NATIONAL COUNCIL OF CHIEF CLINICAL CONSULTANTS

CCC CORNER

Focus on the Health of American Indians and Alaska Natives

Vol 6, No 08
Aug 2008

Colorectal Cancer Screening and Surveillance

What to do with patients with polyps, by Dr. Hope Baluh

Periodic screening for colon cancer in asymptomatic patients results in decreased mortality from this common and frequently fatal disease. As public awareness of the benefits of colon cancer screening has increased so has the demand for colonoscopy services. Evidence-based guidelines developed separately by the US Preventive Services Task Force, a consortium of five US medical and surgical GI societies, and the American Cancer Society recommend that all asymptomatic, average-risk people over age 50 years be offered screening with annual fecal occult blood tests and/ or flexible sigmoidoscopy every 5 years because these options are strongly supported by direct scientific studies. Colonoscopy is recommended when either of these tests is positive. The guidelines also include doing direct screening with air-contrast barium enema every 5 years or colonoscopy every 10 years. Periodic colonoscopy is also recommended for patients with an above average risk for colorectal cancer. Patients with an increased risk profile include those with a personal or family history of colorectal cancer or adenomatous polyps, as well as those with long-standing chronic inflammatory bowel disease.

Public surveys indicate that less than 40% of the at-risk population has yet to be screened. Once screened, patients with increased risk factors benefit from surveillance. Determining optimal intervals for surveillance often requires knowing the patient's family history and findings from initial screening procedures including pathology reports.

Davila RE et al ASGE guideline: colorectal cancer screening and surveillance. Gastrointest Endosc. 2006 Apr;63(4):546-57 Erratum in: Gastrointest Endosc. 2006 May;63(6):892.

The following are guidelines for screening and surveillance

Indication	Interval
Screening	
Average risk	10 y (begin at age 50 y)
Single first degree relative (FDR) with cancer (or adenomas) at age > 60 y	10 y (begin at age 40 y)
>2 FDRs with cancer (or adenomas) or 1 FDR Diagnosed at age <60 y	5 y (begin at age 40 y or 10 y younger, whichever is earlier)
Prior endometrial or ovarian cancer diagnosed at age <50 y	5 y
Hereditary nonpolyposis colorectal cancer (HNPCC) begin age 20-25	1-2 y
Postadenoma resection	
1-2 tubular adenomas of <1 cm	5-10 y
3-10 adenomas or adenoma with villous features, > 1 cm with high grade dysplasia	3 y
> 10 adenomas	< 3 y
Sessile adenoma of > 2 cm, removed piecemeal (in order to inspect site for residual polyp)	2-6 months
Other Follow-Up	
Postcancer resection	Clear colon, then 1 y then 3 y, then 5 y
Ulcerative colitis, Crohn's colitis surveillance After 8 y of pancolitis or 15 y of left-sided colitis	2-3 y until 20 y after onset of symptoms, then 1 y

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THIS MONTH

ACOG / IHS Course in Salt Lake City, Utah this year

Obstetric, Neonatal and Gynecologic Care
September 14–18, 2008
Salt Lake City, Utah

This annual women's health update for Nurses, Advanced Practice Clinicians, and physicians provides four days of lectures, workshops, and hands-on sessions. The course is a good foundation for those who are new to women's health care or new to the Indian health system. Many faculty members are from IHS and Tribal facilities. A Neonatal Resuscitation Program is also available.

Early registration holds your place, and puts you in line for a possible scholarship.

Contact
ymalloy@acog.org

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

"The beginning is the most important part of any work."
—Plato

Introduction

This spring and summer most IHS clinics have had requests for blood lead level testing for children entering Head Start. This is an attempt to explain why blood level testing is mandatory for Medicaid eligible AI/AN children even if the risk of elevated lead levels is likely small in our patients.

Blood Lead Screening in American Indian/Alaska Native Children

In March of 2008 the Office of Head Start issued an Information Memorandum that reaffirmed the requirement within the Head Start Program Performance Standards for all children entering the program to be screened for lead poisoning as per the schedule of well child care utilized by the EPSDT program.(1). It appeared that many Head Start programs that serve American Indian/Alaska Native (AI/AN) children were encountering difficulty in obtaining documentation of the required screening blood lead levels (BLLs) performed at 12 and 24 months of age. The Health Director of the IHS Head Start Program asked the Indian Health Service for guidance on this issue. This request prompted a review of current standards for screening BLLs in children < 6 years old.

Lead is a potent neurotoxin. At higher levels (>70ug/dL) lead poisoning can cause encephalopathy and death. Such extreme lead toxicity is now rare as primary prevention efforts in the past few decades mandated the removal of lead from gasoline and consumer products. Lead exposure from paint in older buildings remains a persistent source of exposure to lead. Recently there has been concern over lead toxicity in toys imported from China. Unfortunately, even small amounts of lead can have irreversible effects on brain development in young children. It is estimated that every 10ug/dL increment in BLLs can decrease IQ scores by 3 to 7 points (2). At present, the accepted definition for elevated BLLs is >10ug/dL. However, there is recent research that BLLs even below 10ug/dL may be deleterious (3). Since BLLs <25ug/dL are clinically undetectable only screening can detect these cases.

Who should be screened for lead exposure? Data show that lead poisoning is overwhelmingly a disease of young children in poverty. In the NHANES III survey in 1994 the overall prevalence of elevated BLLs (>10ug/dL) in 1- 5 year olds was 4.4%. However, the prevalence of elevated BLLs was only 0.9% in upper income children while the rate was as high as 21% in poor children who lived in older homes. Further analysis showed that 10% of children enrolled in Medicaid had elevated BLLs. Medicaid enrollees also accounted for 60% of the total children with BLL >10ug/dL and 83% of the children with BLLs>20ug/dL (4).

Many AI/AN children potentially would fall into the high- risk group because of widespread poverty in many AI/AN communities. However, few AI/AN communities have commercial homes built before the 1950s, which would tend to diminish the likelihood of exposure to lead paint.

The current prevalence of elevated BLLs in AI/AN children is unclear. A review of Pubmed for the past 20 years with the search terms, "American Indian", "children" and "lead" disclosed only one article on mining exposures in Oklahoma. The Indian Health Service has unpublished data from the mid 1990s on lead levels in 7of 12 Areas. The percentage of children screened in each area varied widely and not all tribal groups were included. However, in this limited data set the overall rate of elevated BLLs after confirmatory testing was < 1% which was lower than the national rate.

Given the low prevalence of lead poisoning in AI/AN children tested, it was agreed that targeted screening of AI/AN children at high risk for lead exposure was a better strategy than universal testing. Universal testing was also discouraged by the United States Preventive Services Task Force (5). No lead screening or targeted lead screening became the standard in most clinics but was never explicitly made a policy for the Indian Health Service. A summary of the costs and benefits of lead screening in AIA/AN children was published in The IHS Primary Care Provider in 1994 (6).

An informal survey of Indian Health Service/Tribal/Urban (I/T/U) clinics suggests that most practitioners have assumed that lead exposure is not a problem in their communities. This lack of lead screening is hardly unique for I/T/U clinics. Despite the demonstrated elevated risk in poor children only 20% of Medicaid enrollees nationwide were screened for BLLs in a recent evaluation by the Office of the Inspector General (7).

However, a review of federal standards indicates BLL testing is a mandated service for all children eligible for Medicaid and Head Start. The Center for Medicaid and Medicare Services (CMS) requires that all Medicaid-eligible children receive a screening blood test at 12 months and 24 months of age (8). Children between the ages of 36 to 72 months must also have a BLL test if lead screening has not been done previously. Head Start is also required to follow the standard of care set forth by CMS. CMS made this decision based on the demonstrated risk of elevated BLL in Medicaid enrollees compared to the general population.

Data show that up to 80% of AI/AN children < 6 years of age in reservation communities are eligible for Medicaid and Head Start. With this high percentage of Medicaid enrollees it is likely more efficient to screen all AI/AN children < 6 years old for elevated BLLs. The risk of elevated BLLs in AI/AN children is likely low, but there is no recent, comprehensive data, and there is no data that includes all tribal groups.

Given the high incidence of iron deficiency anemia in AI/AN children many I/T/U clinics already screen for anemia with a complete blood count (CBC) at 9 months and 18 months. Testing at 9 months of age is preferable to testing at12 months as this will result in the earlier detection of iron deficiency anemia earlier treatment. It is also known that iron deficiency promotes lead absorption and that repletion of iron stores will diminish absorption of lead (9 & 10). Therefore, timely treatment of iron deficiency is one of the best preventive measures to minimize lead poisoning. BLLs tend to peak at age 24 months so this is the optimal time for the follow-up test to be done. To minimize the number of blood draws CBC and lead testing could be combined in the following schedule:

9-12 months: draw a CBC and lead level
24 months: draw a CBC and lead level
36-72 months – draw a lead level if not done previously

Management of elevated BLLs (>10ug/dL) is beyond the scope of this report. Follow-up should be based on the guidelines published in the AAP Policy statement lead poisoning published in 2005 (2).

