



# *Air Force Global Strike Command*



## **Missile Community Cancer Study (MCCS) Update**

Overall Briefing: UNCLASSIFIED

Gen Stephen L. Davis  
AFGSC/CC  
27 Mar 2026  
CAO: 25 Mar 2026



# Missile Community Cancer Study Objectives



Assess the as-is environmental state at the three active Missile Wings.

Environmental Sampling



Identify the risk of exposure to our Airman and develop institutional processes to document and communicate potential risks for Airman and their families.

DOEHRS/ILER



Understand the scope of potential exposures, 1976 through current day, and document exposures for DoW, separated and retired members, families, and VA partners.

Epidemiology Review



# External Partners

- Environmental Protection Agency – Sampling/Hazard Cleaning/Remediation/Mitigation
- Environmental Sampling – AF Institute of Technology; Wright State University; Rutgers University
- Epidemiology Study – Experts from National Institute of Occupational Safety and Health, University of Cincinnati, Wright State University, and University of Nebraska Medical Center



**Dr. Timothy Crawford (Wright State University, Boonshoft School of Medicine)**

- Hazard Documentation – ILER Working Group; DOEHRS
- Burn Classified Materials Study – 711th Human Effectiveness Directorate; University of Dayton, Ohio



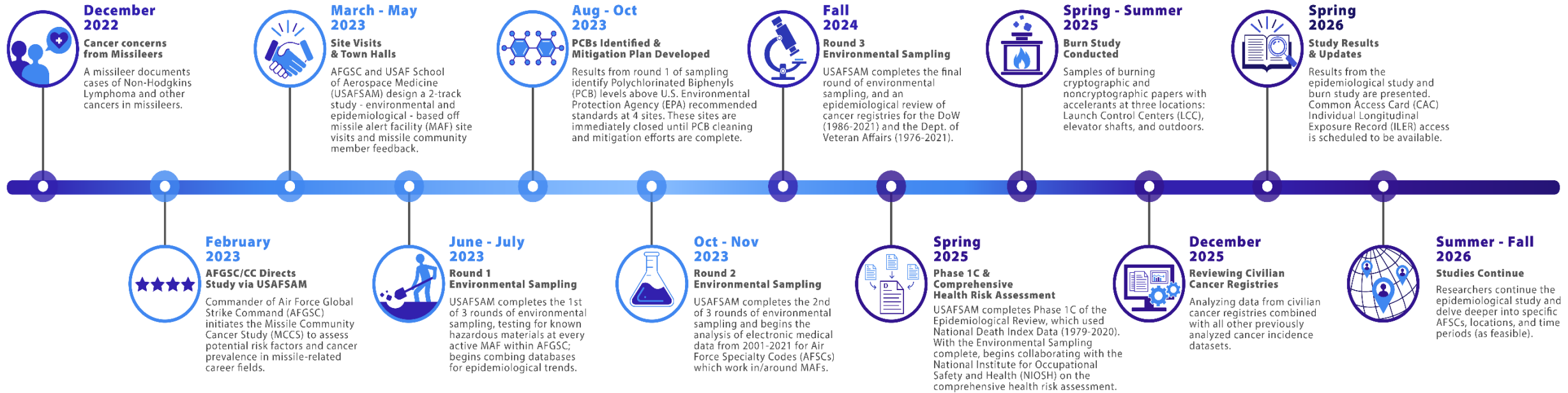
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# MCCS Timeline/Recap

December 2022 – Space Force Guardian and Former Missileer started an important dialogue: *Do Missileers have an increased cancer risk?*

## Missile Community Cancer Study Current Timeline



Current as of 24 March 2026  
Air Force Global Strike Command Public Affairs



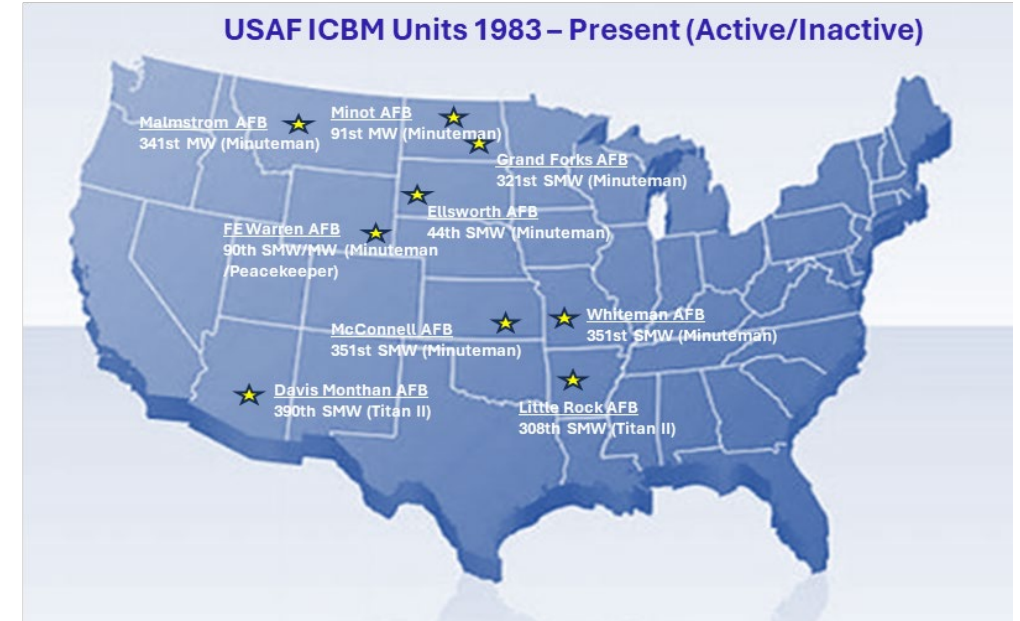
# ***Occupational Environment***



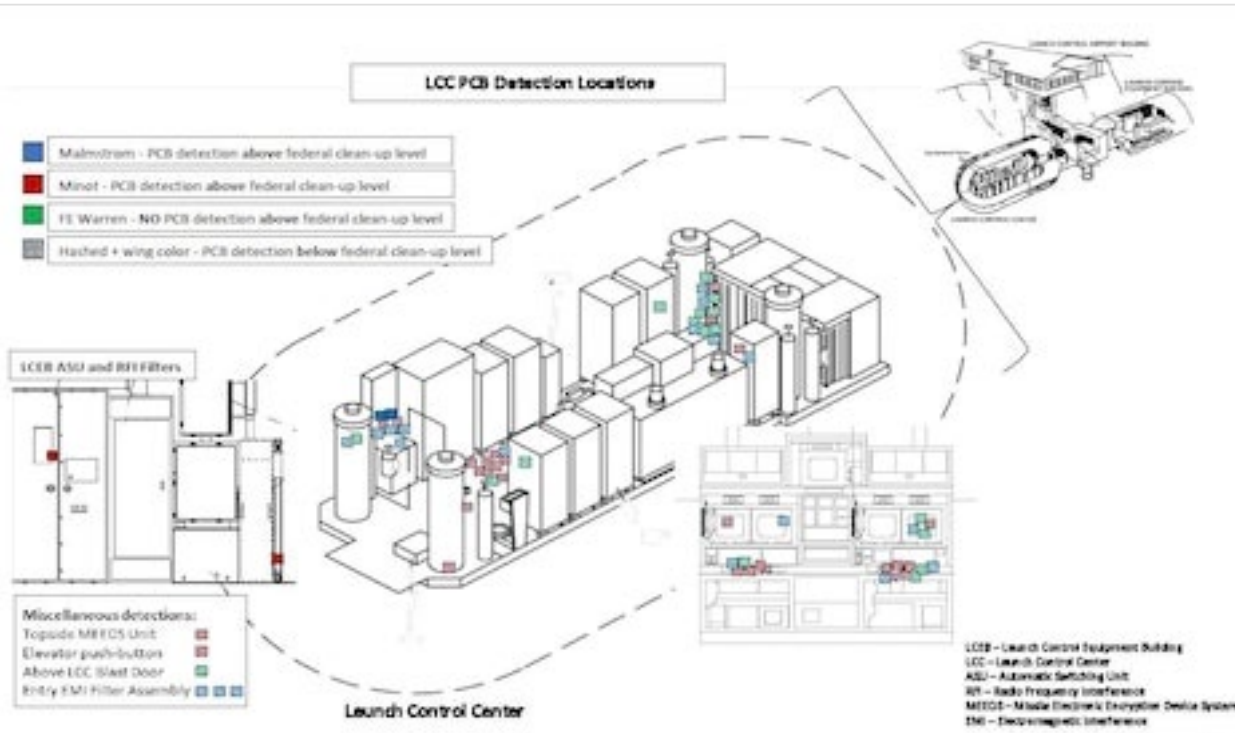
# Ongoing Efforts

## ■ PCB response protocols standardization complete

- Maintenance Technical Orders (TOs)
- Civil Engineer Manuals
- Signage



- **Missile Alert Facility (MAF)** improve environmental system inspection processes
- Deep Cleaning contract in progress
- PCB Cleaning contract awarded
- **Launch Facility (LF)** PCB sampling integrated into inspection processes





# Occupational Health Assessment

- Workplace Supervisors, Workplace Visits, Safety Inspections   

- Medical Surveillance, Work Related Illness/Injury, Trend Analysis, Follow-up   

Workplace Supervisors/members, Process Change, etc.   

