NATIONAL COUNCIL OF CHIEF CLINICAL CONSULTANTS

CCC CORNER

Focus on the Health of American Indians and Alaska Natives

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Minorities Underrepresented

in both public and private umbilical cord blood banking

Two types of banks have emerged for the collection and storage of umbilical cord blood—public banks and private banks. Public banks promote allogenic (related or unrelated) donation, analogous to the current collection of whole blood units in the United States. Private banks were initially developed to store stem cells from umbilical cord blood for autologous use (taken from an individual for subsequent use by the same individual) by a child if the child develops disease later in life. If a patient requests information on umbilical cord blood banking, balanced and accurate information regarding the advantages and disadvantages of public versus private banking should be provided. The remote chance of an autologous unit of umbilical cord blood being used for a child or a family member (approximately 1 in 2,700 individuals) should be disclosed. The collection should not alter routine practice for the timing of umbilical cord clamping. Physicians or other professionals who recruit pregnant women and their families for for-profit umbilical cord blood banking should disclose any financial interests or other potential conflicts of interest.

Umbilical Cord Blood Banking. ACOG Committee Opinion No. 399. American College of Obstetricians and Gynecologists. Obstet Gynecol 2008;111:475–7.

OB/GYN CCC Editorial

Providers should give balanced information when discussing cord blood banking

Minorities, especially American Indians and Alaska Natives. are underrepresented in both modalities of banking, especially American Indians and Alaska Natives. This deficiency could have significant implications for our (now) young patients later in their lives. The Indian Health system should cooperate fully with both groups of banking methods.

The MCH Frequently Asked Questions page has long had a discussion of the advantages and disadvantages of AI/AN cord blood banking which includes a template Disclaimer Form.
www.ihs.gov/MedicalPrograms/MCH/M/documents/CordStem4206.doc

ACOG recommends providers give balanced information to their pregnant patients who are considering cord blood banking, presenting both the advantages and disadvantages of public vs. private cord blood banks.

ACOG also advises physicians who recruit patients for for-profit cord blood banking to disclose their financial interests or other potential conflicts of interest to pregnant women and their families.

Blood from a newborn's umbilical cord, once considered a waste product that was routinely discarded along with the placenta, is now considered to contain potentially life-saving stem cells. Private banks were initially developed to store cord blood stem cells from newborns, for a fee, for potential future use by the same child or a family member if he/she developed disease later in life. Today, there are public banks that store, for free, stem cells that can be used by anyone needing them similar to how public blood banks work.

"Patients need to be aware that the chances are remote that the stem cells from their baby's banked cord blood will be used to treat that same child—or another family member—in the future," said Anthony R. Gregg, MD, chair of ACOG's Committee on Genetics. ACOG's Committee Opinion is a joint document produced by the Committee on Obstetric Practice and the Committee on Genetics.

Although ACOG takes no position for or against cord blood banking, it recommends that physicians disclose that there is no reliable estimate of

(continued on page 15)

THIS MONTH

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Sex Education:

Providers should fill the gap

Lindau et al reports that nearly one in three sex education teachers are not trained. (Page 4) Lindau suggests that providers caring for adolescents may need to fill gaps in adolescent knowledge due to deficits in content, quality, and teacher training. On page 5 Dr. Beth Crow, ANMC, relates how she provided an age appropriate sexual health curriculum in a community setting. I would like to offer kudos to Dr. Crow and encourage other providers to follow her example. You could positively influence sexual and reproductive health, as well as lead to a more confident, safer young population.

Also on-line....

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

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

IHS Child Health Notes

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

Quote of the month

"For every complex problem there is an answer that is clear, simple, and wrong"
—H. L. Mencken

Articles of Interest

Symptom profile of common colds in school-aged children.

Pediatr Infect Dis J. 2008 Jan;27(1):8-11.

Effect of honey, dextromethorphan, and no treatment on nocturnal cough and sleep quality for coughing children and their parents.

Arch Pediatr Adolesc Med. 2007 Dec;161(12):1140-6.

Article Comment

The past few weeks we have been swamped in pediatric clinic with fever, cough and runny nose. Parents' first concern is, "does my child have pneumonia?" When my answer is "no" (which it is most of the time) the next question is, "how long will he/she be sick?" The first article above tries to answer that question for school aged children.

Healthy school-aged children were screened as part of a study on the effects of viral URI on middle ear pressure. Nasal aspirates were obtained; about half of the patients had rhinovirus recovered. Approximately 1/3 had pathogenic bacteria such as Moraxella or Haemophilus species. The authors gave families preprinted sheets listing common signs and symptoms of colds.

Not surprisingly, cough and congestion were the most common symptoms. Fever usually resolved by 4 to 5 days. What was noteworthy was that most (73%) of patients still had some symptoms after 10 days of which 40% still had cough. A previous study of children ages 0-3 years with colds suggested a mean duration of symptoms of 7 days. Previous studies in adults suggested that cold symptoms resolved by 10 days

Parents frequently return to clinic with healthy children zooming around the exam room but concerned that their child is still coughing after 4 or 5 days of illness. This study is helpful in counseling parents about the expected duration of cold symptoms in their children.

The second article suggests that honey may be the answer to cough and the common cold. Investigators compared honey to dextromethorphan and placebo and found it superior in cough suppression and improvement in sleep quality. Possible mechanisms of action for honey to reduce cough include antioxidant and antimicrobial effects or it may be as simple as honey's demulcent properties. Given the recent FDA warning on cough medications for children under age 5 years there is a cough treatment vacuum waiting to be filled. Look for this study to be repeated to see if the results hold up.

Editor's Note

Below is the last review by Dr. Doug Esposito. After a 13 year distinguished career in clinical pediatrics in the Indian Health Service, Doug is joining the CDC in the Epidemiological Investigation Service. Our loss is their gain.

My hope is that at the completion of his epidemiology training he will return to Indian Health Service. I suspect he will continue to worry, argue, fuss and be cranky at the CDC in the same beneficial way he has done so in Fort Defiance, Anchorage, and on these pages. Most physicians as they mature get middle-aged, boring and predictable. Doug has remained enthusiastic and committed about improving AI/AN health and we and his patients are the beneficiaries of his passion.

Recent literature on American Indian/ Alaskan Native Health

Douglas Esposito,MD, MPH

Singleton RJ, Bruden D, Bulkow LR. Respiratory syncytial virus season and hospitalizations in the Alaskan Yukon-Kuskokwim Delta.

Pediatr Infect Dis J. 2007 Nov;26(11 Suppl):S46-50.

Editorial Comment

By the time you read this, it is likely that those of us working with AI/AN kids in the lower 48 will be emerging from the depths of a pretty rotten RSV year. How about a collective sigh of relief...OK, everybody together...Whew!

Unfortunately, if history is any indication, our snow-bound colleagues in Alaska will still be holding their breaths. They are likely to be in the thick of things...continuing to battle against RSV bronchiolitis and thick nasal secretions for at least another couple of months! In fact, they might not even have seen the worst of it yet!!

This report, authored by our own Ros Singleton, looks at RSV hospitalization rates for Alaska's Y-K Delta population, assesses the risk factors associated with RSV-related hospitalizations there, identifies the impact of Synagis prophylaxis on high-risk Y-K Delta infants, and documents the prolonged annual RSV season in Alaska that simply makes me shudder (for those of you who are unaware, I was a pediatric hospitalist at the Alaska Native Medical Center in Anchorage for four years, and just barely made it out alive!).

