Society of U. S. Naval Flight Surgeons

P.O. Box 33008
Naval Air Station, Pensacola. FL 32508-3008

Forwarding And Return
Postage Guaranteed
Address Correction Requested

NON-PROFIT
ORGANIZATION
U.S. POSTAGE
PAID
PERMIT NO. 459
PENSACOLA, FL

VOL. XVI, NO. 4 **NEWSLETTER** **OCTOBER 1992**

PRESIDENT'S COLUMN

It's difficult to believe that it's already time for another column. It seems like it was just yesterday that we were all in Miami at the Aerospace Medical Association meetting. Well, a great deal has taken place since then. It would appear that the landscape in both Florida and the Navy has been rearranged. In both instances, the changes have been rather dramatic and to some, particularly in the Navy, it appears as if a hurricane struck in the Pentagon. However, unlike Dade County in Florida, the Navy will "recover" quickly and continue to prove to the world that the Navy-Marine Corps Team represents this nation's force in readiness.

Clearly the *paradigm* for the Navy as an organization has changed. The restructuring within the Pentagon combining the aviation, surface, and subsurface communities under one three star admiral should ultimately be transparent to the flight surgeons in the field. What will not be transparent to the operational flight surgeons are the changes that are taking place at the level of the battle groups and forces and how they are organized. Similarly the emerging structure of the Marine Corps as the latter force gets smaller will also ultimately impact on how we do our business. What does all this mean? Simply put, as I tried to layout in my first letter, unless we all work smarter, more efficiently, and keep our collective minds free of parochialism, we could wind up being out of a job as the force structure changes. Once a billet is out, it almost never gets reestablished.

Go the extra mile! Prove to all those around you what we already know: naval aviation is not going to survive without the aeromedical community. As naval flight surgeons, you have received the best training available for an entry level flight surgeon in the world. There is no other entry level program like the one at NAMI. We can do the job whatever the task. Don't let the Line ever forget that, not by telling them but through our actions day in and day out.

Perhaps, I can illustrate what I am trying to convey about a shift in the paradigm by describing one of the policy "battles" that I periodically get involved with in Washington. Basically Senator Sam Nunn has said that everything is on the table and it is all negotiable. Take my word for it, he is serious about this and has the muscle to make it happen. As we all know, stuff, regardless of its composition, tends to run down hill. Where this impacts in my relatively very small corner of the Washington arena is in the area of the length it takes to train a flight surgeon in the Navy. Naturally, there are a lot of people in the Pentagon and on the Hill who want to know why it takes six months to train a flight surgeon in the Navy but only seven weeks in the Army and eight weeks in the Air Force. In part the question comes up because many people don't understand what a naval flight surgeon really does, particularly as compared to the other services' flight surgeons. Then I get to explain what it is we do and why we do it, as well as who we support. I particularly point out how different our operating environments are from the other services. In the end, the arguments for our training appear to carry the day until the next time.

There are some green eyeshade folks who would like to just merge all flight surgeon training and call it a day. I will continue to fight this battle each year but I need your help. The only way we as a community will survive is if the Line genuinely understands our worth and refuses to let us get wiped out or otherwise wind up being ineffectual.

On a more mundane level, there are a couple of other topics I would like to address. First, the upcoming Problems Course is going to be the usual great event from the standpoint of learning and idea exchanges. NAMI is doing their usual outstanding job in organizing the event and ensuring that it will be something special. I would urge all of you to make every possible attempt to get to the meeting. I look forward to seeing you there.

Next, I'm pleased to report that your society, SUSNFS, is in great shape and getting better all the time. In large measure this is due mainly to the officers you elected to do the real work: such as our dynamite secretary/treasurer, LCDR Glenn Merchant.

Finally, I want to say a few words about the upcoming Graduate Medical Education Selection Board (GMESB). The messages from the Fleet and the FMF have gotten through to BUMED and HSETC. It is my understanding, not having read the actual board precept, that every effort is being made to stack the odds in favor of those applicants coming from an operational tour. The popular residencies such as ENT, Orthopedics, Dermatology, Ophthalmology, will continue to be very tight because of the number of applications. People applying in the primary care specialties such as Family Practice, OB/GYN, Internal Medicine, Pediatrics, have an excellent chance of being accepted. No one will be taken directly from internship for a program if there is a qualified applicant from the Fleet. Send in your application and make it look good! Check your application before sending it in.

