IHS PEDS NOTES

A Newsletter for American Indian/Alaska Native Child Health

June, 2000 Volume 16 Bill Green, Editor

Reach Out and Read recently received a $2 million grant to extend their Pediatric reading programs to minority and underserved populations, including Indian health care sites There are already over a dozen sites at IHS and tribal clinics, recently including ours, with a strong commitment to expand significantly from their national office. As part of the AAP Spring meeting in Boston I attended an outstanding presentation on Literacy Promotion in Primary Care and spoke to ROR national medical director Perri Klass, M.D. who along with the ROR staff would be more than happy to answer any specific inquiries 617/638-3380, perri.klass@bmc.org. Many of you may have attended ROR workshops by Lori Byron, M.D. at the Phoenix meeting a year ago or January at the Combined Councils. There are three components: (1) during well-child visits pediatricians and other clinicians encourage parents to read aloud to their children and provide tips and guidance, (2) clinicians then give a new, age-appropriate book to every child between 6 months and 5 years and (3) volunteers read aloud to children in clinic waiting rooms. Research on this program presented at the meeting, including one poster including Indian children, show a potentially favorable impact on reading behaviors and language acquisition of participants that will need to be validated in more comprehensive studies (see Pamela High et al, Literacy Promotion in Primary Care Pediatrics: Can we make a Difference? April, 2000 Pediatrics, 105, (4) pp. 927-934.) The application process is simple and essentially supports the purchase of books; the involved health provider can be a family physician, nurse practitioner, anyone providing well-child care. Publication and dissemination of more Indian specific books is also an achievable goal as the number of sites expands. I encourage you to take advantage of this expanded opportunity!

7-Valent Conjugate Pneumococcal Vaccine is approved but awaits adoption by Vaccines for Children and specific guidelines for use PCV7 (Prevnar) was accepted by the PHS Advisory Committee on Immunization Practice in February as a 2, 4, 6 and 12 to 15 month schedule based on a large study of 38,000 children in Northern California where the vaccine achieved over 90% overall efficacy. With invasive pneumococcal disease rates in studied Indian populations 5 to 24 times higher than the general population this vaccine has been eagerly awaited. Unfortunately, with a list price of $58 a dose it is cost prohibitive for many Indian care sites though probably still cost-effective a March JAMA article actually questioned cost-effectiveness for the general population at this price! The ongoing study of vaccine efficacy in Navajo and Apache children continues at present because the seven vaccine serotypes were less prevalent than anticipated and community clustering may impact on significance, according to lead investigator Kate O Brien, M.D. who presented update on the study May 14th at the AAP Spring meeting. Despite Internet allegations there is no credible scientific evidence that this vaccine is associated with type 1 Diabetes, which in contrast to Type 2 Diabetes, has been and remains rare in Indian children. A favorable trend of 10 to 15% decrease in otitis media in vaccine recipients with recurrent otitis in the Kaiser study shows promise but needs to be studied prospectively. There is also essentially no data to guide policy makers for recommendations in older age groups than those specifically studied. Meanwhile, the relatively inexpensive and available 23-valent

Unconjugated Pneumovax 23 PS remains an option for children over two with high-risk conditions and living situations see the September, 1999 PEDIATRICS statement for additional guidance. The new statement currently being prepared for release by the AAP Redbook Committee contains language specific to high and moderate risk AI/AN populations, and because of low prevalence of the seven PCV7 serotypes will recommend in certain situations combining PCV7 with a 23 PS booster to broaden coverage.

Two new textbooks can help clinicians learn skills to practice evidence-based pediatrics Evidence Based Pediatrics and Child Health edited by Virginia Moyer, (British Medical Journal Books, 2000) is the first book I have found that attempts to provide guidance on how to use evidence-based data bases such as the Cochrane Library and evaluate articles from medline on your own to answer important clinical questions. The first part is essentially a primer on how to frame questions, search for evidence and evaluate results using basic epidemiological and statistical concepts with specific pediatric examples. The second section deals with evidence for routine practices such as well-child care, obesity and injury prevention, highly relevant in our population. The final section discusses selected common conditions such as the febrile infant, asthma, ADHD. The authors of articles in sections 2 and 3 show their work, i.e. exactly what search strategy they used. Updates will be available at a designated website. The second text, Evidence-Based Pediatrics Feldman, (BC Decker, 2000) is a more conventional textbook using evidence-based articles to review a broader list of common conditions and is accompanied by a searchable CDROM.

