<table>
<thead>
<tr>
<th>Speaker</th>
<th>Topic</th>
<th>Time</th>
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<tbody>
<tr>
<td>MRD-SD</td>
<td>LT Hightower</td>
<td>5</td>
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<tr>
<td>Third Fleet</td>
<td>LCDR Wetzel/HMCM Lugo</td>
<td>30</td>
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<tr>
<td>NMCSD Infect. Disease</td>
<td>Dr. Stone-Garza</td>
<td>15</td>
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<td>FST-5</td>
<td>Dr. Marvin</td>
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<td>NEPMU-5</td>
<td>LT States</td>
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<td>NMCSD Fleet Liaison</td>
<td>HMC Sanchez/HM1 Merriman</td>
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<td>Fleet Mental Health</td>
<td>CDR King-Hollis</td>
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<tr>
<td>MRD-SD</td>
<td>LT Hightower</td>
<td>5</td>
</tr>
</tbody>
</table>

Total: 130
Presentation Topics:
• THIRD Fleet Then.
• THIRD Fleet Now.
• MedEvacs & ISOS.
• THIRD Flt(Fwd).
• Q&A.

Staff Introduction:
• Fleet Surgeon
  - CAPT Tim S. Hinman, MC.
  (Retires July, Relief Not Yet ID’d.)

• Med Planner / Deputy Fleet Surgeon:
  - LCDR Kevin J.P. Wetzel, MSC / POM
  (Medical Svc Corps / Plans, Ops, & Med Intel).

• Fleet Corpsman / Asst Planner
  - HMCM(SS/SW/AW) Miguel A. Lugo.
THIRD Fleet Then

World War II: 3rd, 5th, & 7th Fleets:

3rd & 5th Fleets:
- 1x big fleet of ships & Marines under overall command of ADM Nimitz, CinC, Central Pacific.
  - Subordinate to ADM Nimitz were 2x Fleet HQs:
    - 3rd Fleet HQ under ADM Halsey.
    - 5th Fleet HQ under ADM Spruance.
  - 1x Fleet with Alternating Command HQs:
    - While ADM Halsey’s 3rd Flt HQ was in command of the ships & operating against the Japanese, ADM Spruance’s 5th Flt HQ was in Pearl Harbor planning the next operation, and vice-versa as 3rd & 5th Flt HQs swapped back and forth.

7th Fleet:
- 2nd smaller fleet of ships & Marines, 7th Fleet, under ADM Kinkaid:
  - Subordinate to GEN MacArthur, CinC, SW Pacific.

Nimitz: - With mostly USN & USMC forces under 3rd/5th Fleets,
  - Island-hopped across the Central Pacific to Japan.

MacArthur: - With mostly Army forces, supported by 7th Fleet’s USN & USMC forces,
  - Island-hopped up the SW Pacific from New Guinea to the Philippines.

- At the War's End:
  - 3rd and 5th Fleet HQs Decommissioned.
  - MacArthur became military governor for occupation of Japan, took 7th Fleet HQ with him.
GEN MacArthur, SW Pac, Supported By 7th Fleet.

ADM Nimitz, Central Pac, Senior to:
- 3rd Fleet HQ / ADM Halsey,
- 5th Fleet HQ / ADM Spruance.

3rd Fleet, off of Tokyo, Aug 1945 @ End of WW II.
THIRD Fleet Now

Since WW II:
- **7th Fleet**: Maintained responsibility for WestPac & IO.
- **3rd Fleet**:
  - 1973: Recommissioned, stationed on Ford Island, Pearl Harbor, to train forces pre-deployment.
  - 1986: Shifted HQ aboard USS CORONADO; AOR now all Ops, EastPac from the Americas to the Date Line.
  - 2003: Shifted ashore from USS CORONADO to NavBase Point Loma.
- **5th Fleet**:
  - 1995: Recommissioned, stationed in Bahrain as the Navy Component of US CENTCOM.