Lead testing will cost I/T/U sites money. This test is usually performed in a reference lab and a BLL usually costs about $15. Medicaid pays a global fee for outpatient visits to most I/T/U clinics so the cost of the test is not recoverable. However, BLL is a CMS mandate: Failure to perform a mandated test could jeopardize Medicaid reimbursement. Money may need to be reprogrammed to I/T/U laboratory budgets to cover this cost.

Lastly, each clinic will need to track BLLs in their patient population over the next year. This will let us answer the question of which, if any, AI/AN children are at risk for lead poisoning. Tribal groups with low lead levels may be able to request a waiver of BLL testing from CMS in the future. As important, if some tribal groups are found to be at elevated risk, appropriate environmental investigation and amelioration can begin.

References Online

Infectious Disease Updates.

Steve Holve, MD

Pentacel®: New May not be Better for American Indian/ Alaska Native Infants

A new combination vaccine, Pentacel® (DTaP-IPV- Hib [PRP-T]), was recently licensed for use in the United States. This vaccine is not ideal for American Indian/Alaska Native (AI/AN) infants served in federal, tribal and urban Indian clinics.

Pentacel® is a vaccine that protects against five serious infections; diphtheria, tetanus, pertussis, polio, and haemophilus influenzae type b (Hib). It is the first combination vaccine in the United States that includes both poliovirus and haemophilus antigens. The vaccine is administered to children at 2, 4, 6, and 15-18 months of age.

There are currently several Hib vaccines available which vary in the protein used to make the vaccine more immunogenic. In Pentacel®, the Hib component of the vaccine is a purified polyribosylribitol phosphate (PRP) capsular polysaccharide covalently bound to tetanus protein (PRP-T). The current Hib vaccine recommended for AI/AN infants has a meningococcal outer membrane protein (OMP) bound to the PRP molecule and is designated as a PRP-OMP Hib vaccine.

The Redbook of the American Academy of Pediatrics recommends that for AI/AN infants the first dose of a Hib conjugate vaccine should contain PRP-OMP. For AI/AN infants "the administration of a PRP-OMP-containing vaccine leads to more rapid seroconversion to protective concentrations of antibody within the first 6 months of life, and failure of use has been associated with excess cases of Hib disease in young infants in this population". (1)

In 1996 Alaska switched from a PRP-OMP Hib vaccine to combination HbOC-DTP vaccine (Tetramune®). During 1996-1997, 17 Hib cases occurred in Alaska Native children <5 years of age, increasing the rate of Hib disease from 19 to 91 cases per 100,000 per year. 8 of the cases occurred in partially vaccinated children who had received 1 or 2 doses of HbOC. Since 2001, Alaska has adopted a schedule using PRP-OMP alone, and the subsequent rate of Hib disease in Alaska Native infants decreased to 5.4 per 100,000 per year.(2)

Physicians, pharmacists and immunization coordinators who work for federal, tribal and urban Indian clinics need to be aware of this change and insure that their state's VFC program continues to supply a PRP-OMP Hib vaccine to their AI/AN patients.

1. 2006 Report of the Committee on Infectious Diseases. American Academy of Pediatrics; Elk Gove, IL page 89.

2. Singleton et al., The Alaska Haemophilus influenzae type b experience: Lessons in controlling a vaccine-preventable disease. Pediatrics 2006;118:421-429.

Addendum:

Questions have arisen over whether this recommendation applies to all AI/AN children. The above update was written for an audience that works in federal, tribal and urban Indian clinics. Private clinics near reservation communities may serve significant numbers of AI/AN patients and may wish to have a PRP-OMP containing Hib vaccine available. The risk of invasive Hib disease for AI/AN infants who do not live on or near reservation communities is unknown.

This issue of increased risk for invasive Hib disease was addressed in the MMWR in December 2007 due to a decrease in the supply of PRP-OMP Hib vaccine due to production difficulties. The pertinent summary of the risk for AI/AN infants is below. Each practitioner should make a decision based on their assessment of risk of invasive Hib for their patients. The full posting with references is available at: www.cdc.gov/mmwr/preview/mmwrhtml/mm5650a4.htm

American Indian/Alaska Native (AI/AN) children also are at increased risk for Hib disease, particularly in the first 6 months of life. Before the use of Hib conjugate vaccines, the incidence of Hib disease among young AI/AN children in AI/AN communities was approximately 10 times higher than among children of comparable age in the general population. Compared with PRP-TT conjugate vaccines, the administration of PRP-OMP vaccines leads to a more rapid seroconversion to protective antibody concentrations within the first 6 months of life. Failure to use PRP-OMP vaccines for the first dose is associated with excess cases of Hib disease in AI/AN infants living in communities where Hib transmission is ongoing and exposure to colonized persons is likely. Although PRP-OMP and PRP-TT vaccines are equally effective after completion of the primary series, availability of more than one Hib vaccine in a clinic could lead

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From Your Colleagues

David Gahn, MD
Kabul, Afghanistan

Afghanistan Update

Most of the readers of the CCC Corner know how much emphasis we put on preconception care, prenatal care, and postpartum care in the United States. We have special procedures and concerns when someone appears on L&D in labor with no prenatal care.

Imagine a city of 5 million people where >95% of the pregnant women have no prenatal care and the average parity a woman reaches is >7. These are the patients that the doctors and midwives at Rabia Balkhi Hospital in Kabul face daily.

Because recent data show a tremendous amount of maternal and perinatal mortality associated with cesarean sections, IHS has recently focused its efforts on improving the care delivered in the operating room as well as working on the decision process that sends a woman to the OR to have her baby. In collaboration with CDC, we are operating under the framework of a quality assurance collaborative on cesarean sections (QAC/CS) which will eventually involve all 4 maternity hospitals in Kabul. In July, IHS, with participation from the Department of Defense, conducted a Surgical Skills Training Workshop at Rabia Balkhi Hospital using a combination of didactics, skills labs, and practical training in the OR. IHS medical epidemiologist Dr. Mei Castor, MD is leading the operational research arm of the QAC/CS, and James Dickens, FNP from the Center for Medicare and Medicaid Services is focusing on training the OR staff in the basic principles of operating a safe and effective OR. Dr. Pat O'Connor, MD from Tuba City, AZ continues to head up the effort in the pediatrics department.

When a cesarean section is performed, every system in the hospital is involved: lab, blood bank, supply, housekeeping, facilities, etc. Using a quality assurance approach focusing on systems and not individual performance has allowed the Afghans to gradually make sustainable changes in their hospital with an understanding that quality assurance is a continuous process. With CDC also involved, we are working on being able to measure our processes through an improved medical record and a functioning Quality Assurance Department. We know that if we can't measure what we are doing, we can't manage it. And if we can't manage it, we can't change it.

IHS is working on the interagency agreement with HHS/Office of Global Health Affairs (OGHA) for FY 2009, and hopes to expand its clinical role in the Afghanistan Health Initiative (AHI). With funding from OGHA, IHS will be able to continue to staff the AHI to make meaningful and sustainable changes to a national health care delivery system. Keep your eyes out for more opportunities to serve the people of Afghanistan, and feel free to contact me at any time.

David.Gahn@ihs.gov

Elaine Locke and Yvonne Malloy
ACOG
(Scholarships still Available!)

ACOG/IHS Postgraduate Course on Obstetric, Neonatal and Gynecologic Care

September 14-18, 2008; Salt Lake City, Utah

This annual women's health update for Nurses, Advanced Practice Clinicians, and physicians provides a four-day schedule of lectures, workshops, hands-on sessions, and team building. The large interdisciplinary faculty collaborates to teach clinical and practical topics as they apply in Indian health settings. Many faculty members are your colleagues in IHS and Tribal facilities; private sector faculty also bring a wide range of experience providing Indian health care. Learn the latest evidence-based approaches to maternal and child health services, and share problems and solutions with your colleagues from across Indian country. The course can also serve as a good foundation for professionals who are new to women's health care or new to the Indian health system.

In addition to the basic course, you may sign up for the Neonatal Resuscitation Program, and come away with your certificate from this convenient pre-course program. The opportunity to fulfill continuing education requirements in a concentrated format is significant: With the optional NRP, we can document your participation in seven half-days of education.

Sign up early! You'll have first chance for support from your facility and coverage for your time in Salt Lake City. Getting these benefits lined up takes time, so don't delay and miss out! In addition, early registration holds your place, and puts you in line for possible availability of scholarship funds.