Here are a few important points made in this report

1. The RSV hospitalization rate for Y-K Delta infants is five times the rate of the general U.S. population.
2. The RSV season is prolonged in Alaska, with the median onset and median offset (mid-October and late-May, respectively) being well outside the range seen in the lower 48 (late November to late March or early April). In fact, the median RSV season in Alaska is twice as long as that experienced in the lower 48 (31 weeks vs. 15 weeks), with around 13% of the yearly RSV hospitalizations occurring in summer (June through September).
3. The median peak RSV season in Alaska occurs in late February, but ranges from mid-December to early-May.
4. Crowding, lack of running water and flush toilets, lack of breast feeding, tobacco smoke exposure, and underlying medical conditions were associated with RSV hospitalization in the Y-K Delta. Wouldn't you know it, overcrowding and smoking rates are high and access to running water and flush toilets low in Yup'ik Eskimo villages.

This paper expertly documents the rationale behind altering the Synagis protocol in Alaska as compared to standard practice in the lower 48. Additionally, factors leading to the high rates of RSV-associated hospitalization seen in kids living in the Y-K Delta region and what might be done to address this disparity are explored. Thanks, Ros, for the critical insight!

A Final Word

I began as a regular contributor to the IHS Child Health Notes back in September, 2005. Now, after subjecting you all to more than two and-a-half years of liberal ranting and nonstop pleas for health equity and the elimination of health disparities among the populations we are privileged to serve, I will be passing on the torch to two very competent and dedicated pediatrician colleagues and friends. So, please welcome Drs. Michael and Margaret Bartholomew to next month's Notes. I know that the two of them will offer excellent reviews of superior insight and objectivity, and perhaps even grammatical correctness and literary appeal. With two of them splitting the job, it should be twice as good, right?

Back in September 2005, Dr. Holve introduced me to you all with the expectation that I would "add knowledge and breadth, and possibly wit, to these pages." I cannot say that I have performed as billed, but I can say that writing these notes has been fun, rewarding, and enlightening. I am grateful for the opportunity to have been able to critically explore the growing body of literature related to AI/AN child health in a manner and depth that I otherwise would not have endeavored to do.

The progress that has been achieved over recent decades related to health status gains for Native American populations has been staggering. And, compared to other races and ethnicities in the U.S., the velocity and magnitude of this change has no equal. This, I am convinced, is testament to the amazing dedication and talent of you; the many wonderful individuals and groups working in partnership with Native American communities toward a common, necessary, and noble goal.

But, there is of course some bad news. Forward progress has stalled recently, with health disparities persisting and in some cases, sadly widening. The quest to achieve true health equity for Native Americans sometimes seems impossibly distant, with so much remaining to be done.

So, I say to all of you, please continue your wonderful work and thank you for the amazing things you do each and every day. It all truly matters.

From your Colleagues

Melissa Toffolon-Weiss, Anchorage

HPV brochure for AI/AN available for broad dissemination

We have developed a brochure for Alaska Native parents to inform them about the new HPV vaccine. We also have a poster. If you would like hard copies of these materials sent to you - please contact me.

Melissa Toffolon-Weiss, PhD, MPH
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Hot Topics

Obstetrics

Evidence Favors Late Cord Clamping in Infants

Results: Of 37 studies identified, eight randomized trials and seven nonrandomized trials, six of which were rated as high quality, were included. Early clamping was defined in most studies as clamping within the first 10 seconds of birth, and late clamping was defined as occurring with cessation of cord pulsations or at three minutes (two minutes was the minimal cutoff for definition of late clamping in this meta-analysis).

Of 1,912 newborns represented in the 15 studies identified, 1,001 underwent late clamping and 911 underwent early clamping. Hematocrit levels, as measured at hours or days after delivery, were higher with late cord clamping, but the difference was not significant at six months. Similarly, the higher hemoglobin levels found with late cord clamping were no longer significant at two to three months of age.

Blood volume in infants with late clamping was higher in some trials and not significantly different in others, especially with increasing passage of time. Three trials reported higher blood viscosity with late clamping. Mean bilirubin levels were similar regardless of clamping approach. Several trials found higher ferritin levels and iron stores with late clamping. In terms of clinical outcomes, infants with late clamping had lower risk of anemia at 24 to 48 hours and at two to three months of age. When ferritin levels were considered, infants were at lower risk of anemia at six months as well. There were no differences in rates of jaundice. Polycythemia risk within the first few days of life was greater in infants who underwent late cord clamping. Clamping approach had no apparent effect on tachypnea or respiratory distress, or neonatal intensive care unit admission.

Conclusion: Late cord clamping had a beneficial effect on infants' anemia risk and iron stores, an effect that lasted well into the neonatal period. Increased viscosity and polycythemia were associated with late clamping, but did not appear to have any clinical adverse effects. The authors conclude that these findings are particularly important in geographic areas with few resources, where late cord clamping would be the most beneficial approach.

Hutton EK, Hassan ES. Late vs early clamping of the umbilical cord in full-term neonates: systematic review and meta-analysis of controlled trials. JAMA. March 21, 2007;297(11):1241-1252.

OB/GYN CCC Editorial

Similar finding in preterm infants

A study published in the March 2007 issue of Pediatrics looked at the effects of late cord clamping on cerebral oxygenation in preterm infants.1 The study of infants at a median age of 30.4 weeks found that infants with late cord clamping had similar cerebral blood volumes but higher tissue oxygenation than infants delivered in the conventional manner. Although this study did not evaluate the clinical impact of this finding, it does identify another high-risk group that could benefit from late cord clamping.

Baenziger O, Stolkin F, Keel M, et al. The influence of the timing of cord clamping on Postnatal cerebral oxygenation in preterm neonates: a randomized, controlled trial. Pediatrics. 2007;119(3):455-459

Continuous suturing for perineal closure vs interrupted methods - Less pain: Cochrane

Authors' Conclusions: The continuous suturing techniques for perineal closure, compared to interrupted methods, are associated with less short-term pain. Moreover, if the continuous technique is used for all layers (vagina, perineal muscles and skin) compared to perineal skin only, the reduction in pain is even greater.

Kettle C et al Continuous versus interrupted sutures for repair of episiotomy or second degree tears. Cochrane Database Syst Rev. 2007 Oct 17;(4):CD000947.

Gynecology

Biofeedback Reduces Psychological Burden in Older Women With Urge UI

In older women with urge urinary incontinence (UI), biofeedback (BFB) therapy significantly improved psychological burden, especially in those with a history of depression.

Conclusion: In older women with urge UI, BFB significantly improves psychological burden, especially in those with a history of depression, in whom psychological burden is linked to change in perception of control. Psychological factors are relevant outcome measures for UI, and these data suggest that focusing on UI frequency alone may have underestimated BFB's efficacy and additional therapeutic benefits.

Tadic SD, et al Effect of biofeedback on psychological burden and symptoms in older women with urge urinary incontinence. J Am Geriatr Soc. 2007 Dec;55(12):2010-5

Not enough evidence to evaluate routine antibiotic prophylaxis with SAB: Cochrane

Main Results: One study involving 140 women was included. A second well-conducted trial was excluded because of high losses to follow-up. No differences were detected in postabortal infection rates with routine prophylaxis or control. However, compliance with antibiotic treatment was also low. AUTHORS' CONCLUSIONS: There is not enough evidence to evaluate a policy of routine antibiotic prophylaxis to women with incomplete abortion.

