Society of U. S. Naval Flight Surgeons

Naval Aerospace Medical Institute, Code 10
Naval Air Station, Pensacola. FL 32508

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VOL. XI, NO. 4 **NEWSLETTER** **OCTOBER 1987**

PRESIDENT'S COLUMN

Naval aviation takes pride in the fact that only the best survive our selection, qualification and training processes. The end result is we have the best product available, maintained at the highest level of combat readiness, capability and safety. U.S. Navy flight surgeons playa key role in all of the above through their performance of the aviation physical examination. To quote Chapter 15, Section V, paragraph 15-67 (2) of the Manual of the Medical Department, U.S. Navy, "The purpose of the aviation physical examination is to select for aviation duty only those individuals who are physically and mentally qualified for such duty, and to remove from such duty those who may become temporarily or permanently unfit because of physical or mental defect."

During the past 24 years I have had 10 minute exams, and 45 minute exams. I have escaped untouched by human hands, and have been thoroughly mauled. The difference was in the attitude of the examiner. After all, who ever finds anything wrong on an annual physical? Why waste your time looking for a problem that probably doesn't exist and would take too long to evaulate. The individual on the examining table is a squadron buddy and you feel embarrassed to probe too deeply. After a few weeks/months/years you find your physical exams are done by rote —you go through the motions over and over and over again but you really don't see, hear or feel —and you just fill in the blanks and check last year's SF-88 for marks and scars. Besides, the examinee wants to get this process over with more than you do, and by the time the physical is typed and ready for signature you will be deployed and some otherflight surgeon who never saw the guy will sign "for" you without paying any attention to what's on the form. Then it all comes back with a nasty note from someone named Koppy.

What I am really saying is any aviation physical exam, whether on a flight school candidate or retiring Vice Admiral, needs your fullest attention. I realize the routine performance of flight physicals becomes boring, but complacency in aviation medicine, just as complacency in aviation safety, will eventually come back to bite you. If you don't know or understand the techniques and physical standards involved, consult the MANMED. Don't be afraid to uncover and report a potentially disqualifying defect, don't let AVR schedule you for 20 flight physicals in one morning, insist that your AVT's are in AVR and not in dependent medical records, review for completeness and sign only your own physicals, and go out there and do the job NAMI trained you to do. Naval Aviation takes pride in the fact that we are the best.

R. K. OHSLUND
CAPT MC USN

NAMI NOTES

AIR TRAFFIC CONTROLLER UPDATE

There is a problem with the disposition of Air Traffic Controllers who are:

1. Overweight (obese)
2. Pregnant
3. Starting BC pills
4. Have self limitedt injuries
5. Any combination of the above

The following is clarification of current policy.

OBESITY -

Military Controllers are not Civilians: Civilian Controllers are not Military. This simple equation must be kept firmly in mind. A military airtraffic controller is first of all an able-bodied sailor and secondarily an aircontroller. Traditionally the U.S. Navy sailor; carpenter, sailmaker, or gunners mate, was expected to strap on cutlass and pistol and join the boarding or landing party. Grannted in todays Navy, most young sailors don't know a sidearm from a side order of fries, *but the concept itself has not changed, or if it has no one has told me. A sailor must still be able to wake up, jump out of his rack, dress, run to his battle station, and arrive r'eady to fight.

This must be done in the matter of a very few minutes. We cannot have an obese member struggle up and forward on the starboard side, breaking watertight integrity every 70 feet, and fall into an exhausted heap at his battle station. It is a long way from an AC2's bunk to his battle station on a CVN. A fat military controller is NPQ. A fat civilian controller is not our concern.

Obesity is not a catastrophic event which falls abruptly on an unsuspecting victim. Nor is it a hidden condition that can only be discovered by meticulous and painstaking probing of the innermost physiological secrets of the individual. Obesity is an obvious condition. The individual knows he is fat. His immediate seniors know it and should have intervened much earlier. No surprises here. None of this helps the OPS Officer to solve the immediate problem of the NPQ individual who is none the less capable of doing the job at hand. It would seem a reasonable request to make of NMPC to allow a person who is NPQ due only to obesity to continue to control traffic while losing weight under close supervision. This is what I recommend you say.

