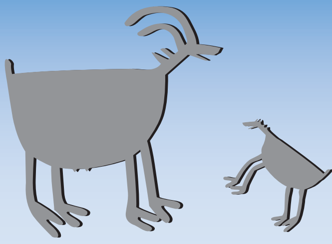

CCC Corner

NATIONAL COUNCIL OF
CHIEF CLINICAL CONSULTANTS

Focus on the Health of American Indians and Alaska Natives

Vol 6, No 02
Feb 2008

THIS MONTH

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Concern for rising Cesarean rates in Native American populations

By Larry Leeman MD, MPH and Eve Espey MD, MPH

Editorial Note: The following is in response to a Point/Counterpoint discussion of trial of labor after cesarean (TOLAC) in rural hospitals, December CCC Corner

We appreciate the willingness to engage in discussion about trial of labor after cesarean (TOLAC) availability and the approach to cesarean delivery at W. W. Hastings Hospital. Every facility faces unique factors in the decision to offer TOLAC services. However, we fear that the high total cesarean rate and lack of TOLAC services will ultimately result in worse perinatal outcomes considered from a population level.

Not only is vaginal birth after cesarean (VBAC) highly desired by many women, but it is preferable to a repeat cesarean delivery in certain women, including those with a single cesarean delivery who have had a successful vaginal birth before or after their cesarean delivery. Evidence suggests that such women should be encouraged to have a TOLAC particularly if they plan to have additional children . Given these data, anesthesia staff should be strongly encouraged to change their policy and offer1 VBAC services in accordance with guidelines similar to those developed in the Northern New England Perinatal Quality Improvement Network (NNEPQIN). Ethically, it is difficult to justify withholding TOLAC when it is the safest option. If services were offered to this group of women, obstetrical and anesthesia staff could develop greater comfort with TOLAC and expand the local eligibility criteria.

Annual cesarean rates at some Indian Health facilities in Oklahoma are > 37% and short term rates over 40%, hence are above the recently published 2006 national rates for the total U.S population (31.1%), the Oklahoma state population (33.3%), and the US Native American population (27.5%)2 We note that the Native American cesarean rate increased 1.5% from 2005 to 2006, almost double the 0.8% increase for the total US population. The rising cesarean rate is likely a reflection of both rising primary cesarean delivery rates and decreased vaginal birth after cesarean delivery.

Given the limited availability of TOLAC services for women in the Oklahoma service area, efforts should be made to minimize the primary cesarean delivery rate. The decision to lower the threshold for primary cesarean delivery as evidenced by an acceptance of the high rate and an unwillingness to look at physician specific factors will result in higher adverse outcomes in future pregnancies3, particularly when combined with the lack of TOLAC services. Women in the Hastings area with primary cesareans can be anticipated to have cesareans in all future births placing them at increased risk for placenta accreta, increta and percreta5. These complications of abnormal placentation may be particularly difficult to address in a rural community hospital setting.

Although Healthy People 2010 does not include a recommendation for the total cesarean rate due to varying patient factors, it recommends that efforts be made to decrease the primary cesarean rate to 15% in women who are giving birth for the first time6. ACOG similarly recommends that comparative cesarean delivery rates for populations, hospitals, or physicians should be based on the subgroup of nulliparous women with term singleton vertex gestations7. We would be interested in seeing the rate for this population at those affected facilities in Oklahoma Area.

We worked in at the Gallup Indian Medical Center (GIMC) and Zuni-Ramah Hospitals in the 1990s and continue to work with Native populations in Albuquerque and New Mexico. Our study of the population based CS rate in Zuni-Ramah in

(continued on page 15)

Confused about distinction between 'Readily' vs 'Immediately' available?

ACOG's Guidelines for Perinatal Care, notes that personnel be "readily available" to perform an emergency cesarean delivery. General consensus includes the capability of beginning cesarean delivery within 30 minutes of the decision to operate.

In contrast, ACOG Practice Bulletin #54 recommends that personnel be "immediately available" for a VBAC patient in active labor. This highlights the need for intervention in the event of uterine rupture. VBAC is an elective procedure that allows for precautions in assuming the small but significant risk of uterine rupture.

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

Neil J. Murphy

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

"Ignoring facts does not make them any less true."
— Alduos Huxley

Articles of Interest

Laterality of acute otitis media: different clinical and microbiologic characteristics.

Pediatr Infect Dis J. 2007 Jul;26(7):583-8.

Is bilateral acute otitis media clinically different than unilateral acute otitis media?

Pediatr Infect Dis J. 2007 Jul;26(7):589-92.

Editorial Comment

Recently there has been an emphasis on decreasing the use of antibiotics for acute otitis media (AOM). There is increasing antibiotic resistance among many bacteria in this country. It is also acknowledged that most cases of AOM will resolve without antimicrobial treatment. The American Academy of Pediatrics recently released guidelines for treating AOM which include an option to withhold antibiotic for some patients with AOM. The authors of these two studies were interested in whether bilateral ear infections might be more severe than unilateral AOM and more likely to benefit from antimicrobial treatment.

Bilateral AOM was more likely to have bacteria recovered on tympanocentesis (70% versus 57%), more likely to have Haemophilus influenzae recovered (31% versus 9%), be younger (< 1 year) and have more severe and persistent symptoms. The authors suggest that physicians should take these factors into account when deciding whether to prescribe or withhold antimicrobial therapy for AOM.

Infectious Disease Updates.

Rosalyn Singleton, MD, MPH

The RSV Season: Is there relief in sight?

On December 7th, CDC reported the RSV activity in the US for the 2006-7 season using the National Respiratory and Enteric Virus Surveillance (NRVSS), a passive voluntary network of laboratories. The national RSV season onset began during the week ending Nov. 11, 2006, and continued for 19 weeks until the season offset March 17, 2007. The season onset ranged from late Oct in the South, to the mid Dec in West. The season offset ranged from mid Feb in Northeast to the late March in West – average duration around 15-16 weeks. Alaska is not represented in the NRVSS data, and the RSV season in Alaska is unique. The average RSV onset over a 10 year period was the week ending Oct 21 and the average offset was the week ending May 21 (30.5 weeks duration).

There is preliminary data from CDC on the season onset for 2007-8 season. Reports through Nov 24th, indicate that although the national RSV season has not yet occurred, the regional season onset occurred during the week ending Nov 17 in South, and week ending Nov 24th in Northeast.

There is exciting news in the RSV prevention arena. Motavizumab, an enhanced monoclonal antibody against RSV which is more potent than Synagis in animal models is in clinical trials, some of which have results to share. In a head-to-head study among premature infants and those with chronic lung disease Motavizumab was non-inferior to Synagis in preventing RSV hospitalizations; it was superior in preventing outpatient RSV disease. In a trial among otherwise healthy full term Navajo and Apache infants, Motavizumab was found to be 83% efficacious compared with placebo for prevention of RSV hospitalizations and 71% efficacious compared with placebo for prevention of RSV outpatient respiratory illnesses. Motavizumab remains investigational at this time. IHS representatives are involved in the policy development process regarding this product if it should become licensed.

Recent literature on American Indian/ Alaskan Native Health

Doug Esposito, MD

Article

Pollack LA, Stewart ST, Thompson TD, Li J. Centers for Disease Control and Prevention. Trends in Childhood Cancer Mortality—United States, 1990–2004. MMWR. 2007;56(48):1257-1261.

Editorial Comment

This study investigates childhood cancer mortality trends for the period 1990 – 2004 using National Vital Statistics System data. Overall, childhood cancer mortality rates have declined over the period for all cancers combined (from 34 deaths per million in 1990 to 27 deaths per million in 2004, or an average decline of 1.7% per year), and for the two most prevalent childhood cancer diagnoses: leukemia (3.0% per year average decline) and brain and other nervous system neoplasms (1.3% per year average decline). Fortunately, this trend in improved mortality has occurred despite the increased cancer incidence trends reported in other studies, and is likely the result of advances in cancer treatment.

On the darker side, disparities do exist (same old, same old) and probably relate at least in part to health care access inequities, although other factors could be at work. Death rates declined at a significantly slower rate for Hispanics (1.0% per year) than for non-Hispanics (1.6% per year). In addition, regional differences existed whereby the decline in cancer mortality was highest in the Midwest (2.1% per year), followed by the South and Northeast (1.8% per year), with the West trailing behind (only 1.4% per year).