CURRENTLY:

- **One of 6x Numbered US Fleets**:
  - 3rd, 4th, 5th, 6th, 7th, and 10th (Fleet Cyber Com).
  - 3rd and 7th Fleets Subordinate to PacFleet (PacFlt HQ’d in Pearl Harbor).
- **Operational Commander for**:
  - 125 Ships and Submarines.
  - Fixed- and Rotary-Wing Air Squadrons.
  - Seabees.
  - Assault Craft Units (Landing Craft).
  - Coastal-Riverine Squadrons.
  - EOD & Dive Units.
  - **TOTAL**: Over 58,000 Sailors.
- **Force Provider**: For 4th, 5th, 6th, 7th Fleets.
- **MOC (Maritime Ops Center)**:
  - Provides Operational HQ, War Planning, & Execution:
    - Fleet-Level Ops.
    - JTF (Joint Task Force / Multi-Service) Ops.
OPCON: Authority to ORGANIZE, EMPLOY/DEPLOY, and TASK Subordinate Commanders:
- Organize Commands,
- Delegate Authority,
- Assign Tasks,
- To Accomplish a Mission.
- Example: 3rd Fleet has OPCON over maritime forces operating in the EastPac.

ADCON: Authority Over Subordinate Commands to MAN, TRAIN, and EQUIP:
- Admin and Support of Forces,
- Control of Resources & Equipment,
- Personnel Management,
- Logistics,
- Individual & Unit Training & Readiness,
- Mobilization & Demobilization,
- Discipline,
- NON-OPERATIONAL Matters.
- Example: SURFPAC has ADCON over Pacific-Based Surface Combatants.

ADCON: Man, Train, & Equip Forces, to Make/Keep Ready for Ops.
OPCON: Command Forces For/During Ops.
### MEDEVAC

#### MEDEVAC

- When higher level of care exceeds what can be safely provided by the CSG, ARG, or SAG.

- The decision to MEDEVAC a patient is a command decision.

- Units requiring medical assistance to evacuate should submit a request for medical assistance addressed to C3F and info’d to any nearby units and medical facilities.

- The SMDR is responsible in supplying patient info to the receiving MTF.

#### MEDEVAC

- The SMDR coordinates with ship’s operations officer for all logistics of transport ashore to the accepting medical facility.

- Ensure all items on the MEDEVAC Checklist, Tab C of the Annex Q – C3F OPORD 201 are with patient prior to evacuation.

- Other things to ensure:
  - 30-day funded travel orders.
  - cash-in-hand.
  - civilian clothes.
  - Passport (if necessary).
International SOS (ISOS): Annex Q to COMTHIRDFLT OPORD 201(U)

BLUF: MedEvac - Getting a patient off of your ship. ISOS - How you MedEvac when there are no USN assets available.

International SOS (ISOS)

- ISOS is a medical assistance company who provides global health care management services.

- In 2002, TRICARE has contracted with ISOS to assist with urgent and emergency care for Active Duty Service Members who are either deployed or are stationed, TAD, or on leave in remote locations where military treatment facilities are not available.

- ISOS network, you will incur no up-front, out-of-pocket costs and no claims to file. In other words, the care is cashless and claimless, which is good news for all of us.

International SOS (ISOS) cont.

- ISOS will identify and contact the nearest qualified health care provider, arrange for ground transfer to the medical facility, and will even coordinate a MEDEVAC if a medical facility is not nearby. All that the command is responsible for is getting the patient to a pier or runway; ISOS will do the rest.

- ISOS services are only applicable for obtaining urgent and emergency medical care. It is not available to obtain routine visits or treatment.

- More info will be provided by your TYCOM.
3rd Fleet’s Evolving Role:

2014: PacFlt TCO (Theater Campaign Order):
- Directed C3F and C7F to increase inter-activity and responsibilities
- “Blur-Out” the geographic line between 3rd Flt & 7th Flt AORs at the International Date Line.
- 3rd Flt be able to operate forward (“3rd Flt(Fwd)”) in the WestPac, in 7th Flt’s normal AOR.
- 2016 Spring “WestPac SAG” the first step in developing 3rd Flt’s ability to exercise OpCon of fleet forces in the WestPac.

