IHS PEDS NOTES

A Newsletter for American Indian/Alaska Native Child Health

January 2002 Volume 19 Bill Green, Editor
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The Special Interest Group (SIG) in Indian Health within the American Academy of Pediatrics (AAP) Section on Community Pediatrics (SOCP) met during the NCE in San Francisco and has developed a proposed 4-part vision statement to guide activities for the coming year .

The 4 parts are:

1. Provide a forum for pediatricians and other health providers that serve Alaska Native/American Indian children to share successes and to attempt to meet needs during a time of profound change in the organization of Indian health care, including provision of both rural and urban health care.
2. Sponsor educational programs at AAP meetings that highlight the unique aspects of providing comprehensive health care to American Indian/Alaska Native children.
3. Support the work of the AAP Committee on Native American Child Health (CONACH) through the dissemination of information about new policy statements and advocacy issues, collaboration in development of educational programs, and assistance in nominating new members to serve on the committee.
4. Attempt to link SIG members in mentoring or consulting relationships to address problems specific to local or regional care of Native American children.

Selection for a steering committee has been completed. Thanks to the efforts of Harold Margolis, DO, and the support of Jeff Goldhagen, MD, and Peter Simon, MD, MPH, a proposal to have a SIG-sponsored workshop entitled A Community Intervention to Prevent Obesity: The Native American Headstart Obesity Initiative has been included in the proposed SOCP program for the 2002 National Meeting (NCE) in Boston. **Indian child health providers and other interested AAP and non-AAP members are again encouraged to join the SIG and make this our home for Indian child health within the AAP!** For information about how to join, contact Wendy Nelson at 847/434-7789 or wnelson@aap.org. Comments about the vision statement and future priorities are welcome.

The National Highway Safety Traffic Administration (NHSTA) encourages us to talk to families about the proper use of car seats in a time of increased use of automobile travel Specific information about the November campaign can be found at http://www.nhtsa.gov/people/injury/airbags/BucklePlan/New/november_announcement.htm. Despite improvement in recent years, death from unintentional injury and, specifically, motor vehicle crashes remains 50% to 100% higher in Indian children, and at least half these deaths could be prevented by proper restraint. Ben Hoffman, MD, formerly at Gallup Indian Medical Center and now at UNM Department of Pediatrics, developed a community coalition to improve car seat use that involved car seat installation clinics, coupons for purchase of seats at cost, and cooperation with law enforcement and merchants, which resulted in significant increase in use after intervention. It has been estimated that 4 out of 5 car seats are used incorrectly, and Ben found the 5-day certification class held by NHSTA to be challenging

but also a catalyst that helped develop the community coalition. The National Safe Kids Campaign handout details some of the points in proper selection and installation of car seats and is available at http://www.nhtsa.dot.gov/people/injury/childps. In an era of concern about airplane hijacking and bioterrorism, we need to continue to address the proven risks of death to Indian children through unintentional injuries and motor vehicle accidents by promoting proper child passenger restraint. Contact me at WGreen@abq.ihs.gov or Ben Hoffman at bhoffman@salud.unm.edu for more information about the Gallup Got Belts program.

The Neonatal Resuscitation Program has a new teaching CD-ROM that accompanies its latest teaching manual and is an outstanding step to more interactive learning Included in the CD-ROM are video clips of live resuscitation scenarios, equipment demonstrations, and interactive screens (eg, a delivery room in which you can click on and examine various equipment). The audio and visual reinforcement greatly aids the learning process, and I recommend those involved in neonatal resuscitations test-drive this new program, which hopefully will become a model for other advance life support modules.

National Shortages of Vaccines have forced interim changes in immunization schedules, particularly in suspending the fourth and even fifth DTaP dose in some states and reserving Prevnar (PCV7) for children under 2 years of age . Currently there are no national recommendations for suspending the fourth DTaP dose, although states such as New Mexico and Minnesota already have taken this step. Sites should check with their states. Spot shortages are projected to continue for at least 3 to 4 months. Aventis Pasteur is expected to join the current single manufacturer (GlaxoSmithKline) in supplying vaccine to the Centers for Disease Control and Prevention (CDC) in the second quarter of next year. On September 14, 2001, the CDC issued recommendations for priority use of Prevnar only in children less than 2 years of age and children 2 to 5 years of age with high-risk medical conditions. American Indian and Alaska Native children, despite increased risk, fall into the moderate rather than high risk category (see CDC guidelines MMWR). Immunization with PPV 23 or unconjugated PNEUMOVAX is a less attractive but approved interim alternative for children older than 2 years of age; efficacy for any of these vaccines including PREVNAR has never been studied in these older children. The shortage in PREVNAR is projected to be over by spring 2002.

