NATIONAL COUNCIL OF CHIEF CLINICAL CONSULTANTS
CCC CORNER
Focus on the Health of American Indian and Alaska Native Women and Children

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CDC Recommendation
Routine, Voluntary HIV Screening in Health Care Settings

The U.S. Centers for Disease Control and Prevention (CDC) released revised HIV Testing recommendations for adults, adolescents, and pregnant women in health-care settings on September 22, 2006, which marks the first time the recommendations have been revised since 2001. After a thorough 2-plus year process of consultations, literature review, and evidence-based research, the revisions were further refined by a panel of multisectoral constituents into the final released guidelines. The guidelines illuminate the need for voluntary HIV screening as a routine part of medical care, which in turn should increase the percentage of the population that is aware of their status and form the foundation for an enhanced public health measure against the pandemic. Here is a list of the major changes:

- Routine, voluntary screening for all persons 13 to 64 years of age, regardless of risk profile. If prevalence has not been documented to be < 0.1%, voluntary HIV screening should be implemented until they establish documented diagnostic yield is <1 per 1,000 patients screened;
- Annual repeat of screening in persons with known risk;
- Opt-out screening process with opportunity to ask questions and ability to decline (declination should be documented in health record). Include HIV consent within general consent for medical care. Specific and separate HIV consent not required. Oral or written pretest information should be provided and the patient should be well informed that they will be screened for HIV;
- 'Prevention counseling' in health-care settings is not required. Patients are still to be linked with clinical care and support. High risk patients advised re-testing and offered or referred for prevention counseling. (Note: the CDC does NOT support removal of prevention counseling in appropriate settings or when it can be done. Rather, it gives the option to streamline the process to remove barriers and include broad screening in the general population or low risk groups);
- For pregnant women: routine opt-out prenatal screening is recommended, repeat screening in third trimester is recommended in certain areas of elevated rates of HIV infection among pregnant women, and opt-out rapid testing in labor and delivery recommended for women with undocumented status;
- General screening for HIV should be considered distinct from HIV counseling and testing conducted as prevention intervention for persons at perceived or known higher risk. There is still a need for community based prevention education, but it is a separate process.

Rationale for the changes included new research that awareness of serostatus substantially reduces high-risk behaviors, data that support screening is cost-effective, and evidence that late testing and diagnosis is common.

The CDC remains committed to the process for minimizing barriers of implementation and will work with state health departments as well as individual agencies for successful implementation.

Editorial comment

Scott Giberson,
IHS HIV Principal Consultant*

A Call to Action for the Indian Health System

Previous recommendations and efforts have not turned the tide of transmission, nor reduced the number of new infections each year in our

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THIS MONTH

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Cesarean delivery, not cesarean section

As Caesar's mother survived his birth, it is unlikely that Julius Caesar was born by abdominal delivery, which was universally fatal for the parturient during that era. The Latin verb caedere means to cut. Others believe the origin was the Roman custom, Lex Cesare. This operative delivery allowed mother and child to be buried separately, when women died during childbirth. Hence, cesarean section is a tautology, as both words refer to incision. The procedure is a hysterotomy. If anterior hysterotomy does not roll off your tongue easily enough, then cesarean delivery is the correct term.

Also on-line....

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

Neil J. Murphy

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

IHS Child Health Notes

Oct 2006

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

"He has never been known to use a word that might send a reader to a dictionary"
—William Faulkner (about Ernest Hemingway)

Articles of Interest

Early prednisone therapy in Henoch-Schonlein purpura: a randomized, double-blind, placebo-controlled trial.

J Pediatr. 2006 Aug;149(2):241-7.

The authors report a randomized, double-blind, placebo-controlled trial of prednisone in the treatment of Henoch-Schonlein Purpura (HSP). They excluded patients who had hematuria or proteinuria at presentation. Patients received prednisone (1 mg/kg/day for 2 weeks with weaning over the following 2 weeks. Patients who received prednisone had reduction of intensity of abdominal and joint pain. Prednisone did not prevent the development of hematuria or proteinuria but abnormal urinalyses resolved in 61% of the treated patients compared to 34% of the placebo patients. There was no difference in the small number of treated versus untreated patients who developed severe nephritis that required renal biopsy.

Editorial Comment

To paraphrase Homer Simpson's description of the power of donuts; "Steroids, is there nothing they can't do." The longstanding debate on steroid use in HSP has been hampered by the relative infrequency of the condition. Assembling a patient series of adequate size for a placebo controlled trial is an achievement in itself. Prednisone appears to decrease abdominal and joint pain and was associated with more prompt resolution of hematuria and proteinuria. Unfortunately, prednisone did not decrease the small number of patients who developed severe nephritis. Since this is the major sequelae of HSP this is very disappointing. Bottom line: Steroids could be prescribed for HSP for symptomatic relief but is not likely to affect long term renal outlook.

Physician documentation of neonatal risk assessment for perinatal infections.

J Pediatr. 2006 Aug;149(2):265-7.

The author looked at documentation on the newborn record of maternal status of hepatitis B, syphilis, *Chlamydia* and group B streptococcus. Over half of the infants lacked documentation in their charts though for most this included negative reports of hepatitis B, syphilis and Chlamydia. The author speculated that many physicians know the test is negative and do not feel the need to record negative findings in the chart. However, 5% of the positive GBS results and 1% of positive *Chlamydia* results were not documented in the infant's chart suggesting that this information was overlooked. The author suggests that nurseries need to establish systematic processes to ensure that information from the mother's record is transferred to the physician caring for the infant.

Editorial Comment

Res ipsa loquitur. (It speaks for itself).

Recent literature on American Indian/ Alaskan Native Health

Douglas Esposito,MD, MPH

The Alaska *Haemophilus influenzae* type b experience: lessons in controlling a vaccine-preventable disease.

Pediatrics. 2006 Aug;118(2):e421-9.

The Arctic Investigations Program of the CDC has been conducting surveillance of invasive *Haemophilus influenzae* in Alaska since 1980. This data, combined with U.S. census data from 1980, 1990, and 2000 were used to calculate Hib infection rates in children < 10 years of age. Case rates from before and after implementation of universal Hib vaccination are compared. Data from vaccination registries, case reviews, and previously conducted Hib carriage studies in Alaska were also analyzed for this report.

Drum roll please! Since implementation of the universal Hib vaccination campaign in 1991, an estimated 479 cases of invasive Hib disease have been prevented in Alaska Native children less than five years of age. Average annual attack rates for that age group fell from 309.4 cases per 100,000 population pre-vaccine to just 5.4 cases per 100,000 population in 2001-2004; a decrease of over 98%! Please refer directly to this important article for a complete and valuable discussion of all the results. The bottom line is that the Hib vaccination campaign represents one of the most successful and important vaccination initiatives in U.S. history.

Editorial Comment

Thanks to the incredible efforts that lead to the development and broad distribution of the Hib vaccine, in my eleven-plus years as a pediatrician, I never encountered a case of invasive

Hib until just a couple of years ago. Today, it's a wonderfully rare occurrence! Having now observed first-hand the ravages of this disease, I hope never to see it again, and due to this particular success story, I likely never will! Hats off to our own Rosalyn Singleton and the CDC Arctic Investigations Program for chronicling the benefits of Hib vaccine for the Alaska Native population!

