ + + + +

DEPARTMENT OF DEFENSE

ARMED FORCES EPIDEMIOLOGICAL BOARD

+ + + + +

1999 MEETING

+ + + + +

WEDNESDAY,

APRIL 14, 1999

+ + + + +

The Board at the North Island Naval Air Station,
Island Club, Trident Room, San Diego, California, at
7:37 a.m., Dr. Dennis M. Perrotta, presiding.

PRESENT:

DR. DENNIS M. PERROTTA,	President
COL. BENEDICT M. DINIEGA,	Executive Secretary
DR. JAMES R. ALLEN,	
DR. HENRY A. ANDERSON,	
DR. MIKE ASCHER,	
DR. DAVID ATKINS,	
PROFESSOR SUSAN P. BAKER,	
DR. E. BARRETT-CONNOR,	
COL. DANA BRADSHAW,	
DR. JAMES CHIN,	
L.CDR. ANN FALLON,	
MAJ. CAROL A. FISHER	
DR. GERALD F. FLETCHER,	
DR. L. JULIAN HAYWOOD,	
DR. RICHARD J. JACKSON,	
COL. JEROME J. KARWACKI,	
MS. SHELLIE ANN KOLAVIC	
MR. TERRENCE LEE	
DR. F. MARC LA FORCE,	
DR. JUDITH H. LAROSA,	
CDR. MCBRIDE	
DR. STANLEY I. MUSIC,	
LCOL. ROBERTO NANG	

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

ALSO PRESENT:

DR. D. STEPHEN NICE,
DR. GREGORY A. POLAND,
DR. ARTHUR L. REINGOLD,
LCOL. JAMES R. RIDDLE,
DR. CAROL W. RUNYAN,
DR. MARGARET A.K. RYAN.
DR. JANE F. SEWARD,
DR. ROSEMARY K. SOKAS,
L.COL. FRANK SOUTER,
DR. CLADDE E. STEVENS,
CDR. MARK TEDESCO
CAPT. DAVID TRUMP,
DR. THEODORE F. TSAI,
DR. RONALD J. WALDMAN,
COL. ANDREW S. WARDE,
DR. NEIL D. WEINSTEIN,

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

I-N-D-E-X

Opening Remarks,	
Dr. Perrotta	4
COL Diniega	4
Summary Review of Previous Question to the Board: Chlamydia Screening,	
COL Karwacki	6
Dr. Poland	13
Draft DoD Immunization Review Report,	
Dr. Poland	26
Subcommittee Meeting,	49
Executive Session,	126
Closing Remarks,	164

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

P-R-O-C-E-E-D-I-N-G-S

(7:37 A.M.)

DR. PERROTTA: Good morning. I trust everybody had a pleasant evening and slept well and are refreshed and ready to go out and run with the Seals. I certainly dressed for it.

COLONEL DINIEGA: You must be from Austin.

DR. PERROTTA: That's right. I'm pretty sure no other meeting has been called to order in these kind of clothes.

Colonel Diniega.

COLONEL DINIEGA: Yes. We have a full schedule as usual this morning. Draft recommendations to four questions which includes the chlamydia from the last meeting. Doctor Poland wants to pretty much finalize the DoD immunization report. Reminder to the Board members, travel vouchers, send in your settlements as soon as you can when you get back home, and then when you do get paid, send in a copy of the payment voucher so we can balance the checkbook. We're not running out of money yet.

And this meeting this morning will be primarily a big disease control meeting, but if some of the subcommittees want to break off and talk about

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

issues, you're welcome to do that too.

The tour, the Executive Session will start at 10:30 or earlier, depending on how we go -- what time we make with the recommendation, and that's for Board members only, essentially the head table.

Lunch at the golf course is their popular lunch of the week, the barbecue buffet. They'll set aside tables along the windows for us, and they said to get there early. So we can finish at around 11:00.

The tour bus will be here at 12:15 to pick us up. Those of you who want the half tour, the ship tour only, there will be a van that can take you to the tour and then bring you back here if you have to leave after the ship tour.

Before we go into the subcommittee meeting, we have several speakers, one, Colonel Karwacki to remind us about the chlamydia question, Doctor Poland to go over the DoD immunization report briefly.

If there's anybody who's using Power Point and needs to load it up, Major Fisher's there, and any questions on the administrative side from the Board members?

UNIDENTIFIED SPEAKER: I'd like to make a

point. Those of you who are just taking the ship tour, we're going to have a dedicated van. So you'll ride there and back, and they'll take you right to the airport. So you'll want your bags on the van.

COLONEL DINIEGA: How many are going to do just the ship tour? I hope you have a big van.

(Simultaneous discussion.)

COLONEL DINIEGA: Because -- we're going to discuss this in a closed session, but the next general meeting of the AFEB looks like it's going to be the 13th to 14th of September, and USUS, the Uniformed Services University, has volunteered to host, and that's at the Bethesda campus, Bethesda Medical Center. I think that will be the dates. If something comes up and they can't handle the AFEB, then it will be a week later, and then there will be another -- a special meeting of the Board, a closed meeting of the Board on May 24 to review some of the BW issues in DoD.

COLONEL KARWACKI: I thought I'd start by taking the opportunity to show you the slide that we couldn't quite see yesterday. Remember this is old data. This is '90 through '95, and we've not updated it since then. But I just thought I'd give you a

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

chance to look at some of those numbers. These were active duty Army individuals inpatient hospital admissions, number of admissions, total days, and then broken down by annual dividing by the number of years, number of cases, and average days. And of course the numbers that we were looking at that sort of jumped off the page that started the discussion about varicella vaccine was the nearly 30,000 days of hospitalization.

This data was not scrubbed to any great extent to verify. This was straight out of what's known as the SIDR, the Standard Inpatient Data Record.

Often we find when we scrub those lists some of that information is incorrect, but this was just a -- what I call a flash look at that data to determine where and how big our problems may have been, and I sort of broke it down into those diseases that we generally use vaccines for through in B and A even though they weren't particularly widespread at that point in 1995.

This was data through '95 that I did in mid '96, and then down here looking at the other infectious diseases for which we didn't have vaccine coverage at the time were pneumococcal pneumonia, the vaccine we weren't using in the population of active duty

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

members. So just to give you an overview of that.

What I want to do this morning is just do a quick recap, and actually I'm sort of out of my element because I wasn't at the meeting where we posed this question, but the question was posed about the need for a chlamydia screening process. You'll recall that this was actually prompted by an article that was published out of Johns Hopkins where they had done a study in military recruits, the female recruits at Fort Jackson, and they found a reasonable -- almost a 10 percent prevalence rate of chlamydia infections. Doctor Charlotte Gaydos made a couple of presentations I believe to the Board about that. And at the end of the article they suggested that DoD should do something about this. So we figure we should perhaps pose a question to determine whether or not there should be a standard approach to this across DoD.

And really the question comes down to deciding the basic approach to this. And not unlike the discussion we had yesterday about using Lyme vaccine and perhaps varicella vaccine, they sort of fall into that category. Do we do this by policy? Do we create in this case a new screening program or do we leave it within the context of the health care

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

provider patient interaction in the clinical setting and perhaps set some parameters around that, and that's what it really comes down to in my mind, whether it's something we do to everybody as a group, identify them as a risk group, say you're coming into the military, you fit such and such a profile, therefore, you're going to be screened, or do we leave it within the context -- and perhaps it is possible to publish a clinical directive that says whenever -- in this case, for female recruits or female active duty members, every PAP smear will be accompanied by a chlamydia screening if that is indicated by the behavior, sexual activity and such for that individual and leave it within the context.

Anything beyond that, and even that to some extent, puts some impact on the laboratory base in terms of how much we need to be doing at any particular post, how widespread these tests are and which test. We'll come back to that.

The other aspect of this then, because the article that generated this discussion centered on the female population of recruits, but then there was a subsequent publication and discussion about some of the male recruits that they screened. They had about

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

half the rate, I think it was about four percent attack rate -- or prevalence rate in the male recruits that they screened, what about the aspects of screening males as well. So it falls under this same category.

Our access to male members in the sense of doing this kind of a screen -- you'll recall that there is a regulation that says every active duty female will have an annual PAP smear. Now, do we do that across the board universally, I'm not quite so sure. We don't have very good records to be able to document that, but at least we have that opportunity to do so.

If we were going to screen males in the same clinical setting, health care provider interaction, our access would be somewhat less universal. There's no particular thing that a male soldier comes in for on an annual basis that says you will appear except a dental visit, and it's not exactly appropriate to do this.

So we might find some way to integrate that into any STD event, any visit and say, anyone with an STD will obviously be screened for other STDs at the same time to include chlamydia.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

The other possibility would be what we call periodic exams, and I think each Service has a different set of criteria, but generally it's about every five years on the zero and five birthday years, everyone gets a comprehensive physical exam, and we could perhaps include it in that to be determined what criteria would be set forth to say this is someone who needs screening for chlamydia, and probably that would be a history of sexual activity of some ilk or other.

The other possibility that Doctor Gaydos I believe directly briefed, she briefed the study, as I recall, at the meeting we had in Norfolk last year about this time. Instead of briefing the study that was published, she briefed another aspect of it, and she suggested to the Board that the most cost-effective method was not even to screen but just to simply hand everybody two pills of azithromycin as they walk through the door and treat them all universally as the option of choice from a purely cost-benefit analysis aspect, and I don't think anyone was too captured by that proposal.

And then, lastly, as I say, we need to touch on the aspects of what would a universal screening program, if it's something we decided to do

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

by policy, if we were going to screen every recruit on day three, well, what does that mean in terms of his infection that's going to occur on day 33, how do we pick up that next infection. But also, even if we're going to do this within the context of the clinical setting, what does that mean in terms of the resources for laboratories, what is it going to take within the laboratory at Fort Jackson, Fort Polk, Fort Irwin, or an Air Force or Navy facilities to have this test universally available. Can we do this on a contract basis where these tests are sent out and done at a central laboratory some place in a larger batch mode perhaps. Generally that reduces the cost, and having a trickle of specimens through a small laboratory where they're having to run all the QA specimens and keep up with that, that generally drives up the cost of running the tests individually as well as the cost of just operating the laboratory and having the personnel there.

Again, just all the basic questions on how, when, and where would we be running these tests if we decided that this is something that we need to integrate into the general program of military medicine. I'll leave it at that for discussion.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

DR. PERROTTA: Any questions for Colonel Karwacki? David?

DR. ATKINS: I'm sorry. I may have missed it. So at present there's no -- is there any preinduction visit where they're collecting urine and blood routinely?

COLONEL KARWACKI: They collect blood routinely for a number of things. There's no urine test. In fact that was one of the issues I didn't mention. The test that was used in this particular study was the urine ligase test which is a relatively new but supposedly easier -- it's done on just a urine specimen as opposed to the older Gen-probe swab testing, and the laboratory people as I recall -- since I wasn't at the meeting, I believe they presented information about the relative sensitivity, specificity, and laboratory aspects of doing those particular tests. So we would be looking to try to unify across DoD the approach in terms of sensitivity and specificity, which of the available tests would be the appropriate one to do if we were going to offer it on a universal basis.

DR. PERROTTA: Doctor Poland.

DR. POLAND: I thought the Marine Corps at

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

the "Moment of Truth" did collect a urine specimen?
That's not true?

COLONEL KARWACKI: I'm trying to remember whether -- John, do we collect urine for drug testing on recruits?

DR. POLAND: Not in basic training. The MEPS test --

COLONEL KARWACKI: Right. It's done at MEPS as a disqualifying issue, but it's not done in basic. And, as I said, I can't speak to the other services to exactly what they do. Perhaps somebody could speak up.

DR. POLAND: The real question I had, Dave, was could you say something about more the practical nature of if we did something like universal screening. How practical is that? What would be the logistics involved, particularly if we did males and females?

COLONEL KARWACKI: Well, again, I'm certainly not an advocate for any kind of a new universal screening process. I don't think that's necessarily going to answer the question. It sort of gets back in my mind to this issue of food handlers' exams in the old days. You know, you can do

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

anything -- on any given day you can screen a person, and you can say yes or no they're positive. You can treat the positives, and then you go on. What happens on day 63? After they finish basic training, they go home on leave. When they come back, we're not going to screen them again. We're not going to have this universal screening.

My approach to his, my preference, if I can bias the Board a bit, would be to try to integrate this more concretely through some directive that says every encounter of a particular kind, whether it be the periodic examination, an STD encounter, a PAP smear encounter for the active duty females would include this screen when appropriate. And we make those screens available through some mechanism, whether it be local laboratory or centralized laboratory support, but not to do it on a one-time basis and think that we've done something. I mean, just because these folks are recruits, they're coming in, we -- yes, we do have access to them. We can make them pee in the bottle. We can take that off and do some testing with that, but what does that truly accomplish down the road if we don't have an opportunity to repeat that. If that's all that we do,

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

I don't think that we've accomplished particularly much.

DR. POLAND: Okay. And, again, in the mode of just the practicality of doing this, I believe one option that we had discussed was the idea of just saying sometime in the first year of service entry let's do this, but not -- that wouldn't necessarily have to be done at the recruit intake stage.

COLONEL KARWACKI: That falls basically -- again, we were talking at that time particularly about the women and doing the PAP smears. There is the regulation that every active duty woman is supposed to have a PAP smear. Now, with some of the newer computerized medical record systems, we would hope that we would be able to track that better as well as to notify individuals when they are delinquent in that process such that we can keep up with that getting it -- actually getting it done but also know the denominators on that.

That also becomes a practical problem in do we have enough practitioners to be able to deliver that service for that many people in that confined period of time in an annual cycle.

That would certainly be a solution for the

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

female population, to say that as part of this PAP smear encounter that a chlamydia test and any other appropriate test would be done at that particular time.

COLONEL DINIEGA: What is the -- I guess if you're going to link it into the PAP smear which gives you -- if you do it within the first year, then I guess there should be a policy if there's none already that says the active duty women will have a PAP smear within the first year of entry.

COLONEL KARWACKI: Well, they're supposed to have one annually. So by default, they should have one --

COLONEL DINIEGA: And then you have to have a policy that will say, you know, they'll also get chlamydia testing at that time. The issue becomes if the Board recommends to also screen males.

COLONEL KARWACKI: Correct, what is the access that we have on an annual basis to males that's not as -- or what would be the point of contact between a male active duty member and the medical services in general.

COLONEL DINIEGA: And then I think the regular requirement for physicals is every five years.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

COLONEL KARWACKI: But it starts at age 30. At least for the Army we have deleted the 20 and 25 requirement for physicals because we were not finding anything in that age group of individuals that was not already known through general clinical encounters. So we had moved up the -- at age 30 is the first time we begin to do the physicals, and we're trying to -- of my mind we don't even to do them then, but that was a compromise that was reached that age 30 was the first time that these physicals would be done.

COLONEL DINIEGA: The Preventive Health Task Force, what were the recommendations -- you had mentioned that at the last meeting, the recommendations for chlamydia screening?

DR. ATKINS: Our recommendations, which are pretty much in line with CDC recommendations, are routine screening for adolescent women and then screening for older women who are at risk for specific -- because of specific behavior, but no routine recommendation for men.

At that time we didn't have the option of urine testing, and the feasibility of swabs was just felt to be impractical. The difficulty about evaluating the screening of men is you're really

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

screening men to benefit women, because it's the long-term complications that occur in women. And your point is a good one. The difficulty about knowing how effective is you don't know whether screening men is just, you know, a stop-gap measure and they're going and getting reinfected, and you don't know whether their partner is getting treated. And so it's a difficult question. Certainly it's a much more -- now that we have urine testing, it's now feasible. It's hard to get the data to know how much of an impact you have on female infection rates. Presumably you'll have some, but if their partner's not getting treated and the men are getting reinfected, it may not be a big effect.

COLONEL KARWACKI: Again, remember the impetus behind this was the recommendation or the discussion in this article basically said DoD needs to have a screening program, and so that went out into the national press as it were, into the world. So we thought we needed to address it up front and make a decision on whether or not that recommendation was indeed something that needed to be done or whether we can encompass this -- have the same effect by doing something more within the confines of a clinical

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

encounter.

DR. ATKINS: Just a quick addendum. Chlamydia is one of the topics the Task Force is now updating. So we hope to have a revised opinion, including the issue of screening men, by early 2000.

DR. ASCHER: Don't you need some data on men like you do on women?

DR. PERROTTA: We have a question here. Would you identify yourself?

DR. CANAS: Yes. This is Linda Canas at Brooks Air Force Base, and my laboratory currently conducts a great deal of chlamydia screening, and we have looked at this issue with the Air Force recruits, and we're not doing any right now. The tests are wonderful. I have done a lot of work comparing them. They almost double the number of positives that are --

COLONEL KARWACKI: The new ligase test?

DR. CANAS: The new ligase chain reaction, which is a urine. And in talking with other laboratory personnel, they agree, once you get started on these tests, this is the way to go. Of course cost is the issue. They're about double the cost. However, in talking to the manufacturer, they're

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

certainly willing to work with us.

The problem with using a urine that's been collected for another purpose, like drug screening, is this test requires first void and only about three to five mls. So to go into a midstream where you have a whole cup, you're certainly decreasing the chances of picking out that bacteria that's there. So you do need your own sample.

There's always the problem of reinfection, and the point of Charlotte Gaydos' article was we've had all of these risk factors for many years on who should be screened, but basically we can throw those out the window and say under the age of 25. Anyone under the age of 25 should be screened. And if you screen anyone, if you say within the first year, you're probably going to catch that age group. But if you suggest that everyone going in for a PAP smear needs to be screened, then your positive predictive value is going to be effected in these tests. So it should not be a -- my opinion is it should not be a universal recommendation but perhaps in that age group under the age of 25.

But the point is you've got young women coming into the Service, and are they entering the

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

Service with a disease that could cause long-term complications? And that's the issue. We know 70 percent of infected women are asymptomatic, and there are some beautiful studies that go on to show of this percentage of women who are asymptomatic, a certain percentage will develop PID. A certain percentage will develop ectopic pregnancies, and infertilities. And these are very high cost, not to mention taking out of the work environment.

So it's the long-term considerations. You know, for my laboratory, the long-term considerations can justify the cost. My laboratory budget cannot.

DR. PERROTTA: Thank you.