Watch your mail for the course brochure and registration form, or download it from here:
http://www.ihs.gov/MedicalPrograms/MCH/F/CN01.cfm?module=08&option=9#top

For more information on the Postgraduate Course or other Indian Health programs please contact ymalloy@acog.org; 800-673-8444, ext 2580

Hot Topics

Obstetrics

Improving neonatal outcome through practical shoulder dystocia training

CONCLUSION: The introduction of shoulder dystocia training for all maternity staff was associated with improved management and neonatal outcomes of births complicated by shoulder dystocia. LEVEL OF EVIDENCE: II.

Draycott TJ, Crofts JF, Ash JP, Wilson LV, Yard E, Sibanda T, Whitelaw A. Improving neonatal outcome through practical shoulder dystocia training. Obstet Gynecol. 2008 Jul;112(1):14-20.

Effect of Timing of Umbilical Cord Clamping at Birth of Term Infants on Mother and Baby Outcomes (Cochrane Update)

AUTHORS' CONCLUSION: One definition of active management includes directions to administer an uterotonic with birth of the anterior shoulder of the baby and to clamp the umbilical cord within 30–60 seconds of birth of the baby (which is not always feasible in practice). In this review delaying clamping of the cord for at least two to three minutes seems not to increase the risk of postpartum hemorrhage. In addition, late cord clamping can be advantageous for the infant by improving iron status which may be of clinical value particularly in infants where access to good nutrition is poor, although delaying clamping increases the risk of jaundice requiring phototherapy.

McDonald SJ, Middleton P. Effect of timing of umbilical cord clamping of term infants on maternal and neonatal outcomes. Cochrane Database of Systematic Reviews 2008, Issue 2. Art. No.: CD004074. DOI: 10.1002/14651858.CD004074.pub2. Obstet Gynecol. 2008 Jul;112(1):177-8.

Gynecology

Comparison of the treatment outcome of pubovaginal sling, tension-free vaginal tape, and transobturator tape for stress urinary incontinence with intrinsic sphincter deficiency

OBJECTIVE: The aim of this study was to compare the treatment outcome of 3 sling procedures for stress urinary incontinence with intrinsic sphincter deficiency.

CONCLUSION: PVS and TVT were more efficacious, but the long-term cure rates were low.

Jeon MJ, Jung HJ, Chung SM, Kim SK, Bai SW. Comparison of the treatment outcome of pubovaginal sling, tension-free vaginal tape, and transobturator tape for stress urinary incontinence with intrinsic sphincter deficiency. Am J Obstet Gynecol. 2008 Jul;199(1):76.e1-4. Epub 2008 Jan 25.

Child Health

Universal newborn hearing screening: systematic review to update the 2001 US Preventive Services Task Force Recommendation

CONCLUSIONS: Children with hearing loss who had universal newborn hearing screening have better language outcomes at school age than those not screened. Infants identified with hearing loss through universal screening have significantly earlier referral, diagnosis, and treatment than those identified in other ways.

Nelson HD, Bougatsos C, Nygren P; 2001 US Preventive Services Task Force. Universal newborn hearing screening: systematic review to update the 2001 US Preventive Services Task Force Recommendation. Pediatrics. 2008 Jul;122(1):e266-76.

Children at High Risk Should Be Screened for Elevated Cholesterol

This clinical report replaces the 1998 policy statement from the American Academy of Pediatrics on cholesterol in childhood, which has been retired. This report has taken on new urgency given the current epidemic of childhood obesity with the subsequent increasing risk of type 2 diabetes mellitus, hypertension, and cardiovascular disease in older children and adults. The approach to screening children and adolescents with a fasting lipid profile remains a targeted approach. Overweight children belong to a special risk category of children and are in need of cholesterol screening regardless of family history or other risk factors. This report reemphasizes the need for prevention of cardiovascular disease by following Dietary Guidelines for Americans and increasing physical activity and also includes a review of the pharmacologic agents and indications for treating dyslipidemia in children.

Daniels SR, Greer FR; Committee on Nutrition Collaborators (13). Lipid screening and cardiovascular health in childhood. Pediatrics. 2008 Jul;122(1):198-208.

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Obstetrics

Progesterone for the prevention of preterm birth: a systematic review

METHODS OF STUDY SELECTION: Randomized trials comparing antenatal progesterone for women at risk of preterm birth were considered. Studies were evaluated for inclusion and methodological quality. Primary outcomes were perinatal death, preterm birth before 34 weeks, and neurodevelopmental handicap.

CONCLUSION: Progesterone is associated with some beneficial effects in pregnancy outcome for some women at increased risk of preterm birth.

Dodd JM, Flenady VJ, Cincotta R, Crowther CA. Progesterone for the prevention of preterm birth: a systematic review. Obstet Gynecol. 2008 Jul;112(1):127-34.

CCC Editorial Note

Welcome Jean Howe, MD, MPH

The new OB/GYN Chief Clinical Consultant

Dr. Jean Howe took over the reins of the OB/GYN Chief Clinical Consultant role on June 1, 2008 and has yet to have her feet touch the ground. Jean has the perfect background and energy to do a great job as Chief Clinical Consultant, so we look forward to a wonderful future for the care of Native Women.

Many of you know Jean already, as she has been participating as the Deputy Chief Clinical Consultant since 2004. As such Jean has excelled in many of the national functions of the CCC and knows the territory. Originally from Vermont and trained at the University of Colorado, Dr. Howe has been an OB/GYN at Chinle Hospital for almost 11 years and department Chief for 10 years. She also currently serves as the Navajo Area OB/GYN consultant. Dr. Howe completed the Johns Hopkins Masters in Public Health program in 2005. Her areas of interest include preventive services, contraception, international health, and diabetes in pregnancy.

What does an OB/GYN Chief Clinical Consultant really do?

The OB/GYN CCC role seems to be a bit unique among the CCCs largely because of its close relationship over the years with the benchmark women's health professional group, American College of Obstetricians and Gynecologists. In addition, the OB/GYN CCC has many national functions that you may interact with everyday and not realize it.

The OB/GYN CCC participates in the annual ACOG/IHS Area site visits which review the care of Native women and young children on-site. The OB/GYN CCC serves as consultant to the ACOG Fellows in Service Program that places ACOG Fellows in short term positions throughout Indian Country. The OB/GYN CCC also participates in the planning of the annual ACOG / IHS Obstetric, Neonatal and Gynecologic Care Postgraduate Course which is thorough multi-day primer and update on the basics of women's health and early child health.

Recently the OB/GYN CCC has been the editor of the Chief Clinical Consultant Corner newsletter since its inception 6 years ago. In addition, the OB/GYN CCC coordinates the single most complete clinical website on the www.ihs.gov which has become a template for many other websites since 2000. The OB/GYN CCC has also been a lightning rod for increasing communication among the various staff groups by creating listserv(s) for maternal child health, the primary care discussion forum, midwives, and OB/GYNs.

What have OB/GYN Senior Clinicians/Chief Clinical Consultant done over the years?

The most unique aspect of the OB/GYN CCC is that the role is built on long standing relationships. The first relationship, as described above, is that between ACOG and the Indian Health system…the second relationship is with you. When is the last time that you heard that a former CCC, or Senior Clinician as they used to be termed, was coordinating the IHS Colposcopy Course, serving a member of the ACOG Committee on American Indian Affairs, or authoring a column in the CCC Corner national newsletter?

If you said, 'just last month', then you are right to all three. Case(s) in point are the active roles that Drs. William Haffner, Alan Waxman and Neil Murphy continue to play in improving the health care of Native women. Here is a brief history on the former OB/GYN Senior Clinicians / CCCs.

It all began with David L Hall. Dr. Hall was an OB/GYN in Shiprock and later at Gallup Indian Medical Center and served as OB/GYN Senior Clinician from 1972–1980. These very formative years included the era when much of the care to Native women was provided by general medical officers with very little specific training in Women's Health.

Dr. Hall's successor was William Haffner, the IHS OB/GYN Senior Clinician from 1980 to 1994. Dr. Haffner's central theme was to facilitate the transition from the era of the general medical officer to more completely trained women's health providers. To that end Dr. Haffner worked at increasing the number, skills, and quality of OB/GYN and CNM providers throughout the IHS full-service OBG hospitals. Bill helped advance and promote a degree of standardization of obstetric care through education and development of a common prenatal record to meet U.S. standards of care at all IHS programs providing prenatal or full-service obstetric care. Dr. Haffner encouraged professional collaborations with ACOG and ACNM to maximize the quality of care and promote advocacy for Indian women's health.

Dr. Haffner was pivotal in the development a basic primer/update course in Native women's health which became the benchmark for all Indian Health care providers. Ultimately, with the help of ACOG this became an annual course, ACOG / IHS Obstetric, Neonatal and Gynecologic Care Postgraduate Course, which included an excellent Reference Text of which he remains the Editor.