Well, this is enough for this outing. If I sounded a bit like doom and gloom above, it was not my intention. We will all be around a bit longer. The only question for all of us to consider is how we, as a group, will be able to influence the events going on around us in the context of a rapidly changing environment?

Semper Fi.

CAPT BOB HAIN
MC USN

SECRETARY-TREASURER NOTES

Where has the time gone? It seems as if "Hey Howdy" departed only three months ago and already it's time for me to say good-bye. Boy, have I enjoyed being your Secretary-Treasurer, but now it's time to move on. But whoa! Before too many start celebrating, I should point out that I'm talking to the 46 members who just received their ***last*** newsletter. Take a look at your mailing label. It's easy to tell if you're one of the "lucky 46," who'll never have to read this column again. If there is a "91" in the right upper corner, this was your last newsletter. Fact is, your membership expired in April of 1991. The Board of Governors decided that, in accordance with our constitution, anyone more than a year delinquent at the end of the Problems Course would be dropped from the rolls. That occurs next month. There's still time to pay your dues. We would like all 46 to renew, but if you're moving on, we wish you fair winds, a following sea, and all "OK 3 wires" in the future. Whether you've been a member of the Society two years or twenty, your contributions to Naval Aviation have been appreciated!

For the rest of the membership, anything less than a "93" means you too are delinquent. Now some of you are undoubtedly saying, "Hey, I just sent you a check. My dues should be up to date." No argument from me --- *dues should be up* to *date!* The sad fact is some of us have allowed our dues to fall more than a year behind, so your check went to last year's dues. It can happen. We're all busy people (and important too!). The easy thing to do is send us a check for $300 and let me add you to the Lifetime Membership list. If you've only been doing this ten or fifteen years and aren't sure you want to make it a career, then send me a check for $15. That will put you on speed and give you another year to decide if aviation medicine is for you.

Again, note that SUSNFS now has its own P.O. Box. That way mail comes directly to me without going through the NAMI "filter" (As overheard in the mailroom: "Hey, do you know what SUSNFS are?"). Also notice the new change of address format. Now that SUSNFS has a laptop computer we'd like everyone to include their duty station and telephone numbers. Expanding the database will allow us to verify addresses and dues, and respond faster to your requests.

That's about all. As one of my helo pals likes to say, "Keep them out of the trees." (I think he's talking about the helos and not the pilots.) See you next month at the Problems Course.

LCDR GLENN MERCANT
MC USN

AEROSPACE MEDICAL ASSOCIATION - THE ORGANIZATION AND SOME ISSUES

This article is written primarily for the LT/LCDR first or second tour flight surgeon who sees AsMA as maybe something he or she should get involved with, but isn't sure why or how.

The discussion is divided in two parts: 1) Organizational structure (including "How do I get on committees?"), and 2) Current AsMA issues -"Does AsMA do anything of interest to me?"

1. ORGANIZATIONAL STRUCTURE AND COMMITTEES

EXECUTIVE COMMITTEE (The President's Cabinet)

The decision/steering center of the Association is the Executive Committee --seven persons (Pres, Pres-elect, etc.) who make policy decisions with or without the consent of the membership depending on the issue. Membership on this committee rotates everyone to three years. At large members are appointed at the pleasure of the president.

EXECUTIVE COUNCIL (The Congress)

The legislative body of AsMA consisting of the Executive Committee, past Presidents, twelve elected-at-large members and a rep from each constituent organization (13). Elected membership rotates every three years. Constituent organizations appoint their rep for varying periods.

"ORGANIZATIONS" (The States)

Within the Association of AsMA are constituent and affiliate organizations. The Society of U.S. Naval Flight Surgeons is a constituent organization. All members of SUSNFS are supposed to be current dues paying members of AsMA -- this is a requirement of constituency. Affiliate status requires only 10% of its members to be dues paying members of AsMA. A constituent organization has a vote at Council; an affiliate does not.