DR. HAYWOOD: If the current studies confirm chlamydia as a risk factor for heart disease, the implications of this discussion become quite different.

DR. CARROL: One of the reasons we were so supportive of Doctor Gaydos' research at Fort Jackson was that it was not just screening. It was screening and education. To just screen without educate, to me we would have been pouring water down a hole, but I was very supportive of her research because it was an education component, even though I saw when these

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

young folks came back from exodus at Christmas, my pregnancy and my STD rate went up dramatically after they came back from their Christmas break.

So perhaps the education wasn't making it through to everyone, but I hope if we decide on screening that we also recommend an educational component with it.

DR. PERROTTA: Colonel Bradshaw.

COLONEL BRADSHAW: Yes, this is Colonel Bradshaw. My comment was actually similar to Doctor Carrol's which was Commander Ryan I believe presented some information that in their group, particularly the men, that if you screened and educated, that there was actually a change in behavior. And I think if we had additional evidence that a program like that would actually make a difference, then I think that would really press us towards screening at the recruit level.

Now, I don't know if we need some replicating studies to use before we make that recommendation, but I think that's the clincher as far as I'm concerned.

COLONEL DINIEGA: There was also at the last meeting some discussion on incremental

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

implementation of a screening program. For example, I think the discussion was you could do the women within the first year of accession, link it with the PAP smear, make mandatory chlamydia, and then the other thing is take a look at what the data was showing incidence prevalence-wise and take a look at what the men's rates were and then come back to the Board with some data and then talk about how to implement the screening of men. That's the other way to go.

DR. PERROTTA: Any other questions?

LIEUTENANT COMMANDER RYAN: I think the issue is a good one with men. I was able to show --

DR. PERROTTA: Reminder that this is being recorded, and we need your name before your statements.

LIEUTENANT COMMANDER RYAN: Doctor Megan Ryan. I believe the issue with men is maybe not completely resolved because even though I could show a change in behavior, I couldn't show a decrease in chlamydia reinfection, and that's sort of a simple study because since the Navy's doing the in-processing screen, we get enough men one year or two years out and do another sample of asymptomatic screening, we'd see if we really did decrease chlamydia reinfection,

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

which is of course one of the primary issues.

DR. ATKINS: Yes. I just hope that whatever policy we decide we collect prospective data because, I mean, this is a very important issue, and it's a unique opportunity to really see whether if we add a new program we are accomplishing what we think we are accomplishing, and that's just the kind of study I think would be very helpful in this field.

DR. PERROTTA: Anything else? Okay.

DR. RUNYAN: Carol Runyan, University of North Carolina. I think the whole issue of education is very important, and I would just encourage if that's going to be a substantial element, that there be substantial research about the education process because it isn't just a, you know, say a few things and it makes a difference. I mean, there's a whole body of literature and research in the educational field that I think needs to be investigated more carefully.

DR. PERROTTA: So an evaluation of whether or not screening's working then and education makes a difference?

DR. RUNYAN: Well, but education taken as not just do you do it, but really looking at what is

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

done and the various methods of delivering it are a research question in themselves.

COLONEL KARWACKI: I would caveat on that that we would have two different approaches. If we were doing a mass screening of recruits, we would almost assuredly be doing the education in sort of a classroom more didactic setting. If we put it back into the clinical setting and provided the education materials, it would be done more on a one on one, probably with a nurse or technician, not the direct health care provider, but it would be done more in the wellness health promotion setting of the clinic than it would be in a sort of I'm telling you what you should do kind of didactic session with recruits. So that would be options we would probably need to look at, determine the body of literature that suggests which of those two approaches might be the most effective.

DR. PERROTTA: Let's wrap up with Colonel Bradshaw.

COLONEL BRADSHAW: Yes. Colonel Bradshaw again. There is an HIV and STD Prevention Committee that's going to be coming under the Prevention, Safety, and Health Promotion Council, and that

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

committee has actually looked into doing some of the evidence-based studies in our population that have been shown to be more effective in terms of educational interventions, and this includes more interactive types educational things rather than just giving you a pamphlet or watching a video. So we could maybe tie in with the efforts of that committee in this regard.

DR. PERROTTA: Okay. Thank you, Jerry. I appreciate your being here. All right. Let's move on to Doctor Poland and the luggage-breaking tome.

DR. POLAND: Didn't the note go out to bring your large briefcase.

DR. PERROTTA: This is an amazing piece of work, ladies and gentlemen, and even before we get started, I would just like to extend officially and personally my thanks to Greg for shepherding all of the work and cajoling the authors and getting everybody to participate as much as they could, because that's what it takes.

DR. POLAND: Thank you. I'm afraid there are a lot of people who even now avoid me or thank God this thing is done.

There is a method to this madness though.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

You know, if you send something like this in, people are going to think next time, wait, before we ask him to do something else, remember what he did last time, and the other part of it is, see, this was the first draft, and this was the second draft. So don't ask me to rewrite this thing.

I and my committee approached this task with the idea that the recommendations we would make in our findings would hopefully make a difference, and I sincerely hope that is the case. As I said to Dennis and Jerry, I think I could have written two or three ROIs in the amount of time it took to do this.

I think what I will do is just skip right to the first section which is the recommendations and just very, very briefly take you through those just so that some of those get read into the record.

DR. PERROTTA: Page number?

DR. POLAND: It would be page nine. For those that don't have a copy of this and want one, there are a few copies left over on your left-hand, my right-hand side of the room. Also I believe that we have -- we will -- Colonel Diniega, is it true that we will actually publish this through DoD?

COLONEL DINIEGA: You want me to address

that now?

DR. POLAND: Sure, why don't you just because there's not enough copies I guess for everybody.

COLONEL DINIEGA: All right. Once the final draft is handed over to me via electrons and hard copy, the U.S. Army Center for Health Promotion and Preventive Medicine has volunteered their services to do the final editing. So you still might hear about this and some changes to it. And then they will also go to publication, just as they did with the work on "Training Injuries, The Hidden Epidemic."

And I'd like to thank them ahead of time for doing that, and hopefully I won't get billed. But Lieutenant Colonel Nang will be working with the CHPPM to get this thing finally published and distributed. So once Greg gives me a final go.

DR. POLAND: The other thing, in fact I don't want to even start without doing it. The very last page of this is an acknowledgement section, and those that are deserving of some special thanks -- and they're not in any particular order but do reflect the amount of time that were put in -- were Doctor Barrett-Connor, Doctor La Force, Doctor Perrotta.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

Military members who were particularly helpful were Colonel Diniega, Captain Trump -- forgive me if I have some of the ranks wrong. I suspect this process has taken so long some of you have been promoted -- but Doctors Ryan, Hoke, Fallon, Engler, Karwacki, Withers, and Nang were also very helpful in this process, had a number of discussions with me, very prompt in submitting material.

Okay. With that then, on page nine, just to take you very quickly through the numbered recommendations, one, and deliberately placed as one is this issue -- and I've had many, many conversations with people about this -- is the really urgent idea that policies and practices that ensure a ready supply to the military of vaccines essential to its mission be developed, and we list a variety of possibilities there and thoughts.

Number two is that DoD further expand and develop efforts towards standardized computerized record-keeping and tracking of both adult and childhood immunizations provided to active duty, reserve, dependents, and other TRICARE beneficiaries.

Three, that each service measure and report up-to-date immunization rates as key indicators

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

of medical care delivery and Force readiness.

Number four, that consideration be given to the concept of some type of a "Vaccine and Immunobiologics Oversight Board," and in particular, that increased involvement by reserves and National Guard be included with their changing mission.

Number five was -- it's already happening, but that there be a new joint instruction developed and disseminated, and we listed some things that we thought should be considered in there.

Number six, the DoD addressed whether current procedures and resources are sufficient to ensure that need-to-know personnel are aware of what portions of official policy documents have been superseded. This we found to be a real issue as we talked to people in the field who didn't know that something had changed in the Joint Instruction, hadn't necessarily been notified. Of course, with electronic communication, that should be an easy one to fix I think.

Number seven, that DoD be committed to fully informing every Service member of the health risks, personal and military benefits, and proper use of all vaccines and other medical countermeasures, a

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

variety of recommendations listed there.

Number eight, that DoD address issues of standardized training and proficiency of immunization delivery practice. Those of you that were at the Parris Island MTF and watched the recruits being immunized I think could appreciate that one.

Number nine, that DoD develop a vaccine policy and practice statement for the use of vaccines and immunobiologics in humanitarian missions. I believe it was at our last meeting that we got a brief on these HuMed missions and some of the real difficulties and practicalities of those. I put one example in there. You know, tetanus immune globulin really has essentially no use for U.S. military forces, but it certainly might have a use for HuMed type missions.

Number 10, that the current centralized procurement systems be maintained, along with adjunct local procurement systems for vaccines and biologics.

Number 11, that DoD continue to participate in the Pandemic Influenza Planning document that you heard about yesterday.

And then number 12 was the idea that -- I can't remember now when the last Joint Instruction was

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

written, '93 or '95.

COLONEL BRADSHAW: '95.

DR. POLAND: -- that there be some thought given to some kind of periodic relook at these same issues and maybe kind of a progress check on where these recommendations have led. So with that I'll just close and ask if there are any questions.

COLONEL DINIEGA: Before questions are asked, Dana, can you update the Board please on what has happened with your work group and the progress that's made so far?

COLONEL BRADSHAW: Well, the work group has convened, and we've had several meetings right now, and we're supposed to actually have our next meeting next week immediately after this meeting, and we'll obviously be incorporating these recommendations as much as possible. But we have a subgroup of the Joint Preventive Medicine Policy Group specifically working on the instruction.

DR. POLAND: Colonel Bradshaw, if you need more copies of this too, we can provide them to you for your committee.

COLONEL DINIEGA: And it does include reserve component members.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

DR. POLAND: Correct.

DR. PERROTTA: Doctor Fletcher.

DR. FLETCHER: Just curious, is the CDCMP involved in this? Are they going to be looking at this, blessing it?

DR. POLAND: CDC?

DR. FLETCHER: Center for Disease Control?

DR. POLAND: There's no official liaison or tie-in from the standpoint of our work. I'm not sure about the committee that Colonel Bradshaw chairs.

COLONEL BRADSHAW: We don't have a direct tie-in with CDC, no.

DR. FLETCHER: I just wonder if that might not be appropriate because they're doing the same type thing, just they'd be aware of it or something.

DR. ASCHER: Well, there are real issues. When you look at vaccinia, for example, that's under military control at the moment and management, and it's a big civilian question mark. So there has to be that link.

DR. POLAND: We have a sort of a tie-in in terms of Captain Trump is on the Advisory Committee for Immunization Practices, and he is one of our members. So I don't know if that's along the lines of

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

what you're thinking of.

DR. FLETCHER: It's a spectacular document. I think the Center for Disease Control can be aware of it or whatever.

COLONEL DINIEGA: We can certainly give them a copy when it's finally out.

DR. POLAND: Jerry, didn't we start this while you were President of AFEB?

DR. FLETCHER: Maybe before that.

DR. ASCHER: I think you should send a copy right away to their new unit on biological terrorism because the anthrax and smallpox issues are really serious. I mean, they got all this money for these stockpiles, so we're going to talk about joint acquisition very soon.

DR. POLAND: Marc.

DR. LA FORCE: I think this is a very good idea. With the biologic warfare threat, et cetera, the more communication that occurs at a certain level, frankly, the better. And the CDC immunization group obviously has a major interest in a document like this, and I would think it would be to everyone's benefit frankly to have not only just a liaison but perhaps ask if somebody might want to come at least

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

just to attend, comment. They may have a lot to offer. I didn't say control. I said offer.

DR. FLETCHER: Some sort of endorsement, just endorsement, you know, a blessing, whatever.

DR. POLAND: Perhaps through the AFEB Office we could do that with a cover letter or something.

DR. FLETCHER: Yes.

CAPTAIN TRUMP: And the one -- this is Dave Trump. The one -- besides the ACIP, the other point of interaction with the CDC and other agencies is through the National Vaccine Program Office and their interagency group. Colonel Hoke, Colonel Engler, and I participated in those conference calls routinely. That would be another less formal but forum for at least asking for a review of this.

DR. STEWARD: I was just going to comment from CDC's perspective. I think CDC would very much like to be formally involved, either the National Immunization Program and/or the National Center for Infectious Diseases, would welcome involvement, and I'll carry this back to my center at least.

DR. PERROTTA: Okay. Thank you Greg.

DR. POLAND: Thank you.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

DR. PERROTTA: Do you have any admins that you want to do? I mentioned the recording and stuff.

COLONEL DINIEGA: Yes. Just a reminder, it's an open meeting up until Executive Session. Name before you talk, come up to the mikes, and members of the press may be in the audience.

The other thing is on the dates for the meeting, I gave the wrong date. I just looked at the calendar. The dates are 14th and 15th, and then if something comes up, it will be the 21st and 22nd of September. It's a Tuesday/Wednesday. I sort of want to stay away from Sunday as a travel day as much as possible.

DR. FLETCHER: 14th and 15th of September?

COLONEL DINIEGA: 14 and 15 September.

DR. PERROTTA: What was the second set?

COLONEL DINIEGA: The second set is a week later, 21, 22, but I'm pretty sure it's going to be the 14th and 15th September. I'll confirm that when I get back.

DR. PERROTTA: Okay. The intent of the committee meetings was that there was nothing specific suggested by any of the Board members on the

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

Environmental Committee or the Health Promotion Committee, and so there's such a big body of work to be done on the questions that we have, the four questions we have in hand, that we thought it would save time if folks could attend this subcommittee meeting of disease control. I'm going to let -- and the good part about it is I get to let somebody else run that since it will be Doctor Poland's committee.

However, in talking with folks, should any of the other committees desire to -- or groups of people desire to excuse themselves and work on some specific issues, if Health Promotion or if Environmental has anything that this would be a good use of your time, then you're welcome to do that. We could probably, you know, sit on one of the tables in there or maybe go outside or whatever, but as many people as could stay here to get the work done so that we don't have to do a committee meeting and thing bring everybody together and then vote on it on the second time. That would probably be the most expeditious way of getting things done, knowing that we have a large number of questions comparatively speaking. Doctor Anderson.

DR. ANDERSON: Yes. Henry Anderson. The

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

Environmental Committee, I guess what I'd like to ask the group to think about is let's come up with some ideas of things that we'd like to have discussed at the next meeting. I think it'd be helpful if we could do that here.

One that came to mind is when we heard about the air exposure concerns from the -- over in Japan. It might be worthwhile, one, to hear what is going on as far as clean air exposures overseas, what kind of epidemiology and strategies are in place to deal with that. I think that would be of great interest. I think we could provide some technical assistance there.

DR. PERROTTA: That provides a lead-in to something that folks have been talking to me for the last day and a half, and that is that clearly the history of this committee has been an infectious disease committee, but good things have been done in other areas. You're a dinosaur, Poland. Good work has been done in the injury, and hopefully folks found the sarin and mustard paper useful at the Pentagon and continuing activities on alcohol and tobacco cessation, and so this really is a committee of more than just infectious diseases although clearly that's

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

where our history has asked us to look at.

If we as a Board sit and wait for our colleagues, the PMOs, to come up with ideas for us to do or if we wait for people from other parts of the Service to come to us -- and I'll be blunt -- to come to us and present information and get blessings so that they can get more money for their program, and that's not a bad thing, but if that's all we do, then I think we have missed the boat.

When we first started, I think that's all we did was wait for people to bring questions. We couldn't comment on very much, and we had this long stream of interesting but not very helpful or informative presentations, and we just sat there just like drones watching this interesting stuff go by, but then at the end of the day, we did nothing with it. And I would prefer that this Board not go that way, either while I'm still president or whenever something else happens.

So that also means that each one of us on the Board has a responsibility to express interest in things that we do see, to continue more communication, not just at the meeting but in between meetings, with the PMOs, with the office at Ben, with any parts of

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

the Services, so that we can be a useful function, more than just a blessing for additional funds for any kind of program, and that's not to say that's all that's happened. But I really think that this Board would miss the boat and would decay in its true utility if that's all we did.

So I'm going to ask or charge or request everybody to put more time into this. We all have full-time jobs, and you guys have a ton of stuff that we don't even understand that goes on, but the intermeeting interactions to get things reviewed, to get input, to start working on things that will be helpful. At lunch yesterday the injury group was sitting down with some of the Navy injury people, and loads of ideas were just coming out of there, and it was amazing, and there's some possibilities of doing something useful and using us to help you do that work. So that actually woke me up this morning, and things generally like this don't wake me up, so I wanted to take a bit of time and let's take two comments on that, and let's give it back to Greg.

DR. SOKAS: Rosie Sokas from NIASH I want to kind of in support of that comment, one of the things I've also noticed is that we tend to bless

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

something and say and it's important to collect more data on it, and then it just kind of goes off and we don't get the follow-up, and I'm thinking of the noise in pregnancy recommendations that were made about a year ago, and a big piece -- there were about a dozen recommendations, and some of them were collect data, let's see what's going on, and it would be very useful I think to have built in automatic follow-up from the preceding recommendations from maybe the two meetings before or something if that hasn't happened.

DR. PERROTTA: That's an excellent plan. What that means is that in my opinion that the things that we do ask for and make recommendations and help the PMOs and other parts of the services do their work has to be institutionalized.

Part of the problem that we probably didn't get much of a follow back on noise and pregnancy is that the commander in the Coast Guard who brought the issue to us has moved on. I can't remember her name, but she --

DR. FISH: Barbara Braden.

DR. PERROTTA: Barbara Braden. And so Dick Jackson had folks look at it. Rosie spent a lot of time on it independent of our meetings, and we came

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

up with good ideas. They came up with good ideas and Barbara was happy with it and then she moves on. If she's the one responsible for it, then those things need to be handed off to somebody else so that they can actually be useful things for services that live rather than just something that Barbara Braden wanted an answer for. Does that make sense?

COMMANDER MCBRIDE: It does. May I respond to that? Wayne McBride. The Service PMOs and others met last week in anticipation of the AFEB, and this issue was acknowledged, and it was recognized that we had not been as good as we can in receiving the recommendations, and even if we don't institutionalize them or not, coming back to the AFEB and said, yes, we did this, no, we didn't, and this is why, because I think we've been doing the Board a disservice by not acknowledging the recommendations and then coming back to the Board and saying this was great. We've institutionalized this. We're doing it or we haven't, and these are the reasons why.

