



What happens if...

your patient hears their results as Negative?

Positive?

Normal?

Abnormal?

We tested whether adding interpretive labels (eg, “negative test”) to prenatal genetic screening test results changes perceived risk and preferences for amniocentesis.

Study Design—Women (N = 1688) completed a hypothetical pregnancy scenario on the Internet. We randomly assigned participants into 2 groups: high risk of fetal chromosomal problems (12.5/1000) or low risk (2/1000). After prenatal screening, estimated risk was identical (5/1000) for all participants, but results were provided either alone or with interpretive labels.

Results—When receiving test results without labels, all participants react similarly. With labels, the participants who received “positive” or “abnormal” results reported a higher perceived risk (P < .001), greater worry (P < .001), and greater interest in amniocentesis (57% vs 37%; P < .001) than did the participants who received “negative” or “normal” results.

Conclusion—Interpretive labels for test results can induce larger changes to a woman’s risk perception and behavioral intention than can numeric results alone, which create decision momentum. This finding has broad clinical implications for patient-provider communication.

Zikmund-Fisher BJ et al Does labeling prenatal screening test results as negative or positive affect a woman’s responses? Am J Obstet Gynecol. 2007 Nov;197(5):528

Editorial comment: Barry Weiss M.D., Tucson Do you understand everything the networking folks in your IT Dept. say about your own facility’s server?

If you understood everything they said the first time you heard it, then you can probably stop reading right here.

On the other hand, have you ever been called on the phone by a friend or relative, who asked you to explain to them something they were told by their doctor but which they didn’t understand? You then explain things to your friend or relative in a simple, easy-to-understand way. Did you ever ask yourself why their physician didn’t use an easy-to-understand explanation in the first place? Did you ever wonder why we don’t all use those simple explanations with our patients every day?

Data from the recent National Assessment of Adult Literacy (NAAL) show that about 1/3 of all American adults have limited health literacy. Such individuals do not understand what you’ve told them, nor what they are supposed to do in response to advice you have given them. NAAL data show that the rate is even higher—approaching 50%—among Native Americans and Alaska Natives. So, whether you know it or not, you are seeing patients—many patients—every day who have difficulty understanding what you’ve told them.

Two of the most important things you can do to address this problem are: first, explain things to patients using easy to understand words—like you might explain them to your grandmother. The second is to use the “teach-back” technique, in which

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Behavioral Health Insights

Dr. Peter Stuart just joined us with the Behavioral Health Insights (see page 7). Dr. Stuart is on assignment with the IHS Division of Behavioral Health as the National Psychiatry Consultant. He spent 14 years in Chinle, Arizona with Chinle Service Unit Counseling Services and prospered despite being 90 miles from the nearest Wal-Mart. His interests include community psychiatry, suicide prevention, use of technology to improve access to Behavioral Health Services, dialogue between traditional and allopathic healing practitioners, veterans care and integration of clinical services across disciplines.

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Also on-line....

Subscribe to the listserv and receive reminders about this service. If you have any questions, please contact me at nmurphy@scf.cc

Dr. Neil Murphy
Ob/Gyn—
Chief Clinical Consultant (C.C.C.)

IHS Child Health Notes

"It doesn't matter if the cat is black or white as long as it catches mice."

—Chinese Proverb

Quote of the month

"Logic is an organized procedure for going wrong with confidence and certainty."

—C. F. Kettering

Stephen S. Hall. *Small and Thin: The controversy over the fetal origins of adult health.* *The New Yorker*, November 19, 2007

Weight in infancy and death from ischemic heart disease. *Lancet*. 1989 Sep 9;2(8663):577-80

Mother's weight in pregnancy and coronary heart disease in a cohort of Finnish men: follow up study. *BMJ*. 1997 Oct 4;315(7112):837-40

Trajectories of growth among children who have coronary events as adults. *N Engl J Med*. 2005 Oct 27;353(17):1802-9

The belief that maternal health in pregnancy can have life long effect on chronic illnesses in their offspring has gone from heresy to orthodoxy in the past 20 years. The driving force behind this theory is David Barker, who was featured recently in an article in *The New Yorker*. Dr. Barker's original hypothesis was based on population studies in England. It was confirmed by similar work in Finland. This epidemiologic work has found correlates in the new field of epigenetics which postulates that environmental factors can produce permanent changes in the activity of genes. Birth effects are not predestination but they do have measurable effects over a population. Dr. Barker argues we need to put more emphasis on maternal nutrition as a cost effective intervention for future health.

Editorial Note

What do skinny children born to skinny, poorly nourished mothers in England in the early 20th century have to do with AI/AN children today? Studies have shown that the children at greatest risk for coronary heart disease as adults are not fat babies: it is thin babies who gain unusual amounts of weight after birth. This perfectly describes infants born 20 to 40 years ago as many AI/AN populations went in one generation from under nutrition to over nutrition. We now have an epidemic of diabetes and coronary heart disease in young adults. It is unclear what will be seen 20 years from now in the current group of large for gestational infants being born to overweight mothers. We can only be sure that there will be epigenetic effects.

Infectious Disease Updates.

Rosalyn Singleton, MD, MPH

2008 Childhood Immunization Schedule: Few changes planned.

There were numerous changes to the Childhood (0-6 year) and Adolescent Immunization Schedules in 2007. Few additional footnote changes are proposed for the 2008 schedule:

Hep B—"If mother is HBsAg-negative, the birth dose can be delayed in rare cases with providers order and copy of mother's negative HBsAg lab report in infant's medical record"

Pneumococcal vaccine—"At ages 24-59 months administer 1 dose of PCV to incompletely vaccinated healthy children and 2 doses of PCV at least 8 weeks apart to incompletely vaccinated children with certain high risk conditions. Administer Pneumovax to children 2 years and older with certain high-risk conditions"

Meningococcal vaccine—"Administer Menactra to children aged 2-10 years with terminal complement deficiencies or anatomic or functional asplenia or HIV infection"

Influenza vaccine

—Yearly for children 6-59 months, close contacts of children 0-59 months

—Yearly for children 5 years + with certain risk factors

—FluMist can be used in healthy children 2 years and older (with out asthma or recurrent wheezing)

—Give 2 doses (separated by at least 4 weeks) to children <9 years receiving Flu vaccine for the first time; or who were vaccinated for the first time last season but only received 1 dose.

Summary: The biggest new change is that Menactra, currently recommended for 11-18 year olds, will be recommended for children down to 2 years of age with certain high risk conditions. Depending on the supply and finances, ACIP may eventually expand Menactra to one dose for any child 2-18 years.

You can download the new schedules in January at:

www.cdc.gov/vaccines/recs/schedules/

Recent literature on American Indian/ Alaskan Native Health

Doug Esposito, MD

Singleton RJ, Holman RC, Yorita KL, Holve S, Paisano EL, Steiner CA, Glass RI, Cheek JE. Diarrhea-Associated Hospitalizations and Outpatient Visits Among American Indian and Alaska Native Children Younger Than Five Years of Age, 2000-2004. *Pediatr Infect Dis J*. 2007;26(11):1006-1013.

Editorial Comment

This study scrutinizes IHS hospital discharge and outpatient visit data

Links to stories at www.ihs.gov/MedicalPrograms/MCH/M/ChPedNotes.cfm

for diarrhea in children <5 years of age for calendar years 2000 – 2004, inclusive. Hospitalization and outpatient visit rates (events/10,000 population) were constructed using the 2004 IHS service-population as the denominator, with statistical adjustments applied to earlier years. The data were analyzed on a regional basis; for the AI/AN population, Northern Plains, Southern Plains, Southwest, East, Alaska, and West designations were used while the general U.S. population was regionalized using Northeast, Midwest, South, and West. Additional analysis was made based on age (<12 months and 1 – 4 years), sex, and diarrhea etiology.

Childhood diarrhea hospitalization rates for the general U.S. population were examined using the 2003 Kids' Inpatient Database (KID). Comparison outpatient visit data for the general U.S. population derived from the 2000 – 2004 National Ambulatory Medical Care Survey (NAMCS) and the National Hospital Ambulatory Medical Care Survey (NHAMCS). Age-specific rates were constructed using 2003 U.S. census and U.S. natality data.