"THE BODY" (The People)

The entire body of AsMA, ie. the general membership is 4,500. AsMA is a national organization with international membership. Twenty-five percent of the membership is international, representing 76 countries. The annual Business Meeting is open to all members. Resolutions developed in Council require ratification by the general membership. Support for Space Station Freedom is a resolution passed at the business meeting in Miami Beach this year.

COMMITTEES (This is how to get involved)

There are three types of committees: 1) Ad Hoc 2) Standing, and 3) Meeting or Convention.

1) Ad Hoc committees are appointed by the president to fulfill special needs. Ad Hoc committees are self-limiting. An Ad Hoc committee was formed to write a position paper on HIV; upon completion, the committee was disbanded.

2) Standing committees are integral to the association and are permanent as established by the constitution and by-laws. Standing committees are: Nominating, Constitution and By-Laws, Resolutions, Membership, Awards, Education and Training, Aviation Safety, Science and Technology, Long-Range Planning, Air Transport Medicine, International Activities, Corporate and Sustaining Membership, History and Archives, and Aerospace Human Factors. Members are approved by the president upon recommendation by the committee chair. Usual membership tenure is 3 years. Ten to thirty members per committee.

To get on a committee, you need to get the attention of the committee chair. This can be done in three ways. I suggest using all three. A) Seek out the committee chair and express your interest. B) Sign up sheet. A sign up sheet for committee membership will be circulated at the committee meeting, and/or posted on a bulletin board in the registration area, and/or found in a "committee notebook" behind the registration desk. This process may seem haphazard and it is. C) Find out when the committee meets and go ahead and attend as an observer. This shows interest and gives you a good idea of the committee's work. Sign up at the end of the committee meeting.

Description of Standing Committees is found in the Constitution and By-Laws. Constitution and By-Laws are published annually in the directory issue of the Journal.

3) Meeting Committees organize and conduct the annual scientific meeting. Meeting Committees are: Scientific Programs, Registration, and Arrangements. Process for joining is the same as for standing.

4) Other. Although not a committee, Associate Fellows is a group of definite significance to anyone aspiring to fully participate in AsMA. This is the group through which the "movers and shakers" of AsMA progress on their way to Fellowship. Membership in Associate Fellows is by application and endorsement, and requires 5 years of AsMA membership as a prerequisite. The Associate Fellows group is explained in the Constitution and By-Laws. Membership applications are found in the back of the annual meeting/program issue or may be obtained by writing the home office (Alexandria, VA).

2. CURRENT AsMA ISSUES

Under recent leadership, AsMA has begun to critically evaluate how it does business, where it wants to be in the future, and what alliances with other organizations may be advantageous. AsMA has taken a public stand on the HIV issue and Age 60 Rule. AsMA is contemplating formalizing some type of legislative lobbying presence in Congress.

a. Age 60 Rule. In 1960 the FAA established age 60 as mandatory retirement age for airline pilots. In 1981 AsMA issued a position statement concurring with that rule. In 1992 after much debate, AsMA affirmed its 1981 position by majority vote of Council. Debate over the Age 60 Rule will be with us for many years. AsMA's reaffirmation position paper on this issue is not published in the Journal. Copies may be obtained from the home office.

b. HIV and Aviation Safety. By vote of Council at Cincinnati in May 1991, AsMA adopted the position that HIV seropositivity was of itself medically disqualifying for flight. The, AsMA position paper on this issue was published in the May Journal. AsMA's position was much debated by the House of Delegates of the American Medical Association and is now before the AMA Board of Trustees. It is the desire of AsMA to have its position be the basis for a like-minded AMA Resolution.

c. AsMA Viability. What's the future of AsMA?

The membership of AsMA has decreased slightly, but consistently for the last 4 years. Why? Desert Storm? Downsizing? Decreasing U.S. Aerospace Industry? Recession? Or has AsMA not been attuned to the needs and desires of the customer? Do we need a greater national impact and political impact to compete with

other organizations who are "taking our members?" An advisory committee has been formed to evaluate these and other questions about what should be the breadth and scope of AsMA activity. The committee is the External Relations Committee. I am very optimistic about the future of AsMA, but firmly believe that we need to get progressive in the area of external relations and customer satisfaction (the customers include ourselves).

The participation of all our membership, and especially our younger members is vital to AsMA. Seek out a mentor. Seek out committee membership. Participate in constituent organizations. The future of AsMA is whatever you want it to be.