And so this was discussed, and a proposal was perhaps having some kind of an audit trail for the recommendations, and following them in the months and years after the Board meeting, to be sure that we've

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

reported back to the Board what we've done with the recommendations so they just don't get lost and are never really if not enacted, at least acknowledged.

And so as we emerge from this meeting, we hope to be able to capture these recommendations and then hopefully report briefly back at the next one what we're doing with those. And so I just offer that to you.

DR. PERROTTA: Appreciate you guys doing that. Let me go to Jerry and then Mike, and then we'll go back to Greg.

DR. FLETCHER: Let me just speak out on Health Promotion a few minutes. Judy and I have talked about it. Judy is the vice chair of our committee, Judy LaRosa's out, and Elizabeth Barrett-Connor's out. David Atkins is with us also. And we've talked when I was presiding over the committee about health wellness and so forth, and I think what we deal with infectious disease is of vital importance. This is currently now a year from now, but the risk factors for cardiovascular disease will impact the military in the future, dependents, veterans, and so forth, the 20,000,000 people we deal with for 20 years in the future.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

There are smoking programs going on. I know we've dealt with alcohol, our preventative services program are going in. We need to do more continually on risk factors for cardiovascular disease to prevent people from having heart attacks at age 45 like someone in your office, and these things that happen in the future, it's not like anthrax or whatever immediately, but in the future they will develop that cardiovascular disease. These risk factors that we deal with -- smoking we're dealing with. High blood pressure, hopefully some. I'm not sure about cholesterol in the military, the major, major risk factor for heart attack.

And last but not least, the obesity problem in this country, and I'm traveling around the various bases. The lean military person is not the totally common type of situation. So I think we need to keep this in mind. And the preventive medicine options I know in the civilian arena as well as I know you're interested in, and you have to be in prevention of infectious diseases, but prevention involves cardiovascular healthy. I really think we need it. And we've been in error I think in not urging the working with you to deal more with this. I just like

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

to make my plea. Dennis gave me two minutes. Let's keep this in perspective as we move on for the future of the AFEB and the military.

DR. PERROTTA: Thanks.

DR. ASCHER: Mike Ascher. I'm not on the Board, so I can say whatever I want, as you've noticed. Historically, some things have changed in the process of this group, which is that a number of times items come before the Board that are not very well developed or really what the Board would like, and a lot of times this tension gets played out as people saying some not so nice things about the things that are presented. And when that started to happen in the past, one of the obvious things is that these things should not be put this far along without prior consultation. That is the key.

And if you look at the tick-borne encephalitis project which had to be done in a hurry, that was done on the side by the Board with partnership with the people. So when it came to the Board, it was fully developed and basically ready to present. But when you bring Lyme or varicella or something in this sort of haphazard way without prior consultation, you have these fights, and I think it's

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

very unhealthy not to have the prior consultation.

If you're just going to do this independent action and then meet like this and have these arguments, it's not very productive.

DR. PERROTTA: And what that tells me is - - is that gives the PMO a more critical role because they're not doing it all. It's the programs within the Services that are coming up with the ideas and then the questions are bubbling up through the ranks and the channels, et cetera, and then it gets brought here, and the PMOs will rely on the program folks to bring those things up in some cases. But if the Preventive Medicine Officers can get involvement before somebody comes up and talks about one program that says, yes, we ought to be doing this and then the other Service says no, we oughtn't, I mean, we -- I think the universal thing was going what the hell's going on. I mean, it was for me.

DR. ASCHER: If we'd done TB that way, it would have been a nightmare.

DR. PERROTTA: Yes. So that puts these guys in pivotal roles that I suspect you guys need to be or have been or I suspect believe the importance of the PMOs in coordinating that and getting folks in

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

between.

Every time Colonel Diniega has asked, every time Colonel Fogelman asked for somebody to help, it may have taken some "Well, I can't do it" or whatever, but they got help, and it was I think willing help, and sometimes maybe like what Greg's doing here, maybe that was -- he probably should have said no a long time ago when this came up, I don't know. But --

DR. POLAND: I learned my lesson.

DR. PERROTTA: Anyway, no more preaching.

COLONEL DINIEGA: I have a comment. Actually, I think there's a new body that was formed, a Joint Preventive Medicine Policy Group, and I think the coordination for the meetings have been pretty good, and the issues that have come to the Board actually are issues that point out the differences among the Services. So that's one of the reasons you're going to see differences of opinion coming to the Board, and that's the reason you're coming to the Board, because there are differences of opinion. I think if the Services --

DR. ASCHER: But you could do it before the meeting is my point, and not have this process go

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

on at this meeting.

COLONEL DINIEGA: No, but I think it's okay to see differences in programs because there are unique aspects. That's why we have three different services, and so they sort of knew there would be differences of opinion on some of these issues. JPMP now solves a lot of issues and keeps it from coming up to the Board because they solved it within their work group. So you're going to see the ones that are "unsolvable" more and more rather than solvable ones, because they'll just go ahead and take it off the table and make it a joint policy.

So I think the coordination is pretty good the way it stands now, and I do agree with the comments from the Board that the follow-up on recommendations is something that really needs a lot of work on, and I think that's going to be one of the things, and we've also discussed at the meetings the need to -- and I constantly remind them that we have three subcommittees on the AFEB, and I think that's going to get better too.

DR. PERROTTA: Well, thanks for letting me vent on that one. Professor Baker.

PROFESSOR BAKER: I was just going to say

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

I think some of the injury people and maybe some of the others on the Environmental Committee would like to break and meet elsewhere. What time do you want us back?

DR. PERROTTA: Before 10:00, is that right, or 10:30?

COLONEL DINIEGA: Before 10:00.

DR. PERROTTA: Before 10:00. How about 10:00 o'clock. Thanks for listening, guys.

DR. POLAND: As much as we kid you, we understand no clean air, no clean water, no ID mission.

DR. PERROTTA: Thank you. Okay. Greg, you want to -- would this be a good time to break, or is it too early? Let's take 10 minutes, start at a quarter to.

(Whereupon, the meeting went off the record at 8:35 a.m.)

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

S-U-B-C-O-M-I-T-T-E-E M-E-E-T-I-N-G

(8:45 A.M.)

DR. PERROTTA: Will you take your seats please.

DR. POLAND: Okay. I think if it's okay with the Board, I'd like to attack what I think might be the toughest one, and that is the chlamydia question. It's also the only one that I had done a little bit of prework on last time. The issue I think, as everybody realizes now, is what are we going to recommend in terms or if any of some type of screening and/or treatment program.

We've seen the data. This is actually the third time that we've received some type of brief on this. We've been dealing with it for at least a year I think, and we certainly have seen the data on the amount of PID and the number of people that end up or potentially could end up discharged as a result of it.

So we need to do or say something regarding this.

As soon as this comes up I'll read you the first part of what the Committee had started to work on at our last meeting. I'm sorry. I should have had this up and running.

While I'm getting this, they took Bill

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

Gates up to the pearly gates, and they showed him this beautiful paradise and then took him down to hell and showed him that, and he said, "Well, of course I'd like to go to the paradise one." They said fine, and so they get ready to take him down there, and instead they take him to this hell hole, and he says "What's going on here? I saw the beautiful paradise," and they say, "Oh, that was the Beta version."

All right. We're getting closer. Okay. At our last meeting we had started on a document, and we had gotten as far as saying at the request of Brigadier General Kiley, the Infectious Disease Control Subcommittee considered the issue of chlamydia screening in the military. The Board heard extensive presentations by both military and non-military workers in the area, including the principal investigators of studies -- of published seroprevalent studies among military personnel.

In addition, the Board learned that the Services are discrepant in their current approach to this issue. For example, the Navy performs universal screening for chlamydia in all female recruits. The Army and Navy currently do not perform any type of universal screening for this disease. Further --

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

COLONEL KARWACKI: The Army and Navy? You said the Navy. You mean Air Force and Army.

DR. POLAND: Sorry.

COLONEL KARWACKI: Or Army and Air Force.

COLONEL DINIEGA: Army first.

DR. PERROTTA: No, Air Force first, alphabetical order.

DR. POLAND: Okay. Further, the Board had the opportunity to review the results of the very large screening study performed at Fort Jackson as well as the results of cost-effectiveness studies demonstrating the significant cost savings to the DoD that could accrue with the potential adoption of the chlamydia screening program.

For these reasons and because -- at least I think this is right -- because of new standards of care recently published by the Centers for Disease Control and Prevention, the Board discussed the issue and makes the following recommendations.

That was the easy part. As a straw man, let me just throw this up, okay. All new recruit accessions, male and female, should undergo screening to detect chlamydia infection. Ideally, this should take place as soon as practical after joining the

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

military, such as during the recruit training period, but screening within the first year of military service would also be acceptable and still accomplish the goals of a screening program.

Number two, all female military service members should be routinely screened for chlamydia at the time of each recommended routine PAP smear, and I had put up to the age of 30 years of age. Maybe 25 is appropriate, but I did that based on the -- I believe on the Fort Jackson study that showed this -- there was kind of a bump up until about 30, and then it was next to nothing after that, but 25 or 30, whatever folks thought was appropriate.

COLONEL DINIEGA: The Task Force recommends 25 and below.

DR. POLAND: Twenty-five, we can make it 25.

COLONEL DINIEGA: At least 25.

DR. POLAND: Really the slope began to get steep downward after 25, so that I think is quite acceptable. As a starting point -- Marc, please.

DR. LA FORCE: Could we discuss as a group perhaps Colonel Noriega's suggestion about -- I was going to take my foot out of my mouth.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

DR. POLAND: Next time we start the meeting about an hour later, get more sleep.

DR. LA FORCE: Well, in terms of the suggestion of some gradation with a recommendation that it be done at every encounter for PAP smear encounter and that at every clinical encounter that makes sense, much along the Preventive Services Task Force guidelines.

DR. POLAND: So right now we have it at the time of each recommended routine PAP smear, which for the military, under age 25 is annually.

DR. LA FORCE: Every year, right. But it's the screening recommendation for males that's the problem, and my suggestion is to perhaps not make a recommendation for universal screening, but to have the Epidemiologic Board make a more permissive statement in terms of encouraging urine screening at appropriate intervals and then trying to get better data in terms of chlamydia either carriage or systems that could be integrated, because my sensing in hearing some of the logistic problems of this particular recommendation for males is that this is not a minor issue, unless I misunderstood.

DR. POLAND: I think I've heard that loud

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

and clear too. So how do we want to phrase something about males? We could say urine-based screening tests of male military personnel --

DR. LA FORCE: Are encouraged at each appropriate clinical encounter.

DR. POLAND: Somebody remind me too, by the way, for males is the percent symptomatic and asymptomatic about the inverse of female?

COLONEL KARWACKI: Yes. It's not more.

DR. POLAND: So males are usually symptomatic with it.

COLONEL KARWACKI: Should we say any appropriate encounter?

DR. POLAND: Okay. I like that.

COLONEL DINIEGA: Could you box them in a little bit and say at all STD-related visits and any other appropriate encounter.

COLONEL KARWACKI: You could do for example, any STD-related visit. That would be the obvious.

DR. LA FORCE: That's a great idea because that makes it by example.

COLONEL DINIEGA: And that brings up the other issue is in -- we got rid of that bird this

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

morning before you got here. What are the Services' policies on contact tracing for chlamydia?

LIEUTENANT COMMANDER FALLON: It's treated like any other STD.

COLONEL DINIEGA: It's reportable. Is it as vigorous as, you know, for syphilis and gonorrhea?

LIEUTENANT COMMANDER FALLON: It's supposed to be.

COMMANDER MCBRIDE: It hasn't always been, but it is now, and it's supposed to be.

DR. POLAND: That's already policy?

COMMANDER MCBRIDE: Yes.

DR. POLAND: The two other things that we might consider putting in are an education component, and the other thing I heard Jerry made a brief comment about the HIV and STD Prevention Committee. Is there anything we want them to do with this or is there any additional data that we think should be collected? For example, after instituting this program, re-reviewing the data that we saw from something like the Fort Jackson study or the PID rate or something like that?

COLONEL BRADSHAW: I think in particular if there could be an intervention that was linked to

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

male screening and education and then follow-up of recurrence or reinfection or change in behavior. It was either change in behavior or recurrence-related outcomes. Now, that might be interesting. I don't know if Commander Ryan would have a suggestion on that.

DR. POLAND: What would you suggest in terms of either an education component or follow-up studies to determine whether behavior had been affected?

LIEUTENANT COMMANDER RYAN: I would say to take advantage of the Navy's current policy for screening all male recruits to do a cross-sectional screen at about one year -- men at about one year after that initial screen to look at reinfection rates, as well as doing the questionnaire kind of thing I did before to assess self-reported behavior, but I think that doesn't mean a lot in the face of not knowing how many are reinfected or newly infected or still infected.

DR. LA FORCE: Except that the fraction of asymptomatic males is likely to be relatively small in comparison to the symptomatic group, is that not true?

LIEUTENANT COMMANDER RYAN: Yes, I think

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

that is true, although we find, you know, that it's about two to four percent of men with asymptomatic infection as they came in. We could just target them to do another -- they're the ones who had the one-on-one education and the treatment. We could target them as the people we want to do a retest on, bring them back, not just wait for a clinical encounter, but bring them back and do another screen.

DR. ATKINS: David Atkins. Just I think with the urine-based testing we're finding that there's a bigger pool of asymptomatic men than we thought and a lot of "symptomatic" men aren't complaining of symptoms. I mean, if you took a careful history, you might find they had some symptoms of urethritis or if you looked at their urine you'd find leukocytes, but they would otherwise go undetected in a routine encounter because they don't come in complaining of dysuria.

COLONEL BRADSHAW: This is Colonel Bradshaw again. I think the thing I'm mainly interested in is whether or not there would be an effect of screening combined with education on subsequent behavior and reinfection. That's the hypotheses that I would be interested in.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

DR. CHIN: Greg, I have a question.

DR. POLAND: Please.

DR. CHIN: Jim Chin. The HIV STD Committee that you referred to, what's their responsibility? Are they addressing this particular issue also?

DR. POLAND: They have looked at instituting some studies on behavioral change, education, particularly peer-to-peer and interactive kind of educational interventions to see if they can affect --

DR. CHIN: So are they just focused mostly on that aspect? The issue of whether to do screening for chlamydia would not be something that they would sort of address also?

COLONEL BRADSHAW: It would possibly fall in their purview as well. I mean, it's a fairly broad -- it's mainly on STD, HIV prevention, but screening would be one aspect of that. And actually the -- one of the co-chairs right now is Doctor Ron Hale, who's the Preventive Medicine Physician associated with recruit training at Lackland.

DR. CHIN: Well, I'm just trying to get clear that if the AFEB comes up with a recommendation,

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

does that go to this other committee for review also or --

COLONEL BRADSHAW: It wouldn't necessarily be for review, but it might be a recommendation that they could take ahold of and then go forward with.

DR. POLAND: Something like the Board recommending that an appropriate education program also be developed and disseminated either to all recruit accessions and at the time of treatment for chlamydia or other STDs?

DR. ASCHER: Evaluate it, not just -- we don't know --

DR. POLAND: Then, finally, the Board recommends that prospective studies be initiated aimed at measuring the effectiveness of the above recommendations and education programs. So putting forth the principle and then letting the appropriate group --

DR. ATKINS: Is there a mechanism by which this can really be studied? I mean, is it possible for you to implement this in a phased way where you could actually compare an area where you've done screening and education to an area where you're continuing your routine screening?

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

DR. POLAND: Yes. I mean, we'd just have to put together some protocols basically and do them as research studies.

COLONEL KARWACKI: For which funding always becomes an issue.

DR. POLAND: That's right.

LIEUTENANT COMMANDER FALLON: Naval Health Research Center has done some studies --

DR. POLAND: I mean, there are pots of funds I mean, that we could --

LIEUTENANT COMMANDER FALLON: -- sexually transmitted diseases, so --

DR. POLAND: Yes.

LIEUTENANT COMMANDER FALLON: -- I mean, they'd be able to already do some of that.

COLONEL KARWACKI: I would be interested in hearing what Doctor Atkins -- you mentioned that the Task Force, the Preventive Medicine Task Force was going to undertake a review. Automatically, if that gets incorporated into the Task Force recommendations, it will become part of the PPIP PHCA Public Health Care Application if it gets integrated. So whatever they come forward with, we would take just as is and then perhaps have to expand on it if it was

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

appropriate, but do you have any idea what the draft proposal is? Does it include an educational component like we're talking about?

DR. ATKINS: It will, but I think we have a separate sort of chapter on STD counseling. So I think we're clearly taking a close look at the issue of screening men. I can't predict whether we'll come out with a stronger recommendation than we did in the past, and the difficulty is there isn't a lot of data.

You clearly have good data you can find men, and you have good data that you can treat them, and there's not a lot of good data that I know of to look one year down the road to see how much of an impact you've had on the reservoir of infected people or on new infections in women, and it seems like the military is in an ideal situation to answer some of those questions for us.

DR. POLAND: We wouldn't have anything from them for at least a year.

DR. ATKINS: Yes.

COLONEL KARWACKI: Well, that's sort of where I was going. Perhaps data that was collected in our population could contribute to their effort, but if they came out with a recommendation in the

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

meantime, it would sort of override anything that was happening in the data collection because it would be automatically instituted as part of a national standard of care.

DR. ATKINS: Yes. Unfortunately, I can't really predict not knowing the data in detail. I mean, one thing that comes to mind, and I'm thinking off the top of my head, is we -- our agency is -- has a strong commitment to the Task Force and a growing commitment to research around clinical preventive services, and it may be conceivable we could free up a small amount of money for data -- you know, the analysis of some of your data where it would help the Task Force deliberations. So I don't think we're in a position to fund big trials, but if you can sort of institute the study as part of policy change but you're looking for funding to actually collect and analyze the data, maybe that's an area where we could partner with you.

COLONEL KARWACKI: Unfortunately, the analysis is probably the thing we can do the easiest and best, and it's the getting somebody out there to do the data collection that becomes the problem.