Of course, the same data limitations exist regarding AI/AN children as described in a previous issue of the Notes.[1] Although aggregated cancer mortality rates (20.0 deaths per million AI/AN children vs. 29.7 deaths per million overall) and the annual percentage change (2.0% per year for AI/AN children vs. 1.7% per year overall) over the 15-year period appear to be most favorable for AI/AN children in the present report, case numbers and the issue of racial misclassification cast doubt that things are quite so rosy. With underestimates of mortality for AI/AN populations as high as 21% (attributable to racial misclassification[2] of death certificate data), the true AI/AN childhood cancer burden remains unclear. Nevertheless, there might be some hope on the horizon.

I would like to direct the reader's attention to the recently published Annual report to the Nation on the status of cancer, 1975-2004, featuring cancer in American Indians and Alaska Natives[3]. Although the direct relevance of this report to AI/AN children is limited (it reports on the top 15 cancers overall, and with cancer in children and adolescents thankfully a fairly rare occurrence, children end up being excluded), it accomplishes something very important. The methods employed by the authors provide the most comprehensive cancer data and best estimate of cancer burden in the AI/AN population to date. Hopefully, this method can be generalized to include other age groups and even disease conditions, giving us a more accurate picture of disease burden in AI/AN populations and sub-populations than has so far been available. I will try to keep you all posted.

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2. Rosenberg HM, Maurer JD, Sorlie PD, Johnson NJ, MacDorman MF, Hoyert DL, Spitler JF, Scott C. Quality of death rates by race and Hispanic origin: a summary of current research, 1999. Vital Health Stat. 2 1999 Sep;(128):1-13. www.ncbi.nlm.nih.gov/pubmed/10611854?ordinalpos=2&itool=EntrezSystem2.PEntrez.Pubmed.Pubmed_ResultsPanel.Pubmed_RVDocSum
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Perinatology Picks
George Gilson, MFM, ANMC

Booster dose of betamethasone just before preterm birth: Results caution against

CONCLUSIONS: According to this study, a single booster dose of betamethasone just before preterm birth may perturb respiratory adaptation. These results caution against uncontrolled use of a repeat dose of glucocorticoid in high-risk pregnancies.

Peltoniemi OM et al Randomized trial of a single repeat dose of prenatal betamethasone treatment in imminent preterm birth. Pediatrics. 2007 Feb;119(2):290-8.

Hot Topics

Obstetrics
Knowledge of cervical length/fetal fibronectin associated with shorter evaluation and PTB

CONCLUSION: The knowledge of cervical length and fetal fibronectin was associated with reduction in length of evaluation in women with cervical length > or = 30 mm and in incidence of spontaneous preterm birth in all women with preterm labor.

Ness A et al Does knowledge of cervical length and fetal fibronectin affect management of women with threatened preterm labor? A randomized trial. Am J Obstet Gynecol. 2007 Oct;197(4):426.e1-7

Gynecology
Misoprostol is as effective as manual vacuum aspiration in SAB of <12 weeks

CONCLUSION: Misoprostol is as effective as manual vacuum aspiration (MVA) at treating incomplete abortion at uterine size of <12 weeks. The acceptability of misoprostol appears higher. Given the many practical advantages of misoprostol over MVA in low-resource settings, misoprostol should be more widely available for treatment of incomplete abortion in the developing world.

Shwekerela B et al Misoprostol for treatment of incomplete abortion at the regional hospital level: results from Tanzania. BJOG. 2007 Nov;114(11):1363-7

Child Health
Secondhand smoke during infancy linked in dose-response fashion with allergies

Swedish children exposed to secondhand tobacco smoke in infancy had a higher rate of indoor inhalant and food allergies than did children whose parents didn't smoke. The study found a dose-response relationship between exposure to smoke and allergy, supporting possible causality and indicating that exposure in early infancy to tobacco smoke may be associated with an increased risk of atopic sensitization.

Lannerö E at al Exposure to environmental tobacco smoke and sensitisation in children.Thorax. 2007 Dec 18

Chronic disease and Illness
'Awake' during surgery: Examining intraoperative awareness

Estimates show as many as 2 in every 1,000 patients who receive general anesthesia remember events that occurred while they were "under."

Given that over 40 million patients undergo general anesthesia each year in North America, it is not surprising the phenomenon has become the subject of a new Hollywood movie. Dr Beverley A. Orser from the University of Toronto and colleagues use the occasion of the recent release of "Awake"—a film depicting a man who experiences "anesthesia awareness" and is conscious, but physically paralyzed during surgery—to delve deeper into the issue of intraoperative awareness.

Orser and colleagues said most patients who experience intraoperative awareness do not experience pain but have "vague auditory recall or a sense of dreaming and are not distressed by the experience." The authors add, however, that some patients do experience pain, and it is occasionally severe.

In a study involving 11,785 patients who had received general anesthesia, the incidence of awareness was 0.18% in cases in which neuromuscular blockers were used and 0.10% in the absence of such drugs. Of the 19 patients who experienced recall, 7 (36%) reported some degree of pain, ranging from soreness in the throat because of the endotracheal tube, to severe pain at the incision site. Patients may remember these events immediately after surgery, or hours or days later.

"Immense efforts have been made to understand the effects of anesthetics on physiologic processes and to develop strategies and technologies to manage the adverse effects of these drugs," the authors said. "However, certain risks remain, including the possibility of intraoperative awareness."

The authors conclude that intraoperative awareness should be viewed as a recognized complication, with many features similar to those of other adverse intraoperative and perioperative events. They add that anesthesiologists are directing research and patient care efforts toward reducing the incidence and consequences of this adverse event, but they suggest that more large-scale studies of the efficacy of brain-monitoring devices in the prevention of awareness are required.

Orser BA et al Awareness during anesthesia. CMAJ. 2007 Dec 11;

Features

ACOG, American College of Obstetricians and Gynecologists

Elective and risk–reducing salpingo-oophorectomy
ACOG Practice Bulletin No. 89

Summary of Recommendations and Conclusions

The following conclusion is based on good and consistent scientific evidence (Level A):

- In women ages 50–79 years who have had a hysterectomy, use of estrogen therapy has shown no increased risk of breast cancer or heart disease with up to 7.2 years of use.

The following recommendation is based on limited or inconsistent scientific evidence (Level B):

- Bilateral salpingo–oophorectomy should be offered to women with BRCA1 and BRCA2 mutations after completion of childbearing.

The following recommendations are based primarily on consensus and expert opinion (Level C):

- Women with family histories suggestive of BRCA1 and BRCA2 mutations should be referred for genetic counseling and evaluation for BRCA testing.
- For women with an increased risk of ovarian cancer, risk–reducing salpingo–oophorectomy should include careful inspection of the peritoneal cavity, pelvic washings, removal of the fallopian tubes, and ligation of the ovarian vessels at the pelvic brim.
- Strong consideration should be made for retaining normal ovaries in premenopausal women who are not at increased genetic risk of ovarian cancer.
- Given the risk of ovarian cancer in postmenopausal women, ovarian removal at the time of hysterectomy should be considered for these women.
- Women with endometriosis, pelvic inflammatory disease, and chronic pelvic pain are at higher risk of reoperation; consequently, the risk of subsequent ovarian surgery if the ovaries are retained should be weighed against the benefit of ovarian retention in these patients.

Elective and risk–reducing salpingo-oophorectomy. ACOG Practice Bulletin No. 89. American College of Obstetricians and Gynecologists. Obstet Gynecol 2008;111:231–41.

Ask a Librarian
Diane Cooper, M.S.L.S./NIH

Cervical Cancer Community-Based Research Project in a Native American Community

The Messengers for Health on the Apsáalooke Reservation project uses a community-based participatory research (CBPR) approach and lay health advisors (LHAs) to generate knowledge and awareness about cervical cancer prevention among community members in a culturally competent manner. Northern Plains Native Americans, of whom Apsáalooke women are a part, continue to be disproportionately affected by cervical cancer. This article examines quantitative and qualitative changes that occurred in the community since the inception of the Messengers for Health program. Paired sample t tests are used to evaluate the one-group pretest and posttest interviews of 83 Apsáalooke women in knowledge, comfort, and cancer awareness levels. Results reveal cervical cancer knowledge gains, gains in participants' comfort discussing cancer issues, and gains in awareness of cervical cancer and the Messengers program. Field notes, meeting minutes, and community perceptions are used to qualitatively evaluate the effectiveness of the Messengers program. Practice implications are discussed.

