NATIONAL COUNCIL OF CHIEF CLINICAL CONSULTANTS

CCC Corner

Focus on the Health of American Indians and Alaska Natives

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Nov 2008

Effectiveness of Maternal Influenza Immunization in Mothers and Infants

Abstract

BACKGROUND: Young infants and pregnant women are at increased risk for serious consequences of influenza infection. Inactivated influenza vaccine is recommended for pregnant women but is not licensed for infants younger than 6 months of age. We assessed the clinical effectiveness of inactivated influenza vaccine administered during pregnancy in Bangladesh.

METHODS: In this randomized study, we assigned 340 mothers to receive either inactivated influenza vaccine (influenza-vaccine group) or the 23-valent pneumococcal polysaccharide vaccine (control group). Mothers were interviewed weekly to assess illnesses until 24 weeks after birth. Subjects with febrile respiratory illness were assessed clinically, and ill infants were tested for influenza antigens. We estimated the incidence of illness, incidence rate ratios, and vaccine effectiveness.

RESULTS: Mothers and infants were observed from August 2004 through December 2005. Among infants of mothers who received influenza vaccine, there were fewer cases of laboratory-confirmed influenza than among infants in the control group (6 cases and 16 cases, respectively), with a vaccine effectiveness of 63% (95% confidence interval [CI], 5 to 85). Respiratory illness with fever occurred in 110 infants in the influenza-vaccine group and 153 infants in the control group, with a vaccine effectiveness of 29% (95% CI, 7 to 46). Among the mothers, there was a reduction in the rate of respiratory illness with fever of 36% (95% CI, 4 to 57).

CONCLUSIONS: Inactivated influenza vaccine reduced proven influenza illness by 63% in infants up to 6 months of age and averted approximately a third of all febrile respiratory illnesses in mothers and young infants. Maternal influenza immunization is a strategy with substantial benefits for both mothers and infants.

Zaman K, Roy E, Arifeen SE, Rahman M, Raqib R, Wilson E, Omer SB, Shahid NS, Breiman RE, Steinhoff MC. Effectiveness of maternal influenza immunization in mothers and infants. N Engl J Med. 2008 Oct 9;359(15):1555-64. Epub 2008 Sep 17.

www.ncbi.nlm.nih.gov/pubmed/18799552

Free Full Text:

http://content.nejm.org/cgi/content/full/359/15/1555

OB/GYN CCC Editorial comment:

This article is important because it demonstrates another way that flu vaccine can be used to protect some of the most vulnerable amongst us. In addition to conferring protection to the mothers in this study (who experienced a 36% reduction in febrile respiratory illness), the infants born to the mothers who received influenza vaccine had 63% fewer cases of influenza than the infants born to the control group of mothers. The infants also experienced 29% fewer febrile respiratory illnesses overall. Influenza vaccine is not currently licensed for use in infants younger than 6 months of age. Their best protections are for their mothers to receive a flu shot in pregnancy and for the household contacts of infants to be immunized as well.

In an article about the study published by Johns Hopkins, the authors of the study observed:

"Even though there is no flu vaccine for these children, our study shows that a newborn's risk of infection can be greatly reduced by vaccinating mom during pregnancy. It's a two for one benefit," said

(continued on page 15)

THIS MONTH

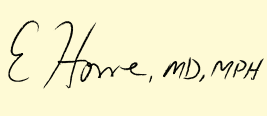
Flu Season

The theme that runs through this issue is influenza prevention.

More than 85% of the U.S. population now falls into at least one of the categories targeted for vaccination. Several segments of this issue have tools to help you improve vaccination rates at your work site. Pregnant women are a special priority for vaccination, as are health care workers. We hope that this issue will help you meet your goals for influenza prevention this season.

Also on-line....

Subscribe to the listserv and receive reminders about this service. If you have any questions, please contact me at jean.howe@ihs.gov



Jean Howe, MD, MPH
Ob/Gyn–
Chief Clinical Consultant (C.C.C.)

From Your Colleagues

Joxel Garcia, U.S. Public Health Service

Influenza Vaccination for Health Care Personnel

I am requesting your assistance in implementing the Departmental initiative for the 2008-09 influenza vaccination season to improve Health Care Personnel (HCP) influenza vaccination levels. The Office of Public Health and Science (OPHS) has formed a task force of relevant OPDIVs and STAFFDIVs, and discussed current activities promoting and/or providing HCP influenza vaccination. The task force has developed the attached toolkit for OPDIVs and STAFFDIVs for use in promoting HCP influenza vaccination.

I urge you to use the toolkit and related strategies to improve vaccination levels of health care personnel in your OPDIV or STAFFDIV. The rationale for this initiative and strategies are fully discussed in the recommendations for influenza vaccination of HCP of the Healthcare Infection Control Practices Advisory Committee (HICPAC) and the Advisory Committee on Immunization Practices (ACIP) (www.cdc.gov/mmwr/preview/mmwrhtml/rr5502a1.htm).

The Department is striving to achieve the Healthy People 2010 objective of 60 percent vaccination coverage for HCP, both for employee HCP, and those outside of the Department.

The toolkit, and other materials to assist you, are available at www.hhs.gov/ophs/. We will pay particular attention to measuring activities promoting influenza vaccination, and vaccination rates for HCP. For further information about this initiative, please contact CAPT Raymond Strikas at 202-260-2652, or at Raymond.strikas@psc.hhs.gov.

Thank you for your assistance in this important effort.

Scott Giberson, IHS Headquarters

Call for Abstracts—Third Alaska Native Health Research Conference

The planning taskforce for the Third Alaska Native Health Research Conference to be held March 19-20, 2009 in Anchorage, AK is announcing a call for abstracts. Please distribute this link to all researchers and students with interests in Alaska Native health research who may wish to submit an abstract for oral or poster presentation. The link for abstract submission is: http://events.SignUp4.net/ANHRC09Abstract . The link is also available by clicking on "Alaska Native Tribal Health Research Conference; March 19-20, 2009" at www.alaskatribalhealth.org

Paul Seligman, Food and Drug Administration

FDA Creates Web Page with Drug Safety Information for Patients, Health Care Professionals; Consolidates information in one access point

Consumers and health care professionals can now go to a single page on the U.S. Food and Drug Administration's Web site to find a wide variety of safety information about prescription drugs. The Web page provides links to information in these categories:

- Drug labeling, including patient labeling, professional labeling, and patient package inserts;
- Drugs that have a Risk Evaluation and Mitigation Strategy (REMS) to ensure that their benefits outweigh their risks;
- A searchable database of postmarket studies that are required from, or agreed to by, drug companies to provide the FDA with additional information about a drug's safety, efficacy, or optimal use;
- Clinicaltrials.gov, a searchable database of clinical trials, including information about each trial's purpose, who may participate, locations, and useful phone numbers;
- Drug-specific safety information, including safety sheets with the latest information about the drug as well as related FDA press announcements, fact sheets, and drug safety podcasts;
- Quarterly reports that list certain drugs that are being evaluated for potential safety issues, based on a review of information in the FDA's Adverse Event Reporting System (AERS);
- Warning Letters, Import Alerts, Recalls, Market Withdrawals, and Safety Alerts;
- Regulations and guidance documents;
- Consumer information about using medications safely and disposing of unused medicines;
- Instructions how to report problems to the FDA through its MedWatch program;
- Consumer articles on drug safety; and
- The FDA's response to the Institute of Medicine's 2006 report on the future of drug safety.

www.fda.gov/cder/drugSafety.htm

Hot Topics

Obstetrics

Alcohol Use Screening for FASD Prevention among a Cohort of American Indian Women

ABSTRACT

INTRODUCTION: The purpose of the study was to compare three sequential pregnancies of American Indian women who have children with FAS or children with incomplete FAS with women who did not have children with FAS.