"Request waiver to continue air traffic control duties at current command only while member is in medically supervised weight control program insofar as member demonstrates steady and progressive weight loss and increasing physical fitness level. Reports by letter to NMPC with copy to NAMI-42 will be made every 3 months by command."

As always the commanding officer of the ATC facility is not bound by recommendation of his medical staff.

**There are those who consider as beneficial the metamorphosis from steely eyed salt encrusted warrior to caring informed individual who feels good about himself. Can't see it myself.*

PREGNANCY--

Pregnancy is CD. When a LBFS on recommendation of members OB specialist recommends return to air controller duty, you should give her an up chit and submit for a waiver in proper format. We routinely recommend waivers until the beginning of the 3rd trimester. Unrestricted 3rd trimester waivers are not a good idea unless you have a tower with an elevator and a portapotti. If you would like to work the 3rd trimester member in a non critical supervisory type billet on lower decks, ask for it -- specifically. As always, no reasonable request refused.

BIRTH CONTROL PILLS--

The 3 month grounding following initiation of birth control pills is traditional and currently under investigation. Expect changes shortly. Watch this space. Alternate methods of birth control are not grounding.

SELF LIMITED INJURIES--

Consider broken legs, relocated shoulders in velpo dressings, and such. Treat this like any light duty situation. If he is capable of doing a portion of his job, let him do it. A man with a leg cast can do almost any ATC job which does not involve climbing ladders, a man with a finger splint can do almost anything, a man with a corneal abrasion should not do anything. If the problem lasts over 30 days, better let me know about it.

If you have any questions, please call me at AV 922-4501 or 4502.

A. F. WELLS
CAPT MC USN
Aerospace Physical Qualifications Dept.

INTERESTING CHEATERS I HAVE MET

Ask any line officer around the O'Club (at Trader Jon's) at Pensacola about the NAMI Whammy: and they'll tell you about the paranoid bunch of bureaucrats whose major joy in life is NPQing pilot hopefuls. Sometimes it's awkward for me to wait in ready rooms for my flight time with half a dozen bespectacled student NFO's staring at me because *I'm* the one that kept them out of the front or left seat of a Navy plane and, eventually, maybe a 747.

The stakes for getting PQ'd for SNA are tremendously high, and the world is not a terribly honest place (why do we have locks on our lockers?) Put these two facts together and we've got a tremendous poterltial for cheating, or as it can be more politely put (to avoid a knuckle sandwich) "reverse malingering."

Just as a cop must wear a gun, but many go through an entire career without firing it for real, we must not only be extremely vigilant for cheaters, but they *should know* we are, to discourage attempts at it. The chutzpah the cheater shows is incredible; I'll relate just three.

One was an SNA candidate who had sailed through his MEPS and Satellite Facility exams and was just about through NAMI (DVA 20/20 O.U.) when I sat him behind the slit lamp and saw the 8 telltale radial keratotomy scars (like a gunsight) on both corneas. I gently asked him where he had gotten his RK done, and he stared at me blankly. I tried a different tack and asked him *who* had done his eye surgery and he stared back at me and said "I've never had any eye operations." We went round and round for a while with me politely explaining that there was no question about it; to an ophthalmologist it was as obvious as a missing finger is to a lay person. Well, hard as it is to believe, he stuck to his story from then (0820) till around 1430 when a student flight surgeon who was doing his refraction developed enough rapport for the candidate to come clean; he stated that the ophthalmologist had told him the scars would be undetectable! (He had paid $2,000.00 for the procedures). NPQ for any service, of course.