- Process Change, Ventilation Design, Certified PPE List, etc.  

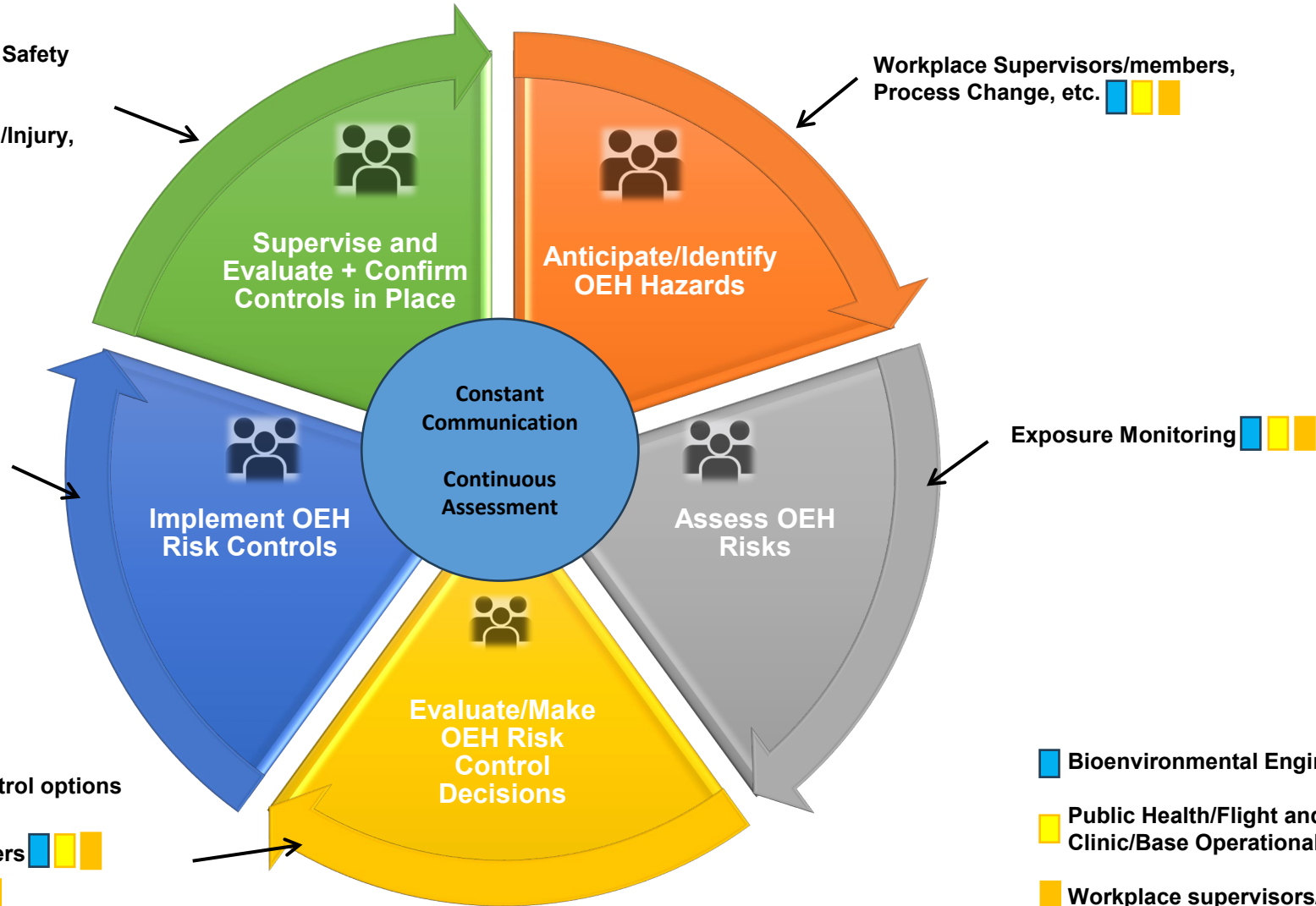
- Coordinate with stakeholders   




- Communicate Risk   

- Recommend exposure control options (interim/long-term)   

- Coordinate with stakeholders   

- Leadership risk decision 





-  Bioenvironmental Engineering
-  Public Health/Flight and Operational Medicine Clinic/Base Operational Medicine Clinic
-  Workplace supervisors/members



# Service Members / Personal Access to ILER

- Personal Accounts are limited to only viewing the Individual Exposure Summary
- Ability to update will be limited to:
  - Garrison Locations
  - Deployment Locations
  - Registries not included in ILER
  - Environmental Exposures
- CAC Link: <https://iler.csd.disa.mil/>
- Dec 2026 Login.gov for Veterans



Individual Longitudinal Exposure Record

[Request Personal Account](#)

[Request Work Account](#)

If further assistance is needed, contact GSC Help Desk  
1-800-600-9332 | dhagsc@health.mil

The complex block contains a silhouette of a soldier on the left, a circular logo with the letters "ILER" in the center, and two blue buttons for account requests. Below the buttons is contact information for the GSC Help Desk.



# Service Member / Personal Access to ILER

ILER Welcome, Morris, Brandon [405] Logout

### Individual Exposure Summary Information

Individual Exposure Summary Information: [Redacted] [Add to My ILER](#)

EDIPI/DoD ID	Last Name	First Name	Middle Name	Date of Birth	Date of Death	Sex	Service	Service MOS Description
[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]

Report Last Modified : 03/20/2025  [Search](#) [Clear](#)

> Individual Deployment History [Count: 5] Information from DMD, VA Registry Questionnaire and Other Sources

> Registry [Count: 1] Information from DOEHRs-IH and VA Registries

Report Last Modified:  
\* Audit data may not be available prior to October 1 2024

- 03/20/2025 : Incident
- 10/31/2023 : Registry

The following patient data does not exist for this criteria:

- Personnel History
- Periodic Occupational and Environmental Monitoring Summary (POEMS)
- Exposure Pathways
- Incident
- Industrial Hygiene
- Health Assessments
- Individual Monitoring
- Medical Exposure Indicator (For clinical information refer to the Electronic Health Record (EHR))
- Reference Information

UNCLASSIFIED (U) / CONTROLLED UNCLASSIFIED INFORMATION (CUI)  
ILER Version 2.4.9.0 - 10.202503201850-44  
Disclaimer



### Add to My ILER

Data submitted is visible to DoD/VA authorized officials. Sensitive or inappropriate information may not be included in your ILER summary.

> Were you stationed at a location (non-deployment) that is not listed in your ILER?  Yes  No

✓ Were you deployed to a location that is not listed in your ILER?  Yes  No

Country \*  Location Name

MOS/Occupation \*  Branch of Service \*

Start Date (MM/DD/YYYY) \*  End Date (MM/DD/YYYY) \*

> Are you registered/participating in a Registry that is not listed in your ILER?  Yes  No

> Do you believe you experienced any toxic exposures that are not listed in your ILER?  Yes  No

