OB/GYN & PEDIATRICS
# CCC CORNER
Maternal Child Health for American Indians & Alaska Natives

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# Use of 'Opt out' HIV screening methods during pregnancy in Indian Country

*Routine Population-Wide HIV Screening May Be Cost-Effective*

## Conclusions

In all but the lowest-risk populations, routine, voluntary screening for HIV once every three to five years is justified on both clinical and cost-effectiveness grounds. One-time screening in the general population may also be cost-effective.
*Paltiel AD et al Expanded screening for HIV in the United States—an analysis of cost-effectiveness. N Engl J Med. 2005 Feb 10;352(6):586-95.*

## Conclusions

The cost-effectiveness of routine HIV screening in health care settings, even in relatively low-prevalence populations, is similar to that of commonly accepted interventions, and such programs should be expanded.
*Sanders GD et al. Cost-effectiveness of screening for HIV in the era of highly active antiretroviral therapy. N Engl J Med. 2005 Feb 10;352(6):570-85.*

*Editorial: Bozzette SA. Routine screening for HIV infection—timely and cost-effective. N Engl J Med. 2005 Feb 10;352(6):620-1.*

## OB/GYN CCC Editorial

While the articles above discuss the cost effectiveness of future population based HIV screening in the general population, the use of universal screening of HIV has already been a reality in pregnancy since 2001. Here are excerpts of the Frequently Asked Question answer that is on the MCH website.

**Q.** What is the Indian Health policy for HIV screening in pregnancy?

**A.** Our goal is to maximize our care by using 'opt out' HIV screening.

In Indian Health we follow the PHS, CDC, ACOG, and Institute of Medicine (see Resources below) recommended 'opt out' system that minimizes barriers to universal screening for HIV in pregnancy.

'Opt out' screening includes elements of prenatal education for our patients that universal HIV screening significantly decreases perinatal HIV transmission. By screening, we may save her infant's life and improve her own maternal health status. We should further inform all pregnant patients that they will be screened for HIV, unless the patient otherwise declines HIV screening.

Initial HIV screening should occur during in the initial prenatal education and intake process. Subsequent screening should be repeated in high risk groups and upon admission to labor and delivery, if screening has not occurred previously.

Our goal is the highest attainable health status for our AI/AN patients. If an Indian Health service facility resides in a state that has additional screening requirements, then those requirements should be considered.

**Q.** Does it have to be a separate specific consent in writing during pregnancy?

**A.** No, staff does not need a specific separate signed informed consent for HIV screening in pregnancy, e.g., the written consent can be part

*(continued on page 7)*

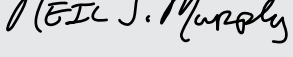
THIS MONTH



## 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 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.



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

# IHS Child Health Notes

## Mar 2005

### Articles of Interest

**Diagnosis and Management of Acute Otitis Media: Clinical Practice Guideline of the American Academy of Pediatrics and American Academy of Family Physicians.**

*Pediatrics: 113;5: May 2004: pages 1451-1465*

### Editorial Comment

The key to management of acute otitis media (AOM) is accurate diagnosis. Numerous studies show that at least 50% of the diagnoses of AOM are incorrect. The most common error is mistaking otitis media with effusion, which is sterile, for AOM that is an acute infection. The driving force behind this guideline is an effort is to decrease the prescription of unneeded antibiotics by making diagnostic criteria more explicit and stringent.

The study acknowledges that history alone is not sufficient. A complaint of fever, crying and earache is present in infants with AOM but also up to 70% of infants who only have URI. An accurate diagnosis of AOM requires:

1. Acute onset of symptoms in the past 48 hours.
2. Presence of middle ear effusion as confirmed by bulging or limited mobility of the eardrum.
3. Signs or symptoms of middle ear inflammation such as erythema of the eardrum or distinct otalgia.

The recommendations also addressed treatment suggestions. This portion of the guideline received a lot of attention in the medical and lay press because it was the first U.S. policy guideline to give the option of withholding antibiotic treatment for AOM. The committee endorsed the option to withhold initial antibiotic treatment in well appearing children over two years of age. This was based on the observation that the vast majority of AOM will improve spontaneously in 48 hours and the risk of invasive disease approaches zero in this age group. Each practitioner will have to make his/her own decision on treatment but everyone who treats children should read this practice guideline.