In the workshop on this subject attended by mostly academic pediatricians there was tension between universal application of presumably evidence-based practice guidelines in teaching centers vs teaching students and residents the critical skills of assessment on their own. Although traditional textbooks remain useful repositories of basic anatomic and descriptive information they are simply too quickly out of date for most therapy questions. Unfortunately pediatric practice is filled with treatments that are based on tradition or expert opinion and evidence-based studies are simply unavailable. Hopefully these early attempts to fill this gap will be supplemented by better well-designed randomized control trials in pediatric care. (see also Gary Onady, Evidence-Based Medicine , May 2000, Pediatrics, 105 95), pp. 1176-1177, which is a response to a recent commentary).

Practice Parameter on Attention Deficit with Hyperactivity published in May, 2000 PEDIATRICS attempts to qualify expert panel opinion with assessment of the quality of evidence ADHD has been in the news recently with ongoing debate about under Vs over diagnosis of the condition in young children. This clinical practice algorithm developed by a consensus panel systematically reviewed evidence for six recommendations that are also organized as a flow sheet. The touchstone for a diagnosis requires meeting specific DSM-IV criteria in more than one setting as well as evaluation for coexisting conditions such as anxiety or depression and learning disabilities. At a Spring Meeting workshop on the guidelines Heidi Feldman, MD presented a Clinicians Tool Kit for the Diagnosis and Management of ADHD of the School-Aged Child that conveniently includes work-sheets and rating scales that can be incorporated into the patient record, as well as information sheets for parents and teachers and medication dosing. Diagnosis under age 6 was felt to be problematic because of significant overlap of developmentally appropriate ADHD behaviors in this age group, possibly requiring specialist consultation. For appropriately diagnosed children age 6 to 12 medication response can be documented in over 70%.

Approaching the diagnosis in this rigorous fashion can help avoid errors of inappropriate selection of children for treatment. (see Pediatrics May 2000, 105 (5) pp. 1158-1170.)

Recently IHS Headstart published a report, Healthy Children, Healthy Families, and Healthy Communities: A Focus on Diabetes and Obesity Prevention which concisely summarizes available evidence and recommends a blueprint for planning specific program interventions. An excellent current reference, Mary Story, et al, The Epidemic of Obesity in American Indian Communities and the need for Childhood Obesity-Prevention Programs , 1999 American Journal of Clinical Nutrition, 69 (suppl): 747S-754S is included in the index. Contact Cheryl Wilson at 505-248-4182, cheryl.wilson@mail.ihs.gov if you would like a copy. Applications for funding for pilot projects are going out to IHS Headstarts this summer. Recent research in obesity highlights the association of early adiposity rebound at age 5 and subsequent obesity (see Ahmad Dorosty et al, Factors Associated with Early Adiposity Rebound , May 2000 Pediatrics, 105(5) pp1115-1118), providing impetus for a targeted intervention in this age group. Evidence-based research on the efficacy of interventions is limited, but the rationale for a community-based, generic public-health approach is thoroughly discussed in the report. The May issue of the British Medical Journal contains an important article on using the Body Mass Index in Establishing a standard definition for child overweight and obesity worldwide: international survey , (Timothy Cole, et al, BMJ 320, pp. 1-6.). This article attempts to use data from six large nationally representative cross sectional growth to link adult cut-off points, 25 kg/m2 for overweight and 30 kg/m2 for obesity, with BMI centiles for children age 2 to 18 and has a convenient table on page 4. Late breaking news: long-awaited U.S. updated growth charts from the National Center for Health Statistics that include BMI centiles were just released last week and are available at www.cdc.gov/growthcharts.

Distinguishing between otitis media with effusion and acute otitis media has important treatment implications The December 1999 issue of Pediatric Infectious Disease Journal (18 (12) pp1115-1151) has a supplement Acute Otitis Media: A Treatment Paradigm for the New Millennium , a collection of articles by Infectious disease specialists including a review of consensus guidelines developed by CDC in 1998. The CDC-AAP principles of judicious use of antimicrobial agents distinguish AOM as a treatable disease from the persistent middle ear effusion (OME). OME after therapy of AOM is expected, may persist for weeks to months and does not require immediate use of antimicrobial agents. Diagnosis of AOM requires documentation of middle ear effusion by pneumatic otoscopy if possible and signs or symptoms of acute illness. Although the policy in some Western European countries is to withhold antibiotics unless children remain ill after 1 to 3 days of observation, the specific criteria for withholding or treating remain poorly defined as well as outcomes. Immediate treatment at least for children younger than 2 is therefore recommended.