Thanks also for demonstrating that, despite a dramatic decrease in incidence, Alaska Native populations still suffer much higher rates of this terrible disease than does the general Alaska and U.S. population. As stated conspicuously in the last line of the abstract and in the last two lines of the report: "Household crowding, poverty, unemployment, and lack of indoor plumbing...are each more prevalent among rural Alaska Native persons than persons living in urban Alaska. Equity in disease rates may not be achieved in indigenous populations with the current vaccines unless other factors contributing to disease transmission are addressed." For minority populations living in the U.S., observed health disparities are inextricably interwoven within socioeconomic disadvantage and racial prejudice. For those of you who are regular readers of my reviews, you get the picture!

Additional Reading

Experience with the prevention of invasive Haemophilus influenzae type b disease by vaccination in Alaska: the impact of persistent oropharyngeal carriage. J Pediatr. 2000 Sep;137(3):313-20.

QuickStats: infant mortality rates, by maternal race/ethnicity---United States, 1995 and 2003. MMWR Morb Mortal Wkly Rep. 2006 Jun 23;55(24):673-6.

Editorial Comment

Click on the link and review! Infant mortality (death in individuals <1 year per 1,000 live births) for American Indian/Alaska Native mothers ranks second highest in the U.S., surpassed only by the rate for non-Hispanic blacks. The infant mortality rate for non-Hispanic blacks in 2003 was 13.61, followed by the AI/AN rate of 8.73. This compares poorly to the overall U.S. rate of 6.84." instead of "The infant mortality rate for non-Hispanic blacks in 2003 was 14.65, followed by the AI/AN rate of 9.04. This compares poorly to the overall U.S. rate of 7.57. In 1998, the U.S., one of the richest nations on the planet, ranked 28th among industrialized nations in infant mortality according to the March of Dimes (www.marchofdimes.com/files/international_rankings_1998.pdf). International comparison of infant mortality is controversial, and reporting bias probably does contribute some to the observed differences. However, few experts would argue that we don't have a real problem here at home. In fact, it would appear that uniquely American styles of socioeconomic disparities, racism, and unequal access to care and supportive services contribute to our poor international showing. Will we ever be able to effectively eliminate these deplorable and embarrassing disparities?

For a more thorough presentation of the infant mortality data in the U.S. for 2003, please refer to the first citation below. The last two citations will be interesting to anyone wanting to learn more about our international infant mortality ranking.

Additional Reading

Infant mortality statistics from the 2003 period linked birth/infant death data set. Natl Vital Stat Rep. 2006 May 3;54(16):1-29.

Infant Mortality and Income in 4 World Cities: New York, London, Paris, and Tokyo. Am J Public Health, 2005 Jan;95(1):86-90.
www.ajph.org/cgi/content/abstract/95/1/86

Comparing international infant mortality rates. CMAJ. 2000 Sep 5;163(5):497-8.
www.cmaj.ca/cgi/reprint/163/5/497

If you have any suggestions, comments or questions please contact Steve Holve, MD, Chief Clinical Consultant in Pediatrics at sholve@tcimc.ihs.gov

Is patient education really working?

Gestational Diabetes Mellitus patients smoke more and eat less vegetables

CONCLUSIONS: Despite their elevated risk for future diabetes, women with history of GDM who lived with children were less likely to meet fruit and vegetable consumption guidelines and more likely to smoke than women with children who did not have history of GDM.

Kieffer EC et al Health Behaviors Among Women of Reproductive Age With and Without a History of Gestational Diabetes Mellitus Diabetes Care. 2006 Aug;29(8):1788-93

From Your Colleagues

Sunnah Kim, American Academy of Pediatrics

Forty years in partnership: the American Academy of Pediatrics and Indian Health

Fifty years ago, American Indian and Alaska Native children faced an overwhelming burden of disease, especially infectious diseases such as pneumonia, meningitis, tuberculosis, hepatitis A and B, and gastrointestinal disease. Death rates of American Indian/Alaska Native infants between 1 month and 1 year were much higher than in the US population as a whole, largely because of these infectious diseases. The health care of American Indian/Alaska Native patients was transferred to the Department of Health, Education, and Welfare in 1955 and placed under the administration of an agency soon to be known as the Indian Health Service. The few early pediatricians in the Indian Health Service recognized the severity of the challenges facing American Indian/Alaska Native children and asked for help.

The American Academy of Pediatrics responded by creating the Committee on Indian Health in 1965. In 1986 the Committee on Native American Child Health replaced the Committee on Indian Health. Through the involved activity of these committees, the American Academy of Pediatrics participated in and influenced Indian Health Service policies and services and, combined with improved transportation, sanitation, and access to vaccines and direct services, led to vast improvements in the health of American Indian/Alaska Native children. In 1965, American Indian/Alaska Native postneonatal mortality was more than 3 times that of the general population of the United States. It is still more than twice as high as in other races but has decreased 89% since 1965. Infectious diseases, which caused almost one fourth of all American Indian/Alaska Native child deaths in 1965, now cause <1%. The Indian Health Service and tribal health programs, authorized by the Indian Self-Determination and Education Assistance Act of 1976 (Pub L. 93-638), continue to seek American Academy of Pediatrics review and assistance through the Committee on Native American Child Health to find and implement interventions for emerging child health problems related to pervasive poverty of many American Indian/Alaska Native communities. Acute infectious diseases that once were responsible for excess morbidity and mortality now are replaced by excess rates resulting from harmful behaviors, substance use, obesity, and injuries (unintentional and intentional). Through strong working partnerships such as that of the American Academy of Pediatrics and the Indian Health Service, progress hopefully will occur to address this "new morbidity." In this article we document the history of the Indian Health Service and the American Academy of Pediatrics committees that have worked with it and present certain statistics related to American Indian/Alaska Native child health that show the severity of the health-status disparities challenging American Indian/Alaska Native children and youth.

Brenneman G, Rhoades E, Chilton L. Forty years in partnership: the American Academy of Pediatrics and the Indian Health Service Pediatrics. 2006 Oct;118(4):e1257-63

Editorial comment: Elaine Locke, ACOG

During the same era that the pediatricians were responding to the needs of AI/AN children, the obstetricians were working in parallel with AI/AN women. The American College of Obstetricians and Gynecologists [ACOG] established a Committee on American Indian Affairs on April 17, 1970 for the purpose of studying and developing expertise in the area of maternal and gynecologic health problems among Native American women. The following is a brief description of what ACOG currently offers as well as links to documents on the history of ACOG involvement as well as the Fellows in Service Program.

ACOG's Indian health activity began in 1970 and now includes programs that:

- Provide medical care when it is most needed to American Indian and Alaska Native women; obstetrician-gynecologists from the private sector fill short-term vacancies in Indian hospitals.
- Offer an annual 4-day course on Obstetric, Neonatal, and Gynecologic Care for Indian Health Service and Tribal nurses and physicians who are not trained in the specialty. An optional Neonatal Resuscitation Program offers certificates of completion and additional education credits.
- Produce a practical reference text for the use of non-specialists in Indian Health Service and Tribal hospitals.
- Conduct site visits to Indian Health Service and Tribal hospitals; reports can support improvements in equipment, staffing, management and clinical care.

ACOG continues to support the Committee on American Indian Affairs as an expression of the College's concern for the health and well-being of American Indian and Alaska Native women and their offspring.

Please Contact: Yvonne Malloy or Elaine Locke 202:863-2580

Historical Background of ACOG AI/AN Involvement

www.ihs.gov/MedicalPrograms/MCH/F/documents/HistACOG101206.doc

History of the ACOG Fellows in Service Program

www.ihs.gov/MedicalPrograms/MCH/F/documents/ACOGFell101206.doc

Various ACOG Programs

www.ihs.gov/MedicalPrograms/MCH/F/documents/ACOG%20Prog101206.doc

Hot Topics

Obstetrics

Can a 29% Cesarean Delivery Rate Possibly Be Justified?