METHODS: Two retrospective case-control studies were conducted of Northern Plains American Indian children with fetal alcohol syndrome (FAS) (Study 1) or incomplete FAS (Study 2) in 1981–1993. Three successive pregnancies ending in live births of 43 case mothers who had children with FAS, and 35 case mothers who had children with incomplete FAS were compared to the pregnancies of 86 and 70 control mothers who did not have children with FAS, respectively, in the two studies. Prenatal records were abstracted for the index child (child with FAS or incomplete FAS) and siblings born just before and just after the index child, and comparable prenatal records for the controls.

RESULTS: Compared to the controls, significantly more case mothers used alcohol before and after all three pregnancies and during pregnancy with the before sibling and the index child. Mothers who had children with FAS reduced their alcohol use during the pregnancy following the birth of the index child. All Study 1 case mothers (100%) and 60% of Study 2 case mothers used alcohol during the pregnancy with the index child compared to 20 and 9% of respective control mothers. More study 1 case mothers experienced unintentional injuries (OR 9.50) and intentional injuries during the index pregnancy (OR 9.33) than the control mothers. Most case mothers began prenatal care in the second trimester.

CONCLUSIONS: Alcohol use was documented before, during and after each of the three pregnancies. Women of child-bearing age should be screened for alcohol use whenever they present for medical services. Mothers who had a child with FAS decreased their alcohol consumption with the next pregnancy, a finding that supports the importance of prenatal screening throughout pregnancy. Women who receive medical care for injuries should be screened for alcohol use and referred for appropriate treatment. Protective custody, case management and treatment services need to be readily available for women who use alcohol.

Kvigne VL, Leonardson GR, Borzelleca J, Brock E, Neff-Smith M, and Welty TK. Alcohol Use, Injuries, and Prenatal Visits During Three Successive Pregnancies Among American Indian Women on the Northern Plains Who have Children with Fetal Alcohol Syndrome or Incomplete Fetal Alcohol Syndrome. Maternal and Child Health Journal. Volume 12, Supplement 1 / July, 2008. pp 37-45.
www.springerlink.com/content/dj5203723n2l7l34/

Prevention of Diabetes in Women with a History of Gestational Diabetes: Effects of Metformin and Lifestyle Interventions

CONTEXT: A past history of gestational diabetes mellitus (GDM) confers a very high risk of postpartum development of diabetes, particularly type 2 diabetes.

OBJECTIVE: The Diabetes Prevention Program (DPP) sought to identify individuals with impaired glucose tolerance (IGT) and intervene in an effort to prevent or delay their progression to diabetes. This analysis examines the differences between women enrolled in DPP with and without a reported history of GDM.

DESIGN: The DPP was a randomized, controlled clinical trial.

SETTING: The study was a multicenter, NIH-sponsored trial carried out at 27 centers including academic and Indian Health Services sites.

PATIENTS: 2190 women were randomized into the DPP and provided information for past history of GDM. This analysis addresses the differences between those 350 women providing a past history of GDM and those 1416 women with a previous live birth, but no history of GDM.

INTERVENTIONS: Subjects were randomized to either standard lifestyle and placebo or metformin therapy, or to an intensive lifestyle intervention.

"Many Voices into One Song"

Did you attend the Albuquerque Women's Health Conference in August 2007? Were you wondering when the next biennial meeting would be? This year we've moved things up a bit to take advantage of an opportunity to partner with organizations working in Indigenous Women's Health and Child Health around the globe. For more details, please see p. 16.

Albuquerque, NM Women's Health March 4-6, 2009
Children's Health March 6–8, 2009

(The 6th is an overlap day with both groups participating!)

Hope to see you there!

MAIN OUTCOMES: The primary outcome was the time to development of diabetes ascertained by semi-annual fasting plasma glucose and annual oral glucose tolerance testing. Assessments of insulin secretion and insulin sensitivity were also performed.

RESULTS: While entering the study with similar glucose levels, women with a history of GDM randomized to placebo had a crude incidence rate of diabetes 71% higher than that of women without such a history. Among women reporting a history of GDM, both intensive lifestyle and metformin therapy reduced the incidence of diabetes by approximately 50% compared with the placebo group, whereas this reduction was 49% and 14%, respectively in parous women without GDM. These data suggest that metformin may be more effective in women with a GDM history as compared to those without.

CONCLUSIONS: Progression to diabetes is more common in women with a history of GDM compared to those without GDM history despite equivalent degrees of IGT at baseline. Both intensive lifestyle and metformin are highly effective in delaying or preventing diabetes in women with IGT and a history of GDM.

Ratner RE, Christophi CA, Metzger BE, Dabelea D, Bennett PH, Pi-Sunyer X, Fowler S, Kahn SE; The Diabetes Prevention Program Research Group. Prevention of Diabetes in Women with a History of Gestational Diabetes: Effects of Metformin and Lifestyle Interventions. J Clin Endocrinol Metab. 2008 Sep 30. [Epub ahead of print]
www.ncbi.nlm.nih.gov/pubmed/18826999

Alpha Testing to Start on the EHR Version of the Well Child Module

Good news! Alpha testing is starting on the EHR version of the Well Child Module. The electronic versions of both the Well Child and Prenatal modules will be available in EHR or as "free-standing" components for sites that have yet to migrate to the IHS EHR.

Cherokee Indian Hospital has volunteered to alpha test the EHR version of the WCM. The other iteration of the electronic version of the WCM (for sites not yet on EHR) will also be alpha tested soon.

The EHR version of the Prenatal Module is also very close to alpha testing and should be ready for testing late this fall.

For further information, contact: **clarence.smiley@ihs.gov.**

Gynecology

FDA Public Health Notification: Serious Complications Associated with Transvaginal Placement of Surgical Mesh in Repair of Pelvic Organ Prolapse and Stress Urinary Incontinence

The FDA has informed healthcare professionals of serious complications associated with transvaginal placement of surgical mesh in repair of pelvic organ prolapse (POP) and stress urinary incontinence (SUI). Over the past three years, FDA has received over 1,000 reports from nine surgical mesh manufacturers of complications that were associated with surgical mesh devices used to repair POP and SUI. The most frequent complications included erosion through vaginal epithelium, infection, pain, urinary problems, and recurrence of prolapse and/or incontinence. There were also reports of bowel, bladder, and blood vessel perforation during insertion. In some cases, vaginal scarring and mesh erosion led to a significant decrease in patient quality of life due to discomfort and pain, including dyspareunia. FDA provided recommended actions for both physicians and patients to reduce the risks.

Additional information is available at:
www.fda.gov/cdrh/safety/102008-surgicalmesh.html

The role of Lactobacillus casei rhamnosus Lcr35 in restoring the normal vaginal flora after antibiotic treatment of bacterial vaginosis

OBJECTIVE: To evaluate the efficacy of additional topical Lactobacillus casei rhamnosus (Lcr35) subsequent to antibiotic treatment of bacterial vaginosis (BV) to restore the normal vaginal flora.
STUDY DESIGN: Single-centre, randomised, observer blinded study.

SETTING: Population-based study in Vienna over 1 year.

SAMPLE: 190 women were enrolled in the study.

METHODS: Women with Nugent scores between 7 and 10 on initial vaginal swab were randomised to the one of two groups. All women were treated with standard antibiotic therapy for 7 days. Only women in the intervention group received vaginal capsules containing 10(9) colony-forming units of live Lcr35 for 7 days after antibiotic treatment. Final vaginal swabs for Nugent scoring were taken 4 weeks after the last administration of the study medication.

MAIN OUTCOME MEASURES: The primary efficacy variable was a change in the Nugent score between the baseline and the end of the study of at least 5 grades in each individual woman. RESULTS: Sixty-nine of the 83 women (83%) in the intervention group and 31 of the 88 women (35%) in the control group showed a reduction of the Nugent score by at least 5 grades. The difference in the number of women with improvement was highly significant (P < 0.001). The median difference in Nugent scores between initial and final swabs was 6.61 in the intervention group and 4.13 in the control group (P < 0.001).