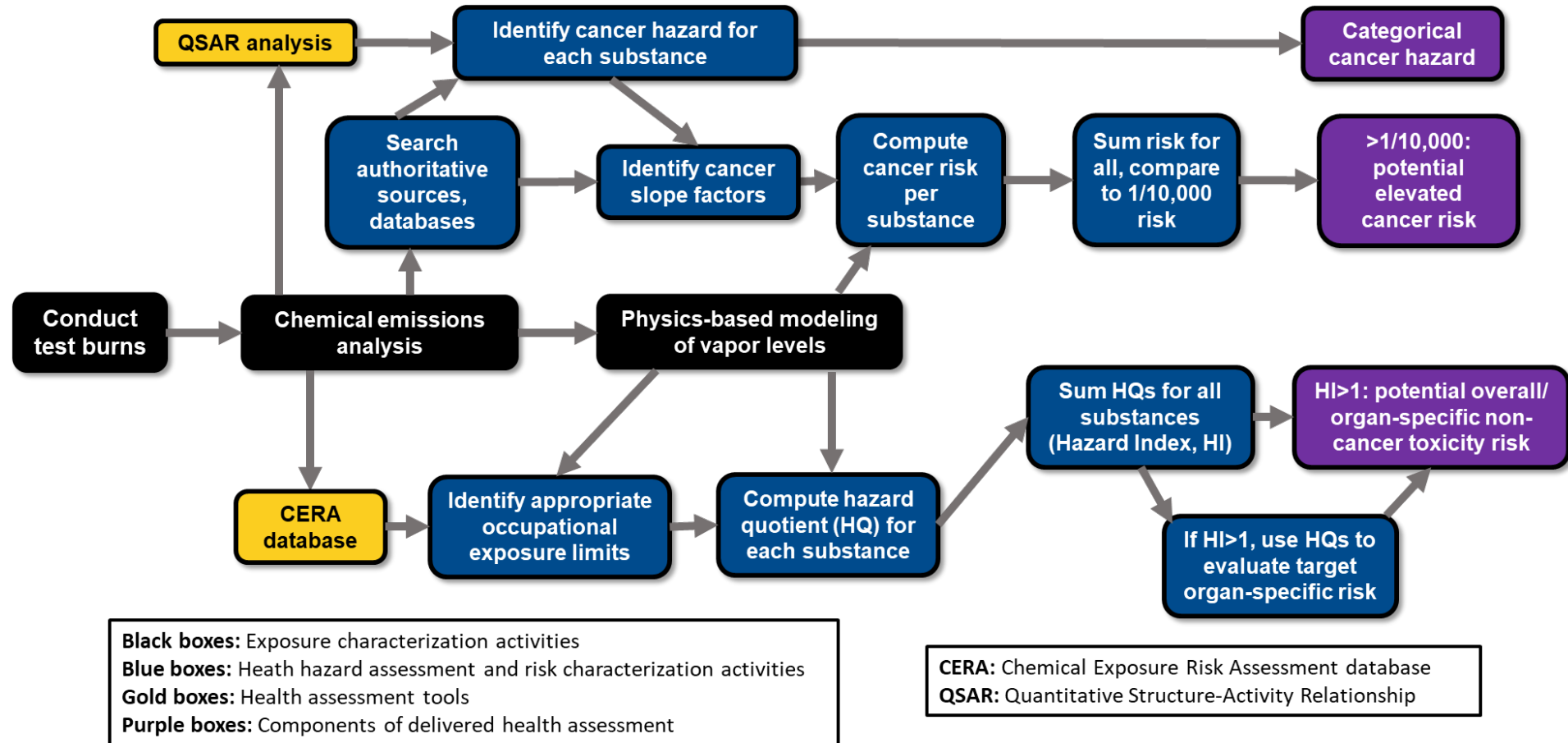
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# ***Burning Classified Materials***



# Burn Study: Overview

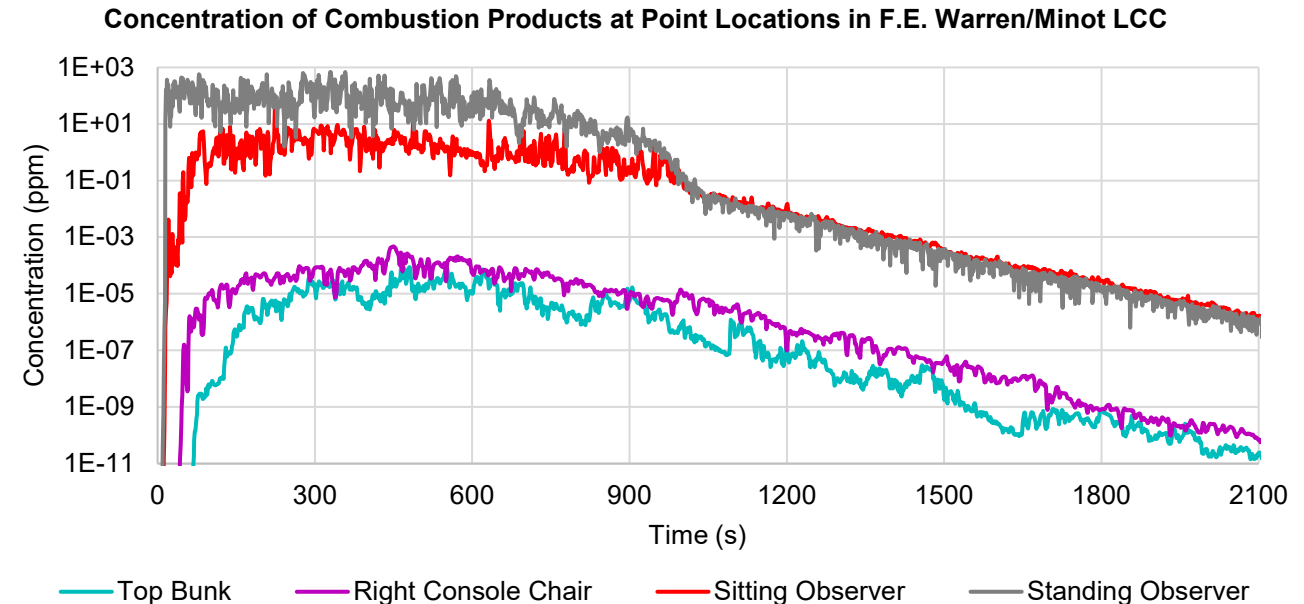
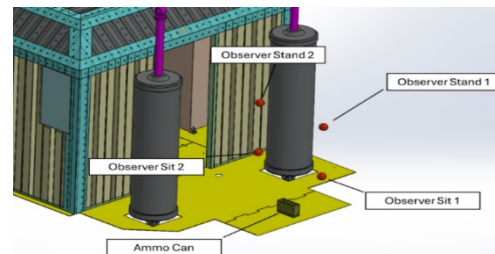
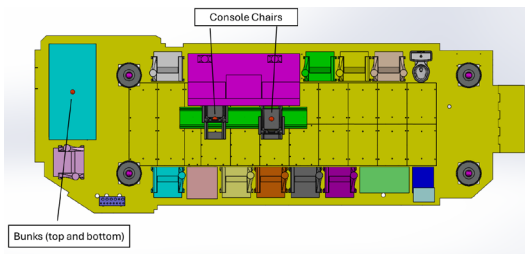
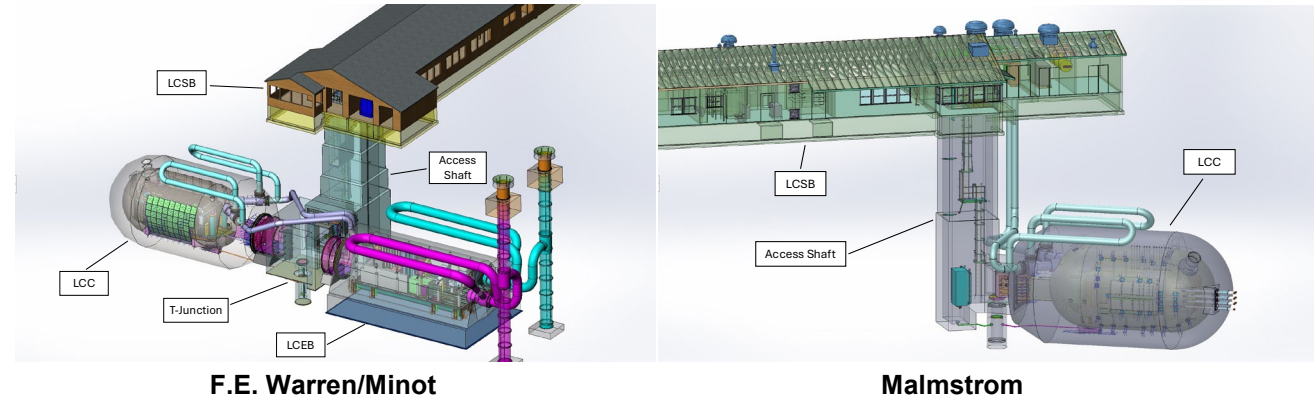


Study design to support assessment of Missileer health risks from past LCC burning practices



# Burn Study: Emissions and Exposure

- Finished chemistry analysis for samples collected during burn testing
- Completed physics-based modeling to predict exposure concentrations
  - Compared both F.E. Warren/Minot and Malmstrom configurations
  - Simulated burns at multiple locations
  - Calculated exposure in multiple locations
  - Malmstrom exposure 2.3-3.2 times lower, so used F.E. Warren/Minot data for health risk assessments





# Burn Study: Cancer Risk Assessment

- **Cancer Health Risk Assessment**
  - 32 out of 68 chemicals measured in the burn emissions can be carcinogenic if present at concentrations that exceed health-based thresholds
  - Authoritative limits for only 8 of them
  - Established predictive cancer limits for the remaining to establish conservative risk
  - Compared to Missileer working timeframe
    - Extended burn concentration to 24 hours
    - 100 burns per year for 8 years
  - **Cancer risk below occupational threshold for elevated cancer risk (less than 1/10000)**

Cumulative Excess Cancer Risk Values

Burn Experiment Condition	24-hour Time-Weighted Average
	100 day/year, 8 year
	Cancer Risk
Crypto + Mix	Number per 10,000
Crypto + Mix + WD40	0.36
TDI + Mix	0.14
TDI + Mix + WD40	0.16
	0.05

- Mix included:**
- tech wipes
  - REACT paper
  - office printer paper
  - cotton balls
  - manila envelope
  - isopropyl alcohol