DR. POLAND: Okay. Given that, any other

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

particular comments about this recommendation, additions, deletions, sound appropriate?

COMMANDER MCBRIDE: Can you read it again as you've developed it?

DR. POLAND: Okay. So the recommendations would be: One, all new recruit accessions, male and female should undergo screening to detect chlamydia infection. We may have to change that to just female.

Ideally, this should take place as soon as practical after joining the military such as during the recruit training period, but screening within the first year of military service would also be acceptable and still accomplish the goals of a screening program.

So I guess we're going to make that for the time being female.

Number two, all female military service members should be routinely screened for chlamydia at the time of each recommended routine PAP smear up until the age of 25 years of age.

Number three, in addition --

LIEUTENANT COMMANDER FALLON: Question. I mean, should there be anything about beyond that, if risk behaviors indicate, because otherwise it sounds like you'll never do it again?

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

Dr. Atkins: Clinically indicated.

LIEUTENANT COMMANDER FALLON: Yes, I mean something to that effect.

DR. POLAND: Further screening -- do they get annual PAP smears throughout?

LIEUTENANT COMMANDER FALLON: Yes.

DR. POLAND: Okay. So we could say further screening at the time of the annual -- I'll just say this should be performed as clinically indicated?

LIEUTENANT COMMANDER FALLON: Yes, something like that.

COLONEL DINIEGA: Well, you say clinically and some people might interpret that as they got to have symptoms, you know.

LIEUTENANT COMMANDER FALLON: How does the Task Force state it or do they?

DR. ATKINS: Well, I mean, the strongest risk factor is probably marital status, and then it's as a proxy for, you know, number of sexual partners. The CDC recommendations are a new partner or multiple partners.

DR. POLAND: All right. I'll say further screening at the time of the annual visit should be

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

performed as clinically indicated by symptoms or risk factors.

LIEUTENANT COMMANDER FALLON: That works.

DR. ATKINS: I like it.

DR. POLAND: Okay. Number three, in addition -- we may not want to be this specific -- but urine-based screening tests of male military personnel are encouraged at any appropriate medical encounter, for example, any STD-related medical visit.

COLONEL DINIEGA: We don't want to lock them into the test.

DR. POLAND: Okay. So screening tests --

LIEUTENANT COMMANDER FALLON: Appropriate screening tests.

DR. LA FORCE: We don't want to make a statement encouraging the newer tests?

DR. Atkins: Well, you're saying use a urine test.

DR. POLAND: I guess I --

DR. LA FORCE: No, no, I --

DR. POLAND: -- say appropriate screening test.

DR. LA FORCE: -- purposefully.

DR. POLAND: I could put in parentheses

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

such as the --

DR. LA FORCE: Yes, because I think that's a major step forward.

COLONEL DINIEGA: Yes, and they do move to the newer technologies. But you just don't want to -- I don't think you want to --

DR. ATKINS: You could say something like the higher sensitivity.

DR. LA FORCE: Can you say something, are encouraged or highly encouraged or --

DR. POLAND: I'll just say appropriate screening tests, in parentheses such as the urine-based ligase screening assay, end of parentheses, of male military personnel.

DR. ATKINS: Again, I think in men the demographics are somewhat similar. You know, it's high -- the prevalence goes down with age. I don't think it should be -- I think it also should be age based.

DR. LA FORCE: Twenty-five?

DR. ATKINS: I don't know the data to say what -- at what point it's --

DR. POLAND: We actually don't have that data. So if we make it, we recognize that we make

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

that recommendation in the absence of data. I'm not opposed to that, but --

COLONEL KARWACKI: Remember that at least -- I think it's probably across the Services -- 95 percent of the Army is 25 and under at any given time. So I don't know if the other services have a similar demographic.

DR. POLAND: Remember, they're the ones that have the high incidence of Lyme disease. So we're suspicious about them being out in the woods a lot. Do we want to say then at any appropriate medical encounter up to the age of 24? That seems kind of --

COLONEL KARWACKI: I mean, 25 is a break point because that is the Army essentially.

DR. ATKINS: If we don't have the data there, we shouldn't say --

DR. POLAND: Yes.

DR. POLAND: Okay. One at a time. Wait a minute. One at a time. Wait. Go ahead.

COMMANDER MCBRIDE: I was going to say we could keep a similar expression on the end of that sentence "as dictated by risk factors or clinical indications," something like that that will leave it

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

somewhat open. Age would be included in that.

DR. ATKINS: I'm a little unclear. How is this -- Dana, I mean, how would you interpret this recommendation? I mean, would you under this recommendation be free to say study this and implement this in one place and not in another and collect some data to see what the yield of it is?

COLONEL DINIEGA: You mean for the males?

DR. ATKINS: Yes.

COLONEL DINIEGA: Well, I think if you're going to want to phase it in, you should say implementation -- have them bring some data back and then have the Board review it is what I would recommend.

DR. LA FORCE: Should we make a specific recommendation to that end?

DR. POLAND: All right. Let me get through it this way, and then let's hit that way.

DR. ATKINS: Do the male equivalent of the other study to get the data.

DR. POLAND: Okay. So, in addition, appropriate screening tests such as urine-based ligase screening of male military personnel are encouraged at any appropriate medical encounter as indicated by

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

symptoms or risk factors. For example, an STD-related medical visit would be an ideal indication.

The Board also recommends that an appropriate education program also be developed and disseminated to all recruit accessions and at the time of treatment for chlamydia or any other STD.

Finally, the Board recommends that prospective studies be initiated aimed at measuring the effectiveness of the above recommendations and education program, for example, a cross-sectional study of reinfection among treated male personnel.

COLONEL DINIEGA: Are we talking about -- see, when you say given to all recruit accessions, you're already putting back into the recruit window, whereas if you put it on a test-based basis and you link it to that, then they can do it within that year.

DR. POLAND: It's two -- I guess two different points. Are we trying to prevent reinfection, are we trying to prevent primary infection or both?

COLONEL DINIEGA: Now --

DR. POLAND: If we link it to the test results, then all we're doing is trying to prevent reinfection.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

COLONEL DINIEGA: If you do it at the recruit level and provide education -- which I think most people do. They get STD education at the recruit level -- you just would have to make sure chlamydia is part of that STD package.

DR. ASCHER: Let me see, one piece at the beginning of that sentence which has to do with actually getting the baseline information on male prevalence. You've gotten a little beyond what you -- so you need a couple of words in the beginning, to obtain information on male prevalence.

DR. ATKINS: Well, we have some of that information.

DR. LA FORCE: Well, I think they have the male prevalence though. The question came up --

DR. ASCHER: No, I understand that, but you're going to do more. You want to get that data so you can broaden the question.

COMMANDER MCBRIDE: As the letter is worded now, it doesn't appear to acknowledge that we don't know for sure about the male screening and that we're encouraging the Services to do these studies to help understand what the screening recommendations should be, and we need to craft the letter just a

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

little bit differently to express that I think.

DR. POLAND: Okay. We can add then before the -- the one I just tried, the education part, we can say the Board recommends studies to determine the prevalence of chlamydia infection among male military personnel.

DR. ASCHER: No, I wasn't saying that. That's been done to some extent. We're saying --

COMMANDER MCBRIDE: We wanted to --

DR. ASCHER: We wanted in the course of implementing this new program of doing male testing at these visits that you'd want to collect the information in a way that --

DR. LA FORCE: I thought the question was if you screen, identify, treat, you don't know a year later whether that treatment has done anything if the same people come back positive a year later because of reinfection. So I'd be precise in terms of saying --

DR. POLAND: Okay.

DR. ATKINS: But that's the second part of the sentence. That reads out as he reads it.

DR. LA FORCE: Okay.

DR. POLAND: Okay. So is there a feeling that we already know the presence of chlamydia

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

infection?

DR. ATKINS: No.

DR. POLAND: Okay. So we want that in there, determine the presence of chlamydia infection.

Okay. Say it again, Mike, of what you're suggesting that say.

DR. ASCHER: Read the sentence. It was correct.

DR. POLAND: How about if we said the Board recommends studies to determine the prevalence of chlamydia infection and reinfection among male military personnel?

DR. ASCHER: I thought it linked to what you were going to do for recommending testing. I thought in the course of this testing it was recommended that data be obtained about prevalence and reinfection and the effects of education.

DR. POLAND: Right, yes.

DR. ASCHER: So it's really linking those two.

DR. POLAND: Wait a minute.

COLONEL DINIEGA: You're asking for implementation at a few sites, get the data, come back to the Board with the data, and see if you should go

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

to a universal screening for men.

COMMANDER MCBRIDE: Well, that's probably better expressed, yeah.

DR. POLAND: Somebody helped me here. All right. We've talked about -- this is the problem writing something by committee, right. Okay. The first one is the female recruits. The second is routine screening of female military service members with PAP smears to age 25 and then with risk factors and symptoms. The third is appropriate screening tests of male military personnel at appropriate encounters by -- indicated by symptoms or risk factors. The fourth now is this study component.

DR. ASCHER: Which links -- in the course of the male testing --

DR. ATKINS: Can we precede the statement about men to say that we recommend that the feasibility and effectiveness of screening programs in men be --

DR. ASCHER: Assessed.

DR. ATKINS: -- you know, given great attention including --

DR. POLAND: Start that at the beginning, okay.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

DR. ATKINS: The Board recommends that the effectiveness and feasibility of screening men, especially with new urine-based technologies receive specific attention, including the implementation of pilot programs that will, you know, collect data on prevalence, incidence, reinfection.

DR. POLAND: I can't type that fast. Including the implementation of the pilot programs that what --

DR. ATKINS: Collect data on prevalence, incidence, reinfection rates --

DR. ASCHER: And effectiveness of education.

DR. ATKINS: And costs and clinical consequences.

DR. POLAND: I'll never be better than about 30 words a minute here. All right. So then number four would be -- we would not include right now about the prevalence of chlamydia because that would be redundant.

DR. ATKINS: Yes.

DR. POLAND: All right. Then four would be the Board recommends that an appropriate education program be developed and disseminated to all recruit

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

accessions and at the time of treatment for chlamydia or other STDs.

COLONEL DINIEGA: At the time of accession. Is that what you said, at the time of accession?

DR. POLAND: Disseminated to all recruit accessions.

COLONEL DINIEGA: To all recruit accessions. So that means during recruit training they're to get chlamydia education.

DR. POLAND: And the idea was that happens now, right, and it's just kind of adding the chlamydia piece if it's not in there. And then, finally, the Board --

COLONEL DINIEGA: What about test-based link, education?

DR. POLAND: All recruit accessions and at the time of treatment for --

LIEUTENANT COMMANDER FALLON: Do you want at other times, you know, as part of routine education just sexual responsibility or something to that effect given with HIV and other STDs.

DR. POLAND: So recruit accessions, at the time of treatment, and at the time of what?

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

LIEUTENANT COMMANDER FALLON: Part of routine military training.

COLONEL DINIEGA: Routine STD training.

LIEUTENANT COMMANDER FALLON: Well, I mean, we all do general military training, and one of the -- there are a lot of health topics that have to be provided every year, and this should be one of them.

DR. POLAND: Everybody happy with it now?

DR. LA FORCE: Can we trust your editorial skills?

DR. POLAND: My typing?

DR. LA FORCE: Yes.

DR. POLAND: Well, I think what's going to happen is -- are we going to attempt to approve all these?

COLONEL DINIEGA: Yes.

DR. POLAND: Okay. Okay. Done with that one, just a note that Doctor Bailey has said that the AFEB will receive at least an annual report of the operation of the DoD Influenza Surveillance Working Group.

COLONEL DINIEGA: Number one today -- yesterday.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

DR. POLAND: Yes. Okay. Okay. To Lyme disease then. Is that a foreshadowing thing that --

DR. ASCHER: Any objection?

DR. POLAND: Okay.

(Simultaneous discussion.)

DR. POLAND: Okay. Everybody has the question before them on Lyme disease. All right. While he's getting that then, we have -- the question before us is request the Board review available data, provide recommendations concerning the use of the recently-licensed Lyme vaccine among active duty service members. For those that didn't get one yesterday, this was passed out to you. It's provided by SKB, the same thing as the green xeroxed copy you got yesterday.

COMMANDER MCBRIDE: There's a couple of other points if I may as you read that that I don't know were fully acknowledged yesterday, and one is that I think we have to realize that the reporting of Lyme disease probably in the military is not accurate.

And, two, it's a challenging -- I think it was expressed. I think Doctor Reingold may have indicated yesterday that it's really a very easily treatable disease, but it's one that at least in my experience

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

is sometimes not easily recognized by a lot of people and can be overlooked. And so we have to keep those things in mind as we prepare a recommendation.

DR. POLAND: Maybe a way to start with this is to kind of put the four fenceposts up and then try to move it in to a more narrow recommendation. Maybe one way of doing that is I did not see a reason to suggest that this vaccine be universally given.

COMMANDER MCBRIDE: True. We can dismiss that.

DR. POLAND: Okay. And then --

COLONEL DINIEGA: No overseas use.

DR. POLAND: And then it's not -- yeah. We don't have any data -- in fact, we have some data to show that it would not be effective at least in some proportion of cases for overseas exposure.

The next point I think then gets to Doctor Engler here -- or Admiral Engler. I'm not sure who it is. She used the word "require" the vaccine be administered. In my own jotting of notes here, I wondered about saying something like consider vaccine for selective occupational groups and to service members in specific high-risk or geographic reasons. We might even say as per ACIP recommendations which we

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

recognize will be out shortly but aren't quite out.

COLONEL DINIEGA: Well, should the first statement be that DoD should use -- do we need a statement that says we should follow ACIP recommendations first?

COMMANDER MCBRIDE: I think that --

COLONEL DINIEGA: Or is that a given because --

COMMANDER MCBRIDE: That's a given, right. I believe that that's an accepted --

COLONEL DINIEGA: Okay. So for military-specific use only. Well, did we get enough data to say where the high risk -- military high-risk training areas are? Did you guys get that?

LIEUTENANT COMMANDER FALLON: No.

DR. POLAND: Well, the idea was that we were going to use that serum repository to start to get at some of that data.

CAPTAIN TRUMP: I think we have to be careful too that even with I think the CDC recommendations, they're going to come out with a map that this year identifies the high-risk, high, moderate, low, and no-risk areas. That is going to be a changing picture over time, and I think that the

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

safest recommendation would be one that relies upon local assessment of what the risk is, and that's going to be very difficult to mandate from on high.

COLONEL DINIEGA: I guess what I'm getting at, Dave, is there were some congressional money for Lyme disease and research. The data that was presented by CHPPM in December, I had a warm fuzzy about pinpointing installations or training areas that had not only human disease associated but had ticks that were infected associated with those areas, and in order to make something mandatory based on high-risk exposure, you're going to have to know where those exposure areas are. I think it's a good idea to say military members who are routinely exposed as part of their training or duty should get the vaccine if those areas can be identified. And, like Dave says, then it depends on some sort of assessment going on if the installation's in some high-risk general geographic area.

DR. LA FORCE: I respectfully disagree. I think the epidemiology should drive the recommendation here, and I would submit there are no data. It's hard to be persuaded when there's nothing to be persuaded about.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

COLONEL DINIEGA: I agree. We haven't seen any data that says it should be used.

DR. LA FORCE: And that's why -- the thing I'm worried about is when the CDC -- we were talking about this at dinner last night -- published their map, I bet Fort Bragg is on there. I bet Fort Bragg is located right there. And, remember, the last time we met in December, we asked specific questions in relation to Fort Bragg, and the sense was it wasn't a problem. There wasn't a problem, and largely because I think there is some education. They are covered with proper equipment. I frankly think that -- I remain not very convinced that this is a big deal at all.

DR. POLAND: Okay. Well, let me just ask the question by starting off with a statement about, you know, something like the ACIP recommendations. Are we meaning that to be a permissive statement for the use in active duty and dependents?

COLONEL DINIEGA: Well, I think --

COMMANDER MCBRIDE: You don't need that. That's going to happen anyway.

DR. POLAND: Who live and recreate in --

DR. ASCHER: That's a given.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

DR. LA FORCE: For the recreation, yeah.

COLONEL DINIEGA: The regs specifically say we're going to use ACIP recommendations.

COMMANDER MCBRIDE: As a foundation.

DR. ASCHER: What Marc was saying, you haven't seen anything that makes any more requirement than what is in that recommendation.

DR. LA FORCE: That's correct.

DR. ASCHER: And I --

COLONEL DINIEGA: Shouldn't that be it?

COLONEL KARWACKI: Now, the complicating factor we brought up yesterday was the reserves, because if we say that the highest incident areas is the northeast, we admit that we don't have huge concentrations of active duty troops there. We're more in the south and south central, yet the reserves are there. So if we're going to talk about ACIP and the reservist has to get it on his own, at his own expense, not at the government expense.

DR. ATKINS: But that's true of flu. That's true for anybody.

COLONEL KARWACKI: Okay. I'm just saying, I mean, if you want to transition over and say you want the government to protect the reservist, then we

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

have to write a recommendation that allows that to occur.

COLONEL DINIEGA: We have the obligation to protect our personnel if it's in the line of duty, there's no doubt. But until you -- you know, the issue with Fort Chaffey and Fort McCoy, you know, they have the ticks up there. There have been cases associated with both places, sporadic cases, but I'm not so sure the tick drags have been as strong as they should be to say that, for example, anybody who trains at Fort Chaffey should be immunized.

DR. POLAND: Okay. Do we want to call for more research first?

DR. ASCHER: Right. Austria routinely immunizes their military for TBE because they demonstrated in very well conducted epidemiologic studies that their troops have higher risk than the general population and higher risk due to their military duties, and those are the questions. And we should ask the research issue, is if there is additional risk to military personnel as a function of their duties, including reserves, at which point you would then make that further recommendation.

COLONEL DINIEGA: Then they can come back

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

to the Board.

DR. POLAND: All right.

DR. STEVENS: I think we need better data.

As you all discussed yesterday, the inpatient data is just completely inadequate, and you need outpatient --

DR. POLAND: Okay. Let's hear -- I thought we might start by saying one, that Lyme vaccine is only one adjunct to the prevention of Lyme disease. Personal tick prevention measures should be encouraged and compliance strengthened. It is apparent not all --

DR. ATKINS: I like it. Good.