Number two was an SNA candidate who failed his FALANT. He loudly protested that he could pass and would prove it. He then went out to his car and brought in a Farnsworth Lantern! He had bought it (about $1,800.00) and had memorized all the possible sequen-

ces if the test was *not* given in a randomized fashion. NPQ for aviation.

Number three -- the best. An SNA candidate NAVIP who had likewise passed all previous screens, and read 20/15 O.U. when he requested to go to the head because he had to go "real bad:" He had pulled a similar stunt after his AFVT screening before the flight surgeon had done his physical, so we said "Sure, but sit down here (behind the slit lamp), this will only take 10 seconds -- You can hold it that long." Sure enough -- soft contact lenses in both eyes. I asked the optometrist to have a look to verify it, and then said "You're wearing contacts" and he stared at me like I'd said he had 2 heads and said no he wasn't. I repeated, he did too. Having learned (fortunately not the *really* hard way) to avoid confrontations *(especially* with militant NAVIPS) I shrugged and walked out, and told the recruiter who was with the group. He looked unhappy and went to talk to the guy. He (the recruiter) came back into my office ten minutes later and said the guy was adamant -- he was *not* wearing contacts. I figured the easiest way to handle it was to show the recruiter the contacts through the slit lamp, so we sat the guy down to look and of course -- they were gone! (Soft contacts can be slipped off in a couple of seconds with someone's head just turned away). So rather than arguing the point with either the guy or the recruiter, I asked the guy to read the Snellen Chart (knowing, of course, he would not be able to) and: he refused! He said "I already passed this and I ain't going to take it again." Again I avoided the confrontation. I took the recruiter aside and pulled my Sherlock Holmes routine. Sherlock Homes said "When you exclude the *impossible,* what remains, however *improbable,* is the answer." I said: "Dr. P. (the optometrist) and I represent 40 accumulated years of eye care, so can we grant it impossible that we cannot recognize contact lenses on an eye? He granted that. Then, I said, "We've excluded the impossible. The only two improbables left are: (1) Dr. P. and I are in collusion to lie about the presence of the contacts to keep this man from being an SNA or (2) he in fact waswearing them and slipped them out in the ample time and privacy he had." The recruiter said "Touche', I'll talk to him." Later that day (the candidate *still* refusing to have his vision retested) they switched him to SNFO candidate. I personally hope he is not a Naval officer today!

Bottom line: no matter how outrageous the deception, it will eventually be tried. Records can be falsified, tests cheated, you name it. But just like in airline magnetic detector screens and luggage inspection, the vast majority of legitimate people must go through an inconvenience to catch that tiny minority of menaces. Let's just make sure we catch them.

A. S. MARKOVITS
CAPT MC USN
Ophthamology Dept.

NEW ANTIHYPERTENSIVES AVAILABLE FOR USE

In June 1987, the Aeromedical Advisory Council recommended that captopril and enalapril, two angiotensin converting enzyme (ACE) inhibitors, be allowed for use as antihypertensives by aircrew in all Service Groups. The use of either medication requires a waiver and must be used with certain restrictions. On initiation of treatment the aircrewman must be grounded for a thirty day period of observation. *The maximal allowable total daily dose* is *150 mg. for captopril* and *20 mg. for enalapril.* This means that only low to moderate dosages are allowed. A complete blood count, routine and microscopic urinalysis, serum electrolytes and serum creatinine are required before therapy and 2-3 weeks after treatment is begun.

ACE inhibitors have been tested and found effective for all levels of hypertension. ACE inhibitors were approved forfirst line therapy of mild to moderate hypertension in 1985. Captopril doses as low as12.5 mg. BID were found to be effective but the best responses were seen with doses of 25-50 mg. TID. BID dosage is allowed and is definitely effective in some patients. Enalapril can be used as a once or twice a day dosage with an initial recommended dose of 5 mg. daily and an average long term dose of 10-40 mg. daily. Presently total doses are restricted in aviation personnel as above.

