OB/GYN & PEDIATRICS
CCC CORNER
Maternal Child Health for American Indians & Alaska Natives

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Have you had your 'morning after' antiretroviral cocktail yet?

When highly active antiretroviral therapy (HAART) is prescribed within 48 to 72 hours of nonoccupational exposure to HIV and continued for 28 days, the likelihood of transmission may be reduced. The earlier the nonoccupational postexposure prophylaxis (nPEP) is administered, the higher the chance that it will interrupt transmission.

Recent data from human and animal studies, case reports, and documentation of the use of nonoccupational postexposure prophylaxis prompted the U.S. Department of Health and Human Services to update its recommendation for the use of nonoccupational postexposure prophylaxis in patients who seek treatment within 72 hours of high-risk exposure to a person known to be HIV positive.

No specific antiretroviral medication or combination is optimal for nonoccupational postexposure prophylaxis. However, preferred regimens include efavirenz and lamivudine or emtricitabine with zidovudine or tenofovir (as a nonnucleoside-based regimen) and lopinavir and ritonavir (co-formulated in one tablet) and zidovudine with either lamivudine or emtricitabine. No evidence suggests that a three-drug HAART regimen is more effective than a two-drug regimen. When the source person is available for interview, his or her medication history and most recent viral load measurement should be considered when choosing medications for nonoccupational postexposure prophylaxis. This could help prevent prescription of medications to which the virus is already resistant.

All patients seeking treatment after HIV exposure should be tested for antibodies at baseline, four to six weeks, three months, and six months. Patients should be informed about the signs and symptoms of acute retroviral infection and should be asked to return for evaluation if these occur. Physicians who provide nonoccupational postexposure prophylaxis also should monitor patients' liver function, renal function, and hematologic parameters.

When a patient's risk of transmission from contact is small or when more than 72 hours have passed since exposure, nonoccupational postexposure prophylaxis is not recommended. However, when a patient seeks treatment more than 72 hours after exposure, but the risk of virus transmission is severe, physicians may decide that the potential benefit of nonoccupational postexposure prophylaxis is greater than the potential risk of complications from antiretroviral therapy.

HIV Status of Source

Patients who have had sexual, injection-drug--use, or other nonoccupational exposures to potentially infectious fluids of persons known to be HIV infected are at risk for acquiring HIV infection and should be considered for nPEP if they seek treatment within 72 hours of exposure. If possible, source persons should be interviewed to determine his or her history of antiretroviral use and most recent viral load because this information might provide information for the choice of nPEP medications.

Persons with exposures to potentially infectious fluids of persons of unknown HIV status might or might not be at risk for acquiring HIV

(continued on page 14)

THIS MONTH

Also on line....

This publication is a digest of the monthly Obstetrics and Gynecology Chief Clinical Consultant's Newsletter which is available on the Internet at **www.ihs.gov/MedicalPrograms/MCH/M/OBGYN01.cfm**
You are welcome to subscribe to the listserv and receive reminders about this service. If you have any questions, please contact me at **nmurphy@scf.cc**.

I am looking forward to hearing from you.

Neil J. Murphy

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

IHS Child Health Notes

June 2005

"It doesn't matter if the cat is black or white as long as it catches mice."
—Deng Hsaio P'ing 1904-1997

Articles of Interest

Lower respiratory tract infections among American Indian and Alaska Native children and the general population of U.S. Children.

Pediatr Infect Dis J. 2005 Apr;24(4):342-51.

Editorial Comment

Lower respiratory tract infections (LRTIs) account for almost 75% of the infectious disease hospitalizations in American Indian and Alaska Native (AI/AN) infants and children. Several studies in the 1990s demonstrated that the hospitalization rate for bronchiolitis was much higher in AI/AN children than in the US as a whole.

This study looked at the burden of disease for all LRTI including ICD-9 codes for bronchitis, bronchiolitis, pneumonia, pertussis and influenza. The rates of disease among AI/AN were much higher with hospitalizations being twice as high in AI/AN children and the outpatient visit rate was three times higher than that of US children. Infants had particularly high rates of LRTIs. The authors point out that the highest disease burden occurs in Alaska and in the Southwest.

The authors discuss potential strategies to reduce this health disparity for AI/AN infants and children

Recent literature on American Indian/ Alaskan Native Health

Disparities in indigenous health: a cross-country comparison between New Zealand and the United States.

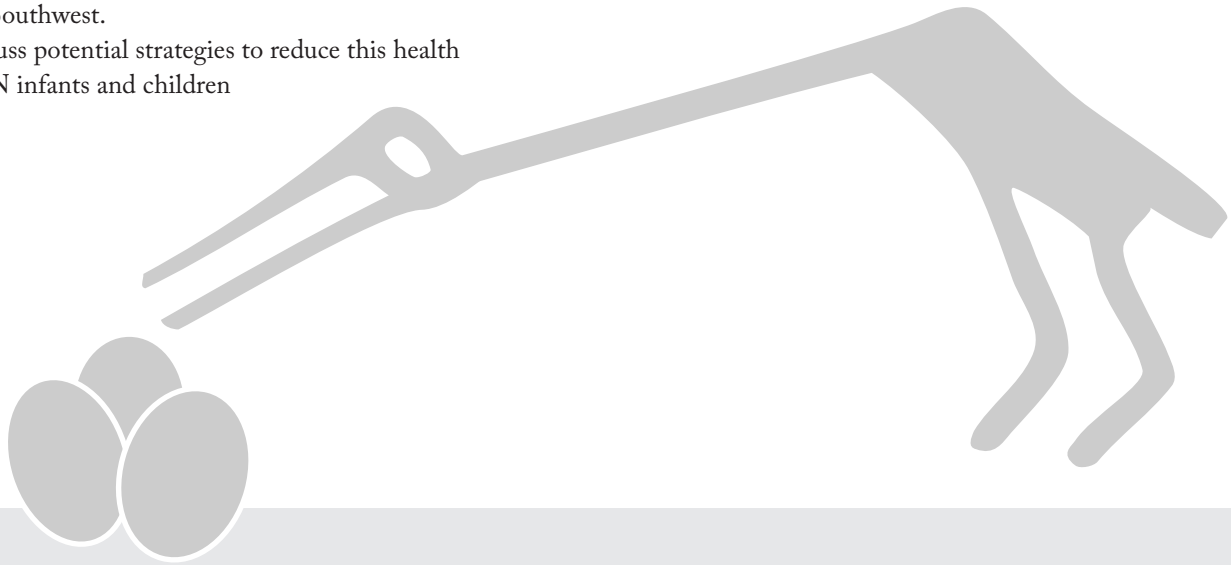
Am J Public Health. 2005 May;95(5):844-50.

- Indigenous people in both the US and New Zealand face significant health disparities compared to the dominant population
- In nearly all indicators of health status the Maori fared more poorly than AI/AN
- For AI/AN the only measured health indicator in which there was no disparity was in immunizations

Measuring the health status gap for American Indians/ Alaska natives: getting closer to the truth.

Am J Public Health. 2005 May;95(5):838-43.