DR. POLAND: Okay. Second one would be -- let's hear a sentence for the research.

DR. LA FORCE: The disease burden in military facilities is not well characterized.

DR. ATKINS: And there are problems in the use of clinical diagnostic data to accurately determine or the -- I thought what we proposed was a study looking at collecting data that would actually look at seroconversion rates.

DR. LA FORCE: We had two things. One, if we identified one area or one installation and actually tried to access both ambulatory and hospital-

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

based disease to try to do a disease burden study, and then the second issue was if that was not possible, then a bird's eye view would be the serum bank approach where you identified a cohort or a series of two or three cohorts and you look before and after, and if you didn't find any seroconversions looking at it that way, particularly with Western Blot, then it's not a problem.

DR. ATKINS: The only part of that that I have come concern about are studies that have very elegantly demonstrated the dynamics of the spread of Lyme disease and this progression across the United States. So I almost wonder, we have to do it for all installations or regions? Do we have to repeat that every three to five years or do you just go ahead and start to say, well --

DR. ASCHER: It's a surveillance program that finds out whether Lyme disease is occurring, and then if it's a particular function of being in the military and/or your duty, period, and those are the unanswered questions. It's an ongoing program.

COMMANDER MCBRIDE: Let me make some comments if I may. The thought of doing a sero survey is because we have these bloods and we do have ways of

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

tracking where these personnel have been and where they have served. So we have our history of an individual who may have been active duty for six years and he had his blood drawn two years ago. We know where he was or she was when they had that blood drawn, so that if that blood shows evidence of a Lyme infection remotely, we can have a little bit of an idea where they possibly could have been infected or where they were when the blood was drawn, and we have their assignment history available to us. And so that might give us an idea if they're positive and roughly where they might have been at least regionally, and that might give us some important information. So that's one point.

DR. POLAND: Do you care whether they got it as a function of their military duty or whether they got it as a function of where they were stationed and lived?

COMMANDER MCBRIDE: Yes.

COLONEL BRADSHAW: This is Colonel Bradshaw. We also have occupational codes. We can link all that data to both occupational code and assignment history.

DR. ASCHER: Where they live and what they

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

do on their own time will be covered under ACIP, and that should be done properly. In other words, people in high-risk areas that are doing high-risk things should probably get the vaccine by the recommendations. This is the question then, is there anything about their being a military person that adds to that recommendation, just because of their being a military person. And if you do that study, you're only going to find the people that live in the high-risk groups that do the high-risk things that are covered by ACIP.

DR. LA FORCE: Unless you take, according to that map, a place like Fort Bragg and you study two or three cohorts serologically, you know, on accession and as they finish their basic training when ostensibly they would be exposed at --

DR. ASCHER: Well, Chaffey was reservists rotating through from Alaska. They had people from totally different geographic regions. They did sero in, sero out, and blood cultures, and that's how they found erliki (phonetic) at Chaffey. So you could say studies like that were used for erlikiosis to determine --

DR. POLAND: Okay. Those are incident

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

studies.

DR. ASCHER: Yes. -- to determine risk to particular military groups.

DR. STEVENS: I'm not sure I understand the point of whether someone in an area where there's a high endemic rate, whether they got it while they were doing their military functions or under recreational conditions.

DR. POLAND: I don't think you'll ever separate them.

DR. ASCHER: The policy for reservists is they're not going to give vaccine to people on that basis, because they're in endemic areas.

DR. STEVENS: Reservists is another issue, but --

COLONEL BRADSHAW: This is Colonel Bradshaw. I think there's two issues for us in the military. One is you got people living in these areas. So if I get assigned to Fort Dix, New Jersey or to Newport, Rhode Island, do I need to get the vaccine. And I'm only going to be there three years or whatever. The second is if I, you know, am deployed for training for three weeks or six weeks or whatever period of time, do I need to get the vaccine,

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

especially since I got to get it a year ahead of time, and is that even feasible.

Those are the two settings that I see that we need to address the issues for.

DR. POLAND: That was our fourth fencepost. Let's start pulling it in now. Yes.

COMMANDER TEDESCO: Just a comment about required vaccines -- well, at least in the Coast Guard, and I'm not sure how the other Services approach this, but our approach to vaccines, what are required, meaning if you refuse it you can be booted out of the service for disobeying an order, are does it make you fit for duty in terms of going somewhere or is it a vaccine that may be required because it's so infectious it could bring down a whole unit, similar to influenza. So even though a Coast Guard member may be at a small boat station in Nantucket, which is high risk geographically, he has no actual mission out in the woods. Therefore, we would say it's not needed for him to perform his mission, and it's not infectious, so he's not going to infect the other troops if he gets it. Therefore, we'd say, well, maybe geographically we may offer it or allow him to get it. It won't be a required immunization

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

for the Service.

DR. POLAND: Okay. We -- sorry. We're going to have to move along here. So right now number two says the burden of Lyme disease in the military is unclear. Studies examining prevalence and studies examining the incidence of Lyme infection as a specific function of military duty should be initiated.

COLONEL DINIEGA: I'd recommend including tick distribution on military -- and infection on military installations and training areas.

DR. STEVENS: That was the point I was trying to make about the specific military duty. That seems like an embellishment that's not very necessary. If they're in an area and they get it while on military duty, do you really require knowing whether it was recreational or otherwise?

COLONEL DINIEGA: They may be thinking -- on some of our installations we do have wildlife management people who are out in the woods as part of their job on the civilian side. So occupational-wise, work-wise, that's appropriate, but it's hard for me to think of somebody who has military duty other than infantrymen and tankers who are in a training area

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

that's infected to get it, but I can't think of any specific military occupational specialty that has as their MOS to be out -- on a routine basis out in the woods being exposed.

DR. POLAND: Well, aren't there --

COLONEL DINIEGA: Special Forces.

DR. POLAND: -- maybe some of the engineers that are out making roads and clearing out --

COLONEL DINIEGA: Training, training.

DR. POLAND: Okay. Then what we can say is we recommend use of the vaccine under the following conditions: One would be as per ACIP. Do we want to say anything specifically about -- where was it -- about either selected occupational groups or --

DR. ASCHER: The comment in advance, I mean, underline in advance use in individuals who are transitioning from low-risk area to high-risk areas, and that's where prevention would really work if you know that.

COMMANDER MCBRIDE: But then you'd need to -- you'd need to know how long they anticipate being in that area, six weeks, six years. We don't want to immunize everyone who's there for a month

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

necessarily. So that's what's so unwieldy about this.

CAPTAIN TRUMP: I guess one way to look at it, this really is no -- except for the timing that's needed to vaccinate, it's not much different than the way we have to approach Malaria prophylaxis, which is that as a dynamic process, the decisions about whether you're going to or not going to distribute Malaria prophylaxis prior to a deployment is based on an assessment of how long they're going to be there, what they're going to be doing, what we know about the disease risk in that local area for this period of time. It's something we do all the time, but it's not something that we spell out from above what the requirement is. It's done in consultation with your preventive medicine advisors, your entomologists, and, you know, using local information, in this case for Lyme disease, state and local assessments of disease risk.

DR. ASCHER: Well, I got the difference for you, which is military people just don't live places. They go places. So the key would be to say that its use in people whose residence in an endemic area is the ACIP default, but the particular military issue is that many people as part of their job go

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

around to places which have risk when they don't live in a place that has risk. So you would say -- you would target it for people whose duties put them in risk areas, even though they're not in the risk area, and that would be -- that could be identified as to who those people are, and that might involve reservists. That might involve people whose job it is to go around and go to training places every year. So that would be the difference between their residence requirement and their duty requirement, is if they go into risk areas. Knowing that, you would immunize them in advance, knowing what their job is. Is that too complicated?

LIEUTENANT COMMANDER FALLON: That would also be as part of the pretraining planning.

DR. ASCHER: That's like rabies going to Asia. That's what I'm saying.

DR. ATKINS: But we have no data to show that the fact that they go places actually increases their risk. We think it might, but maybe --

DR. ASCHER: But it increases the risk of the people that live in those areas. So it's an inference.

(Simultaneous discussion.)

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

DR. POLAND: We can -- in the interim -- in the interim, prior to this data, the Board recommends consideration of use of Lyme vaccine under the following conditions: As per ACIP recommendations number one; number two, for selected occupational groups considered to be at high risk because their duties place them in high-risk geographic areas.

DR. ASCHER: Not just in the area but place them in --

DR. POLAND: High risk.

DR. ASCHER: -- contact --

(Simultaneous discussion.)

CAPTAIN TRUMP: I would use that ACIP-type language, which is frequent and prolonged exposure to endemic -- areas where the tick vector is present. I mean, it's not the geographic area.

DR. POLAND: Okay. Place them in high-risk areas that what, Dave?

CAPTAIN TRUMP: Where they incur frequent and prolonged exposure.

DR. POLAND: Where frequent and prolonged exposure could be anticipated or might be anticipated.

Okay. Vaccine should -- seems silly to say it, but I guess I heard several people say it -- vaccine should

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

be used in advance of exposure and how much time? I mean, somebody's going to go to this area for a week.

COLONEL BRADSHAW: Year ahead by current recommendation.

COMMANDER MCBRIDE: We encourage the further --

DR. POLAND: But, I mean, but how long do they have to be in the high-risk situation.

COMMANDER MCBRIDE: Yes. That's the tough thing. We can't answer that I guess.

DR. POLAND: So should be used in advance of exposure, period.

COMMANDER MCBRIDE: I think you could say that further guidance should be guided by additional evidence based on studies. We'd sure like to have you say one year, three years, or whatever, but I just don't think you can.

DR. ASCHER: But you also recommend the development of this accelerated schedule which would be much easier, three doses, one, two, three.

COMMANDER MCBRIDE: When FDA releases that, if they approve that, that's within three months they have --

DR. POLAND: Right. Do we want to make a

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

statement about that now or that seems premature?

COMMANDER MCBRIDE: We could say that further consideration may be made in the future pending the FDA's anticipated consideration -- accelerated schedule is -- an FDA approval of an accelerated schedule is pending. Once this is done, it may change things. I don't know.

COLONEL BRADSHAW: I don't think you need that.

LIEUTENANT COMMANDER FALLON: Well, it's not going to change our recommendations though. It will just --

DR. ASCHER: It will make it easier.

LIEUTENANT COMMANDER FALLON: Yes, it will make it easier.

DR. POLAND: That's true. Okay. Do we need anything beyond what we've sketched out here?

DR. LA FORCE: Are you making this a requirement, are you just saying this should be offered, or how should --

DR. POLAND: No. So we're going to say, one, Lyme vaccine is an adjunct to the prevention, you know, encouraged compliance with tick prevention measures. Second is burden of Lyme disease in the

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

military is unclear. Studies examining prevalence and studies examining the incidence of Lyme infection as a specific function of military duties should be initiated, including tick distribution and infection on military installations.

In the interim, the Board recommends consideration of use of Lyme vaccine under the following conditions: One, as per ACIP recommendations and, two, for selected occupational groups considered to be at high risk because their duties place them in high-risk areas where frequent and prolonged exposure might be anticipated. Vaccine should be used in advance of exposure.

COMMANDER MCBRIDE: Should we say the military duties or is it necessary to qualify that?

DR. POLAND: I'll say that.

DR. LA FORCE: That's great, terrific.

COMMANDER MCBRIDE: Because we want to make sure they understand -- we want to -- we're talking military duties here, not --

DR. POLAND: Yes. If you're going camping in northern Minnesota for two weeks --

(Simultaneous discussion.)

LIEUTENANT COLONEL SOUTER: Instead of

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

high-risk areas, could you not just substitute the word "environments?" Like they can be in the areas without being at risk, and I think if you just say environments, then --

DR. POLAND: Changed. What else, anything else? We happy with it? Dave.

CAPTAIN TRUMP: The only -- I think one thing that would be very helpful is just reiterating that, you know, this is -- can't be -- is not a blanket decision. It's a very -- it has to be made at a very local level.

COLONEL BRADSHAW: Yes. Just say that local conditions and risk information should be utilized in making any decision regarding Lyme vaccine.

CAPTAIN TRUMP: In consultation with preventive medicine authorities, military and civilian preventive medicine.

COLONEL BRADSHAW: It's a moving target.

DR. POLAND: That's why that is a good idea, for that very reason.

COLONEL BRADSHAW: Risk changes. California is now very, very low overall, and we are not going to recommend it for this state.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

DR. POLAND: Okay. Now, the good Admiral did say if the -- if this option we've just selected was used, provide a required period of time for which a member either must be in the high-risk region or must be anticipated to remain in the high-risk region before vaccine administration will occur. We can ignore that or we can address it.

LIEUTENANT COMMANDER FALLON: I think you have to leave it up to local preventive medicine.

DR. POLAND: All right.

COLONEL BRADSHAW: Well, the only issue there I think is the current schedule is what, a year ahead. So if you're only going to be there a year --

DR. ATKINS: We're not accepting option (c) because we're not endorsing any requirement.

DR. POLAND: Okay. All right. Next is --

LIEUTENANT COMMANDER FALLON: Do you want to put something to that effect, that we're not making it mandatory?

DR. POLAND: -- varicella. We got to move along here. You want to pull your varicella question out.

UNIDENTIFIED SPEAKER: Offered, do you have the word offered in there?

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

DR. POLAND: I said recommends consideration or we could say --

UNIDENTIFIED SPEAKER: I think that's okay.

(Simultaneous discussion.)

DR. POLAND: Okay. Varicella. Again, the memorandum from General Kiley requests that we review available data and provide a recommendation concerning the use of varicella vaccine among Service members. Jerry this morning and yesterday showed us quite vividly at least an order of magnitude idea of what kind of a problem this is.

They request that we address timing of the use of the vaccine, use of the vaccine versus serologic screening, where we might do this, the impact on laboratory resources, and whether concurrent screening for MMR immunity to lessen the overall cost of the vaccine program would be a good idea.

DR. ASCHER: Okay. General comment that varicella is a disease that has particular predilection for military recruit populations.

DR. POLAND: Fits the criteria that Commander Tedesco --

DR. ASCHER: Right. And, number two, and

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

can through epidemic spread cause disruption of training. That's just sort of a preamble. And then vaccine cannot prevent the cases that are incubating - - we don't have to say that -- but can prevent epidemic spread in basic training. We haven't seen that. We haven't seen that being prevented. So what?

That's a principle that would work. That's point one.

DR. STEVENS: What did you say?

DR. POLAND: I didn't get it all. It was too fast for me.

DR. ASCHER: Okay. First of all, varicella is a disease that occurs in young -- in people -- young people of military age and can be disruptive through epidemic spread in basic training to military operations. Vaccine can prevent the epidemic spread within an area like basic training. My editorial comment was that --

DR. STEVENS: That was an editorial comment. That's what I --

DR. ASCHER: -- the fact that when they tried to assess it, they didn't have situations where epidemic spread was going on. So they couldn't show much prevention, but it sure as hell is a good thing

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

to do because it sure can happen. You don't have to show that you've got something to justify preventing it when evidence is clear.

DR. POLAND: Okay. We've got about 10, 12 minutes to get through this and IPV. So really focused comments here. How do we want to approach this? I think it probably boils down to screen and vaccinate or universal vaccinate.

LIEUTENANT COMMANDER FALLON: Screen and vaccinate makes more sense based on the --

DR. ATKINS: Didn't all the data even from the Army analysis suggest that the least costly procedure is screening and selective vaccination?

DR. POLAND: Remember, we saw very discrepant --

DR. ATKINS: Right, but even under --

DR. POLAND: But even under their assumptions --

DR. ATKINS: It still was the best way.

DR. POLAND: -- it was still --

DR. ATKINS: Not cost-effective, but it was the best of the --

DR. POLAND: Correct.

UNIDENTIFIED SPEAKER: Yes.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

DR. POLAND: And with the screening, remind me, was that screening everybody or screening people with a negative or uncertain history?

(Simultaneous discussion.)

DR. STEVENS: Everybody.

UNIDENTIFIED SPEAKER: Negative history. History was a pretty good predictive value if you said, yes, I had varicella, but the uncertain --

(Simultaneous discussion.)

DR. POLAND: Okay. Wait, wait. Sorry. One at a time. Ann and then Cladde.

LIEUTENANT COMMANDER FALLON: The Air Force Academy data showed that screening everybody and then selective vaccination, but -- and doing the history one was not as cost-effective because you missed some people.

DR. POLAND: Different group -- and very different group of people I think we could see perhaps in terms of reliability. Cladde.

DR. STEVENS: I was just going to say I'm not sure that we heard the data that said that the history was in fact any good. In particular, the point that Doctor Ryan made about picking up the negatives, you want to pick up the negatives, and the

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

history wasn't very good at that.

DR. POLAND: But it was -- we were just talking -- I think for the Air Force Cadets, for the Coast Guard that was helpful. Other studies showed that it wasn't, and it probably -- that's probably a proxy for other issues. So how do we want to handle that?

DR. ASCHER: But what you're going to miss is a very small proportion of people when you have the wrong answer. That's going to be all your susceptibles that are left. So you're still going to have a huge effect on prevention. You don't really care about that very small tail I wouldn't think.

DR. POLAND: Or at least it's very expensive to get at that --

DR. ASCHER: Correct.

DR. POLAND: -- the last few percent.

DR. ASCHER: If you miss that five percent, that's all the susceptible -- sorry. You start with seven percent susceptibles. You get six of them by history. You miss --

DR. STEVENS: No, that's not true. That's not the data that was presented.

UNIDENTIFIED SPEAKER: I thought you got

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

three of them from history.

DR. STEVENS: Exactly.

(Simultaneous discussion.)

DR. POLAND: The data you presented was 50 to 80 percent sensitivity?

(Simultaneous discussion.)

UNIDENTIFIED SPEAKER: The Navy got half, but that's the -- you know, that's the lowest I've ever seen in any reliability study.

DR. POLAND: The studies we saw, as I recall, varied from a low of 49 percent to a high of --

COMMANDER RYAN: Eighty percent.

DR. POLAND: So that's the range that we're in.

DR. STEVENS: I think --

DR. POLAND: So as a general policy across the services, it probably isn't going to work to say just screen the no's and uncertain's.