# Burn Study: Non-Cancer Risk Assessment

- **Noncancer Health Risk Assessment**
  - **Used Military Exposure Guideline Definitions**
    - **Negligible – few if any health effects**
    - **Marginal – many noticeable but not incapacitating reversible health effects**
  - **Threshold for at each is Hazard Quotient (HQ) of 1**
    - **HQ is the sum of the Hazard Index (HI) for each individual chemical**
- **Exceeded threshold for “negligible” effect**
- **Less than threshold for “marginal” effects**
- **Less than threshold for long-term irreversible health effects**

Refined Noncancer Risk Assessment Crypto + Mix in LCC

Substance	CAS	Source of Marginal Effect 15-min. TRV	Refined HQ (marginal effect)	Refined HQ (negligible effect)
Formaldehyde	50-00-0	AEGL-2	0.50	1.49
2,3-Butanedione	431-03-8	DOE PAC-2	0.00106	0.39
Benzofuran	271-89-6	Not available	--	0.49
Naphthalene	91-20-3	DOE PAC-2	0.00014	0.00084
Carbon monoxide	630-08-0	AEGL-2	0.03	0.091
2,3-Pentanedione	600-14-6	Not available	--	0.19
Benzene	71-43-2	AEGL-2	0.0008	0.03
Acrolein	107-02-8	NextGenMEG	0.01	0.15
Total HI of listed substances			<b>&gt;0.54</b>	2.83
Total HI of substances with TRVs for “marginal effects”			0.54	2.15
Total HI of all included substances (n = 67)			--	--

AEGL: Acute Exposure Guideline Level, CAS: Chemical Abstract Number, DOE: Department of Energy, HI: Hazard Index, HQ: Hazard Quotient, LCC: Launch Control Center, MEG: Military Exposure Guideline, PAC: Protective Action Criteria, TRV: Toxic Reference Value

**Health effects for chemicals detected primarily eye and respiratory irritation**



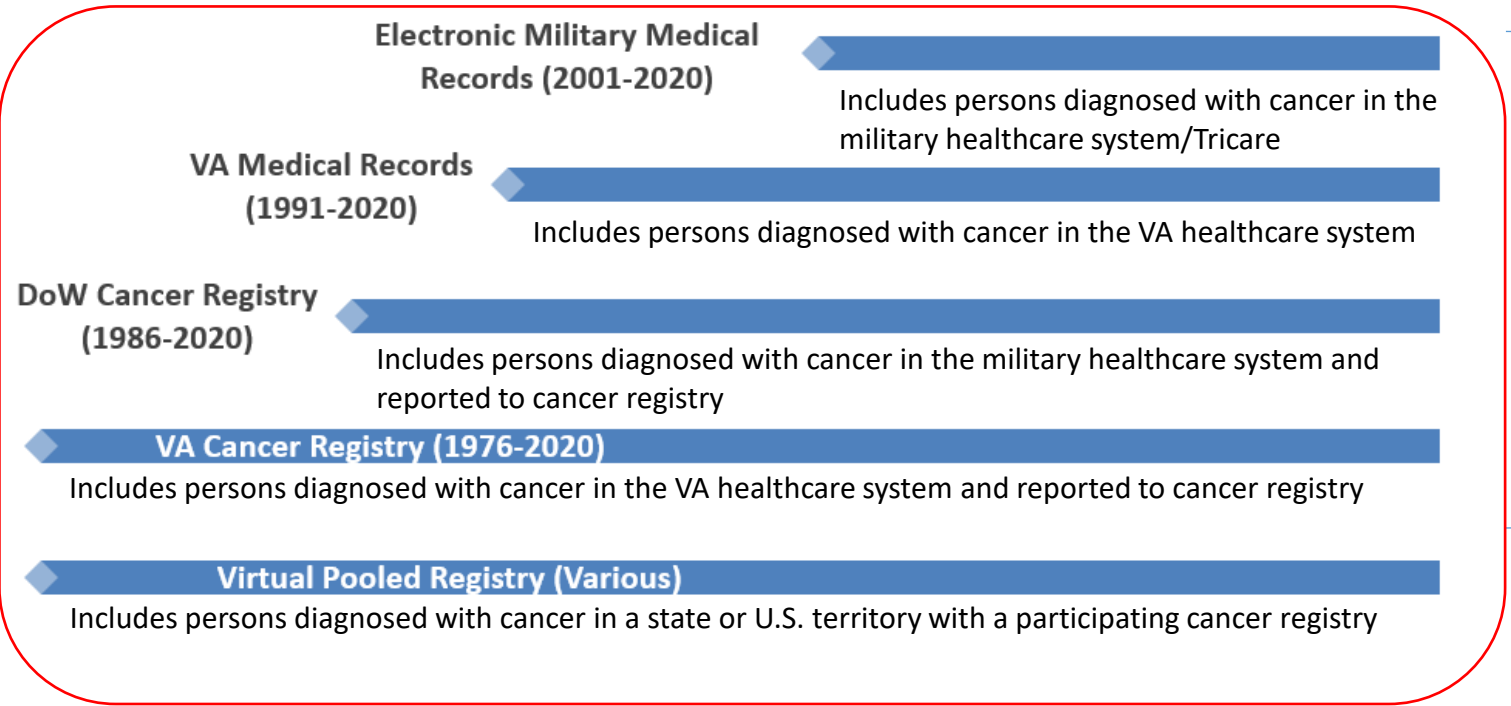
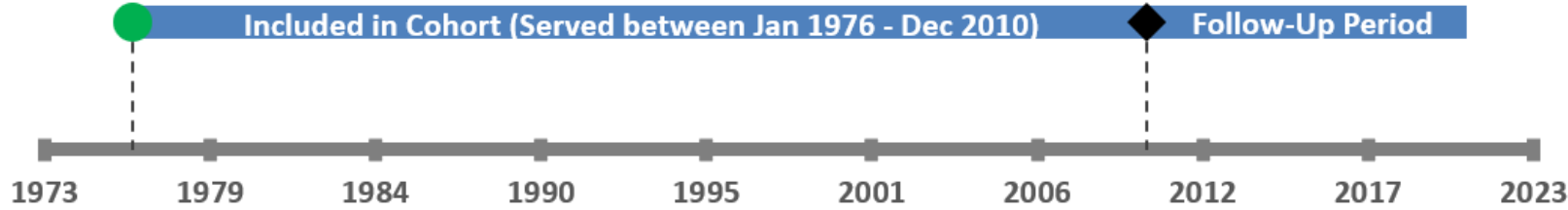
# ***Epidemiology Review***



# Epidemiology Review

Beginning of Cohort

End of Cohort



## Phase 1 Results (review from October 2024):

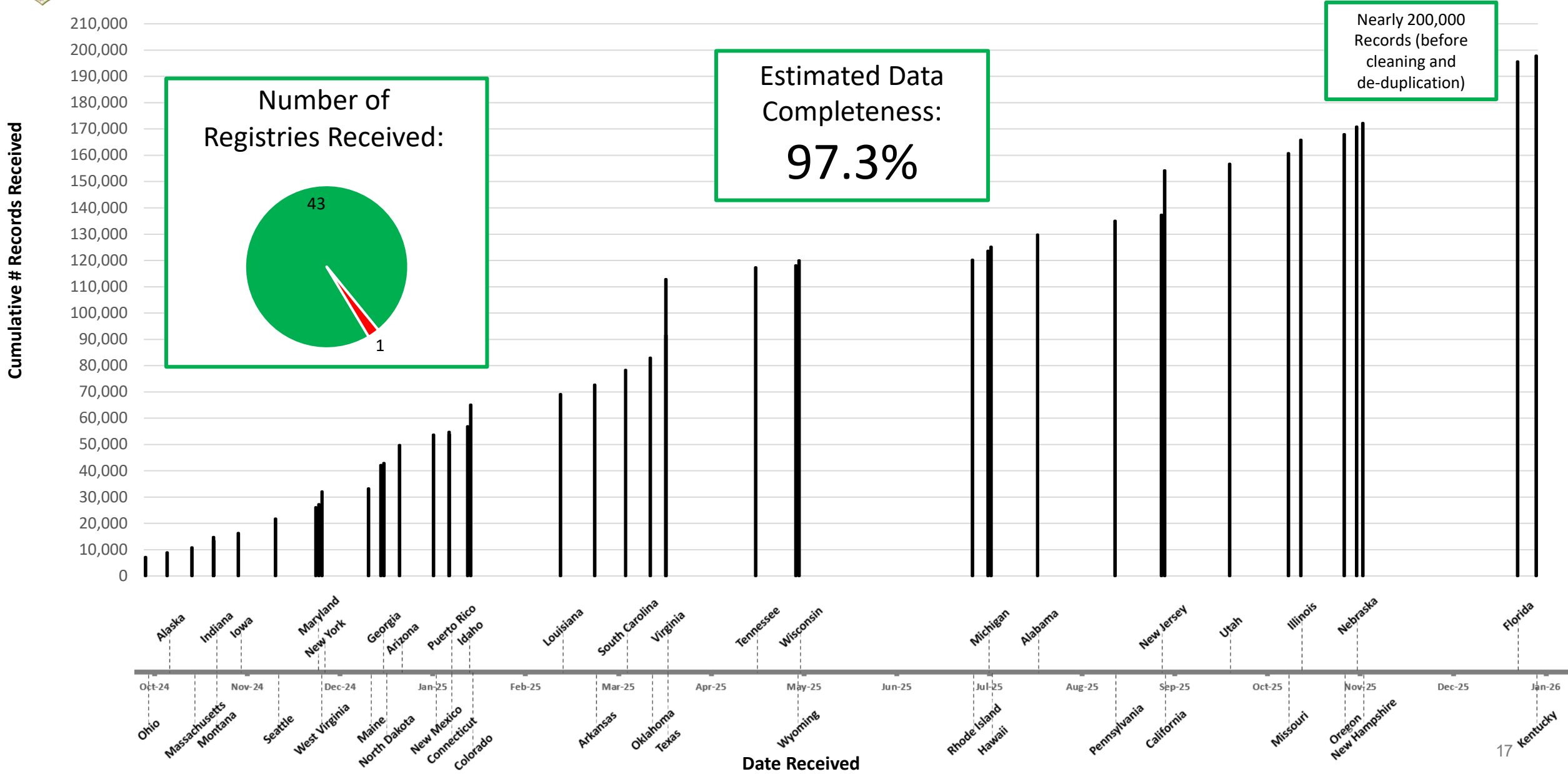
- No statistically significant increased risk of cancer or death from cancer
- Based on 55,224 cancer cases
- Phase 2 added Virtual Pooled Registry (VPR) data: 2.7 times more cancer cases than Phase 1