- Health disparities remain for AI/AN
- This entire issue of the American Journal of Public Health is devoted to problems of AI/AN health disparities and is worth reading.



Meetings of Interest

Annual ACOG/IHS course on Obstetric, Neonatal and Gynecologic care

This outstanding course focuses on practical approaches to the recognition, management, consultation, and referral of American Indian and Alaska Native women and infants. Led by an excellent faculty this course provides a great overview of women's health to new providers and nurses, or a review and update for experienced providers.

Logistics

The course will be held 6/19-23 in Denver, CO.
Web site (go to url and then scroll down to June 19 – 23)
www.ihs.gov/MedicalPrograms/MCH/M/CN01.cfm#June05

Contact Yvonne Malloy at 202-863-2580 to register or to obtain more information.
YMalloy@acog.org

From Your Colleagues

Tammy Brown, National Diabetes Program, ABQ

Seeking Recipes Using Traditional Foods

The IHS Diabetes Treatment and Prevention Division is looking for healthy, low-cost, and easy-to-prepare recipes that use traditional foods. The recipes are needed for a recipe book we are developing as part of an obesity/diabetes prevention toolkit for parents of adolescent girls that emphasizes healthy eating and regular physical activity.

We would appreciate, if available, nutritional content for recipes submitted. However, if you do not have this information, our staff will conduct a nutritional analysis for recipes that will be included in the toolkit. We can later provide you with the analysis of any of your recipes that are selected for the cookbook. Please send all recipes to tammy.brown@ihs.gov

If you would like the source for the recipes credited, please provide that information too. Thanks for your help

Zelda Collett-Paule, Anchorage

Why Prozac is OK during pregnancy and not for breastfeeding…. and why Zoloft is

Prozac use during pregnancy has been well-studied, and many new mothers are already taking it at delivery. Its use during breast-feeding is controversial, however. Fluoxetine's long half-life and potential for accumulation in breast milk has prompted some recommendations to avoid its use in women who are breast-feeding young infants.

Sertraline (Zoloft) is likely to be the safest choice among the SSRI's because it has been studied extensively and because drug levels found in nursing infants are usually minimal.

Spencer JP, Gonzalez LS 3rd, Barnhart DJ. Medications in the breast-feeding mother. Am Fam Physician. 2001 Jul 1;64(1):119-26.

Ruddock B. Antidepressant Use and Breastfeeding – Focus on Patient Care. CPJ / RPC 2004 October Vol. 137, No. 8:39-41

George Gilson, Anchorage

Is Gestational Diabetes Mellitus Just a Diagnosis Waiting for a Disease?

No, there is recent evidence from this blinded matched control study that shows untreated gestational diabetes mellitus carries significant risks for perinatal morbidity in all disease severity levels. Timely and effective treatment may substantially improve outcome.

Langer O, Yogev Y, Most O, Xenakis EM. Gestational diabetes: the consequences of not treating. Am J Obstet Gynecol. 2005 Apr;192(4):989-97.

OB/GYN CCC Editorial comment:

In Hunter's 1985 letter he raised the issue of whether "Gestational diabetes is a diagnosis still looking for a disease". Two recent articles show that glucose intolerance in pregnancy is in fact associated with perinatal and neonatal morbidity.

In the blinded study above reported by Langer et al which showed untreated gestational diabetes mellitus carried significant risks for perinatal morbidity in all disease severity levels. In addition, Saydah et al found similar results from a large nationally representative survey data. Saydah et al findings confirm that pregnancies in women with GDM are more likely to be associated with maternal medical complications compared with pregnancies in women without diabetes.

Saydah SH, Chandra A, Eberhardt MS. Pregnancy experience among women with and without gestational diabetes in the U.S., 1995 National Survey of Family Growth. Diabetes Care. 2005 May;28(5):1035-40.

Hunter DJ, Milner R. Gestational diabetes and birth trauma. [letter] Am J Obstet Gynecol. 1985 Aug 1;152(7 Pt 1):918-9.

Use of Prescription Drugs During Pregnancy

Almost one half of the women in this study received medications that have no evidence of safety during pregnancy or for which evidence shows a risk to the fetus in animals or humans. They add that these results indicate the need to develop and implement systems that eliminate the exposure of pregnant women to these medications. CONCLUSION: Our finding that almost one half of all pregnant women received prescription drugs from categories C, D, or X of the United States Food and Drug Administration risk classification system highlights the importance of the need to understand the effects of these medications on the developing fetus and on the pregnant woman.

Andrade SE, et al. Prescription drug use in pregnancy. Am J Obstet Gynecol August 2004;191:398-407.

Hot Topics

Obstetrics

Slight delay in umbilical cord clamping better for Preterm infants

Cochrane for Clinicians: Putting Evidence into Practice

CLINICAL QUESTION

What is the optimal time to clamp the umbilical cord for infants born at less than 37 weeks' gestation?

EVIDENCE-BASED ANSWER

In preterm infants, clamping the umbilical cord between 30 seconds and two minutes after delivery is associated with lower rates of blood transfusion and intraventricular hemorrhage.

REVIEWERS' CONCLUSIONS

Delaying cord clamping by 30 to 120 seconds, rather than early clamping, seems to be associated with less need for transfusion and less intraventricular haemorrhage. There are no clear differences in other outcomes.

Rabe H, et al. Early versus delayed umbilical cord clamping in preterm infants. Cochrane Database Syst Rev 2004;(3):CD003248

Public versus Private Umbilical Cord Blood Banking: Editorial Green Journal

An individual's chance of using the blood is low.

The possibility of a child's needing hematopoietic stem cell transplantation is low. Best estimates suggest the risk is 1 in 2,700 and the risk advanced by private companies, which one might expect to present the "best case" for cord blood need, is 1 in 1,400 Indeed, the literature reports few cases of an individual's receiving back his or her own banked cord blood, and industry publications, which one might expect would be eager to promote such cases, cite no more. Further, of reported cases, some involve families whose histories suggested the potential need for stem cell therapy before delivery and collection.

PUBLIC SETTING BEST AT THIS TIME

In sum, our arguments are not about the potential of umbilical cord stem cells, but are about the setting and system where that potential is best realized. We argue for public umbilical cord blood banking as a matter of good public health and economic sense. We foresee a day in which most patients will volunteer their cord blood to such banks. Those who do so will value real public benefits against the, sometimes, exaggerated claims of individual benefit advanced by private cord blood banks. We prefer, as a matter of public health and policy, to rely on public institutions to manage such a valuable resource as umbilical cord blood and trust that the integrity of these institutions and their obligation to the public will insure the future safety and availability of banked samples.

Although we offer this vision, we cannot predict the future. Some private banks suggest that, in the future, stem cells and cord blood may be used to treat a host of other diseases, such as diabetes or Alzheimer's, in which specific cell lines are depleted or dysfunctional. For now, however, such potentials are, at best, hypothetical and, at worst, exaggerated claims designed to attract business. Time may prove that umbilical cord stem cells have compelling benefits to the individual, but for now the available evidence argues for the promotion of public rather than private cord blood banking.

Ecker JL, Greene MF. The case against private umbilical cord blood banking. Obstet Gynecol. 2005 Jun;105(6):1282-4.