May W et al Antibiotics for incomplete abortion. Cochrane Database Syst Rev. 2007 Oct 17;(4):CD001779

Child Health

Sex education: Providers need to fill gaps in adolescent knowledge

Results: Representing 91.3% of sampled schools, the teacher survey response rate was 62.4%. The most frequently taught topics included HIV/AIDS (97%), STDs (96%), and abstinence-until-marriage (89%). The least frequently taught topics were emergency

contraception (31%), sexual orientation (33%), condom (34%) and other contraceptive (37%) use, and abortion (39%). Abstinence-only curricula were used by 74% of teachers, but 33% of these teachers supplemented with "other" curricula. Overall, two thirds met comprehensiveness criteria based on topics taught. Curricular material availability was most commonly cited as having a "great deal" of influence on topics taught. Thirty percent had no training in sex education; training was the only significant predictor of providing comprehensive sex education in multivariable analysis.

Conclusion: Illinois public school-based sex education emphasizes abstinence and STDs and is heavily influenced by the available curricular materials. Nearly one in three sex education teachers were not trained. Obstetrician-gynecologists caring for adolescents may need to fill gaps in adolescent knowledge and skills due to deficits in content, quality, and teacher training in sex education.

Lindau ST et al What schools teach our patients about sex: content, quality, and influences on sex education. Obstet Gynecol. 2008 Feb;111(2):256-66.

Editorial comment: Beth Crow, Anchorage

Learning about sexuality is really important for children's health, safety, and confidence

In order to offer something that our schools lack, I teach Our Whole Lives (OWL), which is an age appropriate sexual health curriculum developed by the Unitarian Universalists of the US and Canada in conjunction with the United Church of Christ. Although there is a supplemental spiritual curriculum, the core OWL curriculum is secular. There is a male and female teaching team for each class. The teachers are trained for whatever age group they want to teach. Our training was at Planned Parenthood with municipal HIV educators and Planned Parenthood staff. The curriculum includes communication, gender identification, gender roles, sexual health and safety, anatomy, contraception, intercourse (when age appropriate), etc. The curricula is available for 5-6 year olds, 9-11 year olds, junior high and senior high school students. Parents are involved in initial meetings and with home links, but the students are in class with peers and their teaching team.

I think many European countries, in particular, Scandinavia, have comprehensive sexual health programs, which results in a fraction of the teen pregnancies and STI's that we have in the US. In addition to universal access to health care and contraception, their schools have age-appropriate sex education curricula from a very early age.

I do believe that this should be a universal curriculum, and not just for children of interested parents. Parents often can't or won't talk to their children about sexuality, so children learn about sexuality from the media, school, other children, etc. These are not reliable sources, even schools, as the article by Landau shows. The sequelae of inadequate sex education is an increasing rate of teen STI's, sexual violence, and pregnancy. The U.S. needs to be proactive about our health care spending by instituting a universal, comprehensive, age-appropriate, sexual education. This will lead to a healthier, more confident, safer young population.

Obstet Gynecol Editorial

Phipps MG. Consequences of inadequate sex education in the United States. Obstet. Gynecol. 2008 Feb;111(2):254-5

Chronic disease and Illness

Diuretics most effective blood pressure medicine for people with metabolic syndrome

Conclusions: The ALLHAT findings fail to support the preference for calcium channel blockers, alpha-blockers, or angiotensin-converting enzyme inhibitors compared with thiazide-type diuretics in patients with the MetS, despite their more favorable metabolic profiles. This was particularly true for black participants.

Wright JT Jr, Clinical outcomes by race in hypertensive patients with and without the metabolic syndrome: Antihypertensive and Lipid-Lowering Treatment to Prevent Heart Attack Trial (ALLHAT). Arch Intern Med. 2008 Jan 28;168(2):207-17.

FDA MedWatch—Chantix (varenicline)—Associated With Reports Of Changes In Behavior

FDA informed healthcare professionals and consumers of important revisions to the WARNINGS and PRECAUTIONS sections of the prescribing information for Chantix regarding serious neuropsychiatric symptoms experienced in patients taking Chantix. These symptoms include changes in behavior, agitation, depressed mood, suicidal ideation, and attempted and completed suicide. While some patients may have experienced these types of symptoms and events as a result of nicotine withdrawal, some patients taking Chantix who experienced serious neuropsychiatric symptoms and events had not yet discontinued smoking. In most cases, neuropsychiatric symptoms developed during Chantix treatment, but in others, symptoms developed following withdrawal of Chantix therapy. See the FDA Information for Healthcare Professionals Sheet for recommendations and considerations for healthcare professionals on using Chantix therapy for patients.

Read the complete 2008 MedWatch Safety Summary including a link to the FDA Public Health Advisory, Healthcare Professional Information Sheet and the prescribing information for Chantix

Features

ACOG, American College of Obstetricians and Gynecologists

ACOG Statement on Home Births

The American College of Obstetricians and Gynecologists (ACOG) reiterates its long-standing opposition to home births. While childbirth is a normal physiologic process that most women experience without problems, monitoring of both the woman and the fetus during labor and delivery in a hospital or accredited birthing center is essential because complications can arise with little or no warning even among women with low-risk pregnancies.

ACOG acknowledges a woman's right to make informed decisions regarding her delivery and to have a choice in choosing her health care provider, but ACOG does not support programs that advocate for, or individuals who provide, home births. Nor does ACOG support the provision of care by midwives who are not certified by the American College of Nurse-Midwives (ACNM) or the American Midwifery Certification Board (AMCB).

Childbirth decisions should not be dictated or influenced by what's fashionable, trendy, or the latest cause célèbre. Despite the rosy picture painted by home birth advocates, a seemingly normal labor and delivery can quickly become life-threatening for both the mother and baby. Attempting a vaginal birth after cesarean (VBAC) at home is especially dangerous because if the uterus ruptures during labor, both the mother and baby face an emergency situation with potentially catastrophic consequences, including death. Unless a woman is in a hospital, an accredited freestanding birthing center, or a birthing center within a hospital complex, with physicians ready to intervene quickly if necessary, she puts herself and her baby's health and life at unnecessary risk.

Advocates cite the high US cesarean rate as one justification for promoting home births. The cesarean delivery rate has concerned ACOG for the past several decades and ACOG remains committed to reducing it, but there is no scientific way to recommend an 'ideal' national cesarean rate as a target goal. In 2000, ACOG issued its Task Force Report Evaluation of Cesarean Delivery to assist physicians and institutions in assessing and reducing, if necessary, their cesarean delivery rates. Multiple factors are responsible for the current cesarean rate, but emerging contributors include maternal choice and the rising tide of high-risk pregnancies due to maternal age, overweight, obesity and diabetes.

The availability of an obstetrician-gynecologist to provide expertise and intervention in an emergency during labor and/or delivery may be life-saving for the mother or newborn and lower the likelihood of a bad outcome. ACOG believes that the safest setting for labor, delivery, and the immediate postpartum period is in the hospital, or a birthing center within a hospital complex, that meets the standards jointly outlined by the American Academy of Pediatrics (AAP) and ACOG, or in a freestanding birthing center that meets the standards of the Accreditation Association for Ambulatory Health Care, The Joint Commission, or the American Association of Birth Centers.

It should be emphasized that studies comparing the safety and outcome of births in hospitals with those occurring in other settings in the US are limited and have not been scientifically rigorous. Moreover, lay or other midwives attending to home births are unable to perform live-saving emergency cesarean deliveries and other surgical and medical procedures that would best safeguard the mother and child.

ACOG encourages all pregnant women to get prenatal care and to make a birth plan. The main goal should be a healthy and safe outcome for both mother and baby. Choosing to deliver a baby at home, however, is to place the process of giving birth over the goal of having a healthy baby. For women who choose a midwife to help deliver their baby, it is critical that they choose only ACNM-certified or AMCB-certified midwives that collaborate with a physician to deliver their baby in a hospital, hospital-based birthing center, or properly accredited freestanding birth center.