- Shifted cancer incidence findings



# VPR Data Timeline





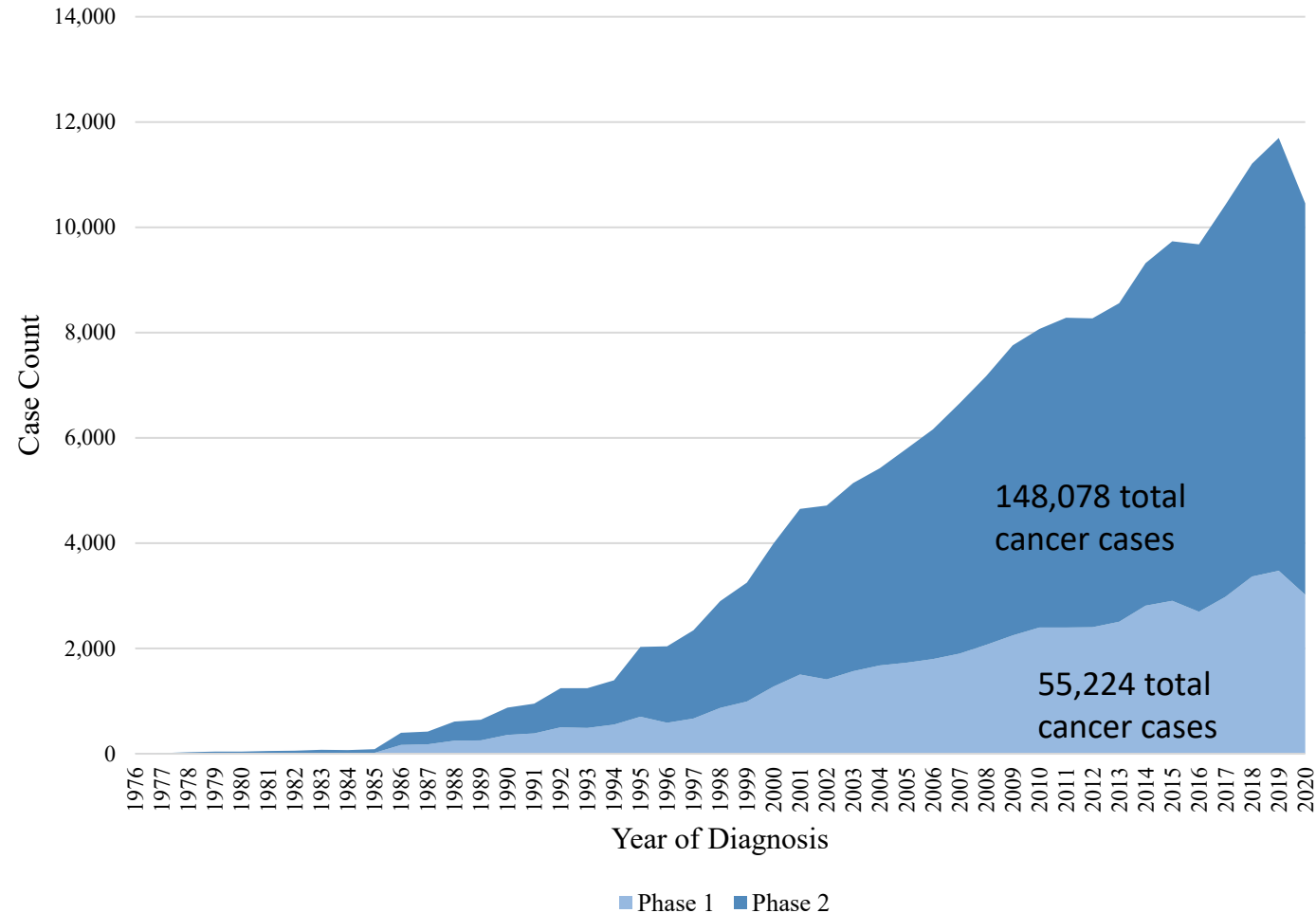
# Case Count

Cancer cases (counts(column %)) among missile community and non-missile community, 1 January 1976 – 31 December 2020

Cancer Type	Missile Community (N=64,735)	Non-Missile Community (N=1,757,033)	Total (N=1,821,768)
All 14 types*	4,942	143,136	148,078
Breast (Female)	109 (2.21%)	7,932 (5.54%)	8,041 (5.43%)
Colon and Rectum	462 (9.35%)	13,729 (9.59%)	14,191 (9.58%)
Hodgkin Lymphoma	67 (1.36%)	1,543 (1.08%)	1,610 (1.09%)
Kidney and Renal Pelvis	320 (6.48%)	7,976 (5.57%)	8,296 (5.60%)
Leukemia	201 (4.07%)	5,457 (3.81%)	5,658 (3.82%)
Lung and Bronchus	582 (11.78%)	18,606 (13.00%)	19,188 (12.96%)
Melanoma of the Skin	546 (11.05%)	14,450 (10.10%)	14,996 (10.13%)
Non-Hodgkin Lymphoma	285 (5.77%)	7,767 (5.43%)	8,052 (5.44%)
Ovarian (Female)	12 (0.24%)	638 (0.45%)	650 (0.44%)
Pancreatic	175 (3.54%)	4,407 (3.08%)	4,582 (3.09%)
Prostate (Male)	1,626 (32.90%)	44,958 (31.41%)	46,584 (31.46%)
Testicular (Male)	111 (2.25%)	2,688 (1.88%)	2,799 (1.89%)
Thyroid	154 (3.12%)	4,543 (3.17%)	4,697 (3.17%)
Urinary Bladder	292 (5.91%)	8,442 (5.90%)	8,734 (5.90%)

\*All primary study cancers counted (individual may have more than 1 primary cancer but not the same type).

## Phase 1 vs Phase 2 Cancer Incidence





# Basics of Epi Statistics

- **Internal Comparison (MC vs non-MC):** Used Incidence Rate Ratios (IRR)
  - Directly compared incidence rates in the MC to the non-MC
    - Counted the number of cases in MC and non-MC
    - Calculated the amount of person-time contributed
- **External Comparison (MC vs U.S. population):** Used Standardized Incidence Ratios (SIR)
  - Cannot directly calculate incidence rates for the U.S. population; used Standardized Incidence Ratios
    - Counted the number of cases in MC
    - Used deidentified data from the National Cancer Institute’s Surveillance, Epidemiology, and End Results Program (SEER)
    - SEER gives age, race, and sex specific rates for each year
      - Example: white females aged 20-24 years in 2001
      - Rate multiplied by person-time contributed by that demographic to get expected count for that demographic for that year
      - Repeated for each demographic slice of the MC for each year; added all slices (90 demographic combination slices per year) together to get total expected # of cases

**Missile Community (MC)**  
**Non-Missile Community (non-MC)**

**Person-time is a measurement that estimates the total time that participants are at risk of developing a disease or dying.**

$$\text{Incidence Rate Ratio (IRR)} = \frac{\text{Incidence Rate of Cancer in MC}}{\text{Incidence Rate of Cancer in non-MC}}$$