IV bolus of 1,000 mL, lateral positioning, and oxygen administration at 10 L/min via nonrebreather face mask significantly increase fetal oxygen saturation during labor.

CONCLUSION: An intravenous fluid bolus of 1,000 mL, lateral positioning, and O(2) administration at 10 L/min via nonrebreather face mask are effective in increasing FSpO(2) during labor. LEVEL OF EVIDENCE: II-2.

Simpson KR, James DC. Efficacy of intrauterine resuscitation techniques in improving fetal oxygen status during labor. Obstet Gynecol. 2005 Jun;105(6):1362-8

A systematic literature review indicated that laser ablation produced better survival for at least 1 twin and lower long-term neurodevelopment morbidity in survivors.

CONCLUSION: In a systematic review of observational and randomized controlled studies, laser photocoagulation of chorionic plate vessels at the intertwin membrane seems to be more effective than serial amnioreduction in the treatment of twin-twin transfusion syndrome with less associated perinatal morbidity and mortality. However, septostomy and selective feticide have not been robustly evaluated.

Fox C, Kilby MD, Khan KS.Contemporary treatments for twin-twin transfusion syndrome. stet Gynecol. 2005 Jun;105(6):1469-77.

Gynecology

More effective than povidone iodine in vaginal hysterectomy: Chlorhexidine gluconate

CONCLUSION: Chlorhexidine gluconate was more effective than povidone iodine in decreasing the bacterial colony counts that were found in the operative field for vaginal hysterectomy.

Although bacterial contamination may have a greater level of reduction in the chlorhexidine group, this does not guarantee a difference in postoperative infection. Among the 50 patients enrolled in this study, none of them were noted to have a postoperative infection. The authors also commented that if they were to structure the study to look at postoperative infections, they would have to enroll 814 patients in each arm to achieve a 50% reduction. Similar but larger studies may be helpful to assess whether chlorhexidine prep should become the standard prep for vaginal hysterectomies.

(Hot Topics continued on page 5)

(Hot Topics continued from page 4)

Culligan PJ et al A randomized trial that compared povidone iodine and chlorhexidine as antiseptics for vaginal hysterectomy. Am J Obstet Gynecol. 2005 Feb;192(2):422-5

Transdermal contraceptive promising for reducing bleeding and delaying menses

CONCLUSION: Compared with cyclic use, extended use of the norelgestromin/ethinyl E2 transdermal patch delayed menses and resulted in fewer bleeding days. This regimen may represent a useful alternative for women who prefer fewer episodes of withdrawal bleeding. LEVEL OF EVIDENCE: I.

Stewart FH, et al Extended Use of Transdermal Norelgestromin/Ethinyl Estradiol: A Randomized Trial. Obstet Gynecol. 2005 Jun;105(6):1389-1396

Sexual functioning / quality-of-life similar in RCT of supracervical hysterectomy

CONCLUSION: Supracervical and total abdominal hysterectomy result in similar sexual functioning and health-related quality of life during 2 years of follow-up. This information can help guide physicians as they discuss surgical options with their patients. LEVEL OF EVIDENCE: I

Kuppermann M et al Sexual Functioning After Total Compared With Supracervical Hysterectomy: A Randomized Trial. Obstet Gynecol. 2005 Jun;105(6):1309-1318.

Uterine Fibroid Embolization - Patient Education

"Known medically as uterine artery embolization, this approach to the treatment of fibroids blocks the arteries that supply blood to the fibroids causing them to shrink. It is a minimally-invasive procedure, which means it requires only a tiny nick in the skin, and is performed while the patient is conscious but sedated /drowsy and feeling no pain...." From Society of Interventional Radiology

Recurrent vulvar itching. Green Journal "In the Trenches"

This month's "In the Trenches" uses a practical question-based case series to assess the evaluation and management of a woman with vulvar itching thought to be due to recurrent vulvovaginitis.

Boardman LA, Botte J, Kennedy CM. Recurrent vulvar itching. Obstet Gynecol. 2005 Jun;105(6):1451-5.

Child Health

Risk of Autism: Parent, Pregnancy, and Birth Factors Found Possible Associations

Pregnancy factors, parental psychiatric history, and preterm delivery may be associated with the risk of autism. Some of the specific factors that the study found to be associated with the risk of autism included: breech presentation at birth, delivery before 35 weeks, a parent who had a diagnosis of schizophrenia-like psychosis before the date that autism was diagnosed in the child, and low birth weight at delivery. The study also found many of these factors were independently associated with autism. For example, there was an association between adverse pregnancy events and autism, regardless of whether one of the parents had a diagnosed psychiatric illness.

Chronic disease and Illness

Women with pregnancy-induced hypertension: Increased risk of metabolic syndrome later

CONCLUSION: In white women in their mid-30s, the prevalence of the metabolic syndrome is 3- to 5-fold increased in those with a history of PIH in their first pregnancy. This emphasizes the importance of long-term follow-up assessment for cardiovascular risk factors in these women. LEVEL OF EVIDENCE: II-2.

Forest JC, et al Early occurrence of metabolic syndrome after hypertension in pregnancy. Obstet Gynecol. 2005 Jun;105(6):1373-80.

American Cancer Society Releases Guidelines for the Early Detection of Cancer

Recommendations

BREAST CANCER SCREENING: Breast cancer screening should begin when women are 20 years of age and should consist of clinical breast examinations, counseling to raise awareness of symptoms, and regular mammography after the age of 39. Clinical breast examinations should take place every three years in women 20 through 39 years of age and annually in women 40 years and older. Women at average risk should begin annual mammography at the age of 40 and should continue the practice as long as they are in good health and would be candidates for breast cancer treatment. The ACS no longer recommends monthly breast self-examinations, but instead recommends that women be informed of the potential limitations, risks, and benefits associated with self-examination. The new guidelines emphasize the physician's role in raising and reinforcing awareness of breast cancer, early detection, and the importance of timely reporting of any symptoms.

CERVICAL CANCER SCREENING: Cervical cancer screening should begin three years after the onset of vaginal intercourse but no later than 21 years of age. Screening should be performed annually until the age of 30 with conventional cervical cytology smears, or every two years until the age of 30 with liquid-based cytology. Women older than 30 years who have had three consecutive normal or negative cytology results may reduce the frequency of screening to every two to three years. Women 70 years and older with an intact cervix may cease cervical cancer screening if they have had three or more consecutive normal or negative cytology results within the 10-year period before the age of 70.

Women with a history of cervical cancer or in utero exposure

(Hot Topics continued on page 13)

Medical Mystery Tour

Follow-up: The Case of the Mystery Question
You may recall that the case involved a severe postpartum hemorrhage in a patient with pre-eclampsia. After a thorough medical and conservative clinical management the house staff were preparing the patient for immediate hysterectomy when the attending physician asked one question.

What is that question?
"Has the patient received her calcium yet?"

The resident staff has done an excellent job of managing the patient's postpartum hemorrhage, but prior to surgical intervention it is very reasonable to attempt short term reversal of the patient's prophylactic magnesium sulfate. The risk of postpartum hemorrhage, possibly related to uterine atony from magnesium's tocolytic effects, has been noted in one trial (Belfort et al).