AFP, American Family Physician

Treating Eating Disorders in Primary Care

Binge-eating disorder, bulimia nervosa, and anorexia nervosa are potentially life-threatening disorders that involve complex psychosocial issues. A strong therapeutic relationship between the physician and patient is necessary for assessing the psychosocial and medical factors used to determine the appropriate level of care. Most patients can be effectively treated in the outpatient setting by a health care team that includes a physician, a registered dietitian, and a therapist. Psychiatric consultation may be beneficial. Patients may require inpatient care if they are suicidal or have life-threatening medical complications, such as marked bradycardia, hypotension, hypothermia, severe electrolyte disturbances, end-organ compromise, or weight below 85 percent of their healthy body weight. For the treatment of binge-eating disorder and bulimia nervosa, good evidence supports the use of interpersonal and cognitive behavior therapies, as well as antidepressants. Limited evidence supports the use of guided self-help programs as a first step in a stepped-care approach to these disorders. For patients with anorexia nervosa, the effectiveness of behavioral or pharmacologic treatments remains unclear.

Am Fam Physician. 2008;77(2):187-195, 196-197

Behavioral Health Insights

Peter Stuart, IHS Psychiatry Consultant

PTSD: A technique that works for me

by Dr. James Lagattuta*

I would like to share with you a technique I use routinely to work with client experiencing trauma. "TIR, or Traumatic Incident Reduction, is a systematic method of locating, reviewing, and resolving traumatic events" link below.

With its roots in psychoanalytic as well as desensitization/exposure literature, it is highly "person-centered, non-judgmental, and non-evaluative" in its treatment of the client. The provider

becomes a very active listener gently only asking the client to state when, where, how long, and what the initial feeling was about the "incident" that happened, followed by asking that it be first viewed in mind, and then told to the provider … and then repeated and repeated. At a certain point the client is asked if they feel "heavier (H)" or "lighter (L)." If lighter, then this incident is "the" root trauma and work on it continues. If "heavier," than "is there and earlier, similar incident" which seems to immediately come to mind, and one goes there and work continues, with the "H" v "L" question continuing to search out "the" root incident to which the other trauma, including the presenting one, is linked. Once this incident is located and neutralized, energy involved with subsequent trauma is freed. This would occur if the presenting trauma involved a battle incident, or the case I shall describe. Some details have been altered to ensure confidentiality.

After the Christmas holidays a mother asked if I would see her 18 y.o. son for a severe depression. The depression started after a multiple car fender-bender with no physical injuries on an icy road. It had been over a month since the incident and the beginning of the second semester of his HS senior year. He had stopped driving, had not returned to school, was missing assignments, and was having difficulty with his role as Captain of the wrestling team. He had already gotten early selection to a prestigious college. I explained what I would do during our session to mother, asking her to explain it to her son and seek his permission to work together.

When the son arrived, I reviewed the procedure and asked him to select an incident to work on. He chose the recent accident. We proceeded in the TIR manner and I asked the "H" v "L" question and his response was "H." He then jumped to a fender-bender in which he was involved as he was driving with his mother with a learner permit at 14.

I asked, "Heavy or Light?"

He responded, "Heavier."

He jumped to another fender-bender at age 9 when his mother was driving.

As I was getting to a time when I would have asked the "H" v "L" question he suddenly said, "and I was curled up in a ball and watched the car run over me."

I responded, "How old were you?"

He said, "Three."

I stated "Go there to the beginning."

Instead of responding directly he immediately replied with the following story, "My brother and I were in the back seat of the car ... it was parked at an incline facing down the hill leading to our house … dad went into the house for something … I jumped out and went to the front of the car … was told later my brother jumped into the driver seat, released the emergency brake and pretended to drive … I saw the car rolling toward me, curled up into a ball and looked up watching the car roll over me."

Then he suddenly said, "That SOB!!! Dad came out of the house yelling at us, blaming us for what was happening and then punished us … and when I was 9 he said nearly the same things, and at 14 and last month, too!!! I never realized how angry I've been at him all these years. "

I asked, "Heavy or Light?"

He said, "Very light!"

He returned the next week, having driven himself to the appointment, went back to school and activities, caught up with all work. He had a direct talk with dad about his feelings that he had held in over the years. He felt he had completed his work and did not need further assistance, and went on to graduate with honors.

Though simple compared with some more seemingly more painful and complex trauma, this procedure can at times deal with significant traumas in as little as one viewing session.

Traumatic Incident Reduction
www.healing-arts.org/tir/

*Dr. Jim Lagattuta is a long-time therapist in Indian country and has been a pioneer in adapting exposure-based therapies for helping AI/AN patients recover from traumatic incidents. The following tale highlights how he approaches this complicated issue and demonstrates how it is not always "talking" about traumatic life events that takes the sting out. Readers should also note that not all therapy requires multiple sessions – in this particular case a good outcome was achieved with one session of focused work.

ACOG
Fatigue and Patient Safety

ABSTRACT: It has long been recognized that fatigue can affect human cognitive and physical function. Although there are limited published data on the effects of fatigue on health care providers, including full-time practicing physicians, there is increasing awareness within the patient safety movement that fatigue, even partial sleep deprivation, impairs performance. Most of the current literature reviews resident function after recent work reform changes. However, the information available from many studies in health care and other occupations can be applied to the work habits of practicing obstetrician–gynecologists.

Fatigue and Patient Safety. ACOG Committee Opinion No. 398. American College of Obstetricians and Gynecologists. Obstet Gynecol 2008;111:471–3

Domestic Violence

Denise Grenier, Tucson

IHS-sponsored training in sexual assault forensic examination

My office will be sponsoring training in sexual assault forensic examination for IHS and Tribal physicians, nurses and Advanced Practice Nurses. In order to plan the training I need an idea of the number of people interested in attending.

Please email me if you might be interested in attending. The training is 40 hours long (either 4-10 hour days or 5-8 hour days) and will be held in either Phoenix or Albuquerque this summer – June or July. I will not be able to provide travel support. **Carolyn.Aoyama@ihs.gov**

Elder Care News

Bruce Finke, Elder Care Initiative

Exciting opportunity to develop new resources in geriatrics

An exciting opportunity to develop new resources in geriatrics in the Indian Health system.

Applications are being accepted until April 2 for the Practice Change Fellows Program. This program, sponsored by The Atlantic Philanthropies and The John A. Hartford Foundation, is designed to expand the number of health care leaders who can effectively promote high quality care to older adults in a wide range of health and health care organizations. The short-term goal of this program is to transform health care professionals working within the broadly defined delivery system into effective leaders. These leaders will have strong management skills and content expertise to effectuate practice improvement within their organizations to better meet the needs of older adults. The long-term goal is to establish a vigorous network of health care practice change specialists with the capacity to influence care for this population on a national scale.

The Practice Change Fellowship is open to nursing, social workers and physician leaders. Leaders in local health systems (Tribal, Federal, or Urban), and those working at an Area or regional Tribal level as well as those working at a national level would be eligible. The fellowship comes with funding to support the leadership and improvement activities ($45,000 per year for two years) and requires a strong commitment of support from leadership of the home organization.

You can find the details on the fellowship at

www.practicechangefellows.org/

I know that the Advisory Board for the Fellowship Program is very interested in supporting improvement in geriatric care in the Indian Health system and I believe that they would look favorably on strong proposals from IHS, Tribal, and Urban applicants.

Dr. Robert Schreiber, a geriatrician who has volunteered for a number of years at Rosebud and has helped Rosebud develop a strong clinical geriatrics program, is involved with the Practice Change Fellowship program and has offered to provide guidance and advice to potential applicants.

