

Society of U. S. Naval Flight Surgeons



Naval Aerospace Medical Institute, Code 10
Naval Air Station, Pensacola, FL 32508-5600

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NEWSLETTER

JULY, 1987

PRESIDENT'S COLUMN

The trials and tribulations of Navy Medicine have been front page news for several years. Like the Stock Market, this publicity concerning our short-falls and short-comings seems to have recently reached new heights with the CP/HP program, CHAMPUS overruns, medical personnel shortages and military malpractice issues turning NAVY TIMES into a NAVMEDCOM newsletter. The written criticism and suggestions for improvement are well founded and stem from the frustration of witnessing a proud and honored organization commit suicide.

If asked by a recruitable civilian physician to cite any reason to join the Navy rather than the Army or Air Force I would be hard pressed to go much beyond our better looking uniforms. We are relatively understaffed, underfunded, undersupported, overdeployed, overworked and overregulated. The most glaring example of misutilization of professional health-care providers is the requirement to review, document, triple-check, counter-sign, transcribe, substantiate and defend our provision of medical care in the name of Quality Assurance. Not that our QA program is nothing less than outstanding, but it is being done with little or no additional non-medical support and at the expense of our being able to deliver any quantity of medical care and at a time when dependents and retired personnel are being turned away from our doors.

Now that I have vented, what has any of this to do with operational aviation medicine? Well, we have a new Secretary of the Navy who is well aware of the needy state of Navy medicine and a new Surgeon General who is a strong advocate of operational medicine and who I believe will provide the leadership necessary to correct the problems surrounding us all. As flight surgeons we have the unique opportunity to interact closely with the line and as a result our attitudes toward Navy medicine will influence their attitudes. At a time when pessimism is prevalent and gripes come easy it is essential that we

keep our chins up and take a firm stance that things will improve. Our Society has produced several leaders in Navy medicine, and if all the good guys wearing wings jump ship it's certain to run aground. It may be presumptuous of me to believe any "fence-sitters" will opt to stay in for another year or two based on my plea or promise of better times ahead, but in reality it will take a supreme effort by each and everyone of us to bring Navy medicine back to its traditional exemplary status.

R. K. OHSLUND
CAPT MC USN

SEC-TREAS NOTES

News of the Society of US Naval Flight Surgeons

The most recent meeting of the Society, held in conjunction with the annual meeting of the Aerospace Medical Association, was held in Las Vegas, Nevada on 13 May 1987. Newly elected officers are:

President: CAPT Ron Ohslund
Vice-President: CAPT Gil Vasquez
Secretary-Treasurer: CDR Dave Yacavone
Board Members: CDR Homer Moore
LCDR George Romano

Appointments to committees and special projects were announced as follows:

Representative to ASMA Nominating Committee:
CAPT Dick Millington
Representative to ASMA Executive Council:
CAPT Garry Holtzman
Nominating Committee Chairman:
CDR Gary Reams
Awards Committee Chairman:
CAPT Andy Markovitz

Handbook Editor: CAPT Charlie Bercier

Attendance at ASMA was very good and the Navy's presence was highly visible. The conference agenda included a wide variety of fascinating topics and dis-

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SEC-TRES NOTES *(continued)*

plays. There was truly something for everyone. Las Vegas, with all its glamor and glitter, was enjoyed by all. Next year's meeting, to be held in New Orleans, promises to be just as stimulating.

The Society is planning several projects, among which is the continued co-sponsoring of the annual Problems Course, to be held at NAMI this coming October. Last year's presentation was a major success and the current plans call for more of the same format. Topics will be announced. The Board also voted to institute a Society sponsored research award, to honor a significant contribution to operational medicine by a Flight Surgeon. The award has yet to be named. It is proposed that it be given no more often than, but not necessarily, annually. In order to qualify, the results of the research must either be published in a peer-reviewed journal or presented at a scholarly conference. The selection will be made by the awards committee. Watch the Newsletter for additional information.

The Society will continue to offer binders and compilations of previous Newsletters as long as interest exists. Please write to the Secretary to place your order. We will also offer the lapel-sized 14K gold wings, as well as the full sized gold uniform wings. If interest is sufficient, we will offer gold miniature wings as soon as possible. Let us know if you want them.

Finally, the Board wishes to offer sincere thanks to CDR Steve Hart for an outstanding job as the out-going Secretary-Treasurer. The Society is a better organization for his efforts. Thank you Steve!

See you in October at the Problems Course.

CDR DAVE YACAVONE

NAMI NOTES

HYPERCHOLESTEROLEMIA

Multiple studies done in the last 10 years have demonstrated that elevated serum cholesterol is a risk factor for the development of atherosclerotic disease. The level of risk begins to increase above a serum cholesterol level of 180 mg/dl. The risk increases steadily as cholesterol level rises and there is no convenient "break point" which can be used to distinguish "normal" from "abnormal",

The Lipids Research Clinics Program (LRC) finished in 1984 a seven-year double-blind, prospective study, involving 3,806 subjects, on the effect of lowering plasma cholesterol through the use of cholestyramine. The 8% differential in cholesterol between placebo and treatment groups was associated with a 19% reduction in cardiac death or heart attack. This is the best planned and performed study in this area and gives the clearest indication that lowering cholesterol decreases risk of coronary artery disease (CAD). The results of this study

have been a catalyst to begin major public education, screening, and treatment programs, to decrease the enormous toll of CAD. In the Navy, routine serum cholesterol, HDL cholesterol, and triglyceride levels are now being drawn on all naval personnel. This screening process will help to identify those servicemen who are at increased risk for development of early CAD.

The decision points as to treatment, either dietary or pharmacologic, are more or less arbitrary and are based on national estimates of average, moderately elevated, and markedly elevated, risk levels. There is much room for individual modifications of treatment as well.

Decision Points for Counselling

	mg/dl	
Chol	<200	No counselling needed
Chol	200-220	Dietary counselling
Chol	220-260	Dietary review, dietary counseling
Chol	>260	Dietary review, plan specific diet Dietary consult if available Consider, pharmacologic intervention

Dietary Counselling

The following areas should be covered with the patient.

1. Increased risk of atherosclerosis with increased serum cholesterol.
2. Ability to reduce risk by lowering cholesterol.
3. Ability to reduce cholesterol by:
 - a. decreasing calorie intake to ideal
 - b. lowering body weight to ideal
 - c. decreasing cholesterol intake to < 300 mg/day
 - d. decreasing total fat content of diet
 - e. increasing percentage of polyunsaturated fats in diet
 - f. stopping smoking
4. Exercise may reduce cholesterol slightly, but does not substitute for dietary changes.
5. Dietary change needs to be life-long and is not temporary or a quick cure.
6. Progress may be slow and gradual, no quick results should be expected. Other areas may certainly be discussed. Dietary literature, handouts, etc. are encouraged. If a dietitian is available, consultation is appropriate and encouraged.

Decision to Treat Pharmacologically

Any patient whose serum cholesterol consistently stays above 260-280 mg/dl despite significant dietary changes, should be considered for drug therapy. If the problem is chiefly or solely cholesterol, drugs available include Nicotinic acid, colestipol, cholestyramine, probucol. The profiles of drug effects and side effects of these agents would suggest the best initial selection for aviators is cholestyramine. It is a resin and is not systemically absorbed, has only GI side effects, chiefly constipation, and it is readily

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NAMI NOTES (continued)

available. Its main drawbacks are cost* and palatability. Colestipol is also a resin with similar advantages and disadvantages.

*Cost to Pharmacy Navy Hospital, Pensacola is \$.47/packet with a usual dose of 1-2 packets with each meal. This results in a monthly cost of \$43.00-\$86.00. Nicotinic acid costs roughly \$20-\$60/month.

Dietary Review and Diet Plan

After dietary counselling has begun, it is of utmost importance to begin the patient on a specific dietary plan. This will include a calorie target, a designated amount of fat and cholesterol in the diet and a designated polyunsaturated to saturated ratio. These numbers can be derived from charts demonstrating ideal intakes of calories for height. Cholesterol intake should be < 300 mg/day. Percentage of dietary calories as fat should be kept to <30%. Charts of fat content, calorie counts and PIS ratio of foods are needed for patient (and physician) education.

The very process of calculating the diet will help the patient understand the requirements necessary to significantly lower body fat and cholesterol. It is important to stress the long-term nature of the required commitment. Do not pressure patients to change instantly if they seem reluctant. Changing one thing at a time (no eggs in the morning) may show the patient change is possible. Only the rare, motivated individual can change all dietary habits at once.

Discourage any type of fad diets by reminding the patient he needs to begin a diet he can live with all his life. New dietary approaches appear all the time (e.g. 3-omega fish oils) and some may prove to be beneficial but emphasize the experimental nature of these diets until more proof is available. These diets are almost always expensive.