### Recent literature on American Indian/ Alaskan Native Health

**This isn't literature but it is from a library.**

The National Library of Medicine has a series of on-line exhibitions on the history of medicine. The exhibits rotate every 3 to 4 months and past exhibits are stored in on-line archives immediately accessible. The exhibits are terrific and cover a wide array of subjects from Islamic medicine to the history of the cesarean section to scientific biographies. Visit the site at

http://www.nlm.nih.gov/exhibition/exhibition.html

The reason I found this site is the 1994 on-line exhibit "If You Knew the Conditions"…Healthcare to Native Americans. The exhibit has text and pictures that cover AI/AN health issues from the 19th century to the present. It helps to put present day issues in the proper historical context. The recurrent theme of neglect and lack of funds for Indian health is a reminder that "the more things change, the more they remain the same". I recommend a visit:

http://www.nlm.nih.gov/exhibition/exhibition.html

Lastly, there is a History of Medicine homepage that can direct you to an archive of original texts and photos about medicine. The site is:

http://www.nlm.nih.gov/hmd/

*If you have any suggestions, comments or questions please contact Steve Holve, MD, Chief Clinical Consultant in Pediatrics at* sholve@tcimc.ihs.gov

## International Meeting on Inuit and Native American Child Health

**April 29-May 1, 2005**
**Seattle, WA**

Join the American Academy of Pediatrics and the Canadian Paediatric Society, in cooperation with the Indian Health Service, for the first International Meeting on Inuit and Native American Child Health.

Pediatricians, family physicians, residents, other health care professionals, clinical researchers, state and federal public health employees, child advocates, and other professionals and family representatives dedicated to working with First Nations, Inuit, and American Indian/Alaska Native (AI/AN) children should attend. Participants will have the opportunity to share ideas on culturally effective health care delivery models, present research findings, and dialogue about strategies to improve the health of First Nations, Inuit, and AI/AN children and communities.

This is the first international meeting on Indian/Inuit health with sponsorship by both countries pediatric societies. It should be an excellent forum for education and sharing of ideas

**For more information visit:**

http://www.aap.org/nach/InternationalMeeting.htm

# From Your Colleagues

## Scott Sunde, Albuquerque

**What is the significance of the latest NEJM article on trial of labor after cesarean (TOLAC)?**

CONCLUSIONS: A trial of labor after prior cesarean delivery is associated with a greater perinatal risk than is elective repeated cesarean delivery without labor, although absolute risks are low. This information is relevant for counseling women about their choices after a cesarean section.

*Landon MB et al Maternal and perinatal outcomes associated with a trial of labor after prior cesarean delivery. N Engl J Med. 2004 Dec 16;351(25):2581-9*

Editorial

*Greene MF. Vaginal birth after cesarean revisited. N Engl J Med. 2004 Dec 16;351(25):2647-9*

## OB/GYN CCC Editorial

"Risk, like beauty, is in the eye of the beholder"

This article is significant both what is says, and what it doesn't say.

This is a large observational 4 year prospective at 19 academic institutions. It showed a small increased risk of hypoxic-ischemic encephalopathy, endometritis, and blood transfusion among the vaginal delivery group. As the Editorial points out it would take approximately 588 cesarean deliveries to prevent a single adverse perinatal outcome.

Due to the timing of this study and its observational nature, approximately ½ of the symptomatic uterine ruptures were involved with prostaglandin administration, so even the 1/588 risk number may be overstated a large factor.

As this is not a RCT we can't know with certainty the exact risk, but this study confirms previous studies that the risk of adverse outcome is very small.

It is reasonable to use the tenets described at the August 2004 Indian Women's Health Conference:

- minimize risk by assuring the entire L/D unit functions as a cohesive team
- perform periodic emergency delivery drills on L/D as a team
- carefully triage TOLAC patients: low, medium, and high risk
- be especially mindful of a lack of timely intrapartum labor progress

See the lecture notes from Michelle Lauria for more details

## Sandra Dodge, Crownpoint

**How many deliveries does a provider need to maintain active privileges?**

Those numbers can be set by the local Medical Staff credentialing committee.

One standard set of numbers that have been used:

- Number needed to get initial privileges
  30 in the previous 2 years prior
- Initial proctoring
  5/year
- Maintain current privileges
  15/year
- Number needed by facility
  120/year

## OB/GYN CCC Editorial

If providers can not maintain those numbers locally each year, then they should perform a rotation at a facility where they can perform deliveries.