Please let me know if you have interest or have a candidate at your facility, Office, or Tribal program who might have interest and who you see as an effective leader who can help build your geriatric program. And feel free to contact me with questions

Bruce Finke, MD
IHS / Nashville Area Elder Health Consultant
Chronic Care Initiative
(413) 584-0790

Family Planning

Ringing Endorsement: Women Prefer Contraceptive Ring Over Patch

In the first study to directly compare a contraceptive vaginal ring and skin patch, more women indicated overall satisfaction with the vaginal ring, researchers report

Conclusion: Women satisfied with combined oral contraceptives and interested in a nondaily method are more likely to continue using the contraceptive ring than the contraceptive patch.

LEVEL OF EVIDENCE: I.

Creinin MD, et al Multicenter Comparison of the Contraceptive Ring and Patch: A Randomized Controlled Trial. Obstet Gynecol. 2008 Feb;111(2):267-277

Misconceptions About Oral Contraception Pills Among Adolescents and Physicians

Results: The prevalence of incorrect beliefs was exceedingly high in the whole adolescent study group and relatively high among the physicians. The prevalence of incorrect beliefs was comparable between COCP users and non-users, regarding the 10 misconceptions investigated. The duration of COCP use did not influence the prevalence of misconceptions about the pill. Age did not serve as a confounding factor for all misconceptions.

Conclusions: Lack of informative communication between COCP-prescribing physicians and users and mistaken knowledge of the caring physicians may contribute to adolescent ignorance of the COCP. Focusing on adolescent-specific disbeliefs could lead to construction of better educational programs in schools and clinics

Hamani Y et al Misconceptions about oral contraception pills among adolescents and physicians. Hum Reprod. 2007 Dec;22(12):3078-83.

Featured Website

David Gahn, IHS MCH Portal Web Site Content Coordinator

Meeting notes now online: 2007 Native Women's Health and MCH Conference*

Kelly Acton, M.D.
- Diabetes in American Indian & Alaska Native Women

Gail Bolan MD
- Current Issues in STD Management: Implications for Improving Women's Reproductive Health Outcomes

Karen Carey CNM MS
- Obstetric Drills

Peter Cherouny, MD
- Idealized Design of Perinatal Care: Plenary
- Quality Care in Obstetrics-Clinical Bundles: Workshop

Donald Coustan, M.D.
- GESTATIONAL DIABETES
- Gestational Diabetes
- Use of Oral Antidiabetic Agents in Obstetrics: Workshop

Scott Deasy, M.D.
- Navajo Nation Breast & Cervical Cancer Prevention Program

Willeen Druley, RN, MS, BC, FNP
- Mobile Women's Health Unit

Denise Findlay, RN BSN
- Using the Feeding & Teaching Scales to Plan Effective Interventions
- Promoting Maternal Mental Health During Pregnancy

Terry Friend, CNM
- SCHOOL-BASED HEALTH (BY ACCIDENT)

Cindy Gebremariam, RN
- iCare: A population management tool

Scott Giberson, Ph. C, Pharm D, MPH
- IHS HIV Program: Risk and Response

George Gilson, M.D.
- HIV Infection in Pregnancy: 2007 Update
- The OB – Peds interface: " Got issues? "
- Prenatal Testing Update 2007

Amy Groom, MPH
- HPV Vaccine Implementation

Howard Hays, M.D.
- Women's Health Software Application V 3.0

Mary Henrikson MN, RNC
- Us versus Them and Being in the Middle

Stephen W. Heath, MD, MPH
- Risk Management in Maternal Child Health

Lynn Hoefer, DV Advocate
- Ketchikan Indian Clinic Domestic Violence Project: Take Home Tips
- Take Home Tips from Alaska IPV/DV Screening Project: Linking Culture and Community to Action

Diane Jeanotte RN
- Billings Area SIDS / Infant Mortality Reduction

Wanda K. Jones, Dr. P.H.
- Optimizing Women's Health in the United States: Deaths
- Optimizing Women's Health in the United States: URLs

Favian Kennedy, MSW
- Northern Plains Smoke-Free Homes Campaign

Nancy Knapp MPH & Brenda Isaacs
- Integrating Brief Motivation Enhancing Interventions into the Primary Care Setting Integrating Brief Motivation Enhancing Interventions into the Primary Care Setting: Handout

Michele R. Lauria, MD, MS
- Optimizing Care Through Simulations and Structured Communication: Plenary
- Vaginal Birth after Cesarean: Still a Viable Option? Workshop

Rachel Locker, M.D.
- Domestic Violence: Screening and Documentation

Tami McBride, CNM, MS, RNC
- Obstetric Emergency Drills
- Obstetric Drill De-Brief Form

Richard McClain, MD
- MONARC vs. Paravaginal wall Repair: A system and surgeon perspective

Paul Melinkovich, M.D.
- Denver School-Based Health Centers

Breastfeeding

Suzan Murphy, PIMC

Promoting, Protecting, Supporting

2001 HRSA USBC Strategic Plan brochure stresses 6 major areas that since 1984 have withstood the test of time:
- Improving professional education in human lactation and breastfeeding
- develop public education and promotion efforts
- strengthen the support for breastfeeding in the health care system
- develop a broad range of support services in the community
- initiate a national breastfeeding promotion effort directed at working women; and
- expand research on human lactation and data collection on breastfeeding.

Mission and Vision, IV Strategic goals and objectives developed around the 2010 goals are quite details. For your review and use.

This will be posted on the IHS breastfeeding web page.

Contact **Judith.Thierry@ihs.gov** to review the strategic plan

Connie Monahan, MPH
- Challenges of SANE in the Clinical Setting (Plenary)
- Making SANE Work: Operational Details (Workshop)
- Challenges of SANE in the Clinical Setting
- Challenges of SANE in the Clinical Setting: Handout
- Making SANE Work: Operational Details
- Appendices: Making SANE work

Neil Murphy MD
- 2007 Data Tally
- 2007 Birth Statistics by Facility
- 2007 Narrative Tally
- Human Papilloma Virus Vaccine 2007
- Save the World
- How to keep current

Sue Murphy, RD, MPH, CDE, CLE
- Breastfeeding Update

Tony Ogburn MD
- Contraception for teens: What's new?

Sharon Phelan MD
- Obesity: A weighty problem

Marilyn Pierce Bulger
- Community Approaches to Reducing Infant Mortality: Nutaqsiivik Program
- Approaches To Reducing Infant Mortality-Nutaqsiivik Program

Usha Ranji, M.S.
- Health Coverage and Access to Care: Key Issues for Native Women

Brigg Reilley
- Prenatal HIV Screening: Workshop

Sharon Schindler Rising, MSN, CNM
- Essential Elements of the Centering Model

Greg Shorr, M.D.
- PCC+ Obstetric Care Module

Melanie Taylor MD, MPH
- Chlamydia Among AI/AN Adolescents: The Stop Chlamydia Project

Judy Thierry, DO MPH
- Improve the System, Improve the Outcome
- PCC+ Obstetric Care Module

Shelley Thorkelson , CNM MSN CDE
- Case Tracking Strategies Using RPMS , CMS, DMS and Hard Copy
- Diabetes in Pregnancy: Case Tracking Strategies
- DM & Pregnancy Program Flow sheet

Sheila Warren, MPH, RN, CPHQ
- Patient Safety in Maternal Child Health

Judy Whitecrane MSN, CNM
- What We Did About Prenatal Substance Abuse

Nancy Whitney, MS, LMHC
- Intervention as Prevention: Working Effectively with Mothers Who Abuse Alcohol and Drugs During Pregnancy
- Parent-Child Assistance Program (PCAP)

*** www.ihs.gov/MedicalPrograms/MCH/F/lecNotes.cfm#wHealthConf**

Midwives Corner

Perineal warm packs reduce 3rd and 4th degree lacerations, pain and urinary incontinence

CONCLUSIONS: The application of perineal warm packs in late second stage does not reduce the likelihood of nulliparous women requiring perineal suturing but significantly reduces third- and fourth-degree lacerations, pain during the birth and on days 1 and 2, and urinary incontinence. This simple, inexpensive practice should be incorporated into second stage labor care.