1.) Have there been measurable improvements in fetal outcome from the use of EFM and its associated increase in the cesarean delivery rate? There is a very high false-positive rate for "nonreassuring" heart rate patterns used to predict a depressed newborn.

It did not achieve its promise because it was designed to prevent intrapartum death, an event so rare that it was not possible to show a significant difference, and to prevent cerebral palsy, which we now know is attributable to birth asphyxia in term infants only about 6–17% of the time. In fact, although most labors are followed with EFM, there has been no reduction in the incidence of cerebral palsy over the last 3 decades.

2.) What about the maternal benefits of cesarean delivery? There is little argument that vaginal delivery is associated with a higher frequency of subsequent stress urinary incontinence and uterine and vaginal prolapse. However, it is also clear that nulliparous women and those who have had only cesarean delivery may also be symptomatic, suggesting that the aging process, pregnancy per se, genetic factors, and just walking upright for more than 50 years are significant contributors to the problem.

3.) In contrast, the risks of the current cesarean delivery rate are not difficult to discern. Getahun and co-workers (below) have reported a 50% increase in the risk of placenta previa and a doubling of the risk of abruptio placenta in the subsequent pregnancy after one previous cesarean delivery. These risks increased with multiple prior cesareans.

Resnik R. Can a 29% Cesarean Delivery Rate Possibly Be Justified? Obstet Gynecol 2006 107:752-4

Gynecology

A new era in ovulation induction: Aromatase inhibitors

Conclusion(s): Aromatase inhibitors are as effective as or superior to clomiphene citrate in ovulation induction and in superovulation. Unlike CC, they do not carry an antiestrogenic effect on the endometrium. Given the advantages of aromatase inhibitors, they can be used to replace CC as ovulation-inducing drugs. Their role in IVF remains to be determined.

Holzer H et al A new era in ovulation induction. Fertility and Sterility 2006 85(2): 277-85

Child Health

Fetal injury at cesarean delivery: Related to the indication and type of uterine incision

Results: A total of 37,110 cesarean deliveries were included in the registry, and 418 (1.1%) had an identified fetal injury. The most common injury was skin laceration (n=272, 0.7%). Other injuries included cephalohematoma (n=88), clavicular fracture (n=11), brachial plexus (n=9), skull fracture (n=6), and facial nerve palsy (n=11). Among primary cesarean deliveries, deliveries with a failed forceps or vacuum attempt had the highest rate of injuries (6.9%). In women with a prior cesarean delivery, the highest rate of injury also occurred in the unsuccessful trial of forceps or vacuum (1.7%), and the lowest rate occurred in the elective repeat cesarean group (0.5%). The type of uterine incision was associated with fetal injury, 3.4% "T" or "J" incision, 1.4% for vertical incision, and 1.1% for a low transverse (P=.003), as was a skin incision–to–delivery time of 3 minutes or less. Fetal injury did not vary in frequency with the type of skin incision, preterm delivery, maternal body mass index, or infant birth weight greater than 4,000 g.

Conclusion: Fetal injuries complicate 1.1% of cesarean deliveries. The frequency of fetal injury at cesarean delivery varies with the indication for surgery as well as with the duration of the skin incision–to–delivery interval and the type of uterine incision.

Alexander JM, et al Fetal injury associated with cesarean delivery. Obstet Gynecol. 2006 Oct;108(4):885-90.

Chronic disease and Illness

Aspirin to Prevent Heart Attack and Stroke: What's the Right Dose? 160 mg/day

Despite hundreds of clinical trials, the appropriate dose of aspirin to prevent myocardial infarction (MI) and stroke is uncertain. In the US, the doses most frequently recommended are 80, 160, or 325 mg per day. Because aspirin can cause major bleeding, the appropriate dose is the lowest dose that is effective in preventing both MI and stroke because these two diseases frequently co-exist. Five randomized clinical trials have compared aspirin with placebo or no therapy for the prevention of stroke and MI. These trials varied with regard to the dose of aspirin, the duration of treatment, and, most important, the populations selected for study varied in their baseline risk of stroke and MI. These studies indicate that the most appropriate dose for the primary and secondary prevention of stroke and MI is 160 mg/day.

Dalen J. Aspirin to Prevent Heart Attack and Stroke: What's the Right Dose? American Journal of Medicine 2006 119: 198-202

Features

American Family Physician

Patient-Oriented Evidence that Matters (POEMS)

Postcoital Bleeding and Cervical Cancer Risk

Clinical Question: Does bleeding after intercourse indicate cervical cancer?

Study Design: Systematic review

Synopsis: The authors systematically reviewed several databases for English-language studies that reported or provided sufficient data to estimate the incidence or prevalence of postcoital bleeding. The authors do not report searching for unpublished data, independent and paired application of inclusion criteria, or paired data abstraction. Ultimately, they included 38 articles.

They found no studies that determined how often women presenting with post-coital bleeding were subsequently found to have cervical cancer. One mass screening study from Finland identified 2,648 women with postcoital bleeding, of whom 12 (0.45 percent) had invasive cancer at the time of presentation. Eight of the studies (including hundreds of thousands of women) evaluated women in community settings. The overall rate of complaints about postcoital bleeding is highly variable (0.7 to 9.0 percent); however, the large population-based studies report the prevalence at approximately 1 percent. It is not known how many women who experience postcoital bleeding seek medical care.

Sixteen studies reported the prevalence of postcoital bleeding in more than 47,000 women with invasive cervical cancer. The range of prevalence in these studies was 0.7 to 39.0 percent.

Bottom Line: In this systematic review, the rate of postcoital bleeding is highly variable and of uncertain significance. The best estimate is that approximately one out of 220 women with postcoital bleeding has invasive cervical cancer. (Level of evidence: 3a-)

Shapley M, et al. A systematic review of postcoital bleeding and risk of cervical cancer. Br J Gen Pract June 2006;56:453-60.

Agency for Healthcare Research and Quality (AHRQ)

Here is an interesting DNR case from this month's AHRQ Web M+M

An elderly woman who had a DNR in place took a fall that required her to have surgery. Discussion with the patient's health care proxy led to the DNR order being suspended during surgery, with the understanding that it would be reinstated postoperatively. Several days later, a nurse noticed that patient remained 'full code' because the DNR had not been restored. See the link below for the rest of the story

DNR in the OR and Afterwards

www.webmm.ahrq.gov/case.aspx?caseID=135

ACOG

Amnioinfusion Does Not Prevent Meconium Aspiration Syndrome

Abstract: Amnioinfusion has been advocated as a technique to reduce the incidence of meconium aspiration and to improve neonatal outcome. However, a large proportion of women with meconium-stained amniotic fluid have infants who have taken in meconium within the trachea or bronchioles before meconium passage has been noted and before amnioinfusion can be performed by the obstetrician; meconium passage may predate labor. Based on current literature, routine prophylactic amnioinfusion for the dilution of meconium-stained amniotic fluid is not recommended. Prophylactic use of amnioinfusion for meconium-stained amniotic fluid should be done only in the setting of additional clinical trials. However, amnioinfusion remains a reasonable approach in the treatment of repetitive variable decelerations, regardless of amniotic fluid meconium status.

Amnioinfusion does not prevent meconium aspiration syndrome. ACOG Committee Opinion No. 346. American College of Obstetricians and Gynecologists. Obstet Gynecol 2006;108:1053–5.

