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Our Mission

The NGWRC provides education, advocacy and support for veterans suffering from the complexities of modern warfare; we specialize in Gulf War Illness with additional focus in Traumatic Brain Injury and Post-Traumatic Stress Disorder.

NGWRC Self-Help Guide

A Guide to Today's Toxic Wars

Information and Support for those involved in and transformed by today's wars.

Updated June, 2013

Distribution and Disclaimer

The contents of this guide are for informational purposes only and neither the National Gulf War Resource Center, Inc., nor its principals assume responsibility for the accuracy or veracity of the information contained herein. This guide is distributed freely to veterans, families, civilians, service providers and others interested in helping those who are ill, injured, or disabled due to the Persian Gulf War, Operation Desert Storm, Operation Iraqi Freedom, Operation Enduring Freedom, and other combat operations of the US Military. Please feel free to copy and distribute this Guide for educational, counseling, self-help, and scholarly purposes. We request only that proper credit be given. Any other use requires the written authorization of the National Gulf War Resource Center, Inc.

Acknowledgments

This updated Guide is the result of months of reviewing changes in regulations and science regarding Gulf War Illness and other conditions affecting veterans who served our country from 1989 to the present day, and turning that information into a reference veterans and their advocates can use. It is a core resource in our work to improve medical treatment and quality of like for these injured veterans.

The NGWRC thanks the following individuals and groups for their contributions to this guide:

The National Veterans Legal Services Program funded and developed the original Guide.

Dr. James N. Baraniuk, MD, Associate Professor with Tenure in the Department of Medicine, Georgetown University, helped us over the years in the areas of chronic fatigue syndrome and fibromyalgia. He conducts Studies on Chronic Fatigue Syndrome with Gulf War Illness.

Dr. Tim Rot works in the field of PTSD, and he reviewed the PSTD chapter of this Guide. I would like to thank him for giving of his free time to help our veterans.

Col. (Ret) George Webb, U.S. Army, was the Executive Director of the Kansas Commission of Veteran Affairs for 5 years. He worked closely with the project that produced a world renowned study on gulf war illness in 2001 commonly called 'The Kansas Study' by Lea Steele PhD.

Cpt. David Winnett, jr. U.S.M.C. (Ret) is the past president and mentor to the Executive Director. He helped identify important research, reviewed drafts of this Guide, and helped in more ways than can be recounted here. He has been on the CDMRP for a number of years to advance our cause.

William Ankenbauer, jr. is a retired DAV service officer and adviser to the NGWRC. He provided invaluable insight and advice on how a veteran may develop his or her claim and work as a team with their VSO Rep. Bill worked when DAV had their school and great National Service Officers like JM.

Ron E. Brown is the acting president and identified much of the research referred to in this Guide.

Lisa Cornett helped review and proofread this guide, among her many contributions to NGWRC.

Tonia Goertz took time out of her her profession, writing for a living, to advise us in the work of making this Guide useful and readable for as many veterans as possible.

Brent Casey reviewed the drafts and contributed ideas.

Paul Davidson edited and organized this edition of the guide.

Finally, we thank the past leaders and members of the NGWRC who wrote previous editions of this guide and performed the advocacy work which allows many veterans to receive care and benefits today that they could not get a few years ago.

-James Bunker, Executive Director

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INTRODUCTION

The NGWRC

Veterans and non-veterans run the National Gulf War Resource Center (NGWRC). We help veterans affected by the 'invisible' injuries most common in the current conflict period, from 1989 to the present day. These injuries include Gulf War Illness (GWI), Traumatic Brain Injury (TBI), and Post-Traumatic Stress Disorder (PTSD).

We are among the most successful Veterans' Organizations in the United States advocating for veterans affected by GWI. We formed shortly after the Persian Gulf War of 1991. Our work has been critical in establishing the rights, treatments, and benefits which these veterans have access to now. Our work is far from done. GWI is still poorly understood and incurable. While no longer in complete denial, the VA and the Department of Defense (DOD) misuse GWI research funds and ignore recommendations from the scientific community that may lead to better treatment. Claims for VA benefits related to GWI are still difficult to prove.

Since Operation Desert Storm, later conflicts, including Operation Enduring Freedom and Operation Iraqi Freedom, have brought many new claims for other 'invisible' injuries, TBI and PTSD, as well as a reduced frequency of new Gulf War Illness cases among recent veterans deployed in and near Iraq. We expanded the original guide to include these conditions. In the last 20 years, we distributed over 200,000 copies of this guide; this 11th edition is a key resource to helping recent combat veterans.

The term 'Gulf War Veteran' refers to any a veteran who served in Southwest Asia during Operations, Desert Shield/Storm, Iraqi Freedom, Enduring Freedom or any other operations with dates from August 1990 until the present day. We work with veterans who have served since 1989 until today no matter the Area of Operation.

Purpose of this Guide

When people are injured on-the-job in civilian work, their employers must pay for related medical treatment and provide compensation. If you are a veteran with injuries or disabilities incurred in the line of duty, you have earned the right to medical treatment and compensation for conditions connected to your service. The VA provides this care and compensation after you are discharged.

Common war injuries like Gulf War Illness (GWI)/Chronic Multisymptom Illness (CMI) and Post-Traumatic Stress Disorder (PTSD) are difficult to diagnose. GWI was not recognized by the scientific and medical community for several years after the events which first caused it.

If you are an ill or injured veteran this is your *Guide* to understanding GWI [including Undiagnosed Illness (UI) and medically unexplained CMI's], ALS, Traumatic Brain Injury (TBI), and PTSD. This guide focuses on what you need to know in order to file a claim with the Department of Veterans Affairs (VA) for disability compensation benefits you have earned as a result of your injury in service.

Information on technical research and legislative developments was moved to the appendices in order to focus on what you need to file a claim or get help and support. If you are reading a guide more than one year old, please visit our website, www.ngwrc.org, to see if it has been updated, and to learn of any important developments in research and benefits.

Chapter I – General information for all Claims

The burden of proof

When you are injured in the line of duty, you earn treatment and compensation for that injury. However, you still have to prove that your injury occurred, is currently disabling, and is connected to your service. Among veterans, as in the civilian world, a small number of individuals make false claims while others make honest but erroneous claims. On the VA side, some adjudicators do not understand injuries like PTSD and GWI/CMI, and a few actively promote misinformation about them. These factors combine to create a complex claims adjudication system which places a heavy burden on veterans. Read on to understand how to build your claim with the facts and increase the chance that you will be treated fairly.

No matter what condition or injury you live with as a result of your service, you have a burden of proof to meet before the VA will grant you the benefits you have earned.

The basic burden of proof carries two components.

- Medical evidence of a current physical or mental disability, **AND**
- Evidence of a relationship between your disability and an injury, disease, or event in military service. Medical records or medical opinions are usually required to establish this relationship.

In some cases, this is a high burden of proof. However, for most of the illnesses and injuries discussed in this guide, the VA has additional rules which ease the burden of proof for many veterans. The rules are different for each condition, so read each chapter carefully if it applies to you.

Develop the lay evidence – testimony of signs, symptoms, and behaviors

This guide focuses on 'less visible' and 'invisible' conditions which affect veterans. In many cases, you and the people in your daily life will see symptoms, signs, or changes in behavior weeks, months, or years before you receive a diagnosis. These may begin while you are still in the military. Developing a written record of the changes, as observed by yourself and those around you, is a critical step in preparing your claim. Develop a record that goes back to the time changed first began if possible. These statements may also help your doctor provide a more accurate diagnosis and measure the extent to which it is disabling.

Here is an example of the importance of lay testimony related to Chronic Fatigue Syndrome (CFS) – imagine yourself as a veteran with severe CFS going to see your doctor. During your few minutes with the doctor, you are fully responsive. You appear normal, fit, and able-bodied. However, your boss at work knows that you call in sick more than anyone else, you need more and longer 'smoke breaks', and you tire out long before the day ends, dragging yourself out of the work place at the end of the day. You are highly motivated and productive, but it is clear that your output is compromised from what it would be if you were healthy. Your partner at home sees that you barely move from the time you get home until the time you have to leave for work the next day, and that you rest all weekend, no longer able to do yard work, go shopping, or go out for social activities like you used to. In this case, lay testimony can prove you are much more disabled than the initial doctor's report will suggest. That affects whether you receive the compensation you deserve or get a much smaller benefit instead.

As you read this guide, highlight the symptoms you have. Create a list of symptoms to share with your doctor. For each symptom, list the start date, how often per [day, week, month, or year] you experience it, and how bad it gets. Every detail you take time to spell out helps you make your case.

Have your loved ones keep a note book on you that describes your health problems and their effects on your life. The notes of your loved ones can be used to write a narrative which supports your claim.

Remember to ask loved ones, co-workers, and friends you served with to write down any changes in your behavior in addition to other symptoms, and ask them to mention when those changes began. They may be more aware of the changes than you are. Evidence of changes in behavior can be important to help diagnose conditions affecting many post-1990 veterans.

Keeping track of your symptoms like this will not only help you with your doctor, but help you write up your statement for your claim. The notes of your daily write-up can also become a part of your claim to help in setting your rating amount.

Statements in Support of Claim

Statements in Support of Claim are Lay evidence presented in the format which the VA requires in order to consider them as part of your case.

You should write a statement in support of claim [VA form 21-4138] for each condition you are claiming. You may also have family members, co-workers, friends, and people you served with fill out this form. Download the form at http://www.va.gov/vaforms/form_detail.asp?FormNo=21-4138.

Get statements from those that you served with during the war if there are parts to your claim that will need these statements. Find those you served with after the war and people who have known you since your discharge. If they saw evidence directly, or if you complained to them, they can write statements about your different symptoms, or about how your behavior changed. While these statements

cannot diagnose your problems, they can attest to what they observe directly, or they can describe a conversation in which you complained of symptoms or how those symptoms affected you.

Be sure each statement is signed and dated. Make sure it has a a line which states: to the best of my knowledge, this statement is true (VA form 21-4138 already includes this). Take a copy of all supporting statements to your Veterans Service Organization Representative (VSO Rep). Make sure you keep the originals.

The perspective of a doctor

Doctors are professionals. Their job is to find out what is going with your body today and determine the best treatments to help you with that. As you work with them, focus on what they need to know to help you now.

When you are giving a doctor information about your medical condition, focus on information related directly to it. What are the symptoms you have now? How severe are they? How do they affect your work and other daily activities? When did they begin? Have they gotten worse or better over time? Does this doctor have full access to your medical records, or do you need to obtain copies of some records and bring them to him or her?

If you go beyond this and begin focusing on specific events that you think caused the condition, or on how you believe you were wrongly ignored or improperly treated in the past, you may end up with a referral for mental health treatment instead of the medical care and diagnoses you need to manage your disability and support your claim for compensation from the VA.

Most of the types of claims listed in this guide are *presumptive* for most of the veterans that file them. If you are part of the qualified group, you are not going to need an 'as likely as not' medical opinion to prove that your injury is connected to your service. You don't need to prove the connection, and trying to do so can be a distraction to providing you with the best medical care.

In the event that you are the exception, that you do need a medical opinion linking your diagnosis or symptoms to your military service, focus on what your doctor needs to know in order to write that letter to support you. In such a case, yes, the doctor will need to know about the event which you believe caused the disability. That is the only extra thing he or she needs to know directly from you. The rest of what your doctor needs are copies of – or links to – scientific and medical research, journal articles, and reports or opinions from other doctors, which support your 'at least as likely as not' position.

If you need an 'as likely as not' letter, try to say just one or two sentences about your date and location of exposure and the onset of your symptoms, then give your doctor a copy of your DD-214 and SMR's that relate directly to those. Bring copies of the relevant pages of an Institute of Medicine report, medical journal article, or other peer-reviewed information from the medical and medical science communities which supports your position. If the doctor's letter requires that you establish onset of symptoms by a certain date, include written statements from other people about when the symptoms manifested. Let the doctor review that so he or she may write the letter based on medical evidence rather than your opinions.

Obtain a diagnosis from a medical professional

You cannot diagnose yourself with any of the conditions in this guide. Only a doctor may do that. In the case of PTSD, which is a mental health condition, the diagnosis must come from a psychologist or

psychiatrist. In any case, your primary care doctor may refer you to a specialist and require testing before determining your diagnosis.

After getting your lay evidence together, take the information with you to your next doctor appointment. Open up a dialogue with the doctor assigned to you as your Primary Care Provider (PCP). Share any chapter of this guide which applies to your claim if it is outside your doctor's normal expertise. Your doctor needs to assess your symptoms, and in some cases, he or she will need to order specific tests and exams to help you meet a burden of proof. The regional VA office which adjudicates your claim may order the same tests and exams; however, you have a stronger claim if they have already been done by, or at the instruction of, a doctor who you know and trust.

When you, as a veteran, encounter difficulties at a VA medical facility you may contact the *patient advocate* at that location for assistance in resolving the problem. If that does not work you may move up the ladder until you get the help you need. In some cases, you may be assigned a doctor who does not understand your injury or who is unwilling or unable to help you.

If you have a doctor who will not work with you, the patient advocate is there to help you get things worked out. Your team social worker and the patient advocate can help you get a different doctor. Do not suffer with a doctor that will not help you.

If you are using a Community-Based Outpatient Clinic (CBOC), you may have to go to a VA Medical Center in order to see a different doctor. A CBOC may not have enough flexibility or staff to change your PCP.

Additional medical evidence

Medical evidence is crucial to your claim. Try to provide only medical evidence which is relevant.

Provide a copy of all relevant medical evidence you have from non-VA doctors. While you may be filling out a VA 21-4142 to grant permission to obtain medical records, the Regional Office (RO) cannot always get the files from private doctors. Outside doctors sometimes ask the VA to pay for making copies, and the VA will not pay for copies. Get a copy for yourself and keep it. Make another copy to give to the VA.

If a civilian doctor's office asks you to pay for copies of your medical records (as many do), let them know that you are a military veteran and need the copies in order to apply for Veterans Disability Benefits. Many doctors and/or their office staff will waive their normal copy fee as an act of good will in honor of your service. If the doctor's office offers to fax or mail your records to the VA for you, politely decline. Tell them you plan to make a copy for yourself first and then mail the records to the VA personally, via certified mail, so you will have proof that the VA received them. Tell them that the VA is notorious for losing and misplacing records.

Go through your service medical records if you have them. Make a copy of the records which are relevant to your claim and include that copy in the material for the VA.

If you have a record showing that you cut your finger in basic training, or anything else that does not support the claim you are filing, leave it out of the copies you send to the VA. Making the ratings officer try to find the needle which proves your claim is valid, in a haystack of other records that have nothing to do with your claim, will not help you.

Disability Benefits Questionnaires (DBQs)

If you use a private, non-VA doctor to help you prepare a Fully Developed Claim (FDC), they will need to fill out Disability Benefits Questionnaires (DBQs) related to your diagnoses and symptoms. Only doctors may fill out a DBQ. You may download or print the correct forms for your doctor in advance, by going here: http://www.benefits.va.gov/COMPENSATION/dbq_disabilityexams.asp .

The VA may order a Compensation and Pension (C&P) examination by a VA doctor regardless of the evidence you provide. The VA doctor should also use DBQs as part of your C&P exam.

There are some diagnoses for which no DBQ is available. Your private doctor may still provide a medical opinion in support of your claim; however they will not be able to use a DBQ in relation to that diagnosis. In most of these cases, the VA will require you to get an exam from one of its doctors.

Find a Veterans Service Organization Representative (VSO Rep)

It is always an advantage, regardless of the nature of the disorder underlying a claim for benefits, to have an accredited veterans service organization representative (VSO Rep) assist you in the prosecution of a claim for VA disability compensation. These individuals may be called a veterans service representative (VSR) or a veterans service officer (VSO). In any case, the VA accredits them as a VSO Rep. You should only have an accredited VSO Rep working on your case, and you can search the database of the VA Office of the General Counsel (OGC) to determine if a VSO Rep is currently accredited or not at http://www.va.gov/ogc/apps/accreditation/index.asp .

You may also use that link to find a VSO Rep. If you want to work with a particular Veterans Service Organization, or with your State Veterans Affairs office, go directly to their website to locate a VSO Rep who works for them. In some states, there are county VSO Reps.

All accredited VSO Reps are familiar with veterans benefits law and procedures, and they can provide more effective representation than trying to handle the claim yourself. Some are volunteers, and others are paid for by tax dollars or private donations. They may not charge you for their services.

Keep in touch. You should talk to your representative at least once per month while your claim is pending. Whenever you get mail from the VA, call your representative to make sure that he or she received a copy (as required by VA regulations) and that you understand exactly what it means.

Ask questions. If you do not understand something about your claim, ask. Part of your VSO Rep's responsibility is to ensure that you understand the claims process.

Exercise your judgment. Your VSO Rep is charged with acting in your best interests. However, you are the ultimate decision maker with respect to your claim. Your VSO Rep will tell you if he or she disagrees with what you want to do and why. He or she can make recommendations but must do as you instruct. The law permits VSO Reps to resign if there are fundamental disagreements.

Insist that your VSO Rep:

- discuss your case with you;
- be familiar with your VA claims file and all of the evidence;
- be able and willing to discuss the specific VA regulations related to your case and what evidence is needed to prevail;
- discuss your case and what to anticipate with respect to personal hearings;

- submit a written statement to the VA before a personal hearing. He or she should let you read the statement before it is submitted.

Although it can be a difficult task, shop around for the best advocate. Talk to the prospective representative; ask if there are any limits on his or her representation. Get a feel for the person who will be working for you before you sign a power of attorney appointing him or her as your representative.

When should you consider a *VA accredited attorney* or *claims agent*?

A VA accredited attorney or claims agent may charge you a contingency fee, a percentage of the back benefits you are awarded when your claim is granted, in return for representing you to the VA as you pursue your claim. This is money out of your pocket, and VSO Reps (no cost to you) are well qualified to represent veterans for most claims. If you have a claim which has already been denied once, and you are looking for highly specialized representation from someone who can spend more time on your individual case, then you may consider an accredited attorney or claims agent to help you pursue your claim.

You may look for accredited individuals in your area using the same OGC database where you would locate VSO Reps, at http://www.va.gov/ogc/apps/accreditation/index.asp .

You may need an attorney if your case is going before the Court of Veterans Appeals or to a higher court. If your case is at the Board of Veterans Appeals or your Regional Office, either an attorney or a claims agent may help you with the case.

Interview anyone you are considering. You may even ask for and contact references before you allow them to represent you. You should find someone who has specific expertise with claims for your type of disability, and who has a proven track record of success. In other respects, you should treat your attorney or claims agent as you would treat a VSO Rep.

Prepare and file your application for benefits

Now it is time to file the claim, and to do so you will need to have all your documents together.

If you never filed a claim before, there are certain documents you should have. They are your DD-214, your marriage certificate [and if you are no longer married, your divorce papers], and paperwork on your children or any other dependents. You need your DD-214 to show when you served in the military. If your claim is rated at 30% or higher, you will receive extra compensation for your spouse and any children under 18 that you claim as dependents.

Gather your Statements in Support of Claim, Medical Evidence from private doctors, and any military records in your possession which support your claim. Keep the original of every document for yourself, and make a copy for the VA. There are several forms involved in preparing and presenting your claim for disability compensation to the VA. Your VSO Rep can help you figure out which forms are needed, and how to get them filled out properly. You may find links to many of the forms below.

You should apply for benefits as soon as your claim is complete. An incomplete claim may be denied; however, each month that passes by without filing is a month of benefits you give up forever.

Talk to your VSO Rep about whether you should apply for benefits other than disability compensation. This guide focuses on that type of claims. For an overview of all VA benefits, go to http://benefits.va.gov/benefits/ .

If you and your VSO Rep believe that the evidence you are presenting is complete and no additional information is needed to grant the claim you are seeking, you may go through the VA's Fully Developed Claims (FDC) Program, described below, to receive a faster decision.

If your claim is missing some records which may help your case, and you want to VA to try to obtain those records before it makes a decision, you should use the traditional claims process, which will take longer to complete. In the long run, your benefits will still go back to the date on which your application is received.

Your VSO Rep will help you make sure all the appropriate forms and evidence are together with your application. Once that is done, the application may be mailed or scanned and filed electronically.

What is a Fully Developed Claim?

The Fully Developed Claims (FDC) Program was developed to provide a faster decision to veterans who are able to fully prepare their own claim for benefits. A VSO Rep will help you with this. FDC is the fastest way of getting your compensation or pension claim processed.

To participate, you provide all private (non-government) medical and lay evidence which you want to be considered, attached to your original claim. You then inform the VA that they don't need to spend time looking for it. Participation in the FDC Program allows for faster claims processing but preserves your right to appeal a decision. Information is at http://benefits.va.gov/transformation/fastclaims/ .

Where to find the forms for your claim

To file a *claim for disability compensation*, use Veterans Benefits Administration (VBA) form 21-526. You may download this form at: http://www.vba.va.gov/pubs/forms/VBA-21-526EZ-ARE.pdf . Form 21-526 and other VBA forms are at http://www.benefits.va.gov/COMPENSATION/index.asp .

To make a *statement in support of claim*, or to get a statement from your friend, comrade, co-worker, or family member, use form 21-4138: http://www.va.gov/vaforms/form_detail.asp?FormNo=21-4138 .

To download or print *Disability Benefits Questionnaires* (DBQs) for your private doctor, go to http://www.benefits.va.gov/COMPENSATION/dbq_disabilityexams.asp . Only doctors may fill out a DBQ. Please use form 21-4138 for all other statements in support of your claim.

There are no DBQs for the following medical examinations: Initial Examination for Post-Traumatic Stress Disorder, Hearing Loss and Tinnitus, Residuals of Traumatic Brain Injury**,** Cold Injury Residuals, Prisoner of War Examination Protocol, Gulf War Medical Examination.

You can request a copy of your *service medical records* from the National Personnel Record Center (NPRC) in St. Louis, Mo., using a Standard Form 180, Request Pertaining to Military Records. This form is available from your representative or any VA office. You can also apply for a copy of your service records online http://www.archives.gov/veterans/military-service-records/ .

The NPRC Fire of July 1973 destroyed many Army and Air Force records of personnel discharged between 1912 and 1964. If you were discharged after Jan 1, 1964, or if you served in the Navy or Marines, your records were not burned, and you should be able to obtain a copy. Source: http://www.archives.gov/st-louis/military-personnel/fire-1973.html .

What to do when you disagree with *part* or *all* of the VA's decision

The first step in appealing a claim is to send your VA Regional Office (VARO) a "Notice of Disagreement" (NOD). There is no official NOD form. Generally, the NOD can be a written statement on VA Form 21-4138 (Statement in Support of Claim) or a letter that states that you disagree with the decision. Be sure to include in your NOD the date of the decision that you disagree with, which issues you disagree with, and that you intend to appeal those issues. You have ***one year*** from the date of the VA's notice of its decision to file your NOD with your VARO. If you miss this deadline, you can only reopen your claim based on new and material evidence or establishing that the VA denial was the product of clear and unmistakable error (which is very difficult to prove). The other exception to these conditions occurs when VA regulations regarding your disability change, as they did with PTSD in 2010. In that case you may have the right to re-open your claim based on the change in regulations.

You do not help yourself if you simply dump a pile of loose records on the VA. Organize the records and explain their significance in a letter you and your VSO Rep prepare together. Once the VARO makes a decision with respect to your claim, you (and your VSO Rep) will receive a notice of that decision which explains the reasons for the VA's determination. Read the notice carefully and discuss it with your representative. Your appeal should address specific reasons why the VA should not have denied a claimed condition, why an awarded rating is too low, or why an effective date is too late.

After the VARO receives your NOD, you should receive a letter that acknowledges your NOD. You will be asked whether you wish to have your appeal sent to the Board of Veterans' Appeals (BVA) in Washington, D.C., or whether you wish to have your claim reviewed on a *de novo* basis. The latter refers to the VA's Decision Review Officer (DRO) program. This is an informal appellate process within each VARO. The DRO has the authority to reverse or modify a VA rating board decision. We recommend that you seek DRO review before you request a BVA appeal. The DRO process is frequently successful and is generally faster than going straight to the BVA. If you do not receive a better decision from the DRO, you can still appeal to the BVA.