Dr. Haffner had worked in the USPHS 1971–2001 with 1971–1981 of that being at Gallup Indian Medical Center. Dr. Haffner was the PHS Chief Medical Officer 1990–1994. Dr. Haffner is a Professor and was Chair of the OB/GYN Department, F. Edward Hebert School of Medicine, 1992–2003. Bill has been the Acting Associate Dean for Faculty Development since 2006 and is in clinical practice at the National Naval Medical Center. In 2002 Dr. Haffner received the ACOG Distinguished Service Award.

Alan Waxman was OB/GYN Senior Clinician from 1994–2000. Dr. Waxman's central theme was promoting a uniform standard of care for all AI/AN women regardless of what IHS or tribal facility they received care at. Dr. Waxman made sure that those standards were based on benchmark best practices, which often relied on ACOG Practice Bulletins and Committee

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Features

ACOG

American College of Obstetricians and Gynecologists

ACOG Practice Bulletin #95 Anemia in Pregnancy

Introduction: Anemia, the most common hematologic abnormality, is a reduction in the concentration of erythrocytes or hemoglobin in blood. The two most common causes of anemia in pregnancy and the puerperium are iron deficiency and acute blood loss. Iron requirements increase during pregnancy, and a failure to maintain sufficient levels of iron may result in adverse maternal–fetal consequences. The purpose of this document is to provide a brief overview of the causes of anemia in pregnancy, review iron requirements, and provide recommendations for screening and clinical management of anemia during pregnancy.

Summary of Recommendations and Conclusions:

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

- Iron supplementation decreases the prevalence of maternal anemia at delivery.

The following recommendation and conclusions are based on limited or inconsistent scientific data (Level B):

- Iron deficiency anemia during pregnancy has been associated with an increased risk of low birth weight, preterm delivery, and perinatal mortality. Severe anemia with maternal Hgb levels less than 6 g/dL has been associated with abnormal fetal oxygenation resulting in nonreassuring fetal heart rate patterns, reduced amniotic fluid volume, fetal cerebral vasodilatation, and fetal death. Thus, maternal transfusion should be considered for fetal indications.

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

- All pregnant women should be screened for anemia, and those with iron deficiency anemia should be treated with supplemental iron, in addition to prenatal vitamins.
- Patients with anemia other than iron deficiency anemia should be further evaluated.
- Failure to respond to iron therapy should prompt further investigation and may suggest an incorrect diagnosis, coexisting disease, malabsorption (sometimes caused by the use of enteric-coated tablets or concomitant use of antacids), noncompliance, or blood loss.

Proposed Performance Measure:

Percentage of pregnant patients with iron deficiency anemia treated with supplemental iron in addition to prenatal vitamins.

American College of Obstetricians and Gynecologists. Anemia in pregnancy. ACOG Practice Bulletin No. 95. Obstet Gynecol 2008;112:201–7.

Ask a Librarian

Diane Cooper, IHS National Library Informationist

Health Services Research Library (HSRL) -a branch of the National Institutes of Health Library

Your information partner

As your partner at the HSRL, I'm here to help you meet your information needs. If you need to find information at either patient point-of-care or as background information for a specific project, I can help. I am here to save you time and ensure you get the information you need. As your information needs evolve, I will expand and enhance my skills and work hard to stay on top of the latest information resources useful to the Indian Health Service.

Benefit from a Content Expert

I have provided clinical and health-related information services to healthcare providers and systems in academic and rural settings in Kentucky, Nevada, and California. With a Master's in Library and Information Science and extensive experience providing information to providers in outreach areas, I am qualified to provide the Indian Health Service with up-to-date and credible information services. As your direct link to the HSRL and partner in your work, I can support you in the following ways:

- Help with complex and difficult literature searches to support direct patient care and patient care activities
- Participate and be a partner in IHS projects and development team activities
- Assist in manuscript preparation (verify references; editing)
- Set up current awareness alerts in your field of interest
- Create customized databases in bibliographic software programs (Endnote; Reference Manager) to organize your information for easy retrieval when you need it
- Provide instruction on how to search literature databases and other information resources more efficiently

Tips to Get You Started

Here's a tip to make finding information a little easier. Try using PubMed's "Clinical Queries" for a quick and easy source of evidence-based medicine information. Let me know if I can help you get started.

Call me at 301.594.2449 or email me at cooperd@mail.nih.gov or Diane.Cooper2@ihs.gov for information.

Health Services Research Library (HSRL)

http://hsrl.nihlibrary.nih.gov

Behavioral Health Insights

Peter Stuart, IHS Psychiatry Consultant

Conference Information/OBOT (Buprenorphine) Certification Training

(Buprenorphine) Certification Training will be available free of charge to IHS providers October 24 in Flagstaff, Arizona. For details please contact Dr. Tony Dekker at Anthony.dekker@ihs.gov. This is an excellent training and expands dramatically your therapeutic effectiveness with patients with narcotic dependency issues—as well as facilitating care for our more complicated chronic pain patients. A personal DEA number is required for certification and federal physicians may receive one free of charge even if not currently licensed in the state of practice. Go to www.usdoj.gov/dea/index.html to see the DEA page (good info on pain etc) and go to www.deadiversion.usdoj.gov/drugreg/index.html to register for a new DEA. It is self explanatory and takes less than 5 minutes to apply.

Heads Up—Be thinking **"Primary Care Based Behavioral Health".** Based on programs developed at Group Health and expanding rapidly in the VA and DOD systems this is a radical revision of the BH role in primary care and offers demonstrated benefits for patients and providers. A site with good material is www.mahec.net/ic. Be patient—it loads slowly but is well worth the wait. Ask your local BH staff "When are you planning on implementing this?" to get things started.

Breastfeeding

Suzan Murphy, PIMC

The Case of the Dwindling Milk Supply

Common scenario—mom and baby come for a well child check up. Mom says she has returned to work and is still breastfeeding. But her breast milk supply seems to slowing down. The following are questions to consider asking:

What kind of pump?

Hospital grade electric pumps work well. They are double sided. They cost $600+ to purchase and are usually rented instead for > $40 per month. There are also pumps that are available at many department stores for ~$250. It is intended to be a single user pump. According to the manufacturer, replacing the attachments will not reduce the risk of possible cross contamination. Many WIC programs offer single-user type pumps for clients to keep or will loan hospital grade pumps. Occasionally insurance companies will reimburse all/part of pump cost.

Anecdotal comments suggest that while other less expensive pumps may work for some moms—they do not have the general success rate of hospital grade pumps. Mothers describe ineffective output and nipple damage.

Please note—nipple damage can happen with any pump. The problem can be caused by attachments that don't fit and/or overzealous pumping.

If a family is interested in a pump, encourage the family to contact WIC, local breastfeeding coalitions, La Leche League, their health insurance company, and their employer. Some businesses provide pump sites for employees. Encourage families to look for pumps that are designed for daily use and have been clinical tested for maintaining milk supply. Assure them that pumping/expressing is not supposed to hurt.

How often is the mom pumping/expressing?

If the baby is under 6 months, the ideal routine is pumping every 3 hours, double sided for 20 or more minutes. If the mom is able to incorporate consistent pump times into her daily routine, it will be easier to maintain supply.

If that is not possible to pump on a routine schedule, encourage the mom to pump when she can. Pumping every 4 hours, like at a lunch break will help reduce risk of plugged ducts and mastitis.

Sometimes a baby will reverse his/her long sleep pattern, so the long sleep is while mom is gone. When mom comes home, the majority of feedings happen then. The milk supply could be slowing during work time because of the baby's pattern shift.

An anecdotal tip is to try pumping marathons—after work, pump 20 minutes, rest 20 minutes, repeat twice for a total of 3 sets. Try this for 2-3 days. It often returns the milk supply.

Other ideas

There are medications reported to increase supply. They include metoclopramide (Reglan), cisapride (Propulsid), fenugreek, and other herbs. Unfortunately, there is no consensus regarding their utility or dosage. For more information, please see resources such as Thomas Hale's Medications and Mothers' Milk, UpToDate (on the ihs.gov web page), and the NIH lactation and medication search engine at http://toxnet.nlm.nih.gov/cgi-bin/sis/htmlgen? LACT. Also consider checking with your local NICU for what they suggest for preemie moms who are pumping.

- Did the mom start birth control pills? They can disrupt milk supply, especially those with estrogen.
- Several studies link regular pacifier use with decreased milk supply. Less (use of pacifiers) could be more (milk).
- If the baby's 6 month birthday is close, remind the mom that when solids start, the baby's need for breast milk will begin slowing down.

For many different reasons, it is not always feasible for moms to pump or to pump enough... A mom may have already decided to formula feed during work time and breastfeed when they get home. With a routine work schedule, her body will adjust and produce milk when she is home.