Final Thoughts:
- Annex Q to COMTHIRDFLT OPORD 201 (U) inputs.
Q&A?
NMCSD Infectious Disease

Kristi Stone-Garza, MD, MPH
LCDR MC USN
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Cell. 619.251.8552
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Going to the Extremes: Heat and Cold Related Illness

LCDR Blake Marvin
Family Physician
Fleet Surgical Team FIVE
Disclosures

- I have nothing to disclose
- The views presented are my own and do not represent those of the US Navy or Department of Defense (unless specifically stated)
Objectives

• Discuss the physiology of thermoregulation
• Identify and categorize heat and cold related injuries
• Discuss appropriate management of these injuries
• Discuss strategies for preventing heat and cold related injuries
• Identify the unique challenges of serving onboard US Navy ships related to these injuries
Homeostasis

- Maintenance of nearly constant conditions in the internal environment
- The hypothalamus functions as the body’s thermostat.
Thermoregulation

- Thermoreceptors in the body detect the temperature is too high.
  - They send impulses via sensory neurones to the hypothalamus.
- The hypothalamus sends impulses along motor neurones to effectors (glands and muscles) saying:
  - Don't sweat!
  - Vasoconstrict
  - Hairs - stand up!
  - Shiver
  - Release adrenalin and thyroxine!
- Effectors respond to commands from hypothalamus. The body produces more heat and also loses less heat.

- Normal human body temperature 37°C

- Effectors respond to commands from hypothalamus. The body produces less heat and also loses more heat.

- Thermoreceptors in the body detect the temperature is too low.
Mechanisms of heat transfer

- Radiation (60%)
- Conduction to air (15%)
- Evaporation (22%)
- Conduction to objects (3%)

Guyton and Hall, Textbook of Medical Physiology. 11th Ed.
Sources of Heating and Cooling Energy Transfer

- Radiant heat (from sun)
- Evaporative cooling (from sweating)
- Radiant heat (from large hot object)
- Conduative cooling (from touching cold object)
- Convective cooling (from cool air/wind)
- Conduative heat (from touching hot deck)
- Internal heat production (metabolism)

Convection heat (from warm air/wind)
Heat Illness

Heat Stroke CAN Kill!
Take Time To Cool Down & Hydrate
Heat Illness

• Definitions:
  – Heat stress vs strain
  – Hyperthermia
    • Fever
    • Differential diagnosis
  – Exertional heat illness (EHI)
    • Heat cramps
    • Heat syncope
    • Heat exhaustion
    • Heat exhaustion
    • Heat stroke
Risk Factors

• Environmental
  — Hot, humid weather
  — Engineering spaces
• Military – MOPP gear, body armor, heat producing equipment
• Congenital
  — Sickle cell trait
• Functional
  — Low levels of fitness, lack of acclimatization
• Acquired
  - recent alcohol use
  - dehydration
  - medication/supplements
    - caffeine?
  - previous heat illness
Heat Cramps

• Exercise associate muscle cramping
• Painful cramps of the extremities and abdomen
• Likely due to:
  – Heavy sweating, dehydration, insufficient sodium intake, lack of acclimatization, preactivity fatigue, and previous hx of heat cramps
• Treatment:
  – Hydration (PO), electrolyte replacement (sports drinks)
• Prevention:
  – Conditioning, appropriate dietary practices, hydration, acclimatization
Heat Syncope

• Exercise associated collapse (EAC) different
• Nonexertional
• Symptoms:
  – Syncope, tunnel vision, pallor, diaphoresis, bradycardia
• Treatment:
  – ABCs
• Prevention
  – Same as above
Heat Exhaustion

• Inability to maintain adequate cardiac output due to strenuous physical activity and environmental heat stress

• Criteria:
  – Difficulty continuing with activity
  – Core body temp 38.3-40 C (101-104 F)
  – NO CNS dysfunction (ie seizure, AMS) present

• Symptoms:
  – Tachycardia, hypotension, weakness, electrolyte abnormalities, syncope, profuse sweating, pallor, headache, abdominal cramps, N/V/D, cramps
Heat Exhaustion Treatment

• Shade, lay supine with legs over head
• Remove excess clothing
• Cool patient until rectal temp is 38.3 C (101 F)
  – Any method is fine; primarily for comfort
• Rehydration
  – PO vs IV
• Monitor
• Transfer/MEDEVAC if no rapid improvement
Heat Illness