Once the DRO has made a decision or has received your request for BVA consideration, the VA will issue a "Statement of the Case" (SOC). This document will explain the VA's decision(s) in detail. You have 60 days from the date of the SOC to file your substantive appeal to the BVA on VA Form 9: http://www.va.gov/vaforms/form_detail.asp?FormNo=9. Your appeal will be certified and forwarded to the BVA for consideration.

You are entitled to one copy of your entire VA claims file (or C-file) without charge. If you have ever had any official contact with the VA that relates to a claim for benefits, your claims file should contain all of the service and post-service medical records that the VA has, as well as any correspondence to or from the VA and adjudication-related documentation.

Survivors' Benefits

Sometimes a veteran's survivors, including spouses, children and dependent parents may apply for service-connected death benefits (Dependency and Indemnity Compensation or DIC program) or for non-service-connected death benefits (pension program). For example, a survivor might be able to show that a veteran with service-connected PTSD died as a consequence of a disease that was secondary to PTSD, *e.g.*, cardiovascular disease, substance abuse (in certain cases). A VSO Rep is able to help the survivor with this type of claim.

What are the compensation rates?

To find the current VA disability compensation monthly payment rates, please go to the VA website at www.va.gov. From the homepage, click on "Compensation", then on "Rate Tables". Additional monthly payments may be available based on the beneficiary's number of dependents.

Filing a claim while still active duty military

If you are currently serving on active duty in the U.S. Military, including a mobilization of your Reserve or Guard unit, you may apply for VA disability compensation if both of the following are true:

- *You know your date of separation, retirement, or release from active duty or mobilization*
- *That date is no more than 180 days away*

To get started, you may go to http://www.benefits.va.gov/PREDISCHARGE/index.asp. Filing sixty days before your separation date will usually allow you to receive benefits within 60 days of discharge.

As you enter into this process, make sure to *report everything,* even the ringing in your ears. If you carried heavy loads around, and you were sore for days afterward at least once, you should report that, even if you feel fine now. These are only two examples – go through every part of your anatomy, every way in which your thoughts and emotional state have changed. If it might possibly interfere with your work or your relationships, now or *ever*, report it as a possible disability.

While this process makes it much easier than it once was to receive the benefits you are due as soon as you leave the military, it also makes it easier to deny anything you forget to mention, or which you believe doesn't matter … now.

Many disabilities will be evident in a thorough and complete exam if you direct the doctor to look for them. Some of them degenerate over time, causing you pain and interfering with your ability to work. Repetitive stress to your back, for example, may not even slow you down today. However, it may have set in motion degradation of a disk, or created some other issue, which will degenerate and be truly disabling in several years. Hearing loss and many other conditions develop in much the same way – getting worse over time.

Remember to get a complete copy of your own Service Medical Record (SMR) before you leave. A VA claims adjudicator may miss evidence that supports your claim when they are reviewing your file. If you can make a copy of the relevant information and highlight it for them, it makes your case much easier to appeal, if you need to, than simply telling the VA 'well, it's in there'.

Once you have a copy of your SMR, keep it forever. If someone else needs information from it, make a copy of what they need and give them the copy.

Chapter II – Claims for *Gulf War Illness* and Infectious Diseases

General information for all CFR 38, §3.317 claims

Chapters II-V deal with claims for presumptive service-connection for Gulf War Illness (GWI)/Chronic Multisymptom Illness(CMI) [Persian Gulf & Iraq Veterans – CFR 38, §3.317(a)] and Infectious Disease Claims [Persian Gulf, Iraq & Afghanistan Veterans – CFR 38, §3.317(c)]. Persian Gulf/Iraq claims for presumptive service connection require that you serve in the Southwest Asia Theater (SWAT) during the time period of 1990-current*. Afghanistan service related claims cover a period of service from 2001 to current.

If you believe you have an infectious disease claim, most of what you need is in Chapter V.

If you have a medically unexplained chronic multisymptom illness, aka Gulf War Illness, whether it is diagnosed or not, you will need to read most of this chapter. You will also need to refer to whichever parts of Chapter III and Chapter IV are related to your symptoms and diagnoses.

What is Gulf War Illness and who may file a claim for it?

Gulf War Illness (GWI) refers to a sickness first documented among veterans of Operation Desert Shield and Operation Desert Storm in 1990-1991. More than one in four of these veterans still experience a wide range of unexplained symptoms, such as fatigue, pain, and problems with digestion, for which there is no visible cause or explanation. Most have had this condition since their deployment or soon after it.

It took years of strong advocacy by the veterans themselves before the much of the medical community, including the VA, accepted GWI as a medical disorder. Today, the exact cause remains unknown. Scientific research proves that, whatever the cause, the disability is real and it is likely related to military service in the Persian Gulf region. Treatment methods and compensation ratings for this condition are still evolving.

Scientists and Medical Researchers now use the term medically unexplained Chronic Multisymptom Illness (CMI) instead of Gulf War Illness (GWI). They mean the same thing. CMI is a more inclusive term which applies to all people affected by the disorder. Exposures present in the Southwest Asia Theater (SWAT) of Operations greatly increased the risk of CMI among Gulf War Veterans.

The National Academy of Sciences (NAS) Institute of Medicine (IOM) uses the following definition in its 2013 report: *Gulf War and Health: Treatment for Chronic Multisymptom Illness* (page *x* in the preface):

> We defined CMI as the presence of a spectrum of chronic symptoms experienced for six months or longer in at least two of six categories—fatigue, mood and cognition, musculo-skeletal, gastrointestinal, respiratory, and neurologic—that may overlap with, but are not fully captured by, known syndromes (such as irritable bowel syndrome, chronic fatigue syndrome, and fibromyalgia) or other diagnoses.

That is the current scientific definition of what we commonly call GWI. In the rest of this guide, we will refer to definitions and symptoms based in Federal Law and used in VA regulations and guidelines, even if they are not updated to reflect the most recent scientific research. When you as an Iraq or Persian Gulf veteran file a claim for compensation related to GWI/CMI, you are filing for presumptive service-connection of a qualifying chronic disability.

Qualifying chronic disability, under 38CFR§3.317(a)(2)(i), means a chronic disability resulting from any of the following or any combination of the following:

(A) An undiagnosed illness;

(B) A medically unexplained chronic multisymptom illness that is defined by a cluster of signs or symptoms, such as

1. Chronic fatigue syndrome (CFS)
2. Fibromyalgia;
3. Functional gastrointestinal disorders (excluding structural gastrointestinal diseases).

This chapter deals with undiagnosed illness claims, the (A) in the list above.

The VA does not recognize the term “Gulf War Illness” as a compensable disability. It uses the term *medically unexplained chronic multisymptom illness* (CMI) instead. The VA does compensate veterans who have it when they file claims using the definitions it recognizes. CFR 38, §3.317(a) and §3.317(b) address the CMI's commonly called Gulf War Illness.

The VA grants presumptive service-connection to 'Persian Gulf Veterans' for medically unexplained CMI's which are rated at least 10% disabling, and which manifest the disabling symptoms for at least six consecutive months before the end of 2016. It does not matter whether the CMI is an undiagnosed illness, a diagnosis named in §3.317(a)(2)(i)(B), a diagnosis not specifically named but which meets the criteria, or some combination of those. If the illness meets basic criteria, and it occurs in a veteran who served in the 'Southwest Asia Theater', it is Gulf War Illness, i.e. a CMI which is eligible for presumptive service connection.

If you have Gulf War Illness or any medically unexplained CMI, and you meet the definition of Persian Gulf Veteran (1990-current* period of service in Southwest Asia) you may file for disability compensation under *CFR 38, section 3.317 - Compensation for certain disabilities occurring in Persian Gulf veterans.*

To keep it simple, we may call this a '3.317(a) claim' in this chapter. That means the same thing as a claim for Gulf War Illness. A '3.317(c) claim' may apply to a claim for certain infectious diseases, covered in Chapter V. Both CMI and infectious disease claims are '3.317 claims'.

What is Persian Gulf War Service (1990-current*)

Only a 'Persian Gulf Veteran' – *a term which* ***includes OIF,*** *Desert Storm****,*** *and most other Iraq veterans* – may file §3.317(a) claims. A Persian Gulf Veteran is any current or former member of the United States Armed Forces who served in the Southwest Asia Theater of Operations for at least one day between August 2, 1990 and the current date*.

This includes, but is not limited to, serving in Operation Desert Shield, Operation Desert Storm, Operation Iraqi Freedom, and Operation New Dawn (Iraq theater).

The VA defines the Southwest Asia Theater (SWAT) of Operations as:

- Iraq
- Kuwait
- Saudi Arabia
- The neutral zone between Iraq and Saudi Arabia
- Bahrain
- Qatar
- The United Arab Emirates (U.A.E.)
- Oman
- Gulf of Aden
- Gulf of Oman
- Waters of the Persian Gulf, the Arabian Sea, and the Red Sea
- The airspace above these locations

You must meet these time and location criteria in order to receive service-connected status under 3.317. Source http://www.publichealth.va.gov/exposures/gulfwar/basics.asp

*The VA is considering an 'end date' to 'Persian Gulf War Service' of December 18, 2011, the last day of Operation New Dawn. If this 'end date' is eventually approved, you will need to show evidence of SWAT service between August 2, 1990 and December 18, 2011 to gain presumptive service-connection.

Which military operations are included?

This is not a complete list. If you meet the criteria, you may file, whether you officially served in one of these operations or not. These are the four large 'umbrella' military operations in which 'Persian Gulf Veterans' have served.

- Operation Desert Shield
- Operation Desert Storm
- Operation Iraqi Freedom
- Operation New Dawn

What about Afghanistan?

Service in Afghanistan after September 19, 2001, may grant you presumptive service connection for a number of *infectious diseases,* covered in Chapter V. These are 3.317(c) claims, but they are not *medically unexplained chronic multisymptom illnesses*. If you served in Afghanistan, but not in the Southwest Asia Theater, you cannot make a 3.317(a) claim for a *medically unexplained chronic multisymptom illness.*

If you have a *medically unexplained chronic multisymptom illness* or a similar illness which you believe is service-connected, but you do not meet the definition of a Persian Gulf Veteran as the VA defines it, you may still file a claim. You may still receive benefits. However, you will have a higher burden of proof, and the claim will not fall under 3.317.

What about the rest of the **Global War on Terror** *or even* **Cold War** *claims of similar nature?*

If you served abroad, you exhibited symptoms of any infectious disease endemic to that region where you served, and those symptoms emerged within one year of your discharge, you have a sound basis to make a claim for compensation related to that disease to the extent it is disabling. You may have a higher burden of proof – the 'presumptive' service connection covered in chapters II-V, at its essence, just allows for a lower burden of proof.

Likewise, if you have a disease which may have been caused by chemical or other exposures in your military service, foreign or domestic, you may file a claim for compensation. Your burden of proof is higher, and it will not be a 3.317(a) claim.

You can win these claims if you take time to meet the burden of proof, and it will change your life for the better when you do. Please carefully research your claim before you file it and contact the NGWRC if we may help.

Where is the current regulation posted?

Go to http://www.benefits.va.gov/warms/bookb.asp and scroll down to 3.317 to download it. These regulations change frequently. You should download it when you are working on your claim. Make a second copy and give it to your Veterans Service Organization Representative (VSO Rep) with your other documentation, unless you have a VSO Rep who already specializes in Persian Gulf Claims.

Starting your claim

GWI/CMI claims are difficult to prove. They involve a combination of undiagnosed symptoms and illnesses which, by definition, are medically unexplained. Because of this, Congress lowered the burned of proof. If you have the symptoms or the medically unexplained illnesses, and you served in the Southwest Asia Theater (SWAT) of Operations after 1990, the VA will presume that your illness is service connected.

You must document your symptoms and their severity, sort out which have become parts of a diagnosis and which remain undiagnosed, and prove your SWAT service in order to establish your claim.

CRITICALLY IMPORTANT CLAIM PROTOCOL

Sometimes, Iraq and Persian Gulf veterans have both diagnosed conditions and undiagnosed symptoms which can be claimed under §3.317(a). Once a symptom is 'claimed by' a diagnosis, it may no longer be claimed as part of 'undiagnosed illness'.

Sorting out your symptoms and your diagnoses is important to building a strong claim for compensation under §3.317(a). If you have a medically unexplained CMI diagnosis, you need to file for that under §3.317(a)(2)(i)(B). You need to remove all symptoms related to your diagnosed CMI's from any claim you might make for undiagnosed illness under §3.317(a)(2)(i)(A).

Here is the complete list of signs and symptoms of qualifying Chronic Multisymptom Illnesses, quoted directly from §3.317(b):

1. Fatigue.
2. Signs or symptoms involving skin.
3. Headache.
4. Muscle pain.
5. Joint pain.
6. Neurological signs or symptoms.
7. Neuropsychological signs or symptoms.
8. Signs or symptoms involving the respiratory system (upper or lower).
9. Sleep disturbances.
10. Gastrointestinal signs or symptoms.
11. Cardiovascular signs or symptoms.
12. Abnormal weight loss.
13. Menstrual disorders.

You may be wondering how to be a little *more specific*, and how it helps your claim when you are. Your claim is strongest if you can match up your symptoms to show that they cover at least two of the six categories in the Institute of Medicine (IOM) definition of CMI. Here is an outline of each of the six IOM categories, and some of the symptoms which the match up with them:

category – *fatigue*: fatigue

category – *mood and cognition*: symptoms of feeling depressed, difficulty in remembering or concentrating, feeling moody, feeling anxious, trouble in finding words, or difficulty in sleeping

category – *musculo-skeletal*: symptoms of joint pain, joint stiffness, or muscle pain

category – *gastrointestinal*: abdominal pain, substernal burning or pain, nausea, vomiting, altered bowel habits (including diarrhea, constipation), indigestion, bloating, postprandial fullness, and painful or difficult swallowing

category – *respiratory:* shortness of breath

category – *neurologic*: [often overlaps with the other five] tremor, paralysis of a limb, speech difficulties, headaches, generalized muscular pains particularly following exertion, seizures or falls, paraesthesia, anorexia with weight loss, chest complaints, isolated non-epileptic seizures, debilitating multiple neuropathies

In addition, skin disorders, chest pain, heart palpitations, abnormal weight loss, menstrual disorders, and any other symptoms that fall under the thirteen *signs and symptoms* should be explained and defined to the best of your ability before you begin this type of claim.

Please remember that each symptom must be a '*medically unexplained symptom*' in order to qualify you for compensation under 38CFR**§**3.317(a). Other medical diagnostic terms with similar meaning to '*medically unexplained*' are '*functional*', '*somatoform*', and '*idiopathic*'. If your doctor uses any of those words to define the cause of your symptoms, or to diagnose them, they are usually '*medically unexplained*'.

As you prepare your claim, remember to list all your symptoms which fall under these categories, and each diagnosis. Match up the symptoms to the diagnoses you have, so that you don't include a 'diagnosed symptom' in a claim for undiagnosed illness. If you also have a Traumatic Brain Injury (TBI) or a Post-Traumatic Stress Disorder (PTSD) diagnosis, consult with your doctor and your VSO Rep about where to assign overlapping symptoms which may result from more than one of those causes. You may be able to list symptoms under more than one diagnosis, but you may never list those same symptoms as 'undiagnosed'.

Here is an example for a veteran who *does not* have TBI or PTSD:

diagnoses the veteran has	*symptoms the veteran has*
Chronic Fatigue Syndrome-CFS	~~unrefreshing sleep~~ *CFS*
Irritable Bowel Syndrome-IBS	~~multi-joint pain without swelling or redness~~ *CFS*
	~~muscle pain~~ *CFS*
undiagnosed symptoms	~~a sore throat that is frequent or recurring~~ *CFS*
	~~significant impairment of short-term memory/concentration~~ *CFS*
neuropathies	~~diarrhea some days~~ *IBS*
paralysis of left arm	~~constipation other days~~ *IBS*
	~~bloating~~ *IBS*
	~~mucus in stool~~ *IBS*
	multiple medically unexplained debilitating neuropathies
	medically unexplained paralysis of left arm

In the above case, the veteran has been diagnosed with CFS and IBS **[***CFR 38, §3.317(a)(2)(i)(B)*]**.** He or she will file claims for both of those. He will not file a claim for the nine symptoms related to either CFS or IBS. This veteran also has multiple medically unexplained debilitating neuropathies and medically unexplained paralysis of left arm. Because those last two symptoms have not been tied to a diagnosis, they may still be claimed as undiagnosed illness [*CFR 38, §3.317(a)(2)(i)(A)*]. The veteran will make a total of four §3.317(a) claims: CFS, IBS, neuropathies, paralysis.

If you have been diagnosed with at least one CMI – CFS, FM, IBS, some other functional gastrointestinal disorder, or any diagnosed condition which falls under the CMI rule – make sure you file for ***each one*** as a separate, unique ***presumptive service connected disability due to your Persian Gulf service, per section 3.317 of title 38 of the CFR***.

It is important that this wording is together with these illnesses on your claim forms.

Remember: most adjudicators are not doctors, and these are unusual claims. This wording tells them where to look up the law which should guide their determination. If you don't help them find the information they need to resolve your claim fairly, there is a good chance they won't.

On many occasions, VSO Reps have left this wording out, and valid claims were denied.

After you have listed each diagnosis, continue with individual symptoms which are undiagnosed. Each of the undiagnosed symptoms is filed in a similar fashion. "I am filing a claim for headaches as a presumptive service connected disability due to my service in the Gulf War per section 3.317 of title 38 of the CFR."

The form 21-526 (claim for disability compensation) will let you list each symptom due to the gulf war, but you should also fill out a 21-4138 (statement in support of claim) and list out each of your symptoms in a statement. Fill out a separate 21-4138 for each symptom. This will keep it clean.

Lay evidence - *Build a record of your symptoms to prove your case*

Any statement provided by someone other than a health care professional is lay evidence when presented as part of a claim for disability compensation to the VA.

Lay evidence is an important part of a claim for any medically unexplained CMI, diagnosed or not. The first and most important source of lay evidence for your claim is you. Once you have your symptoms all written out, and a log of when they occur, how often they occur, and how severe they are, you may take that to your doctor as the starting point to build up medical evidence.

First, keep a log of your own that details your symptoms. Use as much detail and description as you can. Here are a couple example symptoms and how you should explain them in your own log:

If you have *headaches*, do not just say "I have a headache and it lasts all day", describe every detail of the headache. Answer all of the following questions. What is the onset like? Does it feel like it starts in a specific spot? Where is that? Does it move from one place in your head to another? Does it feel like it grows to affect a larger area over time? Where does it expand to? How long does it take? Does the pain increase in each place affected, or only cover more territory? Are you still able to work with the headache? Does it affect your temper? Does it make it hard to write, type, or do calculations? Does it make it hard to walk, use your hands in manual labor, or play an instrument? Are you incapacitated, forced to sit in a chair or lie in bed, doing nothing else, until the headache subsides or goes away? What were you doing when the headache started? Does the headache start during the day, night or both? How long does it last and do you have more than one type of headache? Does it ever go away completely?

If you have *diarrhea,* do not just say "I have diarrhea all the time." You need to state exactly how many times a day you go to the bathroom. Example: "When the diarrhea comes I have use to the stool about [seven] times, once every [30 minutes] over a period of [three to four hours]. At least once during that time, I cannot leave the bathroom at all for [about an hour]. This happens [once or twice a day], about [10 times every week]." Re-write that in a way that accurately describes your experience, and you have something that will help your claim. You will have to state how it comes on; how long it lasts, any pain or discomfort, and whether or not you have constipation afterward. State if you take any medication for the diarrhea, whether it's over-the-counter or prescribed, and whether it is working or not.

For each of the symptoms, you should be going to your doctor at the VA, or at least calling the VA and asking what to do. This is not only to get treatment for your symptoms, but to build a paper trail to support your case. These calls to the VA usually go into your file. Your medical file establishes a record of the number and severity of your symptoms which helps you establish your claim.

Look carefully over all the chronic multi-symptom type illnesses in Chapter IV and the diagnostic criteria that the VA has for some of these illnesses. If you believe you may have an illness such as chronic fatigue syndrome (CFS), talk to your Doctor about it. If you are likely to be diagnosed with CFS or fibromyalgia, make sure to account for that in developing your claim before you continue to the undiagnosed illness part of the claim. If you have enough information to rule those out, proceed with your undiagnosed illness claim in chapter III.

Statements in Support of Claim

You should write a statement in support of claim [VA form 21-4138] for each diagnosed CMI you are claiming, and for each symptom of undiagnosed illness. You may also have family members, co-workers, friends, and people you served with fill out this form. The form can be downloaded as a fillable PDF form at http://www.va.gov/vaforms/form_detail.asp?FormNo=21-4138.

Work with a Veteran Service Organization Representative (VSO Rep) to complete & file a claim

Find a VSO Rep, often called a *Veterans Service Officer* outside the VA, with knowledge and experience specific to Gulf War claims, and have him or her help you file your claim. It is important that you specifically mention that you are *claiming a presumptive service connection due to your service in the Southwest Asia Theater (Persian Gulf) per section 3.317 of title 38 of the CFR*. As you get into specific forms, the 21-526 will let you list each symptom due to the gulf war. However, you should also fill out a 21-4138 and list out your symptoms in a statement. Fill out one 4138 per symptom.

If you are filing for CFS, fibromyalgia (FM), IBS, or any other diagnosed CMI which is medically unexplained, please refer to Chapter IV of this guide. Each will be filed in a similar fashion, *and each must mention that you are filing it as a presumptive service connection due to your service in the Southwest Asia Theater (Persian Gulf) per section 3.317 of title 38 of the CFR.*

Chapter III: Gulf War Illness/CMI Claim – Undiagnosed Illness

[CFR 38, §3.317(a)...(A)]

Introduction

This is a guide to filing a claim for disability compensation for Undiagnosed Illness in Persian Gulf Veterans. What we in common language call *Gulf War Illness (GWI)* be *either* an *undiagnosed illness or* a *medically unexplained chronic multisymptom illnesses*, such as, but not limited to, chronic fatigue syndrome (CFS), fibromyalgia, functional gastrointestinal disorders.

This chapter covers only undiagnosed illness covered in [CFR 38, §3.317(a)(2)(i)(A)].

If you have been diagnosed with a *medically unexplained chronic multisymptom illness* such as CFS, fibromyalgia, or a functional gastrointestinal disorder, please go to Chapter IV for those specific diagnoses. You may get a faster response on your claim by filing under the diagnosis. Filing for undiagnosed illness at the same time may delay your claim.

This chapter only addresses the part of your claim related to undiagnosed symptoms.

Undiagnosed Illness in Persian Gulf Veterans – Who may file a claim?

If you have undiagnosed symptoms of Gulf War Illness/Chronic Multisymptom Illness, and you served in Iraq or the Persian Gulf while in the US Military after 1990, you may file a claim as long as the symptoms manifest before the end of 2016. Please refer to page 17 in Chapter II for detailed definitions of Persian Gulf War Service (which includes most OIF and other Iraq veterans) and the Southwest Asia Theater (SWAT) of Operations.

If you have a *medically unexplained chronic multisymptom illness* or similar illness which you believe is service-connected, but you do not meet the definition of a Persian Gulf Veteran (nearly all Iraq veterans count as 'Persian Gulf' veterans) as the VA defines it, you may still file a claim. You may still receive benefits; however, you will have a higher burden of proof, and the claim will not fall under 3.317(a). Please contact the NGWRC if we may help you file a claim related to undiagnosed or unexplained illness which may be related to chemical or other exposures outside SWAT.