For more ideas to supporting/advocating for breastfeeding employees, check with local breastfeeding coalitions. Helpful web resources include I.H.S. Lactation in the Workplace policy at www.ihs.gov/MedicalPrograms/MCH/M/bf.cfm and the United States Breastfeeding Committee web page at: www.usbreastfeeding.org.

International Health Update

Claire Wendland, Madison, WI

Cervical cancer screening where resources are scarce

Every year, over a quarter million women worldwide die of cervical cancer. Cervical cytology has made a huge impact in the wealthier parts of the world, but cytology programs require substantial infrastructure. If your region (or even your country) doesn't have a cytologist, or has no reliable means of transporting Pap tests to a central location or tracking women down to follow up positive results, cytology makes a poor screening tool. It's not surprising, then, that today third-world women are disproportionately affected by cervical cancer. Researchers have been looking for simple, effective, and affordable screening tests, and two recent studies take us a step further toward this goal.

Arbyn and colleagues report a new meta-analysis of eleven large screening studies in India and in Francophone Africa. The studies, sponsored by the Gates Foundation, enrolled more than 58000 women. Each woman was screened with two or more of the following methods: VIA (visual inspection with acetic acid); VILI (visual inspection with Lugol's iodine solution); VIAM (visual inspection with acetic acid and a magnifying loupe); Pap (standard Papanicolaou screening); or HC_2 (HPV high-risk probe of the Hybrid Capture-2 assay). No matter whether screening was positive or negative, colposcopy was immediately done on all women. Negative colposcopy was accepted as a negative result for purposes of analysis. Positive colposcopy required colposcopic biopsies which were then interpreted by a pathologist. The authors then compared sensitivity and specificity of all of these methods for detecting biopsy-proven CIN_2 or worse—with some surprising results.

The visual inspection methods, especially VILI, performed very well. The authors were surprised at the poor performance of the HPV test and speculate that samples may have deteriorated due to high temperatures at many of the study sites.

The study has two significant weaknesses. First, colposcopy and colposcopically directed biopsies tend to identify—and perhaps more importantly, to miss—the same lesions as the VIA or VILI methods. Thus its use as the "gold standard" in this study probably led to overestimation of the visual methods as screening tests. (Cone biopsy or hysterectomy specimens would be better gold standards methodologically, but impossible to justify ethically.) Second, other studies have showed much greater variability in the quality of visual methods for screening. The good performance in this group probably reflects their rigorous training. All screeners had gone through an intensive 5-day course and had been proctored for 150-200 exams before they began enrolling patients, which certainly represents more formal training than I had as an obstetrician-gynecologist performing screening for cervical cancer!

In real-world situations, then, visual methods have a good (12-13%) positive predictive value and an acceptable (well over 99%) negative predictive value. They're affordable, quick, and easy. So what sort of difference might a very simple visual screening program make? Another large study shows the savings in women's lives can be substantial. Investigators working in Tamil Nadu randomized panchayaths or municipal units in one administrative district to "standard care"—meaning no cervical cancer screening—or an intervention in which study nurses did a single round of VIA screening. Women who were VIA-positive immediately had colposcopy. When colposcopy suggested precancerous lesions (low-grade or high-grade) directed biopsies were taken and cryotherapy or LEEP done immediately. Follow-up of the over 70,000 women in this district used an intention-to-treat model and lasted seven years from the initiation of the study. Cervical cancer incidence, cervical cancer mortality, and overall mortality rates were equal between the two groups the first year of analysis, but there have been widening gaps every year since. Despite the bolus of patients diagnosed with cervical cancer in the intervention group at screening, by the time of this report the intervention group demonstrated a significant 25% reduction in cervical cancer incidence, and a 35% reduction in cervical cancer mortality compared with the control group.

Simpler screening methods aren't perfect, but they turn out to be pretty good. Now it's time to figure out how to get them implemented in the poorer parts of the world.

Sankaranarayanan R et al. Effect of visual screening on cervical cancer incidence and mortality in Tamil Nadu, India: a cluster-randomised trial. Lancet 370:398-406, 2007

Arbyn M et al. Pooled analysis of the accuracy of five cervical cancer screening tests assessed in eleven studies in Africa and India. International Journal of Cancer 123 (1): 153-60, 2008

MCH Headlines

Judy Thierry HQE

Three Maternal Risk Factors Associated with Elevated Risk of Postneonatal Mortality among Alaska Native Population

OBJECTIVE: Compared to non-Natives in Alaska, the Alaska Native population has a postneonatal mortality rate 2.3 times higher (95% CI 1.9, 2.7). The objective of the study was to identify variables that account for this elevated risk.

METHODS: The dataset used included birth and death certificate records for all Alaska-resident live births and infant deaths occurring during 1992-2004. Race was defined as Alaska Native or non-Native. The association between race and postneonatal mortality was examined using univariate, stratified and regression analyses. Variables were considered confounding if they resulted in a change of at least 10% in the odds ratio between race and postneonatal mortality when added to a bivariate model, or when removed from a multivariate model.

RESULTS: In stratified analysis, race remained associated with postneonatal mortality within most categories of marital status, maternal education, maternal age, prenatal tobacco or alcohol

use, prenatal care utilization, parity and residence. The odds ratio between race and postneonatal mortality was reduced to 1.3 (95% CI 1.0, 1.6) by controlling for education, a composite variable of marital status and the presence of father's name on the birth certificate, and prenatal tobacco or alcohol use.

CONCLUSIONS: A small number of potentially modifiable factors explain most of the postneonatal mortality disparity between Alaska Natives and non-Natives, leaving a relatively small increase in risk. These findings suggest that by targeting Alaska Native women who display these characteristics, the postneonatal mortality gap may be reduced.

Blabey MH, Gessner BD. Three Maternal Risk Factors Associated with Elevated Risk of Postneonatal Mortality Among Alaska Native Population. Matern Child Health J. 2008 Apr 4. [Epub ahead of print]

Submitted by Vanessa Hiratsuka, MPH; Tobacco Prevention and Control Program, Section of Chronic Disease Prevention and Health Promotion State of Alaska, Division of Public Health

MCH Editorial Comment

Reducing the post-neonatal mortality gap by addressing a finite number of modifiable risk factors is as relevant in 2008 as it was in 1992. As the authors note it is well known that a variety of social and economic factors are at play in perinatal health disparities. By adapting analytic techniques first used by Baker in California and a model by Greenland, the Alaska team subjected "selected" variables (dependent variable) to their model observing the effect on the odds ratio (OR) between race (independent variable) and post neonatal mortality (also a dependent variable). Similarly during a "deletion cycle" variables were removed, the OR for race observed and then "re-entered" before another variable was deleted and an OR observed. Criteria for confounding variables were those who changed the OR by < or > 10%. Ample tables and a well referenced discussion support the author's hypothesis focusing on elevated rates of alcohol and tobacco use, lower education levels (not completing high school) and "a greater frequency of a father's name missing on the birth certificate among unmarried mothers" as three key variables for intervention.

Quality assurance issues of chart data abstraction and maternal interview during the birth registration process should be considered. The advantage of school health as a point of care for a segment of this vulnerable population, while not suggested, seems a reasonable and an essential focus. Attention to children with special needs and special education needs falls into this category as well. Continued services during pregnancy and postpartum for school age Alaska Natives and basic reproductive health services for adolescents (male and female) is an important investment. Intimate partner tolerance for physical and emotional abuse and risky behaviors including alcohol and tobacco use converge in adolescence or at even younger ages, pressing for increased mental health and social services located in their learning environments. Tobacco cessation programs especially for low SES women are being given more national attention.

Lastly attention to education around building healthy intimate partner relationships and diffusing stress may be an indirect way to increasing the frequency of entering a father's name on a birth certificate—just a thought.

Medical Mystery Tour

Neil Murphy, Alaska Native Medical Center

Fetal Heart Monitoring

Everyone knows how to read a fetal heart rate (FHR) tracing, right?

Well let's make sure we are describing fetal heart rate (FHR) tracing with the same terms.

1.) A complete description of a fetal heart rate (FHR) tracing requires a qualitative and quantitative description of beat-to-beat variability

True False

2.) According to standardized National Institute of Child Health and Human Development (NICHD) definitions, the normal FHR range is 110-160 beats per minute

True False

3) According to standardized NICHD definitions, an amplitude range of between 6 and 25 beats per minute is termed 'marked variability'

True False

4) Before 32 weeks, a fetal heart rate acceleration is defined as a visually apparent increase in rate at least 10 beats per minute above the baseline lasting between 10 seconds and 2 minutes

True False

5) According to standardized NICHD terminology, a variable FHR deceleration reaches its nadir more than 30 seconds after its onset

True False

6) A prolonged FHR deceleration lasts between 2 and 10 minutes

True False

7) Fetal heart rate accelerations and moderate variability are highly predictive of the absence of metabolic academia

True False

For a discussion of the answers to the above questions, please tune into the September CCC Corner.