The Clinical Practice Guideline: Management of Sinusitis in the September issue of* Pediatrics *provides specific definitions and treatment algorithms for children 1 to 21 years of age Diagnosis of acute bacterial sinusitis is based on clinical criteria of children presenting with upper respiratory symptoms that are either severe (temperature of at least 102 accompanied by purulent nasal discharge for at least 3 to 4 days in a child who appears ill) or persistent (nasal or postnasal drip lasting longer than 10 to 14 days, daytime cough, or both). Physical exam and imaging studies are not usually helpful, and CT scans should be reserved for those for whom surgery is being considered. Antibiotics are recommended for management of children diagnosed using the above criteria, although this is based on limited data of 5 controlled randomized trials and 8 case series. Optimal duration has not received systematic study; the review suggests that antibiotic therapy be continued until the patient becomes asymptomatic and then be administered an additional 7 days. A useful management algorithm for uncomplicated acute bacterial sinusitis appears on page 804 of the article.

Recent evidence-based reviews question the benefits of antibiotics and myringotomy in the treatment of acute otitis media in children

Our longstanding faith in these treatment modalities that has been based on prevailing practice and literature has been challenged by recent, more careful review of the evidence. In a 2-part article in the August 2001 issue of *Pediatrics*, Glenn Tanaka, et al, at USC performed a systematic review of the literature on the role of antibiotics in the treatment of uncomplicated otitis media. Of 3491 citations reviewed, only 80 studies had appropriate criteria as either randomized control trials or cohort studies. Children with AOM not treated with antibiotics experienced a 1 to 7 day clinical failure rate of 19% with few suppurative complications; treatment with amoxacillin reduced the clinical failure rate to 7%. The researchers concluded that the majority of uncomplicated cases of AOM resolved spontaneously Amoxacillin confers a limited therapeutic benefit. There is no evidence to support any particular antibiotic regimens as more effective in relieving symptoms. In the second part, Research Gaps and Priorities for Future Research, they further conclude that despite the large body of literature on AOM, its quality is uneven and its findings are not generalizable.

In an article in the October 2001 *Archives of Pediatric and Adolescent Medicine*, Pichichero and Poole present data on the accuracy of pediatricians and ENT physicians in assessing otitis media and performance of tympanocentesis during a series of CME courses conducted in 35 cities. The overall correct diagnosis of AOM vs otitis media with effusion (OME) or normal ear was 50% for pediatricians and 73% for ENTs; the main error was overdiagnosis of AOM. However, with training tympanocentesis was optimally performed by 83% of pediatricians and 89% of ENTs. In an accompanying editorial, Should Watchful Waiting Be Used More Often in Otitis Media, Sandi Pirozzo, points out that the diagnostic inaccuracy would result in 50% of myringotomies performed for inappropriate indications (OME rather than AOM) and that 15% of these might be harmed by improper technique on an immobile study mannequin. The study did not examine whether myringotomy is an effective treatment for acute OM, with only 1 RCT and 1 case series in the literature.

Watchful waiting rather than antibiotic treatment has been adopted in entire populations, such as the Netherlands. An article in the November/December 2001 issue of the *Journal of the American Board of Family Practice* describes differences in practices in the US, Great Britain, and the Netherlands, using the International Primary Care Network and Ambulatory Sentinel Practice Network: The Dutch avoid antimicrobials unless fever and pain persist, the British use them for 5 to 7 days, and the Americans use them for 10 days. These differences in practice were supported by data in the review that also noted that the Dutch children presented initially with more severe symptoms, possibly because of parental attitudes and their care-seeking behavior. The consequences of the Dutch approach to AOM care and care-seeking behavior were reduction in the development of antimicrobial resistance and costs Adopting Dutch guidelines restricting the use of antimicrobials for AOM in the United States would result in annual savings of about $185 million.

The AAP Committees on Attention-Deficit/Hyperactivity Disorder (ADHD) and Quality Improvement have issued a Clinical Practice Guideline: Treatment of the School-aged trial with Attention Deficit/Hyperactivity Disorder, published in the October 2001 **Pediatrics.** This supplements the Diagnosis and Evaluation guideline published more than a year ago. (See the June 2000 newsletter issue in the archives.) As in the previous guideline, recommendations are qualified with strength of evidence

and a consensus strength of recommendation: ADHD should be recognized as a chronic condition; the treating physician, child, family and school should collaboratively specify target outcomes; stimulant medication and/or behavior therapy should be recommended to improve target outcomes; and there should be periodic, systematic follow-up directed at target outcomes. When selected management has not met target outcomes, original diagnosis and treatments should be reevaluated, including adherence and presence of coexisting conditions. The guideline includes useful treatment algorithms and a well-referenced discussion of the use of stimulant medication and effective behavioral techniques. The AAP also has recently published an information pamphlet for families about understanding ADHD.

