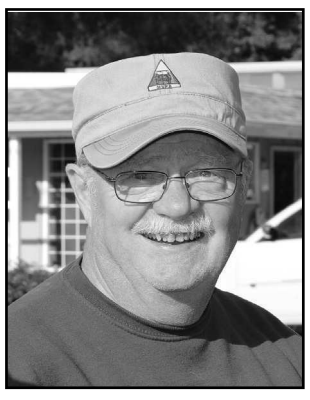
Siuslaw News

Community Voices

Military Heritage Chronicles — Food for Thought



Cal Applebee
Special to Siuslaw News

We've covered a broad range of topics over the years in the Chronicles, and I thought we'd touch on food fed to our troops over the years. After all, I am a distant relative of the Applebee restaurant franchise — but as we say in my side of the family, "We know them, but they don't know us."

This topic really covers the entire alphabet with something for every palate — richness, blandness, sweetness and salty.

Starting with the Civil War, when field kitchens on the battle fields couldn't keep up with the task of feeding troops due to complex logistics, the government attempted to feed soldiers with salt pork and hardtack — a stale biscuit — as an early attempt at individual rations.

While both the North and the South attempted to follow rations guidelines, with the field kitchens not keeping up and rations somewhat problematic, soldiers often had to in-fill when they could from local resources or the occasional food box from home. However, the lessons learned would benefit those serving in World War I.

After the hardtack experience in the Civil War days, in the pre-WWI years, the government began developing different ration levels for different needs. Between 1907 and 1937, those evolved as "Iron Ration" for soldiers in the field, consisting of combination of cakes, chocolate and salt/pepper.

The "Trench Ration" developed specifically for the doughboys serving overseas consisted of canned meats. It was developed primarily in response to field kitchen meals being spoiled by the gas attacks.

The end of WWI saw the development of "Reserve Ration," utilized up to 1937. Its contents were expanded to include canned meat, coffee, sugar, salt and bacon. Oh, and hardtack was back as well.

In the years leading up to WWII, attempts to improve the rations included substituting pork and beans and chocolate. At one point, there were five variations: A-ration or Garrison Ration, B-ration or Field Ration, C-ration or Individual Ration, K-ration as another Individual Ration, and D-ration or Emergency Ration. Each had various combinations of contents.

Some rations were produced with whatever meat and produce that could be obtained locally, so product contents could vary.

In post-WWII years, the C-Ration would continue to evolve as the "Meal Combat, Individual" (MCI), and after 1983, the "Meal, Ready to Eat" (MRE) that we still have today. In addition, A- and B-rations are still in use.

Pentagon officials eventually realized that the nutrition needs of the modern soldier went beyond serving an across-the-board balanced meal in the field. Armed forces serving in various regions, combat situations and missions received different meal ingredients, hopefully lighter in weight as combat soldiers carried increasingly heavier loads in the field.

The "Long Range Patrol," or LRP Ration, evolved in the mid-1960s, with a water-proof canvas pouch. In the mid-1970s, the dehydrated meal in a plastic pouch began to evolve, first seeing service in 1981.

The MRE has become the mainstay since then, incorporating modern dietary needs. Although designed for military use, the MRE has also been distributed in times of disaster for civilian consumption. And despite a warning statement on the carton "commercial resale is unlawful," I have seen MREs on the shelf at surplus stores, and in fact, have a carton in my "prepper supplies" acquired at a garage sale some years back — although I haven't tried any yet!

MREs have not evolved without some controversy — particularly as to what the abbreviation actually stands for.

Some variations include "Meals Rejected by Everyone," "Meals Rarely Edible" and "Meals Ready to Exit," among those that can be printed in the press.

Any discussion about food for our troops would be incomplete without mentioning two entrées — SPAM, and M&M's. Both used extensively in WWII, they not only served our troops well and survived, but went on to serve our society with distinction to this day.

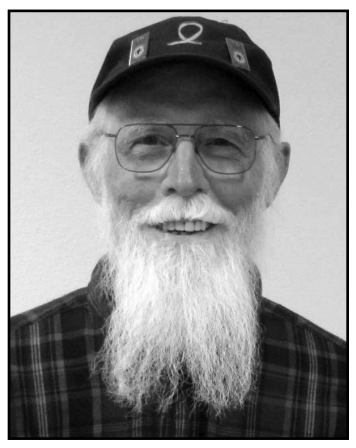
Introduced in 1937 by Hormel Foods, **SP**iced h**AM** was used in B-rations and, by 1944, 90 percent of Hormel's supply was going to the military. By April 1945, 100 million pounds of SPAM had been shipped abroad. Even though I am not a Veteran, I have eaten my fair share of SPAM and it too is in our prepper supplies.