In the meantime, if you want to learn more about the results of the National Institute of Child Health and Human Development Research Planning Workshop, go here

Electronic fetal heart rate monitoring: research guidelines for interpretation. National Institute of Child Health and Human Development Research Planning Workshop.

Am J Obstet Gynecol. 1997 Dec;177(6):1385-90.

Menopause Management

Gallbladder Disease Risk Lower with Transdermal vs. Oral Hormone Therapy

OBJECTIVE: To determine whether transdermal compared with oral use of hormone replacement therapy reduces the risk of gallbladder disease in postmenopausal women.

DESIGN: Prospective cohort study (Million Women Study).

CONCLUSION Gallbladder disease is common in postmenopausal women and use of hormone replacement therapy increases the risk. Use of transdermal therapy rather than oral therapy over a five year period could avoid one cholecystectomy in every 140 users.

Bette Liu, Valerie Beral, Angela Balkwill, Jane Green, Siân Sweetland, Gillian Reeves, for the Million Women Study Collaborators. Gallbladder disease and use of transdermal versus oral hormone replacement therapy in postmenopausal women: prospective cohort study BMJ 2008; 337:a386

Midwives Corner

Lisa Allee, CNM

4 Corners Regional Health Center, Red Mesa, AZ

Including the Non-rational in Midwifery

Parratt and Fahy present a fascinating picture of the art of midwifery. They describe how midwives can practice using embodied knowledge that goes beyond the scientific, rational model of care and how women who are attended by midwives who use this broader-based knowledge can in turn tap into their own ways of knowing and the combination provides for superior care and experiences than care based on only rational, scientific information. Before reading this article please be sure to notice that the word is non-rational and not irrational. The authors very nicely point out that in the rational-dominated way of thinking that clings to dichotomies, the opposite of rational is irrational and since we have all been well initiated into the rational Western scientific way of thinking, our minds will tend to go directly to this dichotomy and see non-rational as irrational. Not so. The non-rational is our embodied knowledge, our inner knowing, that we gain from our lived experiences and other sources, which are hard to articulate. Actually, the non-rational overall is very difficult to articulate into language as it is felt and known in ways that defy words. However, Parratt and Fahy do well in explaining the importance and benefits of including the non-rational as the art of practicing midwifery. They use the issue of safety as one example, pointing out the importance and validity of approaching each situation as unique and drawing on both the rational and the non-rational sources of information from both the midwife and the women in order to respond to any situation at hand in the best way possible. They also do a wonderful job of pointing out that there is truly a spectrum to consider in the overall issue of safety—that the rational-thinking-only dichotomy of safe and unsafe as the only possibilities is not realistic or helpful. This article affirms to us all that using our whole being and honoring each woman's whole being in each pregnancy, labor, and birth is the essence of the art and science of the midwifery model of care and the reason that midwifery care is so powerful, successful, satisfying, empowering, and down right excellent!

Please, if you cannot get to the full-text article via these links, feel free to contact me and I will send you the article in electronic or hard copy form—just let me know! Email: lisa.allee@ihs.gov

Parratt JA, Fahy KM, Including the nonrational is sensible midwifery. Women Birth. 2008 Mar;21(1):37-42. Epub 2008 Feb 20

Office of Women's Health, CDC

Impact of Periodic Follow-Up Testing Among Urban American Indian Women with Impaired Fasting Glucose

INTRODUCTION: Impaired fasting glucose (IFG) often progresses to type 2 diabetes. Given the severity and prevalence of this disease, primary prevention is important. Intensive lifestyle counseling interventions have delayed or prevented the onset of type 2 diabetes, but it is not known whether less intensive, more easily replicable efforts can also be effective.

METHODS: In a lifestyle intervention study designed to reduce risks for type 2 diabetes, 200 American Indian women without diabetes, aged 18 to 40 years, were recruited from an urban community without regard to weight or IFG and block-randomized into intervention and control groups on the basis of fasting blood glucose (FBG). Dietary and physical activity behaviors were reported, and clinical metabolic, fitness, and body composition measures were taken at baseline and at periodic follow-up through 18 months. American Indian facilitators used a group-discussion format during the first 6 months to deliver a culturally influenced educational intervention on healthy eating, physical activity, social support, and goal setting. We analyzed a subset of young American Indian women with IFG at baseline (n = 42), selected from both the intervention and control groups.

RESULTS: Among the women with IFG, mean FBG significantly decreased from baseline to follow-up (P < .001) and converted to normal (<5.6 mmol/L or <100 mg/dL) in 62.0% of the 30 women who completed the 18-month follow-up, irrespective of participation in the group educational sessions. Other improved metabolic values included significant decreases in mean fasting blood total cholesterol and low-density lipoprotein cholesterol levels. The women reported significant overall mean decreases in intake of total energy, saturated fat, total fat, total sugar, sweetened beverages, proportion of sweet foods in the diet, and hours of TV watching.

CONCLUSION: Volunteers with IFG in this study benefited from learning their FBG values and reporting their dietary patterns; they made dietary changes and improved their FBG and lipid profiles. If confirmed in larger samples, these results support periodic dietary and body composition assessment, as well as glucose monitoring among women with IFG.

Allen P, Thompson JL, Herman CJ, Qualls C, Helitzer DL, Whyte AN, et al. Impact of periodic follow-up testing among urban American Indian women with impaired fasting glucose. Prev Chronic Dis 2008;5(3).

Osteoporosis

National Osteoporosis Foundation Releases New Clinical Recommendations for Low Bone Mass and Osteoporosis Incorporating Absolute Fracture Risk

The National Osteoporosis Foundation (NOF) is releasing its new Clinician's Guide to Prevention and Treatment of Osteoporosis representing a major breakthrough in the way healthcare providers evaluate and treat people with low bone mass or osteoporosis and the risk of fractures. NOF's new Clinician's Guide introduces guidelines beyond Caucasian postmenopausal women to include African-American, Asian, Latina and other postmenopausal women, and addresses men age 50 and older for the first time.

Osteoporosis is a major public health problem that has both a medical and economic impact in the U.S. Fractures caused by either osteoporosis or low bone mass can lead to chronic pain, disability and even death, as well as psychological symptoms, including depression. Each year broken bones due to low bone mass or osteoporosis cause over 432,000 hospital admissions, almost 2.5 million medical office visits and about 180,000 nursing home admissions.

"NOF's new Clinician's Guide dramatically alters the approach to assessing fracture risk and treatment," said Bess Dawson-Hughes, M.D., chair of the Clinician's Guide Development Committee and past president of NOF. "The Guide provides evidenced-based recommendations to help healthcare providers better identify people at high risk for developing osteoporosis and fractures and assures that those at highest risk are recommended for treatment to lower that risk."

The new Clinician's Guide applies the recently released algorithm on absolute fracture risk called FRAX® by the World Health Organization (WHO). FRAX® is also referred to as a 10-year fracture risk model and 10-year fracture probability. This algorithm estimates the likelihood of a person to break a bone due to low bone mass or osteoporosis over a period of 10 years.

Absolute fracture risk methodology provides a markedly improved method to assure that people with the highest fracture risk get treated. Those at highest risk include postmenopausal women and older men with a diagnosis of osteoporosis, based on a BMD test T-score of -2.5 or lower, or those with a clinical diagnosis based on having sustained a hip or spine fracture. In addition, absolute fracture risk calculations help to resolve many of the questions about management for people with low bone mass, also called osteopenia. These are people with a T-score between -1.0 and -2.5 on their bone mineral density (BMD) test.

The WHO algorithm takes into account not only bone mineral density (BMD) at the hip but also nine specific clinical risk factors for osteoporosis and related fractures. NOF has adapted this algorithm for the U.S. and incorporates not only fracture outcome and mortality data from U.S. women and men, but also cost effectiveness analysis to determine when it is cost effective to treat a person with an osteoporosis medication to prevent a fracture.

"In developing the new Clinician's Guide, NOF is providing healthcare professionals in the U.S. with the newest advances for diagnosing and managing osteoporosis," said Ethel Siris, M.D., president of the National Osteoporosis Foundation. "To be able to better identify and treat those patients at risk for osteoporosis and costly fractures will have a positive impact on the medical, emotional and economic burden that osteoporosis bears on this country."

In the near future, some central DXA (dual-energy x-ray absorptiometry) machines that test the bone mineral density of the hip and spine should be able to provide a report that gives information on a person's absolute fracture risk by incorporating the NOF application of the WHO algorithm into the bone density machine's computer. Alternatively, clinicians can also enter a patient's bone mineral density hip T-score and other risk factor information in a simple web-based version of the algorithm in the doctor's office to obtain absolute fracture risk in seconds. The information about absolute fracture risk will help both healthcare providers and patients decide whether treatment with an osteoporosis medication is needed.

