IHS PEDS NOTES

A Newsletter for American Indian/Alaska Native Child Health

November, 1999 Volume 15 Bill Green, Editor

"Immunizations for Native American Children" in the September 1999 issue of Pediatrics highlights important differences in immunizing strategy in Indian/Alaska Native infants and children…

Sponsored jointly by the Committee on Native American Child Health and the Committee on Infectious Disease of the American Academy of Pediatrics, this statement has been under preparation for several years, and incorporates recent AAP recommendations to limit thimerosal or mercury exposure to youngest infants with some specific exceptions. Some of the conclusions: PRP-OMP HIB conjugate vaccine (Pedvax and COMVAX) is the preferred initial immunizing dose for prevention of invasive Haemophilus Influenzae B disease. Hepatitis A vaccine should be a routine immunization for all AI/AN children at age 2, and catch-up immunization for older children should be considered. Pneumovax should be considered at age 2 years in communities where increased risk of invasive pneumococcal disease has been demonstrated. The conjugate pneumococcal vaccine will be a priority for use in our infants when released, possibly as soon as next year. Hepatitis B vaccine is also a priority in our infants and children; the text discusses whether to modify the previous schedule of immunization at birth based on both community and population risk.

I urge everyone to read the complete statement carefully, including the disclaimer at the bottom of the first page: "recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate." My particular thanks to Rosalyn Singleton for preparing initial drafts of the statement and the hard work of the two committees to come to this consensus. (PEDIATRICS, Vol. 104 No. 3 September, 1999, 564-567.) The September issue also contains the statements on thimerosal and suspension of oral rotavirus vaccine because of recent increased cases of intussusception in immunized infants.

Over one million teens in the United State are addicted to gambling according to the National Gambling Impact Study Commission Report….

The congressionally mandated study found that 5 million Americans suffer from pathological gambling, and 1.1 million adolescents ages 12 to 17 or 5% of the total 20 million American teenagers engage in severe pathological gambling each year. Quotations from several pediatricians formerly on the AAP CONACH were featured in the article of August 1999 AAP news, reflecting concern of the committee members of the possible impacts on Indian children.

"It's not easy to identify adolescent gamblers: they are smart, energetic and highly motivated…may enjoy and early "winning phase" before the bottom drops out…and mounting losses lead to a "desperation phase" that leaves may at risk for suicide." Key symptoms of pathological gambling include stealing money or other valuables from the home; withdrawal form ordinary activities; exaggerated displays of gambling winnings; school truancy; and lying about one's whereabouts, according to Elizabeth George, executive director of the non-profit Minnesota Council on Compulsive Gambling. Although Indian gaming operations have allowed economic development for many tribes who have often used revenues to improve health, education and housing for

tribal members, health providers and families need to recognize these negative impacts and screen adolescents for pathologic gambling in their practice. The AAP will be publishing a parent/patient education brochure in the near future, developed with the assistance of CONACH. The entire National Gambling Impact Study Commission report is available at www.ngisc.gov/

Asthma rates in children are rising rapidly, particularly in minority groups including Indian Children…

A 1990 review of respiratory disease found asthma to be "rare" in Indians. However, in a 1995 school based parent survey in Jemez we found 12.3% reported prevalence vs. 5% in national NHANES surveys. At Ft. Peck, Montana Roman Hendrickson, James Bresette and Julie Bemer have recently found over 17% prevalence among the Assiniboine and Sioux children in their service unit, indicating that this high prevalence is not unique to the Southwest. Nationally since 1984 asthma has increased 80% among schoolchildren and 160% among preschoolers. Deaths from asthma in children under 18 have nearly tripled in the past 15 years. Asthma is currently the most common chronic disease of children; the most common cause of missed school days and places children at increased risk for academic problems and school failure. In 1997 the second expert panel on the management of asthma for the NIH published updated guidelines for the diagnosis and management of asthma, including diagnostic and therapeutic recommendations for children.

Despite wide availability of this guide and an abbreviated "Practical Guide for the Diagnosis and Management of Asthma", it is evident that children are often not diagnosed and not treated effectively**.** The panel advocates categorizing patients into "steps": step 1 "mild intermittent", step 2 "mild persistent", step 3 "moderate persistent", and step 4 "severe persistent", based on days and nights with symptoms, and peak flow and peak flow variability. Both "Quick Relief" and "Controller" medications should be used for all asthma over step 1. Educating families about the inflammatory nature of the disease, identification and avoidance of specific triggers, and proper use of MDIs including spacers are important components to success. Home peak flow monitoring and written action plans for more severe disease are advocated by the guide, though peak flow monitoring has not been conclusively demonstrated to be effective. "Pediatric Allergy and Asthma: The Complete Course for Primary Care Providers" is an excellent annual AAP course that provides up to date information in plenary, workshop, and point/counterpoint formats. I presented information from this and other sources at the April 1999 IHS Primary Care Conference, "A Primary Care Approach to Childhood Asthma" which I would be happy to share. The NIH guidelines "Practical Guide" is NIH publication # 97-4053, also available from GlaxoWellcome, website (www.glaxowellcome.com). The September issue of AAP News highlights the important issue of access to inhalers during school hours and has some of the current statistics cited above.

Evidence-based medicine needs to be applied in pediatric clinical care…

Evidence-based medicine has been defined as "the process of systematically finding, appraising, and using contemporaneous research finding as the basis for clinical decisions. " Ideally it integrates individual clinical experience with the best available external clinical evidence. On a practical level, there is a growing body of resources in print, CD-ROM, and on the web that attempt to organize the medical literature to answer clinical questions. Some important resources include the Cochrane Library www.cochrane.org that publishes a database of systematic reviews and critical assessments and structured abstracts of good systematic reviews published elsewhere.

The Agency for Health Care Policy and Research, USPHS has created 12 evidence based practice centers and has collaborated in a National Guideline Clearinghouse at www.guideline.gov. The clearinghouse offers structured abstracts of guidelines, tabular comparisons of abstracts generated "on the fly" by user, "hot links" to full text when possible, and syntheses of guideline on similar topics. A pediatric website that offers a comprehensive introduction and compendium of evidence based medicine is found at http://PedsCCM.wustl.edu/EBJ/EG Resource.html. This is a critical care website maintained by Adrienne Randolph, MD from Childrens Hospital Harvard Medical School and Barry Markowitz, MD St. Louis Childrens Hospital, Washington University School of Medicine, and offers "hot links" to literature on evidence-based medicine, statistics, meta-analysis and the Pediatric Critical Care Medicine Evidence Based Journal Club.

Clinical Guidelines for Type 2 DM in children and adolescents are under development by the American Academy of Pediatrics and American Diabetes Association…

Kelly Moore from IHS and Sheila Gahagan from CONACH are part of national workgroups addressing this important issue. Many diagnostic standards will probably be adapted from those currently developed for adults. The American Academy of Family Physicians and American Diabetes Association recently published a systematic evidence based review of "The Benefits and Risks of Controlling Blood Glucose Levels in Patients with Type 2 Diabetes Mellitus". Two large well-designed prospective studies, the Diabetes Control and Complications Trial (DCCT) in 1993 in Type 1 Diabetes, and in 1998 the United Kingdom Prospective Diabetes Study Trial (UKPDS) in Type 2 Diabetes have convincingly shown that treatment can decrease morbidity from microvascular and neuropathic complications of diabetes. UKPDS showed that the 10 year incidence of microvascular complications was 25% lower in patients who were intensively treated with diet and medications than in those receiving conventional treatment. The intensive medication regimens combined different oral agents and insulin to achieve better control; no specific regimen was superior.

This suggests but does not prove that early diagnosis and intensive treatment in children and adolescents may significantly decrease their lifetime complications and disease burden from diabetes. Hopefully the guidelines under development will provide a framework for how to proceed, acknowledging that at present we simply don't have the evidence to decide which specific treatment approach is best. Involving adolescents and families in individual treatment decisions, as emphasized by Amy Hyde this spring at the IHS Pediatric Conference, is critical for success. The CDC has a website that has current information about epidemiology of diabetes in Indian children: www.cdc.gov/diabetes/. Some preliminary diagnosis and treatment recommendations for adolescents and children are expected soon in an upcoming issue of Diabetes Care.

Dorothy J. Meyer, CNM, MPH is recipient of this year's Native American Child Health Advocacy Award presented by AAP President Joel Alpert at the Annual Meeting in DC in October…

Dot, as most of us know her, has demonstrated outstanding leadership in child health policy for the Phoenix Area over the past 13 years as MCH coordinator. She has served on two sub-committees of the Arizona Child Fatality Review, systematically periodically reviewed well-child care and more recently child diabetes care at Phoenix Area sites, provided training for all health providers in diagnosis of child sexual abuse, and generally provided an exemplary model program of maternal child health coordination. She has also sponsored annual meetings in child health for the entire Phoenix area, and most recently has helped me by providing virtually all the coordination

for the two national IHS Pediatricians meetings in 1997 and 1999. To quote Kelly Moore, "Dot performs outstanding well child care reviews and offers her time and services to review any MCH area of interest at any site that requests it. She has been instrumental in the success of the Arizona fetal/infant/child mortality review and has provided follow-up services to service units sometimes when they weren't even aware of a death. She has shown tremendous pediatric advocacy in her concerns about child abuse and child protection team functioning. I could go on and on..what a great tribute to a remarkable career."

David Grossman reports on CONACH activities and his vision for future Committee priorities….

As the new chair of the American Academy of Pediatrics Committee on Native American Child Health, I am truly excited and honored to work with you all on our mission of improving the health of American Indian and Alaska Native children in North America. Lance Chilton, our former chair, left giant footsteps behind. Lance served on various iterations of CONACH for 14 years, leaving a legacy of tremendous accomplishment and permanence for CONACH. His many contributions will forever be remembered by our colleagues. Lance is moving on to become the Vice-President of the New Mexico AAP chapter, where he can further exert his influence on behalf of Indian children. We also lost tremendous expertise when Jon Jantz and Joann Bodurtha left our committee in July. Jon and Joann were also "long-termers", each bringing their own special expertise and enthusiasm to CONACH. No doubt that they, too, will continue to carry the cause in other ways.

With departing members, we also gained fresh talent on the committee. George Brenneman "re-joined" the committee as a regular member after serving as a liaison the past several years. George is a retired IHS pediatrician who used to head up the national Maternal Child Health branch of HIS and now works with the Hopkins Center for American Indian and Alaska Native Health. He also works as a locums for several Indian health sites. Indu Agarwal is a neonatologist from Fargo North Dakota who has been active in the CATCH program of the Academy, and has worked extensively with the Spirit Lake Nation on many different health programs. James Jarvis is a pediatric rheumatologist of Mohawk extraction from the University of Oklahoma School of Medicine who has been active in working with Indian communities on chronic and rheumatic diseases. Vincent (Vinny) Biggs is a pediatrician in private practice from Amherst, Massachusetts who formerly practiced in Shiprock. Remaining with the committee are Bernadette Freeland-Hyde (Phoenix) and Sheila Gahagan (Ann Arbor).

I hope to accomplish several goals during my tenure as CONACH chair. First, I hope we can establish the AAP as <u>THE</u> leading advocate for Indian and Native children in the United States. We are already well on our way. Every other meeting is now held in Washington, D.C. so that our members can make visits to members of Congress and their staff. Thanks to Todd Askew, our Washington representative, the AAP is well recognized as one of the leading members of the Friends of IHS, a coalition of professional health organizations working to support Indian health programs. From appropriations to the reauthorization of the Indian Health Care Improvement Act, outside support is needed to educate Congress about the needs of children and the doctors taking care of them.

Second, we need to attract more Indian and Native pediatricians into pediatric careers. Obviously, this is a multi-step process. Many organizations, including the Association of American Indian Physicians and university programs, are working hard to attract Native Americans into medicine starting even at the high school level. We should assist with these efforts but broaden them to trying to influence more Native American

medical students to think about pediatrics. Our committee will be looking into ways of doing this.

Third, CONACH needs to continue to establish relations directly with tribes and tribal organizations in its mission to improve the health of Native American children. Increasingly, we find that our "clients" are tribes or Native corporations, and not necessarily the Indian Health Service. While the IHS provides support for some CONACH activities, we must learn to relate directly to tribes and offer our expertise to them. We will work hard on this in the coming years. Finally, you are also our "clients". We rely on you to keep us informed, energized about how we can help to make your job more productive and fulfilling. We will try to establish closer ties to pediatricians and family physicians serving on the 'front line'. We will strive to communicate with you via this newsletter, as well as directly by telephone and mail. Please tell us your concerns and ideas by writing CONACH at the AAP office or e-mailing us at nativeamerican@aap.org. You can also follow our activities at the AAP website (www.aap.org) in the members-only channel (this does require AAP membership).

One final thought: our strength depends on the support of pediatricians with the same mission, such as yourselves. Your can truly help our mission by becoming a member of the AAP, if you have not yet joined. I look forward to working with you. You can always drop me a note directly at navajo@u.washington.edu. I look forward to hearing from you.

OTHER CONACH NEWS

- CONACH visited the Alaska Area for consultation visits this past Spring. Three groups fanned out to Anchorage, Bethel and Kotzebue to learn more about the strengths and qualities of all of these health programs, and to assemble recommendations for expanded programs. Each time we make these visits, we are humbled by the fantastic work that is going on.
- The Indian Health Service has awarded a contract to the AAP to develop guidelines for pediatricians on the recognition and treatment of Type II diabetes. Dr. Sheila Gahagan of CONACH will be heading up this effort for our committee.
- Next meetings of the CONACH will be in Washington, DC in February 2000 and Phoenix in the fall of 2000.

David Grossman, MD, MPH.

Please e mail me or FAX back suggestions for newsletter topics.

I am on both IHS Microsoft Exchange at wgreen@albmail.albuquerque.ihs.gov, which accepts attachments, and the venerable MAILMAN at green.bill@ihs.gov. Additional contact information is on the FAX BACK form on the next page. Ana Garcia, MPA in the Division of Community Pediatrics, AAP has graciously consented to collate and send out this issue of the newsletter, and now is official keeper of the mailing list. This is yet another example of how the Academy can support us in our work. To echo David's sentiment, this support will only become more important in future years and I urge all of you who are eligible to become members.

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Dear Bill,

I have the following information for the next newsletter or comments on this one:

The following pediatricians or practitioners need to be added to your mailing list: (you can also email or fax these changes to Ana Garcia at the American Academy of Pediatrics—agarcia@aap.org. FAX 847/228-5097).