Algorithms for antibiotic treatment have changed in the era of drug resistant strep pneumoniae; amoxacillin remains initial drug of choice but higher dosing 80 to 90 mg/kg, and consideration for use of amoxacillin/clavunate if antibiotics were administered within the past month. Ten-day course is recommended for children under 2 but shorter 5 to 7 day course can be considered for children over that age. Unfortunately resistance to sulfa/trimethoprim by DRSP is often higher than that for amoxacillin, which limits its usefulness as an alternative. Further treatment for treatment failures is more controversial, and includes higher dose amoxacillin/clavunate (80-90 mg/kg amoxacillin that requires new formulation or extra amoxacillin dosing to keep clavunate at 6.4 mg/kg/day!), ceftriaxone, cerfuoxime, clindamycin, and/or tympanocentesis. Suggested

algorithms appear on page 1153 along with a full discussion of the rationale for the conclusions.

Because of the high spontaneous resolution rate of AOM and lack of locally documented DRSP many Indian care clinicians may be reluctant to change treatment algorithms at present. Yet DRSP is increasing everywhere it is looked for, and I would recommend obtaining cultures, monitoring pneumococcal resistance in your clinics, and becoming familiar with these current consensus diagnostic and therapeutic strategies.

Jim Flaherty in Tuba City reports on resources available to upgrade EMS programs .Beginning in FY 2000, the Maternal and Child Health Bureau has entered into an inter-agency agreement with the IHS to facilitate the promotion of the goals of the EMSC program. As you likely know, the EMSC program has enjoyed continued and increasing funding over the last16 years. The Program is primarily a grant program aimed at three eligible recipients within states and territories: EMS bureaus, MCH Bureaus or medical schools. There are different categories of grants; most states at this point have received generations of grants, and are presently in the partnership or continuation phase. Although American Indian, Alaska Native and Hawaiian Native children are specifically mentioned as special populations targeted to benefit from EMSC programs, neither IHS service units nor Tribal health programs are eligible to directly receive grant funds. Dave Short, a graduate of the IHS Injury Prevention Fellowship program, completed an EMSC needs assessment of Tribal EMS Programs by phone survey in 1998 and 1999, at the request of Headquarters. About half of existing Tribal EMS programs responded, and the findings were consistent. The majority identified that training and equipment (including computers and web access) were their most pressing needs. One of my goals is to facilitate or directly provide this training and equipment by working with Tribal EMS programs and their respective state EMS Bureaus. (To date, I have had limited requests to facilitate or provide EMSC training in response to my letter soliciting such requests.) The EMSC Program has many resources available to you, your prehospital providers, and emergency department staffs. Primary among them is the National Resource Center located in Silver Spring, MD. The NRC has a highly knowledgeable and professional staff with extensive contacts in every state, and in all federal agencies which pertain to the EMSC Program goals. The phone number of the NRC is (301) 884-4927, the web site is www.ems-c.org, and the e-mail address is info@emscnrc.com. One of the many activities which the NRC coordinates is the Partnership For Children program. By contracting with fifteen professional organizations (e.g., AAP, ACEP, Emergency Nurses Association, American Pediatric Surgical Association), the NRC involves them in planning and implementing EMSC goals and activities consistent with the Program's Five Year Plan. The broad goal of the EMSC Program is to improve the spectrum of emergency care and services for all children. As the physician liaison to the IHS, I am available to you, my fellow IHS pediatricians, as a resource to make these improvements for our patients. Call me. Jim Flaherty, MD, Navajo Area EMS Medical Director Emergency Department, Tuba City Indian Medical Center (520) 283-2960 (office/Voice mail) 283-2406 (page), 283-24089(fax), or jflaher1@tcimc.ihs.gov

David Grossman, MD, MPH provides update of CONACH activities

Greetings from the Committee on Native American Child Health of the American Academy of Pediatrics. I wanted to update you on some committee issues and projects.