Preparing a claim for undiagnosed illness

A claim under section 3.317(a) for undiagnosed illness can be one of the hardest ones to work. Many veteran service organization representatives (VSO Reps) have a hard time preparing these claims or appealing a denial. DO NOT file for one of the 38CFR§3.317(a)(2)(i)(B) presumptive illnesses listed

on page 16 unless you have a diagnosis of that illness. If you have a 38CFR§3.317(a)(2)(i)(B) illness, refer to Chapter IV. Use the information in this chapter to help prepare a claim for undiagnosed illness, or for specific symptoms which have not been associated with any diagnosis.

If you have a diagnosed illness with the same symptoms, but it is not listed on page 16 and is not a medically unexplained chronic multisymptom illness as outlined in the regulation, then you should file under a different section of VA regulations. You do not have a 3.317(a) claim for presumptive service connection.

List your signs and symptoms, and separate out those which are undiagnosed

List out each and every one of the symptoms that you have. As you list each symptom, include the date it first appeared – you may refer to page 19 in Chapter II for the list of signs and symptoms. Once you have all your symptoms listed, sort out those which are undiagnosed, covered here, and those which are part of a diagnosis, covered in Chapter IV. An example of how to do that is listed on page 20 in chapter II.

If you have a diagnosis, such as Chronic Fatigue Syndrome (CFS), remember to list only those symptoms which are *not* CFS (or any other diagnosis) in your claim for undiagnosed illness. You may claim both the CFS and the completely undiagnosed symptoms, but they are separate issues in the VA's eyes. If you confuse the issues in your claim, that may delay your claim. It may even increase your claim's chance of being denied by confusing the adjudicator.

For CFS, FM, IBS, or any other '*medically unexplained*', '*functional*' or '*somatoform'* diagnosis, refer to Chapter IV for that part of your claim.

There is a presumptive end-date, December 31, 2016, for the symptoms to manifest, but you may file your claim after that date as long as you have a record of symptoms going back to 2016 or earlier.

Refer to Chapter II for details related to filing your claim.

Key elements that must be established in your claim

To receive a rating for undiagnosed illness in Persian Gulf veterans, you need to prove the following to the VA:

1. US Military Service in the Southwest Asia Theater between 1990 and the current date*.
2. You have some of the thirteen 'signs and symptoms' but no diagnosis to explain them.
3. The symptoms began before the end of 2016. Go back as far as you can.

*The VA is considering an 'end date' to 'Persian Gulf War Service' of December 18, 2011, the last day of Operation New Dawn. If this 'end date' is eventually approved, you will need to show evidence of SWAT service between August 2, 1990 and December 18, 2011 to gain presumptive service-connection.

Chapter IV: Gulf War Illness/CMI Claim – Qualifying Diagnosed Conditions

[CFR 38, §3.317(a)...(B)]

Introduction

This is a guide to filing a claim for disability compensation if you have been ***diagnosed*** with a *medically unexplained chronic multisymptom illness* (CMI) such as, but not limited to, chronic fatigue syndrome (CFS), fibromyalgia (FM), or a functional gastrointestinal disorder like irritable bowel syndrome (IBS).

What we in common language call *Gulf War Illness* (GWI) is always a CMI. It can be *either* an *undiagnosed CMI or* a *medically unexplained CMI diagnosis*.

This chapter covers only diagnosed CMIs covered by [CFR 38, §3.317(a)(2)(i)(B)]. To make a claim for Undiagnosed Illness in Persian Gulf Veterans, please go to Chapter III.

If you have both diagnosed CMIs and undiagnosed symptoms, make sure to file a claim for each diagnosis first. Never include symptoms of your diagnosed CMI's (such as CFS, FM, or IBS) in your claim for undiagnosed illness.

If you confuse the issues in your claim, that may delay your claim. It may even increase your chance of denial by confusing the adjudicator. Some veterans have success by filing only for their diagnosed CMI's first. Then, after those claims are granted, they go back and file for any remaining undiagnosed symptoms.

What counts as a *medically unexplained chronic multisymptom illness?*

CFR 38, §3.317(a)(2)(i) reads as follows:

For purposes of this section, a *qualifying chronic disability* means a chronic disability resulting from any of the following (or any combination of the following):

(A) An undiagnosed illness;

(B) A medically unexplained chronic multisymptom illness that is defined by a cluster of signs or symptoms, such as:

(*1*) Chronic fatigue syndrome;

(*2*) Fibromyalgia;

(*3*) Functional gastrointestinal disorders (excluding structural gastrointestinal diseases).

Sub-paragraph (B)(1-3) is this chapter's topic.

Your claim is ***not*** *limited to* CFS, FM, or functional gastrointestinal disorders. Any diagnosis you have which meets the '*signs and symptoms*' criteria, and which is also *chronic, multisymptom*, and *medically unexplained*, can be used to file a claim under CFR 38, §3.317(a)(2)(i)(B)

Medically unexplained has a very similar meaning to '*functional*', '*somatoform*', and '*idiopathic'* in medical terminology when diagnosing a condition. If your doctor diagnoses you with something, and you think it may be related to your service in Iraq or the Persian Gulf, it is appropriate to ask more questions about the diagnosis, to find out if it is '*medically unexplained', 'functional*', or '*somatoform*'. If the illness is also *chronic* (you have it for longer than six months), and *multisymptom*, either by itself or together with other medically unexplained conditions, then it may be part of your claim for VA compensation under CFR 38, §3.317(a)(2)(i)(B).

Please refer to page 19 in Chapter II for a complete list of 'signs and symptoms' associated with CMI related to Persian Gulf or Iraq service.

Are they all Gulf War Illness?

All illnesses named in CFR 38, §3.317(a)(2)(i)(B), or which meet the same criteria, have been determined by law, after scientific review of medical studies, as being 'at least as likely as not' connected to service in the Southwest Asia Theater (SWAT) in the year 1990 or later. So, in that sense, whether you have 'undiagnosed illness', CFS, FM, IBS, or a similar *somatoform* diagnosis not specifically named in the CFR, you have 'Gulf War Illness'.

What makes these CFR 38, §3.317(a)(2)(i)(B) diagnoses different from undiagnosed illness?

In truth, each of the CMI's covered by CFR 38, §3.317(a)(2)(i)(B) contains a subset of symptoms which closely overlaps at least one of the symptoms associated with Gulf War Illness. However, once you have the diagnosis, you are required by law to file for compensation benefits under that diagnosis, not claim it as 'undiagnosed illness'. If you have additional symptoms which fall outside the definition of your diagnosis, you may still claim those symptoms separately as 'undiagnosed illness'.

Filing your Claim

Why are diagnosed CMI's done as a separate claim from undiagnosed illness?

If you file in a way that is essentially asking the VA to compensate you twice for the same symptom (e.g. once as part of CFS and again as part of undiagnosed illness), it is highly likely that your claim will be delayed, denied, or both.

What diseases are specifically mentioned in CFR 38, §3.317(a)(2)(i)(B)?

The section mentions CFS and FM by name. It also lists several functional gastrointestinal disorders: irritable bowel syndrome (IBS), functional dyspepsia, functional vomiting, functional constipation, functional bloating, functional abdominal pain syndrome, and functional dysphagia.

Remember, you may claim any diagnosis which meets the criteria, whether it is listed here or not.

What diseases other than those named in CFR 38, §3.317(a)(2)(i)(B) are allowed?

There is no list for the 'other' diagnoses. Each regional office, and frequently each individual claim adjudicator, is on their own when trying to determine if a diagnosis meets the criteria of *medically unexplained CMI* and *the 13 signs and symptoms*, or not. While you must, by law, file any diagnosis under CFR 38, §3.317(a)(2)(i)(B) whether that particular diagnosis is listed there or not, the burden of proof is more like undiagnosed illness. The difference is: now you need to prove that the diagnosis meets a subset of the criteria, which are the same whether the condition is diagnosed or not.

First, if the diagnosis is not one of those named in the CFR, make sure you can establish in your claim that your diagnosis meets, i.e. strongly overlaps, the criteria of explained in Chapter II starting on page 19. You should have a doctor sign an affidavit to that effect if possible.

Most adjudicators are not doctors; if it is not on their list, they may simply deny it unless you go the extra mile to prove the case to them.

If you have been diagnosed with at least one CMI – CFS, FM, IBS, some other functional gastrointestinal disorder, or any diagnosed condition which falls under the CMI rule – make sure you file

for ***each one*** as a separate, unique ***presumptive service connected disability due to your service in the Gulf War, per section 3.317 of title 38 of the CFR***.

How are Chronic Fatigue Syndrome (CFS) and Fibromyalgia (FM) alike?

Fibromyalgia and chronic fatigue syndrome are very similar illnesses. In fact, up to 70% of their symptoms overlap. Overlapping symptoms include:

A. muscle pain
B. fatigue
C. irritable bowel symptoms
D. cognitive dysfunction
E. sleep disorders

They can be *Concurrent Disorders*. It is possible to suffer from both fibromyalgia and CFS at the same time. In fact, between 20% and 30% of fibromyalgia sufferers have CFS. 35% of chronic fatigue patients also have fibromyalgia. It has been theorized that CFS is actually a sub-disorder of the fibromyalgia syndrome.

Why is it so important to get tested for CFS (if you already have FM)?

You may be asking yourself: *What difference does it make if you have CFS or FM?*

The VA may grant you a 100% service-connected disability rating on CFS by itself, $2,816.00 per month, if the symptoms are severe enough. The highest rating allowed for FM is 40%, $569.00 per month. That is a difference of up to $2,247.00 in untaxed compensation every month, for two different veterans with no dependents – identical symptoms but different diagnoses (the FM diagnosis being incomplete or incorrect). If you have a family, the amount – and the loss of income – is greater; all because you got the wrong diagnosis, FM alone, when you really have CFS (either instead of, or in addition to, FM).

Many veterans who meet the criteria for CFS never get properly tested for CFS. Instead they are diagnosed with FM only, denied the compensation they deserve because of that.

There is a specific test for CFS. Make sure you get that test done, and you know the results, before you file a claim for any CMI. If you have CFS, and your symptoms are severe, it may bring you more benefits than any other one condition.

Chronic Fatigue Syndrome (CFS)

Chronic fatigue syndrome (CFS) is a condition that makes you feel so tired that you can't do all of your normal, daily activities. There are other symptoms too, but being very tired for at least 6 months is the main one. Myalgic encephalomyelitis (ME) is another name for CFS. Sometimes you will see the acronym ME/CFS used to refer to CFS.

The illness is characterized by prolonged, debilitating fatigue and a characteristic group of accompanying symptoms, particularly problems with memory and concentration, unrefreshing sleep,

muscle and joint pain, headache, and recurrent sore throat. It is marked by a dramatic difference in pre- and post-illness activity level and stamina.

CFS shares various symptoms with many illnesses, including fibromyalgia, lupus, Lyme disease, sleep apnea, narcolepsy, untreated hypothyroidism, chronic hepatitis and depression.

The disease is not well understood. Most experts now believe that it is a separate illness with its own set of symptoms, but some doctors do not believe this.

There is no simple test for CFS, making it difficult to recognize. The process of 'testing for CFS' is really a battery of tests to rule everything else out. Because it is hard to diagnose, many people have trouble accepting their disease or getting their friends and family to do so. Having people who believe your diagnosis and support you is very important. Having a doctor you can trust is critical.

Your tiredness is real. It's not "in your head." It is your body's reaction to a combination of emotional and physical factors. In the case of most SWAT veterans with CFS, it is the body's reaction to a complex combination of unhealthy exposures and conditions acting together to create the illness.

Diagnostic Resources

The Centers for Disease Control created resources to assist health care professionals in diagnosing and managing CFS. It may work best if you can get your doctor to spend time browsing the resources, but you may also print out resources for your care giver, your VSO Rep, and perhaps even to go with your claim. They may be accessed here: CFS Toolkit and additional information for health care professionals

What causes CFS?

Of all chronic illnesses, CFS is one of the most mysterious. Several possible causes have been proposed, including:

1. Depression
2. Iron deficiency anemia
3. Low blood sugar (hypoglycemia)
4. History of allergies
5. Virus infection, such as Epstein-Barr virus or human herpes virus 6
6. Dysfunction in the immune system
7. Changes in the levels of hormones produced in the hypothalamus, pituitary glands or adrenal glands
8. Mild, chronic low blood pressure (hypotension)
9. An autoimmune process causing inflammation of certain nervous-system pathways
10. A viral infection complicated by a dysfunctional immune response
11. A low blood pressure disorder that triggers the fainting reflex

A good link for up to date information is this one at the Mayo Clinic.

Symptoms similar to those of CFS sometimes have straightforward, correctable causes, such as:

1. An active, identifiable medical condition that often results in fatigue

2. Medication side-effects

What are the symptoms?

A CFS diagnosis should be considered in patients who present with six months or more of unexplained fatigue accompanied by other characteristic symptoms. These symptoms include:

1. cognitive dysfunction, including impaired memory or concentration
2. postexertional malaise lasting more than 24 hours (exhaustion and increased symptoms) following physical or mental exercise
3. unrefreshing sleep
4. joint pain (without redness or swelling)
5. persistent muscle pain
6. headaches of a new type or severity
7. tender cervical or axillary lymph nodes
8. sore throat

Other Common Symptoms

In addition to the eight primary defining symptoms of CFS, a number of other symptoms have been reported by some CFS patients. The frequency of occurrence of these symptoms varies among patients. These symptoms include:

1. irritable bowel, abdominal pain, nausea, diarrhea or bloating
2. chills and night sweats
3. brain fog
4. chest pain
5. shortness of breath
6. chronic cough
7. visual disturbances (blurring, sensitivity to light, eye pain or dry eyes)
8. allergies or sensitivities to foods, alcohol, odors, chemicals, medications or noise
9. difficulty maintaining upright position (orthostatic instability, irregular heartbeat, dizziness, balance problems, or fainting)
10. psychological problems (depression, irritability, mood swings, anxiety, panic attacks)
11. jaw pain
12. weight loss or gain

Clinicians will need to consider whether such symptoms relate to a comorbid or an exclusionary condition; they should not be considered as part of CFS other than how they can contribute to impair functioning.

Finding the right doctor

The more you know about CFS the better prepared you'll be when trying to find a doctor. It's a difficult process, and you may need to educate a few health-care professionals along the way. Be sure you know the list of symptoms and become familiar with the various ways CFS is treated.

The crux of the problem is that no medical specialty has "claimed" CFS, so finding a knowledgeable doctor isn't as easy as with most illnesses. Even fibromyalgia, which is considered closely related to CFS, falls under the auspices of rheumatology. CFS is not well understood, and many health-care providers have a hard time recognizing it. Some don't even believe it is an actual condition.

This means that the burden of finding someone qualified to treat you falls squarely on your shoulders. However, you have a number of resources to use in your search.

1. **Your primary care provider**
   If your regular doctor isn't well educated about CFS, see if he or she is willing to learn or knows of someone who is more knowledgeable.
2. **Other care providers**
   If you see a physical therapist, massage therapist or chiropractor, ask whom he or she would recommend.
3. **Local support groups**
   People involved in local support groups likely will be able to recommend qualified doctors. To find a support group in your area, you can check with your doctor, local clinics and hospitals.
4. **Advocacy groups**
   CFS advocacy group websites may be able to help. Check out this patient-recommended "good doctor" list from Co-Cure.
5. **Friends, family and associates**
   Talk to everyone you know to see if they can recommend a doctor, or whether they know someone with CFS who may be able to recommend one. While most people aren't qualified to say whether a doctor is competent, they can tell you whether he or she is compassionate, patient and willing to go an extra mile for you.
6. **Referral services** Check with local clinics and hospitals to see if they have referral services. Also, call your insurance company to see if they have any doctors listed as specializing in CFS.

How is CFS diagnosed?

A CFS diagnosis is not based on one single test, but a battery of tests, measurements of symptoms, and questionnaires, done to rule out other possibilities and ultimately give the diagnosis of CFS. You may learn more about the protocol from the Centers for Disease Control by following this link: http://www.cdc.gov/cfs/diagnosis/ .

You cannot self-diagnose CFS. Many other health problems can cause fatigue, and most people with fatigue have something other than chronic fatigue syndrome.

How is CFS treated?

There is no treatment for CFS itself, but many of its symptoms can be treated. A good relationship with your doctor is important, because the two of you will need to work together to find a combination of medicines and behavior changes that will help you get better. Some trial and error may be necessary, because no single combination of treatments works for everyone.

Home treatment is very important. You may need to change your daily schedule, learn better sleep habits, and start getting regular gentle exercise.

Counseling and a gradual increase in exercise help people with CFS get better.

Even though it may not be easy, keeping a good attitude really helps. Try not to get caught in a cycle of frustration, anger, and depression. Learning to cope with your symptoms and talking to others who have the same illness can help you keep a good attitude.

Fibromyalgia (FM)

Fibromyalgia (FM) is a syndrome predominately characterized by widespread muscular pains and fatigue. The causes of FM are unknown. There are difficulties in diagnosing FM. Its clinical picture can overlap other illnesses, and there are no definitive diagnostic tests. Patient education, pharmacologic agents, and other nonpharmacologic therapies are used to treat FM. Exercise has been found to improve outcomes for people with FM. The medical community's understanding of this disease is evolving. For more in-depth and up-to-date information, visit the websites of the Mayo Clinic or the Centers for Disease Control.

Symptoms

Signs and symptoms of FM can vary, depending on the weather, stress, physical activity or even the time of day.

Widespread pain and tender points

The pain associated with FM is described as a constant dull ache, typically arising from muscles. To be considered widespread, the pain must occur on both sides of your body and above and below your waist.

Fibromyalgia is characterized by additional pain when firm pressure is applied to specific areas of your body, called tender points. Tender point locations include:

1. Back of the head
2. Between shoulder blades
3. Top of shoulders
4. Front sides of neck
5. Upper chest
6. Outer elbows
7. Upper hips
8. Sides of hips
9. Inner knees

Fatigue and sleep disturbances

People with FM often awaken tired, even though they seem to get plenty of sleep. Experts believe that these people rarely reach the deep restorative stage of sleep. Sleep disorders that have been linked to FM include restless legs syndrome and sleep apnea.

Co-existing conditions

Many people who have fibromyalgia also may have:

1. Chronic fatigue syndrome
2. Depression
3. Endometriosis
4. Headaches

5. Irritable bowel syndrome (IBS)
6. Lupus
7. Osteoarthritis
8. Post-traumatic stress disorder
9. Restless legs syndrome
10. Rheumatoid arthritis

Test for FM

The American College of Rheumatology has established two criteria for the diagnosis of FM:

- Widespread pain lasting at least three months
- At least 11 positive tender points — out of a total possible of 18

Tender points

During your physical exam, your doctor may check specific places on your body for tenderness. The amount of pressure used during this exam is usually just enough to whiten the doctor's fingernail bed. These 18 tender points are a hallmark of FM.

Blood tests

While there is no lab test to confirm a diagnosis of FM, your doctor may want to rule out other conditions that may have similar symptoms. Blood tests may include:

1. Complete blood count
2. Erythrocyte sedimentation rate
3. Thyroid function tests

Because many of the signs and symptoms of FM are similar to various other disorders, you may see several doctors before receiving a diagnosis. Your family physician may refer you to a rheumatologist, a doctor who specializes in the treatment of arthritis and other inflammatory conditions.

What you can do

You may want to write a list that includes:

1. Detailed descriptions of your symptoms
2. Information about medical problems you've had in the past
3. Information about the medical problems of your parents or siblings
4. All the medications and dietary supplements you take
5. Questions you want to ask the doctor

What to expect from your doctor

In addition to a physical exam, your doctor may check your neurological health by testing your:

1. Reflexes
2. Muscle strength
3. Muscle tone
4. Senses of touch and sight
5. Coordination
6. Balance

Associated Conditions of Fibromyalgia

Fibromyalgia has often been called the "great imitator" because so many of its symptoms mimic those of other disorders. As a result, it can often be difficult to receive a proper diagnosis of FM. However, there are subtle differences between many of the illnesses and FM. Learning more about each of these disorders can help you figure out just how FM is distinct from them.

Common disorders that fibromyalgia is often mistaken for include:

1. Lyme disease
2. Lupus
3. Osteoarthritis
4. Rheumatoid arthritis
5. Cushing's syndrome
6. Hypothyroidism
7. Polymyalgia Rheumatica
8. Reflex sympathetic dystrophy syndrome
9. Cervical spinal stenosis

A rheumatologist can run the tests which you need to rule out the above nine conditions. Only after you test negative for each of these, can you be diagnosed with FM. It is possible to have hypothyroidism and FM at the same time – but in that situation, you cannot win a claim for FM until the other condition has been treated and stabilized for six months, and the FM symptoms persist.

People with FM are also at greater risk of developing a number of other disorders, many of which can exacerbate FM symptoms, or are linked to certain conditions which may lead to fertility problems. Illnesses, diseases and conditions that fall into this category include:

1. Irritable Bowel Syndrome
2. Osteoporosis
3. Endometriosis
4. Carpal Tunnel Syndrome
5. Sjogren's syndrome
6. Crohn's disease
7. Multiple Sclerosis
8. Raynaud's Phenomenon
9. Chronic Fatigue Syndrome
10. Anemia
11. Morton's Neuroma
12. Seasonal Affective Disorder
13. GERD
14. Interstitial Cystitis
15. Yeast Infections
16. Bruxism
17. Low Cytokine Levels
18. Hypoglycemia

Fibromyalgia can also affect the way your body functions. FMS impacts the following systems:

1. Cardiovascular System
2. Nervous System

FM can also impact your libido, which in turn affects sexual intimacy. Find out why FM affects your sexual desire and learn about tips to improve sexual intimacy in your relationship in the following via the following link: Sexuality.

Functional Gastrointestinal Disorders

Functional Gastrointestinal Disorders are a group of digestive system disorders which are medically unexplained because they have no structural cause. CFR 38, §3.317(a)(2)(i)(B)(3) states that these include, *but are not limited to*:

Irritable bowel syndrome (IBS)
Functional dyspepsia
Functional vomiting
Functional constipation
Functional bloating
Functional abdominal pain syndrome
Functional dysphagia.

All of the above diagnoses count. If you have more than one, you may file a separate claim for each diagnosis. By far the most common diagnosis among Persian Gulf and Iraq veterans is IBS. Most of this section deals with that diagnosis.

Functional vs structural disorders

If there is a *structural* cause in your digestive tract, any symptom connected to it is *not* a functional disorder. *Structural* causes include, but are not limited to, any tear, ulcer, polyp, cancer, or improperly working valve in your digestive tract. You may be able to claim a *structural* disorder, but it will *not* fall under §3.317(a). You should seek other guidance before you submit a claim to the VA for compensation related to any *structural* gastrointestinal disorder.

Irritable Bowel Syndrome (IBS)

What is irritable bowel syndrome (IBS)?

Irritable bowel syndrome (IBS) is a disorder characterized most commonly by cramping, abdominal pain, bloating, constipation, and diarrhea. IBS causes a great deal of discomfort and distress, but it does not permanently harm the intestines and does not lead to a serious disease, such as cancer. Most people can control their symptoms with diet, stress management, and prescribed medications. For some people, however, IBS can be disabling. They may be unable to work, attend social events, or even travel short distances.

As many as 20 percent of the adult population, or one in five Americans, have symptoms of IBS, making it one of the most common disorders diagnosed by doctors. It occurs more often in women than in men, and it begins before the age of 35 in about 50 percent of people affected.

What are the symptoms of IBS?

Abdominal pain, bloating, and discomfort are the main symptoms of IBS. However, symptoms can vary from person to person. Some people have constipation, which means hard, difficult-to-pass, or infrequent bowel movements. Often these people report straining and cramping when trying to have a bowel movement but cannot eliminate any stool, or they are able to eliminate only a small amount. If they are able to have a bowel movement, there may be mucus in it, which is a fluid that moistens and protect passages in the digestive system.

Some people with IBS experience diarrhea, which is frequent, loose, watery, stools. People with diarrhea frequently feel an urgent and uncontrollable need to have a bowel movement. Other people with

IBS alternate between constipation and diarrhea. Sometimes people find that their symptoms subside for a few months and then return, while others report a constant worsening of symptoms over time.