Family Planning

Ortho Evra Patch Linked to Risk for Venous Thromboembolism

On September 21, 2006 the US Food and Drug Administration (FDA) and Ortho-McNeil Pharmaceutical (a Johnson & Johnson company) notified healthcare professionals regarding changes to the safety labeling for a weekly norelgestromin/ethinyl estradiol transdermal system (Ortho Evra).

The label has been updated to reflect new data from 2 US epidemiologic studies that evaluated the relative risk for developing nonfatal venous thromboembolism (VTE) in women using the contraceptive patch vs oral contraceptives containing 35 µg of ethinyl estradiol, according to an alert sent yesterday from MedWatch, the FDA's safety information and adverse event reporting program. Both studies were conducted using electronic healthcare claims data, and the second study also included patient chart reviews.

Although findings from the first study revealed no significant difference in VTE risk for patch users compared with those taking oral contraceptives containing 35 µg of ethinyl estradiol (odds ratio [OR] = 0.9; 95% confidence interval [CI], 0.5 - 1.6), the second study linked the patch to more than double the risk for the event (OR = 2.4; 95% CI, 1.1 - 5.5).

The FDA notes that the latter finding supports the agency's concerns regarding the risk for VTE in women using the contraceptive patch.

Healthcare professionals are advised to balance the higher estrogen exposure and the possible increased risk of VTE against the chance of pregnancy if the patch is not used; contraceptive options other than the patch should be considered for women with risk factors for thromboembolic disease.

Adverse events related to use of the norelgestromin/ethinyl estradiol contraceptive patch should be reported to the FDA's MedWatch reporting program by phone at 1-800-FDA-1088, by fax at 1-800-FDA-0178, online at www.fda.gov/medwatch, or by mail to 5600 Fishers Lane, Rockville, MD 20852-9787.

International Health Update

Claire Wendland, Madison, WI

Maternal survival worldwide: consensus and controversies

In the year 2000, 189 countries and many major international agencies signed a "Millennium Declaration" that was to provide a blueprint for improving conditions around the world—in particular, the conditions of the poor. The blueprint was divided into eight goals. Millennium Development Goal #5 committed signatory countries to improve maternal health; since improving health is difficult to measure, the agreement was to try to reduce maternal mortality by two thirds by 2015.

Anyone interested in maternal and child health will want to take a look at the Lancet's new series on maternal survival, hot off the presses last week. In a series of five review articles and several associated commentaries, major figures in maternal health review what we know about maternal mortality (and to a lesser extent morbidity) and what to do about it. The upshot? Six years into the millennium, progress on maternal mortality does not look good. Statistics are unreliable, but it appears that maternal deaths have stabilized at about 400 per 100,000 live births (far from the MDG target of 141per 100,000 by 2015). Improvements in some countries, like Bangladesh, have been offset by worsening in others, such as Afghanistan and much of sub-Saharan Africa. Inequality is worse for obstetric risk than for any other health indicator: a woman in Sweden has a 1in 30,000 lifetime risk of death in childbirth, while for a woman in Sierra Leone that risk is 1 in 6.

Readers will find both consensus and controversy here. All contributors agree that political commitment and financial investment fall short of what they should be. All contributors seem to agree that funding competition between maternal health programs and child health programs, and between community-based and clinic-based programs, has been a waste of opportunity and time. (To use the memorable Cameroonian proverb quoted in one editorial, "When the elephant and the rhino fight, it is the grass that suffers.") And all contributors agree that women have a right to birth in a safe facility attended by a skilled health worker—preferably a midwife. Major areas of controversy remain, however: chief among them are the role of home birth with skilled attendants in the developing world; the contribution of iatrogenic illness, especially infection, to maternal death; and the importance of providing safe abortion.

Review articles 1 (by C Ronsmans and WJ Graham), 2 (OMR Campbell and WJ Graham), and 5 (V Filippi et. al) are especially helpful overviews of global research on maternal health and survival. The authors provide evidence debunking some myths many of us will find hard to let go (for instance, that risk screening during antenatal care will improve maternal mortality). They also provide heartening evidence that many different strategies can improve maternal health, from improving control of infectious diseases to ensuring access to hospital care to providing midwifery in the community.

You can access all five articles and several related commentaries at www.thelancet.com (requires free registration). Look for the Maternal Survival Series, September 30, 2006.

Primary Care Discussion Forum

December 1, 2006

Causes of Type 2 Diabetes: Old and New Understandings

Moderator: Ann Bullock M.D.

In 2002, the International Diabetes Federation determined that the medical literature supports 4 etiologies of type 2 diabetes:
—Genetics
—Fetal Origins
—Lifestyle
—Stress

We will explore these issues

- Diabetes prevention programs focus on lifestyle modification—what might these programs look like if lifestyle is only one factor?
- What else can be learned from the DPP (Diabetes Prevention Program)?
- Pregnancy and early life risk factors
- What are the particular roots of the diabetes and obesity epidemics in Indian Country

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Midwives Corner—Lisa Allee, CNM, Chinle

External Fetal Monitors… Can you kick the habit?

Hindley, et al, undertook a three year research project due to the indiscriminate use of electronic fetal monitoring (EFM) in the United Kingdom despite evidence that states it should be used sparingly. They point out that extensive research in the last 30 years has shown limited benefit of EFM in low risk women and an increase in cesarean section rates when women are monitored continuously during labor. The evidence instead states that the most appropriate method of fetal monitoring for women of low obstetric risk is intermittent auscultation (IA).

Hindley, et al, present their qualitative research interviewing midwives about EFM and IA. They interviewed 58 midwives practicing in northern England with an average of 15 years of experience. For IA they found three main categories: freedom/liberating effects for the woman; closeness/proximity of the midwife; and quicker progress in labor. For EFM the categories included: oppressive/restrictive; midwife by proxy; and increased requirements for pain medications. For both monitoring methods the interviews also revealed paradoxes. For IA there was a paradox that the midwives' positive comments were tempered by fears that they would miss some pathological event between auscultations. The paradox for EFM was that the midwives' negative comments and their insights that EFM is causing midwives to attend less to women and more to machines and to loose sight of what is normal are contradicted by their practice realities of continuing to work with EFM, even for low risk women. In their discussion, Hindley, et al, illuminate what occurs for many midwives—a belief in the normal process of birth and a desire to work with women to support and enhance that process, but then the realities of where they work including the reliance on EFM resulting in a devaluation and decreased use of the traditional, watchful, hands-on approach of the midwife and an increased likelihood of the cascade effect leading to increasing numbers of interventions in the process of birth. They point out a persistent paradox in our practices—the evidence shows overwhelmingly that the use of EFM is not beneficial and may be harmful to patients and to midwifery practice, but we keep on using it.

Hindley, et al, bring to the forefront the quandary we are in—we know that evidence-based care would mean not using EFM, especially with low risk women, as it has not been shown to improve outcomes and has been shown to increase interventions, yet we continue to use it with virtually all laboring women. The authors discuss the many influences that make this so, including: lack of institutional support for IA; staffing issues causing EFM to be used as a midwife proxy—"a substitute for the presence of the midwife who would otherwise use the clinical skills of perception, auscultation, palpation, and communication"; trust in machines; that it's easier to busy oneself with the monitor than to engage deeply with a laboring woman; medical policies and the persistent belief by many obstetricians that birth is inherently dangerous and should be risk managed. They also make suggestions for finding our way out of the quandary: where guidelines exist for appropriate use of EFM, audit compliance with the guidelines; provide resources for one-to-one midwifery care in labor to ➔

Navajo News—Telluride Conference, January 26–28, 2007

Jean Howe, Chinle

Great, low-cost, fun CME opportunity

This is a great, low-cost, fun CME opportunity attended by many current IHS providers and IHS alumni. Please share this announcement with anyone who might be interested at your facilities.