Treatment

Lipid lowering medications are clearly indicated if:

- 1) There is evidence from serum lipoprotein electrophoresis of a congenital hyperlipoproteinemia (e.g. Type IIa with high cholesterol).
- 2) Despite dietary counselling, planning and adherence, serum cholesterol remains > 260-280 mg/dl.
- 3) There is evidence of atherosclerotic disease already existing in patient (e.g. angina, claudication).
- 4) Patient desires preventive therapy with serum cholesterol > 260 mg/dl.

The decision to treat must be made between the patient and the physician as this is preventive therapy. At this point cholestyramine and colestipol, two exchange resins, are preferred treatment in aviators as there is no systemic absorption. Side effects are constipation and long-term malabsorption of vitam-

ins A and D. Supplemental vitamins might be helpful to avoid deficiencies.

CDR R. G. OSBORNE
HEAD, INTERNAL MEDICINE DEPT.

MMPI PILOT NORMS

1. The Flight Surgeon performing a psychological examination on designated Naval Aviators may well be aware that mental characteristics of this group of people are atypical in comparison to the general population. Consequently, psychological evaluations, based on test parameters derived for the general population, provide misleading venues for the aeromedical examiner.
2. A series of normative studies established the utility and efficacy of personality testing in the aviation milieu. The Flight Surgeon may want to use these data for psychological formulations in regard to student and designated Naval Aviators. Using the MMPI with the "newly" derived norms has increased the level of confidence, at NAMI, when making aeromedical dispositions. Specific figures, research design etc. will be submitted for ASMA publication.
3. This note intends to quickly disseminate practical findings applicable to the Flight Surgeon. You can use the new norm for your squadron pilots. The "validity and the basic clinical scales" are printed in the following format: raw score mean followed by standard deviation for the scale. T scores (standard score) is computed by using the formula $T = 50 + 10 ((\text{raw score} - \text{mean}) / \text{standard deviation})$.

L = 4.3/2.0	Pd = 13.4/3.6
F = 3.1/3.0	Mf = 22.8/3.5
K = 19.0/4.2	Pa = 9.4/2.3
Hs = 1.8/2.1	Pt = 5.9/4.2
D = 16.6/3.3	Sc = 6.0/6.15
Hy = 19.5/3.9	Ma = 15.9/3.6
	Si = 17.7/6.4

4. Note there was no K correction added on scales Hs, Pd, Pt, Sc, and Ma. It was counter productive, thus not used for aviators.
5. Scale elevations indicative of emotional disturbance and traits incompatible with aviation safety were identified. Elevated D, Pt, and lowered K scores were highly correlated with grounding of pilots at NAMI. Note that these relatively elevated scales for grounded pilots were within the normal range for the general population.

You may want to share this information with the Psychiatry Department of your station. That way you can receive better mental health support. For further information, contact NAMI Psychiatry, AV 922-4238.

LCDR L. I. NAVRADSZKY MSC
CLINICAL PSYCHOLOGY
DIVISION OFFICER

CHANGE IN ATC PHYSICAL REQUIREMENTS

COMNAVMECOM MSG R172125ZJUN87 has eliminated the requirement for Navy ATC's to hold a Second Class FAA Certificate. ATC's are still required to have an annual flight physical in accordance with Manual of the Medical Department 15-77(8).

SATELLITE UPDATE

From time to time, an article will appear to give advice and guidance on the proper format of physicals, common errors and changes in the tests or procedures for satellite physicals for applicants to aviation programs. This edition is concerned with laboratory tests required by Chapter 15 of the Manual of the Medical Department. Change 100 of Chapter 15 mandates microscopic urinalysis (15-52(7)). Acceptable limits are 0-3 WBCs and 0-1 RBCs PER high power field. Chapter 15,52 (12)(c) requires serum total and HDL cholesterol and fasting blood glucose determinations on all initial physical examinations. Please make these changes on your future physicals.

LCDR M. R. AMBROSE MC
PHYSICALEXAMINATIONDEPT

GIANT PAPILLARY CONJUNCTIVITIS

About 30% of long-term soft contact lens wearers have a syndrome that's almost identical to vernal (spring allergy) conjunctivitis. Their symptoms of itching and burning are usually not as pronounced as vernal, probably because their corneas have become desensitized because of the daily use of contact lenses. Their bulbar conjunctiva is intermittently injected and their upper lid conjunctiva has about a hundred small or large whitish or reddish "bumps". These "bumps" give this syndrome its name, Giant Papillary Conjunctivitis. Their lower lid conjunctiva is mildly injected and has much less papillae. They usually have mild or marked punctate keratitis (fluorescein-stained dots on the cornea).