Dahlen HG et al Perineal outcomes and maternal comfort related to the application of perineal warm packs in the second stage of labor: a randomized controlled trial. Birth. 2007 Dec;34(4):282-90.

International Health Update

Claire Wendland, Madison, WI

Good intentions and unintended consequences

At the turn of the twenty-first century, activists, politicians, and academics pushed hard for a major increase in international funding to solve seemingly intractable health problems in the Third World. Two results are the GAVI Alliance, formed in 2000 to expand mass vaccination programs (particularly for children), and the Global Fund, created in 2002 to tackle HIV/AIDS, tuberculosis and malaria. Most observers agree that both organizations have been very successful at bringing together government, industry and other private funds – at a scale larger than imagined possible in the past – and directing them to programs, private or governmental, that address these pressing health issues in poor countries. Two recent analyses, however, raise concerns about some unintended side effects.

At issue is a shift in the concept of sustainability. Conventional ideas of sustainability meant that recipient countries would need to gradually take over any internationally funded health intervention. Because the cost of vaccines and AIDS drugs is so high, programs involving treatment of AIDS or prevention of childhood infections were clearly not going to be sustainable by this definition anytime soon. An innovation of the new funders was to consider programs "sustainable" if they could be paid for indefinitely at the international level. If wealthy countries made long-term pledges to buy drugs and vaccines, the poorest recipients would only have to be sustainably responsible for provision of basic health-system needs like transport, nutritional sup-

port, and health care staffing. And therein lies the rub.

The "vertical" programs (those targeted toward a specific problem rather than general primary health care) funded through these new mechanisms keep their staff lean and their programs efficient by refusing to integrate other kinds of care. Where transport is difficult, as in much of the Third World, villagers may walk for hours to bring a sick or starving child in for a mass vaccination campaign, but be unable to speak to anyone about their child's malnutrition, seizure disorder, or diarrhea – not to mention the mother's new pregnancy. These primary health tasks shift downward to untrained laypeople, or to no one at all, and health systems become more fragmented.

Perhaps even more problematic are the effects on public health sector staffing. When vertical programs such as those providing antiretrovirals are part of the public health system, donors pay for the drugs but not the new staff needed to distribute them and monitor patients. When these programs are non-governmental, they hire qualified nurses and doctors away from the public sector, because they can afford to pay more than the local salary. Most of the time, both types of programs are funded in any given country. A ministry of health must train, recruit, and pay salaries for new staff even as existing doctors and nurses are being hired away by better-funded employers. But governments are required by the international financial institutions from which they borrow to keep civil service salaries at a pre-specified cap. Ministries of health are left with two ugly choices. They can violate the salary cap to recruit and retain health workers, but lose all development loans (which may amount to half a country's total budget), or they can keep salaries low and risk ongoing hemorrhage of qualified health professionals into the non-governmental sector – not to mention the strikes, retirements, and emigration that take their toll on the well-being of patients in public hospitals and clinics.

The jury is still out on the actual impact of these big new funding programs on the health problems they target. (Expect early reports for the Global Fund by later this year.) But it's already clear that in some of the most heavily targeted areas, maternal and child health indicators are deteriorating even as vaccination rates rise and deaths from AIDS begin to plateau. As a doctor in Malawi told me flatly, talking about hospital staffing and maternal deaths in that country, "these NGOs are killing us." It may be time to think again about what sustainability really means, and whose responsibility it really is.

Ooms G. et al. 2007 Medicines Without Doctors: Why the Global Fund Must

Fund Salaries of Health Workers to Expand AIDS Treatment. PLoS Medicine 4(4):e128.

MCH Headlines

Judy Thierry HQE

Findings from the National Survey of Children's Health includes Native Americans

The authors set out to examine racial/ethnic disparities in medical and oral health, access to care, and use of services in a national sample.

They used the National Survey of Children's Health which was a telephone survey in 2003-2004 of a national random sample of parents and guardians of 102,353 children 0 to 17 years old. Disparities in selected medical and oral health and health care measures were examined for white, African American, Latino, Asian/Pacific Islander, Native American, and multiracial children. The authors found many significant disparities were noted; for example:

-Uninsurance rates were 6% for whites, 21% for Latinos, 15% for Native Americans, 7% for African Americans, and 4% for Asians or Pacific Islanders,

- The proportions of children with a usual source of care were as follows: whites, 90%; Native Americans, 61%; Latinos, 68%; African Americans, 77%; and Asians or Pacific Islanders, 87%.
- Many disparities persisted for one minority group in multivariate analyses, including increased odds of suboptimal health status, overweight, asthma, activity limitations, behavioral and speech problems, emotional difficulties, uninsurance, suboptimal dental health,no usual source of care, unmet medical and dental needs, transportation barriers to care, problems getting specialty care, no medical or dental visit in the past year, emergency department visits, not receiving mental health care, and not receiving prescription medications.
- Certain disparities were particularly marked for specific racial/ethnic groups: for Latinos, suboptimal health status and teeth condition, uninsurance, and problems getting specialty care; for African Americans, asthma, behavior problems, skin allergies, speech problems, and unmet prescription needs; for Native Americans, hearing or vision problems, no usual source of care, emergency department visits, and unmet medical and dental needs; and for Asians or Pacific Islanders, problems getting specialty care and not seeing a doctor in the past year.
- Multiracial children also experienced many disparities.

The authors conclude that minority children experience multiple disparities in medical and oral health, access to care, and use of services. Certain disparities are particularly marked for specific racial/ethnic groups, and multiracial children experience many

Flores G and Tomany-Korman SC. Racial and Ethnic Disparities in Medical and Dental Health, Access to Care, and Use of Services in US Children PEDIATRICS Vol. 121 No. 2 February 2008, pp. e286-e298

Medical Mystery Tour

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

You may recall last month when we posted this question…

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

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

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

The answers are:

- St. John's wort may be effective in milder forms of major depression
- St. John's wort is better tolerated than prescription antidepressants
- St. John's wort may reduce the efficacy of combined oral contraceptives

Here is some background

The data on efficacy of St. John's wort in treating depression are confusing, mixed, and subject to criticism over concerns about lack of standardized preparations, adequacy of blinding of patients, short study duration, and inclusion of patients not meeting criteria for major depression. Most studies show benefit compared with placebo for mild depressive syndromes (including many patients without major depressive disorder who may not require treatment with medication). However, evidence is mixed when analyses of St. John's wort compared to placebo are restricted to patients with major depressive disorder. Some studies, however, do suggest that St. John's wort is as effective as SSRIs and low-dose tricyclic antidepressants for patients with mild to moderate major depression. Most head-to-head studies show that patients are less likely to discontinue St. John's wort because of side effects, compared with standard antidepressants. The combination of St. John's wort and SSRIs has not been studied; combining them poses an increased theoretical risk for serotonin syndrome. St. John's wort may induce the metabolism of oral contraceptives containing ethinyl estradiol, possibly resulting in an unplanned pregnancy.

Midwives Corner

Lisa Allee, CNM, Chinle

Factors for the fear of childbirth in first-time mothers (see next article, too)

This study is interesting as it demonstrates how the fear of childbirth can have an affect on some women during pregnancy. These fears are not irrational and have a social and/or psychological root. Knowing what factors make some women more prone to this type of fear helps doctors and midwives to identify those most in need of extra support.