CONCLUSION: Our data show that the restoration of the vaginal flora after antibiotic treatment of BV can be significantly enhanced by exogenously applied lactobacilli.

Petricevic L, Witt A. The role of Lactobacillus casei rhamnosus Lcr35 in restoring the normal vaginal flora after antibiotic treatment of bacterial vaginosis. BJOG. 2008 Oct;115(11):1369-74.
www.ncbi.nlm.nih.gov/pubmed/18823487

Child Health

Prevention of Rickets and Vitamin D Deficiency in Infants, Children, and Adolescents

ABSTRACT: Rickets in infants attributable to inadequate vitamin D intake and decreased exposure to sunlight continues to be reported in the United States. There are also concerns for vitamin D deficiency in older children and adolescents. Because there are limited natural dietary sources of vitamin D and adequate sunshine exposure for the cutaneous synthesis of vitamin D is not easily determined for a given individual and may increase the risk of skin cancer, the recommendations to ensure adequate vitamin D status have been revised to include all infants, including those who are exclusively breastfed and older children and adolescents. It is now recommended that all infants and children, including adolescents, have a minimum daily intake of 400 IU of vitamin D beginning soon after birth. The current recommendation replaces the previous recommendation of a minimum daily intake of 200 IU/day of vitamin D supplementation beginning in the first 2 months after birth and continuing through adolescence. These revised guidelines for vitamin D intake for healthy infants, children, and adolescents are based on evidence from new clinical trials and the historical precedence of safely giving 400 IU of vitamin D per day in the pediatric and adolescent population. New evidence supports a potential role for vitamin D in maintaining innate immunity and preventing diseases such as diabetes and cancer. The new data may eventually refine what constitutes vitamin D sufficiency or deficiency.

Carol L. Wagner, MD, Frank R. Greer, MD, and the Section on Breastfeeding and Committee on Nutrition. Prevention of Rickets and Vitamin D Deficiency in Infants, Children, and Adolescents. Pediatrics 2008;122:1142–1152.
www.aap.org/new/VitaminDreport.pdf

Use of a fan during sleep and the risk of sudden infant death syndrome

OBJECTIVE: To examine the relation between room ventilation during sleep and risk of sudden infant death syndrome (SIDS).

DESIGN: Population-based case-control study.

SETTING: Eleven California counties.

PARTICIPANTS: Mothers of 185 infants with a confirmed SIDS diagnosis and 312 randomly selected infants matched on county of residence, maternal race/ethnicity, and age.

INTERVENTION: Fan use and open window during sleep.

MAIN OUTCOME MEASURE: Risk of SIDS.

RESULTS: Fan use during sleep was associated with a 72% reduction in SIDS risk (adjusted odds ratio [AOR], 0.28; 95% confidence interval [CI], 0.10-0.77). The reduction in SIDS risk seemed more pronounced in adverse sleep environments. For example, fan use in warmer room temperatures was associated with a greater reduction in SIDS risk (AOR, 0.06; 95% CI, 0.01-0.52) compared with cooler room temperatures (0.77; 0.22-2.73). Similarly, the reduction associated with fan use was greater in infants placed in the prone or side sleep position (AOR, 0.14; 95% CI, 0.03-0.55) vs supine (0.84; 0.21-3.39). Fan use was associated with a greater reduction in SIDS risk in infants who shared a bed with an individual other than their parents (AOR, 0.15; 95% CI, 0.01-1.85) vs with a parent (0.40; 0.03-4.68). Finally, fan use was associated with reduced SIDS risk in infants not using pacifiers (AOR, 0.22; 95% CI, 0.07-0.69) but not in pacifier users (1.99; 0.16-24.4). Some differences in the effect of fan use on SIDS risk did not reach statistical significance.

CONCLUSION: Fan use may be an effective intervention for further decreasing SIDS risk in infants in adverse sleep environments.

Coleman-Phox K, Odouli R, Li DK. Use of a fan during sleep and the risk of sudden infant death syndrome. Arch Pediatr Adolesc Med. 2008 Oct;162(10):963-8.
www.ncbi.nlm.nih.gov/pubmed/18838649

Chronic disease and Illness

Patients and Caregivers Benefit from End-of-Life Discussions

CONTEXT: Talking about death can be difficult. Without evidence that end-of-life discussions improve patient outcomes, physicians must balance their desire to honor patient autonomy against a concern of inflicting psychological harm.

OBJECTIVE: To determine whether end-of-life discussions with physicians are associated with fewer aggressive interventions.

DESIGN, SETTING, AND PARTICIPANTS: A US multisite, prospective, longitudinal cohort study of patients with advanced cancer and their informal caregivers (n = 332 dyads), September 2002-February 2008. Patients were followed up from enrollment to death, a median of 4.4 months later. Bereaved caregivers' psychiatric illness and quality of life was assessed a median of 6.5 months later.

MAIN OUTCOME MEASURES: Aggressive medical care (e.g., ventilation, resuscitation) and hospice in the final week of life. Secondary outcomes included patients' mental health and caregivers' bereavement adjustment.

CONCLUSIONS: End-of-life discussions are associated with less aggressive medical care near death and earlier hospice referrals. Aggressive care is associated with worse patient quality of life and worse bereavement adjustment.

Wright AA, Zhang B, Ray A, Mack JW, Trice E, Balboni T, Mitchell SL, Jackson VA, Block SD, Maciejewski PK, Prigerson HG. Associations between end-of-life discussions, patient mental health, medical care near death, and caregiver bereavement adjustment. JAMA. 2008 Oct 8;300(14):1665-73.
www.ncbi.nlm.nih.gov/pubmed/18840840

Patients with Coronary Heart Disease Benefit from Screening for Depression

ABSTRACT: Depression is commonly present in patients with coronary heart disease (CHD) and is independently associated with increased cardiovascular morbidity and mortality. Screening tests for depressive symptoms should be applied to identify patients who may require further assessment and treatment. This multispecialty consensus document reviews the evidence linking depression with CHD and provides recommendations for healthcare providers for the assessment, referral, and treatment of depression.

Lichtman JH, Bigger JT Jr, Blumenthal JA, Frasure-Smith N, Kaufmann PG, Lespérance F, Mark DB, Sheps DS, Taylor CB, Froelicher ES. Depression and Coronary Heart Disease. Recommendations for Screening, Referral, and Treatment. A Science Advisory From the American Heart Association Prevention Committee of the Council on Cardiovascular Nursing, Council on Clinical Cardiology, Council on Epidemiology and Prevention, and Interdisciplinary Council on Quality of Care and Outcomes Research. Circulation. 2008 Sep 29. [Epub ahead of print]. www.ncbi.nlm.nih.gov/pubmed/18824640
Free full text:
http://circ.ahajournals.org/cgi/reprint/CIRCULATIONAHA.108.190769v2

Resources for Depression Screening:

The McArthur Initiative on Depression and Primary Care:
www.depression-primarycare.org/clinicians/toolkits/

Sample PHQ_2:
www.commonwealthfund.org/usr_doc/PHQ2.pdf

Sample PHQ_9:
www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/questionnaire_sample/

National Influenza Vaccination Week

December 8–14, 2008

Free Flu Materials from the CDC

Make sure that your community is ready with patient educational materials and posters from the CDC. This year's seasonal flu materials are free for download—no printed versions are available. They may be printed on a standard office printer, or you may use a commercial printer.

Emphasis remains on outreach to high-risk groups, as well as parents of all children, health care workers, and people in the workplace.
www.cdc.gov/flu/professionals/flugallery/index.htm

Features

ACOG American College of Obstetricians and Gynecologists

ACOG Practice Bulletin #98 Ultrasonography in Pregnancy

Most women have at least one ultrasound examination during pregnancy. The purpose of this document is to present evidence regarding the methodology of, indications for, benefits of, and risks associated with obstetric ultrasonography in specific clinical situations. Portions of this document were developed collaboratively with the American College of Radiology and the American Institute of Ultrasound in Medicine. The sections that address physician qualifications and responsibilities, documentation, quality control, infection control, and patient safety contain recommendations from the American College of Obstetricians and Gynecologists.