DR. ASCHER: Because you'll miss up to half. Okay. Okay. Point well taken. Let me look at the '95 recommendation. Basically if you haven't seen it recently, varicella represents a limited but potentially disruptive infection in recruit

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

populations. In face of background immunity of 90 percent, universal immunization is not recommended.

And then here came the pilot study to conduct the -- assess the preventive effectiveness of serologic screening, followed by the statement, "The reliability of the history of chicken pox should be determined in the study with the goal of probably lessening the need for screening." So this fits right into this as follow-on. You don't have to write all that background. It's already here.

COLONEL DINIEGA: The issue do you screen everybody and then you find the non-immunes and vaccinate those. That's a given. The other --

DR. POLAND: Universal screening.

COLONEL DINIEGA: Right. The other issue is the Coast Guard found 99 percent --

DR. ASCHER: Positive.

COLONEL DINIEGA: -- positive that is they said they thought they had varicella, then 99 percent were accurate. And then you take the other ones, and you screen only that other group that said they weren't sure or they didn't have varicella, screen those and then immunize the non-immunes. That's the issue.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

DR. ASCHER: Well, that's very clever. You could say that it could be tailored to the reliability of the history as determined by individual Services.

DR. STEVENS: And --

DR. POLAND: Let's hear some comments on --

DR. ASCHER: Maybe it depends on how you ask the question. If you come up with the right question and we all ask the question the same way, we may get a more reliable history.

COLONEL KARWACKI: I think one recommendation is that universal vaccination is definitely not recommended.

DR. POLAND: That's already been said.

COLONEL KARWACKI: Right, already been said. The second one is that, you know, immunization of susceptibles is recommended, and then how you go about doing that is screening, and I think you can make a recommendation that screening by history may be appropriate. More ideal would be serological screening, but acknowledgement that if you can't do serologic screening for whatever reason, screening and immunizing by history is better than what -- than not

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

doing anything at all and I think puts us more in compliance with what the CDC recommendations are moving to.

DR. ATKINS: And what we heard seemed to imply that the cost of screening really varied, you know. So, clearly, if you've got a two-dollar test, the cost -- the incremental cost of screening everybody are not that great, and you'll pick up more people. If you don't have a two-dollar test and you've got an \$11 test and a more difficult implementation program, it may not be the best policy.

DR. POLAND: Okay. Let's work on this wording. We make the background statements. We say or acknowledge that it prevents epidemic spread but cannot prevent disease due to incubating infection. Say universal immunization is not recommended but immunization of susceptibles is recommended. Susceptibles may be identified by screening either by history or serology or do we want to make -- it's the last part of that that we probably need work on.

LIEUTENANT COMMANDER FALLON: Well, you'd probably prefer serology, but if that's not readily available, then by history would be the next best.

DR. POLAND: So we could say preferably

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

by --

DR. ATKINS: We could say serologic --

DR. POLAND: -- serology.

DR. ATKINS: How about serologic screening of all individuals is the most sensitive means of detecting susceptibles, and where it can be done at a reasonable cost and feasibility, it's preferred.

DR. ASCHER: And then not a recommendation but a statement where history can be shown to be good surrogate, then you could make the case for using history, but you'd have to validate that as a process within your own environment. So you start with the gold standard, which is serology. That's what we're aiming for, and then if you want to back off, you have to demonstrate that you can do that using history, not sort of either or play around.

DR. POLAND: Okay. Immunization of susceptibles is recommended. Universal serologic screening is the most sensitive, and where this can be feasibly done is recommended. If this is not feasible, susceptibles may be identified by other types of screening, by history, by --

COLONEL BRADSHAW: You could say screening by history where it's been validated to be --

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

DR. LA FORCE: It's not other types. It's just history.

DR. POLAND: Where it's not -- where universal serologic screening is not feasible, initial screening with history can be used to identify the subgroup in whom serology should be performed.

DR. ATKINS: I think that's what Ben was saying.

DR. POLAND: Okay. Let me see.

DR. ATKINS: Because if you -- if you skim off the ones that say I definitely had it and you -- you've reduced your responsibility for screening and you're going to find a lot of positives among those who say I really don't know.

DR. ASCHER: You'd still need the serologic screening.

DR. POLAND: Do we want to say where it's been validated or just say --

DR. STEVENS: I think that's important because there's --

DR. ASCHER: Right. That was the number I was referring to, the false negative history -- I'm sorry, the false-positive history, the people who --

UNIDENTIFIED SPEAKER: ACIP recommendation

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

states strongly that history is a reliable indicator.

DR. ASCHER: Unreliable?

UNIDENTIFIED SPEAKER: Reliable. I mean, I think the Navy -- you'll miss a few, but if you're vaccinating almost everybody, there's nothing that actually says that --

LIEUTENANT COMMANDER FALLON: But see, in our population, we wouldn't be vaccinating almost everybody. So --

DR. STEVENS: No. You're vaccinating very few.

UNIDENTIFIED SPEAKER: No. Most are not susceptible. So you're getting most of the susceptibles.

UNIDENTIFIED SPEAKER: A history.

(Simultaneous discussion.)

DR. STEVENS: Well, in this circumstance is we had a range of detecting the susceptibles from 49 to 80 percent. Is 80 percent -- is missing 20 percent of the susceptibles acceptable? I mean, if you take --

UNIDENTIFIED SPEAKER: I think by the time you add lab error and misclassification, you're not missing 20 percent.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

DR. POLAND: Okay. But one point is still true is that those with no or uncertain histories -- I can't remember about the military studies, but civilian studies show that they're highly likely to be seropositive. Okay. So if we say immunization of susceptibles is recommended. Universal serologic screening is the most sensitive, and where this can be feasibly done is recommended. If this is not feasible, susceptibles may be identified by serologically screening those with negative or uncertain histories and providing vaccine to those that are seronegative.

DR. STEVENS: Or a high proportion of susceptibles maybe. You're not going to identify all of them.

DR. ASCHER: To prevent epidemic spread, you know. You're dropping the population of susceptibles very significantly.

DR. ATKINS: If you do -- if there are only two susceptible people in a group, they're much less likely to get infected.

DR. POLAND: Okay. Are we happy with that? Do we --

DR. ATKINS: The logistics problems for

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

the Army is where this becomes the difficulty, because for the Navy and the Air Force, they only have the one recruit site. So they have a more captive population.

The Marines have two, and you're not screening there although you're screening the Navy.

LIEUTENANT COMMANDER FALLON: They've started at San Diego.

COLONEL KARWACKI: Parris Island is starting soon. San Diego has already started.

DR. POLAND: Do we want to do this at the time of recruit training?

COLONEL KARWACKI: Well, see, that's -- and I need to -- that's why John is here because we have six going to five sites, and that complicates the logistics of being able to do this. You know, I think what you're saying so far is probably compatible with the concept. Whether we can logistically pull it off still becomes an issue.

DR. POLAND: Is it more difficult and expensive for the Army to do it during recruit training or to -- I mean, I imagine where you see the epidemic disease is during that time period or to incur the cost of disruptions.

(Simultaneous discussion.)

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

DR. POLAND: I mean, or is it more expensive to incur the cost in disruption of not doing it during recruit training and having epidemic disease?

COLONEL KARWACKI: Well, my point was, to move it back -- and this is one of the political issues -- to move it back into the MEPS screening so that they arrive with that information onboard, which is why we were trying to move -- we proposed the concept of the measles and rubella, because of the high immunity rates in that group as well as -- we're doing universal measles, mumps, rubella now.

DR. POLAND: Do we want to say something like ideally this should be done at the time of --

COLONEL KARWACKI: Well, see, the problem -- the political problem with them is they say if it's not disqualifying, we don't do it. So I don't know whether an AFEB recommendation would be of assistance in shifting it back.

CAPTAIN TRUMP: I think the AFEB recommendation on the public health side is, you know, screening and immunization should occur early in recruit training to have the greatest benefit. How we accomplish that is probably not the AFEB's

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

recommendation.

DR. ASCHER: If you added this to the HIV panel, you would do it for 35 cents.

COLONEL KARWACKI: It costs two dollars. And we've already explored this.

DR. ASCHER: It would come in -- the person would arrive at basic with a stamp in their record that says HIV negative, which they all have to have, and it would say varicella susceptible. They get their shot the first day.

COLONEL KARWACKI: Right. Measles susceptible, rubella immune, and we move on.

DR. POLAND: Well, I can say it one of two ways. In order to have the greatest benefit, this should be done as early in accession as possible and leave it that way or no later than conclusion of recruit training or.

(Simultaneous discussion.)

LIEUTENANT COMMANDER FALLON: Well, as early into accession as possible, because that allows you to do it at the MEPS station if the Army prefers to do that.

DR. POLAND: But is that so broad as to allow it to go a year into --

LIEUTENANT COMMANDER FALLON: No, I don't read it that way. Would the Army read it that way?

DR. POLAND: Okay. So if we say in order to have the greatest benefit, this should be done as early in accession as possible.

UNIDENTIFIED SPEAKER: Even say the accession process perhaps.

DR. ASCHER: And you could, if you want to get bold, say possibly in conjunction with HIV screening.

DR. ATKINS: But it's -- I mean, we heard the incremental cost of adding the serologic screen was two dollars. Is that feasible to add two dollars to the cost of accession screen?

DR. POLAND: It was really done, and she doubled it to be conservative.

COLONEL KARWACKI: That is the most cost-effective way, to do it at MEPS, because you already have all of the overhead of drawing the blood, shipping the blood, and moving through the process.

DR. POLAND: All right. I'll add --

COLONEL KARWACKI: Running the test --

LIEUTENANT COMMANDER FALLON: Well, then put as an example, yeah.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

COLONEL KARWACKI: -- becomes very little of a problem.

(Simultaneous discussion.)

COLONEL KARWACKI: It is pennies as opposed to when you're doing relatively small batches and you have to run all the quality control at some place like Fort Sill, it drives up the cost to that \$10 range because you're doing a whole lot more overhead related to the fewer tests that you're running.

UNIDENTIFIED SPEAKER: But how many of those at MEPS show up for basic training?

COLONEL KARWACKI: Two-thirds. We screen 150,000 to get 100,000.

DR. POLAND: Okay. How about if I say this -- again, we're running out of time here. So let me try to be very focused with it. In order to have the greatest benefit, this should be done as early in the accession process as possible. In order to decrease costs and laboratory impact, this -- I could say ideally this should be done in conjunction with other -- how do I say --

LIEUTENANT COMMANDER FALLON: You could just put, you know, i.e., at the MEPS station, you

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

know, for example, at the MEPS station.

(Simultaneous discussion.)

DR. POLAND: MEP or PP?

COLONEL KARWACKI: Military Entrance Processing Stations.

DR. POLAND: All right. Appropriate to say at the MEPS level or at the --

COLONEL KARWACKI: During MEPS processing, during MEPS accessioning processing.

(Simultaneous discussion.)

DR. ATKINS: Jerry, didn't you say one of the problems is who pays for it?

DR. POLAND: Okay. Everybody happy with that?

COLONEL KARWACKI: No, because the Army already pays for --

DR. POLAND: Any objections? I'm moving on.

(Simultaneous discussion.)

UNIDENTIFIED SPEAKER: Since only 10 percent of the disease burden's in the recruits, what about the other 90 percent in young adults?

LIEUTENANT COMMANDER FALLON: Are you addressing the burden that's already out there?

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

UNIDENTIFIED SPEAKER: That's what I'm saying.

UNIDENTIFIED SPEAKER: Catch-up immunization.

LIEUTENANT COMMANDER FALLON: Catch-up screening.

DR. POLAND: Well, the way it says right now, it doesn't say anything about recruits. It just says during accession. Now, that could be enlisted or officer, right?

LIEUTENANT COMMANDER FALLON: Correct. If you're talking about the people out there now, you need to look at other high-risk occupational type settings as part of, you know, occupational --

DR. POLAND: Well, so the issue is whether we start now and we recognize that in three to five years we have a fully nonsusceptible force or do we do some kind of catch-up.

LIEUTENANT COMMANDER FALLON: You may want to put for everyone else follow the ACIP recommendation.

COLONEL KARWACKI: Just put ACIP there.

(Simultaneous discussion.)

DR. POLAND: I could say for all other

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

military personnel --

LIEUTENANT COMMANDER FALLON: Follow ACIP recommendations.

DR. ASCHER: Be fully aware so you don't get shot later, the burden of this is going to go up in the next few years as we heard.

DR. POLAND: We don't know that.

DR. ASCHER: Well, possibly. So if somebody has the idea this is a fixed-cost program --

DR. POLAND: Okay. IPV, folks. We're making progress. All right. General Mabrey I guess it is sent the memorandum requesting that the Board review the available data and provide a recommendation concerning the use of IPV in new recruits and officer accessions. Options, which we can modify, were continue present policy of a single dose of trivalent oral vaccine unless a previous adult booster is documented, change the policy to require a single dose of IPV in all who have not had an adult booster, or discontinue use of a booster or routine polio vaccination at accession except for those without documentation of a primary series.

I really hoped we were going to have some data that said there is no polio in military

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

personnel.

COLONEL BRADSHAW: Well, there was one case in a child in the Army reportable disease. There was zero in the Air Force. I didn't have the Navy. That's in the reportable disease databases. So that's as far as reportable databases, and then the other stuff I mentioned was a little bit muddled since it could be old cases.

DR. POLAND: Right, post-polio chronic stuff.

COLONEL BRADSHAW: Right. But as far as reportable disease from two of the three, we only had one child.

DR. POLAND: Okay. Fenceposts first, stake out an area.

LIEUTENANT COMMANDER FALLON: We really don't have enough data to be able to make a data-driven decision.

DR. POLAND: So do we call for -- flush that out a little bit, Ann. I mean, do we call --

LIEUTENANT COMMANDER FALLON: I mean, you don't have any on is there really any post-polio paralysis, you know, data that way show or cost benefit or are the stocks going to run out, you know,

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

why are we changing to this. I mean, is there any particular data.

DR. POLAND: I can't imagine there are any cases of acute polio that have gone unrecognized in a U.S. citizen.

LIEUTENANT COMMANDER FALLON: Agreed.

DR. POLAND: Agreed.

LIEUTENANT COMMANDER FALLON: So you could assume then it's zero. So since zero is there, then it could be, well, there isn't a problem now, so why change.

DR. POLAND: That's one framing of it. The other is there is no risk from wild virus disease. Continued use of oral polio incurs a one in one million to one in five million, depending on what dose it is, risk of vaccine-associated disease.

LIEUTENANT COMMANDER FALLON: Which we haven't had any --

DR. POLAND: Which we don't know that we had.

LIEUTENANT COMMANDER FALLON: -- in the military.

COLONEL BRADSHAW: One thing we haven't heard which is inevitable part of the equation is

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

what's -- if IPV cost the same and were as easy to administer, we wouldn't be having this debate, and the question is how much would it cost and how difficult would it be to implement for treating a problem that may not be there.

LIEUTENANT COMMANDER FALLON: It is a significant difference. I don't recall the numbers off the top of my head, but it is a big difference.

DR. POLAND: Yes, I think it is.

DR. ASCHER: But it's a program that's already using needles and giving shots. It's not changing the whole public health --

DR. POLAND: But if --

DR. ASCHER: It's another needle.

LIEUTENANT COMMANDER FALLON: It's another needle.

DR. ATKINS: But if they're getting two routine shots, getting a third --

DR. ASCHER: Incremental cost again.

DR. POLAND: The other aspect we're dealing with is we're assuming giving any kind of a booster is worthwhile, and there, to my knowledge is -- and Marc made the comment about where this even came from. At least in current epidemiology, there is

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

no documented benefit.

LIEUTENANT COMMANDER FALLON: For in the U.S., but we're giving it as part of the deployment-type preparation so that it's done once in a recruit setting and you never have to worry about it again within your military career.

DR. POLAND: Well, even outside of the U.S., do we have any documentation that Americans who have received the primary series and go anywhere in the world develop polio if they don't get a booster?

LIEUTENANT COMMANDER FALLON: They did show that from the missionary study.

DR. POLAND: That was that old study with --

UNIDENTIFIED SPEAKER: Four years ago.

LIEUTENANT COMMANDER FALLON: But those have been CDC travel recommendations since then.

COLONEL BRADSHAW: But they also make the statement that oral polio vaccine gives "lifelong" immunity, yet we're giving an adult booster. So it gives -- if you've had oral polio vaccine and it's supposed to give you lifelong gastrointestinal immunity, why are we giving a booster?

CAPTAIN TRUMP: And there were six cases

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

that were acquired outside the United States.

COLONEL BRADSHAW: That's right.

CAPTAIN TRUMP: In 10 years or --

DR. ATKINS: Yes, since 1980.

COLONEL BRADSHAW: Acquired by whom?

CAPTAIN TRUMP: Travelers outside the U.S.

I can't tell you what the demographics were.

DR. LA FORCE: Well, I for one am not very persuaded that we need to change anything. All that we do if we change this, from looking at disease burden and looking at the economics, is adding expense plus another needle.

COLONEL KARWACKI: Unless you --

DR. POLAND: There is the issue that the rest of the U.S., at least for kind of routine polio use though, is moving to IPV.

DR. LA FORCE: So this is --

DR. POLAND: And is there a political --

DR. LA FORCE: -- a political issue.

DR. POLAND: -- issue of the government's giving us --

DR. LA FORCE: Okay. If we can sort of sort out the medical or epidemiology, which I was hoping was going to run this --

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

DR. ASCHER: Marc, if most of the people coming in have had OPV, have survived it without paralysis, this is their third or fourth go-round for OPV --

DR. POLAND: That's a good point.

DR. ASCHER: Then their risk is nil. So the only people that have risk are the ones this is their first go, and that's -- that's one in two and a half million of those.

LIEUTENANT COMMANDER FALLON: Right, and those people need the polio series then, which you would give with IPV, which is what the regulations state.

DR. LA FORCE: How disruptive would it be to continue the -- I would ask the CDC, how disruptive is it to continue the current policy with OPV in the military?

DR. SEWARD: To continue the -- to switch to OPV?

DR. LA FORCE: No, not switch.

(Simultaneous discussion.)

DR. SEWARD: To continue with OPV. Well, it's less disruptive obviously. You're not changing to needles.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

CAPTAIN TRUMP: I mean, I think at present CDC and ACIP has not changed its recommendation about OPV for travelers. that is certainly something that is being considered, and, you know, based on the lack of any data to the contrary, I think one recommendation would be to await that ACIP recommendation. Then -- if you don't do that, then you get into the issues of well, if we think we should stop OPV, do we replace it with IPV, do we not do anything in recruit training and then only do -- and actually, if we're going to continue with OPV, I feel more comfortable doing it in recruit training when you have them there for, you know, eight to 12 weeks, and hopefully, you know, not exposed to children and other adults who might be at high risk for secondary --

DR. POLAND: Like all recommendations, this is an interim one. OPV's not going away in the immediate future. What if we were to continue the policy of a single dose of oral polio vaccine in all enlisted accessions and officer candidates or cadets unless a previous adult booster is documented. IPV would be used according to ACIP recommendations as an alternative. If they have not had a primary series, they would receive IPV.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

DR. ASCHER: And then when OPV goes away you fix the program.

DR. POLAND: And at that point, we fix it within maybe some five years, 10 years from now.

COLONEL BRADSHAW: I like it.

(Simultaneous discussion.)

DR. POLAND: The rest of the world's going to use OPV for a long time. Does that sound appropriate?

DR. ASCHER: Well, they said 2000 was what the APA was looking at for an all-IPV schedule.

DR. POLAND: Right.

(Simultaneous discussion.)

DR. POLAND: Thank you.

DR. PERROTTA: Okay. Does anybody have a burning desire to go over all of these again for the full committee since many of the full committee were here anyway?

DR. SOKAS: Well, could we just hear what the results were? I mean, were they like conclusions?

DR. POLAND: It was unanimous.

DR. PERROTTA: A three-minute break and then Executive Committee.

(Whereupon, a brief recess was taken.)

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

NEAL R. GROSS
COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

E-X-E-C-U-T-I-V-E S-E-S-S-I-O-N

(10:44 A.M.)

DR. PERROTTA: Everybody can rejoin. What we'll do is we'll review the work of the Committee very quickly, and then we'll go into the Executive Session so everybody can still hang out if they need to. But then after we're done here, we'd like to move forward and clear the room as appropriate after that. Go ahead.

DR. POLAND: Okay. I guess the first thing, Mr. Chairman, we'd like to have the Board's approval for the final Vaccines in the Military Immunization Report.

DR. PERROTTA: So moved. I have a motion, and do I hear a second.

DR. STEVENS: Second.

DR. PERROTTA: I hear a second. Further discussion? Hearing none, a vote is called. All those in favor of the motion signify by saying aye.

BOARD MEMBERS: Aye.

DR. PERROTTA: Those opposed? Hearing none, the motion passes. Congratulations. Next.

DR. ANDERSON: I juts have one --

DR. PERROTTA: And the reason why I moved

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

it so quickly is because he promised that if we sent it back to him, it would be 600 pages instead of 300.

Yes, sir.

DR. ANDERSON: Just one amendment. Page 15, at the introduction and purpose.

DR. POLAND: Thank you. Anything you see like that in this document, just send to me and we'll make the final little editings like that.

DR. ANDERSON: Some of the rank abbreviations aren't correct, but we can correct those.

DR. POLAND: Okay. Next we'd like to get approval for the recommendation on chlamydia screening, and rather than go through the background, I'll just in each case discuss the recommendations for chlamydia.

So, one, all new female recruit accessions should undergo screening to detect chlamydia infection. Ideally, this should take place as soon as practical after joining the military such as during the recruit training period. But screening within the first year of military service would also be acceptable and still accomplish the goals of a screening program.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

Number two, all female military service members should be routinely screened for chlamydia at the time of each recommended routine PAP smear up until the age of 25 years of age. Further screening at the time of the annual visit should be performed as clinically indicated by symptoms or risk factors.

Number three, in addition, appropriate screening tests such as molecular amplification testing -- I've made some changes already -- of male military personnel are encouraged at any appropriate medical encounter as indicated by symptoms or risk factors. For example, an STD-related medical visit would be an appropriate indication.

Further, we recommend -- what did I write here -- we recommend that the effectiveness and feasibility of screening men receive specific attention, including the implementation of pilot programs that collect data on prevalence, incidence, and reinfection rates, and the effectiveness of interventions, including education.

And then, finally, the Board recommends that an appropriate education program be developed and disseminated to all recruit accessions and at the time of treatment for chlamydia or other STDs and as a part

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

of routine military STD training. We'll work the wording here a little better and grammar.

COLONEL DINIEGA: Did you want to put in that you want the results of the pilot programs to be presented --

DR. POLAND: Sure, yes.

COLONEL DINIEGA: -- back to the Board for further review and recommendations?

DR. POLAND: I'll write that in under number three there.

DR. STEVENS: You mean education program on chlamydia, right? It's not just reading --

UNIDENTIFIED SPEAKER: Can you change it to aerial font too? I think it will project better.

(Simultaneous discussion.)

DR. POLAND: Okay. So that is the -- we would propose that recommendation for Board approval.

DR. PERROTTA: Can I hear that in a motion?

UNIDENTIFIED SPEAKER: I move.

UNIDENTIFIED SPEAKER: So moved.

UNIDENTIFIED SPEAKER: Second.

DR. PERROTTA: I have a motion and a second. Further discussion? Hearing none, all those

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

in favor of the motion signify by saying aye.

BOARD MEMBERS: Aye.

DR. PERROTTA: Those opposed? Motion carries.

DR. POLAND: Lyme disease. Number one, Lyme vaccine is only one adjunct to the prevention of Lyme disease. Personal tick prevention measures should be encouraged and compliance strengthened.

Number two, the burden of Lyme disease in the military is unclear. Studies examining prevalence and studies examining the incidence of Lyme infection as a specific function of military duty should be initiated, including tick distribution and infection on military installations.

In the interim, the Board recommends consideration of use of Lyme vaccine under the following conditions:

Number one, as per ACIP recommendations.

Number two, for selected occupational groups considered to be at high risk because their military duties place them in high-risk environments where frequent and prolonged exposure might be anticipated. Vaccines should be used in advance of exposure, and local conditions and risk information

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

should be used in determining risk.

I'd like to submit that for Board approval.

DR. PERROTTA: Do I have a motion?

UNIDENTIFIED SPEAKER: So moved.

DR. PERROTTA: A little bit slower on that one. Do we have a second?

UNIDENTIFIED SPEAKER: Second.

DR. PERROTTA: Discussion? Hearing none, all those in favor signify by saying aye.

BOARD MEMBERS: Aye.

DR. PERROTTA: And those opposed? Motion passes.

DR. POLAND: Okay.

DR. PERROTTA: Varicella.

DR. POLAND: For varicella, varicella can and does disrupt military training and readiness. With this in mind, the Board recommends the following:

(a) Recognize that vaccine can prevent epidemic spread but cannot prevent disease due to incubating infection.

(b) Universal immunization is not recommended.

(c) Immunization of susceptibles is

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

recommended. Universal serologic screening is the most sensitive, and where this can be feasibly done is recommended. If this is not feasible, susceptibles may be identified by serologically screening those with negative or uncertain histories and providing vaccines to those who are seronegative.

(d) In order to have the greatest benefit, this should be done as early in the accession process as possible. In order to decrease costs and laboratory impact, ideally this should be done in conjunction with other accession training during MEPS processing.

(e) For all other military personnel, the ACIP recommendation should be followed. Basically that's a catch-up program.

DR. CHIN: Greg, (a) is really not a recommendation. I think you probably --

DR. POLAND: Yes. As I read that, I realized it.

DR. CHIN: -- push (a) up into the preamble.

DR. POLAND: Yes. We'll clean this up.

DR. STEVENS: Yes. And under (c), the providing vaccine to those that are seronegative,

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

obviously it doesn't -- it's sort of independent of what screening method you use. So that could be a separate phrase.

DR. POLAND: Okay.

DR. PERROTTA: Would you like that in a motion?

DR. POLAND: We would just accept that as a friendly amendment.

DR. PERROTTA: Okay.

COMMANDER MCBRIDE: Can I ask about number (d) please or paragraph (d). At the MEPS station, if they're tested, then that would require that they would have to come back. That's acknowledged, of course, isn't it or would they receive immunization in the MEPS or would they receive the immunization at the boot camp upon arrival?

DR. POLAND: We're not specifying. I guess each Service --

COLONEL KARWACKI: MEPS will never give immunizations. That is an intervention. We'll never ask them to do that, no.

COMMANDER MCBRIDE: The consideration there is --

UNIDENTIFIED SPEAKER: Do we incur any

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

obligation if --

DR. PERROTTA: They could identify susceptibles though.

COMMANDER MCBRIDE: If we identified susceptibility at the MEPS station, occasionally it's several weeks to sometimes a couple or three months before they actually come in the door at the boot camp, and if they're sitting around susceptible, then have we created some liability for us if we haven't acted upon that susceptibility? And I think there'd be many people who feel that having this recommendation from the Board perhaps is a little strong. We could say the Services can consider some of this to occur at the MEPS, but to give this as the recommendation --

DR. POLAND: Now, we say ideally it should be done. We're not saying it must be done at that time. We're just saying in view of getting it done as early as possible, ideally --

COMMANDER MCBRIDE: Well, I guess I don't think it's ideal. That's my personal view.

DR. STEVENS: What's the liability you're worried about?

LIEUTENANT COMMANDER FALLON: Well, the

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

ideal part is to do it as early in accession process as possible. For example, it could be done in conjunction with other MEPS --

COMMANDER MCBRIDE: That would be helpful.

LIEUTENANT COMMANDER FALLON: That softens it a bit.

DR. STEVENS: So what, they're not in the military.

(Simultaneous discussion.)

DR. POLAND: Okay. So we'll say for example, this could be done during --

DR. SOKAS: There's two questions. Are you drawing blood for other purposes at the MEPS?

(Simultaneous discussion.)

DR. SOKAS: Well, I mean, I don't think their risk of varicella will be a whole lot worse, you know, in terms of informing or not informing them for HIV. As long as you inform people of their status, you don't have to act upon it. It's just a matter of sharing information.

DR. POLAND: But we'll make the change. We'll just -- I'll say in conjunction with other accession testing. For example, this could be done during MEPS processing. Okay. With those two changes

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

then, submit it.

DR. PERROTTA: Do I have a motion?

UNIDENTIFIED SPEAKER: So moved.

DR. PERROTTA: And a second?

DR. SOKAS: Second.

DR. PERROTTA: Further discussion?

Hearing none, all those in favor signify by saying aye.

BOARD MEMBERS: Aye.

DR. PERROTTA: And those opposed? Okay.

Motion passes.

DR. POLAND: Okay. Thank you. Lastly, IPV recommendations. We recommend continuing the present policy of a single dose of trivalent oral polio vaccine in all enlisted accessions and officer candidates and cadets unless a previous adult booster is documented. IPV would be used as an alternative to OPV in selected individuals according to ACIP recommendations.

Number two, IPV would be used in all accessions who did not have documentation of having received a full primary polio series.

DR. PERROTTA: Is number two essentially ACIP?

DR. POLAND: Yes.

DR. PERROTTA: Okay.

DR. POLAND: Or the evolved ACIP.

DR. ATKINS: I have a question because in fact as -- I mean, Dana, you --

COLONEL KARWACKI: We don't have documentation.

DR. ATKINS: Dana can clarify this, but the reality is that there are a lot of people who don't have documentation but presumably have had it because they -- you know, giving their age.

DR. POLAND: You're dealing with that right now if I understand in that you're to give a primary series if there's not documentation of having received one. But in practice that's not done.

COLONEL KARWACKI: We're assuming that if they went to school in the United States, they got it.

DR. POLAND: Okay. This is consistent with existing policy.

DR. ATKINS: It doesn't sound like it is. I mean, it sounds like they are giving OPV to a lot of people who don't have documentation.

COLONEL KARWACKI: It's not consistent with current practice.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

LIEUTENANT COMMANDER FALLON: But isn't it though to go to school in the United States for this -- within the last 20 years, you need to have had polio to get into school, polio vaccine to get into school?

COLONEL KARWACKI: Could you say history rather than documentation, soften it a bit by the fact that they've gone to school means that they have --

DR. LA FORCE: What's the problem with the way it's written?

COLONEL KARWACKI: Documentation.

DR. LA FORCE: Unless a previous adult booster is documented.

DR. POLAND: No, number two. I'll accept that just as a friendly amendment.

DR. PERROTTA: A lot of folks don't have their shot records, and so we would end up giving IPV to almost everybody that exists, is that right?

COLONEL KARWACKI: Right. It could be interpreted that way.

DR. POLAND: Okay. That's fine. We'll put that.

DR. PERROTTA: So what will number two read?

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

DR. POLAND: It will read IPV would be used in all accessions who do not have a history of having received a full primary polio series.

DR. PERROTTA: And the current practice is if somebody's a U.S. citizen who went to U.S. schools, you're making the assumption that they had received that.

UNIDENTIFIED SPEAKER: Yes.

DR. HAYWOOD: Should the second word be should or is would what you're intending?

DR. PERROTTA: Should it be IPV should?

DR. POLAND: Should, right.

DR. PERROTTA: Okay.

DR. POLAND: Okay.

DR. PERROTTA: Can I have a motion for acceptance as amended?

UNIDENTIFIED SPEAKER: So moved.

DR. PERROTTA: And a second?

UNIDENTIFIED SPEAKER: Second.

DR. PERROTTA: Further discussion? Any questions about the way it reads? If not, all those in favor signify by saying aye.

BOARD MEMBERS: Aye.

DR. PERROTTA: And those opposed?

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(No response.)

DR. POLAND: The last thing is we did not make any recommendation at this point about adenovirus unless the Committee feels differently, in part because it is addressed in the DoD report that was just approved. Does the Committee feel we should make a statement though?

DR. CHIN: Well, the only thing I would recommend would be for a statement saying that we're -- that this problem is still sort of ongoing and that the Board would like to be appraised perhaps at the next meeting as to what progress has been made.

DR. POLAND: Can we do that without a formal --

COLONEL DINIEGA: I can schedule an update.

DR. POLAND: Would that meet with your getting it, Jim?

DR. STEVENS: Do the Preventive Medicine Officers need anything from us?

COMMANDER MCBRIDE: Well, I think that's a good question. I think that a periodic communication from the Board to Health Affairs or to the powers that be acknowledging that you're still concerned about

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

this, still on the radar screen, we need to continue to keep this in front of them, and I'm not sure if this has to be through a recommendation, but just some communication that this issue was again discussed at the AFEB. Continued interest is such that we're hoping that progress is moving on this issue. I don't know how to communicate that though.

DR. STEVENS: Yes, and it's clear that it's still a problem.

UNIDENTIFIED SPEAKER: Could we be even stronger in terms of concern, particularly as a result of the epidemic investigation or the results of the epidemic investigation.

DR. PERROTTA: Like what I said yesterday. I would like for us to make a strong point. However that point is made is up to the judgment I think of you guys and Ben, but then it would be that we have yet still -- nothing has appeared to have changed other than some hopeful research going on, but we have yet again heard another epidemic investigation. It is extraordinarily clear that the vaccine is effective, and the adenovirus four if you want to say continues to be a significant health problem in recruit situations, and I want more than just an update of

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

what's going on. I want somebody to understand that we think that people need to move on this.

DR. SOKAS: Well then maybe it needs to be a recommendation or something.

COLONEL DINIEGA: Do we need to send a memo to Health Affairs that would basically --

DR. PERROTTA: How about if -- does anybody agree with the kinds of things I was trying to verbalize?

DR. SOKAS: Yes.

UNIDENTIFIED SPEAKER: Absolutely.

DR. PERROTTA: Can I take the responsibility to write that, and perhaps I'll E-mail it to everybody or E-mail it to Greg or whatever, and then work with Ben on getting it out. Then it will just be a memo from the President.

COLONEL DINIEGA: I think what you'd like to say is that it continues to be a problem -- you heard evidence it continues to be a problem. You also heard that there are moneys that were put into the budget, and it looks hopeful that we may be -- they may be close to a solution, but you're very concerned that it doesn't get sidetracked in some way.

DR. STEVENS: And you need a vaccine.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

DR. PERROTTA: Okay. I will work on that if that's okay by the Board.

COLONEL KARWACKI: As I read it, you're -- in this book, your recommendation from 28 February '95 is the last time that was addressed. You might just want to read and reference and basically say what have you done in the last five years.

DR. PERROTTA: Yes. I want to know what's been done, but I also want to reiterate to the new Health Affairs Chief that this Board considers this a continuing problem, and we have been for a long time, and we want to see something done, something like that. Okay. What else?

DR. POLAND: Done, sir.

DR. PERROTTA: Okay. Do you have anything specific that you need to report from your committee?

DR. ANDERSON: Well, I think that we had a very productive meeting out on the porch, and now we have a number of issues that will be coming to the Board I think at the next session, and we're looking forward to an active work group.

DR. PERROTTA: What I've recommended is that some of the issues get to Ben so that Ben and the PMOs can work up an appropriate not only presentation

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

but bring in the right kind of people to sit down and get some work done, and I know, for example, that Doctor Music's been sort of either volunteered or appointed to be a point man on a particular topic, and so I'm trying to encourage the intermeeting interactions so that we're not sitting here hearing something and then we say, yeah, this is a good idea, and then we fold all the paperwork and bring it home and file it away, and then we don't see it until the day before the next meeting. That just doesn't work there.

DR. ANDERSON: I'll be putting a summary of our minutes together, and what we did decide to do is identify specific individual, resource individuals, for specific topics. So that will be listed there as well.

DR. PERROTTA: What else do we need to talk about in the Executive Committee?

COLONEL DINIEGA: Okay. I do have a list of things. I went around asking about attendance at the BW Threat Review meeting. Let me just for the new members go over what this is about.

UNIDENTIFIED SPEAKER: And, Ben, is -- are we in the executive session now?

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

UNIDENTIFIED SPEAKER: We still have some spectators so to speak.

DR. PERROTTA: All right. The close of the regular meeting, the beginning of the Executive Session. Could anybody but the PMOs and the Board members please clear the room. Thanks guys for keeping us on track here.

(Whereupon, the subcommittee meeting went off of the record.)