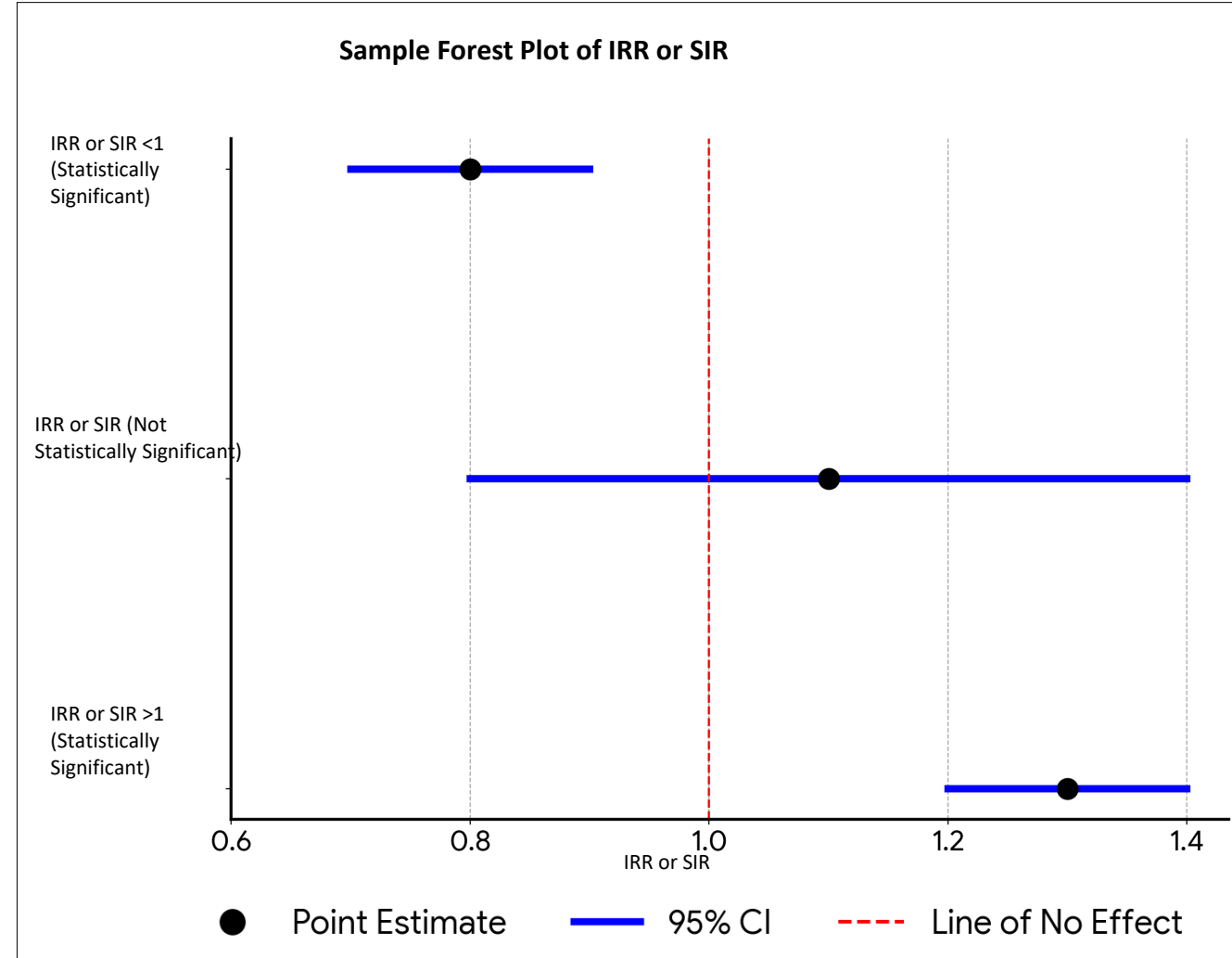
$$= \frac{\frac{\text{Number of Cancer Cases in MC}}{\text{Person - Years}}}{\frac{\text{Number of Cancer Cases in non-MC}}{\text{Person - Years}}}$$

$$\text{Standardized Incidence Ratio (SIR)} = \frac{\text{Observed \# of cases in MC}}{\text{Expected \# of cases}}$$



# Basics of Epi Statistics (cont)

- **IRR and SIR interpreted similarly**
  - IRR or SIR < 1: incidence rate is lower in the MC
  - IRR or SIR = 1: incidence rate is the same
  - IRR or SIR > 1: incidence rate is higher in the MC
- **Statistical significant and 95% confidence intervals**
  - “Statistically significant” findings likely to be true
  - “Not statistically significant” findings may be due to chance
- **The Forest Plot: An easy visualization of statistical significance:**
  - Dot: “point estimate”
  - Lines: 95% confidence interval
  - Entire line to the left of 1 (the Line of No Effect): statistically significant **decreased** cancer incidence in the MC
  - Line touches or crosses 1: not statistically significant findings; statistically **similar** incidence
  - Entire line to the right of 1 (the Line of No Effect): statistically significant **increased** cancer incidence in the MC





# Results – BLUF

- **BLUF (1): With MC vs non-MC (the Internal Comparison) there was found an increased incidence of testicular cancer and Hodgkin lymphoma, however:**
  - **Neither cancer is typically associated with adult occupational exposures, or likely to have significant contribution from adult occupational exposures;**
  - **The Phase 2 study will continue with an in-depth review of specific jobs, time periods, and locations, where feasible**
- **BLUF (2): With MC vs US population (the External Comparison) there was found an increased incidence of melanoma, however:**
  - **This increased incidence of melanoma is consistent with other cancer epidemiology studies among specific DAF and DOW populations;**
  - **Non-UV occupational exposure is unlikely to contribute significantly to melanoma;**
  - **The Phase 2 study will continue with an in-depth review of specific jobs, time periods, and locations, where feasible**



# Results – Internal Comparison

## ■ MC vs non-MC

### ■ Increased incidence:

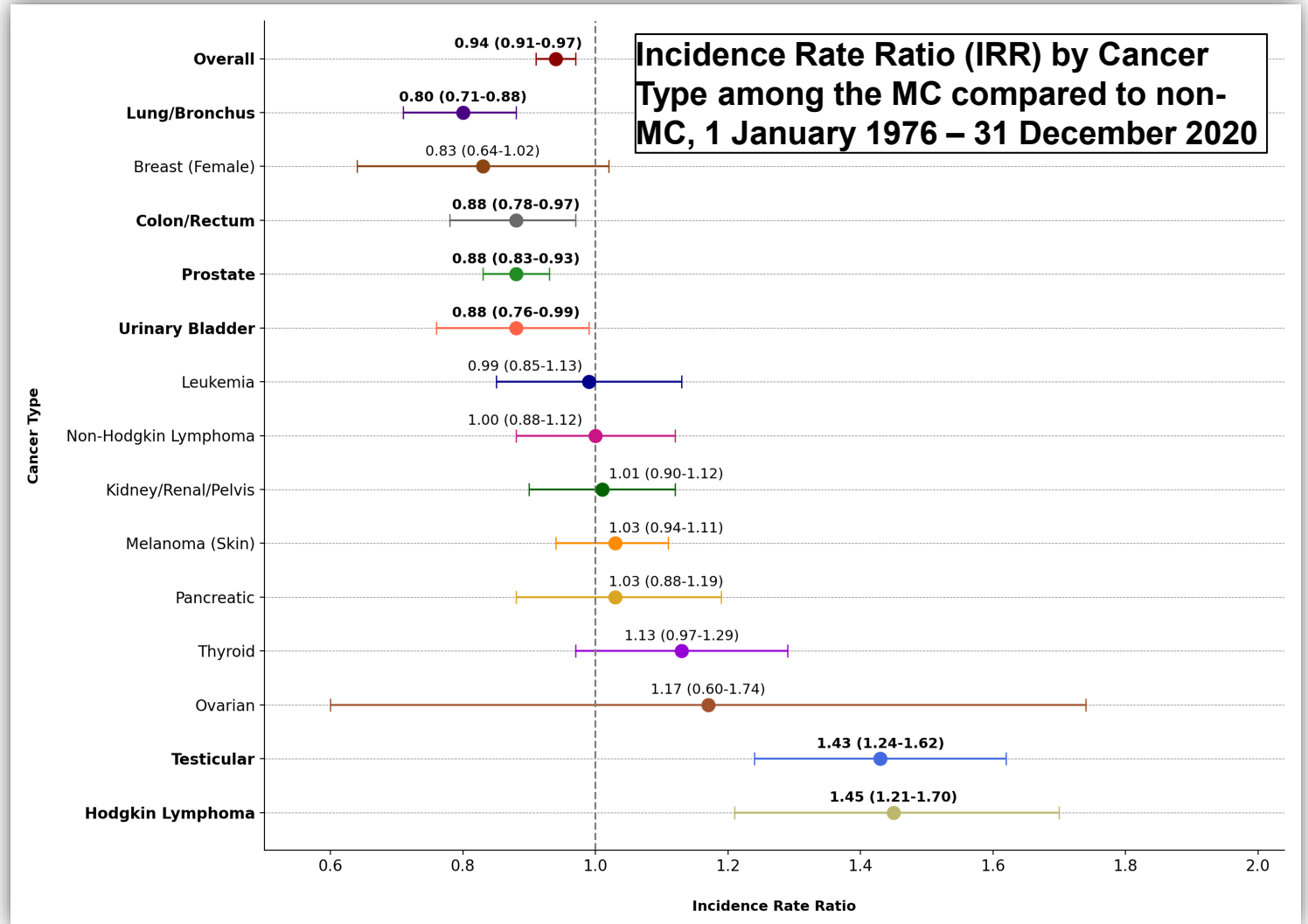
Testicular cancer  
Hodgkin lymphoma

### ■ Statistically similar incidence:

Female breast cancer  
Leukemia  
Non-Hodgkin lymphoma  
Kidney/Renal pelvis cancer  
Melanoma  
Pancreatic cancer  
Thyroid cancer  
Ovarian cancer