Symptoms include

1. Abdominal pain or discomfort for at least 12 weeks out of the previous 12 months. These 12 weeks do not have to be consecutive.
2. The abdominal pain or discomfort has two of the following three features:
    - It is relieved by having a bowel movement.
    - When it starts, there is a change in how often you have a bowel movement.
    - When it starts, there is a change in the form of the stool or the way it looks.
3. Certain symptoms must also be present, such as
    - a change in frequency of bowel movements
    - a change in appearance of bowel movements
    - feelings of uncontrollable urgency to have a bowel movement
    - difficulty or inability to pass stool
    - mucus in the stool
    - bloating

Bleeding, fever, weight loss, and persistent severe pain are not symptoms of IBS and may indicate other problems such as inflammation, or rarely, cancer.

The following have been associated with a worsening of IBS symptoms

1. large meals
2. bloating from gas in the colon
3. medicines
4. wheat, rye, barley, chocolate, milk products, or alcohol
5. drinks with caffeine, such as coffee, tea, or colas
6. stress, conflict, or emotional upsets

Researchers have found that women with IBS may have more symptoms during their menstrual periods, suggesting that reproductive hormones can worsen IBS problems.

In addition, people with IBS frequently suffer from depression and anxiety, which can worsen symptoms. Similarly, the symptoms associated with IBS can cause a person to feel depressed and anxious.

How is IBS diagnosed?

If you think you have IBS, seeing your doctor is the first step. IBS is generally diagnosed on the basis of a complete medical history that includes a careful description of symptoms and a physical examination.

There is no specific test for IBS, although diagnostic tests may be performed to rule out other problems. These tests may include stool sample testing, blood tests, and x-rays. Typically, a doctor will perform a sigmoidoscopy, or colonoscopy, which allows the doctor to look inside the colon. This is done by inserting a small, flexible tube with a camera on the end of it through the anus. The camera then transfers the images of your colon onto a large screen for the doctor to see it.

If your test results are negative, the doctor may diagnose IBS based on your symptoms, including how often you have had abdominal pain or discomfort during the past year, when the pain starts and stops in relation to bowel function, and how your bowel frequency and stool consistency have changed. Many doctors refer to a list of specific symptoms that must be present to make a diagnosis of IBS.

How does stress affect IBS?

Stress—feeling mentally or emotionally tense, troubled, angry, or overwhelmed—can stimulate colon spasms in people with IBS. The colon has many nerves that connect it to the brain. Like the heart and the lungs, the colon is partly controlled by the autonomic nervous system, which responds to stress. These nerves control the normal contractions of the colon and cause abdominal discomfort at stressful times. People often experience cramps or "butterflies" when they are nervous or upset. In people with IBS, the colon can be overly responsive to even slight conflict or stress. Stress makes the mind more aware of the sensations that arise in the colon, making the person perceive these sensations as unpleasant.

Some evidence suggests that IBS is affected by the immune system, which fights infection in the body. The immune system is affected by stress. For all these reasons, stress management is an important part of treatment for IBS. Stress management options include:

1. stress reduction (relaxation) training and relaxation therapies such as meditation
2. counseling and support
3. regular exercise such as walking or yoga
4. changes to the stressful situations in your life
5. adequate sleep

CHAPTER V – *Other Iraq/Gulf/Afghanistan Claims*: Infectious Diseases
[CFR 38, §3.317(c-d)]

Introduction

Paragraph (c) of §3.317 grants presumptive service connection for ***nine infectious diseases*** which are endemic to many parts of the world, including *Iraq, Afghanistan*, and the *Persian Gulf*. Please read this chapter carefully if it may apply to you; the requirements for presumptive service connection are not the same for each disease.

The nine diseases are *(i) Brucellosis, (ii) Campylobacter jejuni, (iii) Coxiella burnetii (Q fever), (iv) Malaria, (v) Mycobacterium tuberculosis, (vi) Nontyphoid Salmonella, (vii) Shigella, (viii) Visceral leishmaniasis,* and *(ix) West Nile virus*. The manifestation time limits – based on how long each disease may take to incubate – are different, so they are divided up accordingly below.

Many of these diseases can lead to other health issues down the road. Getting the initial disease on the record and connected to your service ASAP protects your rights and your ability to take care of yourself later on.

Who is covered by this section?

CFR 38, §3.317(c) applies to all veterans who served in *Iraq* and the *Persian Gulf* after Aug 2, 1990, and all veterans who served in *Afghanistan* after September 19, 2001.

If you served in some other overseas location and have one of the nine diseases, you may still file a claim under the normal standards – you simply have a higher burden of proof.

Is there a time limit for the symptoms to manifest?

Yes, in most cases there is a time limit for automatic presumption of service-connection. However, if there is medical evidence or a doctor's opinion to validate your claim of service-connection, you should file even if you do not meet the presumptive deadline. The VA has a legal obligation to consider a valid claim on its merits, but it will hold you to a higher standard of evidence if you miss the presumptive window.

What are the six diseases with a one year manifestation requirement for presumption?

Most veterans have one year from their final date of separation to manifest symptoms of the following diseases to meet 3.317(c) guidelines for presumptive service-connection of:

- *Brucellosis.*
- *Campylobacter jejuni.*
- *Coxiella burnetii (Q fever).*
- *Nontyphoid Salmonella.*
- *Shigella.*
- *West Nile virus.*

The disease must be considered to 'have become manifest to a degree of 10 percent or more within one year from the date of separation' to qualify. It is important to get it service-connected as soon as you can, even if it doesn't bother you much today. You don't know when secondary health issues will follow or how bad they will get.

Is Malaria limited to one year, or not?

Malaria is also limited to one year after your discharge for the time being, and it must manifest to a degree of 10 percent in that time. The VA reserves the right to allow a longer presumptive period in the future, without a new law from congress, if research supports that.

The last two diseases have no time limit to manifest

There are two diseases which will be presumptively service-connected unless proven otherwise, no matter how long they take to manifest.

They are ***mycobacterium tuberculosis*** and ***visceral leishmaniasis.***

Secondary Conditions and Filing a Claim on them

CFR 38, §3.317(d) addresses the long term health consequences of the diseases named in §3.317(c). They are not presumptively service-connected at this time. However, the VA recognizes a potential connection between the infectious disease (listed in column A in the table below) and the associated long-term health effects beside it (in column B).

Once you have your rating for one of the *nine infectious diseases*, you should look at the long-term effects associated with it. If any of those impact your own health, then you should seek out medical opinions and pursue a claim.

Before granting any of these secondary claims, the VA must receive a medical opinion from a doctor that: '*it is at least as likely as not that the condition was caused by the veteran having had the associated disease'* (in column A).

You may file the claim and let the VA send you to their doctor for his opinion (which they have the right to do regardless), or you may get a doctor's statement on your own and submit it with your claim. While the VA may still get a second opinion from its own doctor, your claim will be stronger with a

doctor supporting your '*at least as likely as not*' position. The VA's doctor is more likely to agree with your claim if you already have a doctor supporting you.

Table of Associated Long Term Health Effects

Here is the full table from CFR 38, §3.317(d) showing the associations which were found by the Institute of Medicine at the National Academy of Sciences:

Table to § 3.317—Long-Term Health Effects Potentially Associated With Infectious Diseases

A	*B* *Disease*
Brucellosis	Arthritis. Cardiovascular, nervous, and respiratory system infections. Chronic meningitis and meningoencephalitis. Deafness. Demyelinating meningovascular syndromes. Episcleritis. Fatigue, inattention, amnesia, and depression. Guillain-Barr syndrome. Hepatic abnormalities, including granulomatous hepatitis. Multifocal choroiditis. Myelitis-radiculoneuritis. Nummular keratitis. Papilledema. Optic neuritis. Orchioepididymitis and infections of the genitourinary system. Sensorineural hearing loss. Spondylitis. Uveitis.
Campylobacter jejuni	Guillain-Barr syndrome *if manifest within 2 months of the infection.* Reactive Arthritis *if manifest within 3 months of the infection*. Uveitis *if manifest within 1 month of the infection*.
Coxiella burnetii (Q fever)	Chronic hepatitis. Endocarditis. Osteomyelitis. Post-Q-fever chronic fatigue syndrome. Vascular infection.
Malaria	Demyelinating polyneuropathy. Guillain-Barr syndrome. Hematologic manifestations (particularly anemia after falciparum malaria and splenic rupture after vivax malaria). Immune-complex glomerulonephritis.

	Neurologic disease, neuropsychiatric disease, or both. Ophthalmologic manifestations, particularly retinal hemorrhage and scarring. *Plasmodium falciparum*. *Plasmodium malariae*. *Plasmodium ovale*. *Plasmodium vivax*. Renal disease, especially nephrotic syndrome.
Mycobacterium tuberculosis	Active tuberculosis. Long-term adverse health outcomes due to irreversible tissue damage from severe forms of pulmonary and extrapulmonary tuberculosis and active tuberculosis.
Nontyphoid Salmonella	Reactive Arthritis *if manifest within 3 months of the infection*.
Shigella	Hemolytic-uremic syndrome *if manifest within 1 month of the infection.* Reactive Arthritis *if manifest within 3 months of the infection*.
Visceral leishmaniasis	Delayed presentation of the acute clinical syndrome. Post-kala-azar dermal leishmaniasis *if manifest within 2 years of the infection.* Reactivation of visceral leishmaniasis in the context of future immunosuppression.
West Nile virus	Variable physical, functional, or cognitive disability.

CHAPTER VI – Traumatic Brain Injury

What is Traumatic Brain Injury?

Traumatic Brain Injury (TBI) is an injury to the brain which can be directly identified and diagnosed with medical scans and tests. It should be linked to one or more specific events, such as a vehicle crash, IED explosion, fall, or other impacts. Here is the VA's lay definition of TBI:

A TBI happens when something outside the body hits the head with significant force. This could happen when a head hits a windshield during a car accident. It could happen when a piece of shrapnel enters the brain. Or it could happen during an explosion of an improvised explosive device (IED).

TBI is one of the things which should be tested for before moving on to consider a possible diagnosis of PTSD or a medically unexplained CMI. Once you are diagnosed with a TBI, and you can trace it to an event during military service, the process of obtaining service-connection for the injury is more clear-cut than for some of the other disabilities discussed in this guide.

If you have a TBI incurred during military service, and you are not utilizing the robust array of VA medical care options and services available, you may learn more here: http://www.polytrauma.va.gov/.

What are the symptoms?

The VA divides the symptoms into categories as follows

Physical effects	Behavioral effects	Cognitive effects
fractures	anxiety	lack of attention and concentration
fever	agitation	memory loss
difficulty eating and speaking	frustration	lack of judgment
degraded vision	impulsiveness	communication problems.
fatigue	repetitiveness	
loss of hearing and sense of touch	depression	
	regression (return to childlike behavior)	
	disinhibition (inability to control impulsive behavior and emotions)	

This is not a complete list of all possible symptoms.

The Defense and Veterans Brain Injury Center (DVBIC), part of the U.S. military health system, provides a training video at http://www.brainlinemilitary.org/conditions_course/introduction.php which is designed for caregivers dealing with TBI. It recognizes these categories of symptoms and secondary conditions: *sleep, mood, pain & headache, stress, attention & memory, substance abuse*.

What secondary conditions are recognized by the VA?

The VA is still processing newly proposed rules. They are not yet part of the Code of Federal Regulations; however, research shows that these conditions may result from a TBI:

- Parkinsonism
- Unprovoked Seizures
- Dementias (presenile Alzheimer and post-traumatic)
- Depression
- Diseases of hormone deficiency that result from hypothalamo-pituitary

These come from the Institute of Medicine's (IOM) 2008 report, *Gulf War and Health, Volume 7: Long-term Consequences of Traumatic Brain Injury.* The IOM found each of these five conditions to be related to TBI with the highest level of confidence they recognize.

At the time of this writing, none of these is a presumptive condition. However, if you provide the supporting information to your doctor, he or she is likely to give you an '*as likely as not*' letter to support your claim for these conditions which frequently result from a TBI.

The proposed change to 38 CFR § 3.310 will add a paragraph D to include the following:

> (1) In a veteran who has a service-connected traumatic brain injury, the following shall be held to be the proximate result of the service-connected traumatic brain injury (TBI), in the absence of clear evidence to the contrary:
> (i) Parkinsonism following moderate or severe TBI;
> (ii) Unprovoked seizures following moderate or severe TBI;
> (iii) Dementias (presenile dementia of the Alzheimer type and post-traumatic dementia) if manifest within 15 years following moderate or severe TBI;
> (iv) Depression if manifest within 3 years of moderate or severe TBI, or within 12 months of mild TBI; or
> (v)Diseases of hormone deficiency that result from hypothalamo-pituitary changes if manifest within 12 months of moderate or severe TBI.
> [quoted from 73369 Federal Register / Vol. 77, No. 237 / Monday, December 10, 2012 / Proposed Rules]

If you have any of these five conditions, you should file a claim for it as secondary to your TBI. However, it is probably best to wait until after your TBI is service-connected. If it is already service-connected, you may file a claim on the secondary conditions now.

If the VA denies your claim for one of these secondary conditions (or already denied it in the past), and the proposed regulations are later finalized and approved, you may then re-open your claim on the basis of the new regulation. If you re-open the claim within six months of the rule change, the VA may grant benefits going back to the date the new regulations take effect.

Establishing your claim

TBI is one of the easiest claims to establish, and the secondary conditions have strong research to back up your claim when you get to that point. Work with your Veterans Service Organization Representative (VSO Rep) to make sure you have a fully developed claim before you submit it. You need to establish the following:

- An 'impact event' during military service when the TBI occurred
- A diagnosis of TBI with medical documentation of the symptoms and severity
- Lay evidence to provide additional documentation of symptoms
- If claiming a secondary condition, *for now*, make sure to get an 'as likely as not' doctor's letter

If you have trouble convincing your doctor, please contact the NGWRC so we may help you get the IOM conclusions supporting your claim to your doctor. That may help convince him or her of the validity of your claim for a secondary condition.

Once your claim is established and developed, your VSO Rep will submit it on your behalf. If you have a TBI claim, it is important to establish the TBI first, before you go on to secondaries to TBI or to a claim for PTSD.

CHAPTER VII – Post-Traumatic Stress Disorder (PTSD)

Introduction

The way in which the VA and the mental health care community at large diagnoses and treats PTSD has changed significantly since the start of recent military operations, such as OIF and OEF. If you have PTSD, and you were denied benefits before July of 2010, you may wish to re-open your claim.

It is easier to prove any claim for PTSD than it used to be. Above and beyond that, the VA is now more likely to give the benefit of the doubt to the veteran in the case of PTSD caused by sexual trauma in the military.

What is PTSD?

The Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), released on May 18, 2013 revised the criteria for diagnosing Post-Traumatic Stress Disorder. The DSM-5 criteria follow.

There must be an identified trigger to PTSD. The trigger (the VA uses the word *stressor* instead of the word trigger in its regulations) is exposure to *actual or threatened death, serious injury or sexual violation*. The exposure must result from one or more of the following scenarios, in which the individual:

- directly experiences the traumatic event;
- witnesses the traumatic event in person;
- learns that the traumatic event occurred to a close family member or close friend (with the actual or threatened death being either violent or accidental); or
- experiences first-hand repeated or extreme exposure to aversive details of the traumatic event (not through media, pictures, television or movies unless work-related).

The disturbance, regardless of its trigger, causes clinically significant distress or impairment in the individual's social interactions, capacity to work or other important areas of functioning. It is not the physiological result of another medical condition, medication, drugs or alcohol.

After establishing a trigger, diagnosis depends on identifying behavioral symptoms that accompany PTSD in one or more of four diagnostic clusters – re-experiencing, avoidance, negative cognitions and mood, and arousal.

- *Re-experiencing* covers spontaneous memories of the traumatic event, recurrent dreams related to it, flashbacks or other intense or prolonged psychological distress.
- *Avoidance* refers to deliberately trying to avoid distressing memories, thoughts, feelings or external reminders of the event.
- *Negative cognitions and mood* represents myriad feelings, from a persistent and distorted sense of blame of self or others, to estrangement from others or markedly diminished interest in activities, to an inability to remember key aspects of the event.
- *Arousal* is marked by aggressive, reckless or self-destructive behavior, sleep disturbances, hyper-vigilance or related problems. The 'flight' aspect is included in this cluster.

The disturbance, as measured by the symptoms above, must persist for one month before it may be diagnosed as PTSD. There is no distinction between acute and chronic phases of PTSD.

At the time of this writing, the VA has not had time to make any changes to its internal definition of PTSD since the DSM-5 was released. Some research used to revise the DSM was accounted for by the VA in 2010, when it made several changes that help veterans with PTSD.

History of the diagnosis *"Post-traumatic Stress Disorder"*

PTSD is not a new problem. It was around before humans developed speech. Written records from ancient Egypt, Greece, and Rome detail symptoms of PTSD occurring in battle veterans. We have used different names for it at different times in our history. In American history, it was previously referred to as "shell-shock" and "war/combat neurosis". PTSD occurs in veterans of all wars and eras and in non-veterans exposed to traumatic events. Similar long-term responses to traumatic events occur in certain non-human creatures, including some of our pets.

In 1980, the American Psychiatric Association (APA) created the diagnosis PTSD when it published the DSM-III. Our understanding of PTSD continues to expand with new research and treatments; the definition, diagnostic criteria, and VA rules around it continue to change over time. This guide provides the most current information available, as it pertains to a claim for benefits, as of May 31, 2013. Any new revisions to VA guidelines will be posted by the VA on their website, www.va.gov. We also discuss changes on our own website, www.ngwrc.org.

The APA diagnostic criteria for PTSD changed with each revision to the DSM since 1980, being revised in DSM-III-R (1987), DSM-IV (1994), DSM-IV-TR (2000), and DSM-5 (2013). For a more thorough overview of PTSD as it relates to veterans, please refer to the VA history and overview at http://www.ptsd.va.gov/professional/pages/ptsd-overview.asp.

Who is eligible to receive benefits for PTSD?

A claim for PTSD is not limited to veterans who participated in combat with the enemy. Some in-service stressors that are recognized by the VA include:

- Military Combat
- Sexual Assault
- Other Personal Assault
- Vehicular Accident
- Being the Victim of a Crime

Other sufficiently traumatic events during service can support a diagnosis of PTSD for VA claims purposes. Merely being in stressful situations, or being "stressed-out" generally will not be sufficient.

Building a VA benefits claim for PTSD

The VA requires three components be proven in order to establish a service-connected rating for PTSD, outlined in CFR 38 §3.304(f).

- *medical* evidence *diagnosing* the condition [in accordance with CFR38 §4.125(a)]
- a *link*, established by medical evidence, between current symptoms and an *in-service stressor*
- credible supporting *evidence* that the claimed *in-service stressor occurred.*

When you establish these three elements, you have a valid claim.

Establishing an in-service stressor

This is much easier for veterans today than it once was. Here is a simplified summary of the sub-paragraphs of CFR 38 §3.304(f) which make is easier to establish your claim. You may find the full regulation in the appendices. The numbers here match with the numbers in CFR 38 §3.304(f):

(1) If you are *diagnosed with PTSD while* you are still *in the military*, your lay testimony alone is usually sufficient evidence of a stressor as long as your claim is consistent with the circumstances, conditions, or hardships of your service.

(2) If your *military records show* you engaged in *combat with the enemy*, and you are diagnosed with PTSD after you are discharged, your lay testimony alone may establish the claimed in-service stressor.

(3) If your claimed stressor is the *fear of hostile military or terrorist activity,* and a VA psychiatrist or psychologist agrees that your stressor is adequate to support your PTSD diagnosis; that may be accepted as the stressor.

(4) If you have evidence that you were a prisoner-of-war, then your lay testimony alone may be sufficient evidence of a stressor.

(5) If your claimed stressor is an in-service personal assault, including sexual assault or rape, evidence other than your service records may corroborate your account of the stressor incident.

A combat-related military occupational specialty (MOS) or combat-related awards or decorations (*e.g.*, a Combat Infantryman's Badge or a Purple Heart) are examples of documented combat experience.

However, if your service records do not demonstrate a combat-related MOS or decorations and you assert that you have experienced combat, enemy fire or attack, the VA is required to assist you in obtaining documentation that supports your claim (including researching government records) that could place you in a documented area of attack or an isolated hostile incident.

If the claimed stressor is *not related to combat or POW status*, the veteran must prove its existence with evidence, such as service medical or personnel records, unit records, morning reports, or buddy statements. The VA allows a broad range of evidence as proof of a stressor for trigger events which the military has a history of leaving off its records, such as in-service rapes, sexual assaults, and other personal assaults.

Evidence to establish a stressor of *in-service personal assault* (*including rape and sexual assault***)**

If your claimed stressor is *rape*, *sexual assault*, or any other in-service personal assault, here are examples of records you may use to corroborate your account.

pregnancy tests or tests for sexually transmitted diseases

records from:

- law enforcement authorities
- rape crisis centers
- mental health counseling centers
- hospitals
- physicians

statements from:

- family members
- roommates
- fellow service members
- clergy

As you obtain statements, keep in mind that the VA accepts *evidence of behavior changes* following the claimed assault as one type of relevant evidence that may be found in these sources. Examples of behavior changes that may constitute credible evidence of the stressor include:

- a request for a transfer to another military duty assignment
- deterioration in work performance
- substance abuse
- episodes of depression, panic attacks, or anxiety without an identifiable cause
- unexplained economic or social behavior changes.

The statements need to *show change* in your behavior. If you were a heavy drinker both before and after the stressor, the fact that you continued to drink is not a change.

The VA may submit any evidence that it receives to an appropriate medical or mental health professional for an opinion as to whether it indicates that a personal assault occurred.

Establish PTSD diagnosis and link it to your stressor

A PTSD diagnosis must come from a psychiatrist or psychologist. Your VA doctor can refer you to one of these specialists to confirm your symptoms and diagnose you with PTSD if you do not yet have that established.

If you have records that document the in-service stressor, let your doctor review them prior to writing his or her report. It is even better to provide your doctor with a copy of your service medical records. If parts of your psychiatric records were redacted, your doctor may be able to obtain those records to help with diagnosis and treatment; however, they may be unable to share those redacted records with you.

Veterans with PTSD may have other diagnoses in areas of mental health and substance abuse, *e.g.*, personality disorder or alcoholism. It is very important that your doctor explain how your current diagnosis of PTSD relates to any other psychiatric disorder that you might have. If there is a history of alcohol or drug abuse, the doctor should state whether it preexisted PTSD or not and whether substance abuse developed because of PTSD (*i.e.*, self-medication).

You can expect the VA to contact you for evidence or for permission to request copies of your medical records. If the VA has treated you for your PTSD, make sure to ask that the VA obtain all records from the treatment center.

The VA may schedule you for an examination by one of its doctors at a VA hospital or clinic. This examination (called a compensation and pension examination [C&P exam]) is intended to confirm a diagnosis of PTSD and, if present, to describe the nature and severity of its symptoms. Bring copies of any prior psychiatric treatment records to the examination with you. If you do not have records of recent treatment for PTSD, you may specifically request that the VA provide you with a C&P exam.

If you do not already have a private doctor's report, you should expect the VA doctor to ask many questions about what symptoms you have, when you began to have them, and how often and how long you have had them. Some of the hardest questions will be about the stressful experience you had. You will need to be able to describe in detail (and sometimes painful detail) exactly what you experienced. You might also be asked to take a written, standardized diagnostic test.

Once you prove evidence of an in-service trigger event, and you are diagnosed with PTSD after the event, the VA is likely to link the two together unless there is other evidence specifically suggesting that your particular case of PTSD was triggered by some event outside of your military service.

It is possible to experience PTSD from multiple triggers both in and out of service. If you have symptoms and experience that match up with your in-service stressor, you should pursue your claim – the VA can legitimately rate you as service-connected and assign benefits to you even if there are additional trigger events besides those in the military.

Re-opening PTSD Claims

What if your claim for PTSD was denied on or before July, 2010?