The treatment is simple: Stop wearing the contact lenses. In addition, topical steroid drops such as 1% prednisolone and 0.1 % decadron ointment at night bring more rapid resolution of the problem. No one knows whether the cause is the contact lens itself or the small deposits that tend to accumulate on the lens' surfaces. To properly evaluate the red eye, stain the corneas with a fluorescein strip. Then have the patient look down and "flip" the upper lid. In the case of Giant Papillary Conjunctivitis, you will discover the cause of the patient's red eyes.

CAPT P. T. BRISKA
HEAD,OPHTHALMOLOGYDEPT

2nd ANNUAL AEROMEDICAL PROBLEMS COURSE

Just a friendly reminder to mark your calendars for the

Aeromedical Problems Course to be held in Pensacola from 20-23 October 1987.

We have looked at a rather long list of topics which have been suggested, and it is apparent that there are many more issues of interest for discussion than time will allow. We will, therefore, select topics for inclusion with the widest coverage and which are most Fleet relevant. Panels and forums will be incorporated by popular demand. NALO Flights from East & West Coasts will be coordinated here.

We keep getting suggestions to invite speakers who are not U.S. Navy. Please remember that funding is not available for this course and we must make do with what we have. Several funding options have been suggested and have been or are being investigated. We will send out messages to the Force Med O's as plans firm up.

CDR G. G. REAMS MC
ACADEMICSDEPT

RESIDENTS CORNER

CRITERIA CHANGED FOR A POSITIVE WESTERN BLOT

A designated Naval Aviator was recently referred to NAMI for evaluation by the Special Board of Flight Surgeons after being found to be positive for the HIV antibody by multiple ELISA and Western blot analysis. The patient had been evaluated by Infectious Disease Service, at Naval Hospital, Portsmouth, and was diagnosed as HIV INFECTION, DOD CLASS I. The patient had no identifiable risks factors for HIV. Further tests, ordered in preparation for the Board, resulted in the patient being reclassified as HIV negative. The purpose of this article is to discuss the following questions that have arisen in association with this case:

1. What is a Western blot and what information does it yield?
2. What is the current criteria for a "positive" Western blot and how has it changed recently?
3. What supplemental tests in addition to Western blot are available and when are they indicated?

Before discussing tests to detect "HIV" infection" it might be helpful to review the basic characteristics of the AIDS virus. This human retrovirus consists of an outer envelope (a double layer of lipid material that is penetrated by glycoproteins) and an inner core (containing several types of proteins and molecules of RNA). The glycoproteins penetrating the outer envelope are made up chiefly of two components: gp41 spans the membrane and gp120 extends beyond it. Examples of core proteins include p17, p24, and p55. A specific viral enzyme ("reverse transcriptase") uses the HIV RNA as a template (in a "reverse" fashion compared with the usual DNA to RNA transcription) to assemble a corresponding double strand molecule of DNA in an infected cell. It is

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RESIDENTS CORNER *(continued)*

important to note that with the exception of viral cultures (a research tool) none of the currently available tests for HIV actually detect the virus itself -but rather detect antibodies produced by the human host against the various proteins and glycoproteins associated with the virus.

Initial screening of Naval personnel for HIV infection by enzyme-linked immunosorbent assay (ELISA) for antibodies to HIV carries a false positive rate (usually less than 1% but may be greater when ELISA testing is used to screen populations in whom the prevalence of HIV is low). ELISA positive reactions thus need confirmation by more specific methods such as the Western blot. Western blot is an example of an immunoelectrophoresis test (ie, if a mixture of proteins on an agar strip is placed in an electric field, each protein will migrate according to its intrinsic charge. Subsequent addition of suitable antibody will produce visible bands wherever antigenically distinct proteins are present.). The Western blot test thus detects antibody to any of several HIV proteins of specific molecular weights (e.g. "p24" represents a major group specific core antigen or "gag" protein with a molecular weight of 24,000 and "p41" represents an envelope protein of molecular weight 41,000). Initially Naval personnel were considered Western blot "positive" if their sera displayed antibodies to "at least bands p24 and or p41" (This criteria for a positive Western blot was consistent with CDC guidelines concerning screening of blood donors - published in MMWR of January 11, 1985). Specifically, personnel whose Western blot showed a p24 only or a p24/55 only were considered "positive". In fact the Naval Aviator described above displayed a Western blot pattern of "p24 only" and was thus considered positive for HIV infection.