- Primarily a military term to describe a condition between heat exhaustion and heat stroke
- EHI with evidence of both hyperthermia and end organ damage but WITHOUT neurological manifestations
- Temp usually, but not always, greater than 40 C (104 F)
- Other findings: metabolic acidosis, rhabdomyolysis, AKI, liver failure
- MEDEVAC
- If unsure, treat like heat stroke
Heat Stroke

• MEDICAL EMERGENCY
• Two types: exertional and nonexertional
• Diagnostic criteria:
  – T > 40 C (104 F) and CNS dysfunction
• Symptoms and signs:
  – Hyperventilation, dizziness, N/V/D, weakness, profuse sweating, dry mouth, thirst, muscle cramps, loss of muscle function, and ataxia
• Absence of sweating does not rule in or rule out heat stroke
Heat Stroke Treatment

- CAB and vital signs
- Rapid cooling
- Reassess and monitor vitals (including urine output, if able)
- Fluid resuscitation
- No antipyretics
- Lab assessment, if available
- Admit and MEDEVAC (once stable)
  - Low threshold to admit/MEDEVAC
Preventing EHI

• Policy/ORM
• Fitness
• ACCLIMATIZE
  – Frequent break
  – Using WGBT to guide training
  – Start with minimal gear
  – Schedule evolutions, if possible, in morning and evenings/night
• Prehydrate and hydrate during activity
  – Diet including salt intake
• Cooling stations
• Adequate recovery time
Figure 3-3. RSS-220

Figure 3-4. Automated Heat Stress System (AHSS) Unit
Wet Globe Bulb Temperature

• Per the NAVMED instruction, the WGBT is the only BUMED-approved heat stress index
• Takes into account four variables of the thermal environment:
  – Air temperature (DB)
  – Humidity (RH or WB)
  – Radiant Heat (GT)
  – Air movement (accounted for in GT)
• WGBT = (DB x 0.1) + (GT x 0.2) + (WB x 0.7)
• AHSS
Table 3-1. Regulating Physical Exertion in Hot Weather by Wet-Bulb Globe Temperature (WBGT) Index

<table>
<thead>
<tr>
<th>Flag Color</th>
<th>WGBT Index (F)</th>
<th>Intensity of Physical Exercise</th>
</tr>
</thead>
<tbody>
<tr>
<td>Green</td>
<td>80 – 84.9</td>
<td>Discretion required in planning heavy exercise for unseasoned personnel.</td>
</tr>
<tr>
<td>Yellow</td>
<td>85 – 87.9</td>
<td>Strenuous exercise and activity (e.g., close order drill) should be curtailed for new and unacclimated personnel during the first 3 weeks of heat exposure.</td>
</tr>
<tr>
<td>Red</td>
<td>88 – 89.9</td>
<td>Strenuous exercise curtailed for all personnel with less then 12 weeks training in hot weather.</td>
</tr>
<tr>
<td>Black</td>
<td>90 and Above</td>
<td>Physical training and strenuous exercise suspended for all personnel (excludes operational commitment not for training purposes).</td>
</tr>
</tbody>
</table>

Note: This table may not be used in lieu of the PHELs for afloat commands.
PHEL Curves

• Developed by the Navy in 1973, these curves determine maximum exposure limits or stay time for various environmental conditions and individual work rates (assuming healthy and acclimatized sailors)

• Allows core temp to rise to 39 C (102.2 F)
<table>
<thead>
<tr>
<th>WBGT Index (F)</th>
<th>Total Exposure Time in Hours:Minutes</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>I</td>
</tr>
<tr>
<td>80.0</td>
<td>&gt;8:00</td>
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<td>0:25</td>
</tr>
<tr>
<td>125.0</td>
<td>0:25</td>
</tr>
</tbody>
</table>
Return to duty

• Normalization of all blood tests and asymptomatic

• ACSM recommends:
  – No exercise for at least 7 days
  – Medical follow up 7 days after discharge
  – Gradual increase in exercise starting in cool environment and increasing over 2 weeks
  – Resume full activity once able to train in heat for 2-4 weeks without adverse effects

• Heat Tolerance Testing, other testing
“What’s cooler than being cool?”
Hypothermia