Summary of Recommendations and Conclusions

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

- Ultrasound examination is an accurate method of determining gestational age, fetal number, viability, and placental location.
- Gestational age is most accurately determined in the first half of pregnancy.
- Ultrasonography can be used in the diagnosis of many major fetal anomalies.
- Ultrasonography is safe for the fetus when used appropriately.

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

- Ultrasonography is helpful in detecting fetal growth disturbances.
- Ultrasonography can detect abnormalities in amniotic fluid volume.

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

- The optimal timing for a single ultrasound examination in the absence of specific indications for a firsttrimester examination is at 18–20 weeks of gestation.
- The benefits and limitations of ultrasonography should be discussed with all patients.

Proposed Performance Measure

Documentation of the discussion of the benefits and limitations of ultrasonography

American College of Obstetricians and Gynecologists. ACOG Practice Bulletin #98, October 2008. Ultrasonography in pregnancy. Obstet Gynecol. 2008 Oct;112(4):951-61. **www.ncbi.nlm.nih.gov/pubmed/18827142**

ACOG Committee Opinion #419 Use of Progesterone to Reduce Preterm Birth

ABSTRACT: Preterm birth affects 12% of all births in the United States. Recent studies support the hypothesis that progesterone supplementation reduces preterm birth in a select group of women. Despite the apparent benefits of progesterone, the ideal progesterone formulation is unknown. The American College of Obstetricians and Gynecologists' Committee on Obstetric Practice and the Society for Maternal Fetal Medicine believe that further studies are needed to evaluate the optimal preparation, dosage, route of administration, and other indications for the use of progesterone for the prevention of preterm delivery. Based on current knowledge, it is important to offer progesterone for pregnancy prolongation to only women with a documented history of a previous spontaneous birth at less than 37 weeks of gestation.

American College of Obstetricians and Gynecologists. ACOG Committee Opinion #419, October 2008. Obstet Gynecol. 2008 Oct;112(4):963-5. **www.ncbi.nlm.nih.gov/pubmed/18827143**

AHRQ Agency for Healthcare Research and Quality

Behavioral Modification Programs Help Obese Children Manage Their Weight

AHRQ released a new report, Effectiveness of Weight Management Programs in Children and Adolescents, that shows obese school-age kids and teens can lose weight or prevent further weight gain if they participate in medium- to high-intensity behavioral management programs. Researchers found that after completing weight management programs, obese children would weigh between 3 pounds and 23 pounds less, on average, than obese children not involved in such programs. Among those enrolled, the weight difference would be greatest among heavier children as well as in those enrolled in more intensive programs. Researchers also found that weight improvements could be maintained for up to a year after the program ended. The report also showed that adding prescription drugs to a behavioral weight management program helped extremely obese adolescents lose weight. However, no studies evaluated maintenance of weight loss after drug treatment ended.

www.ahrq.gov/clinic/tp/chwghttp.htm

Copies of the report may be ordered free of charge by calling the AHRQ Publications Clearinghouse at 1-800-358-9295 or sending an E-mail to AHRQPubs@ahrq.hhs.gov. For information on how children's and teenagers weight is assessed and a BMI calculator to use for them, go to http://apps.nccd.cdc.gov/dnpabmi/Calculator.aspx.

AHRQ also has a free DVD for families and children age 5 to 9 called Max's Magical Delivery: Fit for Kids. The 30-minute DVD teaches children and their parents about smart eating and physical activity. Copies are available by calling 1-800-358-9295 or E-mailing AHRQPubs@ahrq.hhs.gov.

AHRQ's 2008 Guide to Clinical Preventive Services Now Available

AHRQ has released the Guide to Clinical Preventive Services 2008, which highlights recommendations from the U.S. Preventive Services Task Force. In addition to previous recommendations, this year's Guide provides new Task Force recommendations released during 2007 on aspirin or nonsteroidal anti-inflammatory drugs for the primary prevention of colorectal cancer; screening for carotid artery stenosis; screening for chronic obstructive pulmonary disease using spirometry; counseling about proper use of motor vehicle occupant restraints and avoidance of alcohol use while driving; screening for illicit drug use; screening for lipid disorders in children; and, screening for sickle cell disease in newborns. The guide contains evidence-based recommendations that have been adapted for a pocket-size book, making it easier for clinicians to consult the recommendations in their daily practice. Recommendations are presented in an indexed, easy-to-use format, with at-a-glance charts.
www.ahrq.gov/clinic/pocketgd.htm

A print copy of the Guide is available by sending an e-mail to ahrqpubs@ahrq.hhs.gov.

Behavioral Health Insights

Peter Stuart, IHS Psychiatry Consultant

Protecting urban American Indian young people from suicide

OBJECTIVE: To examine the likelihood of a past suicide attempt for urban American Indian boys and girls, given salient risk and protective factors.

METHODS: Survey data from 569 urban American Indian, ages 9-15, in-school youths. Logistic regression determined probabilities of past suicide attempts.

RESULTS: For girls, suicidal histories were associated with substance use (risk) and positive mood (protective); probabilities ranged from 6.0% to 57.0%. For boys, probabilities for models with violence perpetration (risk), parent prosocial behavior norms (protective), and positive mood (protective) ranged from 1.0% to 38.0%.

CONCLUSIONS: Highlights the value of assessing both risk and protective factors for suicidal vulnerability and prioritizing prevention strategies.

Pettingell SL, Bearinger LH, Skay CL, Resnick MD, Potthoff SJ, Eichhorn J. Protecting urban American Indian young people from suicide. Am J Health Behav. 2008 Sep-Oct;32(5):465-76.
www.ncbi.nlm.nih.gov/pubmed/18241131

Breastfeeding

Suzan Murphy, PIMC

A Skinny Little Secret

Sometimes it takes a celebrity to make an old idea work. Now, thanks to Angelina Jolie, the secret is out about breastfeeding's sleek down potential. While other superstars like singer Christina Aguilera, Gwyneth Paltrow (Shakespeare in Love), and Kate Winlset (Titanic) have publicly commented about how breastfeeding sped their maternal weight loss, one picture of Ms. Jolie in a "great dress" at 11 weeks post partum from twins, told the story.

While the resources available to superstars—like personal trainers, money-is-no-object menus, chefs, exotic entrees, spa pampering, etc—help post partum weight loss, they are not likely public health obesity risk interventions. But breastfeeding could be.

In the last 15 years, several clinical studies have looked at the impact of lactation on maternal weight retention. Studies of US subjects found that lactation reduced weight retention to varying degrees. Variables associated with greater weight retention included single marital status, older maternal age, not breastfeeding, mixed feeding, and/or early weaning to formula. In 1993, Dewey et al found that exclusive breastfeeding significantly enhanced weight loss if continued for at least 6 months, when compared to weight loss patterns of mothers who formula fed. In 1997, Janney C et al found that maternal weight loss was slowed when moms increased formula use or stopped breastfeeding.

A recent study by Hatsu IE et al (2008) found that exclusive breastfeeding resulted in greater maternal weight loss in the first 12 weeks when compared to mixed feeding mothers. The exclusive breastfeeding mothers consumed more calories (1980 +/- 618 kcals, vs 1541 +/-196 kcal p = 0.08). Despite less weight loss, the mixed feeding mothers reported a higher physical activity level. A limitation of the study was small size, 24 participants.

There are several factors that could contribute to breastfeeding women losing more weight than those formula or mixed feeding. The maternal levels of prolactin, oxytocin, and estrogen are different in lactating compared to non-lactating postpartum women. Many breastfeeding women do not resume menses until a year or longer post partum. Also, the caloric cost of milk production is significant. By the second month of lactation, daily breast milk production is roughly 600-900 ml, resulting in approximately 400-600 kcals of milk for the baby. There are also maternal energy costs needed to fuel lactogensis. Although the kcal cost of the mechanics of breast milk production are not yet well understood, it is likely that the process of making breast milk adds to the drain of maternal energy stores.