It appears that AI/AN children <5 years of age had similar or slightly lower rates of hospitalization for diarrhea than the general U.S. population [65.9 (95% CI: 63.8 – 68) vs. 79.3 (95% CI: 74.9 – 83.6)/10,000], while rates of diarrhea hospitalization for AI/AN infants were almost two-fold higher [(262.6 (95% CI: 252.3 – 273.3) vs. 154.7 (95% CI: 145.6 – 163.8)/10,000]. Also of note is that the hospitalization rate for AI/AN infants was 10 times the rate for 1 – 4 year-old AI/AN children! This difference was not as striking among the general U.S. population. Higher rates of outpatient visits for diarrhea were found for AI/AN children <5 years of age [2255.4 (95% CI: 2245.1–2265.7) vs. 1647.9 (95% CI: 1398.4 –1897.4)/10,000], with infants being seen at about twice the rate of the general U.S. population.

The pattern of diarrhea-associated hospitalization and outpatient visits for AI/AN children varied by region, but the regions of highest and lowest burden did not completely match. Overall, hospitalization rates were highest in the Southwest and in Alaska and lowest in the Northern and Southern Plains while outpatient visit rates were highest for the East and the Southwest and lowest for the Southern Plains and the West. Please refer to the article itself for details of these differences and the regional variability based on age group. Seasonal variation occurred for both in and out-patient events and mimicked what might be expected based on the known epidemiology of viral etiologies (especially rotavirus) of childhood diarrhea.

Given that these data reflect IHS hospital discharge and outpatient visit data, some inherent peculiarities exist that might reasonably be expected to have underestimated hospitalization rates overall and to have possibly impacted the variability observed by IHS region. For example, in regions where hospitalizations occur mainly outside the IHS or contract facilities (e.g. the Northern and Southern Plains), hospitalization rates would be expected to be biased lower (i.e. the disparity between AI/AN children and the general U.S. populations is actually worse than it appears). Additionally, differences in hospital

admission criteria, health care seeking patterns, diagnosis and coding issues, and issues with the denominator (user population) all could serve to skew the rate estimates. These issues are discussed by the authors both in the current article and in another article employing an identical methodology to investigate rates of hospitalization for a different condition.¹ Finally, given that AI/AN groups are known to be very diverse and not uniform with regard to traditions, lifestyle, health behaviors, socioeconomic factors, and others, variability in health status and health outcomes is to be expected. American Indian/Alaska Native is a highly diverse racial designation which is reflected in the health statistics of individual band and tribal designations.

Although disparities in diarrhea still exist and are possibly even greater than demonstrated by this study, one cannot argue the impressive progress that has been made over the years with regards to the burden of diarrhea among AI/AN children. Substantial credit for this progress belongs to the IHS itself and to the dedicated individuals that have worked with and within the system to accomplish so very much with so very little.² These improvements are certainly the result in large part of the targeted deployment of the same basic public health interventions that have so positively impacted health status throughout the world, namely safe water systems, improved sanitation, and better hygiene practices.

According to the authors, further improvements and reductions in diarrhea-associated hospitalization and outpatient visit rates, especially for infants, might be expected as a result of the newly available rotavirus vaccine. That, however, remains to be seen. At a minimum, continued deployment of technologies known to be effective should be a focus of our efforts. Significant proportions of AI/AN populations still lack basic systems of safe and available water and sanitation that most of us take for granted. Additionally, components of poverty that are widely known to adversely affect susceptibility and transmission of infectious disease (e.g. overcrowding, unhygienic living environments, nutritional integrity), must continue to be targeted. To me, disparities in diarrhea reflect basic and unacceptable societal inequities. Until we as a society address these fundamental facts, health equity and the complete elimination of health disparities will be a long time in coming.

References

1. Singleton RJ, Holman RC, Cobb N, Curns AT, Paisano EL. Asthma Hospitalizations Among American Indian and Alaska Native People and for the General US Population. *Chest*. 2006;130(5):1554-62.
2. Forty years in partnership: the American Academy of Pediatrics and the Indian Health Service. *Pediatrics*. 2006 Oct;118(4):e1257-63.

Additional Reading

Holman RC, Parashar UD, Clarke MJ, Kaufman SF, Glass RI. Trends in diarrhea-associated hospitalizations among American Indian and Alaska native children, 1980-1995. *Pediatrics*. 1999;103(1):E11.

From Your Colleagues

David Gahn, Tahlequah, OK You can make a big difference in women's and children's lives

Colleagues,

Here are some unique opportunities that are available for Indian Health staff

1) The Office of Global Health Affairs (OGHA), within the Department of Health and Human Services (HHS), has invested in improving the level of care at Rabia Balkhi Hospital (RBH), one of four maternity hospitals in Kabul, Afghanistan. HHS/OGHA has also contracted with a few non-governmental organizations (NGOs) to provide expertise in certain aspects of the program, run with the permission of and under the supervision of the Afghanistan Ministry of Public Health (MoPH). HHS partners include the Centers for Disease Control and Prevention (CDC), the Health Resources and Services Administration (HRSA), the Agency for Health-Care Research and Quality (AHRQ) and the Indian Health Service (IHS).

2) RBH provides care to women, mostly in obstetrics. There is also a small component of general surgeons, internists, and dermatologists. 40 to 60 women a day deliver at RBH. One of the other four hospitals in Kabul, Malalai, is also this busy. Because of the U.S. presence at RBH, it has become the main referral hospital in Kabul, and receives the sickest women for delivery. RBH also houses a residency program in obstetrics and gynecology, with about 50 residents and 14 faculty.

3) The current focus of the HHS project is a Cesarean section quality-assurance (QA) program. The project is starting at RBH, but will branch out to collaborate with the other hospitals in Kabul. Over the last several years, HHS/CDC has developed a system within the MoPH for collecting data on maternal and child health in Kabul. The current data show an increase in the Cesarean section rate from 4% to 10%, which the Ministry and our partners thought would decrease maternal and perinatal morbidity and mortality. However, the data also show a concurrent increase in mortality.

4) HHS/OGHA is looking for obstetricians/gynecologists and pediatricians to go to RBH to work as advisors to the local physicians, to improve their skills, and to work on the QA programs as well the Cesarean section quality-assurance collaborative. The primary role for HHS/IHS staff would be to serve as advisors, by working at the bedside with the Afghan doctors and residents to improve the level of care.

5) The role of IHS CNM's has not been completely clarified, but deployment in 2008 is highly likely. I encourage CNM's who are interested to contact me.

6) The length of the tour would be 1-3 months, and could start as early as January 6, 2008. This is a TDY assignment. Candidates must be Federal employees (civil service or Commissioned Corps). HHS/OGHA will pay travel and per diem and will also reimburse service units for the salary. The interagency agreement between HHS/IHS and HHS/OGHA is under negotiation, and should be complete in the next two weeks.

7) Security in Afghanistan is always an issue. HHS personnel in Kabul will stay on the U.S Embassy compound. Trained security personnel in armored SUVs will accompany HHS staff to RBH. Leisurely travel about town is absolutely forbidden, but HHS staff may go to the army base, the International Security Assistance Force (ISAF) base, and the MoPH.

8) The U.S. Embassy itself is self-sufficient, and has two post exchanges (PXs), two dining halls, a gym, a swimming pool, etc. The rooms in which HHS staff will stay are converted shipping containers called "hooches." The rooms are relatively small, but include all the amenities: fridge, microwave, TV with cable, DVD player, bed and linens, desk, Internet access, phone, shower, toilet, sink, and hot-water heater.

9) My role in all of this is to coordinate recruitment and scheduling within HHS/IHS, and to participate in the operational aspects of the project. I will be going to Kabul in January with a pediatrician, a pharmacist, and a scrub tech. If you are interested in going to Kabul, please send me a CV, and we can discuss things over the phone. Afghanistan is an exciting place, and I can promise you a life-changing experience, as well as provide an opportunity to improve some of the highest maternal-mortality rates ever recorded. This is also a chance to contribute meaningfully to international efforts to stabilize Afghanistan.