Safety must remain the most important criterion for drug use in aviation so careful consideration of the profile of side effects of ACE inhibitors is necessary. The most significant adverse effects of captopril have been neutropenia, proteinuria and decreasing renal function. Analysis of patients demonstrating these adverse effects showed that if patients had normal renal function and no collagen-vascular disease, neutropenia and proteinuria were extremely rare (0.02% and 0.2% respectively). As these concomitant problems are rare in the aviation community these complications should not be a practical problem. These adverse effects are not documented yet with enalapril.

Minor side effects including dizziness, headaches, vertigo, hypotension and nausea are unlusual (< 5%), usually transient, and often associated only with initial doses. I n large trials a total of 6% of patients on captopril had to be taken off the drug due to side effects. This compares favorably with hydrochlorothiazide. During the required thirty day observation period careful evaluation for orthostatic hypotension, nystagmus, and poor balance, should be emphasized. Occurrences of mild symptoms upon initiating either drug do not necessitate discontinuation of the drug but indicate careful and close observation.

At present, concomitant therapy with diuretics is not approved in aviation personnel due to the possiblity of significant hypotension. Monitoring of BP response should be done on at least a weekly basis initially but as

a stable dose and adequate BP control are achieved every 3-4 months should be adequate. As in all conditions requiring a waiver, yearly written evaulations are mandatory.

R. G. OSBORNE
CDR MC USN
HEAD INTERNAL MEDICINE

ANTHROPOMETRIC Q/A

Frequently, Code 26 has to remeasure candidates for anthropometric data to complete satellite physical examinations. All too frequently, major discrepancies are found, especially in the buttocks-knee length. This measure is especially crucial in ejection seat aircraft and needs the close personal attention of the flight surgeon whenever the screening evaluation suggests marginal values. Trigger values for the flight surgeon should be height of 67" or less and/or a BKL measurement of 22.4" or less. These values should be remeasured by two flight surgeons or a flight surgeon and an experienced AVT. The correct way to preclude cheating, whether conscious or unconscious. is to have the individual (1) sit on the anthro chair, (2) bend forward at the waist, (3) push himself backward until his lumbosacral area is firmly against the back of the chair, (4) measure the buttocks-knee length with the lower leg perpendicular to the floor while, (5) one observer insures that the lumbosacral area remains in contact with the seat back. This last item is the most critical step in insuring the measurement is performed correctly.

In the April 1987 Newsletter, I submitted a Normogram for evaulation of Hay Fever in applicants for aviation programs. I was recently reminded that in some areas of the country, Navy allergists are available. If you are lucky enough to be near a facility with an allergist, they too can assist in your evaulation of those applicants with a history of hay fever.

M. R. AMBROSE
LCDR MC USN
Physical Examinations Dept.

NAVY AEROMEDICAL PROBLEMS COURSE

This year's course dates are Tuesday through Friday, 20-23 October 1987.

A partial list of the program's topics are:

Fleet Medical Support
HIV Seropositives
Aeromedical DCS
ALSS and injury
Laser threat
Mitral Valve Prolapse
and more

We have an outstanding roster of speakers for you this year coming from the four corners of the country. Among them are representatives from AFIP, the Safety Center, NAVMEDCOM, and our own clinical experts. You don't want to miss the latest in night vision, or the future of the Navy in the space program, orthe presentation by our special guest, Vice Admiral Zimble. All in all, this year's program promises to be a good one. Don't miss it.

Now, to the nuts and bolts of the meeting:

Times will be 0745 Tuesday to 1600 Friday. CME is expected to be 25 hours.

NALO flights will be requested for Monday, 19 October for the trip to Pensacola, and Saturday, 24 October for the return trip.

Pickup points will be NAS Alameda arid NAS North Island on the West Coast, Andrews Air Force Base, Washington, DC, and NAS Norfolk on the East Coast.