In facilities with delivery numbers chronically less than 120/year, the administration should have an active ongoing program to send their providers out for delivery rotations. Providers should be allowed maintain their delivery numbers up as part of their standard job status, e.g., providers need not have to use annual leave to attend delivery rotations.



## Concern over rising cesarean delivery rate:

**ACNM approaches Congress**

The American College of Nurse Midwives in February sent a letter to Congress expressing concern over the rising cesarean delivery rate (27% in 2003) and the declining VBAC rate (10.6% in 2003) in this country. They have asked Congress to explore these issues from a public health perspective.

# Hot Topics

## Obstetrics Gynecology Child Health Chronic Disease and Illness

### Obstetrics

**A single dose of intravaginal misoprostol decreases oxytocin use compared with intracervical dinoprostone, largely due to labor within the ripening period.**

CONCLUSION: A single dose of misoprostol administered in the outpatient setting significantly decreases oxytocin use, largely due to labor within the ripening period.

LEVEL OF EVIDENCE: II-1.

*Meyer M, Pflum J, Howard D Outpatient misoprostol compared with dinoprostone gel for preinduction cervical ripening: a randomized controlled trial. Obstet Gynecol. 2005 Mar;105(3):466-72.*

### Gynecology

**Vaginal pH for Diagnosing Status of Menopause**

A vaginal pH greater than 4.5 indicates menopause in women who are without vaginitis and are not receiving estrogen therapy. They add that vaginal pH is similar to FSH levels in establishing the diagnosis of low estrogen levels or menopause, and that a vaginal pH of 4.5 or less can be used to monitor adequate response to estrogen replacement therapy.

*Roy S, et al. Vaginal pH is similar to follicle-stimulating hormone for menopause diagnosis. Am J Obstet Gynecol May 2004;190:1272-7.*

### Child Health

**Pregnancy and Birth Rates Decline for Teenagers Aged 15–17 Years, 1976-2003**

Since 1990, pregnancy rates have declined substantially for teenagers aged 15-17 years. From 1990 to 2000, the pregnancy rate decreased 33%, from 80.3 per 1,000 females to 53.5, a record low. The birth rate declined 42%, from its peak at 38.6 in 1991 to 22.4 in 2003. The induced abortion rate peaked in 1983 at 30.7 and decreased by more than half to 14.5 by 2000.

### Chronic disease and Illness

**Low-dose aspirin can prevent cardiovascular disease in older women**

CONCLUSIONS: In this large, primary-prevention trial among women, aspirin lowered the risk of stroke without affecting the risk of myocardial infarction or death from cardiovascular causes, leading to a non-significant finding with respect to the primary end point

*Ridker PM et al A Randomized Trial of Low-Dose Aspirin in the Primary Prevention of Cardiovascular Disease in Women. N Engl J Med. 2005 Mar 31*

# Midwives Corner

**Marsha Tahquechi, CNM, GIMC**

**Emergency OB Drills: The Phoenix Indian Medical Center Experience**

After attending the American Native Women's Health & Maternity Care Conference in Albuquerque last August, the Phoenix Indian Medical Center Midwifery Services created an Emergency OB Drill team, which includes CNMs and RNs from the obstetrical services. The team has been holding emergency OB drills in the areas of emergency cesarean section and postpartum hemorrhage, with future plans to add eclamptic events and shoulder dystocia. The drills have been quite successful with participation from the OB/GYN providers, CNMs, RNs, and most ancillary services, such as, anesthesia, laboratory, radiology, and respiratory therapy. They have been instrumental in discovering areas to improved and well received by staff.

**OB/GYN CCC Editorial comment:**

Thanks very much to Tami McBride, RNC; Karen Carey, CNM of PIMC for that posting

This is exactly what we all need to continue to do to keep up our skills as a team.

### Other Midwives Corner items:

**Alternative Medicines' Popularity Prompts Concern**

Use of Alternative and Complementary Remedies on the Rise—Midwives and Ob-Gyn providers are not strangers to the use of traditional and alternative medicine in native populations.

The Center for Complementary and Alternative Medicine at NIH released a survey in May 2004 demonstrating the widespread use of CAM's across the nation. The need for careful screening of ob-gyn patients in the use of CAM's at entry into care is essential in safely and effectively treating patients. The "WHO Guidelines: Developing Information on Proper Use of Traditional, Complementary and Alternative Medicine" can be found online.

**Ice Massage for the Reduction of Labor Pain**

Two recent studies have explored the use of ice message for the reduction of pain in early labor. This technique may be added to the armamentarium of providers for some patients seeking pain relief in early labor.