Over the last several months newer, more specific tests for HIV infection (e.g. indirect fluorescence antibody and recombinant technology derived high molecular weight antigen employed in an anti-envelope antibody ELISA) have become available. Eventually newer generation assays may supplement the Western blot result. In addition, further studies have begun to better delineate the significance of band patterns such as p24 or p24/55 - once considered "early markers of HIV infection." THE LANCET, article (August 2, 1986) "Blood Donor Sera with False Positive Western Blot Reaction to HIV" describes a situation where 3 sera from Swedish blood donors were called Western blot positive (p24 and p55 present) and subsequent tests for HIV (competitive ELISA and immunofluorescence) were HIV negative. The article suggests that sera showing Western blot reactivities with p24 and/or p55 only should be tested by some other confirmatory assay.

The Navy (implementing DOD guidelines) has recently changed its criteria for a "positive Western blot" (see COMNAVMEDCOM R141927ZMAY87). Basically, until this change Navy Western blot results were considered

positive if they exhibited at least bands p24 and/or p41. Based on current scientific information, clinical studies and recommendations the Navy now interprets Western blot results as follows:

- a. a specimen is positive if it exhibits at least two of the bands at p24, gp41, or gp121/160.
- b. a specimen is negative if its Western blot exhibits no bands.
- c. if the Western blot exhibits other currently HIV associated bands (e.g. p24 only or p24/55 only) then additional testing is required.

Under current criteria (discussed in COMNAVMEDCOM R141927ZMAY87) in the case of the Naval Aviator discussed above the p24 Western blot pattern would have resulted in supplemental confirmatory tests being done which would have been negative. The report to the Aviators command would have stated "HIV negative" with no indication that any supplemental testing had been done or any indication that further evaluation of the patient was indicated.

Current information about this admittedly detailed and changing area may be obtained from CAPT Stek (MEDCOM code 241 at 294-1788 or 202-653-1788) or from CDR Hickey (MEDCOM code 313 at 294-0229 or 202-653-0229).

LCDR MYRON ALMOND
RESIDENT IN AEROSPACE MEDICINE

CONCERNS

What concerns me is what concerns *you*: "Me" should be construed to mean a concerned senior officer in the Medical Corps, an elected official in your society (SUSNFS), and, in August, a TYCOM medical "rep" (Force Medical Officer, AirLANT). Obviously, by now, you have concluded that I have been doing some thinking (which I have not been accused of doing very often, I admit). And "YOU", represent, for purposes of this narrative, the first or second tour Flight Surgeon, (or anyone slaving in the pits, trenches, or at the "grass roots" level), but can be anyone interested in Naval Air/Medicine and willing to read on:

The genesis of my *concern* began at ASMA, annual meeting, Las Vegas, last month. Two FSs' expressed concerns about the problems they faced in just doing their routine everyday jobs. Very real and legitimate problems. I am not sure if I offered any reasonable solution, outside the "sounding board", but I surely have not forgotten what their problems are. One of the most rewarding aspects of attending the annual ASMA meetings (and now the annual problems course at NAMI), are the opportunities we are afforded to interface with our colleagues and discuss (or even cuss) mutual problems and (hopefully) solutions. The SUSNFS Newsletter was

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CONCERNS *(continued)*

designed to be the alternative "direct" line of communication within our community (since only a small percentage of us can ever get together at anyone time) to provide current informative material, special instructions, and news items to *all* Flight Surgeons. However, unless I have been blind sided, most of the info communicated has been one way.....from NAMI STAFF and RAMS outbound. Most everything published comes from "in-house". Very few of you at the golf romeo (grass roots) level submit articles for the benefit of the organization.....your Society.

Our Naval Flight Surgeon community contains a wealth of talent and I am sure that we would all benefit bleeding off more of that wealth than has occurred in the past. The experts here at NAMI can fill up the Newsletter, no problem! But, taking this one step further: (another concern) Are the experts "in-house" fulfilling your needs? Are you reading what you need? Are you getting the necessary data to do your job? Did you get all the training, as a SFS, to do your job? If the answer to this interrogatory contains even one negative, then why have you not let someone know about it (anyone of your officer's of SUSNFS, for instance)? And if you choose not to rattle cages, letting apathy prevail, then SUSNFS can not help you, and our organization is not entirely effective, excepting to provide for lousy food but great Navy Day Luncheon speakers (and CONGRATULATE the CAPT Richard E. Leuhr's awardee) for those of us fortunate enough to come by a set of TAD orders to ASMA.