Christopher S et al A Cervical Cancer Community-Based Participatory Research Project in a Native American Community. Health Educ Behav. 2007 Dec 12

Behavioral Health Insights
Peter Stuart, IHS Psychiatry Consultant

Autism Screening
Guest editor Joshua Cabrera, MD

Identifying children with autism early has several benefits; it allows family to adapt to unusual and challenging behaviors in their toddler, it leads to early interventions that may improve outcomes , and it opens the door for increased services at school. The American Academy of Pediatrics currently advocates screening for autism at the age of 18months.

General developmental screening tools may be abnormal when administered to autistic children, especially language screens. General screens do not distinguish children with developmental delays

Primary Care Discussion Forum
Ann Bullock, Cherokee, NC

Topic:
Mental health issues in children and adolescents

Moderator:
Dr. Frank Armao, Psychiatry staff at Winslow

When:
March 2008

How to subscribe/unsubscribe to the Primary Care Discussion Forum?
Subscribe to the Primary Care listserv www.ihs.gov/cio/listserver/index.cfm?module=list&option=list&num=46&startrow=26

STD Corner

Lori de Ravello, National IHS STD Program

The cervical cancer risk is still increased 25 years after treatment for CIN 3

CONCLUSIONS: Women previously treated for cervical intraepithelial neoplasia grade 3 are at an increased risk of developing invasive cervical cancer and vaginal cancer. This risk has increased since the 1960s and is accentuated in women aged more than 50. The risk is still increased 25 years after treatment.

Strander B et al Long term risk of invasive cancer after treatment for cervical intraepithelial neoplasia grade 3: population based cohort study. BMJ. 2007 Nov 24;335(7629):1077.

from autism, but can trigger further screening and evaluation. A specific screening tool for autism is the Checklist for Autism in Toddlers (CHAT) . This screen consists of 9 questions asked of the parents and 5 simple in office tests, administered at the age of 18-24 months. The key elements of the CHAT assess the child's capacity for shared attention and imaginative play, both per history and in the office.

A child demonstrates shared attention when pointing to an object of interest, for example, a stuffed giraffe, and then glancing at another person's eyes or face to measure if they are also noticing the giraffe. The examiner also should initiate the test for shared attention by pointing to an object, demonstrating interest in it, and observing the child share the examiners attention in the object (usually through gaze). Autistic children may point as part of an imperative, but not as part of sharing attention. For example the autistic child may point at food, and may even lead you by the arm to the food, but will likely not look at your eyes or face to measure or implore your shared attention. The second key ability, imaginative play, is abundantly demonstrated in an office that has age appropriate toys. In the CHAT, developed in the UK, the examiner uses a cup to pretend to drink tea and asks the toddler to join in. Using a spoon and play bowl to pretend to scoop up stew or blue corn mush may be more appropriate for those in the Southwest. Autistic toddlers may play with toys, but do not play imaginatively with them at 18mo, focusing instead on sensory qualities such as its sound or feel. Often their play is repetitive and stereotyped as well. Toddlers who lack shared attention and imaginative play, by history and on exam, likely have an autism spectrum disorder. Children who have a mixed result, for example, whose parents report shared attention, but who can not do so for the examiner, have a moderate risk of autism.

So what role does autism screening have in day to day practice? Children who have family histories, who have language delays, or whose parents express concern for their development in language/social domains, warrant further screening and evaluation. General screening, advocated by the AAP, may be the first step to improving outcomes. Becoming familiar, or having easy access to some form of the CHAT, can improve its routine use in the office. Its essential elements, shared attention and imaginative play, can be screened for effectively with brief office tests and have good specificity for autism spectrum disorders.

For further reading on screening for autism, visit the website www.autismresearchcentre.com.

References: Online

Breastfeeding

Suzan Murphy, PIMC

Breast Pumps: The good, the bad, and the ugly

New families usually ask about breast pumps. Many retail pumps work well for occasional pumping. But, most retail pumps are not clinically evaluated or labeled so that families know what to expect. For example, a retail hand or electric pump may work well for the occasional bottle so mom can go to the store or out to eat, but not work well enough to maintain a milk supply when mom goes to work or school. It can be confusing and frustrating for new families and providers.

The following are suggestions for…suggesting a pump:

- If the family needs a pump for once in a while, often a retail breast pump will work. Also the hand pumps associated from hospital grade electric pumps producers, such as Medela or Ameda/Egnel will work.
- If the family needs a pump for more than 3-4 hours of routine separation, encourage them consider a hospital grade electric pump. Resources for these pumps are:

WIC

If WIC has electric pumps available, the rules are that the mom needs to be exclusively breastfeeding. This means the family cannot be receiving formula from the WIC program. If the family is getting formula on their own for occasional use, that is usually okay. If WIC doesn't have pumps, they might be able to suggest local resources.

Locally

If the baby is in a NICU, hospitals often have pump loaners. If not, the hospital usually has hospital pump available for moms to use when they are at the hospital. Usually they have a breastfeeding consultant or staff members trained in breastfeeding support. They can be very helpful.

Encourage families to check with local hospital gift shops. Sometimes they have pump loaners/rentals.

The yellow pages/internet - under "breastfeeding" is another place to look. Suggest that families look for pump resources that have an IBCLC (International Board Certified Lactation Consultant) on staff. Pump rentals often cost at least $30 per month to rent, attachments are often $30 or more.

Ebay

A word of caution: The Medela Pump in Style pumps are designed for single person use, the contaminant filter is inside the machine. Replacing the attachments will not reduce the potential contamination risk.

If your hospital or clinic is interested in having pumps to loan, the hospital grade pump companies have rental programs. Some companies have low cost "loss waivers/insurance" so that if a pump is loaned and lost, the company will assume responsibility. Rental costs to I.H.S. vary, depending on manufacturer and pump. For example, one I.H.S. facility reported a current cost of ~ $125/year for Medela Lactina Plus pumps. Attachments are $30-40 per set. For more details, check with local pump loaner stations or call PIMC Breastfeeding Helpline at 1-877-868-9473.

Domestic Violence

Denise Grenier, Tucson/Rachel Locker, Warm Springs

Family violence in health care and public health settings: Accepting Manuscripts

The Family Violence Prevention and Health Practice e-journal invites you to submit manuscripts on addressing family violence in health care and public health settings. The next issue will look at the relationship between childhood and adult sexual and physical violence and obesity. For information on submission guidelines go to the "info for contributors" tab of the journal Denise.Grenier@ihs.gov

International Health Update

Claire Wendland, Madison, WI

Multiple Chlamydia species pose an unexpected challenge for blindness prevention

In the United States, most health care providers hearing the word "chlamydia" think immediately of the sexually transmitted infection caused by Chlamydia trachomatis. Chlamydia the STI is common around the world, but C. trachomatis has long been believed also to be the major cause of trachoma, an eye infection that is the leading cause of preventable blindness worldwide. A new report calls into question some of the conventional wisdom about trachoma, and raises concerns about treatment and prevention efforts.

Trachoma is spread when ocular or respiratory secretions from an infected person get into the eyes of an uninfected person (typically through direct contact, when carried by house flies or other insects, or by shared towels). It causes a conjunctivitis that ultimately turn the eyelashes inward, resulting in corneal scratching and ulcerations. Left untreated, it progresses to blindness over a span of one to four decades. The disease is found disproportionately in poor countries, especially in Asia, the Middle East, and Africa, and especially among women. Dry and dusty places where people are inclined to rub their eyes and don't have much water to wash may be particularly affected.

Though trachoma was once a serious problem in the United States, it has been greatly reduced by antibiotic treatment and by provision of clean water to affected communities. In fact, the CDC claims trachoma has been eradicated in the U.S., though a 1997 report on eye disease on the Navajo reservation still listed it as a significant cause of blindness there. Efforts to wipe out trachoma in the Third World, however, fail consistently. Cases quickly reappear following mass antibiotic treatment of affected communities, and may persist or reappear even when testing fails to demonstrate the presence of C. trachomatis. These anomalies led researchers to investigate whether another pathogen might be responsible.