We need to know the exact numbers of passengers, and the pick up points *before* the 19th in order for NALO to provide the size aircraft required. Departure times for each pick-up point will be passed to COMNAVAIRLANT and COMNAVAIRPAC Force Medical Officers:

COMNAVAIRLANT	AUTOVON 564-7028
COMNAVAIRPAC	AUTOVON 951-6251

Please call me to:

Sign up for NALO and point of pick-up.
Sign up for Social on the evening of October 20th.
Reserve a BOQ room. (125 available)

Uniform — will be Khaki for meeting and travel.

Civilian attire — Casual dress for social, coat and tie for dinner on Thursday evening, October 22nd.

Commercial Air carriers to Pensacola are Eastern, Delta, Continental and Piedmont. Driving time to NAS about 30 minutes.

Point of Contact —CDR Reams

AUTOVON 922-2457/2458/2741/4659
Commercial (904) 452-2457/2458/2741/4659

-- EDITORIAL POLICY--

The views expressed are those of the individual authors and not necessarily those of the Society of U.S. Naval Flight Surgeons.

This Newsletter is published quarterly by the Society on the first of January, April, July and October. Material for publication is solicited from the membership and should be typed **double spaced,** reaching the Editor at least one month prior to the scheduled date of publication. Unsigned material will not be considered.

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MOMENT OF SILENCE

DR. LINDA BONO

Dr. Linda Bono, L T, USNR, an August 1987 graduate of the Aviation Medical Officer Course at the Institute was killed in an auto accident in Orlando, Florida on 4 September 1987. She had just reported for duty at the Naval Hospital. Dr. Bono was a graduate of Boston University and Boston University School of Medicine where she obtained a BA, MA, and MD. She interned at Portsmouth Naval Hospital in 1986-87 and was starting her first Navy tour.

Linda was a bright, happy, enthusiastic physician looking forward to participation in aviation medicine. She was planning to return for the Flight Surgeons Course as soon as possible. For four weeks in August she brought some sunshine into our midst and we will miss her.

GOOD-BY CHET

Lieutenant Stephen Chetneky, Naval Flight Surgeon, and Captain Daniel Campbell, Marine Aviator, died in a Harrier aircraft accident during a training flight from Cherry Point, North Carolina on August 12, 1987.

My husband and I, both Flight Surgeons at Cherry Point, were commuting into work as usual when over the radio came the news that an aircraft from Cherry Point crashed the evening before and the pilots were missing. We looked at each other - this was not going to be the usual kind of workday.

We walked into our office shared by about ten flight surgeons and I asked, “What’s this about a crash last night?” A fellow flight surgeon motioned me over. He seemed tired and a little pafe. Then he said he was the flight surgeon called out to the crash. He said, “It was Steve and a pilot.”

I asked in a voice of disbelief, “You mean Steve Chetneky, Chet?” The answer was a nod. “Well, they’ve been found, haven’t they? They’re okay, right?”

“No, they’re dead.”was the reply. I remember thinking this cannot be for real - Chet could not be dead.

I sat down. I knew I was supposed to be in Sick Call seeing patients. But the thought of Chet gone haunted me. Why? How could it happen? I did not understand.

I struggled to get to Sick Call. Patients were waiting. It could have happened to anyone of us - it could have been my husband. I went through the motions, calling back my first patient. I could not concentrate on the patients’ problems. Every few minutes I was distracted by some thought of Chet. I remembered little things - meeting him upon reporting in, working with him, sharing fun times together like that beach party not too long ago... Why Chet? Why did this have to happen? Sick Call patients are waiting. I saw more patients while trying not to feel or think about Chet.

The next chart I opened was for a follow-up visit from two days ago when the patient had been seen by Dr. Chetneky. I looked at the note in the record - at Chet’s writing - and thought of him here just yesterday. He won’t be here anymore. The patient looked at me as if to ask why I seemed to be taking so long looking at the chart. I wanted to tell him that the doctor he saw last time was dead. A talented young man, a nearly trained general surgeon, a flight surgeon was dead. Our friend and co-worker was dead.