Regards,

Dave Gahn

David.Gahn@ihs.gov

Hot Topics

Obstetrics

Cesarean delivery on request not recommended if desiring several children, ACOG

ABSTRACT: Cesarean delivery on maternal request is defined as a primary cesarean delivery at maternal request in the absence of any medical or obstetric indication. A potential benefit of cesarean delivery on maternal request is a decreased risk of hemorrhage for the mother. Potential risks of cesarean delivery on maternal request include a longer maternal hospital stay, an increased risk of respiratory problems for the baby, and greater complications in subsequent pregnancies, including uterine rupture and placental implantation problems. Cesarean delivery on maternal request should not be performed before gestational age of 39 weeks has been accurately determined unless there is documentation of lung maturity. Cesarean delivery on maternal request should not be motivated by the unavailability of effective pain management. Cesarean delivery on maternal request is not recommended for women desiring several children, given that the risks of placenta previa, placenta accreta, and the need for gravid hysterectomy increase with each cesarean delivery.

Cesarean Delivery on Maternal Request. ACOG Committee Opinion no. 394. American College of Obstetricians and Gynecologists. Obstet Gynecol 2007;110:1501-4.

Sense of coherence and symptoms of post-traumatic stress after emergency caesarean

CONCLUSIONS: Symptoms of post-traumatic stress following emergency caesarean delivery are associated both with the new mother's personal coping style and with the circumstances of the event. We recommend that women who belong to groups who more often report a low of coherence or who had imminent asphyxia as an indication for the operation should be offered support and follow-up.

Tham V et al Sense of coherence and symptoms of post-traumatic stress after emergency caesarean. Acta Obstet Gynecol Scand. 2007;86(9):1090-6.

Spinal analgesia increases the success rate of external cephalic version from 32% to 67%

CONCLUSION: Administration of spinal an-

algnesia significantly increases the success rate of external cephalic version among nulliparous women at term, which allows possible normal vaginal delivery.

Weiniger CF et al External cephalic version for breech presentation with or without spinal analgesia in nulliparous women at term: a randomized controlled trial. Obstet Gynecol. 2007 Dec;110(6):1343-50

Gynecology

Early feeding within the first 24 hours after major abdominal gynecologic surgery is safe

SELECTION CRITERIA: Randomized controlled trials that compared the effect of early versus delayed initiation of oral intake of food and fluids after major abdominal gynecologic surgery were considered. Early feeding was defined as having oral intake of fluids or food within the first 24 hours after surgery regardless of the presence or absence of the signs that indicate the return of bowel function and delayed feeding was defined after first 24 hours following surgery and only after clinical signs of resolution of postoperative ileus

CONCLUSIONS: Early feeding after major abdominal gynecologic surgery is safe however associated with the increased risk of nausea and a reduced length of hospital stay. Whether to adopt the early feeding approach should be individualised. Further studies should focus on the cost-effectiveness, patient's satisfaction, and other physiological changes.

Charoenkwan K, et al Early versus delayed (traditional) oral fluids and food for reducing complications after major abdominal gynecologic surgery. Cochrane Database Syst Rev. 2007 Oct 17;(4):CD004508. Review.

Child Health

Rapid response team: Implications of findings on mortality rates for children are dramatic

Implementation of an RRT [rapid-response team] in our free-standing, quaternary care academic children's hospital was associated with statistically significant reductions in hospital-wide mortality rates and code rates outside the ICU [intensive care unit] setting.

Late-preterm (34–36 weeks) infants have higher mortality rate than term at one year of age

RESULTS: Significant declines in mortality rates were observed for late-preterm and term infants at all age-at-death categories, except the late-neonatal period. Despite the decline in rates since 1995, infant mortality rates in 2002 were 3 times higher in late-preterm infants than term infants (7.9 versus 2.4 deaths per 1000 live births); early, late, and postneonatal rates were 6, 3, and 2 times higher, respectively. During infancy, late-preterm infants were approximately 4 times more likely than term infants to die of congenital malformations (leading cause), newborn bacterial sepsis, and complications of placenta, cord, and membranes. Early-neonatal cause-specific mortality rates were most disparate, especially deaths caused by atelectasis, maternal complications of pregnancy, and congenital malformations.

CONCLUSIONS: Late-preterm infants have higher mortality rates than term infants throughout infancy. Our findings may be used to guide obstetrical and pediatric decision-making.

Tomashek KM Differences in mortality between late-preterm and term singleton infants in the United States, 1995-2002. J Pediatr. 2007 Nov;151(5):450-6, 456.e1.

Featured Website
David Gahn, IHS MCH
Portal Web Site Content
Coordinator

Preconception Counseling
for Women with Diabetes
and Hypertension: New
module

This is a new module in the Perinatology Corner Series

This particular topic is coming up a lot more frequently in our patients.

What can you treat with and not endanger the fetus?

What you can't treat with?

This module offers good advice on these and many other issues, plus lots of resources, even if you don't want the free CME www.ihs.gov/MedicalPrograms/MCH/M/PNC/PreconCouns01.cfm

The authors found that

- A significant decrease in the hospital-wide mortality rate of 18% occurred after RRT implementation. Mean monthly mortality rates preintervention and postintervention were 1.01 and 0.83 deaths per 100 discharges, respectively.
- The rate of codes outside the ICU per 1,000 eligible patient-days decreased by 71.2% after RRT implementation, with preintervention and postintervention rates of 0.52 and 0.15, respectively.
- The rate of codes outside the ICU per 1,000 eligible admissions decreased by 71.7%, with preintervention and postintervention rates of 2.45 and 0.69, respectively.
- The estimated code rate per 1,000 admissions for the postintervention group was 0.28 times that for the preintervention group.

The potential implications of these findings on national mortality rates for children could be dramatic.

Sharek PJ, Parast LM, Leong K, et al. 2007. Effect of a rapid response team on hospital-wide mortality and code rates outside the ICU in a children's hospital. JAMA, the Journal of the American Medical Association 298(19):2267-2274

Chronic disease and illness
Reconsider use of rosiglitazone

A 2004 meta-analysis described both drugs have similar effects on glycemic control and body weight. Both drugs appear to have a beneficial effect on serum lipids. In a meta-analysis comparing the effect of thiazolidinediones on cardiovascular risk factors, pioglitazone produced a more favorable lipid profile. The Proactive study measurement of macrovascular events included all cause mortality and non-fatal stroke with combined endpoints. It was noted the study narrowly made statistical significance. Both drugs increased HDL, rosiglitazone increased LDL and had a neutral effect on TG whereas pioglitazone had a neutral effect on LDL and lowered TG. Rosiglitazone was shown in JAMA June and September 2007 meta-analysis to increase macrovascular events. The first study demonstrated increase risk of MI with rosiglitazone and the 2nd study displayed increased risk of MI but not death. No head-to-head trials have been conducted to date. In regards to adverse effects, both drugs may cause fluid retention which may exacerbate or lead

to heart failure. Thiazolidinediones are not recommended for patients with NYHA Class 3 & 4 cardiac status. Some clinicians chose to avoid this class of drugs in NYHA Class 2 as well. Edema was more pronounced as a side effect with both drugs; rosiglitazone 4.8% and pioglitazone 4.8% versus placebo 1.3% and 1.2%, respectively. LFT monitoring is recommended for both drugs. Post-marketing experience with rosiglitazone reported some cases of angioedema and urticaria. Rifampin decreased rosiglitazone AUC by 66% and the clinical significance of this is unknown. Look-alike, sound-alike: Avandia and either Coumadin or Prandin; Actos and Actonel noted by the Institute for Safe Medication Practices. Use of rosiglitazone has changed from 2005 to 2007, from 170 to 119 patients, respectively. Use of pioglitazone has increased from 2005 to 2007, from 66 to 128 patients. Clinical trials have shown similar decreases in A1C between pioglitazone 15 and 30mg. Based on safety, pioglitazone has been shown better safety profile than rosiglitazone. Dialogue regarding the Accord trial pointed out the study is still in progress, and results inconclusive with cardiovascular events. Pioglitazone has a significantly lower risk of death. Today, rosiglitazone is not as cost effective as it was back in 2005. The current data describes a potential increase in cardiovascular events associated with rosiglitazone that has not been seen with pioglitazone.

Conclusion—Reconsider use of rosiglitazone. Patients who are taking rosiglitazone 2 or 4 mg can be switched to pioglitazone 15mg and those taking rosiglitazone 8mg can be switched to 45mg of pioglitazone.