The same myriad of variables that complicate childhood and adult weight patterns impact maternal weight retention. Food

choices/availability, stress, meal preparation methods, socio-economics, activity patterns, life style issues, co-existing diseases/handicaps, genetics, and medication can exert subtle but potentially significant sway over weight change. Controlling for these variables and others will require on-going study.

For more information about your clinic's early feeding choice and maternal weight retention patterns, please consider data available on RPMS/EHR. The infant feeding tool will define how babies are fed and can include the mothers' names. Specific information about the infant feeding tool is available at www.ihs.gov/MedicalPrograms/MCH/M/bf.cfm, under the Breastfeeding Headlines section: Frequently asked questions about capturing infant feeding choice on RPMS and E.H.R. or call 1-877-868-9473.

Featured Website

The Immunization Action Coalition

The Immunization Action Coalition, a 501(c)3 nonprofit organization, works to increase immunization rates and prevent disease by creating and distributing educational materials for health professionals and the public that enhance the delivery of safe and effective immunization services. The Coalition also facilitates communication about the safety, efficacy, and use of vaccines within the broad immunization community of patients, parents, health care organizations, and government health agencies.

Help yourself to the unique resource materials we offer. All of our print materials are camera-ready, copyright-free, and reviewed by CDC for technical accuracy with the exception of opinion pieces written by non-CDC authors. Our materials are ready for you to make copies and distribute to your patients and staff. Be our guest!
www.immunize.org/

The Immunization Action Coalition has an excellent on-line resource page to assist providers in addressing parents' and patients' concerns about immunization.
www.immunize.org/concerns/

Frequently asked questions

Neil Murphy, ANMC, SouthCentral Foundation

Q. Should we treat asymptomatic trichomonas found on a Pap smear?
A. It depends what type of Pap smear you are using. See details below

ANSWER: If is it was a conventional Pap, then please bring the non-pregnant patient in for a confirmatory test. If it was a liquid based Pap, then you can treat the patient without further evaluation.

Treating asymptomatic trichomoniasis is not recommended in pregnant women given the potentially increased risk of preterm birth associated with antibiotic therapy, but treatment of symptomatic non-pregnant women is recommended.

BACKGROUND: Treatment is indicated in all nonpregnant women* diagnosed with trichomonas vaginitis, even if asymptomatic. The rationale for treatment of asymptomatic women is that if left untreated, up to one-third become symptomatic within six months and they continue to transmit the infection to sexual partners while untreated.

The most sensitive method of detecting trichomonas vaginitis is culture. Unfortunately trichomonas culture is not available at most sites, plus one would also need a special medium to even send it to most outside laboratories. Microscopy and pH is only 50 to 70 percent sensitive and is time sensitive secondary to motility. DNA probes are sensitive and specific, but not readily available. Conventional cytology has a sensitivity of only 60 to 70 percent and false positive results are common (at least 8 percent). Thus, conventional Pap smear should not be used to diagnose trichomoniasis. Asymptomatic women with trichomonads identified on conventional Pap smear should be evaluated by wet mount, or culture if the wet mount is negative and should not be treated until the diagnosis is confirmed.

By comparison, the reliability of liquid-based cervical cytology appears to be higher. Although the sensitivity of liquid-based smears for trichomonas infection is low (61 percent), specificity is high (99 percent) compared to conventional Pap smear, resulting in a false positive rate of only 1 percent. Therefore, although liquid-based cervical cytology is not a sensitive test for diagnosis of trichomoniasis, we feel treatment of asymptomatic women with trichomonads noted on liquid-based cervical cytology is a reasonable approach.

In summary, patients with trichomonas on a conventional Pap need to come in confirmation before treatment. If you utilize a liquid based prep, then it is recommended that you treat based on that alone.

*Treating asymptomatic trichomoniasis is not recommended in pregnant women given the potentially increased risk of preterm birth associated with antibiotic therapy, but treatment of symptomatic pregnant women is recommended.

Bonus FAQ:

Q. Should I withhold contraception from a woman who is not 'current' on her pap?
A. No, there should be no barriers to the use of FDA approved contraception.
(Detailed answer to follow next month.)

Indian Child Health Notes

Steve Holve, Pediatrics Chief Clinical Consultant

November 2008

Quote of the month

Our capability to prevent and treat disease seems to exceed our willingness to apply our interventions.

—C Everett Koop, MD, Former Surgeon General

Article of Interest

Effectiveness of Maternal Influenza Immunization in Mothers and Infants.

N Engl J Med. 2008 Sep 17. (See "Abstract of the Month" for the abstract of this article.)

The current influenza vaccine is not licensed for use in infants < 6 months age. Unfortunately; this age group is at highest risk for morbidity and mortality from influenza infections. Researchers looked at immunizing mothers in the third trimester of pregnancy as a way to transfer immunity to infants at birth.

340 women participated in a randomized controlled trial and were followed for 24 weeks after birth. Women who were vaccinated for influenza had 36% less febrile respiratory illnesses themselves. Their infants had 29% less febrile respiratory illnesses than unvaccinated mothers. More striking was the 63% reduction of laboratory confirmed influenza in infants born to mothers that had been vaccinated. These numbers suggest that for each 100 mothers vaccinated 7 maternal febrile illnesses and 14 newborn illnesses will be prevented.

Pediatrics CCC Editorial Comment

Few interventions in medicine are this cheap and effective. Even though vaccination of pregnant women has been a recommendation of the CDC for several years the number of pregnant women vaccinated has been low. The quote from Dr. Koop above highlights the fact that we often fail to use treatments of known benefit.

Our challenge is to make sure that this intervention is available to as many patients as possible. Prenatal clinics should consider standing orders for administration of flu vaccine. Obstetric wards should also consider the use of standard orders for flu shots at discharge from mothers who were not vaccinated during pregnancy. This strategy will not result in transplacental protection of the infant but can decrease mother-child transmission.

Recent literature on American Indian/Alaskan Native Health

Michael L. Bartholomew, MD

Naimi TS, Cobb N, Boyd D, Jarman DW, Brewer R, Nelson DE, Holt J, Espey D, Snesrud P, Chavez P. Alcohol-Attributable Deaths and Years of Potential Life Lost Among American Indians and Alaska Natives---United States, 2001-2005. MMWR Morb Mortal Wkly Rep. 2008 Aug 29;57(34);938-941.

www.ncbi.nlm.nih.gov/pubmed/18756193

Excessive alcohol consumption is both a pervasive problem and the leading cause of preventable death in both the general U.S. population and the American Indian and Alaska Native (AI/AN) population. This study is the first to estimate the average annual number of alcohol-attributable deaths and years of potential life lost among AI/ANs. By using death certificate data and the CDC Alcohol-Related Disease Impact (ARDI) software, estimates of alcohol-attributable deaths and years of life lost were generated by analyzing multiple data sources including the Behavioral Risk Factor Surveillance System from 2001-2005.

Among AI/ANs, 1,514 alcohol-attributable deaths occurred annually from 2001-2005, accounting for 11.7% of all AI/AN deaths. For the general U.S. population, alcohol-attributable deaths accounted for 3.3% of total deaths. Acute causes, such as motor vehicle crashes, accounted for nearly 51% of these deaths, while 49% were attributed to chronic causes (alcoholic liver disease). Similarly, 60% of years of potential life lost were attributed to acute causes and nearly 40% were related to chronic conditions. Men accounted for more alcohol-attributable deaths in all age groups and nearly 7% of these deaths were in persons aged <20 years. Within the Indian Health Service (IHS) regions, the Northern Plains had the greatest number of alcohol-attributable deaths followed by the Southwest, and the Pacific Coast. Additionally, the age adjusted alcohol-attributable death rates were highest in the Northern Plains, Alaska, and the Southwest.

AI/AN age adjusted alcohol-attributed death rates were higher than the general U.S. population (55 per 100,000 for AI/AN versus nearly 27 per 100,000 for general U.S. population). The average number of years of life lost per alcohol-attributable death was 36.3 years for AI/ANs and 29.9 years for the general U.S. population.

Estimating the years of life lost and the alcohol attributed mortality rate in AI/ANs demonstrates the effect of excessive alcohol consumption within our population The authors conclude that effective population based interventions to reduce excessive alcohol consumption should be implemented and regional differences in alcohol-attributable deaths be explored.

International Health Update

Claire Wendland, Madison, WI

Disease risks of premastication as an infant feeding practice

Before the era of blenders, and beyond the reach of the purveyors of canned baby food, parents have long chewed up solid foods and fed the resulting mash to their weaning infants. This practice, called premastication, is old and widespread. It makes physiological sense: the chewing not only makes food manageable for little ones without teeth, but also mixes it with salivary enzymes to begin the digestive process. Unfortunately, premastication also seems to have some health risks that may not have been adequately considered.

Although the anthropological literature on premastication is not extensive (primarily because the anthropological record does not have much to say about infant feeding in general), we have evidence that it is practiced in every major region of the world. Using the Human Relations Area Files, a fascinating compendium of ethnographic records collected over the course of sixty years, I was able to identify good evidence of premastication of infant food in fifteen cultural groups from Asia, South America, North America, Oceania, and Africa. (Two others premasticate food for animals: one Amazonian group occasionally chews up taro for their prized dogs, and a South Seas people masticates yam for the boars that have grown such long spiral tusks – valuable among the South Seas islanders for ceremonial purposes – that they can no longer open their mouths enough to chew.) Anecdotal reports from the Indian Health Service indicate that premastication for infants is at least occasionally practiced among many Native peoples in North America as well, particularly among Navajo, northern Plains, and Alaska Native groups. Just how prevalent the practice is, however, is unknown.

So why does it matter? There have been suggestions that premastication can introduce the infant to pathogens carried by the adults who pre-chew their weaning food. A Canadian First Nations study (Sinha et al. 2004) implicates maternal saliva – potentially transferred to the infant through premastication and possibly also on pacifiers – in the oral-oral transmission of Helicobacter pylori, etiologic factor in both peptic ulcer and gastric cancer later in life. A Thai study (Imong et al. 1995) documents bacterial contamination of premasticated infant food and raises concerns over diarrheal diseases. Finally, a study from China (Huang 1990) raises concerns over the transmission of blood-borne pathogens in some cases: the author reports a two-fold rise in relative risk of hepatitis B among kindergartners whose mothers premasticated food for them in infancy, even when controlled for other routes of transmission. If further research confirms that blood-borne pathogens like HBV and HIV can be transmitted by premastication, even if such transmission is a relatively minor route, the implications for global health are obvious.

There are reasons for caution, however. First, the research available is preliminary; it is not at all clear whether premasticated infant food really is an important route of disease transmission. Second, the alternatives must be carefully thought through, especially for families who cannot afford commercial baby food. (Clinicians and public health professionals should be chastened by remembering the catastrophic impact of pushing bottle-feeding to mothers in the Third World.) Imong and colleagues' Thai study of infant feeding cited above showed bacterial contamination of both premasticated and mashed foods. Anthropologists provide another cautionary tale. Public health officials convinced the Orokaiva people of Papua New Guinea that premasticating babies' food was unhygienic and uncivilized. But their instructions to mash taro instead were ignored: mashing was a grievous offense to the taro spirit. Babies fed solid taro could not digest it; Orokaiva babies suffered critical weaning-period malnutrition because of this well-intentioned public health intervention, and the anthropologists' suggestion that going back to premastication would help was taken as a distasteful joke. It is not yet time to rush out and start a new public health campaign against premastication, but it probably is time to start considering—and researching—the risks of this and alternative weaning approaches among those who practice them.

Sinha SK et al. The incidence of Helicobacter pylori acquisition in children of a Canadian First Nations community and the potential for parent-to-child transmission. Helicobacter 9(1):59-68, 2004.

Huang MJ. [An epidemiological study on prevalence and risk factors of hepatitis B virus (HBV) infection in preschool children.] Zhongua Liu Xing Bing Xue Za Zhi 11(3):129-32, 1990. Note: article is in Chinese and only the abstract is available in English.

Imong SM et al. Maternal behaviour and socio-economic influences on the bacterial content of infant weaning foods in rural northern Thailand. J Trop Pediatr 41(4):234-40,1995.

MCH Headlines

Judy Thierry HQE

Native American Action Plan: Addressing Tobacco Abuse among Pregnant and Postpartum Women

The 32 page: "Native American Action Plan: Addressing Tobacco Abuse among Pregnant and Postpartum Women," developed by The National Partnership to Help Pregnant Smokers Quit with contractual technical assistance from LaDonna BlueEye was released in PDF and hard copy November 1st.

Meant for Tribal Leaders, Healthcare providers, Program planners and policy makers, and Funding agencies the TOC with cases, lessons learned and action steps in each section as follows:

I. The National Partnership to Help Pregnant Smokers Quit
II. Introducing the Issues; The Problem; The Challenge; The Current Intervention, The Opportunity
III. Action to Reduce Smoking among Pregnant Native Americans: The 5 C's
- Collaborate with other organizations; Traditional Ties
- Cultivate cultural competency; SEMA Tobacco Project
- Coach providers on working with Native American populations; Southern Ute Health Clinic
- Care for patients using evidence-based practices; Alaska Nicotine Research and Control Program
- Communicate cessation messages through multiple media; Aberdeen Healthy Start

An online version including the appendices will be available soon at:
www.tobacco-cessation.org/pregnantsmokers.htm.
Limited hard copies are available by contacting LaDonna BlueEye at **lblueeye@indiana.edu**.

Cough and Cold Medications Not Recommended for Children Under 4 Years of Age

FDA notified healthcare professionals and consumers that the Consumer Healthcare Products Association (CHPA) is voluntarily modifying the product labels for consumers of over the counter (OTC) cough and cold medicines to state "do not use" in children under 4 years of age. FDA supports CHPA members to help prevent and reduce misuse and to better inform consumers about the safe and effective use of these products for children. FDA continues to assess the safety and efficacy of these products and to revise its OTC list of approved ingredients and amounts for these medicines. Parents and care givers should adhere to the dosage instructions and warnings on the label that accompanies OTC cough and cold medications before giving the product to children, and should consult their healthcare professionals if they have any questions or concerns.

Read the entire 2008 MedWatch Safety Summaries, including a link to the FDA Press Release regarding the above issue at:
www.fda.gov/medwatch/safety/2008/safety08.htm#CoughCold

Medical Mystery Tour

Neil Murphy, ANMC, SouthCentral Foundation

Test your knowledge on Polycystic Ovarian Syndrome (PCOS)

1. Menstrual cycles become more irregular in women with polycystic ovarian syndrome (PCOS) as they approach menopause
- True
- False
2. Medical management of adolescents with PCOS are most appropriately directed towards
- Maximizing fertility
- Preventing excessive weight gain
- Arresting the progression of hirsutism
- Decreasing insulin levels
3. Intrauterine growth retardation is associated with an increased risk of PCOS in offspring
- True
- False
4. Brothers of women with PCOS are at greater risk for which of the following conditions?
- Decrease sperm counts
- Type 2 diabetes
- Hirsutism
- Increased pregnancy wastage
5. The most appropriate first line modality for ovulation induction in women with PCOS is
- Ovarian drilling
- Clomiphene citrate
- Metformin
- Exogenous gonadotropin

Answers to follow in the December CCC Corner…

Midwives Corner

Lisa Allee, CNM,
4 Corners Regional Health Center, Red Mesa, AZ

Centering Pregnancy ListServe Revived

Hello All! The Centering Pregnancy ListServe is being revived!!