Calcium gluconate (1 g intravenously slowly over at 5 to 10 minutes) may be administered to counteract magnesium toxicity, if necessary. As the patient becomes more stable the magnesium can be restarted and the risk of developing an eclamptic seizure in the meantime is small.

Another use for calcium can be to reverse the Magnesium sulfate before starting a Cesarean delivery to decrease intra-operative blood loss. The magnesium sulfate can be re-started 1 hour after surgery.

On a slightly different tangent, there is a synergistic effect of calcium with prostaglandin (Weinstein 1976, Droegemueller 1980) outside the setting of postpartum hemorrhage. Though ineffective in this case, the trial of rectal misoprostol may have been worth the effort.

OB/GYN CCC Editorial
This is a helpful anecdote to manage patients treated with magnesium sulfate, either as pre-operative treatment in the case of cesarean delivery or as in this case, severe postpartum hemorrhage.

Avoid too rapid I.V. administration and avoid extravasation. Use with caution in digitalized patients, severe hyperphosphatemia, respiratory failure or acidosis. May produce cardiac arrest. Hypercalcemia may occur in patients with renal failure, frequent determination of serum calcium is necessary.

Extra credit: Who asked the question?
A hint: This MFM is well know in obstetric circles for his early misspelling of this word,

'H E L P'

The CCC Corner learned about this technique from Louis Weinstein, MD from Thomas Jefferson University, formerly of the University of Arizona, Tucson. Dr. Weinstein was influential in the early delineation of the HELLP syndrome.

If you have other illustrative clinical scenario(s) you would like to share in the Medical Mystery Corner, please contact **nmurphy@scf.cc**

Information Technology

Tribal access to library services

After much research it has been determined that all Tribal programs are eligible to access the new library services through the NIH Library system. Diane Cooper from the NIH Library stated that 'We will have a proxy built to include those not on IHS (HHS) computers so access can be available to all'." At the current time, this proxy is NOT available; however you can still access the library and the librarian services.

Information on these resources is currently available at the IHS Clinical Information Resource Web site/ medical library at: http://hsrl.nihlibrary.nih.gov

Elder Care News

Is your patient with chronic somatic symptoms just depressed?
In this study, as in previous studies, physical symptoms were common among depressed patients. Even though depression initially improved rapidly and continued to improve gradually over nine months, physical symptom improvement plateaued after an initial change for the better. Pain symptoms improved least. These findings suggest that physical symptoms are at least somewhat separate from psychologic symptoms. Targeting these symptoms independently may be helpful, although more studies are needed to determine which interventions are effective.

Greco T, Eckert G, Kroenke K. The outcome of physical symptoms with treatment of depression. J Gen Intern Med. 2004 Aug;19(8):813-8

ACOG

Urinary Incontinence in Women

Practice Bulletin NUMBER 63, JUNE 2005

Summary of Conclusions and Recommendations

The following recommendations are based on good and consistent scientific evidence (Level A):

- Behavioral therapy, including bladder training and prompted voiding, improves symptoms of urge and mixed incontinence and can be recommended as a noninvasive treatment in many women.
- Pelvic floor training appears to be an effective treatment for adult women with stress and mixed incontinence and can be recommended as a noninvasive treatment for many women.
- Pharmacologic agents, especially oxybutynin and tolterodine, may have a small beneficial effect on improving symptoms of detrusor overactivity in women.

The following recommendations are based on limited or inconsistent scientific evidence (Level B):

- Cystometric testing is not required in the routine or basic evaluation of urinary incontinence.
- Bulking agents are a relatively noninvasive method of treatment for stress incontinence and can be used in women for whom any form of operative treatment is contraindicated.
- Long-term data suggest that Burch colposuspension and sling procedures have similar objective cure rates; therefore, selection of treatment should be based on patient characteristics and the surgeon's experience.
- The combination of a hysterectomy and a Burch colposuspension does not result in higher continence rates than a Burch procedure alone.
- Tension-free vaginal tape and open Burch colposuspension have similar success rates.
- Anterior colporrhaphy, needle urethropexy, and paravaginal defect repair have lower cure rates for stress incontinence than Burch colposuspension.

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

- After the basic evaluation of urinary incontinence, simple cystometry is appropriate for detecting abnormalities of detrusor compliance and contractibility, measuring postvoid residual volume, and determining capacity.
- Patients with urinary incontinence should undergo a basic evaluation that includes a history, physical examination, measurement of postvoid residual volume, and urinalysis.

Urinary incontinence in women. ACOG Practice Bulletin No. 63. American College of Obstetricians and Gynecologists. Obstet Gynecol 2005;105:1533–45.

ACOG

Ob-Gyns Address Health Needs of Underserved Women With New Publication:

Special Issues in Women's Health

Special Issues in Women's Health, a unique new book released by The American College of Obstetricians and Gynecologists (ACOG), will help physicians address the health care needs of underserved women, including women with disabilities, incarcerated women, lesbian and bisexual women, and transgendered individuals.

Domestic Violence

McCain introduces safety to Indian Women Act

This legislation creates a new federal criminal offense authorizing federal prosecutors to charge repeat domestic violence offenders before they seriously injure or kill someone and to use tribal court convictions for domestic violence for that purpose. It authorizes the creation of tribal criminal history databases to document these convictions and protection orders for use by all law enforcement. The bill authorizes BIA and tribal officers to make arrests for domestic violence assaults committed outside of their presence and would authorizes a comprehensive study of domestic violence in Indian Country to determine its impact to Indian tribes

Oklahoma Perspective

Greggory Woitte – Hastings Indian Medical Center

West Nile Virus in Women

After moving to Oklahoma, I quickly realized that the summer months were quite warm and humid from the large storms of the early summer. In this warm humid climate, I found that the mosquitoes were quite plentiful. Over the past couple of years, the transmission of West Nile virus has been an equally hot topic when talking about mosquitoes. In spite of my perception of swarms of mosquitoes, only 24 cases of West Nile Virus were confirmed in Oklahoma during 2004. Despite this low number, the CDC encourages clinicians to keep West Nile virus in the differential when dealing with a woman presenting with unexplained fever or neurological illness.

OB/GYN CCC Editorial

Gregg's comments are very helpful because the effects of West Nile (WN) virus during pregnancy are new to all of us. Gregg had previously lived in Illinois, Virginia, and Bethesda, MD, yet in Oklahoma, he had gotten bitten by mosquitoes more frequently. Though Illinois had the largest number of West Nile virus cases while he was in residency, it was unique that Oklahoma did not have the same proportion of West Nile cases according to the CDC. Despite our own swarms of mosquitoes in Alaska, we have been spared West Nile virus to date.

As this illness is new to many of us throughout Indian Country, let us review what is known about West Nile virus in women. First, there is minimal information on the effects of West Nile (WN) virus during pregnancy. Hence, the Centers for Disease Control (CDC) has established a registry to track these pregnancies (call 970-221-6400 to enroll patients).