CAPT STEVE HART
MC, USN

CODE 42 PERSPECTIVE

Among the advantages of attending the Aeromedical Problems Course is the excellent opportunity to review the changes in policy with respect to aeromedical dispositions. Pending final approval of Change 107 to the Manual of the Medical Department, a discussion may outline the significant changes to that document, as well. Besides the general session presentation, Code 42 will be participating during the afternoon workshops designed to answer your individual questions. It is anticipated that the workshop will also provide a venue for updating your knowledge of the Micro-88/AMDRS system.

Several topics of the Aeromedical Advisory Council have received BIJMED endorsement and are presented below:

Japanese B encephalitis vaccine. In the event that operational requirements dictate that JEV be administered to aviation personnel, the following guidelines have been adopted. Those personnel are to be grounded for a minimum of 72 hours after the first dose, 5 days after the second dose, and for 72 hours after the third dose. These restrictions are necessary due to the delayed onset of adverse reactions.

Salmonella typhi oral vaccine. Individuals receiving oral S. *typhi* immunization should be grounded during the entire immunization period. If immunized individuals are asymptomatic 24 hours after the last dose, flight status may be resumed. It is recognized that this total period of grounding exceeds that for use of the parenteral vaccine, and operational commanders should be advised of the potential mission impact upon using the oral preparation rather than the parenteral preparation. As always, it is our responsibility as flight surgeons to appropriately advise our operational commanders.

Nicotine transdermal patches. The nicotine transdermal systems may be utilized by aviation personnel in conjunction with a smoking cessation program and with monitoring by the flight surgeon. Aviation personnel should be grounded for 48 hours following application of the first patch. It is requested that its use be noted on the SF-93/0PEQ, but it is not disqualifying.

IOP's for candidates. Confusion over a standard "tripline" has existed for what intraocular pressures should be considered disqualifying for aviation candidates. For aviation candidates, a glaucoma work-up should be initiated if two or more applanation tonometry readings are 20 mmHg, or if there is a difference between eyes of 5 mmHg. The glaucoma work-up should include: family history, serial IOP's, dilated fundus examination to include in-depth disc evaluation, automated visual fields (i.e., Humphrey30-2, 24-2), biomicroscopy (SLE), and gonioscopy. If disc pathology or visual field changes are not noted, the candidate is NPQ, but waiverable. Annual applanation tonometry will be required.

Acyclovir (oral). Acyclovir (oral) is now an approved antiviral medication used for the treatment of primary or recurrent herpes in aviation personnel. The following need to be followed when prescribing oral Acyclovir: (1) The patient should be grounded and monitored for side effects for a minimum of three days during the initial treatment. (2) Dosages in excess of 200 mg five times daily are not waiverable. (3) BUN and creatinine should be obtained at the initiation of therapy and every two months. Again, the use of oral Acyclovir is disqualifying, however, is waiverable if the above conditions are met.

Augmentin. Augmentin has been approved for use in aviation designated personnel. After initiating treatment for an indicated infection, the individual should be grounded for a period of five (5) days to observe for side effects attributable to the medication. If, at the end of this period the individual is asymptomatic both from the illness and the medication, they may be placed on flight status prior to the completion of therapy.

Input for hospital formularies. Recently, you have expressed concern as hospital formularies have deleted a medication approved for use in aviation personnel, only to replace it with one which is either not approved, or has not yet been addressed. A prime example is the substitution of Pravastatin for Lovastatin. Hospital formularies are changed for a multitude of reasons, not the least of which are monetary, however, aeromedical input to formulary changes apparently has not existed. This concern is being addressed by BUMED and, hopefully, hospital formulary changes will receive prior review by operational forces. Please do your part and become active on hospital pharmacy and therapeutics committees when given the opportunity.

Once again, it is hoped you will attend the Annual Aeromedical Problems Course, an excellent forum for discussion of these and other operationally pertinent issues.