Resource—Charbonnel B. Glitazones in the treatment of diabetes mellitus: clinical outcomes in large scale clinical trials. *Fndam Clin Pharmacol.* 2007 Nov;21 Suppl 2:19-20.

Features

ACOG, American College of Obstetricians and Gynecologists

Human Immunodeficiency Virus

ABSTRACT: Because human immunodeficiency virus (HIV) infection often is detected through prenatal and sexually transmitted disease testing, an obstetrician–gynecologist may be the first health professional to provide care for a woman infected with HIV. Universal testing with patient notification and right of refusal (“opt-out” testing) is recommended by most national organizations and federal agencies. Although opt-out and “opt-in” testing (but not mandatory testing) are both ethically acceptable, the former approach may identify more women who are eligible for therapy and may have public health advantages. It is unethical for an obstetrician–gynecologist to refuse to accept a patient or to refuse to continue providing health care for a patient solely because she is, or is thought to be, seropositive for HIV. Health care professionals who are infected with HIV should adhere to the fundamental professional obligation to avoid harm to patients. Physicians who believe that they have been at significant risk of being infected should be tested voluntarily for HIV.

Human immunodeficiency virus. ACOG Committee Opinion no. 389. American College of Obstetricians and Gynecologists. Obstet Gynecol 2007;110:1473-8.

Ask a Librarian Diane Cooper, M.S.L.S. / NIH Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity

In February 2004, the American Medical Association convened a second expert committee to guide the development of 3 articles that would explore current evidence-based science and form the basis of new recommendations on the assessment, prevention, and treatment of child and adolescent overweight and obesity. Representatives from 15 national organizations

formed the second expert committee. The committee used a multidisciplinary model and integrated approaches across disciplines. The conceptual framework is the chronic care model with the goal of achieving family/self-management of childhood obesity.

The product was 4 articles, 1 on each of the aforementioned overview areas of the management of obesity and 1 overarching support document. The articles were written by national experts in the field of childhood obesity who were nominated jointly by the members of the expert and steering committees.

Barlow SE and the Expert Committee Expert Committee. Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report PEDIATRICS Volume 120, Supplement 4, December 2007 S164 - S192

Krebs NF et al Assessment of Child and Adolescent Overweight and Obesity. PEDIATRICS Volume 120, Supplement 4, December 2007: S193 - S228

Links to stories at www.ihs.gov/MedicalPrograms/MCH/M/OBGYN01.cfm

Davis MM Recommendations for Prevention of Childhood Obesity PEDIATRICS Volume 120, Supplement 4, December 2007 S229 - S253

Spear BA et al Recommendations for Treatment of Child and Adolescent Overweight and Obesity PEDIATRICS Volume 120, Supplement 4, December 2007 S254 - S288

http://pediatrics.aappublications.org/content/vol120/Supplement_4/index.shtml

or www.pediatrics.org

Behavioral Health Insights

Peter Stuart, IHS Psychiatry Consultant

Teens, Depression, Black Box Warnings and Suicide

After a substantial period of gradually decreasing rates of suicide in adolescents including AI/AN adolescents, recent 2004 data documenting increased suicide rates for adolescents suggests more attention will be coming to adolescent mood problems. The increase in suicides was most dramatic in female populations with rates rising dramatically in younger female populations ages 10-14 (75.9%) and significantly so in older adolescent females ages 15-19 (32.3%) and males ages 15-19 (9%). The increases coincide with the FDA's black box requirement for many antidepressants that is likely responsible for an overall reduction in the prescription of antidepressants for teenagers. Does this mean decreased antidepressant prescription was causally related to the increase in suicides? We don't know but the temporal association is suggestive.

Our adolescents are unfortunately at the forefront of the suicide curve. Indian country has received significant attention recently due to increasing concern about suicide clusters in adolescent populations and more generally young adults. Theories abound as to why this is occurring—and given the low base rates of the event and the high frequency of conditions and behaviors associated with increased risk real understanding is still some time away.

There is a general consensus, however, that part of the solution lies in identifying and treating depression in Primary Care. The American Academy of Pediatrics recently released GLAD-PC (Guidelines for Adolescent Depression in Primary Care) I and II which include excellent resources for developing primary care based approaches to management. The full documents can be found at www.glad-pc.org and include screening and assessment instruments as well as treatment tracking tools.

The recent publication of further results from the TADS (Treatment of Adolescent Depression Study) is also encouraging as it suggests that risks related to antidepressant treatment can be mitigated with appropriate therapy and management.

Combined Depression Regimen Appears to Reduce Suicidality. Psychiatr News, Mar 2007; 42: 28—35

Some basic recommendations for tackling adolescent depression:

1. Screen using a systematic assessment (screening tool)—for those of you familiar with the PHQ-9 there is a slightly modified instrument for adolescents available on www.glad-pc.org Other instruments with established psychometric properties are also available for use and several are free.
2. Develop relationships with your local BH system—you can treat and manage many patients successfully with fairly limited consultative support,
3. Take adequate time—pediatric and primary care schedules are often crazy and packed—this is for better or for worse one of those occasions where time up front reduces emergencies and time later. If you have the opportunity to integrate BH care into your primary care services your schedule interruptions can be minimized.
4. Treatment works—and while there may be issues with the relative strength of psychotherapy vs. medications both have demonstrated efficacy over placebo or treatment as usual approaches. Keys to successful treatment include having a plan, reassessing progress frequently particularly in the early stages of treatment, and getting help if there is no improvement or improvement plateaus before full resolution.
5. Access to lethal means restriction counseling may reduce risk of self-injury see www.sprc.org/featured_resources/bpr/ebpp_PDF/emer_dept.pdf.
6. The "Medical Home" is an encompassing model that if applied properly in conjunction with developmentally appropriate preventive counseling provides maximum opportunity to identify, intervene and mitigate at least some of the risk for self-destructive behaviors in adolescence—whether that behavior be self-injury, smoking, unprotected sex or drug and alcohol use.

If you decide to use medications, keep in mind the following:

1. Medications should be used to treat full MH disorders and generally avoided in sub-syndromic states in children and adolescents,
2. Fluoxetine remains the best option to start with for adolescents—it has the best risk profile and is indicated for treatment of adolescent depression.
3. Educate the patient and parents/guardians/family members about use of the medication, including the possible development of agitation, restlessness, and anxiety—these symptoms may portend the development of medication-induced suicidal thinking. The FDA and AACAP guidelines suggest initial weekly face-to-face visits—while this is desirable it is often not feasible or practical but the pearl here is to plan regular weekly contact whether in person, by phone or through other means, with the patient and family and identify this in your documentation. Follow-up may actually need to be more frequent if there is any significant suicidal ideation or self-harm concerns.
4. Screen for history of bipolar symptoms both in the patient and through the family history—be very cautious using medications without consultation where there is a history of mania-like symptoms or family bipolar disorder.
5. Stop medications gradually—risk periods for increased suicidal thinking appear to be both around the initial time of initiation of

- antidepressant therapy AND AFTER sudden discontinuation.
6. Limit refills. Keep dispensed amounts to only slightly more than necessary to get to the next contact or appointment for the first three months of treatment.

References: Online

Breastfeeding Suzan Murphy, PIMC

Breastfeeding, it is not just about the baby

According to a 2005 meta-analysis by the Agency for Healthcare Research and Quality (AHRQ), postpartum depression (PPD) is a major depressive disorder that effects between 5-25% of women in developed nations. Compared to men, women are twice as likely to experience depression in their lifetime.

Risk factors for PPD include:

adolescence	unplanned/unwanted pregnancy
poverty	life stress (including child-care issues)
family or personal history of depression	challenging infant temperament (fussy, colicky)
relationship discord	low self-esteem
lack of social support	prenatal anxiety

Symptoms include:

Loss of interest or enthusiasm for daily activities	Feelings of worthlessness, hopelessness, excessive/inappropriate guilt or shame
Depressed mood	Suicidal ideation
Difficulty making decisions or concentrating	Somatic complaints such as headaches, g.i. distress
Fatigue	Psychomotor disturbance
Appetite disturbance	Sleep changes

For many reasons, PPD is often undiagnosed. PPD left untreated can be devastating for new mothers and their families..