Hope to see you there!

Jean.Howe@ihs.gov

22nd Annual Midwinter Indian Health OB/PEDS Conference
www.ihs.gov/MedicalPrograms/MCH/F/CN01.cfm#Jan07

➔stop the use of EFM as a proxy; continued debate and discussion about routine use of oxytocin and epidurals that often necessitate EFM use and about precise clinical risk indicators for the use of EFM. They also offer a first step in the process of change:

Simple strategies such as removing fetal monitors from rooms might also help the midwife to consciously question the need for EFM rather than applying it routinely, merely because it is proximal."

English midwives' views and experiences of intrapartum fetal heart rate monitoring in women at low obstetric risk: conflicts and compromises. J Midwifery Womens Health. 2006 Sep-Oct;51(5):354-60.

Editorial Comment: Lisa Allee, CNM

First, I have got to say that I love qualitative research because the results sound like actual humans and not just numbers. For example, the quotes the authors put in this article will likely ring true with many of us:

"I think it (IA) gives the woman more freedom. She can mobilise. I think the labour tends to get quicker because she is not pinned to the bed in one position. She can move around, it's more natural, it's more normal."

"I think a lot of the women feel really restricted by monitoring. It also means that as a midwife, your time is taken up with analysing and looking at the machine a lot of the time when you could be giving other support to the woman."

"I think, especially with the monitors, they are waiting for the next pain. The focus is on the pain. Certainly, there are more epidurals as opposed to the woman who is labouring in the bath or moving about."

"I think IA brings you closer to them, and it's just more natural and normal, so it's less technology that I am in favour of."

Second, when I got to the end of this article I let out a whoop and did a little happy dance—someone finally said in print "TAKE THE MONITOR OUT OF THE ROOM"!!!! Wow, what a concept. There are so many reasons to do this, but most of all it would mean that everyone would have to really think about using EFM, it's appropriateness and it's implications, because to use it you would have to drag the thing into the room. This change would also make it ok to not use EFM, as appropriate, using doptones instead and, thus, make the focus of our care the laboring woman, the baby, and the family instead of the machine. Those of us who have practiced in home birth, birth centers, and internationally know that this really is ok, safe, and so satisfying for all involved. I would love to hear from any site that makes this change or has already done so!

E-mail me at **lisa.allee@ihs.gov** and I will include the information in a future column.

One Last Thing:

It is time to update the midwifery page on the IHS website.

A few ideas I have are patient education section, midwifery conferences, an ask the midwife column, why you are lucky to have midwifery care, and profiles of the different midwifery services in IHS. PLEASE send me your comments on these ideas and your suggestions for other items. Also, please send me pictures that could be used on the page! Thanks for your help!!!

Agency for Healthcare Research and Quality (AHRQ)

What processes are in place for "same last name" awareness?

Doctor removes ovaries from wrong patient.

Bramson K, Mooney T. Providence Journal. August 18, 2006.

This article reports on a case of mistaken identity that resulted in erroneous surgery, despite a "time out" before beginning the operation.

http://psnet.ahrq.gov/resource.aspx?resourceID=4211

Alaska State Diabetes Program

Barbara Stillwater

No improvement in fetal outcome, plus increased maternal morbidity: Who pays for this? You do

More than one-quarter of all children born in the United States—over 1 million—are delivered by Cesarean section.

The national bill for childbirth as a whole in 2003 totaled $34 billion, with hospital stays for C-section delivery accounting for nearly half this amount—$15 billion.

Medicaid was billed for 43 percent of childbirths overall and 41 percent of those for C-section delivery.

Agency for Healthcare Research and Quality, HCUP, Statistical Brief #11: Hospitalizations Related to Childbirth, 2003

www.hcup-us.ahrq.gov/reports/statbriefs/sb11.jsp

Nurses Corner

Carolyn Aoyama, HQE

Interventions for Depression in Reproductive Age Women in Family Planning Programs

This policy brief explores family planning programs as a possible site for incorporating interventions around depression, including screening and treatment, in reproductive age women.

The brief looks at the opportunities to reach women who otherwise may have little contact with the health care system, as well as the challenges of locating these services within family planning programs, and offers a list of potential interventions and recommendations for further action for FP programs, state and local public health agencies, and mental health providers. This was developed through the Women's and Children's Health Policy Center.

The brief is available in PDF form on the WCHPC website: **www.jhsph.edu/wchpc**

Ask a Librarian

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

From your Library: Updated Cochrane Systematic Reviews

Aerobic Exercise and Pregnancy

A review of 11 trials involving 472 pregnant women suggested that pregnant women who engage in vigorous exercise at least two to three times per week improve or maintain their physical fitness, and there is some evidence that these women have pregnancies of the same length as those who maintain their usual activities. There is too little evidence to show whether there are other effects on the woman and her baby. The trials reviewed included non-contact exercise such as swimming, static cycling and general floor exercise programs. Most of the trials were small and of insufficient methodologic quality, and larger, better trials are needed before confident recommendations can be made about the benefits and risk of aerobic exercise in pregnancy. Aerobic exercise is physical activity that stimulates a person's breathing and blood circulation.

Kramer MS, McDonald SW. Aerobic exercise for women during pregnancy. Cochrane Database of Systematic Reviews 2006, Issue 3.

Calcium Supplementation Safe and Cheap

Calcium supplementation during pregnancy is a safe and relatively cheap means of reducing the risk of pre-eclampsia in women at increased risk, and women from communities with low dietary calcium, according to a recent review.. Preterm birth (birth before 37 weeks) is often caused by high blood pressure and is the leading cause of newborn deaths, particularly in low-income countries. No adverse effects have been found from calcium supplementation, but further research is needed into the ideal dosage.

Hofmeyr GJ, Atallah AN, Duley L. Calcium supplementation during pregnancy for preventing hypertensive disorders and related problems. Cochrane Database of Systematic Reviews 2006, Issue 3.

Preclampsia Drugs: No Clear Choice

A review of 24 trials including 2949 women found that while antihypertensive drugs lower blood pressure, there is not enough evidence to show which drug is the most effective when taken by pregnant women with hypertension. There is some evidence that diazoxide may result in the woman's blood pressure falling too quickly, and that ketanserin may not be as effective as hydralazine. Further research into the effects of antihypertensive drugs is needed.

Duley L, Henderson-Smart DJ, Meher S. Drugs for treatment of very high blood pressure during pregnancy. Cochrane Database of Systematic Reviews 2006, Issue 3.

OB/GYN CCC Editorial comment:

Cochrane Library: Evidence based reviews of an array of clinical topics

Thanks to Diane Cooper at the NIH library, the link below will take you from our Indian Health website to the NIH Health Services Research Library. The Cochrane Library is the definitive evidence based medicine resource. It reviews only randomized controlled trials.

Place the link below into your browser. Click on the Cochrane Library link. This will take you to the NIH Library site. Scroll across the top menu to RESEARCH TOOLS. In the drop down box select DATABASES, and scroll down the list to COCHRANE.

www.ihs.gov/MedicalPrograms/CIR/index.cfm?module=cir_answering_clinical_questions

Contact Diane Cooper for questions: **cooperd@ors.od.nih.gov**

Breastfeeding

Suzan Murphy, PIMC

Do you have breastfeeding questions? The new Breast feeding site has the answers

The I.H.S MCH Breastfeeding webpage has been updated. To see the new look, go to www.ihs.gov, click on Medical Programs, then Maternal Child Health and then Breastfeeding.