The new Clinician's Guide also provides recommendations for clinicians on when to do bone mineral density testing, clinical evaluation, risk factors for falls and universal recommendations for the prevention of osteoporosis. NOF summarizes the universal recommendations in its 5 Steps to Bone Health. These 5 Steps advise people to:

1. Get the daily recommended amounts of calcium and vitamin D.
2. Engage in regular weight-bearing and muscle-strengthening exercise.
3. Avoid smoking and excessive alcohol.
4. Talk to your healthcare provider about bone health.
5. Have a bone density test and take medication when appropriate.

The new Clinician's Guide recommends that adults over age 50 get 1,200 mg of calcium and 800-1,000 IU of vitamin D_3 daily. Vitamin D_3 is the form of vitamin D that best supports bone health. It is also called cholecalciferol.

View the guidelines online at:
www.nof.org/professionals/Clinicians_Guide.htm

Women's Health Headlines

Carolyn Aoyama, HQE

New Research Indicates That Significant Numbers Of Children As Young As 11 Are Engaging In Sexual Activity And That Dating Violence And Abuse Are Part Of Their Relationships

A new survey reports today that a surprising number of young adolescents are experiencing significant levels of dating violence and abuse. One in five children between the ages of 13 and 14 (20%) say their friends are victims of dating violence and nearly half of all tweens in relationships say they know friends who are verbally abused. Alarmingly, 40% of the youngest tweens, those between the ages of 11 and 12, report that their friends are victims of verbal abuse in relationships and nearly 1 in 10 (9%) say their friends have had sex.

Liz Claiborne Inc. and loveisrespect.org, National Teen Dating Abuse Helpline, commissioned the survey on Tween and Teen dating relationships that was conducted by Teenage Research Unlimited (TRU) to explore how relationships among young adolescents are fueling high levels of dating violence and abuse.

This very interesting study of "tween" dating violence and abuse highlights the need to start DV/SA screening at around age 11. View the results of the study at:
www.loveisnotabuse.com/pdf/Tween%20and%20Teen%20Dating%20Abuse%20Survey.pdf

The "Love is Not Abuse" website can be found at:
www.loveisnotabuse.com

What Every Parent Needs to Know About... Inhalant Abuse

One out of every five teens in America has used inhalants to get high—and inhalant abuse can begin at a very young age. The Partnership for a Drug-Free America created this special section to help parents seeking specific information, guidance and resources about inhalants.
www.drugfree.org/Parent/Resources/Parents_Guide_to_Inhalants_Prevention

OB/GYN CCC Editorial comment:

(Screening and Surveillance…, continued from page 1)

AI/AN peoples are more likely to be diagnosed with advanced stage disease

I would like to thank Dr. Hope Baluh, the IHS Chief Clinical Consultant for Surgery, for reviewing the current recommendations for colonoscopy screening and the appropriate intervals for follow-up of polyps and other high-risk conditions. Colon cancer screening guidelines are only one example of the guidelines available online at http://www.guidelines.gov/. At this website it is possible to view and download a wide range of guidelines as well as to make comparisons between recommendations from several organizations.

The overall incidence of colon cancer for American Indians and Alaska Natives (AI/AN) is declining as is the trend nationally for the general population. However AI/AN peoples are more likely to be diagnosed with advanced stage disease and there are wide disparities in access to care. For example the prevalence of endoscopy services for Native Americans in the Southwest has been half that of those available to non-Hispanic whites.1 Efforts are underway at many health care sites to improve these screening rates.

For those of us whose focus is women's health care, it is also worthwhile to review the recent Committee Opinion of the American College of Obstetricians and Gynecologists. In this document, ACOG now recommends colonoscopy as the preferred method of colon cancer screening.2

1 Espey DK, Wu XC, Swan J, et al, Annual report to the nation on the status of cancer, 1975-2004, featuring cancer in American Indians and Alaska Natives. Cancer. 2007 Nov 15;110(10):2119-52.

2 American College of Obstetricians and Gynecologists. Colonoscopy and Colorectal Cancer Screening and Prevention. ACOG Committee Opinion No. 384. Obstet Gynecol 2007;110:1199-1202.

Chronic Illness

Diabetes and Depression Linked

DESIGN, SETTING, AND PARTICIPANTS: Multi-Ethnic Study of Atherosclerosis, a longitudinal, ethnically diverse cohort study of US men and women aged 45 to 84 years enrolled in 2000–2002 and followed up until 2004–2005.

CONCLUSIONS: A modest association of baseline depressive symptoms with incident type 2 diabetes existed that was partially explained by lifestyle factors. Impaired fasting glucose and untreated type 2 diabetes were inversely associated with incident depressive symptoms, whereas treated type 2 diabetes showed a positive association with depressive symptoms. These associations were not substantively affected by adjustment for potential confounding or mediating factors.

Golden SH, et al., Examining a bidirectional association between depressive symptoms and diabetes. JAMA. 2008 Jun 18;299(23):2751-9

(CCC Editorial Note…, continued from page 6)

Opinions. One great example is that Dr. Waxman developed, and continues to direct, the IHS Colposcopy Courses. This program emphasizes training primary care providers in advanced cervical cancer screening techniques. Ultimately, those primary care staff who participate in the IHS Colposcopy Courses can work toward providing colposcopy at their home service unit.

Dr. Waxman had worked in IHS 1976–2000, primarily at Gallup Indian Medical Center, but with two very rewarding years at the Alaska Native Medical Center. Alan had been the OB/GYN Chief Clinical Consultant for the Navajo Area IHS 1980-2000. Dr. Waxman is currently on the faculty of the University of New Mexico, Department of Obstetrics and Gynecology and is a Consultant to the ACOG Committee on American Indian Affairs.

Dr. Neil Murphy served as OB/GYN CCC from 2000 to 2008. As Drs. Haffner and Waxman had done most the 'heavy lifting' already, Dr. Murphy choose to increase access to evidence based information and improve communication in the widespread Indian Health system.

In 2000 Dr. Murphy began to create the MCH suite of websites that offers up to the moment evidence based resources to all tribal and Indian Health staff and patients. The MCH complex of websites, which now contains hundreds of pages and thousands of subpages, includes online continuing medical education modules, a monthly online newsletter, hundreds of frequently asked questions, and a wide variety of MCH specific content. The MCH site also serves as a portal for easy access to UpToDate, the Indian Health virtual online library, and the ACOG Postgraduate Course Reference text, to name a few others. In 2004 the monthly online newsletter added a printed version to increase access for staff without easy Internet access and for those whom a printed newsletter was more easily utilized in the moments between patients or while on the move.

Dr. Murphy initiated several listserv(s) to increase communication including the Primary Care Discussion Forum for more in depth discussion which was then posted online for others to benefit from. Dr. Murphy also transformed the biennial clinicians meeting from a small primarily business meeting of department chiefs to a large educational conference to include all the major stakeholders in Native Women's Health. This meeting now regularly features internationally known speakers and in 2009 it will be held in conjunction with the international Native Child Health meeting to increase communication across borders on areas of joint clinical relevance.

Dr. Murphy remains a staff physician at Alaska Native Medical Center and continues to coordinate the Indian Health MCH web based resources.

Haffner Native Women's Health Award

Another example of the unique value of the OB/GYN CCC role is the William H.J. Haffner American Indian/Alaska Native Women's Health Award. The ACOG Committee on American Indian Affairs is raising money for a new award that would recognize an individual who has made a major contribution to improving the health care of American Indians / Alaska Natives.

The William H.J. Haffner American Indian/Alaska Native Women's Health Award is named after Dr. Haffner (see above) who has been involved with ACOG's Indian health programs since their inception. To learn more about the Haffner Award Fund, please contact Yvonne Malloy at YMalloy@acog.org.

Jean Howe welcomes your thoughts and input

Dr. Howe is very interested in establishing a dialogue and/or networking with anyone involved in women's health or maternal child health, especially as it applies to Native or indigenous peoples around the world. Please don't hesitate to contact her by e-mail at Jean.Howe@ihs.gov or by phone at 928-674-7422.

(Hot Topics…, continued from page 5)

Chronic disease and illness

Prevalence and Correlates of Subclinical Atherosclerosis in Alaska Eskimos. The GOCADAN Study

BACKGROUND AND PURPOSE: The recent increase in clinical cardiovascular disease in Alaska Eskimos suggests that changes in traditional lifestyle may have adverse public health consequences. This study examines the prevalence of subclinical vascular disease and its relation to risk factors in Alaska Eskimos.