The CDC also made the following recommendations:

Pregnant women should take precautions to protect themselves from bites from potentially infected mosquitoes (e.g., avoid being outdoors at dawn and dusk, wear protective clothing, use insect repellants containing DEET).

Pregnant women with meningitis, encephalitis, acute flaccid paralysis, or unexplained fever in an area of ongoing WN virus transmission should have serum tested for antibody to WN virus. If laboratory tests indicate recent infection with WN virus, the infection should be reported to the local or state health department, and the woman should be followed to determine the outcome of her pregnancy.

If WN virus infection is diagnosed in pregnancy, care is supportive. An ultrasound examination of the fetus to screen for abnormalities should be considered no sooner than two to four weeks after onset of symptoms. A causal relationship between WN virus and fetal abnormalities has not been proven. There is a single report of a woman who had WN virus encephalitis during the 27th week of her pregnancy and subsequently delivered a term infant with chorioretinitis, cystic destruction of cerebral tissue, and laboratory evidence of congenitally acquired WN virus infection.

Amniotic fluid, chorionic villi, or fetal serum can be tested for evidence of WN virus infection. However, the sensitivity, specificity, and predictive value of these tests to evaluate fetal WN virus infection are not known, and the clinical consequences of fetal infection have not been determined. In cases of spontaneous or induced abortion, testing of all products of conception for evidence of WN virus infection is advised to document the effects of WN virus infection on pregnancy outcome.

Screening asymptomatic women for WN virus infection is not recommended because there is no treatment and the consequences of infection during pregnancy have not been well-defined.

Clinical evaluation is recommended for infants born to mothers known or suspected to have WN virus infection during pregnancy. Further evaluation should be considered if any clinical abnormality is identified or if laboratory testing indicates that an infant might have congenital WN virus infection.

Cord Blood Donation: Infectious Disease

West Nile virus in pregnancy has wider implications and points up other pregnancy related issues, e.g., infectious disease and cord blood banking. Potential donors, and their husbands, should be queried for risk factors for infectious diseases, inherited immunologic and hematologic diseases, cancer, and other conditions that could be transmissible by blood.

Maternal blood testing is performed to screen for West Nile virus in addition to hepatitis B, hepatitis C, HIV-1 and -2, HIV p24, CMV, syphilis, and in some programs human T-lymphotropic virus (HTLV)-I/II. Finally, upon delivery of the infant, the mother's hospital chart is reviewed for labor and delivery factors that could put the infant donor, and thus the collected stem cell product, at risk for infection.

Midwives Corner

Virginia Glifort, CNM, ANMC

Primary Care for Midwives: Two Resources

#1 ACNM approved home study program specifically for midwives available through Midwife Publications 207-633-3479 or **www.midwifepublications.com**

#2 Here is a source for cheap / free CME in Primary Care: **www.pri-med.com**

Screening for Genital Herpes

Summary of Recommendations USPSTF

The U.S. Preventive Services Task Force (USPSTF) recommends against routine serological screening for herpes simplex virus (HSV) in asymptomatic pregnant women at any time during pregnancy to prevent neonatal HSV infection.

RATING: D Recommendation.

RATIONALE: The USPSTF found fair evidence that screening asymptomatic pregnant women using serological screening tests for HSV antibody does not reduce transmission of HSV to newborn infants. Women who develop primary HSV infection during pregnancy have the highest risk for transmitting HSV infection to their infants. Because these women are initially seronegative, serological screening tests for HSV (enzyme-linked immunosorbent assay [ELISA], immunoblot, and western blot assay [WBA]) do not accurately detect those at highest risk. There is no evidence that treating seronegative women decreases risk for neonatal infection. There is limited evidence that the use of antiviral therapy in women with a history of recurrent HSV, or performance of cesarean section in women with active HSV lesions at the time of delivery, decreases neonatal herpes infection. There also is limited evidence of the safety of antiviral therapy in pregnant women and neonates.

The potential harms of screening include false-positive test results, labeling, and anxiety, as well as false negative tests and false reassurance, although these potential harms are not well studied. The USPSTF determined there are no benefits associated with screening, and therefore the potential harms outweigh the benefits.

The USPSTF recommends against routine serological screening for HSV in asymptomatic adolescents and adults.

RATING: D Recommendation.

RATIONALE: The USPSTF found no evidence that screening asymptomatic adolescents and adults with serological tests for HSV antibody improves health outcomes or symptoms or reduces transmission of disease. There is good evidence that serological screening tests can accurately identify those persons who have been exposed to HSV. There is good evidence that antiviral therapy improves health outcomes in symptomatic persons (e.g., those with multiple recurrences); however, there is no evidence that the use of antiviral therapy improves health outcomes in those with asymptomatic infection. The potential harms of screening include false-positive test results, labeling, and anxiety, although there is limited evidence of any potential harms of either screening or treatment. The USPSTF determined the benefits of screening are minimal, at best, and the potential harms outweigh the potential benefits.

According to ACOG Practice Bulletin #8 (Management of Herpes in Pregnancy (October 1999): "In which situations should cesarean delivery be considered?

Cesarean delivery is indicated in women with active genital lesions or symptoms of vulvar pain or burning, which may indicate an impending outbreak. The incidence of infection in infants whose mothers have recurrent infections is low, but cesarean delivery is warranted because of the potentially serious nature of the disease. The low incidence of neonatal HSV has raised concern that cesarean delivery is unwarranted for recurrent genital herpes (41). The extent to which maternal antibodies will protect a neonate from infection during a recurrence has not been determined with certainty. Cesarean delivery is not warranted in women with a history of HSV infection but with no active genital disease during labor."

Resources

Screening for Genital Herpes:
U.S. Preventive Services Task Force
www.ahrq.gov/clinic/uspstf/uspsherp.htm
Management of Herpes in Pregnancy
ACOG Practice Bulletin, NUMBER 8, OCTOBER 1999
Gynecologic Herpes Simplex Virus Infections
ACOG Practice Bulletin NUMBER 57, NOVEMBER 2004

STD Corner

Laura Shelby, STD Director, IHS

Screening for Gonorrhea: USPSTF Recommendation Statement

The U.S. Preventive Services Task Force (USPSTF) recommends that clinicians screen all sexually active women, including those who are pregnant, for gonorrhea infection if they are at increased risk for infection (that is, if they are < 25 years old or have other individual or population risk factors; see Clinical Considerations for further discussion of risk factors). B recommendation.

Women with asymptomatic gonorrhea infection have high morbidity due to pelvic inflammatory disease, ectopic pregnancy, and chronic pelvic pain. Pregnant women with gonorrhea infection are at risk for preterm rupture of membranes, preterm labor, and chorioamnionitis. There is fair evidence that screening tests can accurately detect gonorrhea infection and good evience that antibiotics can cure gonorrhea infection. There is fair evidence that screening pregnant women at high risk for gonorrhea, including women at high risk because of younger age, may prevent other complications associated with gonococcal infection during pregnancy, such as preterm delivery and chorioamnionitis. Potential harms of screening and treatment for gonorrhea include false-positive test results, anxiety, and unnecessary antibiotic use. There is insufficient evidence (due to a lack of studies) to quantify the magnitude of these potential harms. The USPSTF judges the magnitide of the potential harms to be small. The USPSTF concludes that the benefits of screening women at increased risk for gonorrhea infection outweigh the potential harms.

