Veterans Affairs Health Administration Screening Protocol Reform

Written Testimony of Anna Brown
to the Senate Subcommittee of Veterans Affairs
October 21, 2015

Senators, upon behalf of my family thank you for allowing us to tell the story of my husband of 31 years, Sergeant Larry Brown.

On March 24th of 1970, only 42 days after celebrating his 18th birthday Larry entered the Marine Corps Recruit Training Center at Parris Island. Being the eldest son he was drafted into the armed services. Most remarkably, despite being pulled-out of his senior year of high school to assist his nation in fighting a war, Larry never complained. He was honored to serve. Larry's devotion, diligence, and zeal quickly earned him several meritorious awards and promotions. Sergeant Brown was as compassionate and empathetic to his comrades as he was to his family, friends, and coworkers, throughout his life. "Screech," a fellow solider, saw the character of my husband, saying, "[Larry] was a great friend and heavy thinker of people." After four-years of service he entered civilian life. Soon thereafter he and I met, married and raised two children, a daughter and a son, and my son is here with me today.

In 1986 after undergoing a routine physical Larry was instructed to see a hepatologist due to an abnormal liver function test within his blood. A liver biopsy showed his liver was "partially" cirrhosed. Throughout the years, Larry experienced chronic fatigue and pain throughout his body—we would later learn that these were symptoms of hepatitis C. In 2001, Larry started attending a VA Clinic for treatment of diabetes, whereupon he was tested and diagnosed with hepatitis C genotype 1a. Early in his VA treatment, he experienced adverse health affects from the Pegasys Ribavirin medicines and his treatment was terminated. Unfortunately, this was common amongst patients with genotype 1a. The VA told him to wait for newer medications to come, medications that did not arrive until 2011.

In January of 2009, my husband tragically and unexpectedly died due to complications of hepatitis C. The virus had caused esophageal varices to develop within his throat. These balloon-like formations abnormally filled with blood and when became lacerated caused upper gastrointestinal bleeding, cardiac arrest, and death. He was only 56-years-old.

Lastly, it is important to mention from the time my husband was taken-off of his medicines in 2003 up until his death in 2009, never did the VA warn him of his increased risk for end-stage liver disease or death. Never did the VA recommend any preventative measures, such as an upper endoscopic procedure, liver biopsy, or check for extrahepatic manifestations. Never did the VA recommend alternative treatments. The VA simply abandoned him.

I now turn it over to my son, Shaun.

Written Testimony of Shaun Brown
to the Senate Subcommittee of Veterans Affairs
October 21, 2015

Senators, I greatly thank you for allowing us to speak and allowing us to give a voice to this often called silent epidemic. Hepatitis C is an epidemic plaguing our nation's veterans.

Miraculously the VA offered my father testing for hepatitis C in 2001 because of his abnormal liver function test in 1986. Miraculous, because otherwise he would have never fit into the listed risk factors. Never did my father engage in injection drug use, never did he have a tattoo, hemodialysis, acupuncture, or risky sexual behavior. He did not have a blood transfusion until the last week of his life. Numerous VA and civilian gastroenterologists, physicians, and nurses noted that my father lacked the risk factors for hepatitis C.

The only risk my father had were the unsterile jet injections he received during his military service. The obscure devices that resembled a pistol attached to an air hose line, along with the observance of blood on the nozzle of the device and blood upon his injection site left a remarkable impression within my father's memory.

In April of 2014, after fighting a tumultuous five-year battle with the VA, my father posthumously received justice. The Board of Veterans Appeals rendered that 1) my father died due to complications of hepatitis C and 2) that he, at least as likely as not, contracted hepatitis C from receiving jet injector vaccinations during his military service [Citation Nr: 1418447]. Although we are not the only claim to win.

The Board of Veterans Appeals has granted a significant number of jet injector cases. A review of case law from 1992 to 2014 found the Board of Veterans Appeals had rendered in 95 cases there existed a positive nexus between jet injectors and hepatitis C.

The granting of these cases was not done out of sympathy. Rather, hepatologists, physicians, and Veteran Law Judges all substantiated the nexus was strong enough to award compensation.

Currently 50,000 veterans are unknowingly living with hepatitis C because the VA has defended its rigid position on jet injectors based on VA Cooperative Study 488. This study found 78 percent of the veterans sampled had risk factors of injection drug use and blood transfusions. The VA then attributed the etiological causes for over 287,000 veterans positive with HCV antibodies based on a study that only assessed 52 veterans with hepatitis C. Herein the sample size of the study is only two-thousandths of a percent (0.02%) of the population. Additionally, VA Cooperative Study 488 is grossly outdated. The study sampled veterans in 2001 at which time the Veterans Health Administration (VHA) had roughly 100,000 veterans with hepatitis C in their system. Yet from 2001 to 2014 the number of hepatitis C veterans within VHA's system rose by over 74,000 people, or rather by 74 percent. There is no guarantee that the risk factors for these additional veterans, who were new patients within the VHA system, are reliably represented in that study.

VA Cooperative Study 488 is a unique study that properly assessed the prevalence of hepatitis C amongst a random sample of veterans. In this study, veterans were randomly selected and then assessed on whether or not they had hepatitis C. However, this is the limits to this study. Assessing the etiological causes of only 52 veterans with hepatitis C, as the study did, is a weak claim in identifying the risk factors for a larger population. This is evidenced based upon the data, which reported spending more than 48 hours in jail posed a greater risk for hepatitis C than military service (which included combat duty and jet injections). Moreover, the study was flawed. The risk assessment questionnaires to be filled-out by veterans were inconsistent. Some questionnaires did not include jet injections amongst the criteria to be studied. Lastly, the researchers themselves stated it would be difficult to detect a nexus between hepatitis C and jet injectors within their data because the study was population-based. Yet this has been **thee** study that the VA has used to guide public health and test at risk populations.

Senators, upon behalf of my family and in remembrance of my Dad, we ask, the Senate Subcommittee of Veterans Affairs to recognize that jet injectors are a high risk factor for acquiring the hepatitis C virus, and to mandate every veteran who experienced such vaccinations be allowed to be tested and treated.