Once on the Breastfeeding home page, you will find quick access to helpful resources like the Easy Guide to Breastfeeding for AI/AN Families, the new Lactation Support Policy in the Workplace, and list of topics designed to make breastfeeding support a reality.

Curious about breastfeeding reducing risk of diabetes and obesity?

Look in the Breastfeeding, diabetes and obesity section for information and references.

Want to know what to tell a mom about commonly asked concerns

Like sore nipples and how-do-I-know-that-my-baby-is-getting-enough-milk? Click on FAQs and scroll to the topic.

How about breastfeeding benefits?

The Breastfeeding Benefits section has a quick list of benefits, plus a link to the American Academy of Pediatrics' (AAP) most recent position paper on breastfeeding. The paper includes numerous, landmark studies about breastfeeding benefits with links to Pubmed for abstracts.

Need ideas for breastfeeding moms who work or go school?

Take a look at the Going back to Work or School section. Also, look at the Home Page link to the NEW I.H.S Circular for Lactation Support Policy in the Workplace (July 2006). The new circular has the latest, most current information about supporting breastfeeding employees in the I.H.S. work environment.

Want to know about medications and breast milk?

The section on Medications is the spot for you. Jim Bresette and his amazing I.H.S. Pharmacists have collaborated to create this section—there is even a link to the NIH Lactnet page where a medication can be typed in and the studies, issues, AAP reviews, possible alternative drugs, etc are listed—quickly and easily read.

What about the nitty, gritty stuff

The things that staff need to make the real work of patient care come together? Like patient education materials/videos/posters, ways to easily keep track of feeding choice rates, PCC templates, job descriptions, policy/procedure ideas, what other agencies/coalitions are doing, etc? Don't recreate the wheel, go directly to Staff Resources, use what fits, edit what you need and send suggestions.

Weary of limiting breastfeeding karma to just mom and baby?

Be in awe of the beautiful dad and child picture on the Dads and Family Page—and email us your pictures!

Want to know about what other groups are doing or what other resources are available for lactation support?

Try out the Links & Contact info page.

Got a bone to pick or question to ask about lactation support?

Put your thoughts on line with the ListServ/Discussion Forum. Lactation is an evolving science, practice and research change the fact of what we do, no one knows all the answers, together we are better.

What is next for the web page?

Possible additions include updates, more links, conference announcements, and CEUs. **Please send pictures, ideas, suggestions, and thoughts to** suzan.murphy@ihs.gov

A New Look for Lactation Support—The New Breastfeeding web page

www.ihs.gov/MedicalPrograms/MCH/M/bf.cfm

Osteoporosis

Fracture risk among First Nations people

Conclusion: First Nations people are at high risk for fracture but the causal factors contributing to this are unclear. Further research is needed to evaluate the importance of other potential explanatory variables.

Leslie WD, et al Demographic risk factors for fracture in First Nations people. Can J Public Health. 2005 Jan-Feb;96 Suppl 1: S45-50.

The prior report

Results: First Nations people had significantly higher rates of any fracture (age- and sex-adjusted SIR 2.23, 95% CI 2.18-2.29). Hip fractures (SIR 1.88, 95% CI 1.61-2.14), wrist fractures (SIR 3.01, 95% CI 2.63-3.42) and spine fractures (SIR 1.93, 95% CI 1.79-2.20) occurred predominantly in older people and women. In contrast, craniofacial fractures (SIR 5.07, 95% CI 4.74-5.42) were predominant in men and younger adults. INTERPRETATION: First Nations people are a previously unidentified group at high risk for fracture.

Leslie WD, et al Fracture risk among First Nations people: a retrospective matched cohort study. CMAJ. 2004 Oct 12;171(8):869-73

Medical Mystery Tour

The words 'bizarre' and 'atypia' in the same pathology report sentence…hmmm….

A 53 yo G6 P5015 presented to a field facility with ongoing menometrorrhagia despite conservative therapy with medroxyprogesterone 10 mg for 10 days a month for 3 months. Initial ultrasound revealed a 2.7 x 2.4 cm endometrial structure felt to be consistent with an endometrial polyp or a leiomyoma.

A follow-up ultrasound 2 months later at the field facility revealed 2 complex masses involving the endometrium with the appearance of some myometrial extension. The first was located in the mid-uterus and endometrium and was larger than the second which was located in the lower uterine segment.

An endometrial biopsy was obtained at the initial visit and was consistent with benign proliferative phase endometrium.

Examination revealed an eight week size uterus and no adnexal masses. There was urethral hypermobility, but no visible incontinence with Valsalva maneuver. The examination was otherwise unremarkable.

A discussion with the patient ensued and it was felt that further imaging modalities were indicated. In addition, the patient was offered a hysteroscopy, further endometrial sampling, and possible hysteroscopic resection. As both the above management options required transportation to a distant referral facility, the patient stated she would prefer a definitive operative intervention, if she needed to make such a trip.

The patient subsequently received an uncomplicated total vaginal hysterectomy with a left salpingo-oophorectomy. The patient was discharged on the second post operative day.

Pathologic evaluation revealed cytologic atypia present throughout the neoplasm that was of a degenerative and bizarre type. Occasional mitotic figures were identified. No tumor type necrosis was seen. The increased cellularity was felt to be somewhat increased over what one normally sees in a highly cellular leiomyoma. The pathologic material was sent to a second site for pathologic evaluation and the above impression was confirmed.

What do you think this patient's diagnosis is?
What is the risk of recurrence?

Stay tuned to next month's Medical Mystery Tour for the rest of the story

Oklahoma Perspective

Greggory Woitte—Hastings Indian Medical Center

Asthma in Pregnancy

Your next patient is a new OB physical. After scanning her history, you note that she reports having a medical history significant for Asthma in the past. Given the high prevalence of asthma in the general population, it is one of the more common complications of pregnancy. Pregnancies complicated with asthma are more likely to also be complicated by Preterm birth, hyperemesis gravidarium, pre-eclampsia, IUGR and neonatal mortality. The goals that should be met in taking care of this patient include:

1. objectively evaluating the maternal fetal clinical condition
2. control of asthma symptoms and prevention of acute attacks by avoidance/control of triggers
3. Maximize lung function with drug while minimizing side effects
4. patient education

Placing a patient into a category, mild-intermittent, mild-persistent, moderate or severe, based on her pre-pregnancy condition will assist in your treatment of the patient during pregnancy. However, the foundation of management of these patients is the Peak Expiratory Flow Rate (PEFR). Use of this peak flow meter can assist in management, recognition and prevention of exacerbations. Here are the National Asthma Education and Prevention Program recommendations.

Asthma and pregnancy report. NAEPP report of the Working Group on Asthma and Pregnancy: management of asthma during pregnancy
www.nhlbi.nih.gov/health/prof/lung/asthma/astpreg.txt

NAEPP expert panel report 2: guidelines for the diagnosis and treatment of asthma
www.nhlbi.nih.gov/guidelines/asthma/asthgdln.htm

NAEPP expert panel report: guidelines for the diagnosis and treatment of asthma—update on selected topics 2002
www.nhlbi.nih.gov/guidelines/asthma/asthupdt.htm

Managing Asthma During Pregnancy: Recommendations for Pharmacologic Treatment—Update 2004
www.nhlbi.nih.gov/health/prof/lung/asthma/astpreg/astpreg_qr.pdf

Perinatology Picks—George Gilson, MFM, ANMC

#1 Fetal Lung Maturity Assessment

The evaluation of fetal lung maturity by use of lipid chromatography analysis of amniotic fluid surfactant with the lecithin-sphingomyelin ratio and per cent phosphatidyl glycerol ("L/S and PG") has been standard obstetric practice for over 40 years. Over the last 20 years however, this test has been largely supplanted by the fluorescence polarization assay, which, in its current iteration, is known as the "TDx-FLM II" test (Abbott Laboratories). There is an extensive literature (see below for partial list of references) evaluating its accuracy, both evaluating its correlation with L/S and PG, as well as investigating its clinical efficacy in predicting infants diagnosed with respiratory distress syndrome (IRDS).