This list serve is for anyone who is doing Centering, is about to start Centering, is interested in doing Centering soon or sometime in the future, or anyone who is just downright curious about Centering. It is our forum to discuss ideas, frustrations, successes, stories, trainings, etc!! Please feel free to send in anything about Centering and forward this to anyone who you think might be interested!

Here are two questions currently being discussed on the ListServe:

Who is currently doing Centering??—where are you, how many groups are you running; average group size; and how many providers and co-facilitators are involved?

Who would be interested in an Advanced Centering Pregnancy and Parenting Training? There is some funding available to put one on if we have the numbers to support it!

To join the ListServe, please contact Lisa Allee at
lisa.allee@ihs.gov.

Nurses Corner

Sandra Haldane, HQE

Strategies to prevent healthcare-associated infections in acute care hospitals

Preventable healthcare-associated infections (HAIs) occur in US hospitals. Preventing these infections is a national priority, with initiatives led by healthcare organizations, professional associations, government and accrediting agencies, legislators, regulators, payers, and consumer advocacy groups. To assist acute care hospitals in focusing and prioritizing efforts to implement evidence-based practices for prevention of HAIs, the Society for Healthcare Epidemiology of America and the Infectious Diseases Society of America Standards and Practice Guidelines Committee appointed a task force to create a concise compendium of recommendations for the prevention of common HAIs. This compendium is implementation focused and differs from most previously published guidelines in that it highlights a set of basic HAI prevention strategies plus special approaches for use in locations and/or populations within the hospital when infections are not controlled by use of basic practices, recommends that accountability for implementing infection prevention practices be assigned to specific groups and individuals, and includes proposed performance measures for internal quality improvement efforts.

Yokoe DS, Mermel LA, Anderson DJ, Arias KM, Burstin H, Calfee

DP, et al. A compendium of strategies to prevent healthcare-associated infections in acute care hospitals. Infect Control Hosp Epidemiol. 2008 Oct;29 Suppl 1:S12-21.
www.ncbi.nlm.nih.gov/pubmed/18840084

Free full text:
www.journals.uchicago.edu/doi/abs/10.1086/591060
New York Times article covering this issue:
www.nytimes.com/2008/10/09/us/09infection.html

Primary Care Discussion Forum

Ann Bullock, Cherokee, NC

Ongoing discussion of Geriatric Medication Issues

This discussion is being led by Bruce Finke, MD and Chris Lamer, PharmD. The case study which will serve as the springboard for our discussion is below. This is certainly a topic that affects all of us in I/T/U settings---how do we offer the benefits of preventive and therapeutic medications to elders without causing more harm than good? We hope you will participate with your thoughts and experiences as the discussion progresses over the next couple weeks. Welcome to Drs Finke and Lamer, the IHS Elder Care Consultant and IHS Clinical Informaticist for Health Education, respectively. See the instructions on enrollment after the following case description.

Case:

An 80 year old woman comes to see you for a routine follow-up. You have seen her episodically in walk-in but her primary care was provided by a physician who recently left. She is accompanied by her daughter who teaches 1st grade at the elementary school.

You greet her and ask her how she is doing. She complains about pain in her knees and thumbs and that her left wrist and hand are still not back to normal after her recent fracture. You are reminded that you saw her in walk-in after that fall (she had tripped on a step when she was pulling weeds from the flowerbed in her front yard)

You take a moment to review her medical problem list and medications. You see that she has diagnoses of diabetes, hypertension, hyperlipidemia, arthritis. You see atrial fibrillation on her problem list but notice that in her most recent visits she was in sinus rhythm. It appears that she had several episodes of atrial fibrillation with a controlled rate in the past two years but is mostly in sinus rhythm.

Current medications:

- Aspirin EC 81mg daily
- Lisinopril 10mg daily
- Diltiazem 180mg daily
- Atenolol 25mg daily
- Alprazolam 0.5mg prn started by the surgeon after the fall
- Digoxin 0.25mg daily
- Glyburide 10mg BID
- Metformin XR 1000mg BID
- Tylenol #3, 2 tablets Q4-6h prn pain
- Ibuprofen 600mg Q6h prn pain
- Tylenol PM 2 tabs HS prn sleep
- Lansoprazole 30mg daily
- Glucosamine 600mg TID
- Simvistatin 5mg daily

Vitals:

T: 94.4 P: 65 R: 18 BP: 150/72 Pain: 5 / 10

Labs at the last visit:

- AIC: 8.2%, goes to 9.0% with change in meds.
- LDL: 125
- TSH: normal
- B12: 330
- CBC: 13.2 / 42.2
- Chemistries: Na+: 142 K+: 3.8 Cl: 108 HCO3: 28 Cr: 1.1 Bun: 28 glucose: 165 random
- Albumin: 3.8
- eGFR: 47.05

What do you think about this elderly woman's medication management?

Are there medications prescribed that she perhaps should not be taking? Are there medications that she is taking that she should perhaps not be prescribed? What further information do you need or want?

How to subscribe/unsubscribe to the Primary Care Discussion Forum?

Subscribe to the Primary Care listserv
www.ihs.gov/cio/listserver/index.cfm?module=list&option=list&num=46&startrow=51
Unsubscribe from the Primary Care listserv
www.ihs.gov/cio/listserver/index.cfm?module=list&option=list&num=46&startrow=51
Questions on how to subscribe, contact
ANNBULL@nc-cherokee.com directly.

STD Corner

Lori de Ravello, National IHS STD Program

This month I wanted to draw attention to draw attention to some innovative uses of technology that are being used to prevent STDs/HIV and to promote safe sex.

Project Red Talon Launches MySpace Page

Project Red Talon, the STD/HIV prevention program at the Northwest Portland Area Indian Health Board, has launched a MySpace page to reach Native youth and young adults with age-appropriate STD/HIV prevention information. Encourage Native youth in your community to check it out and send Project Red Talon their comments and feedback. The website link is: http://www.myspace.com/projectredtalon. Project Red Talon's website is: **www.npaihb.org/epicenter/project/project_red_talon**.

Some other innovative uses of technology to address STDs include:

Confidential web-based chlamydia testing—At "I Want the Kit" people living in participating areas can confidentially order a home-based chlamydia test that gets returned to the project's lab in an unmarked envelope. Results are provided, linkages to local public health agencies for partner services are made, and treatment is provided. The Alaska native Tribal Health Consortium, the State of Alaska STD Program, and the IHS National STD Program are having discussions about implementing a variation of I Want the Kit in Alaska in the near future. To learn more, visit www.iwantthekit.org.

Anonymous web-based partner notification—InSpot is a web-based service that allows you to anonymously tell sex partners they have been exposed to an STD. InSpot's website is **www.inspot.org**.

Cellular ringtones with a STD message—BBC World Trust has produced a cellular phone ringtone in India that says "condom, condom" to promote safer sex and curb the spread of HIV in the country. It features a popular professional singer who sings the word "condom" more than 50 times—a "playful approach" that some advocates hope will "spark discussion and make condoms more socially acceptable". To hear the ring tone, visit: http://www.condomcondom.org.

Safe sex messages via text messaging—SexText is a project developed by the San Francisco Department of Health where youth can text a number that allows to receive targeted STD prevention messages tailored for their geographic location. Some rural areas—such as Wyoming—have considered using this service. To learn more, visit www.sextextsf.org.

Internet dating for people with STDs/HIV—There are many websites that link people who know they have STDs or HIV. People who use these sites say it takes the stigma of having to disclose having an STD or HIV to a new partner away, since both people know up front that they both have something. To learn more, visit: Meet People with Herpes (www.MPwH.net), Positive Personals (www.positivepersonals.com), Positive Singles (www.positivesingles.com), A Greater Date (www.agreaterdate.com).

Advertising on social networking sites—The Queensland Government in Australia is launching a "Safe Sex. No Regrets" campaign through advertisements on internet sites such as MySpace, Facebook and Google.