Another concern: Your SUSNFS does not necessarily have to limit itself to educational, anecdotal, or otherwise just interesting "stuff". What are the *real* problems existing for you as Flight Surgeons? Why are we losing so many "Quacks" to the white shoe side of the house, or worse, choosing CIVLANT? If the answer lies inherently within the domain of Naval Aerospace Medicine (also known as the system vs establishment), such as a lack of guidance, poor supervision, poor leadership by your superiors, etc., then may I ask why has SUSNFS not been made aware of the problems? Documenting and then letting your Society in on "what gives" could help a lot. Got a problem? Let SUSNFS know, and when appropriate, we can put it on the Agenda for action. Your SUSNFS officers would like to hear from the fleet "sailors". In the meantime, keep up the good work. And remember, most of us *are aware* that you FS's are doing a terrific job!

CAPT GEORGE E. HILL
Class of 87 (RAM)
Bd of Governors, SUSNFS
New Address: COMNAVAIRLANT,
NORFOLK, VA 23511-5188

GRADUATES**STUDENT FLIGHT SURGEON
CLASS 87002 5 JUNE 87**

David J. Barnette, Jr. LCDR, MC, USNR	Patrol Squadron FOUR (VP-4) Barbers Point, HI (FPO SF 96601-5901)
Phillip B. Beshany LCDR, MC, USNR	Marine Air Group 29 Marine Corps Air Station New River, Jacksonville, NC 28545
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GRADUATES *(continued)*

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Ronald N. Shull LT, MSC, USNR	Naval Aerospace Medical Research Laboratory Naval Air Station Pensacola, FL 32508
Tammy L. Smith LT, MC, USNR	Patrol Wing FORTY-SEVEN (VP-47) Naval Air Station Moffett Field, CA 94035-5000
Nicholas L. Webster LT, MC, USNR	Strike Fighter Squadron 127 (VFA-127) Naval Air Station Lemoore, CA 93245-0001

graduated from the University of Southern California. Dr. Stanton served in the Navy from 1956 to 1980 and was a member of the Medical Corps for 20 years. He was discharged with the rank of captain. He flew airsea rescue missions in Vietnam in 1963 and 1964. Dr. Stanton was a member of the American College of Cardiology, American Medical Association and the El Paso County and Colorado Medical Societies.

He was married April 9, 1962, in San Diego, Calif., to Carol Joan Magby, who survives.

Other survivors are two daughters, Karene Renee and Kathleen Denise, both of Colorado Springs; and a brother, John L. of Sacramento, Calif.

A son, Brian Curtis, died Oct. 14, 1986.

Our condolences to his family.

LUEHRS AWARD

LCDR David M. Brown, MC, USNR, COMNAVAIR-PAC, was selected as this year's recipient of the Leuhrs Award as Operational Flight Surgeon of the year. It was a tough decision for the Selection Committee and gets more so every year because of the outstanding accomplishments of the nominees. One thing is patently clear. The interest, attention, initiative, and industry of our flight surgeons has no bounds. Each has compiled an impressive record and deserves high praise. The nominees were as follows:

- LT Joseph P. Dervay, MC, USNR
COMNAVAIRLANT
- LT Matthew D. Gibb, MC, USNR
COMNAVAIRRESFOR
- LCDR Robert K. Hanson, MC, USN
3rd MAW
- LCDR David A. Kallman, MC, USNR
2nd MAW
- LCDR John B. Raff, MC, USNR
CNATRA

MOMENT OF SILENCE

DR. KEVIN C. STANTON

Dr. Kevin C. Stanton, 52 of Colorado Springs died March 24 in Memorial Hospital.

A cardiologist, Dr. Stanton was director of invasive cardiology at Memorial Hospital and served as chief of medicine there in 1985-86. He also was a consultant to the Federal Aviation Administration's general flight surgeon, surgeon general consultant for the Naval Hospital, an investigator for the Sky Lab Project and director of aviation medicine at the Naval Aerospace Medical Institute in Pensacola, Fla.

Dr. Stanton was born March 21, 1935, in Los Angeles and had lived in Colorado Springs since 1980. He

-- 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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