METHODS: Participants in the population-based Genetics of Coronary Artery Disease in Alaska Natives (GOCADAN) Study underwent evaluation of cardiovascular disease risk factors and carotid ultrasound. Outcome variables were carotid intimal-medial thickness and presence and extent of atherosclerosis.

RESULTS: In multivariate analyses, intimal-medial thickness and presence and extent of atherosclerosis were all associated with traditional cardiovascular disease risk factors but not dietary intake of omega-3 fatty acids. Rates of carotid atherosclerosis were higher than those reported in 2 large population-based US studies.

CONCLUSIONS: Alaska Eskimos have similar traditional risk factors for carotid atherosclerosis as other ethnic and racial populations but have higher prevalences of atherosclerosis, possibly attributable to higher rates of smoking.

Cutchins A, Roman MJ, Devereux RB, Ebbesson SO, Umans JG, Zhu J, Weissman NJ, Howard BV. Prevalence and Correlates of Subclinical Atherosclerosis in Alaska Eskimos. The GOCADAN Study. Stroke. 2008 Jul 10.

(IHS CHN…, continued from page 15)

to administration of the wrong vaccine for the first dose in these populations. For these reasons, CDC recommends that providers who currently use PRP-OMP-containing Hib vaccines (PedvaxHIB and Comvax) to serve predominantly AI/AN children in AI/AN communities continue to stock and use only PRP-OMP-containing Hib vaccines not affected by the recall and vaccinate according to the routinely recommended schedules, including the 12–15 month booster dose. In its vaccine stockpile, CDC has PRP-OMP-containing Hib vaccines not affected by the recall and will prioritize distribution of available PRP-OMP vaccines for use in AI/AN communities. AI/AN children not in AI/AN communities or who already receive PRP-TT conjugate vaccines should continue to be vaccinated with available vaccines according to the routinely recommended schedules, including the 12–15 month booster dose.

Recent literature on American Indian/Alaskan Native Health

Michael L. Bartholomew, MD

Brim SN, Rudd RA, Funk RH, Callahan DB. Asthma prevalence among US children in underrepresented minority populations: American Indian/Alaska Native, Chinese, Filipino, and Asian Indian. Pediatrics. 2008 Jul;122(1):e217-22.

Asthma continues to be a prevalent childhood disease in the United States. Recent studies estimate that 8.9% of US children ages 0 to 17 years of age have asthmar. Asthma prevalence among Asian Americans, specifically subgroups of Asian Americans, and American Indians and Alaska Natives (AI/AN) has largely been unknown.

Anecdotal reports of the 1960's and 1970's suggested that asthma in American Indians was rare2. In the 1990s, Clark et al showed that asthma was more prevalent than once believed when he documented the asthma burden in Jemez Indian childhood population3. Between 2004-2005, the prevalence of asthma in AI/AN children was estimated to be 9.9%1.

Many recent studies defining asthma prevalence rates among children have yielded varied results in regards to age, race, socioeconomic and ethnic backgrounds. Due to small sample sizes in large scale studies, the national prevalence of diseases has thus far been difficult to determine for certain ethnic groups or subgroups.

Estimates of current asthma prevalence according to race and place of birth ranged from 4.4% for Asian Indian children to 13.3% in black children. AI/AN children had an asthma prevalence of 13.0%, while Filipino and Chinese children had a prevalence of 10.7% and 5.1%, respectively. White children had a current asthma prevalence of 8.4%.

Lifetime asthma prevalence estimates among races showed a similar trend. The lifetime prevalence among the races ranged from 9% in Chinese children to 18.1% for black children. The lifetime asthma prevalence estimates for AI/AN children was 18 % and for Asian Indian and Filipino was 9.4% and 15.7% respectively. A high prevalence of current and lifetime asthma was noted in children born in the United States than in children born outside the United States (Current asthma: 9.4% vs. 4.3%; Lifetime asthma: 13.6% vs. 7.3%). The prevalence of asthma attack in the past 12 months did not vary among races or place of birth.

After controlling for place of birth, gender, age, ethnicity, region, household income, and health insurance coverage, AI/AN children are 1.82 times likely to report having asthma than their White counterparts. Black children are 1.57 times likely while Filipino children are 1.64 times likely. Additionally, children born inside the United States were twice as likely to report having asthma as children born outside the United States.

This study is not without limitations. The authors cite small sample sizes of the study populations to be problematic, requiring aggregate data of 5 years to provide limited statistical power. There is also the potential for selection bias since the survey was administered in either the English or Spanish language. Lastly, additional risk factors (BMI and environmental tobacco smoke exposure) for asthma were not analyzed due to lack of inclusion in the survey model. Despite these limitations, the authors concluded that the results support previous assertions that certain ethnicities including black, AI/AN, and Filipino children as well as those born in the United States tend to have a disproportionately higher prevalence of asthma.

Reference:

1. *Akinbami L; Centers for Disease Control and Prevention, National Center for Health Statistics. The state of childhood asthma, United States, 1980-2005. Adv Data. 2006;(381):1-24.*

2. *Galloway JM, Goldberg BW, Alpert JS. 1999. Primary Care of Native American Patients: Diagnosis, Therapy, and Epidemiology. Boston: Butterworth-Heinemann*

3. *Clark D, Gollub R, Green WF, Harvey N, Murphy SJ, Samet JM. Asthma in Jemez Pueblo schoolchildren. Am J Respir Crit Care Med. 1995 May;151(5):1625-7.*

AFP American Family Physician

The mirror lies: body dysmorphic disorder

Body dysmorphic disorder is an increasingly recognized somatoform disorder, clinically distinct from obsessive-compulsive disorder, eating disorders, and depression. Patients with body dysmorphic disorder are preoccupied with an imagined deficit in the appearance of one or more body parts, causing clinically significant stress, impairment, and dysfunction. The preoccupation is not explained by any other psychiatric disorder. Patients present to family physicians for primary care reasons and aesthetic or cosmetic procedures. Cosmetic correction of perceived physical deficits is rarely an effective treatment. Pharmacologic treatment with selective serotonin reuptake inhibitors and nonpharmacologic treatment with cognitive behavior therapy are effective. Body dysmorphic disorder is not uncommon, but is often misdiagnosed. Recognition and treatment are important because this disorder can lead to disability, depression, and suicide.

Hunt TJ, Thienhaus O, Ellwood A. The mirror lies: body dysmorphic disorder. Am Fam Physician. 2008;78(2):217-222, 223-224.

Save the dates

Sexual Assault Nurse Examiner/Forensic Examiner (SANE/SAFE) Training Course

- August 18–22, 2008
- Oklahoma City, Oklahoma
- 40 hour didactic portion of SANE/SAFE training
- For additional information contact Lisa Palucci, **lisa.palucci@ihs.gov**, at the IHS Clinical Support Center

Postgraduate Course on Obstetric, Neonatal and Gynecologic Care

- September 14–18, 2008
- Salt Lake City, Utah
- Comprehensive Women's Health Update for Nurses, Advanced Practice Nurses, and Physicians
- NRP offered as pre-conference session
- Contact Yvonne Malloy, **ymalloy@acog.org**, for more information

International Indigenous Women's and Children's Health Meeting

- March 4–8, 2009
- Albuquerque, New Mexico
- Joint conference of Women's Health and Children's Health Providers from Canada and the United States

Abstract of the Month

- Colorectal Cancer Screening and Surveillance

IHS Child Health

- Blood Lead Screening in American Indian/Alaska Native Children
- Infectious Disease Updates—Pentacel®: A new Vaccine not Suitable For American Indian/Alaska Native Infants

From Your Colleagues

- David Gahn, MD—Afghanistan Update
- Elaine Locke and Yvonne Malloy—ACOG/IHS Postgraduate Course on Obstetric, Neonatal and Gynecologic Care
- September 14-18, 2008; Salt Lake City, Utah

Hot Topics

- Obstetrics—Improving neonatal outcome: practical shoulder dystocia training
- Gynecology—Comparison of the treatment outcome of pubovaginal sling, tension-free vaginal tape, and transobturator tape for stress urinary incontinence with intrinsic sphincter deficiency
- Child Health—Universal newborn hearing screening: systematic review to update the 2001 US Preventive Services Task Force Recommendation
- Children at High Risk Should Be Screened for Elevated Cholesterol

CCC Editorial Note

- Welcome Jean Howe, MD, MPH—The new OB/GYN Chief Clinical Consultant
- What does an OB/GYN Chief Clinical Consultant really do?
- What have OB/GYN Senior Clinicians/Chief Clinical Consultant done over the years?

Features

- ACOG—ACOG Practice Bulletin #95 Anemia in Pregnancy
- Ask a Librarian—Health Services Research Library (HSRL)-a branch of the National Institutes of Health Library
- Behavioral Health Insights—Conference Information/OBOT (Buprenorphine) Certification Training
- Breastfeeding—The Case of the Dwindling Milk Supply

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