The accuracy of the TDx-FLM is now considered excellent, and, in the latest studies, demonstrates that it is probably superior to L/S and PG determinations. Our consultants at the University of Washington and our reference lab have now largely abandoned the L/S and PG in favor of the TDx-FLM II. I would therefore like to propose that we also exclusively use this simpler and less costly test, which can be done locally, with results provided within several hours, and which only requires 1 mL of amniotic fluid. Currently, if the FLM is negative or indeterminate, Providence sends the specimen out for confirmation with an L/S and PG determination. This is called the "sequential" or "cascade" strategy, and was likewise proposed over 20 years ago. This takes about 48 hours for the result, accrues a substantial additional charge, and is probably not necessary with the accuracy of the current TDx-FLM II.

While most laboratories report specific cut-off points (immature: <39; indeterminate: 40-54; mature: >55 mg/g), gestational age-specific risk estimates are more accurate (see nomogram hanging in OB Triage and reference [11] below), and do not give just a "yes or no" answer. For example, a FLM of 50 at 36 weeks predicts a risk of IRDS of 4.3%, probably an acceptable risk depending on the indication for early delivery. Like the L/S, amniotic fluid specimens contaminated with significant quantities of blood, meconium, or bilirubin may give erroneous results. Insufficient data has been accrued on vaginal pool amniotic fluid specimens. All tests of fetal lung maturity, including the L/S, have over a 95% negative predictive value (if the test is reported mature, there is only a 5% chance of IRDS), but only a 60% positive predictive value (test reported as immature, but infant does not develop IRDS).

Amniocentesis for fetal lung maturity is currently only thought to be useful in 2 clinical situations: 1) between 34-36 weeks where delivery is thought to be indicated for maternal or fetal reasons, but the need is not urgent (under 34 weeks: rarely ever mature results, over 36 weeks: rarely ever severe IRDS), and 2) in a woman with unsure dating with a differential diagnosis of possible fetal growth restriction (requiring delivery) versus lesser (premature) gestational age. In other situations, if there is an urgent indication for delivery, the pregnancy should be delivered regardless of the results of fetal lung maturity testing.

References: Online

Maternal oxygen administration for fetal distress

Conclusion: The administration of supplemental oxygen to laboring patients with nonreassuring fetal heart rate patterns increases fetal oxygen saturation substantially and significantly. Fetuses with the lowest initial oxygen saturations appear to increase the most.

Haydon ML, et al The effect of maternal oxygen administration on fetal pulse oximetry during labor in fetuses with nonreassuring fetal heart rate patterns. Am J Obstet Gynecol. 2006 Sep;195(3):735-8

OB/GYN CCC Editorial

Haydon et al would seem to be encouraging that the administration of supplemental oxygen to laboring patients with nonreassuring fetal heart rate patterns increases fetal oxygen saturation substantially and significantly. Rather, meaningful data could not be gleaned from this relatively small sample size regarding changes in FHR patterns that were subsequent to oxygen supplementation.

Unfortunately, there were no consistent changes in FHR after exposure to oxygen. The specific aspects of these changes could be addressed only in a much larger study. Haydon et al's findings do not support or refute the use of supplemental oxygen for any specific nonreassuring FHR pattern. This would require more patients having each abnormal pattern type for analysis. Additional studies are necessary to determine the optimal supplemental oxygen concentration in labor. Larger studies would be required to evaluate the effects of oxygen therapy in nonreassuring FHR patterns on neonatal outcomes that include umbilical cord blood analyses, ventilatory assistance, and neonatal intensive care admission.

At this point the following conclusion from the Cochrane Library* still stands: There is not enough evidence to support the use of prophylactic oxygen therapy for women in labour, nor to evaluate its effectiveness for fetal distress.

In the meantime, I suggest that we initially give the laboring patient with a questionable strip a bolus of intravenous fluids to increase intravascular volume, hence increasing perfusion in addition to other conservative measures, e. g., position change, oxygen supplementation, and intrauterine resuscitation.

**Fawole B, Hofmeyr GJ. Maternal oxygen administration for fetal distress. Cochrane Database of Systematic Reviews 2003, Issue 4. Art. No.: CD000136. DOI: 10.1002/14651858.CD000136.*

(Routine Voluntary Testing, continued from page 1)

population. From a public health perspective, release of these guidelines truly represents a positive step forward in HIV/AIDS mitigation efforts. The revisions have appropriately stimulated discussion and revealed the challenges and barriers of implementation, yet this gives us an opportunity to utilize them as a springboard for action. In the spirit of the release and rationale, it is critical that we do not create unnecessary barriers to screening within our system.

There may be concerns surrounding specific recommendations such as 'general consent' or the 'guidelines surrounding prevention counseling', as well as the potential for stigma and discrimination and conflicting state health regulations. Given these revisions, there have been concerns raised surrounding the removal of specific informed consent, the quality of care if prevention counseling is not required, the cost to implement, and issue of stigma and discrimination.

The alternative—not taking advantage of these revisions—could keep us locked into a pattern that will not improve or protect the health of our people. These recommendations are for streamlining general procedures and must be interpreted and applied with competence. The American Indians / Alaskan Natives represent a specific population with unique sub-populations of higher risk. This situation must be taken into consideration with the science behind the revisions. There are behavioral health, education, and health disparity components and issues that will surface.

Programmatic Synergy

These guidelines are intended to improve *population* health by lowering or preventing disease transmission (Read as: Health Promotion / Disease Prevention, which is one of our Director's priorities).

Attempt to adopt the methods and be mindful of the individual, cultural, and system barriers and perspectives with good communication and collaboration as they arise. (Read as: Both a GPRA indicator and a Healthy People 2010 goal)

At Headquarters, we are addressing the current HIV/AIDS testing policy since the information is out-dated. In lieu of new IHS HIV/AIDS policy, we suggest implementing the CDC guidelines (as best possible) and realize there is more work to be done. Additional comments and progress on the revisions will be forthcoming.

OB/GYN CCC Editorial

HIV transmission is a sentinel event, signaling a missed opportunity for prevention

Important take home points are:

- Awareness of serostatus substantially reduces high-risk behaviors, plus screening is cost-effective.
- Hence, the revised recommendations call for routine HIV testing for ALL individuals between the ages of 13 and 65 years in the United States.
- No separate written consent form is needed for screening, plus high-risk patients should be tested for HIV annually
- The revised recommendations advocate for streamlining general procedures and should be applied with competence

Two clinical pearls and some food for thought—A teachable moment

1) You still need to provide 'pre-test' counseling, either verbal or written. This is a very important teachable moment with your patient that you should not let slip through your fingers.

'Pre-test' teaching is very different from 'Prevention' Counseling. 'Prevention' Counseling is relatively long and involved, while 'pre-test' counseling can be concise and to the point. In a way a negative HIV screen result may be more important than a positive result, because you still have the chance to prevent that patient with a negative result from becoming a future HIV patient.