Conclusions: The prevalence of fear of childbirth among healthy nulliparous women with singleton pregnancies did not increase during the study period. Fear of childbirth among nulliparous women was most often seen in individuals with few social and psychological resources. Testing the women twice, we found the same prevalence of fear in early and late pregnancy, but found that half the women who expressed fear during early pregnancy had no fear later in pregnancy, an effect that was counterbalanced by a similar number of women who became fearful between the two interviews.

Laursen M, Hedegaard M, Johansen C. Fear of childbirth: predictors and temporal changes among nulliparous women in the Danish National Birth Cohort. BJOG 2008;115:354-360

Women's fear of childbirth boosts cesareans

Women suffering from significant childbirth fear indicate that they are less self-confident, unhappy, afraid that the child will be injured and don't long for the child. This clearly emphasises the need for pre and postnatal support.

For each women requesting to have a caesarean, as doctors, we provide them with a consultation on the advantages and disadvantages of the procedure.

The overall c-section rate in the UK is high but comparable to other western countries. If we are to lower the numbers, we need to understand sympathetically why some women, with no medical reasons, are choosing to have caesareans.

Healthy women are sometimes criticized for choosing a c-section over a normal delivery. This study reveals that a psychological reason may be behind elective caesareans. Some women may be too scared, rather than too posh, to push.

Conclusions: Women requesting caesarean section did not always suffer from clinically significant fear of childbirth. The finding that women subjected to complicated deliveries had a negative birth experience emphasizes the importance of postnatal support

Wiklund I, Edman G, Ryding E, Andolf E. Expectation and experiences of childbirth in primiparae with caesarean section. BJOG 2008;115:324-331.

Navajo News

John Balintona, Shiprock

Adnexal Masses during Pregnancy

The presence of adnexal masses during pregnancy is not uncommon at 0.5% to 2%. Discovery of an adnexal mass during pregnancy can prove to be a management dilemma for the obstetric provider. The clinician must develop and communicate a plan of expectant management versus intervention that exposes the patient to the least amount of morbidity.

Prior to the routine use of ultrasound in early pregnancy, most masses were found incidentally or were symptomatic and this often led to prompt surgical intervention. Now with the near universal prenatal ultrasound, the majority of masses are found earlier allowing for more conservative management.

Diagnosis

Adnexal masses have nongynecologic causes, however most are gynecologic and benign in nature. The age of the patient, prior medical history, and gestational age may be useful in determining the likely etiology of the mass. The most common cause is leiomyoma, which may be uncovered in review of the past medical history. Corpus luteum cysts are common in the first trimester of gestation. Benign ovarian entities like functional cysts, benign teratomas, and serous cystadenomas are found in younger patients. The potential for ovarian malignancy does rise as the patient ages.

Ultrasound is the primary imaging technique used to detect adnexal masses and to assess the risk of malignancy. Some experts suggest the MRI may be useful in the evaluation, especially if the ultrasound diagnosis is uncertain. Various morphologic characteristics found on ultrasound may be useful in determining the risk of malignancy in adnexal masses.

Low Risk	Moderate - High Risk
Cystic, unilocular	Cystic, multilocular
Size; 5 cm or smaller	Size; greater than 5 cm
	Complex mass
	Solid mass
	Thick septations
	Nodules
	Persists past 16 weeks EGA

Laboratory tests are of limited use in the evaluation of adnexal masses as many of the tumor markers, e.g. CA-125, AFP, BHCG; etc may be elevated in normal pregnancy.

Occasionally the patient will present with signs and symptoms due to the mass. These patients may have abdominal pain, back or flank pain, digestive disorders, furthermore, the patient may appear to have a gestational size greater than expected due date. The rate of torsion can be up to 20% and rupture rate can be as high as 10%. Some suggest that the risk of torsion is increased in masses between 6 cm and 10 cm in size.

Management

The main management option for the clinician is in choosing expectant management versus intervention. Expectant management decreases the potential for invasive procedures, however, can expose the patient for potential torsion, mass rupture, or obstruction of labor. Surgical intervention carries its own inherent risks of adverse outcome for mother and fetus. A rational decision can be made based on natural history, malignancy risk, and presence of symptoms.

Most ovarian cysts discovered during pregnancy will resolve spontaneously prior to 16 weeks EGA. This is especially true if the cyst is less than 5 cm. Observation for small cysts is recommended. It is reasonable for the obstetric provider to recommend surgical intervention for cysts that persist after 16 weeks EGA and surgery be indicated for any adnexal mass that may be causing symptoms such as pain or digestive difficulties.

Adnexal masses that have morphologic characteristics that are consistent with a low risk of malignancy may be observed throughout pregnancy. Less than 1% of adnexal masses found in pregnancy prove to be malignant and even in these cases, the majority is of low-grade disease. Nevertheless, any mass that is deemed moderate or high risk should be surgically removed. If the clinician has strong evidence that malignancy is likely, it may be prudent to transfer the patient to a facility that can provide the proper staging surgery and expedient histologic diagnosis.

Adverse fetal outcome is typically associated with abdominal catastrophe from ovarian torsion or mass rupture during surgery. Uncomplicated surgery for adnexal masses has not been shown to increase the risk for fetal loss or preterm delivery. Laparotomy is generally used, but in certain cases, i.e. early first trimester, benign appearing small cyst, expertise of the surgeon, laparoscopy may be entertained. Regardless of the approach, efforts should be made to perform the most conservative procedure possible.

The following is a summary of scenarios that the author advises surgical intervention.

- Strong suspicion for malignancy
- Large (> 8-10cm) masses
- Symptomatic complaints
- Persistent masses (after 16 weeks EGA)

Osteoporosis

SSRI Use and Bone Loss in Older Women

Conclusion: The authors conclude that the use of SSRIs in older women is associated with an increase in the rate of bone loss: this association does not occur with the use of TCAs. The authors add that these results should be further investigated with more follow-up to determine the long-term effect of SSRI use on bone metabolism.

Diem SJ, et al. Use of antidepressants and rates of hip bone loss in older women: the study of osteoporotic fractures. Arch Intern Med. June 25, 2007;167(12):1240-1245.

References

1. *Leiserowitz G. Managing Ovarian Masses During Pregnancy. Obstetrical and Gynecologic Survey. 2006. Vol 61. 463-470*
2. *Giuntoli R, et al. Evaluation and Management of Adnexal Masses During Pregnancy. Clinical Obstetrics and Gynecology. 2006. Vol 49. 492-505*
3. *Ribic-Pucelj M, et al. Surgical Treatment of Adnexal Masses in Pregnancy. Journal of Reproductive Medicine. 2007. Vol 52. 273-279*

Nurses Corner

Sandra Haldane, HQE

Integrating Nursing and Behavioral Health

Wyatt Massi, PsyD, Chief of Behavioral Health Services, is developing an integrated behavioral health approach for the Fort Peck primary care clinic and is recruiting for a psych-mental health NP or an APN who is interested in going back to school for a post-masters psych-mental health certificate.

Dr. Massi has "integrated" the behavioral health consultant duties into a traditional psychiatric nurse practitioner position. The most common model for the BHC is using a counselor or psychologist in the position. Dr. Massi elected to go with a Psych NP because it was part of the "deal" that I brokered with my service unit to get the funds for the position. At first Dr. Massi thought he was making compromises, but Dr. Massi came to the conclusion that a NP dedicated to integration is an ideal person to bridge the gap b/w Primary Care, Health Promotion, and Behavioral Health. As a primary care provider, who has come up through the nursing education system, and has a place as a Behavioral Health staff member, Dr. Massi thinks this individual will be able to facilitate a cultural change in the health care environment. And hopefully Dr. Massi will save some money on my psychiatrist contracts while revolutionizing the world of IHS !