# Early epidural provided shorter labor...

## …Did not increase cesarean delivery

CONCLUSIONS: Neuraxial analgesia in early labor did not increase the rate of cesarean delivery, and it provided better analgesia and resulted in a shorter duration of labor than systemic analgesia

*Cynthia A. Wong, et al. The Risk of Cesarean Delivery with Neuraxial Analgesia Given Early versus Late in Labor N Engl J Med. 2005 Feb 17;352(7):655-65.*

and

*Camann W. Pain relief during labor. N Engl J Med. 2005 Feb 17;352(7):718-20.*

### OB/GYN CCC Editorial

This was a randomized trial of 750 nulliparous women at term who were in spontaneous labor or had spontaneous rupture of the membranes and who had a cervical dilatation of less than 4.0 cm. Neuraxial analgesia in early labor did not increase the rate of cesarean delivery. As epidural analgesia is both safe and effective, it may deserve a larger role in the care of AI/AN.

AI/AN birth rates have been steadily declining over the last decade. The reasons for the decreasing birth rate are myriad, but include demographic, educational, and socio economic factors among others.

One other factor is that some AI/AN patients choose to deliver outside the Indian Health system because epidural or intrathecal analgesia is not available. In many cases there is a loss of patient continuity or a loss of the patient and her family to another health system for future care, as many times these patients function as the health care gatekeepers for the extended family. In that latter process, there is also a loss of alternate funding resources that could be helpful for the whole system.

Please also review Dr. Diane Pond's comments below. Dr. Pond is the Anesthesia Chief Clinical Consultant for the Indian Health Service.

### Anesthesia CCC Editorial (Diane Pond, MD, PIMC)

In the earlier days of epidural analgesia for labor and delivery, it was common practice to utilize more concentrated doses of local anesthetics. Infusions consisted of 1/8%, and ¼% bupivicaine with or without narcotics. At this concentration it was common to see mild-moderate motor block in addition to sensory blockade. Excessive motor block has been related to difficulty with the pushing phase of labor. Lack of ability to effectively push can intuitively lead to an increase in cesarean rate. Since then further studies with more dilute solutions have shown effective analgesia can be achieved with minimal motor blockade. Solutions as dilute as 1/16% with 1-2 mcg of Fentanyl have been shown to be effective. The phrase "walking epidural" has been coined to describe the possibilities now available to patients with the dilute solutions, and intrathecal techniques.

There is also evidence that effective analgesia can actually result in a shorter duration of labor. The mechanism that has been postulated to explain this is a reduction in maternal systemic catecholamines. By reducing the sympathetic system response to a pain challenge, delivery outcome can actually be improved.

Bottom line: Advantages far outweigh the risks and include:

1. Safe method
2. Effective pain relief
3. Minimize depressive effects on infants
4. Method provides a rapid means of inducing surgical anesthesia if needed in emergent situations.

It is my opinion that relief of pain during childbirth should be a medically indicated human right.

**Take two Clomid and….**
**A true story**

OK, well at least the rest of this is true. I recently returned from an itinerant GYN clinic in a remote Alaskan regional center above the Arctic Circle. While there, I corresponded by e-mail with a colleague who retired from a career in Indian Health after 24 years of service and was currently at the University of New Mexico.

As he signed off his e-mail message, he asked that I give his regards to the staff at the field hospital, as he had worked in that area nearly 30 years prior.

To my amazement as I performed a chart review on my next patient, I saw a note with his name on it from 1978, 27 years prior. He had prescribed clomiphene by phone for a patient who desired fertility. As luck would have it, it seems the Indian Health staff had very effective reproductive endocrine techniques in those days. The patient conceived soon thereafter. That clomiphene must have kept working for quite a while, as the patient went on to have 6 more children. The patient was very appreciative of her interaction with my colleague, as her ninth child delivered in 1992, 14 years after that phone call.

*(cont. on page 7 sidebar)*

### Steve Holve, Tuba City

**What are some of the issues in adoption of an American Indian child?**

Adoption of American Indian children is delineated by federal legislation titled "The Indian Child Welfare Act" or ICWA. Adoption of Indian children cannot take place through state courts but must proceed through a tribal judicial system.

The purpose of the law is to prevent Indian children being removed inappropriately from their tribal groups as happened in the past. Adoption must be offered first within a child's family, then the tribal group and then any federally recognized Indian family. An Indian mother may not put her child up for adoption outside of ICWA supervision. The child's tribal division of social services has supervisory authority over any adoption. Many of the larger tribes have an ICWA caseworker.