The early Mars Candy Company introduced M&M's in 1941 and it was issued as part of the C-ration during WWII, as the hard sugar coating prevented them from melting in the hotter climates. Returning soldiers kept the taste for the sweat treat. In 1948, they changed from the original tube container issued to the military to the bags we see today.

I hope this has given you a taste of what our soldiers over the decades have had to consume. And if not, maybe we'll schedule a SPAM-fest at the Oregon Coast Military Museum in the future!

You can learn more about military heritage by visiting www.oregoncoastmilitarymuseum.com or stopping in at 2145 Kingwood St. in Florence.

Us TOO Florence — Behind the headlines



Bob Horney
Special to Siuslaw News

On June 23, I spent about six hours attending a webinar conference from Kirkland, Wash., presented by Us TOO International. The conference was titled, "Prostate Cancer Pathways for Patients and Caregivers." Since it was presented as a webinar, I could attend it from the comfort of my home in Florence, which I did.

Presenters included Dr. Jonathan Wright, Medical Director of the UWMC Urology Clinic and UW associate professor of Urology; Dr. Brian Lawenda, Radiation oncologist at Northwest Cancer Clinic and 21st Century Oncology; Dr. Cobie Whitten, Psycho-Oncology Consultant at Providence Regional Cancer System; Katie Stoll, Executive Director at Genetic Support Foundation; and Dr. Heather Cheng, Director Prostate Cancer Genetics Clinic.

One thing that was clear from the get-go was that each presenter was an established expert in his/her field. Their presentations, with accompanying slides, were of highest professionalism and gave critical information for prostate cancer patients and caregivers. I was greatly impressed with the level of information brought by each presenter.

On the other hand, as the webinar concluded, I realized I had a good basis for understanding much of the material and information that they covered. Why? Chalk that up to having had Urologist Dr. Bryan Mehlhaff, Prostate Cancer Specialist at Oregon Urology Institute (OUI), attending our Us TOO Florence meetings since 2004. In addition, his years with us have been supplemented by a combined 8 years with Urologists Dr. Doug Hoff and Dr. Roger McKimmy at our lunch meetings.

But, Mehlhaff is the key to all the information we receive, just as he is the key to keeping everyone at OUI on the front line with prostate cancer care.

By attending the webinar and listening to those prostate cancer experts share their expertise on varied aspects of the disease, I came away with an increased appreciation of the expert level of information we receive right here in Florence — and that it is available twice a month. All it takes is showing up at Ichiban Restaurant the second Tuesday of the month from 5 to 7 p.m. with Mehlhaff or the third Tuesday from noon to 1 p.m. with McKimmy and his PA, Cameron Derbyshire.

The doctors' reasons for joining us are to keep us current with the latest in diagnosis/treatment of prostate cancer and to answer all the questions that we have.

I can assure you that there are very few meetings where we aren't advised of something new that is working its way through clinical trials or hasalready received FDA approval and is being used somewhere in the U.S.

The men and women who meet regularly with the urologists have had a chance to keep up with dramatic changes in prostate cancer care, from screening to diagnosis and treatment. These changes are coming from many different directions as our researchers are pulling out all the stops in their search for better screening instruments, more definitive diagnostic tools and effective treatments for the cancer.

Serious attention is being directed toward a new screening instrument (IsoPSA) that appears to provide more prostate-cancer-specific information than the current PSA test.

"To be clinically useful, a biomarker must be both tissue-specific and cancer-specific. While PSA is prostate-specific, it is not specific for prostate cancer, leading to diagnostic inaccuracy and too many unneeded biopsies," said Dr. Klein, chair of Cleveland Clinic's Glickman Urological & Kidney Institute. "IsoPSA fulfills both the tissue- and cancer-specificity needed for a useful biomarker, and this validation study shows that it can more accurately detect high-grade cancer and reduce the rate of unneeded biopsies in patients at low risk of this disease."

Knowing the above study validated the results of an earlier study is a good step forward. However, I've read enough questions and concerns from prominent urologists to know IsoPSA isn't a "slam dunk." At this point, I sense that there are more questions than answers about its use. I look forward to future Us TOO Florence meetings with Mehlhaff to see how it all plays out.