A recent study by Mancini et al (cited below), described using the Postpartum Depression Screening Scale (PDSS) developed by Beck et al to screen women in large midwifery and obstetric practice in Albuquerque, New Mexico. The practice saw approximately 2000 deliveries per year, 40% enrolled in the Medicaid program. The goals of the study were to look at prevalence of positive PDSS screen at 6 weeks, determine the benefits and challenges of using the PDSS screening tool and find demographic and clinical characteristics that were related to positive screens.

In a 12 month period, 755 women were screened, 740 with complete data sets. Data was collected on PDSS score, age, parity, race/ethnicity, education, marital status, infant feeding, type of delivery, and history of depression. The prevalence of a positive screen at 6 weeks

was 16% with major PPD and 20% with symptoms suggesting potential PPD risk. The PDSS was integrated into the patient care routine ultimately with positive feedback by the staff and patients. A total of 75% of the providers participated, 6 of 11 obstetricians, all of 9 CNMs. They reported a sense of providing more comprehensive care and the opportunity to gently educate about mental illness. Patients reported appreciating the chance to talk about mental wellness issues.

The study found that women who had a positive screen at 6 weeks postpartum were more likely to not have completed high school, not be partnered, be exclusively bottle feeding, and have a history of depression. The 2 characteristics that were statistically significant as predictors of a positive PDSS screen were history of depression (risk ratio, 4.8; 95% CI, 4.4-5.2) and exclusive bottle feeding (risk ratio, 2.0; CI, 1.6-2.4). The possible reasons suggested for breastfeeding reducing risk of PPD included decreased maternal stress sensitivity, and enhanced response/action of the parasympathetic nervous system.

Like many other articles about PPD, the authors reiterated the need for more research and attention to timely screening and early intervention.

A side note: Other possible reasons for reduced PPD risk with breastfeeding mothers include increased levels of prolactin and oxytocin, shortened duration of post partum bleeding with enhanced involution, possible delayed return to menses—and so less risk of PMS symptoms, possible weight loss, reduced stress due to less infant illness, and likely increase in maternal self-esteem.

Reference: *Online*

Domestic Violence

Denise Grenier, Tucson / Rachel Locker, Warm Springs

Improving Domestic Violence Law Enforcement Response on the Tohono O'odham Nation

The IHS Office of Emergency Services is happy to share with you that Emerging Leader, Michelle Begay's, article "Improving Domestic Violence Law Enforcement Response on the Tohono O'odham Nation" has been published in The IHS Primary Care Provider.

It was published in the October edition—October being DV Awareness Month.

Improving Domestic Violence Law Enforcement Response on the Tohono O'odham Nation Vol. 32 #10 Oct 2007 Issue. IHS Primary Care Provider

Links to stories at www.ihs.gov/MedicalPrograms/MCH/M/OBGYN01.cfm

Elder Care News

Training in Palliative and End of Life Care—SAVE THE DATE

March 25 -27, 2008—Minneapolis, MN

and

April 22-24, 2008—Flagstaff, AZ

The Education in End of Life and Palliative Care—Oncology (EPEC-O) for Indian Health is a 3 day training program designed to improve knowledge in pain and symptom management and end-of-life care. The format includes formal presentations and small group discussions and will provide those who attend with a modular curriculum to bring home for training and program development at their home facilities.

This training, using the NCI EPEC-O with AI/AN Cultural Considerations curriculum, is designed to provide a basic introduction to palliative and end-of-life care and familiarity with the modular EPEC-O curriculum. Those attending last year's session in Window Rock were able to take home the curriculum to use for local training and program development.

The target audience includes IHS, Tribal, and Urban physicians, nurses, PAs and APNs, behavioral health providers, and pharmacists.

EPEC-O for Indian Health is a collaboration between the IHS and the National Cancer Institute (NCI), with funding provided for travel and per diem. Location and application information coming soon. For questions, contact Tim Domer MD at tim.domer@ihs.gov

Family Planning Intrauterine Device and Adolescents, ACOG Committee Opinion

ABSTRACT: The intrauterine device (IUD) is highly effective and widely used by women throughout the world. Data support the safety of IUDs for most women, including adolescents. This document addresses the major benefits of IUD use in adolescents, a population at particular risk of unintended pregnancy.

Intrauterine Device and Adolescents. ACOG Committee Opinion no. 392. American College of Obstetricians and Gynecologists. Obstet Gynecol 2007;110:1493-5.

Barbara Stillwater

Hypertensive disorders of pregnancy are predictive of diabetes mellitus 21 years later

CONCLUSION: Hypertensive disorders of pregnancy are associated with reported diagnosis of diabetes mellitus 21 years

Callaway LK et al Diabetes mellitus in the 21 years after a pregnancy that was complicated by hypertension: findings from a prospective cohort study. Am J Obstet Gynecol. 2007 Nov;197(5):492

Frequently asked questions

Q. How should we manage a patient with a previous abruptio placenta?

A. There are significant risks after 2 previous abruptions or if fetal death resulted

(See details)

Short take

In the vast majority of cases no change in management is required in subsequent pregnancies. Reversible risk factors can be modified (eg, avoid cigarette smoking or cocaine use) and women with nonrecurrent risk factors (eg, trauma) may be reassured.

In selected patients, such as those with two or more prior perinatal deaths or one perinatal death with persistent nonmodifiable risk factors for abruption, offering patients the option of preterm delivery upon documentation of fetal lung maturity is reasonable.

Full answer online @ MCH FAQ site

“How should we manage a patient with a previous abruptio placenta?”

www.ihs.gov/MedicalPrograms/MCH/M/documents/AbruptioRec12907.doc

doc

International Health Update Claire Wendland, Madison, WI

Disparities, Inequalities, or Inequities?

Everyone knows that the average health status of people living in poor countries is generally worse than that of people living in wealthier ones. When health outcomes differ among different population groups, are they health disparities or inequalities? Or, in the only term that implies a moral wrong, are they health inequities? Inequities based on differential access to a society's resources are difficult to detect without some sort of assessment of wealth. Because of technical problems with the measurement of wealth, and perhaps because of a lack of political will, we've had a real dearth of information on inequality within countries—especially poor countries—until recently. Now a new World Bank report focuses on the correlations between economic status and health within fifty-six poor countries in Africa, Asia, the former Soviet Union, and Latin America. The authors made female-male and rural-urban comparisons as well, but their focus is primarily on economics.

Why is this data so late to the scene? Economic status was neglected in most of the earlier studies of health disparities because it is very hard to measure. Household income may not be in cash at all, especially where unemployment is high; people may be much more reluctant to estimate family income for analysts than to check a box revealing gender or race; and proxy measures like education or occupation did not prove to be good analogues for wealth. All of these problems were magnified in poor countries. In the late 1990s, researchers realized that various assets (for instance bicycles, radios, piped water, or corrugated iron roofing rather than thatch) could be compiled into an “asset index” that worked very well to rank economic

status. It's only been in the last decade, therefore, that researchers were able to correlate economic status and health with reasonable accuracy.

I urge you to check out the report itself. For those of us interested in maternal and child health, it includes detailed tables on child and infant health, basic fertility indicators and STD prevalence, and some maternal health indicators (such as deliveries attended by skilled staff). The results are sobering, though preliminary. Infant and child mortality, fertility, and malnutrition are all much greater among the poor than the rich. Immunization, antenatal care, medical treatment of respiratory infections, oral rehydration for diarrhea and other basic health interventions are all less likely to be used (or available) the poorer the household. Even primary health care offers greater benefits to the better-off than to the poor—12% of benefits accrue to the poorest 20% of the population, 29% to the richest 20%—though it isn't as skewed in this regard as hospital care, where 10% of benefits go to the poorest quintile and over forty percent to the richest. The only indicator in which the poor do better is breastfeeding: in nearly every country surveyed, the poorest were more likely to breastfeed their infants. (Other studies have shown that the richer are also more likely to get unnecessary operations like excess Cesarean sections, and to suffer the associated morbidity. That particular issue is not addressed in this report.)

Most sobering of all, the authors predict that as new health improvements find their way into poor countries, inequalities are likely to worsen. Whether it is antiretrovirals for HIV or surfactant for prematurity, the rich have means to learn about these improvements and to access them long before the poor do. Average health status may improve even as inequalities—and inequities—worsen. As the authors conclude, “Much more will be needed if the global health community is to move beyond platitudes about improving the health of the poor to effective action that can do so.”

Gwatkin DR, Rutstein S, Johnson K et al. 2007 Socio-economic differences in health, nutrition, and population within developing countries: an overview. Washington DC: World Bank.

MCH Alert

Insights on Implementing Cultural and Linguistic Competence in MCH

And the Journey Continues: Achieving Cultural and Linguistic Competence in Systems Serving Children and Youth with Special Health Care Needs and Their Families highlights experiences in infusing cultural and linguistic competence into the policies, structures, and practices of selected state programs. The monograph, developed by the National Center for Cultural Competence (NCCC) at Georgetown University with support from the Maternal and Child Health Bureau, presents stories collected from 23 Title V Children with Special Health Care Needs programs. Also included are key lessons that NCCC faculty, staff, and consultants have learned about providing program guidance, as well as an analysis of the various aspects of linguistic and cultural competence described in each state's story. A list of references and state and territorial contacts is included.

www.gucchdgetown.net/NCCC/journey

MCH Headlines

Judy Thierry HQE

Oral Health for Head Start Children: Best Practices

This 12 page document provides evidence-based approaches and interventions to improve the oral health of Head Start children and their families. The Best Practices are divided into three key points of intervention; pregnancy, birth through two years, and two years through five years of age.

Readership should include: Head Start administration and staff, medical, dental, and community health staff who will need to work together to effectively improve the future oral health of American Indian and Alaska Native children.

IHS Head Start Program website:

www.ihs.gov/nonmedicalprograms/headstart/

You can also find current information and bulletins on oral health as it relates to Head Start at the Head Start Bureau Learning Center at the following website: <http://www.eclkc.ohs.acf.hhs.gov/hslc>

Medical Mystery Tour

What is the presenting part?

You may recall we presented the case of a 20 year old gravida 4 para 1,0,2,1 at 40 2/7 weeks in active labor. The patient had had a 39 pound weight gain throughout her otherwise unremarkable prenatal care. The patient's obstetric history was significant for one previous vaginal delivery of a term 9 pound 15 ounce infant. Laboratory testing was essentially unremarkable. On admission the patient's exam was cephalic presentation, 4 cm dilation, -1 station. The cervix was soft and in a mid position. External fetal monitoring was reassuring. Sixty second contractions were noted every 5 minutes.

At 01:30 the CNM noted that patient had progressed nicely in labor to 7 cm dilated and 100% effaced. The presenting part was still at -1 station. The membranes were intact. The CNM was unable to completely identify the presenting part. The FHR tracing was reassuring. The CNM noted that a suture line and fontanelle were palpable, but other tissue may have been present. The MD on call was asked to perform a bedside ultrasound to confirm the presenting part.

The bedside ultrasound confirmed a cephalic presentation which was slightly oblique. The physician proceeded to perform a digital exam.

What did the physician find on digital exam?

In the interim since the physician had been initially called, the patient's membranes had ruptured and the FHR remained reassuring. The physician noted several long loops of umbilical cord presenting. Otherwise the fetus was in cephalic presentation with complete cervical dilation and effacement. The CNM then elevated the fetus's head out of the pelvis with her hand and the patient was moved to the operative suite in an expeditious manner while in knee-chest position.

As the obstetric team reached the OR table before the anesthesia team was ready and the patient was completely dilated, an attempt was made at funic reduction. This maneuver was only successful for part of the prolapsed cord, but loops remained distal to the fetal skull.

The maternal skin incision was made within 13 minutes of anesthesia's notification and the fetus was delivered within one minute as a Joel-Cohen technique was used. The infant female was delivered from an occiput posterior position and weighed 3450 g with Apgars of 8 and 9. At the time of surgery the cord was felt to be clinically 'long' plus had a true, but loose, knot with no proximal edema. A generous section of umbilical cord was obtained for possible cord gases.

The arterial pH was 7.17 with a base excess of -5.4. The venous pH was 7.23 with a base excess of -4.0. Of note, the arterial CO₂ was 70.5 (mmHg) (49.2 to 50.3) so some cord occlusion had begun shortly before delivery.

Examination of the placenta in the pathology department the next day revealed a somewhat eccentric umbilical cord insertion, 4 cm from the placental margin. Even after formalin fixation and not measuring the either portion of the umbilical cord sent for cord blood gases, nor the area remaining on the infant at surgery, the cord was still 53 cm. There was a true knot at 17 cm from the insertion. As you will see below the most accurate measurement of cord is actually done in the delivery suite, not after formalin fixation and other incisions for cord gases, etc...

Both the patient and her new daughter had unremarkable hospital courses for two days prior to discharge.

So, what was the presentation the CNM had noted?

The patient had a funic presentation prior to SROM.

In this case there was so much cord that it essentially filled the pelvic outlet. By the time the physician performed a digital exam after SROM and the ultrasound exam, the patient had been in an unrecognized cord prolapse with reassuring FHRs for approximately 10-15 minutes.

Long umbilical cord

Cord length increases with advancing gestational age. The average length at term is 55 cm (22 inches), with a wide normal range (35 to 80 cm) (14—32 inches) (Rayburn). The length should be noted and compared with published standards (Table below). Umbilical cord accidents were most frequent in the presence of a long cord (20 of 32 cases, 62%). In addition, mothers with a history of an excessively long umbilical cords are at increased risk of a second long cord.

The length measurement should include the portion of cord on the infant after cord transection at delivery as well as the part remaining with the placenta, thus it is best determined in the delivery room.

Cord length is determined in part by hereditary factors, but also by the tension the fetus places on the cord when it moves. For this reason, short cords are associated with fetal inactivity related to fetal

malformations, myopathic and neuropathic diseases, and oligohydramnios. Long cords may be caused by a hyperactive fetus and have been associated with cord accidents, such as entanglement, knotting, and prolapse (Rayburn). Long cords are also associated with placental lesions indicative of intrauterine hypoxia, as well as fetal death, fetal growth restriction, and long term adverse neurologic outcome. (Baergen).

Normal umbilical cord length

Gestation, weeks	Length, cm
20	32 +/- 9
24	40 +/- 10
28	45 +/- 10
32	50 +/- 12
36	56 +/- 13
38	57 +/- 13
40	60 +/- 13

Fetal malpresentation—Abnormal fetal presentation (breech, transverse, or oblique lie) is consistently associated with a high risk of UCP. In one review, the overall frequency of UCP in vertex, breech, and transverse lies was 0.24, 3.5, and 9.6 percent, respectively. Footling breech presentations carry a higher risk of UCP than other types of breech presentation. However, the majority of UCPs occur with vertex presentations because of the relatively low incidence of noncephalic presentation.

Knots—False knots are tortuosities of the umbilical vessels that form bulges; they are not associated with any adverse outcome.

True knots occur in 1 percent of births and are generally single and loose. However, tight or multiple true knots and knots associated with coiling or twisting of the cord increase the risk of intrauterine demise, particularly if the cord is long and during the second trimester when the fetus has a lot of room to move. The medical record should document the presence of a true knot, the tightness or laxity of the knot, the presence of unilateral edema of the cord relative to the knot, and whether there are thrombi in the vessels. A pathologist should obtain a section through the knot for histologic examination. The appropriate management of true knots identified by ultrasound examination antepartum is unclear.

MANAGEMENT: Umbilical cord prolapse

Standard obstetric management of Umbilical cord prolapse (UCP) requires prompt delivery to avoid fetal compromise or death from compression of the cord between the presenting fetal part and the margin of the pelvic inlet. We suggest cesarean delivery as the safest clinical course of management for the viable fetus, especially in the first and early second stages of labor. There are no data from prospective or randomized studies on which to base recommendations because of the infrequent and urgent nature of this problem.

Various preoperative maneuvers can be helpful to reduce pressure on the cord:

Funic decompression—This is the most common method to alleviate cord compression. After diagnosis of UCP, the examiner’s hand is maintained in the vagina to elevate the presenting part off of the cord while preparations for an emergency cesarean delivery are being made. The patient can be placed in steep Trendelenburg or the knee-chest position to try to move the fetus and further alleviate cord occlusion. Manipulation of the cord and exposure to a cool environment may exacerbate poor perfusion by inducing spasm of the cord vessels.