Ken Fleshman, MD, MPH, received the Native American Child Health Advocacy Award at the 2001 AAP NCE in San Francisco He was granted this award for his work in developing innovative public health approaches to solve American Indian and Alaska Native health problems during 30 years of IHS pediatric practice from Southern Arizona to Alaska. In his acceptance speech at the SOCP reception, Dr Fleshman stressed the importance of using knowledge of local epidemiology of health problems to collaboratively develop community-based interventions.

Judy Thierry, DO, a pediatrician and CO, has been selected as Chief of Maternal Child Health at Headquarters East In her IHS career, Judy has been a busy clinician at Albuquerque Indian Hospital; a Clinical Director at ACL hospital, with a term as head of the National Council of Clinical Directors and member of the IHS Executive Leadership Group; and currently is completing a Masters in Public Health at Johns Hopkins. She is thus uniquely qualified to provide leadership on MCH issues at the national level. My thanks to the CONACH and other groups that strongly advocated that this position be filled.

I will be stepping down as Chief Clinical Pediatric Consultant as of December 31, 2001 The past 6 years have gone by quickly, and I have enjoyed the opportunity to meet with many outstanding child health providers throughout the Indian Health Service and urban and tribal programs, as well as IHS graduates volunteering on CONACH and other AAP committees dedicated to the health of Indian children. Despite the changes in administration of Indian health programs, I feel there remains a need for ongoing communication and sharing that I have tried to encourage through this newsletter, the semi-annual IHS Pediatricians conference, and the new Special Interest Group. Kelly Moore, MD, FAAP, recently has been selected by Chief Medical Officer Craig Vanderwagen to replace me as the new Pediatric Chief Clinical Consultant, pending agency approval. As many of you know, Kelly has been particularly active in developing standards for the care of children with Type 2 diabetes and has helped plan the last 3 IHS Pediatrician conferences. She brings a wealth of clinical and administrative experience from working in the Phoenix, Navajo, and Billings Areas currently, she is Chief Medical Officer for the Billings Area, as well as an active member in the American Indian Physicians. Her impressive CV of service, professional organizations, and original articles does not sufficiently reflect her patience, wisdom, and quiet but vigorous commitment to improving the health of Indian children that I have come to know and value in the past 6 years. Contact her at kelly.moore@mail.ihs.gov.

David Grossman reports on recent CONACH activities .
The AAP Committee on Native American Child Health continues to meet bi-annually, alternating sites between Washington, DC, and Indian country. The CONACH continues to use its DC meeting to advocate for improved funding of Indian health programs, particularly those with likelihood of improving children s health and quality of life.

We met most recently in December 2001 in Window Rock, AZ, the capital of the Navajo Nation. Prior to our meeting, 3 teams conducted 3 independent consultation visits at Fort Defiance, Shiprock, and Winslow. The teams were warmly greeted in all the service units, and deeply impressed with the enthusiasm and commitment demonstrated by the pediatricians and other child health providers at the sites.

Each site will receive a written document recognizing the strengths of the service unit, and the opportunities that exist to make changes based on the input from the in-depth interviews. The CONACH views these consultation visits as a mechanism to provide closer ties between the AAP and pediatricians working in Indian communities, as well as an important witnessing that must occur to remain credible advocates at state and federal levels.

The CONACH will soon release the results of an in-depth review of optimal strategies to screen, and treat and prevent Type II diabetes. Led by CONACH member Sheila Gahagan, MD, FAAP, the report was funded by the IHS as a means to improve pediatric capabilities in battling this increasing problem.

The CONACH is excited by the development of an Indian Health Special Interest Group (SIG) within the AAP Section on Community Pediatrics. The SIG will provide common ground for all of us with an interest in Indian and Native health to convene, share our work, and educate our colleagues. If you would like to join this group, please contact Wendy Nelson at 800/433-9016, ext 7789, or wnelson@aap.org.

We will miss Bill Green on the committee, who has proven to be a staunch ally and advocate. Bill kept the committee continually challenged and imbued us all with his can-do spirit. Kelly Moore is also a good friend of the committee and will provide us with the kind of gentle wisdom that is often needed in our efforts. Welcome Kelly!

One final reminder: We are excited to conduct our work with the full enthusiasm of the AAP Board and the AAP Department of Community Pediatrics. Your membership in the AAP helps to sustain these efforts. If you don t belong, PLEASE do join and participate in our mission. Call the AAP Membership Department at 800/433-9016 or visit the AAP Web site at http://www.aap.org/, to join!

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Dear Bill,

YES, I want to join the Special Interest Group in Indian Health, Section on Community Pediatrics! Please send me the necessary application forms.

I have the following comments on this newsletter and suggestions for future topics:

I have visited the child health page at: www.ihs.gov/MedicalPrograms/MaternalChildHealth/ChildHealth.asp and have suggestions for content or links to this page:

The following pediatricians or practitioners need to be added to your mailing list: (You can also E-mail or fax these changes to Ana Garcia at the American Academy of Pediatrics at agarcia@aap.org or 847/228-6432.)