- Cold Stress
- Wind chill
- Core temperature < 35°C
- Categories
  - Mild (35-32°C)
  - Moderate (32-28°C)
  - Severe (<28°C)
Risk Factors

- Environmental
- Previous cold injury
- Activity level
- Lack of acclimatization
- Poor nutrition
- Alcohol use
- Nicotine use
## Table. Swiss Staging System of Hypothermia

<table>
<thead>
<tr>
<th>Stage</th>
<th>Clinical Findings</th>
<th>Core Temp</th>
<th>Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>HT-1</td>
<td>Conscious, shivering</td>
<td>35°C to 32°C</td>
<td>Warm environment, clothing, and liquids</td>
</tr>
<tr>
<td>HT-II</td>
<td>Impaired consciousness, not shivering</td>
<td>32°C to 28°C</td>
<td>Cardiac monitoring, full body insulation, and active external and minimally invasive rewarming techniques (eg, heating packs, warm parenteral fluids)</td>
</tr>
<tr>
<td>HT-III</td>
<td>Unconscious, but vital signs are present</td>
<td>28°C to 24°C</td>
<td>HT-II plus airway control; if vital signs are unstable, CPB or ECMO</td>
</tr>
<tr>
<td>HT-IV</td>
<td>No vital signs</td>
<td></td>
<td>Attempt to restore vital signs with epinephrine, defibrillation, then rewarmed with ECMO or CPB</td>
</tr>
</tbody>
</table>

**Abbreviations:** CPB, cardiopulmonary bypass; ECMO, extracorporeal membrane oxygenation.
Treatment

“You’re not dead until you’re warm and dead”

• Handle gently
• Passive vs Active rewarming
• Afterdrop phenomenon
• ACLS

• Ship capabilities
Localized Cold Injury

- Chilblains
- Trenchfoot
- Frostnip
- Frostbite

- Treatment
Reporting

• Per the NAVMED instruction, all heat stress-related injuries shall be reported through the Naval Disease Reporting System and, simultaneously, through the Naval Safety Center’s Web Enabled Safety System (WESS)
Questions?
References

• UpToDate
• NAVMED P-5010-3 – Manual of Preventive Medicine – Ch 3 Heat and Cold Stress Injuries
Zika Virus: Overview

LT Leith J States, MD MPH
MC USN (FMF)
Zika Virus

- Single stranded RNA Virus
- Genus *Flavivirus*, Family *Flaviviridae*
- Closely related to dengue, yellow fever, Japanese encephalitis and West Nile viruses
- Transmitted to humans primarily by *Aedes* species mosquitoes
# Similar Diseases

<table>
<thead>
<tr>
<th>Symptom/Sign</th>
<th>Zika</th>
<th>Dengue</th>
<th>Chikungunya</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fever</td>
<td>++</td>
<td>+++</td>
<td>+++</td>
</tr>
<tr>
<td>Rash</td>
<td>+++</td>
<td>+</td>
<td>++</td>
</tr>
<tr>
<td>Conjunctivitis</td>
<td>++</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Arthralgia</td>
<td>++</td>
<td>+</td>
<td>+++</td>
</tr>
<tr>
<td>Myalgia</td>
<td>+</td>
<td>++</td>
<td>+</td>
</tr>
<tr>
<td>Headache</td>
<td>+</td>
<td>++</td>
<td>++</td>
</tr>
<tr>
<td>Hemorrhage</td>
<td>-</td>
<td>++</td>
<td>-</td>
</tr>
<tr>
<td>Shock</td>
<td>-</td>
<td>+</td>
<td>-</td>
</tr>
</tbody>
</table>

Epidemiological History

- First isolated from a monkey in Uganda in 1947
- Prior to 2007, only sporadic human disease cases reported from Africa and southeast Asia (17 cases in the literature)
- In 2007, first outbreak reported on Yap Island, Federated States of Micronesia (70%)
- In 2013–2014, >28,000 suspected cases reported from French Polynesia*

- In February 2014, first locally-acquired cases in the Americas were reported in Easter Island (Chile)
- Locally-acquired cases reported in Brazil in May 2015 after World Cup
- Currently, outbreaks are occurring in 26 countries or territories in the Americas, including Puerto Rico and U.S. Virgin Islands
- Note also current travel advisories for American Samoa, Samoa, Cape Verde