Funic reduction—Funic reduction is a controversial approach to the management of cord prolapse. It is employed to alleviate pressure on the cord from the presenting part while preparations for cesarean delivery are being made. This procedure involves lifting the fetal head from the vagina and then digitally elevating the cord above the widest part of the vertex so as to place it in the nuchal area. Gentle suprapubic pressure can help with raising the fetal head and decreases the chance of creating an oblique or transverse lie.

Funic reduction had been considered an appropriate initial step in management of UCP, but was subsequently discarded in favor of cesarean delivery because the procedure appeared to be associated with an increase in intrapartum asphyxia and demise. However, this association was observed prior to the advent of continuous fetal monitoring. With use of continuous fetal monitoring, this technique may permit vaginal delivery and avoid emergent cesarean delivery in some patients. This was suggested by a small series of eight patients with UCP in which five vaginal deliveries were achieved 14 to 512 minutes after a successful funic reduction without anesthesia. The other three patients either delivered vaginally shortly after the diagnosis of UCP or were delivered by cesarean. All of the fetuses were in vertex presentation and had less than 25 cm of cord prolapsing. There was no morbidity or mortality reported. Thus, funic reduction in the setting of continuous fetal monitoring can be considered a viable approach if vaginal delivery is considered imminent or if cesarean delivery cannot be performed immediately.

Bladder filling—A temporizing technique involves insertion of a Foley catheter into the maternal bladder immediately upon diagnosis of UCP. The bladder is then rapidly filled with 500 to 700 milliliters of normal saline with the patient in Trendelenburg position. The distended bladder elevates the presenting part and keeps it off of the cord, thus relieving the compression and potentially obviating the need for prolonged vaginal digital decompression.

One series of 51 cases employed both a tocolytic (ritodrine) and bladder filling to relieve cord compression. The mean interval from diagnosis to delivery was 35 minutes and there were no fetal or neonatal deaths; the majority of infants had Apgar scores ≥7 at five minutes. Tocolytic use in this series was not associated with postpartum uterine atony or hemorrhage. Thus, the technique of bladder filling may be a useful approach, particularly when immediate cesarean delivery is not possible.

Delivery—There are few data regarding attempted vaginal delivery in the setting of UCP. Successful operative vaginal delivery with vacuum or forceps has been reported when cesarean delivery could not be performed immediately.

Despite these case reports, immediate cesarean delivery remains the optimal mode of delivery. While preparations are being made for cesarean delivery, it is important to ensure adequate intrauterine resuscitation by changing maternal position, cord decompression by funic decompression or bladder distention, and tocolysis, where appropriate.

Reference: Online

Navajo News

Jean Howe, Chinle

Informed Refusal, Leaving Against Medical Advice, and Asking Questions

A recent article in the “Clinical Practice” series of the New England Journal of Medicine addresses the assessment of patient’s competence to consent to (and decline) treatment. This series uses a case vignette and discussion to address common clinical problems. In this case, a 75 year old woman with type II diabetes, peripheral vascular disease, and a gangrenous foot ulcer who refuses a recommended amputation is described. The patient states that she “prefers to die with her body intact” and the provider is concerned about apparent increasing confusion and possible depression limiting her ability to provide informed consent. Legally relevant criteria for evaluating decision-making capacity are outlined for the patient’s tasks of communicating a choice, understanding the relevant information, appreciating the situation and its consequences, and reasoning about treatment options. Approaches to assessment and the consequences of a finding of incompetence are reviewed. The lack of formal practice guidelines for assessment of competence to consent is highlighted.

Refusal of treatment is also the focus of an overview of hospital discharge “against medical advice” in this month’s American Journal of Public Health. This database audit of over 3 million discharges from U.S. non-federal acute care hospitals identified a rate of 1 in 70 (1.44%) of “self-discharges”. Higher rates were associated with young age, male gender, African American race, and low socio-economic status. Because this study is a database review only, no information is available on the reasons for AMA discharge. The authors discuss possible reasons, including frustration with administrative delays in the discharge process, pressing domestic or social concerns, and disagreement with their physician’s assessment of their health status. They also discuss the public health significance of these discharges and the importance of addressing shortcomings of the health care system that may place underserved patients at higher risk for this event.

Meanwhile, the Agency for HealthCare Research and Quality is launching a campaign called “Questions are the Answer” encouraging patients to ask questions about their healthcare as a safety measure and in an effort to improve overall health through greater understanding and ownership of health care decisions. Their sample

questions for patients and more information about this campaign, including video clips of singing and dancing health care workers are available at the AHRQ website.

I happened to encounter all three of these articles/information on the same day and was struck by the increased attention to patient autonomy and recognition that medical advice may be rejected, ignored, or poorly understood. We, as healthcare providers, have an ongoing duty to encourage our patients’ understanding and ownership of their health and their right to make informed decisions about their care. Vulnerable groups may benefit from additional attention to their needs, whether for respectful assessment of decision-making capacity or for culturally appropriate hospital care that minimizes the risks of “self-discharge”. I’m not sure if the singing health care workers in the AHRQ videos will help but we must continue our efforts to welcome, encourage, and respect our patients’ efforts to make truly informed health care decisions.

Resources:

Paul S. Appelbaum, *Clinical practice. Assessment of patients' competence to consent to treatment*, *N Engl J Med*. 2007 Nov 1;357(18):1834-40

Said A. Ibrahim, C. Kent Kwok, and Eswar Krishnan, *Factors Associated With Patients Who Leave Acute-Care Hospitals Against Medical Advice*, *Am J Public Health* 2007 97: 2204-2208, 10.2105/AJPH.2006.100164

AHRQ

www.ahrq.gov/questionsaretheanswer/index.html

CCC Editorial comment:

What are the elements of a patient decision making?

This is a very timely topic as ACOG has just released the three Committee Opinions below that relate to a patient’s decision making process. We need to have made all efforts possible to assure that the decision is informed, on the patient’s actual educational level, as well as ethical. Please also note this month’s Abstract of the Month and Dr. Weiss’s comments on Health Literacy, above.

ACOG

Health Literacy. ACOG Committee Opinion no. 391. American College of Obstetricians and Gynecologists. Obstet Gynecol 2007;110:1489-91.

The Limits of Conscientious Refusal in Reproductive Medicine ACOG Committee Opinion no. 385. American College of Obstetricians and Gynecologists. Obstet Gynecol 2007;110:1203-8.

Ethical Decision Making in Obstetrics and Gynecology. ACOG Committee Opinion no. 390. American College of Obstetricians and Gynecologists. Obstet Gynecol* 2007;110:1479-87.

Perinatology Picks

George Gilson, MFM, ANMC

Less errors with more standardization of corticosteroid regimens

Repeat vs single dose corticosteroids did not differ significantly, except NS cerebral palsy

CONCLUSIONS: Children who had been exposed to repeat as compared with single courses of antenatal corticosteroids did not differ significantly in physical or neurocognitive measures. Although the difference was not statistically significant, the higher rate of cerebral palsy among children who had been exposed to repeat doses of corticosteroids is of concern and warrants further study.

Wapner RJ et al Long-term outcomes after repeat doses of antenatal corticosteroids. N Engl J Med. 2007 Sep 20;357(12):1190-8.

Editorial comment: George Gilson, MFM Less errors with more standardization of corticosteroid regimens

It would probably be good if we all standardized our use of antenatal corticosteroids for fetal lung maturation. I have seen various regimens being used, but the one below is the one recommended by ACOG on the basis of the available evidence. Steroids are given over a 48 hour interval. Their maximum effect is maintained for 7 days, although a lesser, but still significant, effect is seen for a considerably longer interval. Giving the doses at closer intervals will not speed up the fetal lung maturation process, even though you think the baby needs to deliver sooner than later!