CDR C.J. NICKLE
MC, USN
Code 42, NAMI

COMMENTS ON BUMEDINST 5300.8 OF 20 MARCH 1992

The recent distribution of BUMEDINST 5300.8 "Disposition of Rehabilitated Alcoholic Aircrew" has generated an unexpected number of questions. Its intent was to clarify ambiguous issues on diagnosis, treatment and disposition of alcoholic aircrew not fully addressed by NAVMEDCOMINST 5300.2, which is cancelled by the new instruction. A major criticism of NAVMEDCOMINST 5300.2 was that, if taken literally, it could take as long as one year for a pilot to obtain Service Group I status after completing treatment for alcohol dependence. Alcohol abuse was not addressed and an observed trend was that many so called alcohol abusers were underdiagnosed. Utilizing the collective experience of NAMI Psychiatry, NAMI Aerospace Physical Qualifications (Code 42) and the Aeromedical Advisory Council, the framework for the present instruction was drafted. For the first time, U.S. Army, U.S. Air Force and FAA guidelines were liberally incorporated in the Navy Instruction. As intended, the updated instruction will not only provide extended and more careful follow-up, but actually allow Class I personnel to return to Service Group I duties as early as one month after treatment. In spite of the attempt at clarity, there will seems to be some uncertainty in some areas. The following addresses most of the inquiries I have received:

1) BUMEDINST 5300.8 does not replace aftercare provided by the treatment center or as directed in OPNAVINST 5350.4B.

2) There is no distinction made between alcohol abuse and alcohol dependence. This is primarily a result of unreliable and inconsistent diagnoses, loss of Level II patients to follow-up and is in line with management by other services.

3) Diagnosis must conform to DSM-III criteria. Alcohol misuse and single episodes of alcohol-related incidents should go to Level I. Accurately diagnosed alcohol abuse or dependence go to Level II and III, respectively.

4) Aircrew must be grounded until treated. Lack of available Level II or Level III facilities should be addressed to BUPERS by line commands as a major support issue.

5) In uncomplicated cases, i.e. successful completion of treatment, established aftercare, minimal personal turmoil and positive attitude, some individuals can go back to flight duties 30 days after completion of treatment. The more complicated the case, the longer one should wait before resuming full flight duties. 90 days is a general policy and some cases might require a year or longer.

6) Total abstinence is required of those individuals resuming flight status after Level II or III treatment. This is not a legal issue as some have proposed but a choice. One can elect to go to controlled drinking after treatment -but that individual will not then be waivered to a flight status.

7) What about those individuals completing Level II prior to March 1992? It would not be feasible to retroactively seek out all individuals completing treatment before March 1992. If they present with further difficulty, then BUMEDINST 5300.8 should be applied.

As I've often stated, when access to alcohol, sex or food is threatened, an emotional debate always follows. In the interest of safety, mission accomplishment and preservation of assets, the Naval Aviation community often has taken a position much more rigorous than that required in other areas. My own attitude is why risk a million dollars worth of training and a 30 million dollar aircraft for a 3 dollar bottle of wine?!!! I'm sure more questions will surface. NAMI Psychiatry will try to provide more information in the November 1992 Problems Course. In the meantime if issues arise call NAMI Psychiatry at DSN 922-3974 or 922-4238, Commercial (904) 452-3974 or 452-4238.

Postscript 28 September 1992: The above comments were written May, 1992. Due to continued concern, primarily the Level II alcohol treatment centers, the AAC re-addressed the issue of alcohol rehabilitation and the aviator. CDR Tony McDonald researched the topic and again polled the Army and Air Force. After re-consideration, the AAC again affirmed the content and principles of BUMED 5300.8. The committee did strongly recommend that OPNAV 5350.4B be re-phrased in order to encourage the utilization of DSM III-R criteria for the diagnosis of substance abuse. At the present time, using OPNAV 5350.4B as a guide, one can diagnose alcohol abuse after one alcohol related incident, which is not always the case.

CAPT J.C. BAGGETT
MC, USN
Director, Clinical Services
NAMI

WHY DO YOU SEE 3 REFRACTIONS ON THIS HEALTH RECORD?

Most refractions are "manifest," which, according to Webster's 9th Collegiate Dictionary, means "readily perceived by the senses and especially by sight; synonyms, obvious and evident." This means the "which is better, one or two" method of measuring refractive error, in which the examiner relies upon the responses of the patient. Obviously this requires a certain amount of smarts and cooperation on the part of the latter and a certain degree of skill on the part of the former. It is effected by the "plus fogging" technique you were taught here at NAMI.

But some patients, especially moderate hyperopes, are so accustomed to accommodating that they are in accommodative spasm, essentially a "Charley Horse," if you will, of the ciliary (accommodative) muscle, and they cannot be "fogged" into relaxing it. These people require a cycloplegic refraction. MANMED mandates cycloplegic exams for all SNA applicants, partly to screen out such people. The results of this refraction, which abolishes "latent hyperopia," the normal physiologic tonus of the ciliary muscle, is usually slightly more hyperopic (plus) than the manifest refraction; this is normal. (For that matter, two **expert** refractionists examining the same patient will usually come up with slightly different results, especially in cylinder axis; it's just not that exact and fixed.)

MANMED mandates visual acuity and refractive standards to **20/20.** Many, indeed most, of our SNA's have visual acuity **better** than 20/20, (which was calculated mathematically as "perfect vision over a century ago -before "New Math!"). All clinicians refract to **best** visual acuity, not just 20/20 if this can be exceeded, (and some can see or be refracted to 20/10 **-twice** as sharp as 20/20!). If I can give this edge to patients, especially aviators, I and most of my colleagues do so. A 20/10 eye will spot that bogey at **twice** the distance of a 20/20 eye. (Studies of WWII fighter aces of both sides showed all had better than 20/20 acuity). But what if the 20/10 refraction exceeds the refractive limits for SNA or SGI? In this case, I (and, I hope, everybody else) will prescribe the **BEST** correction, even if it exceeds standards.

For an example, let's take ENS Lance Skybolt, SNA candidate who has 20/30 uncorrected, (that's the rule nowadays), and for simplicity, let's consider sphere and one eye only. His manifest refraction to best V.A. is -1.50 which gives 20/10; -1.00 gives 20/20. Cycloplegic exam, pushing the plus, is -1.25 to give 20/1 0; -1.00 gives 20/20; (MANMED upper limit of minus refractive error for SNA is -1.00 cycloplegic.) What's a flight surgeon to do?

1. Block 59 (Distant Vision) 20/30, corrected to 20/**20** (not 20/15, or 20/13 or whatever -- fouls up the computer!)

2. Block 60 type in "CYCLOPLEGIC" in front or in back of refraction and write in "-1.00 sphere." We don't **care** about the fact that -1.25 sphere cycloplegic gives 20/10; it's extraneous information.

59. DISTANT VISION	60. REFRACTION Cycloplegic	61. NEAR VISION
RIGHT 20/30 CORR TO 20/20	BY -1.00 S. SPHERE CX	CORR TO BY
LEFT 20/ CORR TO 20/	BY S. CX	CORR TO BY

3. **Then** go down to block 73 ("notes") and write:

73. NOTES (Continued) AND SIGNIFICANT OR INTERVAL HISTORY

BVE _____% Uncorrected
BVE _____% Corrected

Manifest Refraction: -1.00 sphere gives 20/20 DVA. Manifest Refraction: -1.50sphere gives 20/10: **This** correction was prescribed.

If the refraction was not a cycloplegic; say on an annual flight physical for an SNA, you would write, in block 59 the same thing as before; however, in block 60 you would type in "MANIFEST" in front of "Refraction," (and then do block 73 also as exemplified above).

Remember MANMED changes mean that nowadays a Naval Aviator will get **one** cycloplegic only; done here at NAMI in almost all cases. The first time a DNA's DVA drops below 20/20, only a manifest, (not a cycloplegic, as required previously) refraction and a mydriatic fundus exam is required. Translation: you can **dilate** (not **cycloplege**) the patient's eye with phenylephrine 2.5% to get a good look inside without paralyzing (cyclopleging) his ciliary Imuscle, maybe persisting for a couple of days and necessitating grounding. It would be helpful to tell Lance, who is no dummy, that he **passes** with -1.00 but sees "twice as well" with -1.50 and that if he loses or breaks his glasses, he needs the Rx in block **73, not** the one in block 60, so he can direct the dispensing corpsman's attention to it.

Obviously, this discussion is valid for SGI, NFO's and others as well; there may be a difference between just passing, and best acuities. Bottom line: regulations and paperwork notwithstanding, the most important consideration is that the aviator fly with his maximum best corrected visual acutiy. You might use the analogy to the patient-aviator of the difference between a C and an A on an examination, C **passes**, but most of us prefer the A.

CAPT A.S. MARKOVITS
MC, USNR
Head, Ophthalmology, NAMI

RAM'S CORNER

The SMOKER Lamp Is Lit

No, it's not a typo. It's supposed to read *smoker.* While you digest the newsletter, out there, somewhere, your CO or XO is being caught up in post-Olympic fever. Motivated by the Dream Team's gold medals he/she is thinking that a sports program would be good for the command's morale. What could be better for building team spirit than allowing his/her troops to engage in the manly, err, "personly" art of pugilism? That's right boxing. (I suspect the idea of encouraging one person to fight another is rooted in our childhood development, i.e., "My parent can beat your parent!"). Knowing that their flight surgeon is critical to the success of this plan, the CO/XO will soon come looking for you.

Before jumping on the idea ("Sure Skipper, I love suturing") you need to do a little research. You won't find anything about smokers in BUMED instructions, but you will find it covered in NAVMILPERSCOMINST 1710.A: ADMINISTRATION OF NAVY SPORTS PRO-

GRAMS. This very specific, non-medical instruction lists exactly what you must do to support Navy Boxing Competitions. No need to bore you with all the details of the entire instruction, but there are a few high points you should be aware of.

First, you must have a copy of and meet all the requirements of the U.S.A. Amateur Boxing Federation's *Physician's Ringside Manual,* as well as their *Safety Awareness Manual.* Your professional qualifications should "at least include current competency in the emergent treatment of head trauma, management of traumatic injury, certification in basic and advanced cardio-pulmonary resuscitation and experience in transport of an unstable patient." (Not a problem Skipper, I can do all that. I'm a Flight Surgeon!) Read on. The last line of paragraph 5, enclosure (4) can be a real show stopper. "The ready availability of sophisticated diagnostic and neurosurgical care must be identified and contingency plans for access developed." (Skipper, we've got a problem.)

Coming back from Desert Storm, an LHA decided to have a smoker, as the final event in the Captain's Cup competition. The ship's MO supported the plan completely, even though the ship was in the middle of the Atlantic. The embarked flight surgeon was finally able to kill the idea by referencing this instruction. Hate to think what ills would have descended on their young heads, had those medical officers allowed the fights to happen and one of the young sailors/Marines suffered a serious injury a thousand miles from shore.

LCDR GLENN MERCHANT
MC, USN
RAM

EXTERNAL OTITIS

"Swimmer's ear," though a common and relatively straight forward disease, frequently receives inadequate treatment in the operational medicine setting. The external ear canal is basically lined by facial skin and is susceptible to the same infections as the face. Hair follicles, sebaceous glands, ceruminous glands and the fissures of Santorini are all structures that may become infected. Maceration of the skin secondary to water retention in the canal or trauma such as from cotton swabs are the most common causes of external otitis. Symptoms may consist of itching, pain (especially with movement of the auricle), hearing loss, a pressure sensation and/or a discharge. Examination usually reveals "pain to pressure" around the meatus, swelling of the canal and debris/purulent discharge. Key to successful treatment is the meticulous cleaning of the canal. This is best done as we do at NAMI, using a binocular operating scope and small pieces of cotton on a metal applicator (essentially a cotton swab about 1/5 -1/8 normal size). This set-up allows for good visualization and depth perception to minimize pain to the patient. It is also readily available in the fleet -- NOT! However, even an ear suction or an otoscope and metal applicator tipped with small pieces of cotton permits an adequate job of cleaning to be done (not Q-tips!). If none of the above are available, washing out with domeboro solution or 2% acetic acid, especially coupled with gentle suctioning, helps. In addition to cleaning, any significant swelling warrants insertion of a wick. The commercial Pope Otowick design by Merocel is excellent but homemade cotton wicks can be fashioned by rolling a pledget of cotton on the handle end of a cotton swab then sliding off the shaped wick for insertion. The most common causative organisms, Pseudomonas and Staphylococcus, are then easily treated by using polymixin B-neomycin-hydrocortisone suspension 4-5 times a day coupled with continued daily cleaning and wick changes. All water should be kept out of the ear during treatment. Systemic antibiotics are required only if a periauricular cellulitis develops. Pain accompanying this malady can be severe; don't under treat it! Otomycosis occurs in only about 5% of all cases and is usually secondary to the use of antibiotic/steroid drops. This can be best treated with Cresatin solution. Remember -- adequate treatment of a significant external otitis requires daily cleaning and wicking in addition to antibiotic drops!

AWARDS COMMITTEE

The Awards Committee is seeking nominations for the Aerospace Medical Technician of the Year. Persons eligible for the award include all AVT's below the rank of Chief. Nominees will be judged based on their professional performance, leadership, and contributions to their command, Naval Aviation, and the Naval Service. Nominations are due NL T 10 November (Semper Fi), and should include the following information: Name, Rank, SSN, Duty Station, principal duties and responsibilities during the past 12 months, date entered service, date designated NEC-8406, EAOS, education to include correspondence courses completed during FV-92, and significant contributions to their command, their community and the Naval Service. A brief summary supporting the nomination should be included. The entire package should be sent to:

SUSNFS Awards Committee
c/o CAPT E.J. Sacks
P.O. Box 33008
NAS Pensacola, FL 32508-3008

This award is open to all AVT's. Take the time to show your young, hard-charging corpsman that you appreciate the job they do -- recognize their accomplishments by getting a nomination in the mail TODAY!

CAPT E.J. SACKS
MC, USNR Ret

ADDRESS CHANGE

NAME _____ RANK _____

STREET _____

CITY _____ STATE _____ ZIP _____

OPTIONAL:
DUTY STATION _____ BILLET _____

PHONE (W) _____ (H) _____

Send to: Society of U.S. Naval Flight Surgeons
P.O. Box 33008
NAS Pensacola, FL 32508-3008

1992 NAVY AEROMEDICAL PROBLEMS COURSE

The 1992 Aeromedical Problems Course will be held 17 through 20 November at the Naval Aerospace Medical Institute. The course is aimed at operational Flight Surgeons, Aviation Medical Examiners, Aviation Medical Safety Officers, Aerospace Physiologists, Aerospace Experimental Psychologists. Aerospace Medical Technicians, Aerospace Physiology Technicians. and medical researchers. During the course, the attendees will receive an update on aerospace operational requirements and standards as well as knowledge of recent studies which affect the operational flight environment. The heavy demands in the rapidly changing milieu of aerospace medicine require continual updating of the operational specialists' information base and knowledge of current aeromedical problems and standards; attendance is a must if you want to stay current.

You may register for the course using the enclosed registration form. There will be a $5 registration fee. For all officers who are pre-registered, the detailers will bring their Officer Data Cards and allot time for career counseling.

BOQ/BEO reservations are limited and will be made on a first come/first served basis. If you have any questions call either ENS Chargois, or CDR Morin at DNS 922-2457/8 or commercial (904) 452-2457/8.

PLEASE PASS THIS INFORMATION TO YOUR A VTs AND APTs.

-- 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.

Correspondence should be addressed to:

CAPT CONRAD DALTON, MC, USN
Editor, SUSNFS Newsletter
P.O. Box 33008
NAS Pensacola, FL 32508-3008

1992 AEROMEDICAL PROBLEMS COURSE
REGISTRATION FORM

Name: _____ Rank/Rate: _____
NAME AS YOU WOULD LIKE IT TO APPEAR ON THE CERTIFICATE

Duty station: _____ Telephone: _____

Address: _____

_____

Make checks payable to:
Aeromedical Problems Course

Do you need a BOQ/BEQ reservation?	☐ Yes	☐ No
Course registration fee (mandatory)		$5.00
Coffee & donuts/fruit for the week - Officers	$15	☐ _____
Coffee & donuts/fruit for the week - AVT/APTs	$8	☐ _____
Tuesday evening Officers' social	$8	☐ _____
Tuesday evening AVT/APT dinner	$10	☐ _____
Thursday evening officers' banquet	$25	☐ _____

Total enclosed: _____

Mail to: Problems Course (Code 32), Naval Aerospace Medical Institute, NAS Pensacola, FL 32508