### ■ Lower incidence:

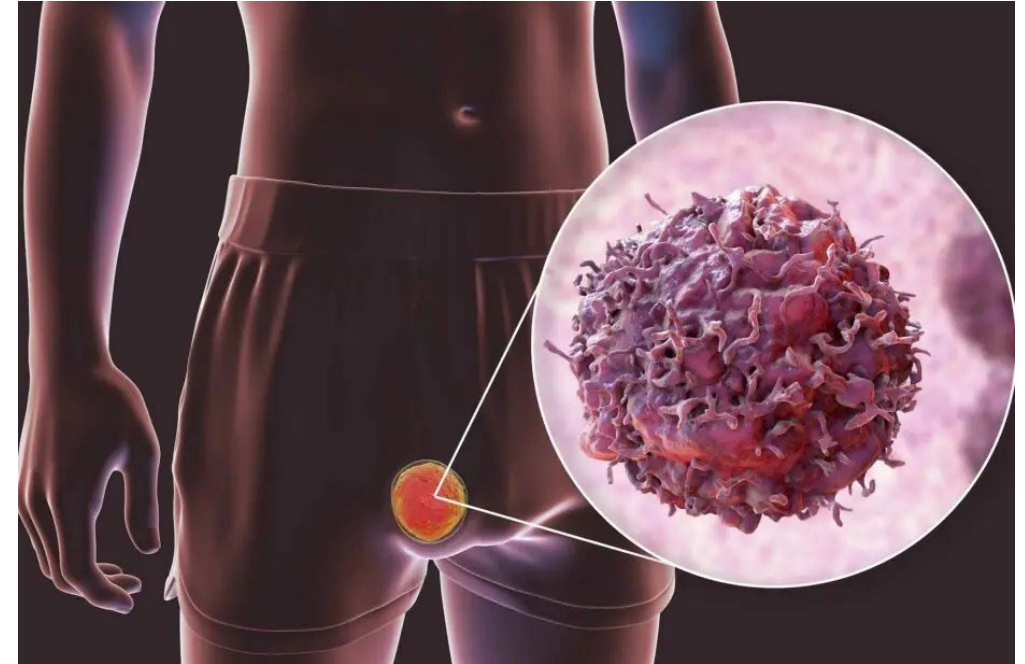
All 14 cancers overall  
Lung/Bronchus cancer  
Colon/Rectum cancer  
Prostate cancer  
Bladder cancer





# What is Testicular Cancer?

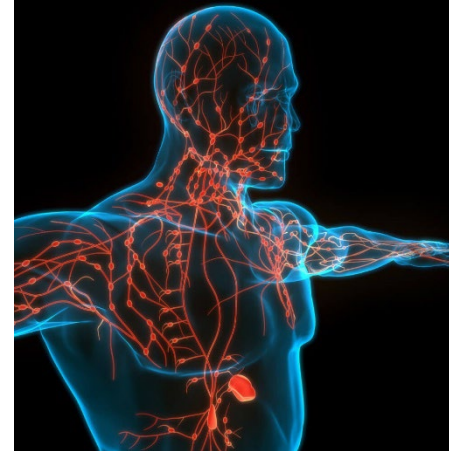
- **Cancer of the male reproductive system**
- **Most common in men aged 20-34 years<sup>1</sup>**
  - 10,000 new cases in the United States annually<sup>1</sup>
  - Highly treatable, 95% 5-year survival rate<sup>1</sup>
- **What causes testicular cancer?**
  - Undescended testes (aka, cryptorchidism) ↑ risk<sup>2</sup>
  - Family history of testicular cancer ↑ risk<sup>2</sup>
  - Prenatal exposure (exposure while fetus is *in utero*) to endocrine disruptors (impacts hormones) ↑ risk<sup>3</sup>
  - Testicular cancer development likely starts *in utero*<sup>4</sup>
- **Do adult occupational exposures increase testicular cancer risk?**
  - Unlikely to have a significant contribution from adult occupational exposure<sup>3</sup>
  - Some cancers have strong associations with occupational exposures, testicular cancer does not<sup>5</sup>





# What is Hodgkin Lymphoma?

- **Specific type of cancer of the lymphatic system**
  - Lymphatic system helps maintain fluid balance, filter waste, and fight infection
- **Notably different from non-Hodgkin lymphoma (NHL)**
  - Less common than non-Hodgkin lymphoma<sup>6</sup>
  - More treatable than non-Hodgkin lymphoma, with an 89% cure rate<sup>7</sup>
- **What causes Hodgkin lymphoma?**
  - Infection with the Epstein-Barr virus (up to 40% of cases)<sup>8,10</sup>
  - Family history and genetics<sup>9,10</sup>
- **Do adult occupational exposures increase Hodgkin lymphoma risk?**
  - Unlikely to have a significant contribution from environmental exposures<sup>10</sup>
  - Some cancers have strong associations with occupational exposures, Hodgkin lymphoma does not<sup>5</sup>



Seminar **THE LANCET**

**Classical Hodgkin lymphoma**  
 Pauline Bricé, Eric de Kerdilic, Jonathan W Friedberg

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Classical Hodgkin lymphoma is one of the more frequent lymphomas and is generally considered a highly curable disease with standard first-line chemotherapy and radiotherapy in some cases. Despite these outstanding results, major problems remain unresolved. First, there are still patients who will not be cured with front-line regimens and, second, many patients who are cured of classical Hodgkin lymphoma continue to die prematurely due to the late toxic effects of their therapy. Because the median age of patients with classical Hodgkin lymphoma is in the mid-50s, the disease's impact on the number of years lost from productive life is remarkable. In recent years, the gold standard of chemotherapy (often combined with radiotherapy) has changed, with the approval of immunotherapy mostly in relapse settings.

**Introduction**  
 Although up to 90% of patients with classical Hodgkin lymphomas at all stages can now be cured, what causes the normal B-lymphocytes to become a malignant biologically active tumour cell is still unknown. Classical Hodgkin lymphoma accounts for 10–15% of all lymphomas and is a unique disease with specific clinical features, evolution, and response to therapy.

**Epidemiology and pathophysiology**  
 Classical Hodgkin lymphoma has been recognised since 1932, when Thomas Hodgkin described the condition as occurring in young adults presenting with enlarged cervical nodes, weight loss, and fever, leading to death in a few months. Dorothy Reed Mendelhall in 1908 and Carl Sternberg in 1902 found the typical Reed-Sternberg cell in microscopic analyses of these nodes.<sup>1</sup> Classical Hodgkin lymphoma is a malignancy of the lymphatic system with an incidence of 2–3 cases per 100,000 people per year in developed countries<sup>2</sup> and is different from nodular lymphocytic predominant Hodgkin lymphoma, which is a B-lymphocyte antigen CD20-positive lymphoma and behaves like a very indolent low-grade B-cell lymphoma with favourable survival.<sup>3</sup> Epstein-Barr virus infections might be causally related to 25–40% of classical Hodgkin lymphoma cases, including a few cases with a personal history of an autoimmune disease or immune deficiency (including HIV infection) and malignancies that arise as a transformation of a low-grade B-cell lymphoma (mostly chronic lymphocytic leukaemia). Genome-wide association studies provide strong evidence that Epstein-Barr virus status is an aetiologically important classification for classical Hodgkin lymphoma.<sup>4</sup> However, little evidence exists for the role of other specific environmental risk factors, although there is a distinctive pattern of incidence rates and risk profiles by age, race or ethnicity, sex, and economic levels.<sup>1</sup> Some 10–12 years but is the most frequent lymphoma in adolescents and young adults and can also arise in patients aged 80 years and older. The first peak in the bimodal incidence pattern of classical Hodgkin lymphoma appears around the age of 20–30 years, whereas the second peak, in which the disease is more associated with Epstein-Barr virus and has a lower cure rate than that in the first peak, appears around the age of 50–70 years.<sup>2</sup> Diagnosis always involves a lymph-node biopsy with immunohistochemistry; the biopsy might concern a peripheral lymph node but, if this is absent, a CT-guided biopsy can be done. Classical Hodgkin lymphomas are composed of rare malignant Reed-Sternberg cells within an extensive inflammatory and immune cell infiltrate. Reed-Sternberg cells, which derive from germinal centre B-cells, interact rigorously with their microenvironment and create their own supportive network of feeder cells, and autostimulators and paracrine mediators of cellular proliferation, inhibition of apoptosis, and suppression of cytotoxic killer cells.<sup>5</sup> The Reed-Sternberg cells lose most of their B-cell identity, including their B-cell receptors, and do not undergo programmed cell death.<sup>6</sup> This inhibition of apoptosis and continuous active cell proliferation might be linked to the constitutively expressed NF-κB transcription factor and, in some cases, the clonal presence of Epstein-Barr virus. Despite this T-cell-rich infiltrate, Reed-Sternberg cells evade effective antitumour immune responses by multiple mechanisms and exhibit frequent copy-number alterations in chromosome 9p24.1 and in the genes encoding the PD-1 receptor ligands PD-L1 and PD-L2.<sup>14</sup> For pathological diagnosis, Reed-Sternberg cells have abundant eosinophilic or amphiphilic cytoplasm and a binucleated or lobulated nucleus, which expresses CD30 (100% of cases), CD15 (75–80%), CD20 (30–40%), and PAX5 (95%) (confirming B-cell origin).<sup>7</sup> Classical Hodgkin lymphoma cases show substantial biological heterogeneity and are subclassified mostly into two histological subtypes (panel 1). To date, classification into histological subtypes has not translated into different treatment approaches, but the subtypes are associated with various factors such as age, Epstein-Barr virus status, and nodal involvement.