The USPSTF found insufficient evidence to recommend for or against routine screening for gonorrhea infection in men at increased risk for infection (see Clinical Considerations for discussion of risk factors). I recommendation.

The morbidity from undiagnosed and untreated genital gonorrhea infection is lower in men than in women. Clinical symptoms are more likely to lead to diagnosis and treatment in men; thus, the prevalence of asymptomatic infection in men is lower. There is fair evidence that noninvasive screening tests can accurately detect gonorrhea infection and good evidence that antibiotics cure gonorrhea infection. Potential harms of screening and treatment for gonorrhea include false-positive test results, anxiety, and unnecessary antibiotic use. There is insufficient evidence (due to a lack of studies) to quantify the magnitude of these potential harms. The USPSTF judges the magnitide of the potential harms of screening men for gonorrhea to be small. Given the low prevalence of asymptomatic infection in men, the USPSTF could not determine the balance of benefits and harms of screening for gonorrhea infection in men at increased risk for infection.

The USPSTF recommends against routine screening for gonorrhea infection in men and women who are at low risk for infection (see Clinical Considerations for discussion of risk factors). D recommendation.

There is a low prevalence of gonorrhea infection in the general population and consequently a low yield from screening. Thus, the USPSTF concludes that potential harms of screening (ie, false-positive test results and labeling) in low-prevalence populations outweigh the benefits.

The USPSTF found insufficient evidence to recommend for or against routine screening for gonorrhea infection in pregnant women who are not at increased risk for infection (see Clinical Considerations for discussion of risk factors). I recommendation.

The prevalence of gonorrhea infection in pregnant women who are not at increased risk for infection is low. The USPSTF could not determine the balance between benefits and harms of screening for gonorrhea in pregnant women who are not at increased risk for infection.

The USPSTF strongly recommends prophylactic ocular topical medication for all newborns against gonococcal ophthalmia neonatorum. A recommendation.

There is good evidence that blindness due to gonococcal ophthalmia neonatorum has become

Famliy Planning

Being overweight may increase the risk of becoming pregnant while using OCs

CONCLUSION: Our results suggest that being overweight may increase the risk of becoming pregnant while using OCs. If causal, this association translates to an additional 2-4 pregnancies per 100 woman-years of use among overweight women, for whom consideration of additional or effective alternative contraceptive methods may be warranted.

Holt VL, et al. Body mass index, weight, and oral contraceptive failure risk. Obstet Gynecol. 2005 Jan;105(1): 46-52.

(STD Corner—continued from page 10)

rare in the United States since the implementation of universal preventive medication of infants.

The National STD-related Infertility Prevention Program

Learn about this innovative program to decrease infertility in your patients.

Centers for Disease Control and Prevention, Coordinating Center for Infectious Diseases, National Center for HIV, STD, and TB Prevention, Division of STD Prevention, Gunter DC, Mosure DJ, Shelby LK

Ectopic Pregnancy/Reproductive Capacity After Chlamydia Positive and Negative Results

A historical follow-up study among 22,264 women tested for urogenital Chlamydia trachomatis infection identified no elevated risk of ectopic pregnancy or reduced reproductive capacity among those tested positive compared with those tested negative for the infection.

Andersen B et al Ectopic Pregnancies and Reproductive Capacity After Chlamydia trachomatis Positive and Negative Test Results: A Historical Follow-Up Study. x Transm Dis. 2005 Jun;32(6):377-81

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Primary Care Discussion Forum

Appropriate use of narcotics for chronic non-malignant (non-cancer) pain
August 1, 2005

Moderator: Charles North

- Are you comfortable using narcotics to treat chronic pain?
- Is there abuse of prescription controlled medications in your community?
- What controls should health professionals have in place to regulate the use of controlled substances?
- Do you use pain contracts? Are they useful?
- What services are available to serve your chronic pain patients in addition to primary care?
- Are you successful in obtaining mental health services for your patients?

Other issues

- Describe your level of comfort based and your experience.
- What are the most popular drugs? Are narcotics, benzodiazepines or stimulants most popular?
- Are particular brand names valued more than others?
- Do you know the local "street value" of prescription pills?

Contact Neil Murphy at nmurphy@scf.cc to subscribe to this discussion.

ACOG Updates Definitive Guide to Pregnancy

Your Pregnancy & Birth, Fourth Edition Gives Women the Latest News on Genetic Disorders, Prenatal Tests, DOs and DON'Ts, and Exercise

The American College of Obstetricians and Gynecologists (ACOG) announced that it has updated the most authoritative, medically vetted consumer book on pregnancy and birth in the US. In releasing the fourth edition of Your Pregnancy & Birth (previously known as Planning Your Pregnancy and Birth), ACOG wants women to know the latest medical recommendations on issues ranging from genetic screening to the safety of foods to the use of alternative medicine during pregnancy

Alaska State Diabetes Program

Barbara Stillwater

Study Links Daily Steps to Specific Health Gains, Costs Saved

How many steps is enough to show positive results and what can we save? The answers are in!

Now a study shows precisely how much exercise it takes to achieve specific gains in blood glucose, blood pressure, total cholesterol and triglyceride levels, along with the average annual medical costs that can be avoided.

CONCLUSIONS: Energy expenditure >10 METs . h(-1) . week(-1) obtained through aerobic leisure time physical activity is sufficient to achieve health and financial advantages, but full benefits are achieved with energy expenditure >20 METs . h(-1) . week(-1).

Di Loreto C et al Make Your Diabetic Patients Walk: Long-term impact of different amounts of physical activity on type 2 diabetes. Diabetes Care. 2005 Jun;28(6):1295-302.

Cognitive Therapy May Be Effective for Moderate to Severe Major Depression

CONCLUSION: Cognitive therapy can be as effective as medications for the initial treatment of moderate to severe major depression, but this degree of effectiveness may depend on a high level of therapist experience or expertise.

DeRubeis RJ, et al Cognitive therapy vs medications in the treatment of moderate to severe depression. Arch Gen Psychiatry. 2005 Apr;62(4):409-16.

Office of Women's Health, CDC

Atlas of Heart Disease and Stroke Among American Indians and Alaska Natives 2005

The Atlas of Heart Disease and Stroke Among American Indians and Alaska Natives documents geographic disparities in heart disease and stroke mortality and risk factors among American Indians and Alaska Natives. The county-level maps of heart disease and stroke death rates indicate that, for American Indians and Alaska Natives, there is a nearly five-fold gap between counties with the highest and lowest rates of heart disease and stroke. High stroke death rates were found primarily in Northwestern counties and Alaska, while high heart disease death rates were located largely in the counties of the northern plains.

WISEWOMAN Works, Vol 2: Success Stories on Empowering Women to Stop Smoking

CDC highlights some of the ways the WISEWOMAN program is making a difference for women smokers. These stories will demonstrate how many communities have established strong partnerships, overcome cultural and geographic health barriers, and maximized resources to expand their reach.

Hormone Replacement Update

Management of postmenopausal hot flushes with venlafaxine hydrochloride: a RCT

CONCLUSION: Extended-release venlafaxine, 75 mg per day, is an effective treatment for postmenopausal hot flushes in otherwise healthy women, based on a significant decrease in patient-perceived hot flush score.

Evans ML, et al Management of postmenopausal hot flushes with venlafaxine hydrochloride: a randomized, controlled trial. Obstet Gynecol. 2005 Jan;105(1):161-6

Use of Soy Not effective for Menopausal Symptoms

CONCLUSION: The available evidence suggests that phytoestrogens available as soy foods, soy extracts, and red clover extracts do not improve hot flushes or other menopausal symptoms.

Krebs EE, et al. Phytoestrogens for treatment of menopausal symptoms: a systematic review. Obstet Gynecol October 2004;104:824-36.

Ask a Librarian

Diane Cooper, M.S.L.S. / NIH

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Available to all Indian Health Staff

The Health Services Research Library's (HSRL) offers an online reference service called AskUs Live! With this service, when you pose a question you get an immediate response. We'll use our expertise to help you use HSRL Library information resources. While you are connected to AskUs Live!, librarians can send you web pages with useful information; help you fill out a form on the Library's website; or even perform a literature search with you.

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(Hot Topics continued from page 5)

to diethylstilbestrol should continue annual screening after age 30. Women who are immunocompromised (i.e., organ transplant patients, those receiving chemotherapy, those with human immunodeficiency virus infection) should be tested twice in the first year after diagnosis and annually thereafter as long as they are in good health and would benefit from early detection and treatment.

Cervical cancer screening is not indicated for women who have had a total hysterectomy for benign gynecologic disease. Women with subtotal hysterectomy should follow the recommendations for women at average risk.

COLORECTAL CANCER SCREENING: Adults at average risk of developing colorectal cancer should begin screening at 50 years of age using one of five options: (1) annual fecal occult blood test or fecal immunochemical test, (2) flexible sigmoidoscopy every five years, (3) annual fecal occult blood test or fecal immunochemical test plus flexible sigmoidoscopy every five years, (4) colonoscopy every 10 years, or (5) double-contrast barium enema every five years.

More intensive surveillance is recommended for patients with a history of adenomatous polyps, a history of curative-intent resection of colorectal cancer, a family history of colorectal cancer or colorectal adenomas diagnosed in a first-degree relative before the age of 60, a history of inflammatory bowel disease of significant duration, or family history of genetic testing indicating one of two hereditary syndromes.

ENDOMETRIAL CANCER SCREENING: Endometrial cancer screening is not recommended for women at average or somewhat increased risk. However, the ACS recommends that women in these categories be informed of the risks and symptoms of endometrial cancer at the onset of menopause. Women at very high risk of endometrial cancer (i.e., those with known hereditary nonpolyposis colon cancer-associated genetic mutation carrier status, substantial likelihood of being a mutation carrier, or absence of genetic testing results in families with suspected autosomal dominant predisposition to colon cancer) should consider annual screening beginning at 35 years of age.

LUNG CANCER SCREENING: Testing for early lung cancer detection is not recommended for asymptomatic persons who are at risk. The ACS maintains that patients at risk for lung cancer because of significant exposure to tobacco smoke or occupational exposures may discuss with their physicians the benefits and risks of testing and may decide to undergo testing on an individual basis. Ideally, testing should be done only in experienced centers that are linked to multidisciplinary subspecialty groups. Patients who currently smoke should be informed that the immediate preventive health priority is the elimination of tobacco use.

The American Cancer Society (ACS) has released its annual recommendations for the early detection of cancer. The report was published in the January/February 2005 issue of CA: A Cancer Journal for Clinicians

Wild is better:

Farmed Atlantic and wild Pacific salmon contaminated with dioxins

Consumption of farmed salmon at relatively low frequencies results in elevated exposure to dioxins and dioxin-like compounds with commensurate elevation in estimates of health risk.

Foran JA, et al Risk-based consumption advice for farmed Atlantic and wild Pacific salmon contaminated with dioxins and dioxin-like compounds. Environ Health Perspect. 2005 May;113(5):552-6.

Agency for Healthcare Research and Quality (AHRQ)

Web M+M

Pregnant with Danger

A woman who was 38 weeks pregnant came to the emergency department (ED) complaining of left leg pain. Ruled out for DVT, she was sent home, only to die the following morning....

For the rest of the story, go to:
www.webmm.ahrq.gov/

(Have you had your 'morning after' antiretroviral cocktail yet? continued from page 1)

infection. When the source is known to be from a group with a high prevalence of HIV infection (e.g., a homosexual or bisexual man, an injection--drug user, or a commercial sex worker), the risk for transmission might be increased. The risk for transmission might be especially great if the source person has been infected recently, when viral burden in blood and semen might be particularly high. However, ascertaining this in the short time available for nPEP evaluation is rarely possible. When the HIV status of the source is unknown, it should be determined whether the source is available for HIV testing. If the risk associated with the exposure is considered substantial, nPEP can be started pending determination of the HIV status of the source and then stopped if the source is determined to be noninfected.

Pregnant Women and Women of Childbearing Potential

Considerable experience has been gained in recent years in the safe and appropriate use of antiretroviral medications during pregnancy, either for the benefit of the HIV-infected woman's health or to prevent transmission to newborns. To facilitate the selection of antiretroviral medications likely to be both effective and safe for the developing fetus, clinicians should consult DHHS guidelines before prescribing nPEP for a woman who is or might be pregnant.

Because of potential teratogenicity, efavirenz should not be used in any nPEP regimen during pregnancy or among women of childbearing age at risk for becoming pregnant during the course of antiretroviral prophylaxis. A protease inhibitor- or nucleoside reverse transcriptase inhibitor-based regimen should be considered in these circumstances. When efavirenz is prescribed to women of childbearing potential, they should be instructed about the need to avoid pregnancy. Because the effect of efavirenz on hormonal contraception is unknown, women using such contraception should be informed of the need to use an additional method (e.g., barrier contraception). In addition, because of reports of maternal and fetal mortality attributed to lactic acidosis associated with prolonged use of d4T in combination with ddI in HIV-infected pregnant women, this combination is not recommended for use in an nPEP regimen.

Evaluation for Sexually Transmitted Infections, Hepatitis, and Emergency Contraception

Evaluation for sexually transmitted infections is important because these infections might increase the risk for acquiring HIV infection from a sexual exposure. In 1996, an estimated 5,042 new HIV infections were attributable to sexually transmitted infection at the time of HIV exposure. In addition, any sexual exposure that presents a risk for HIV infection might also place a patient at risk for acquiring other sexually transmitted infections, including hepatitis B. Prophylaxis for sexually transmitted disease, testing for hepatitis, and vaccination for hepatitis B (for those not immune) should be considered.

For women of reproductive capacity who have had genital exposure to semen, the risk for pregnancy also exists. In these instances, emergency contraception should be discussed with the potentially exposed patient.