Dr Massi is happy to describe the position and the model of care. This is a very exciting opportunity. If you have questions please contact Dr. Massi directly.

Massl Wyatt, PsyD
Chief, Behavioral Health Services
Ft. Peck IHS
Poplar, Montana
406-768-3491

Perinatology Picks

George Gilson, MFM, ANMC

Usefulness of middle cerebral artery Doppler of the fetus at risk for anemia

The use of Doppler ultrasound evaluation to measure the peak systolic velocity of the fetal middle cerebral artery (MCA) has been a major breakthrough in the noninvasive detection of fetal anemia. An elevated peak MCA velocity of >1.5 multiples of the median is useful in the timing of the initial intrauterine transfusion (IUT) in the red cell–alloimmunized pregnancies. Data reported to date suggest that a threshold of 1.32 multiples of the median can be used to time the second IUT; the MCA Doppler evaluation does not appear sensitive for the timing of subsequent IUTs in these pregnancies. The peak MCA velocity has also proved useful in the detection of other anemic states that include Kell alloimmunization, fetal parvovirus infection, fetomaternal hemorrhage, alphathalassemia, and after-laser therapy for twin-twin transfusion.

Moise KJ Jr. The usefulness of middle cerebral artery Doppler assessment in the treatment of the fetus at risk for anemia. Am J Obstet Gynecol. 2008 Feb;198(2):161

(…umbilical cord blood banking, continued from page 1)
a child's likelihood of actually using his or her own saved cord blood later. Some experts estimate this likelihood at 1 in 2,700, while others argue the rate is even lower. Physicians should also disclose to their patients that it is unknown how long cord blood can successfully be stored.

Pregnant women should be aware that stem cells from cord blood cannot currently be used to treat inborn errors of metabolism or other genetic diseases in the same individual from which they were collected because the cord blood would have the same genetic mutation. "Cord blood collected from a newborn that later develops childhood leukemia cannot be used to treat that leukemia for much the same reason," said Dr. Gregg.

Federal legislation was passed in 2005 that provides funding for continued growth of a national cord blood registry in the US. Several states have laws requiring physicians to inform patients about cord blood banking options. Physicians should consult with their state medical association for more information about their individual state laws.

Alaska State Diabetes Program

Barbara Stillwater

Diabetes A Stronger Risk Factor For Death In Women than In Men

Eighteen years of follow-up shows that men are twice as likely to die from heart disease as women. However, this gender gap is markedly reduced when only patients with diabetes are considered.

Conclusion: Diabetes is a stronger predictor for IHD mortality in women than in men, and diabetes attenuates the usual gender gap in IHD mortality. With both diabetes and established CVD present, the gender gap is fully attenuated.

Dale AC, et al Diabetes mellitus and risk of fatal ischaemic heart disease by gender: 18 years follow-up of 74,914 individuals in the HUNT 1 Study. Eur Heart J. 2007 Dec;28(23):2924-9

Pedometers help people lose weight even without changes in diet

People who participate in a pedometer-based walking program can be expected to lose a modest amount of weight even without changing their diet, with more weight loss the longer they stick with the program, according to a University of Michigan Health System analysis of nine studies.

Conclusion: Pedometer-based walking programs result in a modest amount of weight loss. Longer programs lead to more weight loss than shorter programs.

Richardson CR et al A meta-analysis of pedometer-based walking interventions and weight loss. Ann Fam Med. 2008 Jan-Feb;6(1):69-77

Women's Health Headlines

Carolyn Aoyama, HQE

Women and HIV/AIDS

Pinn Point On Women's Health

The Office of Research on Women's Health (ORWH) is broadcasting the eighth in a series of podcasts, "Pinn Point on Women's Health," hosted by Dr. Vivian W. Pinn, Associate Director for Research on Women's Health and the Director of the Office of Research on Women's Health. The monthly podcast discusses the latest news in women's health research and includes conversations with guests on a variety of subjects.

In the latest podcast, Dr. Pinn talks with Dr. Victoria Cargill, Director of Minority Research and Clinical Studies, Office of AIDS Research, Office of the Director, National Institutes of Health. Dr. Cargill discusses women and HIV/AIDS from the perspective of a researcher and practicing physician in the community. Dr. Cargill emphasized that AIDS continues to be a major health problem for women and that "African American and Hispanic women are almost 80 percent of AIDS cases reported in women." This podcast also discusses differences in how AIDS affects men and women.

"Podcasting" is a relatively new method of distributing audio and video information via the Internet to iPods and other portable media players on demand, so that it can be listened to at the user's convenience. The main benefit of podcasting is that listeners can sync content to their media player and take it with them to listen to whenever they want. Because podcasts are typically saved in MP3 format, they can also be listened to on nearly any computer.

To listen to Dr. Pinn's podcast, visit the ORWH homepage at **http://orwh.od.nih.gov** and click on Pinn Point on Women's Health (podcast). If you need further assistance on how to use podcasts, go to **http://videocast.nih.gov/faq/podcast/default.asp**.

For questions, contact Marsha Love at the Office of Research on Women's Health by calling (301) 496-9472 or e-mailing lovem@od.nih.gov.

SAVE THE DATES

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

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

Keeping Native Women & Families Healthy & Strong
- April 23–25, 2008
- Milwaukee, WI
- Great Lakes Tribal Epidemiology Center
- E-mail contact EpidemiologyCenter@gmail.com

Training in Palliative and End of Life Care
- April 22–24, 2008
- Flagstaff, AZ
- Contact Tim Domer MD at tim.domer@ihs.gov

Advances in Indian Health (AIH) Conference
- April 29–May 2, 2008
- Albuquerque, New Mexico
- 28 credits, Indian Country's Primary Care Conference
- Contact ANNBULL@nc-cherokee.com

Abstrace of the Month
- Minorities Underrepresented in both public and private umbilical cord blood banking

IHS Child Health Notes
- Symptom profile of common colds in school-aged children.
- Effect of honey, dextromethorphan, and no treatment on nocturnal cough and sleep quality for coughing children and their parents.
- Recent literature on American Indian/Alaskan Native Health—Respiratory syncytial virus season and hospitalizations in the Alaskan Yukon-Kuskokwim Delta.

From your Colleagues
- Melissa Toffolon-Weiss, Anchorage—HPV brochure for AI/AN available for broad dissemination

Hot Topics
- Obstetrics—Evidence Favors Late Cord Clamping in Infants
- Gynecology—Biofeedback Reduces Psychological Burden in Older Women With Urge UI
- Child Health—Sex education: Providers need to fill gaps in adolescent knowledge
- Editorial comment: Beth Crow, Anchorage—Learning about sexuality is really important for children's health, safety, and confidence
- Chronic disease and Illness—Diuretics most effective blood pressure medicine for people with metabolic syndrome

Features
- ACOG Statement on Home Births
- AFP, American Family Physician—Treating Eating Disorders in Primary Care
- Behavioral Health Insights—PTSD: A technique that works for me
- Domestic Violence—IHS-sponsored training in sexual assault forensic examination
- Elder Care News—Exciting opportunity to develop new resources in geriatrics
- Family Planning
  —Ringing Endorsement: Women Prefer Contraceptive Ring Over Patch
  —Misconceptions About Oral Contraception Pills Among Adolescents and Physicians
- Featured Website—Meeting notes now online: 2007 Native Women's Health and MCH Conference
- International Health Update—Good intentions and unintended consequences

Neil Murphy, MD
SCF
PCC–WH
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