If you were denied compensation on a claim for PTSD before the most recent change in VA rules, July, 2010, you are permitted to request that your previously denied claim for PTSD be reopened and reevaluated based on the VA's new criteria. You may send a letter to your VA Regional Office asking to have your previously denied claim reevaluated under the new regulations.

This rule change, or any change in the regulations for disability compensation under a specific diagnosis, allows you to re-open a claim without presenting “new and material evidence”. If you are awarded benefits under these circumstances, they will go back to the date on which the VA receives your request to re-open the claim.

There was a window in which re-opened claims could be granted back to the date on which the new rule took effect, rather than the date the claim was re-opened. However, that window was six months, ending in January, 2011.

If you believe you have new and material evidence to reopen a PTSD claim denied after July, 2010, consult with your VSO Rep.

VA Medical Services

The VA operates a network of Vet Centers throughout the country that provides treatment for veterans suffering from PTSD. Treatment at Vet Centers is often conducted with a group of veterans. Sometimes the VA will pay for treatment by a local mental health professional, if services through the nearest VA are not readily available. To apply for this "fee basis" care, contact your nearest VA medical center.

There are also a few VA medical centers that offer intensive inpatient care. If this is something you need, ask the nearest Vet Center to help arrange for your admission.

The VA's gateway site for PTSD is http://www.ptsd.va.gov/.

CHAPTER VIII – Amyotrophic Lateral Sclerosis (ALS) Claim
[CFR 38, §3.318]

What is ALS?

Amyotrophic Lateral Sclerosis (ALS), or Lou Gehrig's disease, kills cells in the brain and spinal cord that control muscle movement, resulting in gradual wasting of the muscles. Fatal in most cases, the disease usually strikes people between ages 40 and 70. The cause of the disease is unknown. ALS does not affect the senses (sight, smell, taste, hearing, touch), bladder or bowel function, or a person's ability to think or reason.

Who may claim service-connection for ALS?

Under most circumstances, if you are a US military veteran diagnosed with ALS, *it **will be** presumptively service-connected*. All you need to do is file the claim. The claim will be expedited because ALS is a terminal illness.

Here is the exact language of CFR 38, §3.318(a):

> Except as provided in paragraph (b) of this section, the development of amyotrophic lateral sclerosis manifested at any time after discharge or release from active military, naval, or air service is sufficient to establish service connection for that disease.

The full section is reprinted in the appendices if you want to look up the exceptions.

Symptoms

1. Difficulty breathing
2. Difficulty swallowing
   - Gagging
   - Chokes easily
3. Head drop due to weak spinal and neck muscles
4. Muscle cramps
5. Muscle weakness that slowly gets worse
   - Commonly involves one part of the body first, such as the arm or hand
   - Eventually leads to difficulty lifting, climbing stairs, and walking
6. Paralysis
7. Speech problems, such as a slow or abnormal speech pattern
8. Voice changes, hoarseness

9. Additional symptoms that may be associated with this disease:
10. Drooling
11. Muscle contractions
12. Muscle spasms
13. Ankle, feet, and leg swelling
14. Weight loss

The VA established a national ALS registry to identify veterans with the disease -- regardless of when they served -- and track their health status. Veterans with ALS who enroll will complete an initial telephone interview covering their health and military service and will be interviewed twice yearly thereafter. For more information about the VA's ALS Registry, based at the Durham VA Medical Center, call 1-877-DIAL-ALS (1-877-342-5257) or e-mail ALS@med.va.gov

More Information on ALS

The following organizations support research and in some cases can provide information and support for patients and their families.

ALS Association (ALSA)

27001 Agoura Road Suite 150
Calabasas Hills, CA 91301-5104
info@alsa-national.org http://www.alsa.org
Tel: 818-880-9007 800-782-4747 Fax: 818-880-9006

Les Turner ALS Foundation

8142 North Lawndale Avenue
Skokie, IL 60076
info@lesturnerals.org http://www.lesturnerals.org
Tel: 888-ALS-1107 847-679-3311 Fax: 847-679-9109

Muscular Dystrophy Association

3300 East Sunrise Drive
Tucson, AZ 85718-3208
mda@mdausa.org http://www.mdausa.org/
Tel: 520-529-2000 800-572-1717 Fax: 520-529-5300

Project ALS

511 Avenue of the Americas Suite #341
New York, NY 10011
projectals@aol.com http://www.projectals.org
Tel: 212-969-0329 800-603-0270 Fax: 212-337-9915

For information on other neurological disorders or research programs funded by the National Institute of Neurological Disorders and Stroke, contact the Institute's:

Brain Resources and Information Network (BRAIN)

P.O. Box 5801
Bethesda, Maryland 20824
(800) 352-9424
www.ninds.nih.gov

Chapter IX – Cancer Claims & Depleted Uranium

Introduction

There is no presumptive service connection to cancer for most veterans of post-Vietnam conflicts. If you have a cancer which you believe is related to your military service, but you do not meet the definition of an Agent Orange or Radiation-Exposed Veteran, then you will have the standard burden of proof applied to your claim. You must provide a medical opinion from a doctor stating it is 'at least as likely as not' that your current cancer is related to your claimed in-service exposure.

This may require extensive research to prove your exposure and to back up your doctor's claim of the relationship. Presenting strong evidence of the relationship to your doctor is, in fact, what can make the difference in whether or not that doctor will write the letter for you. Some doctors are not up-to-date on research showing the relationship between a particular exposure and a particular cancer.

Depleted Uranium & Cancer for SWAT veterans

Depleted Uranium (DU) is a mildly radioactive heavy metal that, like lead and mercury, is highly toxic when inhaled or ingested. Its long-term effects remain a subject of debate.

No cancers are presumptive for Iraq, Persian Gulf, or other recent (1990-current) conflict veterans on the basis of their foreign deployments, but the VA does grant service connection on a case-by-case basis. The VA realizes that cancers take decades to manifest - there is no '1 year limit' on symptoms for cancer.

DU is recognized as a possible cause or accelerator of cancer, but the evidence is not yet strong enough to make it presumptive. If a veteran can both make a case that he or she has high exposure to it, such as DU shrapnel fragments in his or her body, and get a doctor's 'as likely as not' statement in support of claim, the veteran may file with a reasonable chance of success.

Agent Orange and other Herbicides [CFR 38 §3.309(e)]

Agent Orange and other herbicides used by the military during the 1960's and 1970's are known to cause an increased risk of several cancers. As a result of this, if you develop one of those cancers later in life, it will be presumed as related to your military service, if one of the following applies to you:

- Exposure to Agent Orange in Vietnam – Exposure on land in Vietnam or on a ship operating on the inland waterways of Vietnam between January 9, 1962 and May 7, 1975
- Blue Water Veterans – Possible exposure on open sea ships off the shore of Vietnam during the Vietnam War
- U.S. Navy and Coast Guard Ships in Vietnam – List of ships and boats with operations in Vietnam between January 9, 1962 and May 7, 1975

- Korean Demilitarized Zone – Exposure along the demilitarized zone in Korea between April 1, 1968 and August 31, 1971
- Thailand Military Bases – Possible exposure on or near the perimeters of military bases between February 28, 1961 and May 7, 1975
- Herbicide Tests and Storage Outside Vietnam – Possible exposure due to herbicide tests and storage at military bases in the United States and locations in other countries
- Agent Orange Residue on Airplanes Used in the Vietnam War – Possible exposure of crew members to herbicide residue in C-123 planes flown after the Vietnam War

Source: http://www.publichealth.va.gov/exposures/agentorange/militaryexposure.asp

These veterans may be presumptively service-connect for Diabetes Mellitis Type 2, Chloracne, Parkinson's Disease, Peripheral Neuropathy, several cancers, and other diseases. For a complete list, go to http://www.publichealth.va.gov/exposures/agentorange/diseases.asp#veterans.

Consult your VSO Rep if you want to consider filing a claim for any of these illnesses with presumptive service-connection as an Agent Orange Veteran.

Ionizing Radiation [CFR 38 §3.309(d)]

Certain veterans are granted presumptive service-connection for several cancers and other diseases which may be related to their exposure to ionizing radiation from a nuclear detonation or at a gaseous diffusion plant.

The VA grants presumptive service connection for 21 types of cancer to certain *radiation-exposed veterans*. The presumption is limited to very specific groups of veterans, and it is not related to service in any combat-related or occupation-related operation which occurred after July 1, 1946. However, veterans who served on the grounds of a gaseous diffusion plant located in Paducah, Kentucky, Portsmouth, Ohio, or the area identified as K25 at Oak Ridge, Tennessee, as recently as 1992 may be presumptively service connected for any of the 21 cancers.

Here is a summary what may qualify a veteran to be considered *radiation-exposed* by the VA:

1. Onsite participation in a test involving the atmospheric (or underwater) detonation of a nuclear device.
2. The occupation of Hiroshima or Nagasaki, Japan, by United States forces during the period beginning on August 6, 1945, and ending on July 1, 1946.
3. Internment as a prisoner of war in Japan during World War II in a location which resulted in an opportunity for exposure to ionizing radiation between August 6, 1945 and July 1, 1946.
4. Service as part of official military duties of at least 250 days before February 1, 1992, on the grounds of a gaseous diffusion plant located in Paducah, Kentucky, Portsmouth, Ohio, or the area identified as K25 at Oak Ridge, Tennessee.
5. Service before January 1, 1974, on Amchitka Island, Alaska, with possible ionizing radiation exposure in the performance of duty related to the Long Shot, Milrow, or Cannikin underground nuclear tests.

If you believe you are affected, please read the full section of CFR 38, §3.309(d) in the appendices and consult your VSO Rep.

Chapter X – Where to Get Help

National Gulf War Resource Center

www.ngwrc.org

2611 SW 17th Street
Topeka, KS 66604

Phone:866-531-7183
Fax:785-235-6531

https://www.facebook.com/groups/Gulfwarvet/

Veterans Benefits Network

http://vets.yuku.com/

This is a good place to search or ask for information about claims.

Find a VSO Rep - State or County

Each organization listed here has a nationwide network of VSO Reps who can help you with your claim for VA Benefits. VSO Reps will not charge you for their services.

National Association of State Departments of Veterans Affairs

(50 states and six territories – each has its own)

www.nasdva.us

107 S. West Street, Suite 550
Alexandria, Virginia 22314
Phone: (334) 242-5075
Fax: (334) 353-5072

Direct link to locate your own state/territory:

http://www.nasdva.us/links.htm

National Association of County Veterans Service Officers

http://nacvso.org/

25 Massachusetts Ave, NW, Suite 500

Washington, DC 20001

Direct links for each state's VSO Reps:

http://nacvso.org/find-a-service-officer/

Find a VSO Rep – National Organizations

Veterans Service Organizations with a nationwide network of VSO Reps.

Disabled American Veterans - www.dav.org

The DAV specializes in assisting veterans with their benefits and helping injured military personnel with their transition to civilian life.

Veterans may find a VSO Rep here:

http://www.dav.org/veterans/NSOffices.aspx

Active Duty may find help here:

http://www.dav.org/veterans/TSOffices.aspx

American Legion - **http://www.legion.org/**

The American Legion has service officers in Mexico, The Phillipines, Puerto Rico, and all 50 states: **http://www.legion.org/serviceofficers**

Veterans of Foreign Wars - **http://www.vfw.org/**

The VFW has service officers (VSO Reps) overseas, on military bases, and in all 50 states: **http://stage.vfw.org/Assistance/National-Veterans-Service/**

Paralyzed Veterans of America - www.pva.org

AmVets - http://www.amvets.org/

Military Order of the Purple Heart

http://www.purpleheart.org/

National Veterans Legal Services Program

http://www.nvlsp.org/

You are required to have an attorney to bring your case before the Court of Veterans Appeals or to a higher court. You may choose to use an attorney for other stages of your claim. Attorneys may charge a contingency fee plus expenses for their services.

Appendices

Federal Regulations

regulations regarding adjudication of VA claims for disability compensation

Appendix I - NGWRC Core Values

1. Advocate tirelessly for veterans from SWA issues - We will promote media awareness and Congressional investigations to ensure that Department of Veterans Affairs (VA) Gulf War review efforts are comprehensive, correct and supportive of the SWA veteran.

2. Provide educational material and assistance to SWA Veterans and their families - We are committed to helping veterans improve their chances of receiving overdue compensation for their service-connected illnesses. A key component of that commitment is producing and updating a Self Help Guide that covers important topics such as medical research and legislative developments, organizations that support veterans of SWA, lessons learned, and assistance available from federal agencies such as the Department of Veterans Affairs.

3. Educate VA, legislators and medical facilities on the complexities of Gulf War Illnesses - We serve the veteran by informing legislators of provisions needed to protect, treat and compensate SWA Veterans, and we educate medical providers on the wide variety of symptoms and illnesses faced by SWA veterans.

4. Create a diverse, dynamic organization membership dedicated to vital veteran issues - Gulf War Illness issues affect veteran, scientific, legal, family, and other constituents, as well as current and future service members. To ensure adequate involvement and to prevent repetition of past mistakes, NGWRC solicits from all interested communities and constantly updates its website with relevant and useful information.

5. Review and analyze all relevant government and industry actions, policies, research efforts, and writings concerning Gulf War Era and future veterans' issues - We are committed to being a leader in understanding the complexities of Gulf War Illnesses by evaluating new concepts in treatment through collaborations with and our organizational presence at the Department of Veterans Affairs Research Advisory Committee meetings. We will continue to create and implement progressive policies that maximize results for the veterans, increase public understanding, help create clear understanding of illness issues, and ensure the protection of future veterans.

6. Furthering comradeship amongst those who are or have been members of the Armed Forces of the United States.

The NGWRC has done much to bring Gulf War issues before Congress and the media, exposing Pentagon and VA policies that have severely impacted veterans and their families. Our most valuable efforts have resulted in legislation that required research and service-connected disabilities for certain conditions associated with Gulf War service. NGWRC does this with the grants and donation we receive from individual and foundations.

Appendix II - Exposures

Veterans serving in the Iraq, the Persian Gulf, and elsewhere in the Southwest Asia Theater between 1990 and the present day were exposed to a wide range of agents which may contribute to long term illness. These exposures include:

Type of Exposure	
Oil Well Fires and Smoke	Pesticides
Depleted Uranium (DU)	Infectious Diseases
Anthrax Vaccine	Sand and Particulate Matter
Vaccine Adjuvants	Petro Chemicals and Solvents
Botulinum Toxoid Vaccine	Vehicle and Aircraft Fuels
Multiple Vaccines	Chemical Resistant Coating Paint
Pyridostigmine Bromide (PB) Pills	Contaminated Food and Water
Chemical Warfare Agents	

Chemical Warfare Agents

Historical Perspective: The NGWRC, our member groups, and many individual veterans uncovered numerous documented chemical incidents and casualties using the Congressional reports, the Freedom of Information Act (FOIA), and information provided to us from individual veterans. As a result, by 1997, the DoD was forced to admit that 100,000 U.S. troops were exposed to low levels of sarin, cyclosarin, and mustard agents during the demolition of an Iraqi military bunker complex at the Kamisiyah depot in March 1991. In 1999, the VA increased the number to more than 124,000 and eventually to over 140,000 U.S. troops exposed. A much clearer picture emerged, in part at least because NGWRC exposed DoD statistical manipulations that demonstrated flawed modeling and understanding of the estimated exposures.

NGWRC's research campaign resulted in the DoD revamping their entire Gulf War Illnesses investigation. By 1999, the DoD employed a staff of more than 150 to investigate the thousands of toxic exposure incidents, many brought to light by NGWRC research volunteers. Official military documents obtained from Congressional reports, using FOIA, or letters sent by Gulf War veterans have revealed the following:

- The U.S. Departments of State, Defense, and Commerce allowed the shipment of dual-use chemical precursors and technology to Iraq until 1990.

- Possible offensive use of chemical warfare agents by Iraq against Israel, according to Central Command Nuclear, Biological, and Chemical (CENTCOM NBC log) incident logs compiled between January and March 1991.
- Possible deployment of chemical warfare agent land mines by Iraq, according to CENTCOM NBC log.
- Exposure of Coalition troops and civilians to chemicals due to Coalition bombings of Iraqi manufacturing and storage facilities during the air war, according to a report and Senate investigation led by former Senator Donald Riegle.
- Exposure of troops to chemicals from artillery and other bombardment and/or exposure of troops to chemicals as a result of post-cease fire demolitions, according to the CENTCOM NBC log.

In spite of the overwhelming evidence of widespread poisonous gas exposures, the DoD continued to downplay the seriousness of these exposures. Documented evidence suggests the Pentagon possessed prior knowledge, before the air war, of the potential for chemical releases and the subsequent health problems that could be caused by exposure to low level chemical warfare agents, according to a report prepared by the Lawrence Livermore Laboratory in California.

Also, part of the problem in dealing with chemical exposures is the DoD's misguided doctrine that in order to confirm exposure, a soldier must experience visible and severe effects (such as death) immediately following exposure.

In 1996, the NGWRC called for the appointment of a special prosecutor from the Department of Justice to investigate the misplacement, concealment, or destruction of government documents related to chemical and biological agent incidents and exposures. As a result of this request, DoD's IG investigated the missing chemical exposure documents and determined they were accidentally destroyed by a computer virus on an unauthorized video game on a DoD computer, lost from at least two locked military safes, and/or still classified.

As of this writing, Representative Rush Holt (D-NJ) continues to push for DoD's declassification of the remaining documents that the CIA and DoD didn't lose or shred.

As a result of NGWRC's work in documenting known exposures and pushing for research demonstrating the health effects of low level exposures, DoD has funded some medical research projects in this area and has also begun reevaluating their low-level chemical exposure doctrine.

Status of Investigations and Epidemiological Research

Numerous studies have essentially disproved the DoD notion that only immediately visible, severe symptoms provide evidence of exposure to chemical agents. According to a study by researchers at the University of New Mexico, Albuquerque, and the U.S. Army Medical Research Institute of Chemical Defense, Aberdeen, MD, exposure to sarin nerve gas in concentrations too low to produce immediate symptoms causes irreversible brain damage in laboratory rats.

A. Publications

The findings, published in three scientific articles in the journal *Toxicology and Applied Pharmacology* supply missing pieces that connect nerve gas exposure in the 1991 Gulf War to

memory loss/cognitive dysfunction, weakened immune response, and DNA and behavior abnormalities.

1. **GAO Report (GAO-03-833T)** on Preliminary Assessment of DoD Plume Modeling for U.S. Troops Exposure to Chemical Agents, dated June 2, 2003.

Gulf War Illnesses: Preliminary Assessment of DoD's Plume Modeling for U.S. Troops' Exposure to Chemical Agents, by Keith A. Rhodes, chief technologist, before the Subcommittee on National Security, Emerging Threats, and International Relations, House Committee on Government Reform; http://www.gao.gov/new.items/d03833t.pdf

The number of U.S. troops exposed to nerve gas after the first gulf war was underestimated because of flaws in how troops were studied, government investigators have concluded.

The computer models used to determine the extent of sarin gas exposure were inaccurate and incomplete. Troops were exposed to sarin, a toxic nerve agent, when a missile arsenal at Kamisiyah in southeastern Iraq was blown up in March 1991.

Over the years, the military has raised its estimate of the number of exposed troops from a few hundred to more than 100,000. Now the General Accounting Office (GAO) says the estimate is inadequate.

In June of 2004 the GAO told a congressional panel that the computer models, developed by the DOD and the CIA, did not take weather patterns into account, The models also underestimated the height of the plumes sent skyward when the arsenal was destroyed. Defense and CIA modeling underestimated the extent of U.S. troop exposure since the modeling was not accurate enough to draw conclusions.
See: http://www.globalsecurity.org/military/library/report/gao/d04821t.pdf

Note: The VA has received 54,000 claims related to exposure at the munitions site. It has granted 41,000 and denied 7,000. Others are pending.

2. **Institute of Medicine (IOM)**

From the IOM website: http://www.iom.edu/Global/Search.aspx?q=gulf+war&output=xml_no_dtd&client=default_frontend&site=default_collection&proxyreload=1

In 1998, the IOM began a series of congressionally-mandated studies to examine the scientific and medical literature on the potential health effects of chemical and biological agents related to the 1991 Gulf War. The studies completed to date are listed at the above IOM web link.

The first study reviewed the scientific literature on depleted uranium, chemical warfare agents (sarin and cyclosarin), pyridostigmine bromide, and vaccines (anthrax and botulinum toxoid) and resulted in the report, **Gulf War and Health Volumes 1: Depleted Uranium, Pyridostigimine Bromide, Sarin, and Vaccines**.

In February 2001, the IOM convened a subsequent committee, to examine the health effects associated with exposure to pesticides and solvents. This study resulted in the report **Gulf War and Health: Volume 2: Insecticides and Solvents**.

In March 2003, a third committee was convened to conduct a review of the peer-reviewed literature on the long-term human health effects associated with exposure to selected environmental agents, pollutants, and synthetic chemical compounds believed to have been present during the 1991 Gulf War including hydrazines, red fuming nitric acid, hydrogen sulfide, oil-fire byproducts, diesel-heater fumes, and fuels (for example, jet fuel and gasoline). This study resulted in the report **Gulf War and Health, Volume 3: Fuels, Combustion Products, and Propellants**.

In January 2005, a fourth committee was convened to review, evaluate, and summarize peer-reviewed scientific and medical literature addressing the overall health status of Gulf War veterans to see what this literature collectively shows about the prevalence of veterans' symptoms and illnesses. This study resulted in the report **Gulf War and Health, Volume 4: Health Effects of Serving in the Gulf War**.

In March 2005, the IOM convened a fifth committee to review, evaluate, and summarize the peer-reviewed scientific and medical literature on long-term adverse human health effects associated with selected infectious diseases (such as diseases caused by pathogenic Escherichia coli, shigellosis, Leishmaniasis, and sandfly fever) pertinent to Gulf War veterans, as well as to veterans of the current conflicts (Operation Iraqi Freedom; Operation Enduring Freedom). This study resulted in the report **Gulf War and Health, Volume 5: Infectious Diseases.**

In May of 2005, a sixth committee was convened to comprehensively review, evaluate, and summarize the peer-reviewed scientific and medical literature regarding the association between stress and long-term adverse health effects (physiological, psychological, and psychosocial) in Gulf War veterans. This study's findings are not only limited to veterans of the 1991 Gulf War conflict but are applicable to veterans of the current conflict (Operation Iraqi Freedom; Operation Enduring Freedom). **Gulf War Health, Volume 6: Gulf War and Health: Physiologic, Psychologic, and Psychosocial Effects of Deployment Related Stress.**

The VA, under authorization granted in the 1998 legislation, has asked IOM to determine long term health outcomes associated with TBI. TBI has been called the signature injury of OEF and OIF primarily due to blast exposure that is characteristic of this conflict. Exposure to blast might cause instant death, injuries with immediate manifestation of symptoms, or injuries with delayed manifestation. Blast-induced neurotrauma, however, has not been studied sufficiently to confirm reports of long-term effects. That many returning veterans have TBI will likely mean long-term challenges for them and their family members. Veterans will need support systems at home and in their communities to assist them in coping with the long-term sequelae of their injuries. Further, many veterans will have undiagnosed brain injury because not all TBIs have immediately recognized effects or are easily diagnosed with neuroimaging techniques. In 2008 the report, **Gulf War and Health, Volume 7: Long-term Consequences of Traumatic Brain Injury** was released.

In April of 2010 the IOM released a new report, this one indicating that Gulf War service was linked to Post-Traumatic Stress Disorder (PTSD), Multi-symptom illness, and other health

problems, but that the causes still remain unclear. Their report is entitled: **Gulf War and Health, Volume 8: Health Effects of Serving in the Gulf War.**

3. **Research Advisory Committee on Gulf War Veterans' Illnesses (RAC-GWVI)**

   From the RAC-GWVI website:
   http://www1.va.gov/RAC-GWVI/docs/Committee_Documents/GWIandHealthofGWVeterans_RAC-GWVIReport_2008.pdf

   The Research Advisory Committee on Gulf War Veterans' Illnesses was created by Congress in 1998, and first appointed by Secretary of Veterans Affairs Anthony J. Principi in January, 2002. The mission of the Committee is to make recommendations to the Secretary of Veterans Affairs on government research relating to the health consequences of military service in the Southwest Asia theater of operations during the Persian Gulf War.