I suggest you coordinate with your patient educators and develop age appropriate materials that you can give to all your patients. The CDC is a great resource, plus the Indian Health system's Patient Education team can help you adapt those materials to be more culturally specific. Our goal is to decrease HIV transmission and all the barriers to that goal.

2) The Indian Health system respects state laws, but be wary of information from other staff that say your individual state 'requires' a written consent.

In most cases your state does not actually 'require' a written consent. Rather, the State Lab may require a written consent to perform free HIV testing at their Lab. If you send your HIV tests out, perform them in your own lab, or perform rapid testing at the bedside, then you would not need a written consent.

When in doubt, check this out yourself. Don't depend on the 'conventional wisdom' without asking the right questions of the appropriate state officials. I have included a great resource from Charlton Wilson which answers that question on a state by state basis below, however a call to your state health department may be the most accurate way to find updated requirements.

Food for thought about missed opportunity

Every perinatal HIV transmission is a sentinel health event, signaling either a missed opportunity for prevention or, more rarely, a failure of interventions to prevent perinatal transmission. When these infections occur, they underscore the need for improved strategies to ensure that all pregnant women undergo HIV testing and, if found to be HIV positive, receive proper interventions to reduce their transmission risk and safeguard their health and the health of their infants. #

Data confirm that testing rates are higher when HIV tests are included in the standard panel of screening tests for all pregnant women. Women also are much more likely to be tested if they perceive that their health-care provider strongly recommends ➔

➔HIV testing. As universal prenatal screening has become more widespread, an increasing proportion of pregnant women who had undiagnosed HIV infection at the time of delivery were found to have seroconverted during pregnancy. A second HIV test during the third trimester for women in settings with elevated HIV incidence (>17 cases per 100,000 person-years) is cost-effective and might result in substantial reductions in mother-to-child HIV transmission.*

For those outside the perinatal and neonatal arena, you now have an opportunity to apply the success the perinatal and neonatal disciplines have shown with reducing perinatal transmission…but you can apply to all persons from 13-64.

I would like to thank Scott Giberson very much for the important update, above. Please contact Scott for other questions at Scott.Giberson@ihs.gov (more on Scott's background below*).

From Charlton Wilson, PIMC

Here is the link for a great resource for all the state laws as of summer 2006. This resource is vast, so use the 'Find' function after you have read the background material at the beginning, e.g., Arizona page 54, New Mexico page 689, North Dakota page 745, and South Dakota page 914.
www.ucsf.edu/hivcntr/PDFs/WEB2006State%20Laws.pdf

References:

1. *Branson et. al. 2006. Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings. MMWR Recommendations and Reports. September 22. 55(RR14);1-17.*

2. *CDC Press Release. September 21, 2006.*

Many other references available upon request: nmurphy@scf.cc

*CDR Scott Giberson, the National IHS HIV/AIDS Principal Consultant, has served 13 years (10 in the IHS) both domestically and abroad in roles as Chief Pharmacist, Public Health Advisor, Medical Unit Lead (for an international health program), and member of Family Practice medical staffs. In his previous position, he was responsible for operational oversight on HIV/AIDS public health programs spanning multiple countries in the Asia-Pacific region for the Department of Defense. He has authored articles and spoken on HIV/AIDS topics at numerous venues across the US and Asia Pacific.

STD Corner

Lori de Ravello, National IHS STD Program

Prevalence of HPV Infection among Men: A Systematic Review of the Literature

Background: Human papillomavirus (HPV) infection is estimated to be the most common sexually transmitted infection; an estimated 6.2 million persons are newly infected every year in the United States. There are limited data on HPV infection in heterosexual men.

Results: We included a total of 40 publications on HPV DNA detection and risk factors for HPV in men; 27 evaluated multiple anatomic sites or specimens, 10 evaluated a single site or specimen, and 3 evaluated risk factors or optimal anatomic sites/specimens for HPV detection. Twelve studies assessed site- or specimen-specific HPV DNA detection. HPV prevalence in men was 1.3%–72.9% in studies in which multiple anatomic sites or specimens were evaluated; 15 (56%) of these studies reported _20% HPV prevalence. HPV prevalence varied on the basis of sampling, processing methods, and the anatomic site(s) or specimen(s) sampled. We included 15 publications reporting HPV seroprevalence. Rates of seropositivity depended on the population, HPV type, and methods used. In 9 studies that evaluated both men and women, all but 1 demonstrated that HPV seroprevalence was lower in men than in women.

Conclusion: HPV infection is highly prevalent in sexually active men and can be detected by use of a variety of specimens and methods. There have been few natural-history studies and no transmission studies of HPV in men. The information that we have reviewed may be useful for future natural-history studies and for modeling the potential impact of a prophylactic HPV vaccine.

Dunne, E et al Prevalence of HPV Infection among Men: A Systematic Review of the Literature. J Infect Dis 2006:194 (15 October)

SAVE THE DATES

Best Practices and GPRA Tracking

- Nov 1–2, 2006
- Sacramento, CA
- California IHS Area Office, Contact: Elaine.brinn@ihs.gov
- www.ihs.gov/MedicalPrograms/MCH/F/documents/BestPracticesFlyer1.pdf

22nd Annual Midwinter Indian Health OB/PEDS Conference

- For providers caring for Native women and children
- January 26–26, 2007
- Telluride, CO
- Contact Alan Waxman at: awaxman@salud.unm.edu

2nd International Meeting on Indigenous Child Health

- April 20–22, 2007
- Montreal, Quebec, Canada
- Solutions, not Problems
- Joint meeting of IHS, AAP-CONACH, First Nations and several other stakeholders
- www.aap.org/nach/2InternationalMeeting.htm

2007 Indian Health MCH and Women's Health National Conference

- August 15–17, 2007
- Albuquerque, NM
- THE place to be for anyone involved in care of AI/AN women, children
- Internationally recognized speakers
- Save the dates. Details to follow
- Want a topic discussed? Contact: nmurphy@scf.cc

Abstract of the Month

- CDC Recommendation Routine, Voluntary HIV Screening in Health Care Settings

IHS Child Health Notes

- Early prednisone therapy in Henoch-Schonlein purpura: a randomized, double-blind, placebo-controlled trial.
- Physician documentation of neonatal risk assessment for perinatal infections.
- Recent literature on American Indian/Alaskan Native Health
- The Alaska Haemophilus influenzae type b experience: lessons in controlling a vaccine-preventable disease.

From Your Colleagues

- Sunnah Kim, American Academy of Pediatrics—Forty years in partnership: the American Academy of Pediatrics and Indian Health

Hot Topics

- Obstetrics—Can a 29% Cesarean Delivery Rate Possibly Be Justified?
- Gynecology—A new era in ovulation induction: Aromatase inhibitors
- Child Health—Fetal injury at cesarean delivery: Related to the indication and type of uterine incision
- Chronic disease and Illness—Aspirin to Prevent Heart Attack and Stroke: What's the Right Dose? 160 mg/day

Features

- American Family Physician—Postcoital Bleeding and Cervical Cancer Risk
- ACOG—Amnioinfusion Does Not Prevent Meconium Aspiration Syndrome
- Family Planning—Ortho Evra Patch Linked to Risk for Venous Thromboembolism
- Midwives Corner—External Fetal Monitors...Can you kick the habit?
- Alaska State Diabetes Program—No improvement in fetal outcome, plus increased maternal morbidity: Who pays for this? You do
- Nurses Corner—Interventions for Depression in Reproductive Age Women in Family Planning Programs
- Ask a Librarian—From your Library: Updated Cochrane Systematic Reviews

Neil Murphy, MD
PCC–WH
4320 Diplomacy Drive
Anchorage, AK 99508

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