My squadron had me scheduled for a three day flight leaving the next day. I was not sure if I warlted to go, but the C-130 is a “super safe” aircraft. It was odd, but I really didn’t remember ever being concerned about flying. I went on the flight and tried to mentally and emotionally get away.

The second day out I was called up to the flight station. The aircraft commander told me it was my turn to fly. I hopped into the pilot’s seat with a big grin on my face. It was such a neat feeling - getting to fly! That’s what Chet felt, too. That thought came unbeckoned. There I was trying to fly a C-130 with Chet on my mind. My time at the controls was over all too soon. I sat back again and my mind wandered. I remembered how much Chet wanted to fly. He was always asking to fly. He had been assigned to an A-6 squadron but requested an AV-8 squadron, because he wanted to fly as a pilot. He could fly as a student in the Harriertralher. That was what he wanted. He died doing the thing he most wanted. He worked so hard to get that first trainer flight. I knew Chet was doing what he really wanted and I could imagine him in the aircraft with the same grin I had minutes ago. Why did he have to die though? It was painful. He really was dead.

The flight returned late Sunday night. .I got dressed Monday morning in Summer Whites. I felt a certain dread. Today was the memorial for Chet and Captain Campbell. First, came a full morning of Sick Call with last minute details of the memorial service being worked out in between seeing patients. A fellow flight surgeon had written and would give the eulogy. I was asked to be the escort for Chet’s only surviving family member, his mother. I was not sure if I could handle it. It was all so painful.

I started to think about Chet’s Mom. I knew her husband had been an Air Force aviator who died in a jet aircraft accident when Chet was a baby. Her husband was awarded the Distinguished Flying Cross and had several campaign ribbons. I thought about my husband. Did he really have to fly A-6’s? No number of medals would replace him. I thought how Mrs. Chetneky must feel - to lose her husband and then her only child, their son, in the same abrupt and violent way.

I was driven in a military sedan to the front gate of the base to meet Mrs. Chetneky. I was nervous. What was I supposed to say? What could I say? We arrived at the gate. There was a group of four adults standing there

and I asked if one might be Mrs. Chetneky. She answered and introductions were made. I thought to myself that she was certainly a pretty lady, soft-spoken but friendly - and that she reminded me of my own mother. The conversation was just small talk. I was surprised at her strength - that she could sit there putting me at ease as we talked.

We arrived at the Chapel. More last minute details were taken care of and then the calm arrived before the service. More introductions were made. Everyone was keeping a stiff upper lip. Then Mrs. Campbell, the young widow with two young sons, walked over to Mrs. Chetneky; they embraced and she said, "You're the only one that truly understands how I feel." They hugged for a long time. Tears were flowing. The pain was so strong in the room. I cried. I was not suppose to cry - I was the escort. Why did Chet have to die? Why did Dan Campbell have to die? We walked out of the room into the chapel. The aisle seemed so long as I started to cry again walking between two straight-faced Marine officers also serving as escorts.

The memorial service was well done…the eulogies, the Colors, the Navy Hymn, and Taps. We were a family, this Navy - Marine Corps family. We shared the pain and we remembered our loved ones. We were also trying to say good-by.

The reception followed. A small group of flight surgeons and friends gathered. The talk centered around sharing little stories about Chet intermixed with other topics so to ease the occasional twinge of pain. We didn't think of Chet as being dead because the thoughts of him were very much alive. We said our good-bys to each other and to Chet's Mom. She was just one amazing lady. How could she bear all this?

I drove home slowly and alone except for my thoughts. As I left the base, a C-130 took off followed by a Harrier. They were training flights, no doubt. I spoke aloud as if he could hear me: "Chet, that could have been any one of us flight surgeons that day. We're doing something we wanted to do, right?"

I bet Chet did have a grin on his face that day doing the thing he most wanted to do - to fly. At least that is how I want to remember him. Good-by, Chet.

KATHLEEN H. MOELLER
LT MC USN
2nd MAW Cherry Point, NC