In an endemic community in Nepal, Deborah Dean and colleagues sampled tears from 146 people in nine affected households and also did eye exams to stage them for clinical trachoma. PCR testing on the tear samples showed that half the sample was infected. The surprise was that of those infected, 35% had only C. trachomatis (and even here there were eight different genotypes involved), 20% had only C. psittaci, 10% had only C. pneumoniae, and 35% had more than one species. All three species were highly correlated with severe eye inflammation consistent with clinical trachoma, and the researchers conclude that all three are pathogenic. It's not clear that the same pattern of infection will prevail outside Nepal. What is clear is that efforts to make a vaccine have just had a significant setback, and that monotherapy with azithromycin (which may not work for all Chlamydiaceae) can no longer be counted on to wipe out the problem.

Reference: Online

Medical Mystery Tour

St. John's wort for depression in a young woman

A 28-year-old female with severe major depression has achieved partial symptom remission with a selective serotonin reuptake inhibitor (SSRI) but complains of persistent diarrhea and loss of libido. She asks you about using St. John's wort to treat her depression

Appropriate advice would include which of the following? (Select all that are true.)

- St. John's wort may be effective in milder forms of major depression
- St. John's wort is more effective than placebo in patients with severe major depression
- St. John's wort is better tolerated than prescription antidepressants
- The combination of St. John's wort and SSRIs is safe and effective for major depression.
- St. John's wort may reduce the efficacy of combined oral contraceptives

Stay tuned to the March issue for the answers and a discussion

CCC Corner Feb 2008

Midwives Corner

Lisa Allee, CNM

VBACs: The evidence supports them, women want and benefit from them, we need to provide them.

The following is in response to the comments of Dr. David Gahn regarding VBACs at Hastings Indian Medical Center that appeared in this column in the December issue of the CCC Newsletter (see link below). This following is a conglomeration of my and other midwives' responses.

First, here is some overall VBAC information to ponder.

We must all remind ourselves of recent history. The change from pro-VBAC thinking to pro-repeat cesarean delivery occurred when ACOG came out with a recommendation (not a requirement) that physicians (doesn't specify anesthesia) should be immediately available (no definition supplied).

This recommendation was based on a poorly done study of discharge diagnosis codes that actually demonstrated the same statistics on uterine rupture as previous studies of VBAC, but the authors came to very different conclusions (Lyndon-Rochelle 2001) Unfortunately, much of this country went wildly swinging to the extreme end of the pendulum's arc and stopped offering VBACs. Luckily, some kept their heads and a plethora of research has been published since which show VBAC to be a safe and reasonable option for the majority of women with a history of cesarean deliveries and many benefits to VBAC over repeat cesarean delivery.

(Please see the many citations that have been reviewed in December Obstetrics section of this publication – link below plus this month's Abstract of the Month. More citations were supplied by Neil Murphy and Sheila Mahoney on the Indian Health Midwives listserv discussion related to VBACs.)

Among the places that have remained sane and continued to offer VBACs are many of us in the Indian Health Service (Alaska Native Medical Center even got an award from the American College Nurse Midwifes) and a group in the Northeast, the Northern New England Perinatal Quality Improvement Network (NNEPQIN). (link below) The folks in the New England coalition have come out with useful guidelines on deciding about VBAC and providing quality care. Their work also helped us all face a bigger picture—how we handle emergency surgery in general and how we can improve. Their suggestions include improving teamwork, communications, and skills via drills. This has the potential to improve responses to emergency birth needs beyond the very few situations related to VBACs. Those of us in IHS who have continued VBACs have shown continued success with excellent statistics and outcomes (see 2007 Indian Health Data Tally Sheet below)

Overall, the pendulum is hopefully beginning to swing back towards a more rational approach to VBACs—there was even a quote from an ACOG official that suggested a possible move towards revising their "immediately available" statement (see August 2006 Midwives Corner below)

Second, let's go over some of the specifics raised by Dr. Gahn.

Since, according to Dr. Gahn, none of the physicians or midwives at Hastings are anti-VBAC, I thought I would use the responses from other midwives and myself to formulate some suggestions to help overcome the barriers to VBACs at Hastings which were elucidated by Dr. Gahn. These suggestions can also be used by the few other IHS sites that may be experiencing problems with offering VBAC services.

1) Have a journal club to present the overwhelming amount of evidence that supports providing VBAC services. Make sure to include the materials from the Northern New England Perinatal Quality Improvement Network and IHS VBAC statistics. Invite (coerce attendance, i.e., pizza or desserts, as needed) all members of the perinatal team including anesthesia and executive staff members who supervise the provider staff. This will help ensure that all involved have the information to begin providing evidence based care and should help to start the efforts to develop a functional interdisciplinary team. This should also help those obstetricians who "are not anti-TOLAC/VBAC", but are not on board with the VBAC plan to start their process of getting on board.
2) Start doing drills for obstetrical emergencies. This will help to improve skills, as well as, teamwork and communication between anesthesia, surgery, midwifery, obstetrics, nursing—your second step in team building. This should help a number of issues. It should help to impress all on-call staff to do what is necessary to improve response time with the goal of your med-staff-rules-and-regulations-required 20 minutes becoming reliable. Maybe this will help folks come to the conclusion of having key personnel located close by—i.e. a call room or on campus housing. This would solve the problem of anesthesia not being available when a VBAC patient is laboring. When the larger picture of response to any emergent surgery is focused upon then the VBAC topic, which represents a very small proportion of the potential emergency surgeries, is automatically included.
3) As a department, or even better as an interdisciplinary team or service unit, review the World Health Organization and USPHS Healthy People 2010 recommendations for cesarean delivery rates. Both of these respected and esteemed organizations have clearly and repeatedly recommended cesarean delivery rates in the 10-15% range. This clearly answers the question about whether a cesarean delivery rate of 37%, which is more than double to triple these recommendations, is too high and gives a very good indication as to what is too high for a cesarean delivery rate.
4) Re-evaluate how VBAC counseling is done. To provide true informed consent the numbers need to be presented clearly. The data consistently shows a uterine rupture rate of 0.5-3%—it is important to explain that this means 97-99.5 women out of 100 will not have a uterine rupture and out of the few that do, not all will have problems. It is, of course, important to discuss the risk of uterine rupture to mother and baby, but to put it in this perspective of being rare and review the high-quality, careful care we provide to women who are VBACing to help prevent problems. It is also very important to review the differences in postpartum morbidity and risk between a vaginal birth and cesarean delivery, (be sure to include the oft ignored higher rates of breastfeeding and orgasm difficulties post cesarean delivery.) If, in contrast, providers only make a recommendation of repeat cesarean delivery and an institution has a policy that only allows for repeat cesarean delivery, then they have effectively negated a woman's right to make an informed decision in a situation where there is a choice.
5) Review the postpartum morbidity and risk differences for women post vaginal birth vs. post cesarean delivery. This will help to dispel the delusion that a woman who has had a cesarean delivery is walking out of the hospital "healthy" and bring a more accurate sense of respect for what is really happening for that woman. She has just had major abdominal surgery and is in recovery from that surgery. She is in pain and is at risk for a number of post-surgical complications. Her future pregnancies have also now taken on a longer list of potential risks. Along with all this she is also a new mother with a newborn to care for and feed every 1-2 hours with an abdominal incision that she is fully aware of each time she moves. This human perspective of the implications of a cesarean delivery might help providers to be concerned with their personal and institutional cesarean delivery rates.
6) Consider IHS as a model for the local standard of care. Since we are not controlled by insurance companies, we in IHS often have more opportunity then our colleagues outside IHS to provide care that is evidence-based. VBAC care is one of those situations and we can proudly stand up in the maternity care community as a model of excellent care.

Most importantly we need to respect the women we care for as the ones who are giving birth and realize that, therefore, it needs to be up to them where, how, and with whom they will do so. We are here to provide information and care—to serve not to dictate.

Please feel free to contact me for any questions or comments and for requests for links to the above mentioned resources at lisa.allee@ihs.gov.

Resources: Online

Judy Whitecrane: Tireless Improvement of Care for Native American women

CDR Judith Whitecrane started her professional career as a Diploma Graduate prepared nurse and over the years has continued her education in a manner which is very inspiring to any nurse.

Today Ms. Whitecrane is a Post Master's Prepared Nurse whose professional activities involve a concentration in Nurse-Midwifery.

Not only is she on staff at Phoenix Indian Medical Center, but she is the first non physician to become Vice-President of Medical Staff. Maintenance of the hospitals level II Obstetrical certification, Ms. Whitecrane is the PIMC Coordinator and Liaison to Arizona Perinatal Trust. Ms. Whitecrane is the original author of the Prenatal Questionnaire used through out the Indian Health Service, Tribal and Urban Centers (I/T/U), widely used in Indian Country. Ms. Whitecrane was one of two individuals responsible for the Public Health Nursing Teen pregnancy program which addressed many issues related to teen pregnancy.

Annually, Ms Whitecrane has overseen the Advance Practice Nurse/ Physician Assistant Seminar which has been historically held in Scottsdale, Az. This national conference has been most successful in meeting the needs of Advanced Practice Nurses & Physician Assistants.

Ms. Whitecrane serves on the National Nurse Leadership Council as one of two Advance Practice Nurse Consultants. In this role she has worked tirelessly on behalf of the many nurses she represents across the I/T/U.

Of specific commendation are her efforts to increase the awareness of the Advanced Practice Nurse working within our current personnel system. Ms. Whitecrane has advocated for the elevation of the Advanced Practice Nurse position to make it more competitive with the private sector. In doing so, she has successfully overseen the updating of the Advanced Practice Nurse Scope of Practice. Both of these activities have been most labor intensive and will have far reaching positive affects on present and future Advanced Practice Nurses working throughout the I/T/U.

Her efforts will not only pave the way for higher pay for the Advanced Practice Nurse, especially in OB and Anesthesia which continue to be the hardest positions to fill, but also will serve to promote a better understanding and provide a firmer framework for facilities who hire Advanced Practice Nurses, by having a true scope of practice which better conforms to local, regional and national guidelines and expectations.

Over the past three years, Ms. Whitecrane has taken on the role of Chairperson of the OB Task Force. This OB Task Force has created significant changes and improvements to our Labor and Delivery Unit at PIMC. She has helped in the creation of OB emergency drills which allow the staff to better learn the necessary skills to help recognize potential process problems which can be corrected. This OB Task Force has also been instrumental in the completion of the remodeling of our Obstetrical triage area to create a HIPAA compliant unit and allow safer treatment areas.

Ms. Whitecrane also started the Special Care Clinic for the pregnant women with drug abusing problems. This clinic is working well and we have seen many good outcomes since its initiation. She also has given many lectures to groups wanting to start such a clinic across I/T/U.

I know that this is long, but Judy has been at PIMC for 26 years and with IHS for 30 years and has worked tirelessly for the improvement of care to our Native American patients. She retired on Jan. 1, 2008, but her valuable services may be available to worthy causes on a contract basis.

Karen.Carey@ihs.gov

Barbara Stillwater
Alaska Diabetes Program

Prepregnancy BMI, hypertensive disorders of pregnancy, and long-term maternal mortality

CONCLUSION: Elevated prepregnancy BMI is associated with increased risk of hypertensive disorders of pregnancy (HDP), which are in turn is associated with increased long-term maternal mortality rates. This association between HDP and mortality rates increases with elevated prepregnancy BMI.

Samuels-Kalow ME et al Prepregnancy body mass index, hypertensive disorders of pregnancy, and long-term maternal mortality. Am J Obstet Gynecol. 2007 Nov;197(5):490. e1-6.

Navajo News
John Balintona, Shiprock

Biliary Gallstone Disease and Pregnancy

Biliary tract disease is the second most common general surgical condition encountered in pregnant women. Often the care of these patients is shared between the obstetric provider and other specialists, i.e. primary care providers and general surgeons. The purpose of this review is to discuss salient points in caring for pregnant patients with biliary gallstone disease. Included in the discussion is the pathophysiology of gallstones, incidence in pregnancy, evaluation of the patient, treatment options during pregnancy, and recommendations for care for obstetric patients with gallbladder disease.

In the United States, cholesterol stones are the most common type of gallstone. The formation of cholesterol stones is a result of cholesterol supersaturation and impaired gallbladder motility. Several risk factors have been associated with the increased occurrence of gallstones:

Risk Factors for Gallstone Formation

- Obesity: BMI > 30
- Pregnancy
- Female Gender
- Native American Race
- Heredity
- Increasing Age
- Ileal disease

Drugs; estrogens, TPN, ceftriaxone

Cholelithiasis is found in about 20% of women over 40. Literature suggests that the yearly risk of intervention is about 1 – 2%. Therefore, treatment for asymptomatic disease is not warranted. Complications can occur however, which change the approach and management of this condition. Acute cholecystitis develops when there is a complete obstruction of the cystic duct usually with colonization from bacteria. Choledocholithiasis occurs when gallstones migrate from the primary site of origin through the cystic duct and into the common bile duct. Gallstones can trigger an attack of acute pancreatitis by transiently impacting in the duodenal papilla. Symptoms related to gallstone disease include steady, nonparyoxsmal pain, usually lasting more than 4 hours. Anorexia, as well as, nausea and vomiting frequently occur. Findings such as low-grade fever and leukocytosis (> 13,000 WBC) are also indicative of cholecystitis. Pancreatic involvement typically results in elevated serum amylase and lipase, elevated liver enzymes and leukocytosis.

The incidence of gallstone disease in pregnancy ranges from 1 in 1000 to 1 in 4000 for symptomatic disease. When taking into account the presence of asymptomatic cholelithiasis, the literature suggests that 2.5% to 10% of pregnant women will have this condition demonstrated on ultrasound. It is believed that several factors predispose pregnancy for the development of gallstones. First, the gallbladder volume during fasting and residual volume after contracting is twice that of nonpregnant patients. Second, Incomplete emptying may result in retention of cholesterol crystals. The effect of progesterone on smooth muscle function is though to be the cause of the slow emptying time of the gallbladder. Biliary sludge is thought to increase in pregnancy, again increasing the risk for stone formation. The signs and symptoms of biliary gallstone disease are similar in the pregnant and nonpregnant patient. Development of cholecystitis and/or pancreatitis during pregnancy increases the risk of maternal morbidity, as well as, fetal complications, e.g. preterm labor, low birthweight, fetal loss. Fetal loss is attributed to a combination of acidosis, hypovolemia, and hypoxia.

Evaluation of possible gallstone disease is similar among pregnant and nonpregnant patients. An appropriate history and physical is warranted. Consideration for other disease processes that are similar in presentation, such as acute fatty liver of pregnancy, preeclampsia, infection, etc should occur. Gestational age specific fetal surveillance and recording of maternal vital signs is warranted. Laboratory data, which may be helpful in the evaluation, include:

- Complete blood count
- Serum amylase
- Serum lipase
- Liver function tests
- Serum chemistries
- Urinalysis

Ultrasonography has been shown to be of greatest importance in the evaluation of patients with biliary tract disease. Stones as small as 2 mm can be seen and the sensitivity and specificity of this imaging modality is well over 95%. Findings on ultrasound that are characteristic for acute cholecystitis include tenderness over the gallbladder (ultrasound murphy's sign), pericholecystic fluid, and thickened gallbladder wall. Cholecystoscintigraphy (HIDA) scan is another radiologic technique used in diagnosis, but is currently believed to be contraindicated in pregnancy.

Early in the evaluation empiric treatment and intervention can be initiated. The patient should be placed NPO, and should be resuscitated with intravenous fluids. Concomitant medical problems should be stabilized. Consideration should be made for nasogastric suction. Paraenteral analgesics should be given and broad antibiotic coverage should be considered especially in cases involving suspected cholecystitis or pancreatitis. In some facilities, it is standard for a consultation to be sought from general surgery and the nutrition/dietary service.