Betamethasone 12 mg IM x2 at 24 hour intervals
-or-

Dexamethasone 6 mg IM x4 at 12 hour intervals

Steroids are appropriate between 24 and 34 weeks gestation (some authorities would restrict their use to 32 weeks or less in women with PPRM). There is no consensus on whether betamethasone or dexamethasone is better, so either regimen is fine. Steroids should ideally only be given once, so you should carefully consider if they are really needed at the time. (One “rescue” dose later, while not recommended, has not been associated with significant adverse neonatal effects, and is also acceptable on an individualized basis.)

Reference:

Antenatal corticosteroid therapy for fetal maturation. ACOG Committee Opinion No. 273. American College of Obstetricians and Gynecologists. Obstet Gynecol 2002;99:871-873

Primary Care Discussion Forum

Ann Bullock, Cherokee, NC

Traditional AI/AN Medicine: Incorporating Into I/T/U Clinical Practice

Ongoing now

Moderator: Theresa Maresca, M.D., University of Washington School of Medicine

What are the pros and cons of asking my patients about their traditional medicine use?

How do I learn more about what traditional practices are common in my area?

What specific strategies can be used to ask my patients diplomatically about their traditional medicine views?

Where can I find resources about plant medicine?

Is there a “right way” to work collaboratively with a traditional healer?

What if I do not agree with my patient’s views of traditional medicine

Questions on how to subscribe, contact ANNBULL@nc-cherokee.com directly

Alaska State Diabetes Program

Barbara Stillwater

Family History more relevant to risk of GDM in nulliparous women than in parous subjects

CONCLUSION: Established risk factors for GDM are relevant in women with FHD but may not be the principal determinants of gestational hyperglycaemia in women without FHD. Moreover, FHD may be more relevant to risk of GDM in nulliparous women than in parous subjects. These findings highlight the complex relationship between FHD and gestational hyperglycaemia, and may hold implications for selective screening for GDM.

Retnakaran R et al The impact of family history of diabetes on risk factors for gestational diabetes. Clin Endocrinol (Oxf). 2007 Nov;67(5):754-60.

Breastfeeding

Milk pollution due to alcohol

RESULTS: The elimination of alcohol and time-to-zero levels in breast milk are described in a nomogram as a function of the amount of alcohol consumed and the body weight of the woman.

CONCLUSIONS: Careful planning of a breast feeding schedule, by storing milk before drinking and/or waiting for complete alcohol elimination from the breast milk, can ensure women that their babies are not exposed to any alcohol.

Ho E et al Alcohol and Breast Feeding: Calculation of Time to Zero Level in Milk Alcohol and breast feeding: calculation of time to zero level in milk. Biol Neonate. 2001;80(3):219-22

Women's Health Headlines

Carolyn Aoyama, HQE

Making a business case for investing in Maternal and Child Health

Healthcare services for children and pregnant women account for \$1 out of every \$5 large employers spend on health care. A substantial proportion of employee's lost work time can be attributed to children's health problems, and pregnancy is a leading cause of short- and long-term disability and turnover for most companies. Yet most companies don't have a strategy for promoting the health of mothers and children.

In November, the Business Group released a new toolkit aimed at improving employer-sponsored health benefits and programs for children, adolescents, and pregnant women. The core component of this toolkit is the Maternal and Child Health Plan Benefit Model, which outlines 34 evidence-informed health, pharmacy, vision, and dental benefits recommended by the Business Group.

This webinar provided an overview of the new toolkit. The speakers will also discuss:

- The business case for investing in healthy pregnancies and healthy children.
- Benefit design recommendations.
- Recommended cost-sharing strategies to promote appropriate utilization and incentive for prevention.
- Data on the cost-offsets associated with prevention.
- "Lessons learned" from Marriott on communicating health benefits and engaging beneficiaries in health promotion and disease prevention.

To view Investing in Maternal and Child Health: An Employer's Toolkit, visit:

www.businessgrouphealth.org/healthtopics/maternalchild/investing/index.cfm

Perinatology corner

Conservative checklist protocol for oxytocin: improves maternal and newborn outcomes

CONCLUSION: Implementation of a specific and conservative checklist-based protocol for oxytocin infusion based on maternal and fetal response results in a significant reduction in maximum infusion rates of oxytocin without lengthening labor or increasing operative intervention. Cesarean delivery rate declined system-wide following implementation of this protocol. Newborn outcome also appears to be improved.

Clark S et al Implementation of a conservative checklist-based protocol for oxytocin administration: maternal and newborn outcomes. Am J Obstet Gynecol. 2007 Nov;197(5):480

Does the dose of oxytocin affect uterine rupture in candidates for VBAC?

Results—Of the 13,523 patients who elected a VBAC trial, 128 women experienced a uterine rupture; 80 of these ruptures were in women who received oxytocin (62.5%). There was evidence of "dose response" for maximum oxytocin amount and uterine rupture, with a uterine rupture rate of 2.07 % (adjusted odds ratio, 2.98; 95% CI 1.51-5.90) at the highest dosages.

Conclusion—In VBAC attempts, a dose-response relationship of maximum oxytocin and uterine rupture exists. These results provide evidence for vigilance when higher doses of oxytocin are given to patients who attempt VBAC.

Cahill AG et al Does a maximum dose of oxytocin affect risk for uterine rupture in candidates for vaginal birth after cesarean delivery? Am J Obstet Gynecol. 2007 Nov;197(5):495

(What happens if..., continued from page 1)

you ask patients to explain back to you what you have just told them. This helps verify that they have understood what they need to know.

Zikmund-Fisher et al, above, illustrate a simple point that interpretive labels for test results can induce larger changes to a woman's risk perception and behavioral intention than can numeric results alone, which creates decision momentum.

Clinicians routinely underestimate the prevalence of limited health literacy among their patients and frequently overestimate the ability of individual patients to understand the information they provide. For more information and a helpful perspective go to the 'Assessing Health Literacy in Clinical Practice' link below.

Assessing Health Literacy in Clinical Practice, Barry D. Weiss, MD

www.medscape.com/viewarticle/566053 Medscape CME

Other recent Health Literacy resources: [Online](#)

SAVE THE DATES

23rd Annual Midwinter Indian Health OB/PEDS Conference

- February 8–10, 2008
- For providers caring for Native women and children
- Telluride, CO
- Contact AWaxman@salud.unm.edu

Training in Palliative and End of Life Care

- March 25–27, 2008
- Minneapolis, MN
- Contact Tim Domer MD at tim.domer@ihs.gov

IHS Basic Colposcopy Course

- April 9–11, 2008
- Albuquerque, NM
- Contact AWaxman@salud.unm.edu

IHS Colposcopy Update & Refresher Course

- April 9–11, 2008
- Albuquerque, NM
- Contact AWaxman@salud.unm.edu

Training in Palliative and End of Life Care

- April 22–24, 2008
- Flagstaff, AZ
- Contact Tim Domer MD at tim.domer@ihs.gov

Keeping Native Women & Families Healthy & Strong

- April 23–25, 2008
- Milwaukee, WI
- Great Lakes Tribal Epidemiology Center
- E-mail contact EpidemiologyCenter@gmail.com

Abstract of the Month

- What happens if your patient hears their results as Negative? Positive? Normal? Abnormal?

IHS Child Health Notes

- Fetal origins of adult health
- Infectious Disease Updates—2008 Childhood Immunization Schedule: Few changes planned.
- Recent literature on American Indian/Alaskan Native Health—*Diarrhea-Associated Hospitalizations and Outpatient Visits Among American Indian and Alaska Native Children Younger Than Five Years of Age*

From Your Colleagues

- David Gahn, Tahlequah, OK—You can make a big difference in women's and children's lives

Hot Topics

- Obstetrics—Cesarean delivery on request not recommended if desiring several children, ACOG
- Gynecology—Early feeding within the first 24 hours after major abdominal gynecologic surgery is safe
- Child Health—Rapid response team: Implications of findings on mortality rates for children are dramatic

Features

- Featured Website—Preconception Counseling for Women with Diabetes and Hypertension: New module
- Chronic disease and Illness—Reconsider use of rosiglitazone
- ACOG, American College of Obstetricians and Gynecologists—Human Immunodeficiency Virus
- Ask a Librarian—Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity
- Behavioral Health Insights—Teens, Depression, Black Box Warnings and Suicide
- Breastfeeding—Breastfeeding, it is not just about the baby

Neil Murphy, MD

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