www.thelancet.com Vol 398 October 23, 2021

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(mostly chronic lymphocytic leukaemia). Genome-wide association studies provide strong evidence that Epstein-Barr virus status is an aetiologically important classification for classical Hodgkin lymphoma.<sup>4</sup> However, little evidence exists for the role of other specific environmental risk factors, although there is a distinctive pattern of incidence rates and risk profiles by age, race or ethnicity, sex, and economic levels.<sup>1</sup> Some



# Results – External Comparison

## ■ MC vs General U.S. population

### ■ Increased incidence:

Melanoma

### ■ Statistically similar incidence:

Hodgkin lymphoma

Bladder cancer

Lung/Bronchus cancer

Leukemia

Thyroid cancer

Pancreatic cancer

Female breast cancer

Kidney/Renal pelvis cancer

Ovarian cancers

### ■ Lower incidence:

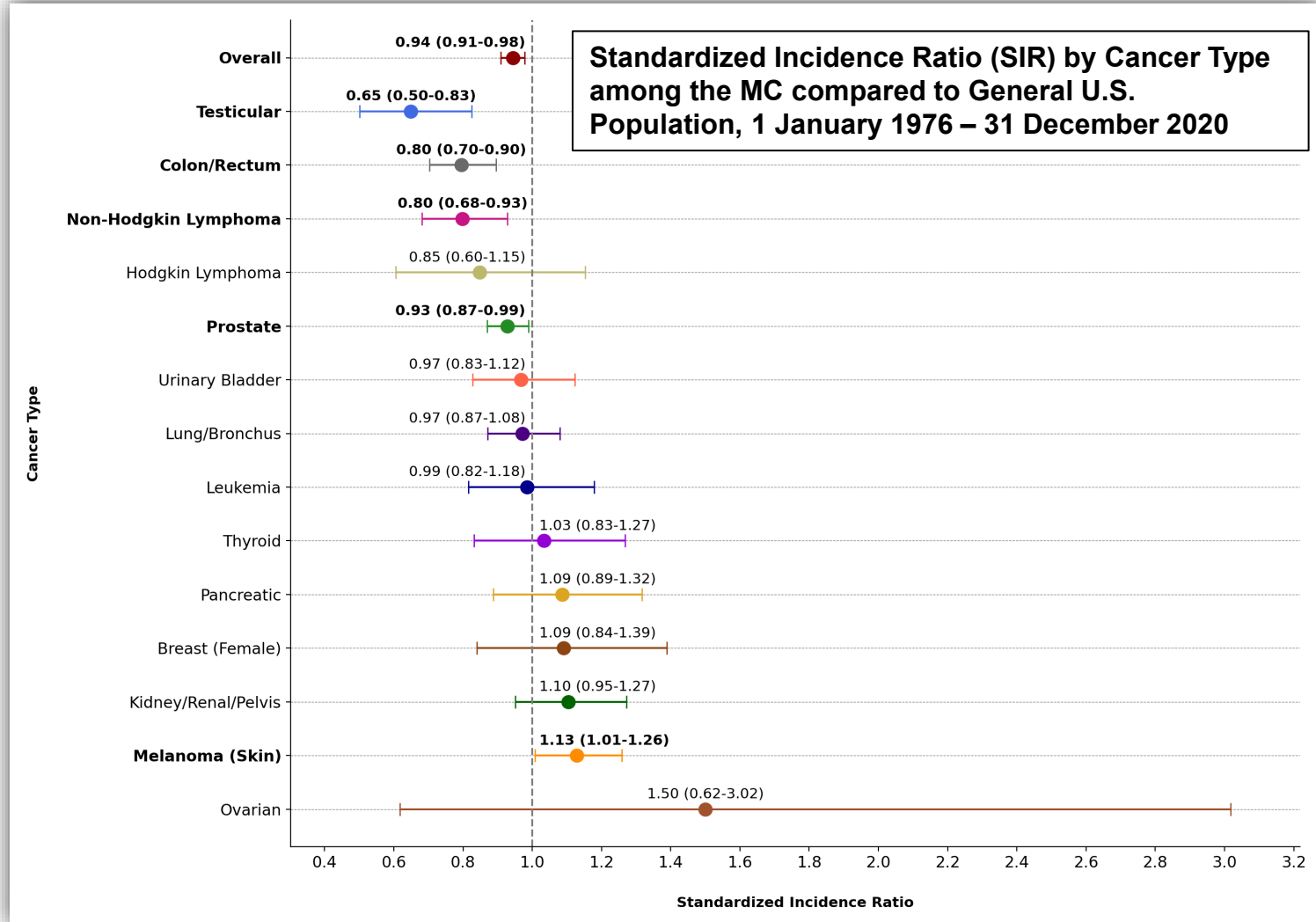
All 14 cancers overall

Testicular cancer

Colon/Rectum cancer

Non-Hodgkin lymphoma

Prostate cancer





# What is Melanoma?

- **Specific type of cancer of the skin**
  - Starts in the cells that give skin its color (called melanocytes)
- **What causes melanoma?**
  - Ultraviolet (UV) radiation exposure<sup>11</sup>
  - Skin type and other genetic factors<sup>11</sup>
- **Do adult occupational exposures increase melanoma risk?**
  - Studies on workplace exposure to UV radiation show mixed results.
    - Outdoor workers have lower rates of melanoma than indoor workers<sup>7</sup>
    - Occasional sunburns (vs steady sun exposure) ↑ risk<sup>12,13</sup>
    - Recreational exposure to UV radiation likely plays a larger role<sup>13,14</sup>
  - Some cancers have strong associations with occupational exposures, melanoma does not<sup>5</sup>
  - Circadian rhythm disruptions increase risk of certain cancers (breast, prostate, colorectal), limited but emerging evidence for melanoma<sup>15</sup>
  - Increased melanoma incidence in specific DAF<sup>16</sup> and military populations<sup>17,18</sup>





# *Epidemiology Review Future Analysis*

- Where feasible, plans to analyze Phase 2 data for increased incidence among:
  - Specific Air Force Specialty Codes
  - Location e.g. Malmstrom
  - Time Periods
- Partnership with Phase 2 external partners
  - Dr. Timothy Crawford (Wright State University, Boonshoft School of Medicine)
  - Dr. Edward Peters (University of Nebraska Medical Center)
- Limitations and expectations



Dr. Timothy Crawford

## MCCS Manuscripts Accepted for Publication:

1. The Missile Community Cancer Study (MCCS): Initial Report on Cancer Incidence and Mortality. Military Medicine. In Press. 2026.
2. Novel Integration of Multiple Data Sources in the United States Department of the Air Force Missile Community Cancer Study: A Methodological Analysis. Military Medicine. In Press. 2026.



# Way Forward

- Ongoing remediation and cleaning of Launch Control Centers
- Enduring emphasis on occupational health and health risk assessment periodicity
- Sustained partnership with ILER Working Group on development and implementation

Health.mil Website:



ILER Fact Sheet:



- Continued Epidemiology Review analysis, where feasible, focusing on specific jobs, time periods and locations
- Sustainment: Missile Community roster successfully transferred to VA for ongoing monitoring/updates
- Persistent Stakeholder Engagement
  - Congressional updates
  - VA Coordination - Military Environmental Exposure Sub-Council
  - [The PACT Act And Your VA Benefits | Veterans Affairs](#)
- Website for public information/questions: [Missile Community Cancer Study \(af.mil\)](#)





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