Primary treatment for symptomatic cholelithiasis in nonpregnant patients remains cholecystectomy. This procedure is safe, relieves symptoms, and has low recurrence rate. Most general surgeons would recommend immediate intervention with the exception of gallstone pancreatitis where many suggest that resolution of the pancreatitis should occur before surgery. There is a consensus that surgical intervention is warranted in pregnant patients with obstructive jaundice, acute cholecystitis failing medical management, pancreatitis, or suspected peritonitis. However, the management of symptomatic cholelithiasis remains controversial.

Medical management of symptomatic cholelithiasis includes previously described steps of bowel rest, IV hydration, IV pain control, and surgical/nutrition consultations. A number of nonsurgical approaches have been used for gallstone disease. Oral bile acid dissolution therapy, extracorporeal shock wave lithotripsy, and contact dissolution have been described, but there is little, if any, experience with these methods during pregnancy and are therefore not recommended. Some authors state that up to 80% of patients will get relief from the initial attack with conservative medical treatment. However, literature also suggests that the recurrence rate is high, up to 50% with even higher rates if the initial attack occurs during the second trimester. Some obstetric providers include symptomatic cholelithiasis as an indication for elective induction of labor in appropriate candidates. Successful induction of labor anecdotally relieves the symptoms and shortens the time to potential surgical therapy. The author believes that induction of labor at term in properly selected patients is a viable option for those with symptomatic cholelithiasis.

Surgical intervention remains a viable option even in the pregnant patient with symptomatic gall bladder disease. As noted above, surgical management is indicated in cholecystitis and pancreatitis. Several studies have shown that laparoscopic cholecystectomy is just as safe as open cholecystectomy and even has a number of advantages as well, e.g. shorter hospital stay, lower post-op pain, better cosmesis, etc. Furthermore, several case studies note that the use of the laparoscopic technique is safe and effective even in the third trimester. No strict recommendations exist regarding the obstetric aspects with patients undergoing cholecystectomy but some factors should be considered:

- Perioperative fetal monitoring, especially in gestational age past 14 weeks
- Adequate maternal hydration prior to surgery
- Use of the open (Hassan) technique for insufflation

Placement of the patient in the left lateral recumbent position

- Pneumoperitoneum pressure less than 15 mm Hg
- Corticosteroid injection for fetal maturity in appropriate patients
- Prophylactic tocolytic therapy

Other sources cite the use of other interventions to include percutaneous cholecystostomy and endoscopic retrograde cholangiopancreatography (ERCP) in selected patients.

Several studies have been published comparing the outcomes of medical versus surgical management of symptomatic cholelithiasis (with no evidence of cholecystitis or pancreatitis) during pregnancy. One such study concluded that surgical management is safe, decreases days in the hospital, and reduced the rate of labor induction and preterm deliveries. Furthermore, the rate of relapse of symptoms in those managed medically was significantly higher. Maternal and fetal mortality in both groups was shown to be similar. The patient's obstetric provider should ensure that she receives an adequate consultation regarding the data and risks regarding surgical intervention.

This review highlighted several salient factors in the role of the obstetric provider in the care of pregnant patients with biliary gallstone disease. The author would like to summarize a few points that are felt to be especially important:

1. Pregnancy is a risk factor for cholelithiasis.
2. Asymptomatic cholelithiasis does not warrant intervention.
3. Symptomatic cholelithiasis can safely be managed medically or surgically.
4. There is a significant recurrence rate for symptomatic cholelithiasis in pregnancy.
5. Induction of labor for appropriately selected term patients with symptomatic cholelithiasis is a viable option.
6. Cholecystitis and pancreatitis increase the risk for maternal and fetal morbidity and mortality and therefore should be treated aggressively.
7. The obstetric provider should provide specific recommendations regarding the obstetric aspects in patients undergoing surgical intervention.

Reference: Online

Sunnah Kim
American Academy of Pediatrics

Native American Child Health Advocacy Award

As many of you are aware, the AAP has a national award to recognize an individual who has made a major contribution to Native American child health. Do you know a physician or non-physician who is worthy of this recognition? If so, I would like to encourage you to submit a nomination.

To have your nominee considered for the 2008 Award, please submit your nomination by February 29, 2008. Please submit a letter of nomination, along with the candidate's contact information to:

Committee on Native American Child Health
American Academy of Pediatrics
141 Northwest Point Blvd
Elk Grove Village, IL 60007

Fax: 847/434-8729
indianhealth@aap.org

The 2008 Native American Child Health Advocacy Award will be presented in October 2008 in conjunction with the AAP National Conference and Exhibition in Boston, MA.
Thanks,
Sunnah

Nurses Corner
Sandra Haldane, HQE

AWHONN—numerous on line courses—materials and fees listed

Introduction to Fetal Heart Monitoring
Self-paced online course introduces fetal heart monitoring (FHM). Perinatal clinicians will gain tools to interpret FHM data, implement interventions, and evaluate the effect of interventions on maternal and fetal well-being.

Five sections cover:

- Maternal-fetal overview
- Uterine and fetal physiology
- Electronic monitoring
- Monitoring and interventions
- Risk management

Individual and Group fees for courses are also available
Association of Women's Health Obstetric and Neonatal Nurses
www.awhonn.org/awhonn/content.print.do?&name=02_PracticeResources/2J_DODLanding.htm

Oklahoma Perspective
Cesarean Delivery: What are the risks and benefits?
Here are a few of the recent articles that describe the risks and benefits of cesarean delivery.

Elective Cesarean Delivery Linked to Higher Risk for Infant Respiratory Morbidity
CONCLUSION: Compared with newborns delivered vaginally or by emergency caesarean sections, those delivered by elective caesarean section around term have an increased risk of overall and serious respiratory morbidity. The relative risk increased with decreasing gestational age.

Hansen AK et al Risk of respiratory morbidity in term infants delivered by elective caesarean section: cohort study. BMJ. 2008 Jan 12;336(7635):85-7

Cesarean delivery can be reduced: Identification of barriers to change is key to success
CONCLUSIONS: The cesarean delivery rate can be safely reduced by interventions that involve health workers in analyzing and modifying their practice. Our results suggest that multifaceted strategies, based on audit and detailed feedback, are advised to improve clinical practice and effectively reduce cesarean delivery rates. Moreover, these findings support the assumption that identification of barriers to change is a major key to success.

Chaillet N et al Evidence-based strategies for reducing cesarean section rates: a meta-analysis. Birth. 2007 Mar;34(1):53-64

Cesarean delivery increases the risk of maternal and neonatal morbidity and mortality
CONCLUSIONS: Caesarean delivery independently reduces overall risk in breech presentations and risk of intrapartum fetal death in cephalic presentations but increases the risk of severe maternal and neonatal morbidity and mortality in cephalic presentations.

Villar J et al Maternal and neonatal individual risks and benefits associated with caesarean delivery: multicentre prospective study. BMJ. 2007 Nov 17;335(7628):1025.

Women's Health Headlines
Carolyn Aoyama, HQE

Women's Leadership Scholarship
Women's Leadership Scholarship is a program of the Channel Foundation, a small, private foundation based in Seattle, Washington, USA that promotes leadership in women's human rights around the globe. Channel's mission is to fund and create opportunities for groups working in many regions of the world to ensure that women's human rights are respected, protected, and fulfilled.

Eligible candidates include women leaders from the Global South and/or from indigenous groups who also meet all the following criteria:

1. They are committed to grassroots organizing and the needs of their communities or indigenous group.
2. They have proof of a bachelor's or a higher degree.
3. They have at least three years of work experience dealing with critical human rights concerns, and other social, educational, environmental, health or economic conditions that negatively affect their communities.
4. They have been accepted into a non-doctoral graduate program at an accredited university for full-time study/research related to their work experience in human rights, sustainable development, and/or public health.
5. They can show evidence of financial need for educational support.
6. They intend to return to their home countries to work, utilizing training and research acquired in the study program.

http://www.nativeleaders.org:80/how.html

MCH Headlines
Judy Thierry HQE

Announcing the 2008 PREVENT Child Maltreatment Institute
The 2008 PREVENT Child Maltreatment Institute: Enhancing Leadership for Child Maltreatment Prevention offers state of the art training to experienced teams from across the country, who are working to stop child maltreatment before the first victimization or perpetration occurs. The Institute will expand skills to lead evidence-based efforts in the primary prevention of child maltreatment and provide teams with an intensive and supportive environment in which to work together with a trained coach on a prevention initiative. Participants can expect to enhance core competencies in the primary prevention of child maltreatment at the state and/or national level, including:

- planning and evaluating effective policy interventions and programs;
- stimulating organizational and social change;
- critically evaluating the literature and translating science into practice;
- effectively communicating with media and policy makers through media and legislative advocacy,
- implementing promising practices, and
- enhancing skills in achieving program sustainability.