The IHS National STD Program would be interested in hearing about other uses of technology to prevent STDs/HIV, especially those that are being used in Indian Country. Also, do you think any of these mentioned uses of technology would work in your community? Why or why not? Let us hear from you!

lori.deravello@ihs.gov

Women's Health Headlines

Carolyn Aoyama, HQE

A web-based resource for oral health providers on screening for domestic violence

Oral health providers are in a pivotal position for identifying head, face and neck injuries typical of domestic violence or child abuse. As primary care providers, we hope to engage them in domestic violence screening so they can also begin to connect women with community advocates as well as the medical, behavioral health and social services that their patients may wish to access.

I am excited to announce that through collaboration with among IHS Division of Oral Health, IHS Women's Health, HRSA's Maternal and Child Health Bureau, and the National Maternal and Child Oral Health Resource Center, a web-based "portal" to materials on domestic violence and oral health is now available at **www.mchoralhealth.org/AZ.html**.

The link takes you to a page on the National MCH Oral Health Resource Center's web site that has a list of references arranged in alphabetical order. Under "D" you will see "Domestic violence and oral health."

Click on the 'library' that appears to the right of "Domestic Violence and oral health" and you'll see 11 items featured - the first three focus on domestic violence, the other eight focus on child abuse.

(influenza immunization …, continued from page 1)
Mark Steinhoff, MD, the study's senior author and professor in the Bloomberg School's Department of International Health. "Infants under six months have the highest rates of hospitalization from influenza among children in the U.S. These admission rates are higher than those for the elderly and other high-risk adult groups."

AWHONN (the Association of Women's Health, Obstetric, and Neonatal Nurses) is publicizing the results of a new national survey, conducted on behalf of the national Women's Health Resource Center (NWHRC), which demonstrated that only 20 percent of those currently pregnant planned to get a flu shot this season. AWHONN has launched a campaign, Flu-Free & Mom To Be; Protect Yourself, Protect Your Baby—Get a Flu Shot!, to encourage influenza vaccination for pregnant women and new mothers.

Is your facility currently offering flu shots to pregnant women? Do you have standing orders to make this a streamlined, efficient process? What about vaccinating the rest of the household? Can partners, older siblings, and grandparents easily receive a flu shot at your facility? If not, then take time to develop strategies to meet this need right away. It's still early enough in flu season for these interventions to make a real difference.

You will find resources for flu season throughout this issue. The Indian Child Health notes also address influenza vaccination, as do other items in the "Features" section from ACOG, the Featured Website section and the Patient Education section. And in the "From Your Colleagues" section you'll find encouragement from Public Health Service leadership for you to get your own flu shot if you haven't already.

Help someone get vaccinated today!

AWHONN website:
http://www.awhonn.org/awhonn/content.do?name=02_PracticeResources/2B1_FluFreeMom2Be.htm

2008 CDC Influenza Vaccination Guidelines:
Vaccination of all children aged 6 months–18 years should begin before or during the 2008–09 influenza season if feasible, but no later than during the 2009–10 influenza season. Vaccination of all children aged 5–18 years is a new ACIP recommendation.

Children and adolescents at high risk for influenza complications should continue to be a focus of vaccination efforts as providers and programs transition to routinely vaccinating all children and adolescents. Recommendations for these children have not changed. Children and adolescents at higher risk for influenza complication are those:
- aged 6 months–4 years;
- who have chronic pulmonary (including asthma), cardiovascular (except hypertension), renal, hepatic, hematological or metabolic disorders (including diabetes mellitus);
- who are immunosuppressed (including immunosuppression caused by medications or by human immunodeficiency virus);
- who have any condition (e.g., cognitive dysfunction, spinal cord injuries, seizure disorders, or other neuromuscular disorders) that can compromise respiratory function or the handling of respiratory secretions or that can increase the risk for aspiration;
- who are receiving long-term aspirin therapy who therefore might be at risk for experiencing Reye syndrome after influenza virus infection;
- who are residents of chronic-care facilities; and,
- who will be pregnant during the influenza season.

Annual recommendations for adults have not changed. Annual vaccination against influenza is recommended for any adult who wants to reduce the risk for becoming ill with influenza or of transmitting it to others. Vaccination also is recommended for all adults in the following groups, because these persons are either at high risk for influenza complications, or are close contacts of persons at higher risk:
- persons aged >50 years;
- women who will be pregnant during the influenza season;
- persons who have chronic pulmonary (including asthma), cardiovascular (except hypertension), renal, hepatic, hematological or metabolic disorders (including diabetes mellitus);
- persons who have immunosuppression (including immunosuppression caused by medications or by human immunodeficiency virus);
- persons who have any condition (e.g., cognitive dysfunction, spinal cord injuries, seizure disorders, or other neuromuscular disorders) that can compromise respiratory function or the handling of respiratory secretions or that can increase the risk for aspiration;
- residents of nursing homes and other chronic-care facilities;
- health-care personnel;
- household contacts and caregivers of children aged <5 years and adults aged >50 years, with particular emphasis on vaccinating contacts of children aged <6 months; and,
- household contacts and caregivers of persons with medical conditions that put them at high risk for severe complications from influenza.

Centers for Disease Control and Prevention. Prevention and Control of Influenza; Recommendations of the Advisory Committee on Immunization Practices (ACIP), 2008. MMWR 2008;57(No. RR-7).
www.cdc.gov/mmwr/PDF/rr/rr5707.pdf

Immunization in Pregnancy Chart:
www.cdc.gov/vaccines/pubs/downloads/f_preg_chart.pdf

Save the Dates

2008 Indian Health Information Management Conference, "Managing Health Information Technology to Improve Performance and Outcomes"

- December 15–19, 2008 ; Phoenix, Arizona
- Information at: www.ihs.gov/cio/ihimc/

Telluride Midwinter Conference on Maternal and Child Health

- January 30th–February 1st, 2009
- Fun and inexpensive CME
- Telluride, Colorado
- www.ihs.gov/MedicalPrograms/MCH/F/CN01.cfm?module=09&option=1#top (scroll down to date)

First International Meeting on Indigenous Women's Health/Third International Meeting on Indigenous Child Health Conference; Many Voices into One Song

- Women's Health March 4–6, 2009
- Child Health March 6–8, 2009
- Albuquerque , NM
- Joint conference of Women's Health and Children's Health Providers from Canada and the United States
- www.ihs.gov/MedicalPrograms/MCH/F/CN01.cfm?module=09&option=3#top

Advances in Indian Health Conference

- April 21–24, 2009 in Albuquerque, NM
- Indian Health's conference for primary care providers and nurses
- 28 hours of CME/CE credit
- Optional Diabetes track
- Contact the Course Director, Dr. Ann Bullock, at annbull@nc-cherokee.com for more information.

Many Voices into One Song

First International Meeting on Indigenous Women's Health
(March 4–6, 2009)

+

Third International Meeting on Indigenous Child Health
(March 6–8, 2009)

These paired conferences are simply the biggest events on the horizon for both Women's Health and Child Health teams working in IHS, Tribal and Urban programs. They each offer:

- Extensive clinical updates focused on the major issues affecting American Indian and Alaska Native Health.
- A variety of formats (plenary sessions, breakouts, roundtables, poster presentations, etc.).
- Nationally known speakers, most with a background in Indigenous Health.
- Opportunities to learn about and share programs and innovations that work.
- Many occasions to network and socialize with others working on similar issues from across the country and around the globe.

Please join us in sunny Albuquerque, New Mexico in March! Better yet, bring an entire team from your facility!!

For more information on these conferences and other upcoming events, please visit the "Conferences" link on the MCH homepage at:
www.ihs.gov/MedicalPrograms/MCH/index.cfm

CCC Corner
c/o Neil Murphy, MD
SCF
PCC–WH
4320 Diplomacy Drive
Anchorage, AK 99508

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