Other Modes of Transmission

- Maternal-fetal
  - Intrauterine
  - Perinatal
- Other
  - Sexual
  - Blood transfusion
  - Laboratory exposure
- Theoretical
  - Organ or tissue transplantation
  - Breast milk
## Aedes dengue vectors

<table>
<thead>
<tr>
<th></th>
<th>Aedes aegypti</th>
<th>Aedes albopictus</th>
<th>Aedes polynesiensis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Where they live</strong></td>
<td>In homes</td>
<td>Around homes</td>
<td>Around homes</td>
</tr>
<tr>
<td><strong>Where they breed</strong></td>
<td>Artificial containers</td>
<td>Natural &amp; Artificial containers</td>
<td>Natural &amp; Artificial containers</td>
</tr>
<tr>
<td><strong>Peak Biting time</strong></td>
<td>Daytime</td>
<td>Dusk</td>
<td>Late Afternoon</td>
</tr>
<tr>
<td><strong>Host</strong></td>
<td>Humans</td>
<td>Humans/Vertebrates</td>
<td>Humans/Vertebrates</td>
</tr>
<tr>
<td><strong>Flight Range</strong></td>
<td>&lt;200 meters</td>
<td>&lt; 600 meters</td>
<td></td>
</tr>
</tbody>
</table>
Countries and Territories with Active Transmission

As of 18Feb2016

Aedes Global Distribution

Predicted range of *Ae. albopictus* (maxent model: Dornak, 2011)

Predicted range of *Ae. aegypti* (maxent model: Nyari, 2011)

Predicted range of *Ae. polynesiensis* (maxent model: Dornak, 2011)
Treatment

- No specific antiviral therapy
- Treatment is supportive (i.e., rest, fluids, analgesics, antipyretics)
  - Aspirin and other NSAIDs should be avoided until dengue can be ruled out to reduce risk of hemorrhage
- If you have a suspected Zika Case: notify NEPMU, notify local DPH, enter DRSi MER, consult NMCPHC Zika Virus webpage
- Zika Diagnostics:
  - RT-PCR: Currently 2 CDC labs, 12 state labs
  - IgM: Currently only Fort Collins and San Juan CDC labs
  - EUA (emergency use authorization) process ongoing
  - COORDINATION is key, county and state DPH vital in notification
Prevention

- No vaccine or medication to prevent infection or disease
- Primary prevention measure is to reduce mosquito exposure
  - Follow the Chik and Dengue recommendations
  - There is no place with Zika that does not have Chik/Dengue
- Pregnant women should consider postponing travel to areas with ongoing Zika virus outbreaks (CDC Travel Notices)
- Protect infected people from mosquito exposure during first week of illness to prevent further transmission
Personal Protection

- Permethrin treated uniform or commercial clothing
  - Long sleeved shirts, long pants
- Appropriate use and application of repellent (DEET, Picaridin, IR3535)
  - Apply to exposed skin (hands, arms, legs, neck, face, ears)
  - Follow label directions for reapplication
Vector Control

- **Source Reduction/Physical Control**
  - Eliminate standing water sources near homes
  - Door and window screens
- **Biological control**
  - Natural predators of larvae; fish or bacteria
- **Chemical Control**
  - Adulticiding – limited efficacy
  - Larvaciding – manpower intensive

**NRSW/NMW/MCI WEST dialogue on vector control measures**
Vector Control

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- “Aedes Surveillance and Control Plan for USN/USMC Installations”

**NRSW/NMW/MCI WEST dialogue on vector control measures**
Challenges in IDing Zika

- Zika virus serology (IgM) can be positive due to antibodies against related flaviviruses.
- Neutralizing antibody testing may discriminate between cross-reacting antibodies in primary flavivirus infections.
- Difficult to distinguish infecting virus in people previously infected with or vaccinated against a related flavivirus.
- Healthcare providers should work with state and local health departments to ensure test results are interpreted correctly.
Resources

- NEPMU-5 Webpage
- NMCPHC Zika Virus Webpage
- WHO dispelling rumors around Zika and Microcephaly
- CDC Zika Webpage

- NEPMU-5 Quarterdeck 619-556-7070
Medical Transition Company (MTC)  
POC Information

LT Myra Wearing, DIVO  
619-532-7736 / 619-279-4850

HMC Rose Sanchez, MTC LCPO  
619-532-5390 / 619-730-9878

HM1 Patrick Merriman, MTC LPO  
619-532-5390 / 757-537-6349

HM2 Emily Burgess, MTC ALPO  
619-532-5390 / 757-537-6349

MTC Front Office  
619-532-9928

MTC After-Hours Duty  
619-453-6005
Social Work Waterfront Support Initiative
Navy Social Work

• Clinical mental health providers
• Focus on individual and environment
• Advocate for at risk/ under served populations

IDC Manned Ships

• Limited mental health resources
• Mental health situations negatively impact command/ mission readiness
• High prevalence of LIMDU for mental health
Initiative

- Facilitate and support Mind Body Medicine groups

Anticipated Outcomes

- Enhanced resiliency skills
- Decreased stress and anxiety
- Improved sleep hygiene
- Positive impact on mental health and fleet readiness
Team

- LCDR Narro: Social Work Department Head
- ENS Stickler
- ENS Henderson
- ENS Zimmer

POC:
- LCDR Narro: 619-532-5618
- ENS Henderson: 619-750-2303
**OPERATION PINC:**
A Walk in Clinic for Birth Control

| Process Improvement for Non-delayed Contraception |

**WHO:**
All women and adolescents (active duty & dependents) in need of birth control services

**WHAT:**
- Birth control pills prescriptions/refills
- IUD insertions
- Nexplanon
- Depo Provera
- Contraception counseling
- Emergency contraception/Plan B

First come, first served; waiting times will vary

**NO APPOINTMENT NECESSARY, JUST COME ON IN!**

**WHERE:**
Naval Medical Center, San Diego (Balboa)
Department of Obstetrics and Gynecology
Building 3, 1st floor
Phone: (619) 532-7082

**WHEN:**
Monday–Thursday 0830–1530
Fridays 1300–1530
New Maternity Leave Policy
Effective 03 MAR 2016

• Sailors and Marines, including eligible members of the Reserve components, who are pregnant or experience a birth event on or before March 3, 2016, will be entitled to up to 18 weeks of Maternity Leave, in accordance with the current Department of the Navy regulations.

• Service members, irrespective of Military Department, who become pregnant after March 3, 2016, will be entitled only to the new, 12-week benefit of non-chargeable Maternity Leave.

• The new 12 week period of Maternity Leave will start immediately following a birth event or release from hospitalization following a birth event (whichever is later), be continuous, and accrue at a rate of 12 weeks for each birth event.
• Commanders may not disapprove Maternity Leave. Maternity Leave will be granted in all cases where eligible Service members apply for it. However, unit commanders and medical providers will continue to grant convalescent leave based on the individual Service member's fitness for duty; This policy does not constrict convalescent leave in excess of 12 weeks, where a health professional/medical authority deems that such leave is warranted.

• In all cases, unused Maternity Leave will be forfeited upon separation from active service.
• In the case of dual-military couples, Maternity Leave under this DTM may not be "transferred" to create any kind of shared benefit.
• No member shall be disadvantaged in her career, including without limitation in her assignments, performance appraisals or selection for professional military education, because she has taken Maternity Leave.
NMCSD Optometry Clinics

- 6 clinics
  - *NMCSD* 0600-1600
  - *North Island* 0700-1600
  - *MCRD* 0700-1530
  - *NTC* 0700-1530
  - *Naval Station* 0630-1530
  - *Miramar* 0630-1600
Walk-In Clinic

- Miramar (AM only)
  Tuesday
  Thursday
- Naval Station (AM only)
  Tuesday
  Thursday
  Friday

***************First come, First Serve***************
New POC

- **Outgoing:** LT Brent Collins

- **Incoming:** LT Victoria Piamonte
  - DIVO, NAVAL STATION 32nd ST. OPTOMETRY DEPARTMENT
  - FLEET LIASION COORDINATOR
  - 619-556-8065/8063
  - VICTORIA.F.PIAMONTE.MIL@MAIL.MIL
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Fleet Dental

Sara A. Chilcutt LCDR DC USN
Fleet Division Officer/ Fleet Liaison Officer
NBHC Naval Base San Diego
Fleet Office: (619) 556-4797
Front Desk: (619) 556-8239/40
sara.a.chilcutt.mil@mail.mil
Medical Readiness Division

MRD_SD_GMO@navy.mil
(619) 556-5191
Bldg 116
San Diego, CA 92136
Active Duty Clinic-Gen Surgery

• Director, MRD CDR Hoang has volunteered to see common general surgery pathology on Fridays at Dept of Surgery, NMCSD to fast track fleet referrals, including:
  – Soft tissue (lipoma, epidermal inclusion cyst, pilonidal cyst);
  – Anal disease (hemorrhoid, anal/rectal abscess);
  – Screening colonoscopy
  – Symptomatic cholelithiasis
  – Hernia (ventral, incisional, inguinal, umbilical)

  – Gen surg matrix referral rules still apply.

• Conditions requiring long term follow up will not be included in active duty clinic, unless discussed with MRD Physician Supervisors.

• Include “forward to Dr. Hoang” in body of the referral.
Upcoming Meetings

• **March 30**
  - 1000-1200
  - Mind Body Medicine
  - Pre-exposure Prophylaxis for HIV

• **April 27**
  - 1000-1200
  - Wound Care/Skin Closure/Suturing/Local anesthesia/digital block
  - GI bleed/DRE/Prostatitis
CME – Registration Help

Following the meeting:
Computers in lobby
Register and/or Login to redeem CME’s
CME – how to
CME – how to

CME CREDITS/CONTACT HOURS ONLINE

A. To view CME/CNE activities offered at Naval Medical Center San Diego:
   a. Log in: Ctrl+Click to follow ULR CME link or copy/cut and paste URL address into your web browser.
      https://cmetracker.net/NMCSD/Login?FormName=GetCertificate
   b. On the “Menu” bar top right hand corner click on “Activity Catalog.”
   c. Scroll up or down to view list of activities.
   d. For additional questions and/or information about the activity please contact person listed under “Point of Contact.”

B. To Claim CME Credits/Contact Hours online you must have the following information:
   a. URL CME Link Login:
      https://cmetracker.net/NMCSD/Login?FormName=GetCertificate
   b. Military E-mail Address and Password
   c. CME Activity Code (CMEC/CNEC to provide after CME/CNE activity session)
   d. Cut-off Date to Claim CME Credits/Contact Hours (CMEC/CNEC to provide after CME/CNE activity session)
CME – how to

NOTE: New Users – Will only need to create a Password **ONCE**. All users **must use the same password** when signing in to access the following functions: Certificate, Transcript, Profile, Activity Catalog and Registration.

C. Instructions/Steps to Claim CME Credits/Contact Hours.

1. Login: Ctrl+Click to follow ULR CME link or copy/ cut and paste URL address onto your web browser.
2. Follow the steps on the CME Certificate screen page. (Need Military E-mail Address and Password)
3. "Sign In"
4. Evaluation screen page is next. Complete the Evaluation and Click on “Submit Response.” (Must be done to receive CME Credits/Contact Hours).
5. Certificate Preparation screen page is next. Follow steps to “Claim Credits/Contact Hours” and Click on “Continue.”
6. On the next screen page Click on “Display Certificate” to view the Certificate and Click on “Print Certificate” if you want a copy or
7. Click on “Close” and “Done” to exit.
8. If you don't want to display/view the certificate simply click on “Done” button.
CME – how to
CME Information

• CME Code (To claim credit online): 8204

• Closing Date (To claim credit online): 04 MAR 2016

• To complete CME
  – Log onto the MRD IDC website and click on the CME credit link
  or
  – Go to NMCSD SEAT SharePoint site (via citrix or NMCSD/BMC computer) and click on MRDSD Waterfront Meeting

http://nmcsd-as-spfe05/sites/dpe/setd/Lists/cmesurvey/Item/newifs.aspx?List=be0f840e%2D0489%2D4b5a%2Db8de%2D9c4cd1a323e5&Web=09011c0e%2Dd444%2D45b8%2D8bc7%2Db9ec10dca77