EXECUTIVE SESSION

COLONEL DINIEGA: Okay. We need to get to lunch, so let me go down the list real quick. The BW Threat Meeting, there's a requirement for Health Affairs, and the Army is executive agency for the NBC things, to review and provide input into the BW, the Biological Warfare Agent Threat List that's released by and approved by the Joint Chief of Staff every year.

They did not release the 1998 threat until about February of this year. The decision that was made was they were going to release the 1999 threat sometime in April. The '98 did not differ from '97 very much, and so there was a decision made to not have the Board review '98 and wait for the '99, and that was released on April 2nd of this month.

Putting the meeting together, they wanted a seven-day turnback on the medical input, and I think we've succeeded in holding it off so we can have the separate meeting with a lot of information additional that the Board members would need to review it and make recommendations based on what they know is occurring in the services.

So on the 24th of May, which is a Monday,

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

at the Institute of Defense Analysis, which is about a half a mile from the Surgeon General's office at Falls Church, at Skyline, we have a secure room, and there's a hotel next door. I think it's the Sheraton Alexandria, and we've put rooms aside for the Board members, and we've checked on secret clearances, and there are -- I went around and told people what their status was, and I've gotten commitments from people who know about their schedules.

So during the meeting, you will hear the purpose of the meeting. You will have the expert on BW affairs from the Defense Intelligence Agency, will give a one-hour brief on the BW agents and the threats, to include status of development in other countries. And Colonel Parker or else his representative will come from USAMID and talk about the BW Medical R and D efforts, what they're working on, what they hope to work on, where in the development and acquisition stage things are, and then he will be followed by a representative from the Joint Program Office for Biological Warfare who will give an update to the Board on what the Joint Vaccine Acquisition Program is doing about acquiring countermeasures, vaccines for those agents and what

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

stage their in.

I anticipate the morning, from 8:00 to 12:00, being taken up with these information briefs, and then we'll have a working lunch, and then the Board will go into deliberations as to what countermeasures recommendations can be made, and then we'll draft those up in the afternoon, and people can leave.

So it would be fly in Sunday night or drive in Monday morning, and you'll be able to leave hopefully before 4:00 o'clock.

DR. HAYWOOD: What specifically is the role of the Board?

COLONEL DINIEGA: The Board is to provide DoD with medical input into the BW threat list on countermeasures and directions for countermeasures. They've done this twice in the past.

DR. PERROTTA: We've seen two I think.

COLONEL DINIEGA: Two. And that would be the role of the Board, and then it would be the -- essentially the DoD Health Affairs input into the BW threat list. I think in the past the briefings that I talked about didn't occur to the Board. They just reviewed the list, took about an hour, hour and a

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

half, and they made recommendations. So some of the recommendations were already things that people were working on or they were looking at acquiring, et cetera. And that's on May 24th.

The next general AFEB meeting will be in mid September on those two dates that I gave you. Fourteen September is the primary date we're looking at, and as a backup the 21st to 22nd of September, and we'll get a block of rooms at the Navy Lodge at Bethesda. Hopefully we'll be able to get all the rooms we need. And then it would be walking distance to the auditorium that we'll use over at USUS, and that will be a day and a half meeting up there, and then we'll see about the -- if there's anything around that area to see that's military related.

Three members end their terms, six-year terms, during the summer, and those are -- I typed up this form here with everybody's E-mail and where they're at and phone numbers. Doctor Fletcher ends on August 15, Doctor Perrotta on August 15, and Doctor Poland July 23rd. So it was important that this thing get approved before he left and all the recommendations be made.

That means the issue of a new president

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

comes up and replacements. Now, on the replacements for Board members, we've received seven nominations from Board members and also from the Preventive Medicine Officers, and there may be one more coming in from the Army.

The way it's done is the Preventive Medicine Officers as the Surgeon General's representatives will already have all the CVs and the letters of recommendation, will review them, and then hopefully by the end of May will put them to a vote.

So if there are anymore people, we need a CV and a letter of recommendation, and the letter of recommendation can be done on E-mail and just sent, but we do need the CV.

DR. PERROTTA: To Ben.

COLONEL DINIEGA: To me. Send it to me.

DR. STEVENS: Can we find out from you who has been recommended just so that we don't -- not redundant?

COLONEL DINIEGA: Yes. I was planning to do that, but I didn't -- can I send it out on E-mail? I'll send it out.

DR. STEVENS: I was just asking. I have a couple of ideas that I could ask if they're already in

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

the pool.

COLONEL DINIEGA: Okay. I'll send it out on E-mail, and I'll put it in the text of -- I'm always hesitant to send out attachments to people. I'll put it in the text of the message. Okay. So I'll do that when I get into the office on Monday.

We were tasked at one time to put together a special committee to review the Rand, period of Stigman Bromide report that was going to come out. DoD was looking for an internal review, but Doctor -- the Office of Gulf War Illness has decided I think pretty firmly to go to Institute of Medicine for review, which will take a longer time to get the review done, but they were looking at forming a joint AFEB and USUS board committee to review the report and make recommendations, and Doctor Perrotta was going to head that, but I don't think that's going to come through now.

We've had requests to provide AFEB members to several work groups or committee meetings. One is the Biomedical Technical Area Review and Assessment that occurs every year, and this is a DoD of Biomedical Research and Development initiatives. Who was on it? In the past they had a Board member on it,

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

and they're looking to have another board member, and I will talk to the Committee the next time and also with Doctor Perrotta or the new president about getting a member to that meeting.

And all it involves actually is reviewing all the biomedical research initiatives and a -- they give an assessment that's coded red, amber, green sort of thing, but it is a very good review of what's happening in DoD research. I've been to the last three, and they've been very influential in making corrections to programs in the course or at the beginning. And that's primarily a civilian advisory board also.

Also at the last meeting in December, there was a request by Major Mott that if they do put together a humanitarian medical assistance work group that they would like a member from this Board. I haven't seen a formal request, but I will check with him as to whether or not they did succeed in getting a board or advisory committee established for that.

DR. PERROTTA: If we have an expert in that field, we could see if he could do that.

COLONEL DINIEGA: Okay. There were some taskings from MRSP, Medical Readiness Strategic Plan

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

for DoD Health Affairs, and there were two taskings. One was to define the core elements for health surveillance in TRICARE and across the spectrum of health care. The other was to look at measures of performance for Force health protection, and I think at the time that they wrote these up back in --

DR. PERROTTA: '96.

COLONEL DINIEGA: -- '96, and some of us were involved with that, they put together a chapter on preventive medicine and then decided who should do this stuff, and for some reason the AFEB was tasked as a primary action group, and I have gone back to the keeper of the taskings and said that it shouldn't come to the AFEB as a primary action, that it should be the Services that do this, but we'd be more than happy to provide input and review the work that comes out of the work group.

In reality, there's already a lot of work groups going on that are doing that work, and I mentioned those groups, and the Preventive Medicine Officers know the names of the group because most of them sit in those groups. So there are other groups already looking at that.

The Joint Instruction on Health

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

Surveillance is out. That is leading to automation data element fields, et cetera, et cetera, and there is a large interagency group that's already looking at measures of effectiveness for Force health protection.

So I'll try to make sure that when their groups come up with something, that they run it by and utilize the Board for those purposes.

And then as I go to meetings -- I started doing this, and I've been pretty bad lately, but I'll try to send out an executive summary of the meetings that I go to so that at least the Board members are aware of what potential areas we can get involved in. That's all I had.

DR. PERROTTA: Okay.

COLONEL DINIEGA: Do you want to say anything about the presidency?

DR. PERROTTA: Sure.

COLONEL KARWACKI: I had a question about the May meeting, if we can revisit that. Is there an agreement on what constitutes the Board in terms of do you need a quorum, do you need representation?

COLONEL DINIEGA: No. We need Board members -- the key here is you got to have a secret clearance.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

COLONEL KARWACKI: I understand. That's what I was -- I mean, you kept saying the Board will do this.

COLONEL DINIEGA: Right.

COLONEL KARWACKI: Is there a requirement to have a minimum number or a subcommittee bring it back to the Board for full Board approval or is it whoever can make it --

COLONEL DINIEGA: Right.

COLONEL KARWACKI: -- constitutes the Board for that day?

COLONEL DINIEGA: Right. And I think in the past, Greg, you mentioned that they just pulled together a few people one time and brought them in for a day, and then they left, but they do want to have the Board involved with that review and recommendation, and that includes the Preventive Medicine Officers.

DR. PERROTTA: And at one time it was -- they focused on bringing in disease control people, which, you know, there was some sense to that. Because it's an issue that now sort of overlaps in civilian, plus we have a lot of new members that would I think need to be brought up to speed on that, I

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

recommended that the entire -- that we draw from the entire Board. Whether you're an environmental person or an infectious disease person, you still have input on this.

COLONEL KARWACKI: I was looking at another aspect. If you were unable to make it, what constituted the Board for that day, did you need to bring it back to the entire Board at some later point or is that the Board, whoever can make it on that day, and if that's the answer, that's fine.

COLONEL DINIEGA: And the Preventive Medicine Officers should be there because the information that's going to be going out is going to be pretty powerful.

DR. PERROTTA: Okay. Anybody have anything else? Any other comments?

DR. MUSIC: Point of information. I'm very much new. This is my second meeting, and you talked about several members rotating off, and therefore we're going to have to have some discussion about president. Is it possible -- is there any mechanically feasible way to extend our current president or is it a fait accompli and there is no mechanism to be extended?

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

COLONEL DINIEGA: Let me just state that I'll check into it, but it is a lot more difficult because in the charter, in the new charter that was written two, three years ago, it does say that you're limited to two two-year terms.

UNIDENTIFIED SPEAKER: Two three-year terms.

COLONEL DINIEGA: No, two two-year terms. So you're limited to four years. Then if you rotate off, you cannot be reappointed for two years, and then you could be reappointed, and from talking to people, the reason that was done was that in the older boards, people were there forever, and so they wanted to make sure there was a rotation. Am I right, Jim?

DR. CHIN: Absolutely.

COLONEL DINIEGA: And there's pluses and minuses of doing it that way too. So, but then, you know, there was a decision made several years back that they wanted to limit the terms. And so that's going to be difficult because our current President and Doctor Poland and Doctor Fletcher are ending their sixth year. But I will look at the -- I will check into -- I think maybe we can get an extension for Doctor Perrotta certainly until October 1st so he can

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

be at the next meeting. It's going to be difficult I think to go beyond that because they're at six years, but I will look into that.

DR. FLETCHER: Ben, let me mention one -- prior to your ever coming on with us, I think two years ago we looked and approved at our level and a little bit higher the procedural changes of AFEB, and the four or five -- and although most Board members will be limited to two consecutive year terms, certain members as designated by the cabinet and approved by the Secretary of the Army Committee Management Officer will be authorized to serve an additional two-year term. So that's what I think you're referring to. That was approved --

DR. PERROTTA: That's the Board -- that's the group of people who makes the decision that allowed the three of us to go for an additional two years.

DR. FLETCHER: This is still in writing.

DR. PERROTTA: Yes, and the argument was is that the constitution of the Board grew very quickly during that time, back up, and we were full of new folks that were not familiar enough with -- and the -- it was the -- I think it was actually Doctor

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

Joseph's idea that you extend some of the committee member -- or the committee chairs to provide sort of a continuation of the leadership so that the new people would have a little more time to do that.

DR. FLETCHER: He actually met with us a couple, three times, really orchestrated these things at his level, and it was very effective meetings.

COLONEL DINIEGA: That's why I say it's going to be difficult because they already extended one term beyond the normal four-year limit, which the charter clearly allows to do, and then, you know, to go beyond that, it's going to be a little hard.

DR. MUSIC: But you are confident that you could get our current President extended until we have one more meeting?

COLONEL DINIEGA: Right.

DR. MUSIC: And since -- I mean, again, I'm very new, but since we've not talked about in any kind of way as far as I know a succession and we've got so many new members, I would urge that unless somebody feels strongly the other way that we do that, and then use the time between now and then to plan for any subsequent presidents.

DR. FLETCHER: It might be good to just

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

list those who might be eligible who are now currently sitting.

COLONEL DINIEGA: Do you want to mention what we were discussing earlier?

DR. PERROTTA: Yes, but let me make a comment before I do. What I would recommend in your or our deliberations is that we find somebody that has more than one year left, because I can tell you that certainly for one year, it -- I feel like I am an interim type person, haven't had -- on top of that, our meeting in September, because of conflicts, et cetera, was -- was lost because Vicky was moving out and Ben was scheduled to come in the day before -- or the week before the meeting, and that was no way to do it. So we canceled that meeting.

So this one-year term as presidency I don't feel like --

UNIDENTIFIED SPEAKER: Two meetings, three meetings.

DR. PERROTTA: Yes, two meetings, maybe three at the most is not enough to make a difference, to provide any leadership or whatever, and I feel remorse at any lapses that have occurred for the body of this group just because of me being in that

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

situation.

My first guess would be or my first shot, what I told Ben was is that there are a number of people who would be good and who are eligible, but some of the things that I think about are willingness, the ability to come to all of the meetings as demonstrated by having come to as many meetings as possible, I mean, a lot of the meetings, and honestly we have a number of good people who would do fine but haven't been here an awful lot. But when it came right down to it, the one that I recommended Ben consider would be Elizabeth Barrett-Connor. I mean, I have truckloads of respect for everybody in here, and I have truckloads of respect for Elizabeth as well, and the only thing that I felt is a negative for Elizabeth was that her attendance -- but she's -- she would be very clear and say yes, I am or no, I am not interested in doing this. But I think we need to take a look at everybody who is eligible, and I would just recommend that it's anybody who's eligible that's got more than one year left.

DR. FLETCHER: She would have to be extended. Her time up is 8/15/99.

COLONEL DINIEGA: But that's her first

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

term.

DR. PERROTTA: That's her first term. So she has another two years to go. I mean, Rosie, I don't know how long you've got to go, but --

DR. ANDERSON: Can it be a federal employee?

DR. SOKAS: It probably shouldn't to tell you the truth.

DR. FLETCHER: It can be.

COLONEL DINIEGA: It has been.

DR. PERROTTA: Sure. Dowdle (phonetic) over at CDC was there. So those are my personal views about the whole thing. I felt handicapped because of the short time and would be pleased to work for at least another meeting if that's what we end up being able to do.

UNIDENTIFIED SPEAKER: That would be good.

COLONEL DINIEGA: And then the other thing is just a reminder. Doctor Tsai changes status. He moved -- retired from CDC, and he's now with White Letterly (phonetic). And he was a federal employee before. The rules are -- the committee management rules are such that when you change a status like that, go to the private sector, federal employee

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

appointments to the Board are handled differently because they're already federal employees.

So we had to go through a renomination process for Doctor Tsai. So technically Doctor Tsai is no longer on the Board until his renomination papers are again processed, which we've started, and then he can become a member of the Board again.

DR. PERROTTA: That process is only for former federal employees that moved to some other --

COLONEL DINIEGA: To a non-federal job.

DR. FLETCHER: Does he have to be fingerprinted again?

COLONEL DINIEGA: Well, it turns out he didn't submit all his security papers.

UNIDENTIFIED SPEAKER: Well, Rosie moved to a new job, but she stayed in the federal system.

DR. PERROTTA: And anybody moving from non-federal to non-federal, that doesn't change it either.

DR. ATKINS: With that in mind, though, can you say whether any of the new nominees are from CDC? I think it's a useful representation to have on the Board.

DR. PERROTTA: I don't think -- I don't

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

think -- there's no nominations from CDC. It's still open. I mean, we've had Claire Broom (phonetic), and we currently have Dick Jackson, both of which have sporadic attendance records because of their important jobs, and Dick was coming until earlier or late last week when he was called to a meeting that as Center Director he could not not go as part of his job. So -- a congressional meeting.

Does anybody else have any feelings about presidency or whatever, I mean, that we can have discussion now?

DR. FLETCHER: I just glanced at the list.

Sue Baker would be in the eligible arena, Anderson would be.

DR. ANDERSON: We'll be only one year left though.

DR. FLETCHER: Well, how long have you been on?

DR. ANDERSON: We're --

PROFESSOR BAKER: We've been on three years.

DR. SOKAS: You could get the two-year extension though potentially.

PROFESSOR BAKER: Well, I would like to

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

decline.

DR. PERROTTA: Well, no, and you know, by not mentioning everybody that's absolutely eligible, I didn't mean to slight anyone, but my suspicion was is that there were those who wanted to do this or was willing to do it and those who had too much of a time commitment otherwise. And if you can only get me extended a meeting, that would be great. But if you could get Doctor Poland extended for two years, he would make an excellent president too. I'll get back at him yet.

DR. FLETCHER: My two -- or only one that might be interested, one trip I was asked to come to the Pentagon for some meeting, a one-day thing. Otherwise it was just a telephone, letter, the regular meetings. I did try to attend all the meetings.

DR. PERROTTA: And then last summer or last fall, some of the what I call hiccupping occurred just because of the change of the office, and Vicky had to leave a lot earlier and she was rushing to the last day to get things, Board things, done, and Ben hit it running thankfully, because he had been to Board meetings before and knew what this was about. And so there was a small lapse, but for me, we were

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

moving along, chugging along, and all the sudden -- and, you know, we're up and running again. I just don't want to see -- whatever happens, I hope that we can avoid those kinds of --

UNIDENTIFIED SPEAKER: Interesting issues.

DR. PERROTTA: -- to move along. Are there any other issues by Board members that would need some discussion in Executive Committee? And seeing none, how about you guys, PMOs and other affiliates? I'd like to thank Ben and Gene Warde for putting it together. I hope Gene's --

UNIDENTIFIED SPEAKER: Carol.

DR. PERROTTA: Obviously, always Carol, and I hope Gene's feeling better soon.

COLONEL DINIEGA: For those who brought their luggage up, if there's somebody else who has to run back to get their luggage, don't, because the van will come here, and it will go there is what I found out. Earlier they said they'd be up here. And the lunch at the golf course is on now. It gets busier as time goes on. So we can walk over, drive over.

DR. PERROTTA: When do we want to be here?

COLONEL DINIEGA: The bus will be -- we should be on the bus by 12:15.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(Simultaneous discussion.)

DR. PERROTTA: Go to lunch, come back, the bus will be here and the van will be here, and we can load it up.

(Whereupon, the meeting was adjourned at 11:11 a.m.)