   In November of 2008 the RAC-GWVI published "*Gulf War Illness and the Health of Gulf War Veterans*". This publication can be viewed in its entirety at the above web link. NGWRC highly recommends that all Gulf War veterans take the time to familiarize themselves with the myriad of information contained in this very detailed publication.

Investigational Drugs

In December 1990, the Food and Drug Administration (FDA) issued a waiver to the DOD allowing the military to administer "investigational new drugs" to U.S. troops without obtaining informed consent. The NGWRC understands the intent of the DOD to provide the best possible protection to U.S. troops deployed overseas. However, the NGWRC filed suit to require the DOD to follow other U.S. laws and the Nuremberg Code. Both require informed consent from the patient before an IND is used.

Informed consent means telling the soldiers what they are getting, why they are getting it, maintaining adequate records, and providing any needed medical care resulting from use. On October 17, 1998 PL 105-261 was enacted, requiring the president of the United States to issue a Finding before any INDs are used on military personnel. Thus, PB and BT could not be used without significant executive branch endeavor to meet legal conditions. Unfortunately, this NGWRC, veteran and service member victory has been virtually nullified by several developments. President Clinton issued Executive order 13139 in 1999 that allowed him and his successors to waive informed consent in times of nation security emergency. Additionally, the FDA instituted an "animal only" rule for bio-warfare drugs and vaccines that circumvented the long-standing requirement for human efficacy testing on the basis that such testing is unethical. Furthermore, the FDA is now differentially licensing drugs and vaccines for service-members and civilians (smallpox vaccine and PB are now fully licensed for wartime use but civilians are receiving smallpox vaccine under an IND). Upon determination by the president, at the request of the Secretary of Defense, and because of the FDA ruling, service members now face the exact same problem of forced experimentation experienced by Gulf War veterans.

A. Pyridostigmine Bromide (PB)

1. Historical Perspective

Pyridostigmine bromide (PB), a nerve agent pre-treatment drug, was a small white pill issued to U.S. and U.K. troops in blister packets. According to the DOD, as many as 250,000 U.S. troops took PB pills. The DOD failed to follow the FDA waiver, and very few records exist documenting who took how many of these pills.

Approved only for use in cases of a severe neurological disorder known as myasthenia gravis or to reverse anesthesia, PB has never been approved for use on civilians to protect against chemical warfare agents – this is why it has IND status (NO longer IND since March 2003).

In the few limited tests conducted prior to the war by the DOD, women, smokers, and anyone who might be at all sensitive to the drug were not allowed to participate. Despite screening, some adverse effects were noted. Some researchers believe pre-treatment with PB is only effective in relation to exposure to soman and they claim it may increase adverse effects of sarin.

2. Status of Investigations and Epidemiological Research

The National Gulf War Resource Center has demanded answers from the FDA concerning the approval of PB as a pretreatment for exposure to the nerve agent Soman. Documents and scientific studies conducted over the last 15 years have clearly shown this drug is both experimental and harmful when used for CW pretreatment, since soldiers are exposed to pesticides and other substances that increase PB's toxicity. The DOD and the Department of Veterans Affairs have both concluded through previous studies that PB could not be ruled out as a factor in Gulf War veteran's illnesses. In fact, Congress banned DOD's use of the substance in an amendment to the FY '99 Defense Authorization Bill unless it was approved for use by a Presidential waiver.

3. Several problems persist for continued use of this substance:

a. Studies have shown that PB's effectiveness against Soman is questionable; more importantly, our enemies in Iraq and Afghanistan have never been shown to have stores of Soman. Prescribing PB as a pretreatment is unscientific, dangerous, and appears to be simply a CYA maneuver in the event other measures, such as personal protective equipment, fail and is not proven effective by scientific fact.

b. PB's dosing for effectiveness is variable in each individual and would require individual evaluation due to the genetics and the size of the person receiving the dose.

c. PB is known to cause muscle damage in the animal studies cited by the FDA with even one dose.

d. Researchers have shown that PB, with simultaneous exposures to combinations of DEET, permethrin, sarin, or jet fuel, causes brain and testicular injury in experimental animals.

Thus, in allowing its use the FDA, DOD, Congress and the President are permitting questionable protection against Soman and increasing the likelihood that troops will be more susceptible to Sarin. It is possible that those who made the decision think they have chosen the lesser of two evils with the troops' protection in mind. But a policy decision that ignores the facts about the risks of PB is irresponsible policy-making.

It is unfortunate that the FDA has approved PB when it is known to have harmed veterans of the last Gulf War. Once again, our government is putting soldiers in another type of "Harm's Way," which could have been prevented. FDA's ruling is most likely the impetus for soldiers saving their sperm prior to the latest deployment to the Gulf region. The very least the Pentagon should have done is to give pre- and post-deployment exams and blood draws that may allow for analysis of PB effects on health.

B. Botulinum Toxoid (BT) Vaccine

The botulinum toxoid (BT) vaccine is also an IND. Before the 1991 war began, Ralph Nader's Public Citizen sought a court order to prevent the military from using the anti-nerve agent pill and botulinum toxoid vaccine. According to the DOD, approximately 8,000 U.S. troops received this vaccine. Again, the DOD failed to comply with the FDA waiver, and few records were kept showing who received the BT vaccine. An amendment by Senator Byrd of West Virginia to the FY 1999 Department of Defense Authorization Bill required the military to stop using this vaccine, along with the PB Tabs, without a waiver of informed consent by the President. The NGWRC is not aware of any research underway or completed regarding the long-term effects of the BT vaccine.

C. Anthrax Vaccine

Anthrax Chronology by Alan Milstein: http://www.sskrplaw.com/vaccine/anthchrono.html

Military Perspective – First known use of Anthrax as a biological weapon was against the Chinese by the occupying Japanese army in the 1930s. In response, the United States, Canada and the United Kingdom developed and experimented with anthrax weapons in 1941. After signing the Biological and Toxic Weapons Convention in 1972, the US stopped development of anthrax weapons.

The Vaccine: Although some form of Anthrax vaccine has been used since 1881, when Louis Pasteur developed the first successful vaccine for veterinary purposes, there are still many questions and problems about its use:

- Several formulations have been developed; some have proved fatal to recipients, others ineffective at preventing disease.
- The anthrax vaccine approved by the FDA is only for skin-contact (cutaneous) exposure; inhalation and ingestion exposures remain unprotected. Ingestion anthrax is rare, but inhalation anthrax seems like a more logical delivery for a bioterrorist to use than cutaneous delivery. The FDA eventually approved the same vaccine for all forms of anthrax, leaving many to doubt the entire process of FDA approval.
- For the 150,000 troops who were inoculated against anthrax in 1990-91, records kept by the DOD were incomplete and inconsistent. Therefore, there is no record to show who received the DOD vaccine, when it was given, or which lots of vaccines were used. According to the DOD,

records were not kept due to a mistaken belief by some military healthcare providers that the anthrax vaccine was a classified matter.
- Some lots of the vaccine may have been contaminated.
- Some shot recipients did not deploy to the Persian Gulf, but did develop illnesses similar to other veterans who had shots and other toxic exposures in theater.
- Hundreds of service personnel have reported adverse reactions, some severe and life threatening.
- There have been no studies regarding the long-term effects of the anthrax vaccine.
- The DOD contracts with one company, Emergent BioSolutions, Inc., which has had issues meeting FDA standards at their production facility.

Following is a link to Dr. Meryl Nass' report to the International Public Conference on Vaccination, September 10, 2000: http://www.mercola.com/2000/oct/29/anthrax.htm

This article provides background information on the anthrax vaccine and the series of ethically-questionable practices by the FDA in approving and the DOD in using it.

Mandatory Vaccination: In 1998, DOD made the vaccine program mandatory for all 2.4 million active duty, reserve, and guard troops. This program is still highly controversial for the reasons listed above. From the beginning of the order, military personnel have refused to take the shots, and many more resigned or retired rather than face it. For news reports concerning refusals, see:

*http://www.washingtonpost.com/ac2/wp-dyn/A28133-2004Mar26 and,
http://www.prisonplanet.com/articles/september2007/170907_b_anthrax.htm
**editor's note – the Washington Post link no longer takes you directly to the article.*

Synthetic Squalene: Another issue that damages DOD's credibility is the possibility that an experimental delivery vaccine booster (adjuvant) was used in anthrax vaccines during the Gulf War. General Accounting Office (GAO) records indicate that the DOD may have used synthetic squalene in some vaccines, which is not an FDA approved adjuvant.

Some Gulf War veterans have long suspected that the use of synthetic squalene in the anthrax shot is the root cause of their ailments. **Dr. Pamela Asa** (Tulane University) and her colleagues created a test to detect antibodies to squalene and discovered that all sick Gulf War veterans tested had these antibodies; no one in the control group had the antibodies. GAO reports indicated that resolution of squalene issues would require cooperation from the Pentagon, which was not forthcoming. After years of total denial about squalene, the FDA discovered squalene in all eight anthrax lots tested in 1999. This information was revealed in a House Government Reform Committee hearing on 3 October 2000 in a 3-year report from Representative Metcalf (State of Washington) who was retiring. The *Washington Times* weekly news magazine "Insight on the News" covered the entire history of the squalene controversy, containing this poignant statement by an unnamed FDA official: "Something is wrong when we find a contaminant in the vaccine [lots tested] that shouldn't be there," an FDA official tells Insight. "That tells me an investigation should have been launched. It wasn't, because of pressure, and that's not right; this vaccine should not be used until DOD finds out how squalene got into those tested batches, whether other batches are contaminated and the health consequences from the contamination."

In January 2003, anthrax vaccine vials washed up in West Bay, Dorset, United Kingdom. Suspicions were very strong that deploying British service members dumped thousands of anthrax vaccine vials overboard as they proceeded to the current Iraqi conflict. An independent British lab (SAL) tested some of the vials and discovered the presence of synthetic squalene. This is considered irrefutable proof of illegal experimentation on service members by the "chain of command." (**Gary Matsumoto**, ***"Vaccine A. The covert government experiment that's killing our soldiers and why GI's are only the first victims"***. Basic Books, 2004).

Neither Congress nor the DOD have made significant moves to clear up the question of squalene in the vaccine. See: http://www.jamesmadisonproject.org/press.php?press_id=6.

The current vaccine, according to Matsumoto's research is patented to include the squalene adjuvant. NGWRC continues to take every opportunity to shine light on this vaccine, hoping to attain recognition, diagnosis, and treatment for Gulf War veterans, and better force protection for the future.

Reactions: Following are a few of the more than 2000 documented short term adverse reactions reported by recipients of the anthrax vaccine to the FDA's Vaccine Adverse Event Reporting System (VAERS):

- Extreme fatigue.
- Local pain at injection site with swelling and pain extending into other body parts.
- Muscle and body weakness.
- Dizziness.
- Heart failure.
- Nausea and vomiting.
- Fever.
- Blurred vision.
- General malaise.

Documented long-term side effects reported by some recipients of the anthrax vaccine include:

- Extreme fatigue.
- Concentration and memory impairment.
- Dizziness.
- Joint and muscle pain.
- Nausea.
- Muscle and body weakness.
- Blurred vision.
- General Malaise.

Status of Investigations and Epidemiological Research **–** On 29 June 2002, the Assistant Secretary of Defense for Health Affairs, Dr. William Winkenwerder announced the resumption of mandatory anthrax vaccine shots for service members after a year hiatus caused by a quarantine of contaminated lots and the inability of the manufacturer to get FDA licensure for its facility. After the shots resumed in earnest in November/December 2002, the NGWRC received several calls per week from troops, their family members, or the media, on the third major military use of anthrax shots (Anthrax Vaccine Adsorbed, or AVA). This ongoing issue remains unresolved for many veterans and military personnel.

The following subtopics report on developments in important areas relevant to anthrax shot concerns of Gulf War veterans, their families, and current service members.

Lawsuits: Ruling against military personnel who refused to take the anthrax shot because of its inappropriate FDA classification, 2004: http://query.nytimes.com/gst/fullpage.html?sec=health&res=9A06E0DB1131F93BA35752C0A9629C8B63.

Groups with severe illness after receiving anthrax shot:
http://www.sskrplaw.com/publications/newguinea.html

A Qui Tam (whistleblower) lawsuit against the manufacturer for making false claims about the anthrax vaccine that caused personal harm to the plaintiff's job:
http://www.pubklaw.com/rd/courts/03-1841.pdf.

Press Coverage: Press coverage regarding problems within BioPort, the sole US manufacturer of the vaccine is available at http://www.wired.com/politics/law/news/2001/10/47410#. Background information on Bioport can be obtained at http://educate-yourself.org/vcd/vcdanthraxvacsanfu10oct01.shtml.

Petition to the FDA: On October 12, 2001, several key opponents of the Anthrax Vaccine Immunization Program (AVIP) policy (service members, attorneys and a retired FDA official) filed a petition with the FDA to declare the vaccine unsafe, misbranded, or ineffective, as well as adulterated and experimental given the DOD's use for inhalation exposure. Additionally, the petition requested the FDA enforce its regulations prohibiting distribution of an adulterated product to government or commercial markets and to revoke the manufacturer's license for such violations.
http://www.fda.gov/ohrms/dockets/dailys/01/Oct01/101501/cp00001.pdf

In their October 2002 response to the petition, FDA admitted the current vaccine's license is improper and that the FDA had not enforced its own regulations. In spite of these glaring admissions, the FDA refused to grant any of the petitioner's requests, thus setting the stage for an appeal or action in federal court, both of which are currently under consideration.
http://www.fda.gov/OHRMS/DOCKETS/dailys/02/Sep02/091102/80027a9f.pdf

A petition to BioPort to destroy quarantined stock:
http://www.petitiononline.com/robi2662/petition.html.

More information at http://www.mvrd.org/AVN/fdahal~1.htm.

VA Developments: On 14 May 2002, the VA General Counsel issued a legal finding specifically establishing service-connected disability solely for the anthrax vaccine by redefining the meaning of the word "injury": http://www.va.gov/ogc/docs/2002/PREC_4-2002.doc.

Citation: *"If evidence establishes that an individual suffers from a disabling condition as a result of administration of an anthrax vaccination during inactive duty training, the individual may be considered disabled by an "injury" incurred during such training as the term is used in 38 U.S.C. § 101 (24), which defines "active military, naval, or air service" to include any period of inactive duty training during which the individual was disabled or died from an injury incurred or aggravated in line of duty. Consequently, such an individual may be found to have incurred disability in active military, naval, or air service for purposes of disability compensation under 38 U.S.C. § 1110 or 1131."*

A number of cases involving Gulf War and post-Gulf War veterans are resulting in award of disability ratings, thus indicating that the VA is following through on its position.

GAO/Congress: Dr. Sue Bailey, Assistant Secretary for Health Affairs, Department of Defense, reported to House Subcommittee on National Security, Veterans' Affairs and International Relations of the Committee on Government Reform, March 24, 1999. Dr. Bailey subsequently participated in a press conference: http://www.fas.org/spp/starwars/program/news00/t02172000_t0217asd.htm.

Dr. Bailey was named to the Board of Directors of BioPort on June 14, 2007: http://www.smartmoney.com/wsj/briefingbooks/doPrint.cfm?page=executives&origin=wsj&symbol=EBS&type=usstock.

Women's/Birth Issues: Early in the AVIP program, the Army injected 600 medical workers at its Tripler Army Medical Center in Hawaii with the anthrax shot. Statistics there showed women experiencing adverse reactions at twice the rate of men. The Army's top immunologist declared at a May 1999 Ft. Detrick meeting that attendees might regret pushing this vaccine, given the women's immune system differences. This warning became reality as the September 2001 issue of *Self* magazine documented several severe cases of women's reactions.

Also in 1999, three congresswomen wrote Secretary of Defense Cohen requesting shots be made voluntary for women http://www.whale.to/v/anthrax4.html.

These concerns were further verified when *The Wall Street Journal* and *Army Times* published stories on Navy studies indicating problems for women:
http://www.ph.ucla.edu/epi/bioter/anthraxvacbirthdefects.html

Other Resources:
http://anthraxvaccine.blogspot.com/2007_07_01_archive.html#6806076506901379532;

http://www.gulfwarvets.com/anthrax.htm,

http://www.thepowerhour.com/articles/anthrax.htm

For legal arguments, see: http://www.law.duke.edu/shell/cite.pl?50+Duke+L.+J.+1835#H1N7.

What the DOD says: http://www.anthrax.mil/whatsnew/FDAorder.asp

What JAMA says: http://jama.ama-assn.org/cgi/content/full/282/22/2104 , read to the bottom to find out the authors' credentials.

DEPLETED URANIUM

Depleted Uranium (DU) is the source of intense controversy. A radioactive derivative of the process of creating nuclear fuel for power plants, it is used in weaponry and as a shield on the exterior of battle tanks. The controversy is between the VA, DOD and some in the scientific community, who declare that DU is safe to use and economically sound -- and a few vocal advocates stating that DU is hazardous, toxic, and environmentally disastrous. We will attempt to present information that will help veterans decide which side they believe.

The U.S. government has stated that exposure to *.01 gram in one YEAR* can cause health problems:

The Army accepts the Nuclear Regulatory Commission's (NRC's) recommended limit of 100 mrem (0.1 rem) per year as the allowed limit on radiation exposure for its tank crews and maintenance personnel. The current exposure limits is specified by the NRC at 10 CFR 20.1301. The Army must assure that individual crew members are not exposed to radiation fields in excess 0.1 rem in any one year (Source – Federal Register, July 14, 1998). *Editor's note – source for mrem/hour limit could not be located; that part of the sentence was removed 2013-jun-27.*

However, a GulfLink website states the following: "Fortunately, it's really impossible to breathe in enough depleted uranium to do you any serious harm," [Naomi H.] Harley says. "If you work in an industry that uses uranium, you're allowed concentrations in the air of 0.2 of a milligram per cubic meter, which means in a work day you might inhale two milligrams. This is the kind of air concentration you find right near [an armored vehicle] where a DU round hits it. When you breathe it in, you breathe in some uranium, but the risk is so low it's very hard to calculate." Resource: http://www.gulflink.osd.mil/news/na_harley_03jan00.html

Defenders of the use of DU in armaments claim, perhaps truthfully, that the alpha radiation emitted by the Uranium^{238} doesn't go far enough to do damage to living organisms (mainly, people). However, radiation does not have far to travel when the U^{238} has been inhaled and lodges permanently in the lungs. Presumably, ingested DU does not accumulate, and passes from the body in a short period of time, limiting exposure. How it could be ingested without being inhaled is a question for research.

Each DU round fired by U.S. M-1 series tanks creates as much as 3,100 grams of ultra-fine radioactive/heavy metal dust upon impact, which is insoluble, easily inhaled, and may remain in the body for years, gradually going from the lungs into other organs and skeletal structures. This is by far the most serious form of exposure. This is also the least studied type of exposure among military scientists.

Here is what the **National Institutes of Health** said about depleted uranium:

"*During the Gulf War, several military regulations required that soldiers' medical records should be noted if they entered areas known or suspected to be contaminated by radioactive materials, and that those soldiers should be provided medical tests to determine the level of exposure, if any. The DOD failed to follow the law, and there no known records of the length or level of DU exposures. As with other Gulf War exposures, the lack of reliable data remains a serious obstacle to researchers investigating DU poisoning*."

In 1999, the VA launched a DU testing program, and veterans who believe they may have been exposed should call the VA at (800) PGW-VETS (800-749-8387): Veterans' Special Issues Helpline) or the DOD at (800) 472-6719 for further information. If the VA or DOD do not respond to your call within one week, write a letter to your military commander or your local VA Medical Center and request the DU test. Although testing results for the presence of DU in urine may be ineffective after so many years, the NGWRC strongly encourages participation in this testing program.

Part of DU testing involves a lengthy questionnaire, and the results of the questionnaire may force the VA or DOD to presume you were exposed, even if the test results are negative. Many soldiers were never informed that the shrapnel in their bodies was DU.

Status of Investigations and Epidemiological Research **–** DU exists in large quantities and its use in munitions relieves governments of their fiscal and legal responsibilities to properly store it.[i] In addition, DU's extreme density (1.7 times that of lead), pyrophoricity (it burns when it fragments), and resistance to deformation (when alloyed with a small amount of titanium) enable it to effectively penetrate tank armor.[ii] The US Navy is, however, phasing out its use of small caliber DU rounds (20mm). It continues to be used in the present Iraqi and Afghanistan Wars.

Exposure to DU armor and/or penetrators poses the greatest potential to cause health problems among people who:

- Are/were in a friendly fire incident involving DU rounds.
- Breathe smoke or dust from a burning vehicle hit by DU rounds.
- Eat food or drink water contaminated by DU dust.
- Climb on or enter a vehicle or bunker hit by DU rounds.
- Collect, handle, or participate in cleaning up spent DU fragments or penetrators.
- Breathe smoke or dust from a fire involving DU armor and/or rounds, such as the July 1991 fire at Doha, Kuwait.
- Treat those injured by DU shrapnel or covered with DU dust; and
- Maintain or repair vehicles struck by DU rounds.

Recently published and/or released information from the Armed Forces Radiobiology Research Institute (part of the DOD), plus findings from a VA follow-up program at the Baltimore, Maryland VA, show evidence that:

- In animal studies, DU settles in the bone, brain, lung, muscle, kidney, liver, and testicles.
- In animal studies, DU transforms cells into a tumorigenic phenotype.
- DU cells form tumors in mice.
- In animal studies, DU is mutagenic.
- In animal studies, DU is associated with reduced litter size.
- From the results of animal studies, strong evidence exists to support a detailed study of potential that DU is associated with cancer.
- In follow-up on Gulf War veterans, DU was found in semen; and
- In follow up on Gulf War veterans, elevated DU in urine is linked to increased neurological problems.

Information on this can be found at the IOM website.
http://www.iom.edu/Reports/2008/Epidemiologic-Studies-Veterans-Exposed-Depleted-Uranium.aspx

Laboratory studies on rats indicate short-term effects include kidney damage, while long-term effects may include cancer, central nervous system problems, immune system disorders and reproductive effects.[iii]

Few humans exposed to DU have been studied, therefore little is known about the effects DU has had or may have in the future on exposed populations. The US government claims it has not found evidence of significant health effects caused by DU in a study of a few dozen Gulf War veterans,[iv] although Pentagon spokesmen have lied about the existence of cancer among these veterans.[v] There have been many claims made about DU causing a large number of serious health effects in Iraq, the Balkans, and Afghanistan, but these claims have not been confirmed by credible, independent sources.

The International Atomic Energy Agency released a report on 13 June 2003 regarding DU in Kuwait
http://www.iaea.org/NewsCenter/News/2003/13-571089.shtml

World Health Organization (WHO) released a report on DU use in Kosovo:
http://www.who.int/ionizing_radiation/pub_meet/en/Report_WHO_depleted_uranium_Eng.pdf

WHO studies of cancer rates in Iraq since the 1991 Gulf War apparently never occurred:
http://www.iacenter.org/depleted/who.htm

http://news.bbc.co.uk/1/hi/world/middle_east/1506151.stm

DU may also contaminate soil, water, and air, as well as plant and animal life. The extent of the contamination and its risk to public health depend on the quantity and size of the DU released its local concentration, and environmental conditions.

The use of DU munitions by the US and its allies in the war in Afghanistan remains unclear. Claims about the use of DU munitions in Afghanistan have neither been confirmed by the US military, nor verified by independent investigations. Nonetheless, it appears likely that US forces used some DU munitions, and the Taliban and/or al Qaeda may have possessed DU rounds.[vi, vii, viii, ix, x, xi, xii, xiii.]

The following articles are very informative about DU:
http://www.thepeoplesvoice.org/cgi-bin/blogs/voices.php/2007/10/17/depleted_uranium_a_8211_far_worse_than_9_11

http://www.sourcewatch.org/index.php?title=Depleted_Uranium

DU in the Balkans:
http://www.isn.ethz.ch/isn/Current-Affairs/Security-Watch/Detail/?id=53886&lng=en
http://intellibriefs.blogspot.com/2007/10/depleted-uranium-depleted-health.html

Many developments have occurred since publication of the initial version of this Guide. Most notable has been the issuance of a November 2008 report by the VA's "*Research Advisory Committee on Gulf War Veteran's Illnesses*" which can be viewed online at:
http://www1.va.gov/RAC-GWVI/docs/Committee_Documents/GWIandHealthofGWVeterans_RAC-GWVIReport_2008.pdf

Appendix III - The History of the Gulf War Illness Act

a. On November 2, 1994, Congress enacted the "Persian Gulf War Veterans' Benefits Act," Title I of the "*Veterans' Benefits Improvements Act of 1994*," *Public Law (PL) 103-446*.
The statute added a new section, 38 U.S.C. 1117, authorizing the Department of Veterans Affairs (VA) to compensate any Gulf War (GW) veteran suffering from a chronic disability resulting from an undiagnosed illness or combination of undiagnosed illnesses which manifested either during active duty in the Southwest Asia theater of operations during the GW, or to a degree of 10 percent more within a presumptive period following service in the Southwest Asia theater of operations during the GW

**b. The "*Persian Gulf War Veterans' Act of 1998*," *PL 105-277*, authorized VA to compensate GW veterans for diagnosed or undiagnosed disabilities that are determined by VA regulation to warrant a presumption of service connection based on a positive association with exposure to one of the following as a result of GW service:

- a toxic agent
- an environmental or wartime hazard, or
- a preventive medication or vaccine

Note: This statute added 38 U.S.C. 1118.

**c. The "*Veterans Education and Benefits Expansion Act of 2001*," *PL 107-103*, expanded the definition of "qualifying chronic disability" under 38 U.S.C. 1117 to include, effective March 1, 2002, not only a disability resulting from an undiagnosed illness but also

- a medically unexplained chronic multi-symptom illness that is defined by a cluster of signs and symptoms, and
- any diagnosed illness that is determined by VA regulation to warrant presumption of service connection

38 CFR 3.317, which implements 38 U.S.C. 1117, defines GW service and "qualifying chronic disability," and provides

- a broad, but non-exclusive, list of signs and symptoms which may be representative of undiagnosed or chronic, multi-symptom illnesses for which compensation may be paid,
- and the presumptive period for service connection

Qualifying chronic disability, under 38 CFR 3.317, means a chronic disability resulting from any of the following or any combination of the following:

- an undiagnosed illness
- a medically unexplained chronic multi-symptom illness, such as chronic fatigue syndrome, fibromyalgia, and irritable bowel syndrome, that is defined by a cluster of signs or symptoms,(there are some rule changes that will help the veterans in this area) and/or
- any diagnosed illness that is determined by VA regulation to warrant a presumption of service connection

The presumptive period for manifestation of qualifying chronic disability under 38 CFR 3.317

- begins on the date following last performance of active military, naval, or air service in the Southwest Asia theater of operations during the GW,
- and extends through December 31, 2011 (There is movement to change this)

38 CFR 3.317 specifies the following 13 categories of signs or symptoms that may represent a qualifying chronic disability:

- abnormal weight loss
- cardiovascular signs or symptoms
- fatigue
- gastrointestinal signs or symptoms
- headache
- joint pain
- menstrual disorders
- muscle pain
- neurologic signs or symptoms
- neuropsychological signs or symptoms
- signs or symptoms involving the skin
- signs or symptoms involving the upper and lower respiratory system, and
- sleep disturbances

Notes:

The list of 13 illness categories is not exclusive.

Signs or symptoms not represented by one of the listed categories may also qualify for consideration under 38 CFR 3.317.

A disability that is affirmatively shown to have resulted from a cause other than GW service may not be compensated under 38 CFR 3.317.

To qualify, the claimed disability must be chronic, that is, it *must* have persisted for a period of six months or more.

Measure the six-month period of chronicity from the earliest date on which all pertinent evidence establishes that the signs or symptoms of the disability first became manifest.

Note: If a disability is subject to intermittent episodes of improvement and worsening within a six-month period, consider the disability to be chronic.

d. In July of 2010 a letter was sent to all of the adjudicators with a revisions to 38 C.F.R. § 3.317 to clarify the Meaning of "Medically Unexplained Chronic Multisystem Illness" Related to Gulf War and Southwest Asia Service. VA is revising § 3.317 to clarify that the three listed diagnosed multisymptom illnesses are not exclusive, but rather are examples that can serve to inform VA medical examiners and adjudicators of the general types of medically unexplained chronic multisymptom illnesses that may qualify for service connection under the § 1117 authority.

This was one of the changes that was briefed in an RAC meeting by the Department of Veterans Affairs Chief of Staff.

Appendix IV - Researchers

a. Lea Steele - The Kansas Commission on Veterans Affairs completed the first state-sponsored study of Gulf War Illnesses in 2000. The VA‟s RAC interim report in 2004 conclusions study agreed with the Kansas study; that Gulf War Illnesses is a major health problem for veterans who deployed to the theater. The Kansas study identified six types of symptom groups associated with Gulf War service:

A. Neurological (memory, headache, mood, dizziness problems)
B. Fatigue and sleep disorders
C. Pain in joints and muscles
D. Gastrointestinal (diarrhea and nausea)
E. Respiratory (persistent cough and wheezing)
F. Skin (rashes and other problems)

This random telephone study of Kansas Gulf War veterans, which was published in the November 15, 2000 issues of *The American Journal of Epidemiology*, noted that deployed Gulf-era veterans were two to five times more likely to report having the above symptoms compared to non-deployed veterans. The tendency of deployed veterans to have multiple symptoms (3-6) on a chronic basis was referred to as "Gulf War Illness." The Kansas study also showed difference in symptom severity based on branch of service, time in theater, and specific in-theater locations. Additionally, this research demonstrated that health problems from vaccines existed even in those who did not deploy – important information for later-serving service members.

The Kansas Study has since been done by many other researchers. All reached the same finding.

b. Dr. Robert Haley - Dr. Haley and colleagues at the University of Texas Southwestern have been conducting epidemiologic, clinical and laboratory research on the "Gulf War Syndrome" and related neurological illnesses in Gulf War veterans since March 1994. The work has been supported by a continuing grant from the Perot Foundation until a contract was done with the VA. In 2009 the VA terminated the contract. The objectives of the research are to define new or unique clinical syndromes among Gulf War veterans, determine their causes, identify areas of damage or dysfunction in the brain and nervous system responsible for the symptoms, develop a cost-effective battery of clinical tests that can diagnose the illness, search for underlying genetic traits that might predispose to the illness, and perform clinical trials of promising treatments.

The initial studies identified three primary syndromes in a Naval Reserve construction battalion (Seabees) that appear to be unique, demonstrated that the syndromes are associated with subtle dysfunction of the brainstem and lower parts of the brain, and found epidemiologic associations between the syndromes and risk factors of exposure to combinations of chemicals in the Gulf War.

Genetic studies have identified a genetic trait (PON1 enzymes) that may explain why some soldiers sustained brain damage from exposure to neurotoxic chemicals while others working alongside them remained well. Most recently, research using magnetic resonance spectroscopy has demonstrated a loss of functioning brain cells in deep brain structures of ill Gulf War veterans. Additional commentaries by Dr. Haley have challenged the government‟s stress theory of Gulf War syndrome and findings of no difference in morality, hospitalization and birth defects between Gulf War-deployed and nondeployed military populations, Additional research and publications are in process.

Appendix V
CFR 38 §3.317 Compensation for certain disabilities occurring in Persian Gulf veterans

(a) *Compensation for disability due to undiagnosed illness and medically unexplained chronic multisymptom illnesses*.

(1) Except as provided in paragraph (a)(7) of this section, VA will pay compensation in accordance with chapter 11 of title 38, United States Code, to a Persian Gulf veteran who exhibits objective indications of a qualifying chronic disability, provided that such disability:

(i) Became manifest either during active military, naval, or air service in the Southwest Asia theater of operations, or to a degree of 10 percent or more not later than December 31, 2016; and

(ii) By history, physical examination, and laboratory tests cannot be attributed to any known clinical diagnosis.

(2) (i) For purposes of this section, a *qualifying chronic disability* means a chronic disability resulting from any of the following (or any combination of the following):

(A) An undiagnosed illness;

(B) A medically unexplained chronic multisymptom illness that is defined by a cluster of signs or symptoms, such as:

(*1*) Chronic fatigue syndrome;

(*2*) Fibromyalgia;

(*3*) Functional gastrointestinal disorders (excluding structural gastrointestinal diseases).

Note to paragraph (a)(2)(i)(B)(*3*): Functional gastrointestinal disorders are a group of conditions characterized by chronic or recurrent symptoms that are unexplained by any structural, endoscopic, laboratory, or other objective signs of injury or disease and may be related to any part of the gastrointestinal tract. Specific functional gastrointestinal disorders include, but are not limited to, irritable bowel syndrome, functional dyspepsia, functional vomiting, functional constipation, functional bloating, functional abdominal pain syndrome, and functional dysphagia. These disorders are commonly characterized by symptoms including abdominal pain, substernal burning or pain, nausea, vomiting, altered bowel habits (including diarrhea, constipation), indigestion, bloating, postprandial fullness, and painful or difficult swallowing. Diagnosis of specific functional gastrointestinal disorders is made in accordance with established medical principles, which generally require symptom onset at least 6 months prior to diagnosis and the presence of symptoms sufficient to diagnose the specific disorder at least 3 months prior to diagnosis.

(ii) For purposes of this section, the term *medically unexplained chronic multisymptom illness* means a diagnosed illness without conclusive pathophysiology or etiology, that is characterized by overlapping symptoms and signs and has features such as fatigue, pain, disability out of proportion to physical findings, and inconsistent demonstration of laboratory abnormalities. Chronic

multisymptom illnesses of partially understood etiology and pathophysiology, such as diabetes and multiple sclerosis, will not be considered medically unexplained.

(3) For purposes of this section, "objective indications of chronic disability" include both "signs," in the medical sense of objective evidence perceptible to an examining physician, and other, non-medical indicators that are capable of independent verification.

(4) For purposes of this section, disabilities that have existed for 6 months or more and disabilities that exhibit intermittent episodes of improvement and worsening over a 6-month period will be considered chronic. The 6-month period of chronicity will be measured from the earliest date on which the pertinent evidence establishes that the signs or symptoms of the disability first became manifest.

(5) A qualifying chronic disability referred to in this section shall be rated using evaluation criteria from part 4 of this chapter for a disease or injury in which the functions affected, anatomical localization, or symptomatology are similar.

(6) A qualifying chronic disability referred to in this section shall be considered service connected for purposes of all laws of the United States.

(7) Compensation shall not be paid under this section for a chronic disability:

(i) If there is affirmative evidence that the disability was not incurred during active military, naval, or air service in the Southwest Asia theater of operations; or

(ii) If there is affirmative evidence that the disability was caused by a supervening condition or event that occurred between the veteran's most recent departure from active duty in the Southwest Asia theater of operations and the onset of the disability; or

(iii) If there is affirmative evidence that the disability is the result of the veteran's own willful misconduct or the abuse of alcohol or drugs.

(b) *Signs or symptoms of undiagnosed illness and medically unexplained chronic multisymptom illnesses*. For the purposes of paragraph (a)(1) of this section, signs or symptoms which may be manifestations of undiagnosed illness or medically unexplained chronic multisymptom illness include, but are not limited to:

(1) Fatigue.
(2) Signs or symptoms involving skin.
(3) Headache.
(4) Muscle pain.
(5) Joint pain.
(6) Neurological signs or symptoms.
(7) Neuropsychological signs or symptoms.
(8) Signs or symptoms involving the respiratory system (upper or lower).
(9) Sleep disturbances.
(10) Gastrointestinal signs or symptoms.
(11) Cardiovascular signs or symptoms.

(12) Abnormal weight loss.
(13) Menstrual disorders.

(c) *Presumptive service connection for infectious diseases*.

(1) Except as provided in paragraph (c)(4) of this section, a disease listed in paragraph (c)(2) of this section will be service connected if it becomes manifest in a veteran with a qualifying period of service, provided the provisions of paragraph (c)(3) of this section are also satisfied.

(2) The diseases referred to in paragraph (c)(1) of this section are the following:

(i) Brucellosis.
(ii) Campylobacter jejuni.
(iii) Coxiella burnetii (Q fever).
(iv) Malaria.
(v) Mycobacterium tuberculosis.
(vi) Nontyphoid Salmonella.
(vii) Shigella.
(viii) Visceral leishmaniasis.
(ix) West Nile virus.

(3) The diseases listed in paragraph (c)(2) of this section will be considered to have been incurred in or aggravated by service under the circumstances outlined in paragraphs (c)(3)(i) and (ii) of this section even though there is no evidence of such disease during the period of service.

(i) With three exceptions, the disease must have become manifest to a degree of 10 percent or more within 1 year from the date of separation from a qualifying period of service as specified in paragraph (c)(3)(ii) of this section. Malaria must have become manifest to a degree of 10 percent or more within 1 year from the date of separation from a qualifying period of service or at a time when standard or accepted treatises indicate that the incubation period commenced during a qualifying period of service. There is no time limit for visceral leishmaniasis or tuberculosis to have become manifest to a degree of 10 percent or more.

(ii) For purposes of this paragraph (c), the term qualifying period of service means a period of service meeting the requirements of paragraph (e) of this section or a period of active military, naval, or air service on or after September 19, 2001, in Afghanistan.

(4) A disease listed in paragraph (c)(2) of this section shall not be presumed service connected:

(i) If there is affirmative evidence that the disease was not incurred during a qualifying period of service; or

(ii) If there is affirmative evidence that the disease was caused by a supervening condition or event that occurred between the veteran's most recent departure from a qualifying period of service and the onset of the disease; or

(iii) If there is affirmative evidence that the disease is the result of the veteran's own willful misconduct or the abuse of alcohol or drugs.

(d) *Long-term health effects potentially associated with infectious diseases*.

(1) A report of the Institute of Medicine of the National Academy of Sciences has identified the following long-term health effects that potentially are associated with the infectious diseases listed in paragraph (c)(2) of this section. These health effects and diseases are listed alphabetically and are not categorized by the level of association stated in the National Academy of Sciences report (see Table to §3.317). If a veteran who has or had an infectious disease identified in column A also has a condition identified in column B as potentially related to that infectious disease, VA must determine, based on the evidence in each case, whether the column B condition was caused by the infectious disease for purposes of paying disability compensation. This does not preclude a finding that other manifestations of disability or secondary conditions were caused by an infectious disease.

(2) If a veteran presumed service connected for one of the diseases listed in paragraph (c)(2) of this section is diagnosed with one of the diseases listed in column "B" in the table within the time period specified for the disease in the same table, if a time period is specified or, otherwise, at any time, VA will request a medical opinion as to whether it is at least as likely as not that the condition was caused by the veteran having had the associated disease in column "A" in that same table.

Table to § 3.317—Long-Term Health Effects Potentially Associated With Infectious Diseases

A	*B* *Disease*
Brucellosis	Arthritis.
	Cardiovascular, nervous, and respiratory system infections.
	Chronic meningitis and meningoencephalitis.
	Deafness.
	Demyelinating meningovascular syndromes.
	Episcleritis.
	Fatigue, inattention, amnesia, and depression.
	Guillain-Barr syndrome.
	Hepatic abnormalities, including granulomatous hepatitis.
	Multifocal choroiditis.
	Myelitis-radiculoneuritis.
	Nummular keratitis.
	Papilledema.
	Optic neuritis.
	Orchioepididymitis and infections of the genitourinary system.
	Sensorineural hearing loss.
	Spondylitis.
	Uveitis.
Campylobacter jejuni	Guillain-Barr syndrome *if manifest within 2 months of the infection.*
	Reactive Arthritis *if manifest within 3 months of the infection*.
	Uveitis *if manifest within 1 month of the infection*.

Coxiella burnetii (Q fever)	Chronic hepatitis. Endocarditis. Osteomyelitis. Post-Q-fever chronic fatigue syndrome. Vascular infection.
Malaria	Demyelinating polyneuropathy. Guillain-Barr syndrome. Hematologic manifestations (particularly anemia after falciparum malaria and splenic rupture after vivax malaria). Immune-complex glomerulonephritis. Neurologic disease, neuropsychiatric disease, or both. Ophthalmologic manifestations, particularly retinal hemorrhage and scarring. *Plasmodium falciparum*. *Plasmodium malariae*. *Plasmodium ovale*. *Plasmodium vivax*. Renal disease, especially nephrotic syndrome.
Mycobacterium tuberculosis	Active tuberculosis. Long-term adverse health outcomes due to irreversible tissue damage from severe forms of pulmonary and extrapulmonary tuberculosis and active tuberculosis.
Nontyphoid Salmonella	Reactive Arthritis *if manifest within 3 months of the infection*.
Shigella	Hemolytic-uremic syndrome *if manifest within 1 month of the infection.* Reactive Arthritis *if manifest within 3 months of the infection*.
Visceral leishmaniasis	Delayed presentation of the acute clinical syndrome. Post-kala-azar dermal leishmaniasis *if manifest within 2 years of the infection.* Reactivation of visceral leishmaniasis in the context of future immunosuppression.
West Nile virus	Variable physical, functional, or cognitive disability.

(e) *Service*. For purposes of this section:

(1) The term *Persian Gulf veteran* means a veteran who served on active military, naval, or air service in the Southwest Asia theater of operations during the Persian Gulf War.

(2) The *Southwest Asia theater of operations* refers to Iraq, Kuwait, Saudi Arabia, the neutral zone between Iraq and Saudi Arabia, Bahrain, Qatar, the United Arab Emirates, Oman, the Gulf of Aden, the Gulf of Oman, the Persian Gulf, the Arabian Sea, the Red Sea, and the airspace above these locations. (Authority: 38 U.S.C. 1117, 1118).

[60 FR 6665, Feb. 3, 1995, as amended at 62 FR 23139, Apr. 29, 1997; 63 FR 11122, Mar. 6, 1998; 66 FR 56615, Nov. 9, 2001; 67 FR 78979, Dec. 27, 2002; 68 FR 34541, June 10, 2003; 71 FR 75672, Dec. 18, 2006; 72 FR 68507, Dec. 5, 2007; 75 FR 59970, Sept. 29, 2010; 75 FR 61356, Oct. 5, 2010; 75 FR 61997, Oct. 7, 2010; 76 FR 41698, July 15, 2011; 76 FR 81836, Dec. 29, 2011; 77 FR 63228, Oct. 16, 2012]

Supplement *Highlights* references: 14(5), 29(1), 48(2), 57(1), 74(3), 75(1), 77(1), 93(1), 94(1), 96(1), 99(1), 104(1).

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Appendix VI
CFR 38 §3.318 Presumptive Service Connection for Amyotrophic Lateral Sclerosis

(a) Except as provided in paragraph (b) of this section, the development of amyotrophic lateral sclerosis manifested at any time after discharge or release from active military, naval, or air service is sufficient to establish service connection for that disease.

(b) Service connection will not be established under this section:

(1) If there is affirmative evidence that amyotrophic lateral sclerosis was not incurred during or aggravated by active military, naval, or air service;

(2) If there is affirmative evidence that amyotrophic lateral sclerosis is due to the veteran's own willful misconduct; or

(3) If the veteran did not have active, continuous service of 90 days or more. (Authority: 38 U.S.C. 501(a)(1))

[73 FR 54693, Sept. 23, 2008, as amended at 74 FR 57072, Nov. 4, 2009]

Supplement *Highlights* references: 82(1), 90(1).

Appendix VII – CFR 38 §3.304 Direct service connection; wartime and peacetime

(a) *General*. The basic considerations relating to service connection are stated in §3.303. The criteria in this section apply only to disabilities which may have resulted from service in a period of war or service rendered on or after January 1, 1947.

(b) *Presumption of soundness*. The veteran will be considered to have been in sound condition when examined, accepted and enrolled for service except as to defects, infirmities, or disorders noted at entrance into service, or where clear and unmistakable (obvious or manifest) evidence demonstrates that an injury or disease existed prior thereto and was not aggravated by such service. Only such conditions as are recorded in examination reports are to be considered as noted. (Authority: 38 U.S.C. 1111)

(1) History of preservice existence of conditions recorded at the time of examination does not constitute a notation of such conditions but will be considered together with all other material evidence in determinations as to inception. Determinations should not be based on medical judgment alone as distinguished from accepted medical principles, or on history alone without regard to clinical factors pertinent to the basic character, origin and development of such injury or disease. They should be based on thorough analysis of the evidentiary showing and careful correlation of all material facts, with due regard to accepted medical principles pertaining to the history, manifestations, clinical course, and character of the particular injury or disease or residuals thereof.

(2) History conforming to accepted medical principles should be given due consideration, in conjunction with basic clinical data, and be accorded probative value consistent with accepted medical and evidentiary principles in relation to value consistent with accepted medical evidence relating to incurrence, symptoms and course of the injury or disease, including official and other records made prior to, during or subsequent to service, together with all other lay and medical evidence concerning the inception, development and manifestations of the particular condition will be taken into full account.

(3) Signed statements of veterans relating to the origin, or incurrence of any disease or injury made in service if against his or her own interest is of no force and effect if other data do not establish the fact. Other evidence will be considered as though such statement were not of record. (Authority: 10 U.S.C. 1219)

(c) *Development*. The development of evidence in connection with claims for service connection will be accomplished when deemed necessary but it should not be undertaken when evidence present is sufficient for this determination. In initially rating disability of record at the time of discharge, the records of the service department, including the reports of examination at enlistment and the clinical records during service, will ordinarily suffice. Rating of combat injuries or other conditions which obviously had their inception in service may be accomplished pending receipt of copy of the examination at enlistment and all other service records.

(d) *Combat*. Satisfactory lay or other evidence that an injury or disease was incurred or aggravated in combat will be accepted as sufficient proof of service connection if the evidence is consistent with the circumstances, conditions or hardships of such service even though there is no official record of such incurrence or aggravation. (Authority: 38 U.S.C. 1154(b))

(e) *Prisoners of war.* Where disability compensation is claimed by a former prisoner of war, omission of history or findings from clinical records made upon repatriation is not determinative of service connection, particularly if evidence of comrades in support of the incurrence of the disability during confinement is available. Special attention will be given to any disability first reported after discharge, especially if poorly defined and not obviously of intercurrent origin. The circumstances attendant upon the individual veteran's confinement and the duration thereof will be associated with pertinent medical principles in determining whether disability manifested subsequent to service is etiologically related to the prisoner of war experience.

(f) *Posttraumatic stress disorder.* Service connection for posttraumatic stress disorder requires medical evidence diagnosing the condition in accordance with §4.125(a) of this chapter; a link, established by medical evidence, between current symptoms and an in-service stressor; and credible supporting evidence that the claimed in-service stressor occurred. The following provisions apply to claims for service connection of posttraumatic stress disorder diagnosed during service or based on the specified type of claimed stressor:

(1) If the evidence establishes a diagnosis of posttraumatic stress disorder during service and the claimed stressor is related to that service, in the absence of clear and convincing evidence to the contrary, and provided that the claimed stressor is consistent with the circumstances, conditions, or hardships of the veteran's service, the veteran's lay testimony alone may establish the occurrence of the claimed in-service stressor.

(2) If the evidence establishes that the veteran engaged in combat with the enemy and the claimed stressor is related to that combat, in the absence of clear and convincing evidence to the contrary, and provided that the claimed stressor is consistent with the circumstances, conditions, or hardships of the veteran's service, the veteran's lay testimony alone may establish the occurrence of the claimed in-service stressor.

(3) If a stressor claimed by a veteran is related to the veteran's fear of hostile military or terrorist activity and a VA psychiatrist or psychologist, or a psychiatrist or psychologist with whom VA has contracted, confirms that the claimed stressor is adequate to support a diagnosis of posttraumatic stress disorder and that the veteran's symptoms are related to the claimed stressor, in the absence of clear and convincing evidence to the contrary, and provided the claimed stressor is consistent with the places, types, and circumstances of the veteran's service, the veteran's lay testimony alone may establish the occurrence of the claimed in-service stressor. For purposes of this paragraph, "fear of hostile military or terrorist activity" means that a veteran experienced, witnessed, or was confronted with an event or circumstance that involved actual or threatened death or serious injury, or a threat to the physical integrity of the veteran or others, such as from an actual or potential improvised explosive device; vehicle-imbedded explosive device; incoming artillery, rocket, or mortar fire; grenade; small arms fire, including suspected sniper fire; or attack upon friendly military aircraft, and the veteran's response to the event or circumstance involved a psychological or psycho-
physiological state of fear, helplessness, or horror.

(4) If the evidence establishes that the veteran was a prisoner-of-war under the provisions of §3.1(y) of this part and the claimed stressor is related to that prisoner-of-war experience, in the absence of clear and convincing evidence to the contrary, and provided that the claimed stressor is consistent with the circumstances, conditions, or hardships of the veteran's service, the veteran's lay testimony alone may establish the occurrence of the claimed in-service stressor.

(5) If a posttraumatic stress disorder claim is based on in-service personal assault, evidence from sources other than the veteran's service records may corroborate the veteran's account of the stressor incident. Examples of such evidence include, but are not limited to: records from law enforcement authorities, rape crisis centers, mental health counseling centers, hospitals, or physicians; pregnancy tests or tests for sexually transmitted diseases; and statements from family members, roommates, fellow service members, or clergy. Evidence of behavior changes following the claimed assault is one type of relevant evidence that may be found in these sources. Examples of behavior changes that may constitute credible evidence of the stressor include, but are not limited to: a request for a transfer to another military duty assignment; deterioration in work performance; substance abuse; episodes of depression, panic attacks, or anxiety without an identifiable cause; or unexplained economic or social behavior changes. VA will not deny a posttraumatic stress disorder claim that is based on in-service personal assault without first advising the claimant that evidence from sources other than the veteran's service records or evidence of behavior changes may constitute credible supporting evidence of the stressor and allowing him or her the opportunity to furnish this type of evidence or advise VA of potential sources of such evidence. VA may submit any evidence that it receives to an appropriate medical or mental health professional for an opinion as to whether it indicates that a personal assault occurred. (Authority: 38 U.S.C. 501(a), 1154)

[26 FR 1580, Feb. 24, 1961, as amended at 31 FR 4680, Mar. 19, 1966; 39 FR 34530, Sept. 26, 1974; 58 FR 29110, May 19, 1993; 64 FR 32808, June 18, 1999; 67 FR 10332, Mar. 7, 2002; 70 FR 23029, May 4, 2005; 73 FR 64210, Oct. 29, 2008; 74 FR 14491, Mar. 31, 2009; 75 FR 39852, July 13, 2010; 75 FR 41092, July 15, 2010]

Supplement *Highlights* references: 7(9), 38(5), 51(2), 66(1), 83(2), 85(3), 91(1).

Appendix VIII – CFR 38 §3.309 Disease subject to presumptive service connection

(a) *Chronic diseases.* The following diseases shall be granted service connection although not otherwise established as incurred in or aggravated by service if manifested to a compensable degree within the applicable time limits under §3.307 following service in a period of war or following peacetime service on or after January 1, 1947, provided the rebuttable presumption provisions of §3.307 are also satisfied.

Anemia, primary.
Arteriosclerosis.
Arthritis.
Atrophy, Progressive muscular.
Brain hemorrhage.
Brain thrombosis.
Bronchiectasis.
Calculi of the kidney, bladder, or gallbladder.
Cardiovascular-renal disease, including hypertension. (This term applies to combination involvement of the type of arteriosclerosis, nephritis, and organic heart disease, and since hypertension is an early symptom long preceding the development of those diseases in their more obvious forms, a disabling hypertension within the 1-year period will be given the same benefit of service connection as any of the chronic diseases listed.)
Cirrhosis of the liver.
Coccidioidomycosis.
Diabetes mellitus.
Encephalitis lethargica residuals.
Endocarditis. (This term covers all forms of valvular heart disease.)
Endocrinopathies.
Epilepsies.
Hansen's disease.
Hodgkin's disease.
Leukemia.
Lupus erythematosus, systemic.
Myasthenia gravis.
Myelitis.
Myocarditis.
Nephritis.
Other organic diseases of the nervous system.
Osteitis deformans (Paget's disease).
Osteomalacia.
Palsy, bulbar.
Paralysis agitans.
Psychoses.
Purpura idiopathic, hemorrhagic.
Raynaud's disease.
Sarcoidosis.
Scleroderma.
Sclerosis, amyotrophic lateral.
Sclerosis, multiple.

Syringomyelia.
Thromboangiitis obliterans (Buerger's disease).
Tuberculosis, active.
Tumors, malignant, or of the brain or spinal cord or peripheral nerves.
Ulcers, peptic (gastric or duodenal) (A proper diagnosis of gastric or duodenal ulcer (peptic ulcer) is to be considered established if it represents a medically sound interpretation of sufficient clinical findings warranting such diagnosis and provides an adequate basis for a differential diagnosis from other conditions with like symptomatology; in short, where the preponderance of evidence indicates gastric or duodenal ulcer (peptic ulcer). Whenever possible, of course, laboratory findings should be used in corroboration of the clinical data.

(b) *Tropical diseases.* The following diseases shall be granted service connection as a result of tropical service, although not otherwise established as incurred in service if manifested to a compensable degree within the applicable time limits under §3.307 or §3.308 following service in a period of war or following peacetime service provided the rebuttable presumption provisions of §3.307 are also satisfied.

Amebiasis.
Blackwater fever.
Cholera.
Dracontiasis.
Dysentery.
Filariasis.
Leishmaniasis, including kala-azar.
Loiasis.
Malaria.
Onchocerciasis.
Oroya fever.
Pinta.
Plague.
Schistosomiasis.
Yaws.
Yellow fever.

Resultant disorders or diseases originating because of therapy administered in connection with such diseases or as a preventative thereof.

(c) *Diseases specific as to former prisoners of war.*

(1) If a veteran is a former prisoner of war, the following diseases shall be service connected if manifest to a degree of disability of 10 percent or more at any time after discharge or release from active military, naval, or air service even though there is no record of such disease during service, provided the rebuttable presumption provisions of §3.307 are also satisfied.

Psychosis.

Any of the anxiety states.

Dysthymic disorder (or depressive neurosis).

Organic residuals of frostbite, if it is determined that the veteran was interned in climatic conditions consistent with the occurrence of frostbite.

Post-traumatic osteoarthritis.

Atherosclerotic heart disease or hypertensive vascular disease (including hypertensive heart disease) and their complications (including myocardial infarction, congestive heart failure, arrhythmia).

Stroke and its complications.

On or after October 10, 2008, Osteoporosis, if the Secretary determines that the veteran has posttraumatic stress disorder (PTSD).

(2) If the veteran:

(i) Is a former prisoner of war and;

(ii) Was interned or detained for not less than 30 days, the following diseases shall be service connected if manifest to a degree of 10 percent or more at any time after discharge or release from active military, naval, or air service even though there is no record of such disease during service, provided the rebuttable presumption provisions of §3.307 are also satisfied.

Avitaminosis.

Beriberi (including beriberi heart disease).

Chronic dysentery.

Helminthiasis.

Malnutrition (including optic atrophy associated with malnutrition).

Pellagra.

Any other nutritional deficiency.

Irritable bowel syndrome.

Peptic ulcer disease.

Peripheral neuropathy except where directly related to infectious causes.

Cirrhosis of the liver.

On or after September 28, 2009, Osteoporosis. (Authority: 38 U.S.C. 501(a) and 1112(b))

(d) *Diseases specific to radiation-exposed veterans.*

(1) The diseases listed in paragraph (d)(2) of this section shall be service-connected if they become manifest in a radiation-exposed veteran as defined in paragraph (d)(3) of this section, provided the rebuttable presumption provisions of §3.307 of this part are also satisfied.

(2) The diseases referred to in paragraph (d)(1) of this section are the following:

(i) Leukemia (other than chronic lymphocytic leukemia).

(ii) Cancer of the thyroid.
(iii) Cancer of the breast.
(iv) Cancer of the pharynx.
(v) Cancer of the esophagus.
(vi) Cancer of the stomach.
(vii) Cancer of the small intestine.
(viii) Cancer of the pancreas.
(ix) Multiple myeloma.
(x) Lymphomas (except Hodgkin's disease).
(xi) Cancer of the bile ducts.
(xii) Cancer of the gall bladder.
(xiii) Primary liver cancer (except if cirrhosis or hepatitis B is indicated).
(xiv) Cancer of the salivary gland.
(xv) Cancer of the urinary tract.
(xvi) Bronchiolo-alveolar carcinoma.
(xvii) Cancer of the bone.
(xviii) Cancer of the brain.
(xix) Cancer of the colon.
(xx) Cancer of the lung.
(xxi) Cancer of the ovary.

Note: For the purposes of this section, the term *urinary tract* means the kidneys, renal pelves, ureters, urinary bladder, and urethra. (Authority: 38 U.S.C. 1112(c)(2))

(3) For purposes of this section:

(i) The term *radiation-exposed veteran* means either a veteran who, while serving on active duty, or an individual who while a member of a reserve component of the Armed Forces during a period of active duty for training or inactive duty training, participated in a radiation-risk activity.

(ii) The term *radiation-risk activity* means:

(A) Onsite participation in a test involving the atmospheric detonation of a nuclear device.

(B) The occupation of Hiroshima or Nagasaki, Japan, by United States forces during the period beginning on August 6, 1945, and ending on July 1, 1946.

(C) Internment as a prisoner of war in Japan (or service on active duty in Japan immediately following such internment) during World War II which resulted in an opportunity for exposure to ionizing radiation comparable to that of the United States occupation forces in Hiroshima or Nagasaki, Japan, during the period beginning on August 6, 1945, and ending on July 1, 1946.

(D) (*1*) Service in which the service member was, as part of his or her official military duties, present during a total of at least 250 days before February 1, 1992, on the grounds of a gaseous diffusion plant located in Paducah, Kentucky, Portsmouth, Ohio, or the area identified as K25 at Oak Ridge, Tennessee, if, during such service the veteran:

(*i*) Was monitored for each of the 250 days of such service through the use of dosimetry badges for exposure at the plant of the external parts of veteran's body to radiation; or

(*ii*) Served for each of the 250 days of such service in a position that had exposures comparable to a job that is or was monitored through the use of dosimetry badges; or

(*2*) Service before January 1, 1974, on Amchitka Island, Alaska, if, during such service, the veteran was exposed to ionizing radiation in the performance of duty related to the Long Shot, Milrow, or Cannikin underground nuclear tests.

(*3*) For purposes of paragraph (d)(3)(ii)(D)(*1*) of this section, the term "day" refers to all or any portion of a calendar day.

(E) Service in a capacity which, if performed as an employee of the Department of Energy, would qualify the individual for inclusion as a member of the Special Exposure Cohort under section 3621(14) of the Energy Employees Occupational Illness Compensation Program Act of 2000 (42 U.S.C. 7384l(14)).

(iii) The term *atmospheric detonation* includes underwater nuclear detonations.

(iv) The term *onsite participation* means:

(A) During the official operational period of an atmospheric nuclear test, presence at the test site, or performance of official military duties in connection with ships, aircraft or other equipment used in direct support of the nuclear test.

(B) During the six month period following the official operational period of an atmospheric nuclear test, presence at the test site or other test staging area to perform official military duties in connection with completion of projects related to the nuclear test including decontamination of equipment used during the nuclear test.

(C) Service as a member of the garrison or maintenance forces on Eniwetok during the periods June 21, 1951, through July 1, 1952, August 7, 1956, through August 7, 1957, or November 1, 1958, through April 30, 1959.

(D) Assignment to official military duties at Naval Shipyards involving the decontamination of ships that participated in Operation Crossroads.

(v) For tests conducted by the United States, the term *operational period* means:

(A) For Operation *TRINITY* the period July 16, 1945 through August 6, 1945.

(B) For Operation *CROSSROADS* the period July 1, 1946 through August 31, 1946.

(C) For Operation *SANDSTONE* the period April 15, 1948 through May 20, 1948.

(D) For Operation *RANGER* the period January 27, 1951 through February 6, 1951.

(E) For Operation *GREENHOUSE* the period April 8, 1951 through June 20, 1951.

(F) For Operation *BUSTER-JANGLE* the period October 22, 1951 through December 20, 1951
(G) For Operation *TUMBLER-SNAPPER* the period April 1, 1952 through June 20, 1952.
(H) For Operation *IVY* the period November 1, 1952 through December 31, 1952.
(I) For Operation *UPSHOT-KNOTHOLE* the period March 17, 1953 through June 20, 1953.
(J) For Operation *CASTLE* the period March 1, 1954 through May 31, 1954.
(K) For Operation *TEAPOT* the period February 18, 1955 through June 10, 1955.
(L) For Operation *WIGWAM* the period May 14, 1955 through May 15, 1955.
(M) For Operation *REDWING* the period May 5, 1956 through August 6, 1956.
(N) For Operation *PLUMBBOB* the period May 28, 1957 through October 22, 1957.
(O) For Operation *HARDTACK I* the period April 28, 1958 through October 31, 1958.
(P) For Operation *ARGUS* the period August 27, 1958 through September 10, 1958.
(Q) For Operation *HARDTACK II* the period September 19, 1958 through October 31, 1958.
(R) For Operation *DOMINIC I* the period April 25, 1962 through December 31, 1962.
(S) For Operation *DOMINIC II/ PLOWSHARE* the period July 6, 1962 through August 15, 1962.

(vi) The term *occupation of Hiroshima or Nagasaki, Japan, by United States forces* means official military duties within 10 miles of the city limits of either Hiroshima or Nagasaki, Japan, which were required to perform or support military occupation functions such as occupation of territory, control of the population, stabilization of the government, demilitarization of the Japanese military, rehabilitation of the infrastructure or deactivation and conversion of war plants or materials.

(vii) Former prisoners of war who had an opportunity for exposure to ionizing radiation comparable to that of veterans who participated in the occupation of Hiroshima or Nagasaki, Japan, by United States forces shall include those who, at any time during the period August 6, 1945, through July 1, 1946:

(A) Were interned within 75 miles of the city limits of Hiroshima or within 150 miles of the city limits of Nagasaki, or

(B) Can affirmatively show they worked within the areas set forth in paragraph (d)(3)(vii)(A) of this section although not interned within those areas, or

(C) Served immediately following internment in a capacity which satisfies the definition in paragraph (d)(3)(vi) of this section, or

(D) Were repatriated through the port of Nagasaki. (Authority: 38 U.S.C. 1110, 1112, 1131)

(e) *Disease associated with exposure to certain herbicide agents*. If a veteran was exposed to an herbicide agent during active military, naval, or air service, the following diseases shall be service-connected if the requirements of §3.307(a)(6) are met even though there is no record of such disease during service, provided further that the rebuttable presumption provisions of §3.307(d) are also satisfied.

AL amyloidosis

Chloracne or other acneform disease consistent with chloracne
Type 2 diabetes (also known as Type II diabetes mellitus or adult-onset diabetes)
Hodgkin's disease
Ischemic heart disease (including, but not limited to, acute, subacute, and old myocardial infarction; atherosclerotic cardiovascular disease including coronary artery disease (including coronary spasm) and coronary bypass surgery; and stable, unstable and Prinzmetal's angina)
All chronic B-cell leukemias (including, but not limited to, hairy-cell leukemia and chronic lymphocytic leukemia)
Multiple myeloma
Non-Hodgkin's lymphoma
Parkinson's disease
Acute and subacute peripheral neuropathy
Porphyria cutanea tarda
Prostate cancer
Respiratory cancers (cancer of the lung, bronchus, larynx, or trachea)
Soft-tissue sarcoma (other than osteosarcoma, chondrosarcoma, Kaposi's sarcoma, or mesothelioma)

Note 1: The term *soft-tissue sarcoma* includes the following:

Adult fibrosarcoma
Dermatofibrosarcoma protuberans
Malignant fibrous histiocytoma
Liposarcoma
Leiomyosarcoma
Epithelioid leiomyosarcoma (malignant leiomyoblastoma)
Rhabdomyosarcoma
Ectomesenchymoma
Angiosarcoma (hemangiosarcoma and lymphangiosarcoma)
Proliferating (systemic) angioendotheliomatosis
Malignant glomus tumor
Malignant hemangiopericytoma
Synovial sarcoma (malignant synovioma)
Malignant giant cell tumor of tendon sheath
Malignant schwannoma, including malignant schwannoma with rhabdomyoblastic differentiation (malignant Triton tumor), glandular and epithelioid malignant schwannomas
Malignant mesenchymoma
Malignant granular cell tumor
Alveolar soft part sarcoma
Epithelioid sarcoma
Clear cell sarcoma of tendons and aponeuroses
Extraskeletal Ewing's sarcoma
Congenital and infantile fibrosarcoma
Malignant ganglioneuroma

Note 2: For purposes of this section, the term acute and subacute peripheral neuropathy means transient peripheral neuropathy that appears within weeks or months of exposure to an herbicide agent and resolves within two years of the date of onset.

Note 3: For purposes of this section, the term ischemic heart disease does not include hypertension or peripheral manifestations of arteriosclerosis such as peripheral vascular disease or stroke, or any other condition that does not qualify within the generally accepted medical definition of Ischemic heart disease.

[41 FR 55873, Dec. 23, 1976 and 47 FR 11656, Mar. 18, 1982, as amended at 47 FR 54436, Dec. 3, 1982; 49 FR 47003, Nov. 30, 1984; 53 FR 23236, June 21, 1988; 54 FR 26029, June 21, 1989; 57 FR 10426, Mar. 26, 1992; 58 FR 25564, Apr. 27, 1993; 58 FR 29109, May 19, 1993; 58 FR 41636, Aug. 5, 1993; 59 FR 5107, Feb. 3, 1994; 59 FR 25329, May 16, 1994; 59 FR 29724, June 9, 1994; 59 FR 35465, July 12, 1994; 60 FR 31252, June 14, 1995; 61 FR 57589, Nov. 7, 1996; 65 FR 43700, July 14, 2000; 66 FR 23168, May 8, 2001; 67 FR 3615, Jan. 25, 2002; 67 FR 67793, Nov. 7, 2002; 68 FR 42603, July 18, 2003; 68 FR 59542, Oct. 16, 2003; 69 FR 31882, June 8, 2004; 69 FR 60089, Oct. 7, 2004; 70 FR 37040, June 28, 2005; 71 FR 44918, Aug. 8, 2006; 73 FR 30485, May 28, 2008; 73 FR 31753, June 4, 2008; 74 FR 21260, May 7, 2009; 74 FR 44289, Aug. 28, 2009; 75 FR 53216, Aug. 31, 2010; 75 FR 54496, Sept. 8, 2010]

Supplement *Highlights* references: 7(6, 8), 10(1), 11(1), 12(1,5), 16(3), 24(3), 43(1), 46(2), 50(1), 56(2), 58(1), 60(2), 62(1), 64(1), 67(1). 72(2), 79(2), 80(1), 86(1), 89(1), 92(1).

[i] See e.g., Joint Technical Coordinating Group for Munitions Effectiveness (JTCG/ME), Ad Hoc Working Group for Depleted Uranium, "Special Report: Medical and Environmental Evaluation of Depleted Uranium," (Richland, WA, 1974) Vol. I: 1, 2.

[ii] The Royal Society, The health hazards of depleted uranium munitions, Part I, (London, 2001) p. 2; R. Pengelley, "The DU Debate: what are the risks," *Jane's Defence Weekly*, 15 January 2001).

[iii] See D.E. McClain, et al, "Biological effects of embedded depleted uranium (DU): summary of Armed Forces Radiobiology Research Institute research," The Science of the Total Environment (2001) 274: 117; Fletcher F. Hahn, Raymond A. Guilmette, and Mark D. Hoover, "Implanted Depleted Uranium Fragments Cause Soft Tissue Sarcomas in the Muscles of Rats," Environmental Health Perspectives (2002) 110: 51; D.E. McClain, "Project Briefing: Health Effects of Depleted Uranium," U.S. Armed Forces Radiobiology Research Institute (Bethesda, MD, 1999).

[iv] See e.g., U.S. Department of Defense, Defense Health Support Directorate, "DU – Health Concerns," undated, http://www.deploymentlink.osd.mil/du_library/health.shtml.

[v] See Dan Fahey, "Depleted Legitimacy: The U.S. Study of Gulf War Veterans Exposed to Depleted Uranium," 4 May 2002, http://www.ngwrc.org/conf2002/NGWRC-DU-Atlanta.pdf.

[vi] The reported dates of A-10 attacks are March 3-6, May 21, August 25, September 20, November 15, and December 20, 2002, and February 12, 2003. U.S. Department of Defense News Transcript, "DOD News Briefing – ASD PA Clarke and Brig. Gen. Rosa," (5 March 2002). Evan Thomas, "'Leave No Man Behind,'" Newsweek (18 March 2002) 26; Thom Shanker, "U.S. tells how rescue turned into fatal firefight," The New York Times (6 March 2002) A1; Peter Baker, "Afghans Strengthen U.S. Force," The Washington Post (8 March 2002) A1. Eric Schmitt, "American Planes Foil an Attack on an Airfield in Afghanistan," The New York Times (22 May 2002) A9. Cesar G. Soriano, "U.S. to stay in Afghanistan indefinitely," USA Today (25 August 2002). Associated Press, "U.S. base in Afghanistan attacked," (20 September 2002). Associated Press, "U.S. Bases Under Fire," (15 November 2002). Eric Schmitt, "Paratrooper from New Jersey dies in Afghan firefight near Pakistan border," The New York Times (22 December 2002). Carlotta Gall, "Afghans report 17 civilian deaths in US-led bombing," The New York Times (12 February 2003).

[vii] See Jeanette Steele, "Red Platoon's light armor passes the test," The San Diego Union-Tribune (20 December 2001) A5.

[viii] Bill Glauber, "Marines move out of shadows and into fray," The Baltimore Sun (4 November 2001) 15A; "Yuma-based Marines who flew combat missions over Afghanistan return home," The Associated Press (3 March 2002).

[ix] Dai Williams, "Mystery Metal Nightmare in Afghanistan?" (2002).

[x] Dai Williams, quoted on Al Jazeera TV (transcript via BBC Worldwide Monitoring), 15 January 2003.

[xi] The figure of 1,000 tons of DU is based on completely unsubstantiated claims about the quantity of DU contained in various missiles and bombs. For example, this figure is based on an assumption that Tomahawk cruise missiles, which have a total in-flight weight of 2,900 lbs, contain 1,000 pounds of DU in addition to a 1,000 high explosive warhead, the guidance system, fuel, rocket engine, outer shell, wings, and other components. This is not only highly improbable, but unsubstantiated: the proponents of this claim offer no evidence to support their estimates on quantities of DU in missiles and bombs.

[xii] U.S. Department of Defense News Briefing, "Sec. Rumsfeld and Gen. Myers," (16 January 2002) http://www.defenselink.mil/news/Jan2002/t01162002_t0116sd.html; U.S. Department of Defense News Transcript, "Secretary Rumsfeld Roundtable with Radio Media," (15 January 2002) http://www.defenselink.mil/news/Jan2002/t01152002_t0115sdr.html; U.S. Department of Defense News Transript, "Secretary Rumsfeld Interview with Baltimore Sun," (27 December 2001) http://www.defenselink.mil/news/Dec2001/t12282001_t1227sun.html; See also "Current Issues – Depleted Uranium Weapons in Afghanistan," (10 February 2002) http://www.antenna.nl/wise/uranium/dissaf/html.

[xiii] Phone conversation with Captain Rico Player, U.S. Department of Defense Public Affairs (703.697.5131), 20 March 2002.