The PREVENT Child Maltreatment Institute will include two (2) intensive three-day, on-site sessions separated by six months of working as a team at home, with selected distance education calls and guidance from an experienced coach focused on a team-developed project. The first three-day session will be held April 21-23, 2008 for Cohort 1 and April 22-24, 2008 for Cohort 2 at the Sheraton Chapel Hill Hotel, Chapel Hill North Carolina. The second session will be conducted in October, 2008.

Multi-organizational teams of up to 5 people will be selected based on their experience working together, demonstration of leadership in child maltreatment prevention AND readiness to take an increased leadership role in making social and organizational changes to prevent child/ maltreatment./ While we will consider multidisciplinary teams from local communities, the most successful applicants will be teams working in large metropolitan areas, or at the state, regional or national level that have already established working relationships. Selected teams are responsible for travel, lodging, evening meals, and a one-time non-refundable $750 team registration fee. For more information and to submit an application, please see the attached flyer and visit http://prevent.unc.edu/education/.

Menopause Management
Smoking Status as a Predictor of Hip Fracture Risk in Postmenopausal Women
The purpose of this study was to determine the effect of cigarette smoking on the risk of hip fracture for postmenopausal women living in rural and urban areas of Northwest Texas. Former and current smoking increased the risk of hip fracture in this population of postmenopausal women. Residence in a rural county (population <100,000) also was associated with increased risk.

Midwives corner
ACNM Clinical Bulletin Recommends Intermittent Auscultation
The American College of Nurse-Midwives has issued a clinical bulletin recommending intermittent auscultation as the "preferred method for monitoring the fetal heart rate during labor for women who at the onset of labor are low risk for developing fetal academia." The recommendation is based on numerous randomized clinical trials and a 2006 Cochrane review (including more than 33,000 women) which all show no benefit of continuous electronic fetal monitoring (EFM) over intermittent auscultation (IA) in terms of perinatal outcomes and significantly higher intervention and morbidity rates in the EFM groups. Included are guidelines on how to perform IA, recommendations from other professional organizations on the frequency of IA, and how to interpret and document IA. The bulletin recommends using a multiple-count method, but unfortunately does not come out with a recommendation or instructions for a specific counting method. References to studies on auscultation are provided to help in the decision making, however, including one that has a method of plotting the counts (see Paine's articles below). The bulletin also sites research that shows patient satisfaction is associated with amount and quality of caregiver support and involvement in decision making and, therefore, that giving patients the choice of IA with it's 1:1 caregiver to patient ratio and frequent human-provided assessment might increase patient satisfaction.

Comment: Here is another great resource for supporting the move to turn off the monitors and even take them out of the birthing rooms of low risk women (and please remember that most women are low risk). We have all heard over and over and over that continuous EFM does not improve outcomes, but does increase intervention and morbidity. Isn't it time yet that we change our practice to fit the evidence? This bulletin says yes it is time! I have used IA in both home and hospital settings and it works well to monitor fetal wellbeing. It is also really wonderful how IA increases the quantity and quality of labor support the patients receive. If you do not use IA at your facility, I highly recommend moving towards it. I realize that change is hard, so here are a couple of suggestions. If your addiction to the monitor is such that you cannot go cold turkey, then try doing IA with the monitor first and work towards using a doptone. If your resistance is the 1:1 ratio and staffing issues then start with using IA when it is slow and 1:1 is not a problem. As people get use to and more skilled with IA, then creative ways to provide it when things are busier will appear. And, of course, when it is too busy and there is not enough staff then use the EFM, but realize that that decision is due to institutional needs not patient needs or for improved outcomes. Lastly, print this clinical bulletin and post it for all to see and check out the articles by Paine, et al for a great way to do IA and graph it and by the other authors for other multiple-count methods you can chose from.

Resources: Online

(Concern for rising Cesarean rates…, continued from page 1)

the 1990s demonstrated a 7.3% cesarean rate despite an incidence of diabetes and hypertensive disorders well above national rates8. Physician specific practices influence cesarean delivery rates9. We believe that the cesarean delivery review initiated at GIMC in the early 1990s was important in identifying factors in patient management that can result in a high cesarean rate.

An important ingredient in reducing cesarean delivery, either in nulliparous or parous women, is to place value on vaginal delivery. The attitude that "None of the physicians in our department are concerned with our cesarean delivery rate" may prove the largest stumbling block in developing strategies more consistent with national goals.

We suggest that the maternity care providers in Hastings present the evidence for improved maternal outcomes in women with prior vaginal delivery to their anesthesia colleagues and make TOLAC available at least for this group of women. Addressing the high total (and presumably) primary cesarean rates will require analysis of the indications and physician specific patterns. Given the increasing evidence for adverse outcomes with multiple repeat cesareans and the limited ability of community hospitals to address problems with placenta accreta, increta and percreta, we support labor management strategies to reduce cesarean rates in the Native American population in the Oklahoma Area and nationwide.

OB/GYN CCC Editorial comment

An argument for better teamwork: Trial of labor after cesarean in Indian Country

First, I want to thank the leaders of the Indian Health Midwives listserv for raising these important issues, as this discussion was originally begun in the Midwives Corner feature. Though the current discussion revolves around Indian Health facilities, it is reflective of most small rural hospitals and increasingly some larger urban facilities.

Next, the availability of the trial of labor after cesarean option is really a 'systems' issue not just a problem confined to midwives or physicians. To decrease the long term morbidity and mortality associated with cesarean rates that now exceed 40%, we need to approach this issue systematically. Specifically, how can we engage our Indian Health administrative staff to foster an environment whereby anesthesia, pediatric, and nursing services work together with the provider staff to decrease excess morbidity in Native women.

Should you offer vaginal birth after cesarean delivery at your facility? Should your referral facility be offering VBAC?

Let's put some of the above issues into perspective.
What are just a few of the risks that you should currently handle very well:

	Incidence/100
Shoulder dystocia	0.2–3.0
Cord Prolapse	0.14–0.62
Abruptio placenta, overall	0.4–1.3
Abruptio placenta, severe - stillbirth	0.12
Placenta previa, third trimester	0.1–0.4
Placenta accreta, overall	0.18
Placenta accreta/previa unscarred	1–5
Placenta accreta/previa with 1 Ces Del.	11–25
Placenta accreta/previa with 2 Ces	35–47
Placenta accreta/previa with > 3 Ces	50–67
Post partum hemorrhage	1–5
Trauma	7

In all but one of the above cases the incidence of these obstetric emergencies is actually increasing each year.

If you can't provide VBAC because of the 0.5% risk of uterine rupture, then should your facility be offering intrapartum care at all?

If you work at a facility that can not develop a rapid response for a clinical issue like symptomatic uterine rupture in a VBAC setting, which happens ~0.5 percent of the time, then your facility, should re-evaluate its ability to manage obstetric intrapartum care.

Taken on their own individual merit, most of the above common urgencies and emergencies occur more frequently than 0.5 percent. Taken as an aggregate, the risks above far outweigh the risks of VBAC. Now seeing the above risks, if you feel you need to re-evaluate offering obstetric intrapartum care because the above risks, then please contact me as soon as possible.

For those facilities that feel they are able to continue to offer obstetric intrapartum care within the risk environment above, then I would suggest a program of emergency obstetric drills, pan-ALSO certification for all nurses and providers**, and an ongoing quality assurance.

Each of the last three national Indian Women's Health and MCH Conferences has devoted significant blocks of lecture time and workshops to improve systems of care and specific content updates. (Link to Meeting Lecture notes below)

Lastly, there seems to be some confusion as some providers at times combine the risk of a TOLAC sequela vs the relative success of a vaginal birth in TOLAC. These are two separate issues that need to be discussed with our patients separately for a fully informed consent.

1.) Success of vaginal delivery

Overall the rate of successful vaginal delivery in TOLAC is actually quite high, often in the range of 75% in the general population, and much higher success rate in the AI/AN population at 85-90% over the years.