1. **Legislation/Advocacy:** The committee s last meeting was held in Washington, D.C. in February 2000. As you may know, we now hold every other meeting there to facilitate our advocacy efforts with Congress. We work closely with the Washington AAP office during this meeting. The big issues legislatively are the elevation of the Director of the Indian Health Service to an Asst. Secretary level and the passage of the Indian Health Care Improvement Act (IHCIA). The appropriations issue is an ongoing issue for us since the president s budget is first introduced in February. Currently, our efforts will be directed toward assisting with the revisions of the IHCIA, supporting the director elevation, and in creating a new infrastructure for maternal and child health. We are also working toward improving our advocacy efforts by staying in touch with AAP members who have an interest in Indian Health. As you know, federal employees cannot lobby Congress but tribal employees may be able to; and physicians who have exited the Indian Health Service certainly can. We hope to get help educating key congressional representatives about Indian Health issues.
2. **Diabetes:** A subcommittee of CONACH chaired by Dr. Sheila Gahagan is writing a guide on Type II diabetes for primary care clinicians caring for children. This guideline will build upon the joint AAP/ADA statement that appeared last month in Pediatrics and will focus primarily on diagnosis, treatment and prevention. This is being written primarily for Indian health clinicians but should have broad applicability with other ethnic groups. Other members of the Task Force include George Brenneman, Indu Agarwal, and Kelly Moore.
3. **Recruitment/Retention:** On another front, we are continuing to look into the disparity in salary levels for pediatrician commissioned officers, compared to other primary care specialties. This issue was taken up on our behalf with the Director of Commissioned Personnel and the Director of the Indian Health Service. We will continue to pursue this.
4. **Consultation** visits: Our next consultation visits will be in the Phoenix Area in the Fall of 2000. We hope to visit several programs and provide some feedback on MCH programming and service delivery, as well as to learn about what s working in your institutions.

I hope you ll stay in touch with us, and let us know of your concerns and needs. You can reach our AAP committee staff person, Ms. Ana Garcia by email at nativeamerican@aap.org or by phone at 1-800-433-9016, ext. 4739. I am available at navajo@u.washington.edu.

The National Diabetes Prevention Center in Gallup is hosting a conference on Type 2 Diabetes in Children August 28 to 31. Contact 1-888-590-NDPC for more information or visit their website at http://hsc.unm.edu/ndpc.

Plans for the biennial Indian child health conference in 2001 are already underway On the FAX BACK form on the back of the newsletter are a list of suggested topics, rating scale, and space to suggest additional topics. Your input is vital if the conference is to continue to be relevant to our practice! This year the American Academy of Pediatrics and Oklahoma University will be collaborating and providing staff support thanks in part to the enthusiastic advocacy of Dr. James Jarvis, CONACH member and Pediatric Rheumatologist in Oklahoma. Tentative dates for the conference are around September 19 to 21, 2001 in Oklahoma City please indicate if you prefer Wednesday through Friday or starting later but including some weekend days. Please FAX back to me and I will forward to the planning committee.

FAX COVER SHEET

TO: William F. Green, M.D. wgreen@albmail.albuquerque.ihs.gov
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FROM: _____ PHONE:
_____

FAX: _____ E MAIL ADDRESS:

Dear Bill,
I would suggest the following topics for the September, 2001 meeting in Oklahoma:

I prefer __workshops ___lectures ___some of each
Wednesday through Friday__ Thursday through Saturday__
On a list of some suggested topics below, rate your level of interest (1=high, 2=medium, 3=low)

__Current approaches to dx and rx of Asthma
__Type 2 Diabetes diagnosis and management
__Control of invasive Streptococcal pneumoniae disease in AI/AN children
__Tobacco use and abuse, treatment strategies
__IGA Nephropathy, implications for the workup of hematuria
__ evidence-based pediatrics/use of the internet resources
__management of common adolescent GYN problems
__rheumatologic diseases in AI/AN children
__prevention, diagnosis and management of fetal alcohol exposure
__practical care of neurologically impaired child
__rational use of antibiotics in an era of antibiotic resistance
__obesity prevention
__practical dysmorphology with emphasis on conditions more common in AI/AN
__diagnosis and management attention deficit, pervasive developmental disorder and autism
__violence prevention
__impacts of gambling on children
__workshop on literacy promotion: lessons of experience so far

Topics for the next newsletter:

You should send copies to these new IHS, tribal, or urban health care pediatricians/nurse practitioners: