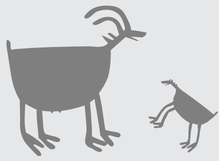


Ob/Gyn & Pediatrics
CCC Corner

Maternal Child Health for American Indians & Alaska Natives

Vol 3, No 7
August 2005

THIS MONTH

Abstract of the Month 1,14–15
IHS Child Health Notes . . 2
From Your Colleagues . 3–4
Hot Topics 5–7
Features 9–13

Open access... can work for any type of practice

It is the wave of the future

OBJECTIVE: Appointment delays impede access to primary health care. By reducing appointment delays, open access (OA) scheduling may improve access to and the quality of primary health care. The objective of this pilot study was to assess the potential impact of OA on practice and patient outcomes by using pilot-study data from 4 North Carolina primary care practices.

METHODS: We conducted an interrupted time-series pilot study of 4 North Carolina primary care practices (2 family medicine and 2 pediatric practices) participating in a quality-improvement (QI) collaborative from May 2001 to May 2002. The year-long collaborative comprised 25 practices and consisted of three 2-day meetings led by expert faculty, monthly data feedback, and monthly conference calls. Our main outcome measures were appointment delays, appointment no-shows, patient satisfaction, continuity of care, and staff satisfaction during the 12-month study period. RESULTS: Providers in all 4 practices successfully implemented OA. On average, providers reduced their delay to the third available preventive care appointment from 36 to 4 days. No-show rates declined (first quarter [Q1] rate: 16%; fourth quarter [Q4] rate: 11%; no-show reduction: 5% [95% confidence interval: 1%, 10%]), and overall patient satisfaction improved (Q1: 45% rated overall visit quality as excellent; Q4: 61% rated overall visit quality as excellent; change in satisfaction: 16% [95% confidence interval: 0.2%, 30%]). Continuity of care followed a similar pattern of improvement, but the change was not statistically significant. Staff satisfaction neither improved nor declined.

CONCLUSIONS: This pilot study suggests that primary care practices can implement OA successfully by using QI-collaborative methods. These results provide preliminary evidence that OA may improve practice and patient outcomes in primary care. These analyses should be repeated in larger groups of practices with longer follow-up.

Bundy DG, et al Open access in primary care: results of a North Carolina pilot project. Pediatrics. 2005 Jul;116(1):82-7.

OB/GYN CCC Editorial

Actually 'Open Access' to care is more than a wave of the future. "Open Access' techniques are used successfully in many Indian Health sites right now and 'Open access' techniques should be used throughout the entire Indian Health system. There is extensive experience with 'Open access' techniques at ANMC dating to the mid and late 1990's, particularly at Southcentral Foundation.

(continued on page 14)

Also on-line....

This publication is a digest of the monthly Obstetrics and Gynecology Chief Clinical Consultant's Newsletter which is available on the Internet at **www.ihs.gov/MedicalPrograms/MCH/M/OBGYN01.cfm**

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

I am looking forward to hearing from you.

Neil J. Murphy

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

IHS Child Health Notes

August 2005

"It doesn't matter if the cat is black or white as long as it catches mice."
—Deng Hsaio P'ing 1904–1997

Articles of Interest

Clinical assessment of pediatric obstructive sleep apnea

Pediatrics. 2004 Jul;114(1):33-43.

- Obstructive sleep apnea (OSA) is thought to occur in 1–3% of all children
- Tonsillectomy and adenoidectomy (T & A) will cure sleep apnea in 90% of children
- The accuracy of a clinical diagnosis of sleep apnea was thought to be poor – only 30–50% of clinical diagnoses of OSA were confirmed on sleep studies
- The AAP currently recommends that all children considered for T & A for OSA should have a sleep study first. However, sleep studies are expensive and often difficult to obtain
- Children with clinical evidence of OSA but negative sleep studies who underwent T & A had significant improvement suggesting that symptoms of OSA may be a better predictor of need for T & A then sleep studies

Excessive Sleepiness in Adolescents and Young Adults: Causes, Consequences, and Treatment Strategies

Pediatrics, Jun 2005; 115: 1774-1786.

- Adolescents are often excessively sleepy
- This sleepiness can have a deleterious effect on mood and performance
- The article reviews available scientific knowledge of sleep changes in adolescents
- An algorithm for work up of excessively sleepy adolescents is provided

Editorial Comment

Physicians, in general, don't have much clinical expertise in treating sleep disorders. These two articles will help.

The first article about OSA reaffirms what is often true in clinical practice. If the history and physical suggest a disorder, further testing may not help or may even be deleterious. Children who have clear histories of OSA do not benefit from sleep studies and such studies may not be the best measure of disordered breathing. Children with negative sleep studies but a clinical history of OSA had significant benefit from T & A. Especially for most of us serving Native children access to a pediatric sleep lab may be nearly impossible. Direct referral for T & A may be the best choice when clinically indicated.

Teenagers are sleepy. That doesn't sound like news, especially to anyone who has adolescent children. However, there is now a surprising bit of science on this subject. It is not sloth but the anterior hypothalamus that makes teens want to stay up late and wake up late. Teens need 9–10 hours of sleep per night but rarely get it. The sleep debt has to be retired which is what leads high school students to sleep until noon on weekends. There is a lot of interesting science covered in this technical report from the AAP. There is even a useful algorithm for work up of sleepy teenagers..

Recent literature on American Indian/ Alaskan Native Health

Tuberculosis among American Indians and Alaska Natives in the United States, 1993–2002.

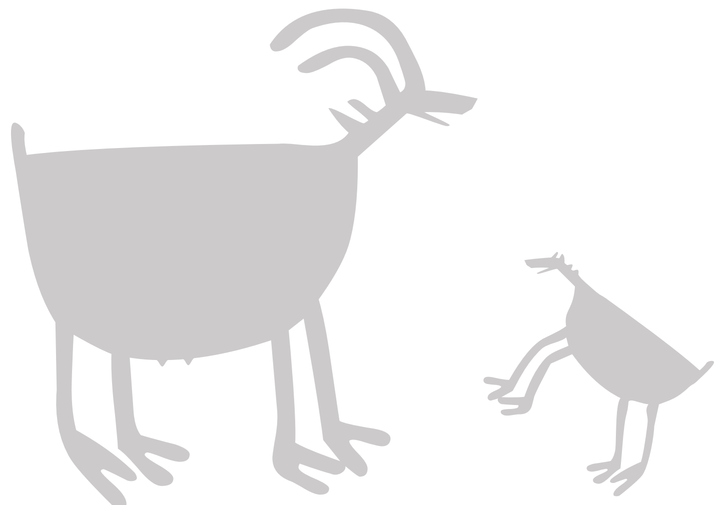
Am J Public Health. 2005 May;95(5):873-80.

- TB rates have declined in the past decade for AI/AN
- The decline was 40% which was the smallest decrease among US born ethnic groups
- The TB rate for AI/AN continues to be almost 5 times the rate of US born whites
- TB rates continue to decline for AI/AN groups but TB remains a disproportionate burden for AI/AN populations

Pediatric Locums Service

The AAP Committee on Native American Child Health has developed a web site to help IHS and 638 contract sites find pediatric locums. The web site has on line form you can fill out describing your locums needs and which will be posted for AAP members. **www.aap.org/nach**

In addition, the AAP is interested in helping site find pediatricians to fill permanent vacancies. Contact AAP staff member Sunnah Kim at 847-434-4729.



From Your Colleagues

Sandy Haldane, HQE

New IHS Women's Health Consultant and Advanced Practice Nurse Consultant

Please help me welcome CAPT Carolyn Aoyama to IHS Headquarters, Division of Nursing.

As the IHS Women's Health Consultant Carolyn will represent the IHS on matters of women's health, providing leadership and technical assistance on program development, implementation, evaluation, and policy. As the Advanced Practice Nurse Consultant, Carolyn will provide leadership and technical expertise on matters pertaining to policy and standards of practice as they pertain to Nurse Practitioners, Certified Nurse Midwives, and Certified Registered Nurse Anesthetists.

Carolyn received her BSN from the University of WI, her MPH from Johns Hopkins and is also a Certified Nurse Midwife. Carolyn began her nursing career in IHS as a PHN at Ft. Defiance. Carolyn has worked as a CNM in the inner city of Baltimore and Phoenix and as the Maternal Child Health Consultant for the State of Alaska's Department of Health and Social Services.

Subsequently she worked as an EIS Officer with the CDC, a Public Health Advisor in the Perinatal Care Program of HRSA's Bureau of Primary Health Care (BPHC), Nurse Consultant for Mental Health/Substance Abuse Service (HRSA/BPHC/Division of Community and Migrant Health), a Community Health Center Project Officer with HRSA/BPHC, and most recently as a Nurse Consultant with HRSA/Bureau of Health Professions/ Division of Nursing.

Carolyn can be reached at 301-443-1028 or in Suite 300 of the Reyes Building.

Sheila F. Mahoney CNM, NIH

Cord clamping: Early versus delayed

Referring to the benefits of delayed cord clamping cited in June's OB/GYN & Pediatrics CCC Corner*:

I would like to refer readers to another study which showed benefits of delayed cord clamping in preterm neonates.

CONCLUSION: The research design is feasible. The immediate benefit of improved blood pressure was confirmed and other findings deserve consideration for further study.

Mercer JS, McGrath MM, Hensman A, Silver H, Oh W. Immediate and delayed cord clamping in infants born between 24 and 32 weeks: a pilot randomized controlled trial. J Perinatol. 2003 Sep;23(6):466-72.

…and to a review of this topic which concluded that there were benefits of delayed cord clamping in both preterm and full term neonates.

CONCLUSION: For both term and preterm infants, few, if any, risks were associated with delayed cord clamping. Longitudinal studies of infants with immediate and delayed cord clamping are needed.

Mercer JS. Current best evidence: a review of the literature on umbilical cord clamping. J Midwifery Womens Health. 2001 Nov-Dec;46(6):402-14. Review.

OB/GYN CCC Editorial

At this time the comments above are best applied to pre-term delivery as the weight of evidence favors early cord clamping in term delivery.

There are two main approaches to term third stage management

Expectant management

- Expectant or physiologic management consists of delivery of the placenta without the use of uterotonic agents, cord clamping, or cord traction.

Active management

- Active management generally consists of early cord clamping, controlled cord traction, and administration of a uterotonic agent.

A classic study randomly assigned 1795 women to expectant or active third stage labor management.

Actively managed patients

- received 5 IU of oxytocin and 0.5 mg of ergometrine upon delivery of the fetal anterior shoulder
- followed by controlled cord traction.

Almost all women allocated to active management actually received it, while just under one-half of those allocated to physiological management received no intervention. The active management group had a significantly lower incidence of postpartum hemorrhage (6 versus 18 percent) and a shorter median duration of the third stage (5 versus 15 minutes).

A Cochrane review of five studies comparing active versus expectant management of the third stage of labor. Expectant management of the third stage of labour involves allowing the placenta to deliver spontaneously or aiding by gravity or nipple stimulation. Active management involves administration of a prophylactic oxytocic before delivery of the placenta, and usually early cord clamping and cutting, and controlled cord traction of the umbilical cord.

Cochrane found that active management was associated with reduced risks of: maternal blood loss (weighted mean difference -79.33 mL, 95 percent CI -94.29 to -64.37); postpartum hemorrhage of more than 500 mL (relative risk 0.38, 95 percent CI

(From Your Colleagues, continued on page 4)

(From Your Colleagues, continued from page 3)

0.32 to 0.46); and prolonged third stage of labor (weighted mean difference -9.77 minutes, 95 percent CI -10.00 to -9.53). Active management was defined as administration of a prophylactic oxytocic before delivery of the placenta; typically with early cord clamping and cutting and controlled traction of the umbilical cord. The authors concluded that "active management should be the routine management of choice for women expecting to deliver a baby by vaginal delivery in a maternity hospital.

Active management of labor is the most common standard of care for term patients, plus there is recent data from Indian Country to support active management of term third stage of labor in Indian Health.

Resources

Prendiville WJ; Elbourne D; McDonald S Active versus expectant management in the third stage of labour. Cochrane Database Syst Rev 2000;(3):CD000007.

Prendiville WJ; Harding JE; Elbourne DR; Stirrat GM The Bristol third stage trial: active versus physiological management of third stage of labour. BMJ 1988 Nov 19;297(6659):1295-300.

Rabe H, et al. Early versus delayed umbilical cord clamping in preterm infants. Cochrane Database Syst Rev 2004;(3):CD003248

Miles Rudd, Warm Springs, OR

Physical exam of the breast as a screening tool

Miles Rudd at Warm Springs, OR raised the issue of the relative value of physical exam of the breast exam in cancer screening. Here are some brief bulleted points for Dr. Eve Espey's presentation on Breast Cancer at the 2005 IHS/ACOG Obstetric, Neonatal and Gynecologic Care Postgraduate Course. More complete discussion below.

Breast self exam (BSE) Canadian Task Force on Prevention*

- Fair evidence of no benefit
- Good evidence of harm
- Overall fair evidence that routine teaching of BSE should be excluded from the annual exam

D recommendation

USPSTF: 2002, Should we recommend BSE?

- insufficient evidence to recommend for or against

I recommendation

Studies evaluating BSE

- 2 RCTs, 1 quasi RCT, 3 case-control studies
- No difference in breast cancer mortality
- No difference in stage of cancer at diagnosis
- More provider visits: 8% vs. 4%
- More benign biopsies

ACOG Practice Bulletin: Breast cancer screening, April, 2003

- Despite a lack of definitive data for or against breast self-examination, breast self-examination has the potential to detect palpable breast cancer and can be recommended.

Costs of BSE

- $700 per competent frequent self-examiner
- Opportunity cost: limited time for counseling
- Anxiety, worry, depression

Summary

- Take down your shower card for BSE
- Encourage mammography
- Work up palpable masses
- Don't worry quite so much

OB/GYN CCC Editorial

The data shows that the foundation of any breast cancer screening effort is a comprehensive mammography based program. The history and physical examination are an important adjuncts to screening, but should not delay, or become barriers to mammography. An equally important public health systems 'process' is a robust follow-up system. The RPMS Women's Health Program, or other tracking system software packages, can be critical to maintaining adequate screening follow up.

What is the Indian Health Manual suggested approach? National benchmarks?

The Indian Health Manual suggested approach is based on mammography and is compatible with national benchmarks. The article referenced below is a good summary of the national benchmarks, though is not entirely internally consistent. The first part of the article articulates the limitations of the data on clinical breast exam (CBE). The second part (their 'Recommendations') is essentially a primer on performing the extensive Mammacare exam. Though Mammacare has been shown to find more lesions during the lengthy exam, the increased detection of non-malignant lesions does not improve breast cancer outcomes.

Please see the IHS/ACOG Obstetric, Neonatal and Gynecologic Care Postgraduate Course Reference Text for more details.

Saslow D, et al Clinical breast examination: practical recommendations for optimizing performance and reporting. CA Cancer J Clin. 2004 Nov-Dec;54(6):327-44

Hot Topics

Obstetrics

Trial of Labor After Cesarean: Evidence based guidelines

The American Academy of Family Physicians Commission on Clinical Policies and Research convened a panel to systematically review the available evidence on trial of labor after cesarean (TOLAC) using the Agency for Healthcare Research and Quality "Evidence Report on Vaginal Birth After Cesarean (VBAC)." The panel's objective was to provide an evidence-based clinical practice guideline for pregnant women and their families, maternity care professionals, facilities, and policy makers who care about trial of labor and maternity care for a woman with one previous cesarean. The recommendations are as follows:

RECOMMENDATION 1: Women with 1 previous cesarean delivery with a low transverse incision are candidates for and should be offered a trial of labor (TOL). (Level A)

RECOMMENDATION 2: Patients desiring TOLAC should be counseled that their chance for a successful vaginal birth after cesarean (VBAC) is influenced by the following: (Level B)

Positive factors (increased likelihood of successful VBAC)

- Maternal age <40 years
- Previous vaginal delivery (particularly previous successful VBAC)

Favorable cervical factors

- Presence of spontaneous labor
- Non-recurrent indication that was present for previous cesarean delivery (CD)

Negative factors (decreased likelihood of successful VBAC)

- Increased number of previous CDs
- Gestational age >40 weeks
- Birthweight >4,000 g
- Induction or augmentation of labor

RECOMMENDATION 3: Prostaglandins should not be used for cervical ripening or induction, as their use is associated with higher rates of uterine rupture and decreased rates of successful vaginal delivery. (Level B)

RECOMMENDATION 4: TOLAC should not be restricted only to facilities with available surgical teams present throughout labor, because there is no evidence that these additional resources result in improved outcomes. (Level C) At the same time, it is clinically appropriate that a management plan for uterine rupture and other potential emergencies requiring rapid cesarean section should be documented for each woman undergoing TOLAC. (Level C)

RECOMMENDATION 5: Maternity care professionals need to explore all the issues that may affect a woman's decision, including issues such as recovery time and safety. (Level C) No evidence-based recommendation can be made regarding the best way to present the risks and benefits of TOLAC to patients.

Borgmeyer C; American Academy of Family Physicians.Guideline showcases AAFP's commitment to evidence-based, patient-centered care—Trial of Labor After Cesarean (TOLAC), Formerly Trial of Labor Versus Elective Repeat Cesarean Section for the Woman With a Previous Cesarean Section. Annals of Family Medicine 3:378-380 (2005)

OB/GYN CCC Editorial

This document is helpful as it more strictly applies the available scientific literature, rather than relying as heavily on tort liability as a premise. The Indian Health system has had extensive discussions about emergency vaginal delivery in rural settings. As symptomatic uterine rupture is a relatively rare event, it is highly recommended that each center offering vaginal delivery have periodic drills on various other emergency delivery scenarios to assure that the whole labor and delivery system is capable of a timely response.

Time of birth and risk of neonatal death: 12–16% increase in mortality at night.
CONCLUSION: Identifying the causal factors

(Hot Topics, continued on page 6)

Interpregnancy intervals

< 12 months
> 59 months
associated adverse perinatal outcomes

Conclusion: In Latin America, interpregnancy intervals shorter than 12 months and longer than 59 months are independently associated with increased risk of adverse perinatal outcomes. These data suggest that spacing pregnancies appropriately could prevent perinatal deaths and other adverse perinatal outcomes in the developing world. Level of Evidence: II-2.

Conde-Agudelo A et al Effect of the Interpregnancy Interval on Perinatal Outcomes in Latin America. Obstet Gynecol. 2005 Aug;106(2):359-366.

Family Planning

Over-The-Counter Sales of Emergency Contraception Do Not Increase Unsafe Sex

CONCLUSION: The awareness and use of EC were low in our study population. They were not ready for more liberal delivery of ECPs as less than 50% of women supported these new delivery modes and their knowledge on ECPs use was inadequate.

Wan RS, Lo SS.Are women ready for more liberal delivery of emergency contraceptive pills? Contraception. 2005 Jun;71(6):432-7.

(Hot Topics, continued from page 5)
and reducing the increased burden of mortality for infants born at night should be a major priority for perinatal medicine.
Level of Evidence: III.

- After adjusting for the adequacy of prenatal care, complications of pregnancy, gender, and birthweight, mortality for infants born during early night and those born during late night increased by 12% and 16%, respectively, compared with mortality for infants born during the day.
- There was an increase in mortality for both VLBW infants and non-VLBW infants born during early and late night.
- Mortality was significantly elevated for singletons born during early and late night. For multiples, mortality was elevated only for infants born during early night.
- During early night there was a significant increase in the mortality of infants delivered vaginally but not in the mortality of infants delivered by cesarean. During late night, the situation was reversed: there was a marked increase in the mortality of infants delivered by cesarean but only a weak increase among infants delivered vaginally.
- After adjusting for differences in risk across time, there was no significant elevation in mortality for infants born in primary care hospitals. In hospitals with intermediate intensive care, infants born during early or late night had elevated mortality. In hospitals providing community and regional intensive care, mortality was elevated only for infants born during late night.

Gould JB, Qin C, Chavez G. 2005. Time of birth and the risk of neonatal death. Obstetrics & Gynecology 106(2):352-358.

OB/GYN CCC Editorial

There have been several studies of European births during the 1990s reported increased mortality for infants born at night, yet no reports have been published about neonatal mortality by hour of birth in the United States. The article describes a study to determine whether the time of birth influenced the risk of neonatal death for infants born in California. This study provides Level III evidence that infants born at night have a 12–16% increase in mortality and it needs be confirmed with larger prospective trials before major health care shifts are considered.

In the meantime, considering the implications of the evidence to date, facilities in the Indian Health system should carefully investigate their local data and consider reevaluating their diurnal staffing patterns

Gynecology

One in ten adult women perceives urinary incontinence to be barrier to exercise

CONCLUSION: Urinary incontinence is perceived as a barrier to exercise, particularly by women with more severe leakage.
Level II-3.

Nygaard I, et al Is Urinary Incontinence a Barrier to Exercise in Women? Obstet Gynecol. 2005 Aug;106(2):307-314.

Ovarian conservation benefits survival in women when undergoing hysterectomy

CONCLUSION: Ovarian conservation until at least age 65 benefits long-term survival for women at average risk of ovarian cancer when undergoing hysterectomy for benign disease.
Level III

Parker WH et al Ovarian Conservation at the Time of Hysterectomy for Benign Disease. Obstet Gynecol. 2005 Aug;106(2):219-226.

Child Health

AAP Releases Report on Excessive Sleepiness in Adolescents

Inadequate sleep has become a widespread problem for adolescents. Physicians have an important role in identifying adolescent patients at risk for inadequate sleep and in providing counseling and support to help manage sleep-related symptoms.

Common causes of sleepiness in adolescents include normal changes that occur during the transition into adolescence (e.g., varying sleep/wake times, relaxed parental control of bedtimes, changing school start times). Many adolescents also have part-time jobs that cut into their sleep time. Studies have shown that the biological system that regulates circadian rhythms may change during adolescence, creating a later timing of sleep. Because of these changes, adolescents get less sleep than they did as children.

(Hot Topics, continued on page 7)

(Hot Topics, continued from page 6)

Insomnia, narcolepsy, idiopathic hypersomnia, restless legs syndrome, and numerous medications are also common causes of inadequate sleep in adolescents.

Lack of sleep can affect adolescents' cognitive function, concentration and attention, alertness, and ability to perform in school. Studies have shown that many adolescents who have sleep disorders also have symptoms of attention-deficit/hyperactivity disorder. Adolescents with clinical mood disorders, especially severe depression, report higher incidences of sleep disturbance. Sleepiness is also the leading cause of motor vehicle crashes among drivers 16 to 29 years of age.

The AAP concludes that physicians should recognize the significant problem of sleepiness among their adolescent patients. Physicians need to ask questions about sleep patterns, how much sleep their adolescent patients are getting, and if they are having any sleep-related symptoms. A sleep history should focus on the following points:

- Bedtime problems
- Excessive daytime sleepiness
- Awakenings during the night
- Regularity and duration of sleep
- Sleep-disordered breathing (e.g., loud snoring)

AAP recommends educating adolescent patients about their sleep needs and the detrimental effects of sleep loss on performance and health.

Based on a meta-analysis, June 2005 issue of Pediatrics.

High-Grade Cervical Lesions Progress in Adolescents at Similar Rate as in Adults

CONCLUSION: Adolescents with LSIL and HSIL cytology are at significant risk for progression to high-grade cervical abnormalities. The rate of development of high-grade cervical abnormalities in adolescents is similar to adults. Adolescents with cytologic abnormalities mandate close follow-up.
Level II-3.

Wright JD, et al Cervical dysplasia in adolescents. Obstet Gynecol. 2005 Jul;106(1):115-

Chronic disease and Illness

Guidelines for Improving Vaccination Rates Among High-Risk Adults, CDC

The Task Force on Community Preventive Services of the Centers for Disease Control and Prevention (CDC) has issued an evidence-based review of interventions to improve influenza, pneumococcal polysaccharide, and hepatitis B vaccination coverage among high-risk adults younger than 65 years. The recommendations were based on a systematic review.

Morbidity and Mortality Weekly Report April 1, 2005

MCH Alert

***Women's Health USA 2005* Data Book Released**

Women's Health USA 2005, the fourth edition of the data book, presents a profile of women's health at the national level from a variety of data sources. The data book, developed by the Health Resources and Services Administration's Office of Women's Health, includes information and data on population characteristics, health status, and health services utilization. New topics in this edition include household composition, maternity leave, contraception, and adolescent pregnancy. The data book also highlights racial and ethnic disparities and gender differences in women's health. The data book is intended to be a concise reference for policymakers and program managers at the federal, state, and local levels to identify and clarify issues affecting the health of women.

http://mchb.hrsa.gov/whusa_05/index.htm

From Your Colleagues

Jennifer Retsinas

Uterine fibroids: uterine artery embolization versus abdominal hysterectomy

CONCLUSION: Compared with hysterectomy, UAE is safe and effective for treatment of bleeding fibroids, necessitates a shorter hospital stay, and results in fewer major complications

Pinto I, et al Uterine fibroids: uterine artery embolization versus abdominal hysterectomy for treatment—a prospective, randomized, and controlled clinical trial. Radiology. 2003 Feb;226(2):425-31.

Features

ACOG

Management of Endometrial Cancer Summary of Recommendations and Conclusions

The following recommendations are based on limited or inconsistent scientific evidence. (Level B):

- Most women with endometrial cancer should undergo systematic surgical staging, including pelvic washings, bilateral pelvic and paraaortic lymphadenectomy, and complete resection of all disease. Exceptions to this include young or perimenopausal women with grade 1 endometrioid adenocarcinoma associated with atypical endometrial hyperplasia and those at increased risk of mortality secondary to comorbidities.
- Women with atypical endometrial hyperplasia and endometrial cancer who desire to maintain their fertility may be treated with progestin therapy. Following therapy they should undergo serial complete intrauterine evaluation approximately every 3 months to document response. Hysterectomy should be recommended for women who do not desire future fertility.
- Patients with surgical stage I disease may be counseled that postoperative radiation therapy can reduce the risk of local recurrence, but the cost and toxicity should be balanced with the evidence that it does not improve survival or reduce distant metastasis.
- For those women who have not received radiation therapy, pelvic examinations every 3–4 months for 2–3 years, then twice yearly following surgical treatment of endometrial cancer are recommended for detection and treatment of recurrent disease.

The following recommendations are based primarily on consensus and expert opinion. (Level C):

- Women who cannot undergo systematic surgical staging because of comorbidities may be candidates for vaginal hysterectomy.
- Only a physical examination and a chest radiograph are required for preoperative staging of the usual (type I endometrioid grade 1) histology, clinical stage I patient. All other preoperative testing should be directed toward optimizing the surgical outcome.

Management of endometrial cancer. ACOG Practice Bulletin No. 65. American College of Obstetricians and Gynecologists. Obstet Gynecol 2005;106:413

Health Care for Homeless Women

Homelessness is a considerable social and health problem in the United States with far-reaching effects on the health of homeless women. Homeless women are at higher risk for injury and illness and are less likely to obtain needed health care than women who are not homeless. It is critical to undertake efforts to prevent homelessness. Until this can be accomplished, community-based services targeted specifically to this population that provide both health care and support services are essential. Health care providers can help address the needs of the homeless by identifying their own patients who may be homeless, treating their health problems, offering preventive care, and working with the community to improve the full range of resources available to these individuals.

Health Care for Homeless Women. ACOG Committee Opinion No. 312. American College of Obstetricians and Gynecologists. Obstet Gynecol 2005;106:429–34.

Domestic Violence

Developing Leaders in Violence Prevention

Travel funding available

Please forward to any group that may be interested, including tribal organizations. Program fees and accommodation costs are borne by the Institute. Travel stipends are available for teams that may not be able to afford travel.

You can contact the institute for further information. Theresa.Cullen@ihs.gov

Case Manager's Corner (R.N.)*

Stress and verbal abuse in nursing

RESULTS: Respondents reported that the most frequent source of abuse was nurses (27%), followed by patients' families (25%), doctors (22%), patients (17%), residents (4%), other (3%) and interns (2%). Of those who selected a nurse as the most frequent source, staff nurses were reported to be the most frequent nursing source (80%) followed by nurse managers (20%). CONCLUSIONS: Verbal abuse in nursing is quite costly to the individual nurses, the hospitals and the patients. Nurses who regularly experience verbal abuse may be more stressed, may feel less satisfied with their jobs, may miss more work and may provide a substandard quality of care to patients.

Rowe MM, Sherlock H. Stress and verbal abuse in nursing: do burned out nurses eat their young? J Nurs Manag. 2005 May;13(3):242-8

OB/GYN CCC Editorial comment:

This is an important article that should serve to remind us that there is no role for verbal abuse in the health care setting. As over ½ of the sources of the verbal abuse are fellow health care workers, this problem can be remedied with improved communication with our colleagues.

*In lieu of a Case Manager submission, Reynaldo Espera, from ANMC Labor and Delivery submitted the above.

Ask a Librarian:

Diane Cooper, M.S.L.S./NIH

The Known and the Unknown —Clinical Evidence Summarized

A new resource offering the best available evidence on the effects of common clinical interventions is now available online. Clinical Evidence summarizes what is known – and not known – on over 200 medical conditions and over 2,000 treatments seen in primary and hospital care. Clinical Evidence is based on thorough searches and appraisal of the literature. It is neither a textbook of medicine nor a set of guidelines. Instead it describes the best available evidence from systematic reviews, randomized control trials, and observational studies. Here are some reasons Clinical Evidence may be useful to you:

- You start with a question—Clinical Evidence does too
- Evidence is presented in clear and easy-to-read summaries
- New and updated topics are added monthly
- Includes information on benefits, harms and outcomes which will help you with you treatment decisions
- Saves you time and effort

To access Clinical Evidence go to:
http://hsrl.nihlibrary.nih.gov
Click on:
Research Tools > Databases > Clinical Evidence

Judy Thierry

Trends and Regional Differences —Latest available

It has come to my attention that some of you do not have the latest *Trends and Regional Differences* publications produced by our Statistics Branch. The 2000–2001 *Trends and Regional Differences* contains data from 1996–1998. They are not online, therefore you need to order the mailed publications. If you would like to order them, please go to **https://propshop.psc.gov/** and begin by clicking the Product Distribution link.

Contact **dsaum@psc.gov** regarding any problems with the ordering process.

NB: Tribal and Seattle Urban program would follow under the '50 states category'.

Please call us (DPS) at (301) 443-1180 or Priscilla Sandoval at (301) 443-9436. We will provide your UserID and password.

Breastfeeding

Fentanyl During Labor May Impede Establishment of Breastfeeding

CONCLUSIONS: A dose-response relationship between fentanyl and artificial feeding has not been reported elsewhere. When well-established determinants of infant feeding are accounted for, intrapartum fentanyl may impede establishment of breastfeeding, particularly at higher doses

Jordan S, et al The impact of intrapartum analgesia on infant feeding.

Perinatology Picks

George Gilson, Maternal Fetal Medicine, ANMC

Glyburide for gestational diabetes in a large managed care organization

RESULTS: In 1999 through 2000, 268 women had GDM diagnosed and were treated with insulin; in 2001 through 2002, 316 women had GDM diagnosed of which 236 (75%) received glyburide....

CONCLUSION: In a large managed care organization, glyburide was at least as effective as insulin in achieving glycemic control and similar birth weights in women with GDM who failed diet therapy. The increased risk of preeclampsia and phototherapy in the glyburide group warrant further study

Jacobson GF et al Comparison of glyburide and insulin for the management of gestational diabetes in a large managed care organization. Am J Obstet Gynecol. 2005 Jul;193(1):118-24.

Overweight and obese in gestational diabetes: the impact on pregnancy outcome

RESULTS: Four thousand and one women were enrolled. Obese women who achieved targeted levels of glycemic control had comparable pregnancy outcomes to normal weight and overweight women only when they were treated with insulin…..

CONCLUSION: In obese women with BMI > or =30 with GDM, achievement of targeted levels of glycemic control was associated with enhanced outcome only in women treated with insulin.

Langer O et al Overweight and obese in gestational diabetes: the impact on pregnancy outcome. Am J Obstet Gynecol. 2005 Jun;192(6):1768-76.

Glargine use in pregnancy?

As long as Dr. Gilson has raised the issue of diabetes in pregnancy, here is a question that was posed to the Area Diabetes Program Director:

"There seems to be frequent discussion about glargine being best for type I diabetics (as their basal insulinization), but not for type 2 DM. Type 2 diabetics are often hyperinsulinemic—especially when pregnant. This comes up most frequently in pre-existing type 2 pregnant diabetics who have used glargine previously. I most frequently recommend switching them to NPH and lispro for the pregnancy.

Will you corroborate that philosophy, or am I just "behind the times."

Response from the Alaska Area Diabetes Program Director:

Glargine is being used extensively in type 2 diabetes. The ANMC pharmacy, however, has it restricted to type 1 patients at the present time. This is in part due to the cost concerns of glargine compared to NPH. We are working with pharmacy to develop a protocol which, after approval by P & T, will allow us to use glargine in type 2 patient more liberally. We do have around 60 type 2 diabetics on glargine at the present time. A recent article in Diabetes Care by Riddle looked at night time NPH and glargine*. There was not great convincing evidence that glargine was significantly better than NPH in type 2 patients; however, there were less hypoglycemic episodes with the glargine group. Both groups had similar improvement in their A1c levels. The main advantage of glargine over NPH is it can be given any time of the day, which makes it much more "user friendly" for patients. It is no longer necessary to only give in the evening.

I had to do a little research to answer your second question. And you are not "behind the times," rather, in line with what most endocrinologists would recommend.

So, I had the opportunity to talk with an endocrinologist who has in-depth knowledge of glargine last night and he helped answer your question.

Neither the analog insulins (lispro and aspart) nor glargine are FDA approved for pregnancy. Despite this, aspart and lispro are used in pumps and for nutritional dosing during pregnancy without problems. The issue with glargine is its binding to IGF1 receptors: glargine has a 7X greater affinity for IGF1 than other insulin(s). This raises concerns of increased risk of possible birth defects.

Studies in rats and (I believe) rabbits have not shown evidence of glargine related birth defects but (needless to say) there are no human stud-

(continued on page 11)

(Perinatology Picks, continued from page 10)
ies. Therefore most endocrinologists would not recommend glargine during pregnancy. The endocrinologist I spoke with felt that this was, in part, due to concerns of a baby born with a birth defect whose mother has used glargine during her pregnancy. The endocrinologist recommended either changing the patient to NPH during the pregnancy or transitioning the patient to a pump in the pre or post conception state.

OB/GYN CCC Editorial

Until further data is available, regimens that include short and intermediate acting insulin(s) are recommended for those Indian Health patients using insulin as their hypoglycemic agent during pregnancy.

Here is the resource discussed above, as well as the Diabetes in Pregnancy Guidelines posted on the MCH web page:

**Riddle MC, et Al The treat-to-target trial: randomized addition of glargine or human NPH insulin to oral therapy of type 2 diabetic patients. Diabetes Care. 2003 Nov;26(11):3080-6.*

Riddle MC. Timely initiation of basal insulin. Am J Med. 2004 Feb 2;116 Suppl 3A:3S-9S.

Janka HU, Plewe G, Riddle MC, et al Comparison of basal insulin added to oral agents versus twice-daily premixed insulin as initial insulin therapy for type 2 diabetes. Diabetes Care. 2005 Feb;28(2):254-9.

STD Corner

Laura Shelby, STD Director, IHS

Condom effectiveness for prevention of Chlamydia trachomatis infection

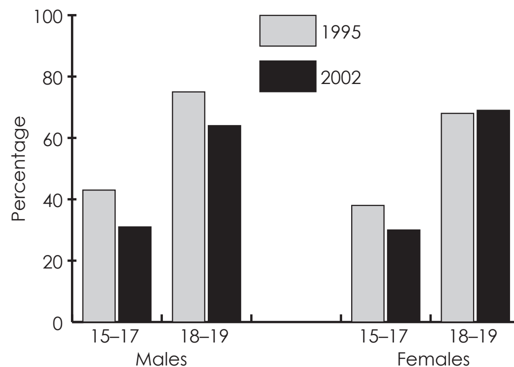
BACKGROUND/OBJECTIVES: A growing body of evidence is increasingly demonstrating the effectiveness of condoms for sexually transmitted infection (STI) prevention. The purpose of the present analysis was to provide a disease specific estimate for the effectiveness of condoms in preventing Chlamydia trachomatis infection while controlling for known exposure to infection.

METHODS: Condom effectiveness for C trachomatis was estimated using a medical record database from a public sexually transmitted disease clinic (n = 1455). Clients were classified as having known exposure to C trachomatis if they presented to the clinic as a contact to an infected partner.

RESULTS: Among clients with known exposure, 13.3% of consistent condom users were diagnosed with C trachomatis infection compared to 34.4% of inconsistent condom users (adjusted odds ratio = 0.10; 95% CI: 0.01 to 0.83). Among clients with unknown exposure, there was no observed protective effect of condoms.

CONCLUSIONS: This study provides further evidence that condoms are effective in preventing C trachomatis infection by reporting a disease specific estimate and restricting analyses to individuals with known exposure.

M Niccolai, A Rowhani-Rahbar, H Jenkins, S Green, and D W Dunne. Condom effectiveness for prevention of Chlamydia trachomatis infection Sex Transm Infect 81: 323-325.



The percentage of male teens who reported ever having sexual intercourse decreased significantly for both younger (aged 15–17 years) and older (aged 18–19 years) teens from 1995 to 2002. Among females, the percentage who reported ever having sexual intercourse declined significantly for those aged 15–17 years.

SOURCES: 1995 and 2002 National Survey of Family Growth; 1995 National Survey of Adolescent Males; and Abma JC, Martinez GM, Mosher WD, Dawson BS. Teenagers in the United States: sexual activity, contraceptive use, and childbearing, 2002. Vital Health Stat 2004;23(24).

Alaska State Diabetes Program

Barbara Stillwater

Women the stronger gender? Men are more carbohydrate intolerant and have less physical endurance

CONCLUSIONS: Severely obese men were more carbohydrate-intolerant and sustained less physical endurance than was predicted according to standards in comparison with obese women. The cycle ergometer data indicated that male gender was associated with less physical fitness.

Dolfing JG, et al Different cycle ergometer outcomes in severely obese men and women without documented cardiopulmonary morbidities before bariatric surgery. Chest. 2005 Jul;128(1):256-62.

AFP

Patient-Oriented Evidence that Matters (POEMS)*

Intensive Diet-Behavior-Physical Activity Program for Obesity in Children

Clinical Question: Can a specific program of diet and exercise result in sustained weight loss in children?

Bottom Line: An intensive three-month program of dietary counseling, a hypocaloric diet, and structured exercise can cause weight loss in children that is sustained over one year. More important, the program seemed to increase the amount of exercise the children performed, and this increase was sustained after the intervention was discontinued.
(Level of Evidence: 2b)

Navajo News

Jean Howe, Chinle

Is the patch more dangerous than the pill? "More fatalities than expected occur from birth control patch"

On July 15th, an Associated Press article with this alarming title was published in one of our local newspapers, The Gallup Independent. It reported that there was a three-fold increased risk of death with contraceptive patch use, as compared to oral hormonal contraceptive use, based on cases reported to the FDA. They cite the following risks:

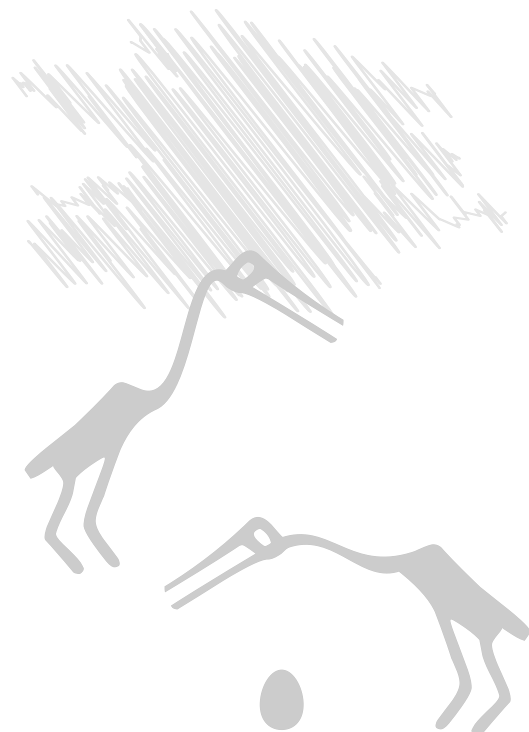
Risk group	Risk of non-fatal blood clot	Risk of death
oral contraceptive	1–3 in 10,000	1 in 200,000
contraceptive patch	12 in 10,000	3 in 200,000

The article also states that 2 blood clots occurred in the 3,300 patch users who participated in clinical trials prior to FDA approval.

The article is quite dramatic, including several touching vignettes of young women who died unexpectedly while using the patch. It offers other death rates for comparison, but only in a somewhat confusing table, and not in the text itself. (These include a death rate of 28 per 100,000 per year for pill users under 35 who smoke, 143 per 100,000 for pill users 35–44 years old who smoke, 10 per 100,000 for women at 20+ weeks gestation, and 100 per 100,000 for motorcycle riders.) The article does not state a risk for non-fatal blood clots associated with pregnancy.

This inflammatory article is another example of non-evidence based data being presented to the public in a sensational manner. The FDA reports are collected to look for unanticipated adverse outcomes associated with medication use that were not identified in studies conducted prior to FDA approval. Their collection is important but the information must be interpreted with caution. Importantly, the AP article apparently bases its risk calculations on a denominator of 800,000 patch users in 2004. Ortho states that the actual number of patch users was closer to 2,000,000 in 2004; clearly that would change the risk calculations dramatically.

This is a perplexing situation. Women's health providers wouldn't want to ignore potentially important safety information about the patch. But it is not clear that these spontaneously generated FDA reports actually represent important new safety information. It is our duty as providers to provide our patients with the best evidence-based information available and protect them from media hysteria. The available data shows that hormonal contraception does pose a slightly increased risk of blood clots, regardless of route (pill, patch, or vaginal ring). This risk is much less than the risk associated with pregnancy. For women who find it difficult to use other methods reliably, the contraceptive patch remains an excellent method of birth control. If anything this article illustrates the need to encourage smoking cessation in all hormonal contraception users under 35 and work with smokers 35 and over both to find acceptable alternative methods of birth control and to quit smoking.



Medical Mystery Tour

Follow-up, 2 positive blood cultures found in a postpartum patient with a fever

A little refresher from last issue

- This 22 year old G1 P0 presented in active labor at 40 weeks gestation after a benign prenatal course that was significant only for a positive perineum and rectal culture for beta streptococcus group B screen at 36 weeks and a weight gain of over 50 pounds with a normal glucose challenge test.
- The patient had a normal spontaneous delivery over a large 4th degree laceration. There was also an extensive left perineal laceration with avulsion. The patient had a standard repair of the 4th degree laceration and a right vulvar skin flap closure of the left perineal laceration in the delivery room. The immediate post partum course was unremarkable.
- The patient returned on postpartum day #5 with a temperature of 101.9 degrees F, a tender uterus with an intact perineum, and a WBC of 13.3K. The patient was re-hospitalized for endometritis and treated with metronidazole and ampicillin/sulbactam. The patient defervesced and was discharged home again on post partum day #8. The patient was called back into the hospital within hours of leaving when it was noted that 2 of her blood cultures had become positive.

The blood cultures are positive with what organism?

What was the source?

The answers

The preliminary findings of gram negative rods isolated in both anaerobic bottles were called STAT to the provider. Subsequent identification revealed fusobacterium mortiferum in both bottles.

Anaerobes account for 2 to 5 percent of blood culture isolates from patients with clinically significant bacteremia, but the rate is decreasing reflecting the frequent use of anti-anaerobic antibiotics. The most common blood culture isolates among anaerobes are the B. fragilis group, which account for 60 to 80 percent. A review of the suspected portal of entry for 855 episodes of bacteremia involving anaerobes indicated an intraabdominal source in 52 percent, the female genital tract in 20 percent, the lower respiratory tract in 6 percent, the upper respiratory tract in 5 percent, and soft tissue infections in 8 percent.

Fusobacterium is one of the anaerobic bacteria species often involved in a variety of infections of the oral cavity and adjacent structures, including serious infections with suppurative (septic) thrombophlebitis of the jugular vein.

On the other hand, fusobacterium sp. are detected in amniotic fluid in preterm labor more commonly than other anaerobes. Fusobacterium burrow through amnion tissue rapidly and sometimes are present in amnion tissue in large numbers as if penetrating between the amnion epithelial cells. Large numbers of fusobacterium have been identified in Wharton's jelly. This suggests a peculiar propensity for these microorganisms to penetrate amnion tissue, which also covers the umbilical cord. Fusobacterium produce a variety of toxins, some of which are extraordinarily potent in stimulating cytokine formation in mononuclear phagocytes. In the setting of premature rupture of membranes it has been hypothesized that fusobacterium penetrate the fetal membranes after the tissues are exposed to these microorganisms in the cervical /vaginal fluid.

The rest of the story

The patient was treated with IV ampillin /sulbactam plus metronidazole intravenously and discharged on oral metronidazole and amoxicillin/clavulanate within 2 days of the positive blood cultures.

The patient initially did well as an outpatient, but had to be re-admitted with a fever and a breakdown of her labial repair six days later. The admission examination revealed that the 4th degree laceration also developed a small fistula. The patient was initially treated with a broad spectrum anaerobic regimen IV, and subsequently underwent debridement and a rectovaginal fistula repair 2 days later.

Though the source can not be known with complete certainty, it appears the source was the perineal and 4th degree lacerations, and not endomyometritis as suspected with the patient's first postpartum admission. The rectovaginal fistula repair was well healed 8 weeks later.

Have a case you would like to discuss in the Medical Mystery Tour? Please contact **nmurphy@scf.cc**

Midwives Corner

Judy Whitecrane, Phoenix

Please help us build the Midwives Indian Health Patient Education Resources page

Do you have any good ideas about links to offer to your colleagues?

Send them to **nmurphy@scf.cc**

Alaska State Diabetes Program

Barbara Stillwater

Teen Inactivity Leads to Obesity for Girls

Decreasing physical activity during adolescence seems to play a major role in weight gain among girls as they transition from children to women. Inactive girls gained an average of 10 pounds to 15 pounds more than girls who were active between the ages of 9 and 19.The number of calories consumed increased marginally and did not appear to be associated with the weight gain.

INTERPRETATION: Changes in activity levels of US girls during adolescence significantly affected changes in BMI and adiposity. Thus, preventing the steep decline in activity during adolescence is an important method to reduce obesity

Kimm SY et al Relation between the changes in physical activity and body-mass index during adolescence: a multicentre longitudinal study. Lancet. 2005 Jul 23-29;366(9482): 301-7.

(Open access..., continued from page 1)

Comments by the author per MD Consult

"Open access scheduling, intended to reduce or eliminate delays when patients need to see a doctor, is a practical, effective way to streamline medical practices while reducing patient frustration, according to results of the above small study. "You spend a 20-minute visit with a patient, and you may spend the first few minutes of it sort of picking up the pieces from the effects your wait has on that patient," said study leader Dr David Bundy, a pediatrician at the University of North Carolina-Chapel Hill Medical School. "They've been waiting in the waiting room for 45 minutes, and then waiting in the patient room for 10 more minutes. You walk in the room and apologize for being late, you make explanations for why the system runs slow. Minutes of the visit are churned up just trying to apologize for the way the system works."

Another impetus for considering open access involves delays in actually getting an appointment, Dr Bundy said. Patient complaints and frustration run high when they can't get an appointment to see a doctor until two months after they call. "Most other businesses do not operate on a similar model," he said. "If you imagine getting your oil changed where you call and they say, 'Well, come in two months.' I mean, you'd hang up the phone right away and call somebody else. So patients have already waited so long to get to their appointment—they may have waited six or eight weeks—and then once six or eight weeks has gone by, then to have to sit in a lobby for another hour-and-a-half for the visit to actually take place, there's a lot of patient frustration that is usually built up by the time the patient is ready to be seen in the room."

Delays in scheduling can cause other problems. "Practices that have really long delays frequently have high no-show rates," Dr Bundy said. "Because a person who made an appointment eight weeks ago has often forgotten, or their plans have changed. They just don't have the same investment that they did when they picked up the phone eight weeks ago. So as a result of the high no-show rate, practices respond by doing several things. Sometimes they'll call the patient the day before, which is now generating even more work." Many practices, anticipating a no-show rate of 25 to 30 percent, double book their schedule, Dr Bundy said.

"You're sort of drifting farther and farther into this parallel universe where the actual schedule doesn't really bear that much of a relationship to what happens on a given day any more," he said. "Because now you're basically scheduling appointments for patients who, six weeks from now when that day rolls around, you're going to suddenly assume are not going to come any more. So you're scheduling more patients into that slot.

"Eventually," he said, "practices are just looking for a way out, a way to turn the system upside-down and say, 'Hey, wait a minute. A hundred patients called today. We're going to see those 100 patients on the same day, it's just that the day we're going to see them is six weeks from now. ... Why can't we just see them today, by working down this backlog that we've built up?'"

To adopt open access, the practices employed such techniques as balancing appointment supply with patient demand, standardizing appointment lengths and making more efficient use of rooms and equipment. In some cases, such as wellness or child care instruction, group visits are appropriate and several patients can be handled at the same time, Dr Bundy said.

For simple follow-ups, such as notifying a patient about lab results, many practices are now calling or e-mailing instead of having the patient come in to the office. Continuity of care, and putting as much content into visits as possible, also reduces the need for repeat appointments.

"These are pretty general principles, and you can pretty rapidly start to think of ways they can be applied in all sorts of different practices," he said. The results are noteworthy. On average, according to the study, providers reduced their delay to the third available preventive care appointment from 36 days in the first quarter to 4 days in the fourth quarter. During this period, the no-show rate declined from 16 percent to 11 percent and overall patient satisfaction improved from 45 percent to 61 percent.

Reducing the backlog is a key to making open access work. "It can definitely be done," Dr Bundy said. "There is a growing track record of practices that have accomplished this, including

(Open access..., continued on page 15)

(Open access..., continued from page 14)
large systems of practices. For example, in the VA system, the veterans system, they undertook an enormous collaborative, trying to improve. They had a big problem in particular with their specialty clinics, having very long delays for appointments. ... The data is out there, and they've made significant improvements for delays in appointments for the VA system."

Practices large and small have been able to implement open access, Dr Bundy said. "The biggest key is just having the commitment on the part of the staff," he said. "That's not just the providers, but down to the appointment schedulers or the practice manager."

This can also extend to senior leadership—from the person who oversees a health system to the person in charge of a group of practices—having "the commitment that this is an important thing to do," he said. "One of the take-away messages is that this takes a lot of work on the front end.

"Getting rid of the backlog is a great example. It takes extra work to do that, extra work beyond what you are doing currently on an everyday basis," Dr Bundy said. "But that's a temporary increase in your work, because once the backlog has been reduced, we're still seeing our same hundred patients a day as a group. We're just seeing the hundred patients who called in today or yesterday, instead of the hundred patients who called in six weeks ago."

Addressing a backlog can be intimidating. "They have to get over that hump," he said. "They have to make an extra effort at the beginning." But it is possible. "The two biggest components are the commitment and the know-how, or the tools," Dr Bundy said. "That's where this collaborative work comes in, to give practices the practical, specific tools, ideas, changes, etcetera, that they need to make to their system in order to implement open access."

The nuts and bolts of open access—the how-to—is being shared among practices that are part of a larger group. Right now, the practices changing to open access are the "motivated, ahead of the bell curve" groups, Dr Bundy said. He hopes that as practices successfully implement open access, they will be able to share what they did with other practices, reducing the learning curve.

"It's such a foreign notion to think that the clinic is providing you a service and that you, the patient, should decide when you want to receive that service," he said. Since reducing the backlog is a gradual process, the first hint of change is subtle, like appointments dropping from six weeks in the future to a month. But when the backlog is gone, patients love the change. "This is something that would attract patients to a practice," Dr Bundy said.

Open access can work for any type of practice, Dr. Bundy said. It should be the wave of the future. "Once some critical mass of practices has achieved this, then it's just going to become the standard. You can't compete any more if you have a six-week wait for an appointment when an adjacent practice which is equally good will see (a patient) today," he said.

Other resources

Murray M, Bodenheimer T, Rittenhouse D, Grumbach K. Improving timely access to primary care: case studies of the advanced access model. JAMA. 2003 Feb 26;289(8):1042-6.

Pierdon S, et al Implementing advanced access in a group practice network. Fam Pract Manag. 2004 May;11(5):35-8.

Obstetrics

Aerobic training increases exercise capacity, overcoming negative effects of pregnancy

Conclusion: Aerobic training in overweight pregnant women substantially increases submaximal exercise capacity, overcoming the otherwise negative effects of pregnancy in this regard. Additional studies are required to evaluate its effect on major clinical outcomes.
LEVEL OF EVIDENCE: I.

Santos IA, et al Aerobic Exercise and Submaximal Functional Capacity in Overweight Pregnant Women: A Randomized Trial. Obstet Gynecol. 2005 Aug;106(2):243-249

Start Planning Now

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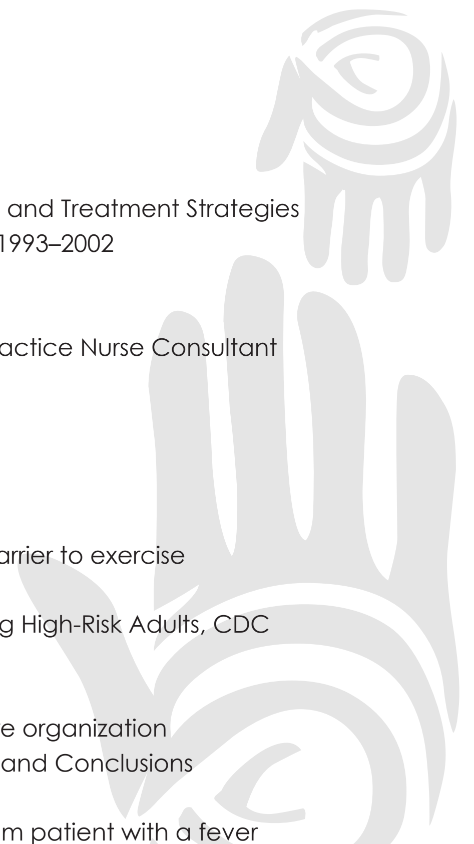

Abstracts of the Month

- Open access can work for any type of practice

IHS Child Health Notes

- Clinical assessment of pediatric obstructive sleep apnea
- Excessive Sleepiness in Adolescents and Young Adults: Causes, Consequences, and Treatment Strategies
- Tuberculosis among American Indians and Alaska Natives in the United States, 1993–2002

From Your Colleagues

- Sandy Haldane, HQE— New IHS Women's Health Consultant and Advanced Practice Nurse Consultant
- Sheila F. Mahoney CNM, NIH—Cord clamping: Early versus delayed
- Miles Rudd, Warm Springs, OR—Physical exam of the breast as a screening tool

Hot topics

- Obstetrics—Trial of Labor After Cesarean: Evidence based guidelines
- Gynecology—One in ten adult women perceives urinary incontinence to be barrier to exercise
- Child Health—AAP Releases Report on Excessive Sleepiness in Adolescents
- Chronic disease and Illness—Guidelines for Improving Vaccination Rates Among High-Risk Adults, CDC

Features

- Perinatology Picks—Glyburide for gestational diabetes in a large managed care organization
- ACOG—Management of Endometrial Cancer Summary of Recommendations and Conclusions
- Navajo News—Is the patch more dangerous than the pill?
- Medical Mystery Tour—Follow-up, 2 positive blood cultures found in a postpartum patient with a fever

These articles and many more, inside this *Ob/Gyn & Pediatrics CCC Corner*