A previous successful VBAC is probably the best predictor of future success; about 90 percent of such women deliver vaginally with trial of labor. By comparison, women delivered abdominally for dystocia are least successful, although approximately two-thirds are delivered vaginally.

Among the previous dystocia group, the success rate is higher if cesarean delivery was performed in the latent phase of labor and lower if performed after full dilatation. Within the former group, 79% of women who originally had surgery while still in the latent phase of labor had a successful trial of labor, compared with 61% of patients who had an arrest of dilation in the active phase of labor and 65% of those who had an arrest of descent. (Duff et al Obstet Gynecol 1988 Mar;71 (3 Pt 1):380-4.)

Multivariate logistic regression analysis identified as predictive of TOL success: previous vaginal delivery (OR 3.9; 95% CI 3.6-4.3), previous indication not being dystocia (CPD/FTP) (OR 1.7; 95% CI 1.5-1.8), spontaneous labor (OR 1.6; 95% CI 1.5-1.8), birth weight <4000 g (OR 2.0; 95% CI 1.8-2.3), and Caucasian race (OR 1.8, 95% CI 1.6-1.9) (all P < .001).

The overall TOL success rate in obese women (BMI > or = 30) was lower (68.4%) than in nonobese women (79.6%) (P < .001), and when combined with induction and lack of previous vaginal delivery, successful VBAC occurred in only 44.2% of cases. (Landon et al The MFMU Cesarean Registry: factors affecting the success of trial of labor after previous cesarean delivery. Am J Obstet Gynecol. 2005 Sep;193(3 Pt 2):1016-23.)

The combination of previous cesarean for dystocia, no previous vaginal delivery, and induced labor had a particularly poor prognosis in the Flamm system, e. g., fewer than 50 percent of such women achieved a successful TOL.

A decision analysis model favored TOL if the chance of success was >50 percent and if the desire for additional pregnancies was 10 to 20 percent. (Mankuta et al Am J Obstet Gynecol 2003 Sep;189(3):714-9.)

2.) Risks:

Numerous risk factors have been cited for uterine rupture during labor in women with a previous CD. However, these risk factors are not consistent across studies, which are generally hampered by small numbers of patients with uterine rupture. Unfortunately, no single factor or combination of risk factors is sufficiently reliable to be clinically useful for prediction of uterine rupture.

Purported risk factors include maternal age greater than 30 years, induction of labor, more than one prior CD, postpartum fever, interdelivery interval less than 18 to 24 months, dysfunctional labor, and one layer uterine closure. Within this framework of incomplete data the New England Perinatal Quality Improvement Network (NNEPQIN) has developed a system to appropriately manage the risks.

Low Risk Patient:

- 1 prior low transverse cesarean delivery
- Spontaneous onset labor
- No need for augmentation
- No repetitive FHR abnormalities
- Patients with a prior successful VBAC are especially low risk. (However, their risk status escalates the same as other low risk patients)

Medium Risk Patient:

- Induction of labor
- Pitocin augmentation
- 2 or more prior low transverse cesarean deliveries*
- < 18 months between prior cesarean delivery and current delivery

High Risk Patient:

- Repetitive non-reassuring FHR abnormalities not responsive to clinical intervention. /li>
- Bleeding suggestive of abruption
- 2 hours without cervical change in the active phase despite adequate labor

* NB: 'Two prior uterine scars and no vaginal deliveries' is listed as a circumstance under which trial of labor should not be attempted by the American College of Obstetricians and Gynecologists ACOG Practice Bulletin No. 54, 'Vaginal birth after previous cesarean delivery'.

Here is a suggested management system per NNEPQIN

Low risk

Notify Pediatrics, Anesthesia, and operating room crew of admission
OB/GYN on campus during active phase
Perinatal Guidelines of Care, ACOG, observed

Medium risk

Notify Pediatrics, Anesthesia, and operating room crew of admission
Operating room on campus in active phase or other plan if crew is busy

High risk

OB/GYN, Anesthesia, and Pediatrics available
No other acute care responsibilities
Rapid decision to incision

Please see the Midwives Corner and Oklahoma Perspective, below, for further discussion on this topic. A complete discussion of risk, benefits, and systems issues is available in the Perinatology Corner module: Vaginal Birth after cesarean

www.ihs.gov/MedicalPrograms/MCH/M/PNC/VB01.cfm

Reference: Online

SAVE THE DATES

Training in Palliative and End of Life Care
- March 25–27, 2008
- Minneapolis, MN
- Contact Tim Domer MD at tim.domer@ihs.gov

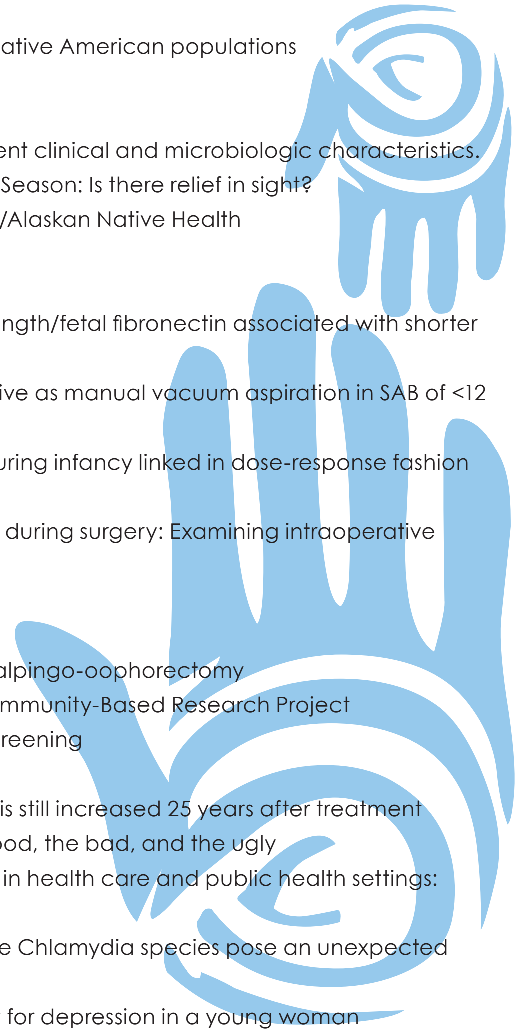
IHS Basic Colposcopy Course
- April 9–11, 2008
- Albuquerque, NM
- Contact AWaxman@salud.unm.edu

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

Advances in Indian Health (AIH) Conference
- April 29–May 2, 2008
- Albuquerque, NM
- 28 credits, Indian Country's Primary Care Conference www.ihs.gov/MedicalPrograms/MCH/F/CN01.cfm?module=2008&option=may#top



Abstract of the Month
- Concern for rising Cesarean rates inNative American populations

IHS Child Health Notes
- Laterality of acute otitis media: different clinical and microbiologic characteristics.
- Infectious Disease Updates—The RSV Season: Is there relief in sight?
- Recent literature on American Indian/Alaskan Native Health

Hot Topics
- Obstetrics—Knowledge of cervical length/fetal fibronectin associated with shorter evaluation and PTB
- Gynecology—Misoprostol is as effective as manual vacuum aspiration in SAB of <12 weeks
- Child Health—Secondhand smoke during infancy linked in dose-response fashion with allergies
- Chronic disease and Illness—'Awake' during surgery: Examining intraoperative awareness

Features
- ACOG—Elective and risk–reducing salpingo-oophorectomy
- Ask a Librarian—Cervical Cancer Community-Based Research Project
- Behavioral Health Insights—Autism Screening
- Primary Care Discussion Forum—
- STD Corner—The cervical cancer risk is still increased 25 years after treatment
- Breastfeeding—Breast Pumps: The good, the bad, and the ugly
- Domestic Violence—Family violence in health care and public health settings: Accepting Manuscripts
- International Health Update—Multiple Chlamydia species pose an unexpected challenge for blindness prevention
- Medical Mystery Tour—St. John's wort for depression in a young woman
- Midwives Corner—VBACs: The evidence supports them, women want and benefit from them, we need to provide them.
- Midwives Corner—Judy Whitecrane: Tireless Improvement of Care for Native American women

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