Summary

The most effective means of preventing human immunodeficiency virus (HIV) infection is preventing exposure. The provision of antiretroviral drugs to prevent HIV infection after unanticipated sexual or injection-drug--use exposure might be beneficial. The U.S. Department of Health and Human Services (DHHS) Working Group on Nonoccupational Postexposure Prophylaxis (nPEP) made the following recommendations for the United States.

For persons seeking care <72 hours after nonoccupational exposure to blood, genital secretions, or other potentially infectious body fluids of a person known to be HIV infected, when that exposure represents a substantial risk for transmission, a 28-day course of highly active antiretroviral therapy (HAART) is recommended. Antiretroviral medications should be initiated as soon as possible after exposure. For persons seeking care <72 hours after nonoccupational exposure to blood, genital secretions, or other potentially infectious body fluids of a person of unknown HIV status, when such exposure would represent a substantial risk for transmission if the source were HIV infected, no recommendations are made for the use of nPEP. Clinicians should evaluate risks and

(Have you had your 'morning after' antiretroviral cocktail yet?, continued from page 14)

benefits of nPEP on a case-by-case basis. For persons with exposure histories that represent no substantial risk for HIV transmission or who seek care >72 hours after exposure, DHHS does not recommend the use of nPEP. Clinicians might consider prescribing nPEP for exposures conferring a serious risk for transmission, even if the person seeks care >72 hours after exposure if, in their judgment, the diminished potential benefit of nPEP outweighs the risks for transmission and adverse events. For all exposures, other health risks resulting from the exposure should be considered and prophylaxis administered when indicated. Risk-reduction counseling and indicated intervention services should be provided to reduce the risk for recurrent exposures.

Antiretroviral Postexposure Prophylaxis After Sexual, Injection-Drug Use, or Other Nonoccupational Exposure to HIV in the United States. MMWR January 21, 2005 / Vol. 54 / No. RR—2

OB/GYN CCC Editorial

Nonoccupational postexposure prophylaxis (nPEP) is a potentially life saving method that the Indian Health system should incorporate into clinical practice in Indian Country. The earlier the non-occupational post-exposure prophylaxis is administered, the higher the chance that it will interrupt transmission. It should be incorporated into selected post coital contraception or alleged sexual assault, among other acute post coital encounters.

When the HIV status of the source is not known and the patient seeks care within 72 hours after exposure, DHHS does not recommend for or against nPEP but encourages clinicians and patients to weigh the risks and benefits on a case-by-case basis.

The Indian Health system should also take advantage of these types of 'teachable moments' to emphasize preconception folic acid therapy, safer sex techniques, and other sexually transmitted infections (STIs).

When a patient's risk of transmission from contact is small or when more than 72 hours have passed since exposure, nonoccupational postexposure prophylaxis is not recommended.

However, when a patient seeks treatment more than 72 hours after exposure, but the risk of virus transmission is severe, physicians may decide that the potential benefit of nonoccupational postexposure prophylaxis is greater than the potential risk of complications from antiretroviral therapy.

Lastly, in follow up to the March 2005 CCC Corner Abstract of the Month, the Clinical Reporting System Project Team has completed a comprehensive document approach about HIV screening in pregnancy in Indian Country. The document outlines how the 'opt out' approach to prenatal HIV screening can be implemented.

Breastfeeding

Metformin was excreted into breast milk, and neither hypoglycemia nor other adverse effects were observed in 3 nursing infants.

CONCLUSION: Metformin is excreted into breast milk, but the amounts seem to be clinically insignificant. No adverse effects on the blood glucose of the 3 nursing infants were measured.
LEVEL OF EVIDENCE: III

Briggs GG, et al Excretion of metformin into breast milk and the effect on nursing infants. Obstet Gynecol. 2005 Jun;105(6):1437-41.

MCH Alert

Summer Fun: Surgeon General issues healthy dozen tips for toddlers

The Surgeon General's Tips to Keep Toddlers Safe and Happy outlines information for parents on keeping toddlers healthy and safe as they look forward to summer fun. The list is the second in a series of Healthy Dozen Tips released by the Surgeon General as part of the Year of the Healthy Child. Topics include healthy eating, oral health, the health risks of smoking and secondhand smoke, giving positive feedback, car seats, safety proofing a home, not leaving a child unattended, the importance of having a primary care provider, immunizations, first aid and CPR, prevention and safety, and having fun. Each tip includes a link to a national resource.

Effectiveness of school based programs to reduce drinking and driving

There is sufficient evidence to recommend as effective school-based instructional programs for reducing drinking and driving and riding with drinking drivers.

Elder RW, Nichols JL, Shults RA, et al. 2005. Effectiveness of school-based programs for reducing drinking and driving and riding with drinking drivers: A systematic review. American Journal of Preventive Medicine 28(5, Suppl 1):288-304.

Start Planning Now

Comprehensive Colposcopy course, ASCCP
- August 4–7, 2005
- San Francisco
- 29 credits, American Society for Colposcopy and Cervical Pathology

www.asccp.org/meetings/comprehensive.shtml

Primary Care Provider Training in Addictions
- August 8–12, 2005
- Tacoma, WA
- Alcoholism and Substance Abuse Program Branch (ASAPB), IHS

Clinical Training in American Indian/Alaska Native Alcohol and Other Drug Abuse
Contact Teresa Sappier, Behavioral Health HQE
Teresa.Sappier@ihs.gov

Native Peoples of North America HIV/AIDS Conference
- May 3–6, 2006
- Anchorage, Alaska
- Embracing Our Traditions, Values, and Teachings
- National Institutes of Health (NIH), DHHS

www.embracingourtraditions.org

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Abstracts of the Month
- Have you had your "morning after" antiretroviral cocktail yet?

IHS Child Health Notes
- Lower respiratory tract infections among American Indian and Alaska Native children
- Disparities in indigenous health: a cross-country comparison between New Zealand and the United States.

From Your Colleagues
- Tammy Brown, National Diabetes Program, ABQ—Seeking Recipes Using Traditional Foods
- Zelda Collett-Paule, Anchorage—Why Prozac is OK during pregnancy and not for breastfeeding…. and why Zoloft is

Hot topics
- Obstetrics—Slight delay in umbilical cord clamping better for Preterm infants
- Gynecology—More effective than povidone iodine in vaginal hysterectomy: Chlorhexidine gluconate
- Child Health—Risk of Autism: Parent, Pregnancy, and Birth Factors Found Possible Associations
- Chronic disease and Illness—Women with pregnancy-induced hypertension: Increased risk of metabolic syndrome

Features
- Elder Care News—Is your patient with chronic somatic symptoms just depressed?
- ACOG—Urinary Incontinence in Women
- Oklahoma Perspective—West Nile Virus in Women
- Midwives Corver—Screening for Genital Herpes: Summary of Recommendations USPSTF
- STD Corner—Screening for Gonorrhea: USPSTF Recommendation Statement
- Hormone Replacement Update—Management of postmenopausal hot flushes with venlafaxine hydrochloride: a RCT
- MCH Alert— Summer Fun: Surgeon General issues healthy dozen tips for toddlers