There is no single entity that oversees adoption of Indian children. The family in question would need to contact the ICWA worker at each specific tribe. They could let them know they are interested in adoption. They would have to show proof of being enrolled in a federally designated tribe, usually by demonstration of a Certificate of Indian Blood.

Most tribes have websites with phone contacts.

# Family Planning

**Effects of Contraception on Bone Mineral Density**

Women using depot medroxyprogesterone acetate contraception lost approximately 3 percent in bone mineral density per year. Because this form of contraception is intended for long-term use, they call for additional studies to determine if the loss continues linearly and to identify strategies to counteract the effect. Berenson AB, et al. Effects of hormonal contraception on bone mineral density after 24 months of use. Obstet Gynecol May 2004;103:899-906.

**OB/GYN CCC Editorial comment:**

Please see the January CCC Corner commentary on caution in use of DMPA for greater than 2 years after the FDA Black Box Warning.

**Women continue to die from unintended pregnancy**

…despite all that is known about them, nearly half of U.S. pregnancies continue to be unintended, women continue to die from unintended pregnancy, and adverse consequences of unintended pregnancy can be felt throughout families, communities, and the larger society *Gardner J, Miller L. 2005. Promoting the safety and use of hormonal contraceptives. Journal of Women's Health 14(1):53-60*

# Ask a Librarian:

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

**Salmonella from Pet Turtles-Again**

Although banned by the FDA, pet turtles have emerged as a source of salmonella disease in children in Wisconsin and Wyoming recently. In some cases, the turtles were given away with purchases in a souvenir shop. Apparently the shop owner thought the FDA ban applied only to selling, but that's not a loophole. In another case, the turtle was sold "for educational purposes," again, not a loophole. Health departments can issue orders to stop distribution in both cases. "Salmonella infections usually (are) mild but can lead to...septicemia or meningitis (especially in infants and immunocompromised persons" the CDC warns.
*MMWR March 11, 2005;54:9*

# Primary Care Discussion Forum

**April 1, 2005: Methamphetamine use in Indian Country**
**Moderator: Steve Holve**

- How common is Methamphetamine use in your area?
- Should all mothers be screened at delivery for Methamphetamine use or only if medically indicated?
- What resources are available in your community if a pregnant mother is found to be using Methamphetamine?
- What resources are available for teenagers and adults who are Methamphetamine users?
- What programs have shown success in treating Methamphetamine addiction?

If you want to participate and subscribe to the Primary Care Discussion Forum contact Neil Murphy at nmurphy@scf.cc

# ACOG

**Pregestational diabetes mellitus. Summary of Recommendations and Conclusions.**

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

- Suspected fetal macrosomia is not an indication for induction of labor because induction does not improve maternal or fetal outcomes.
- Antepartum fetal monitoring, including fetal movement counting, the nonstress test, the biophysical profile, and the contraction stress test when performed at appropriate intervals, is a valuable approach and can be used to monitor the pregnancies of women with pregestational diabetes mellitus.
- Adequate maternal glucose control should be maintained near physiologic levels before conception and throughout pregnancy to decrease the likelihood of spontaneous abortion, fetal malformation, fetal macrosomia, intrauterine fetal death, and neonatal morbidity.
- Patients and their families should be taught how to respond quickly and appropriately to hypoglycemia.
- Preconceptional counseling for women with pre-gestational diabetes mellitus has been reported to be beneficial and cost-effective and should be encouraged.
- The use of oral agents for control of type 2 diabetes mellitus during pregnancy should be limited and individualized until data regarding the safety and efficacy of these drugs become available.
- To prevent traumatic birth injury, cesarean delivery may be considered if the estimated fetal weight is greater than 4,500 g in women with diabetes.

*Pregestational diabetes mellitus. ACOG Practice Bulletin No. 60. American College of Obstetricians and Gynecologists. Obstet Gynecol 2005;105: 675–85.*

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*(continued from page 1)*

of a 'bundled consent'. This written consent may be handled differently in pregnancy compared to the non-pregnant state in some facilities. From the 2001 Revised CDC guidelines:

> "…Information regarding consent may be presented separately from or combined with other consent procedures for health services (e.g., as part of a package of tests or care for certain conditions). However, if consent for HIV testing is combined with consent for other tests or procedures, the inclusion of HIV testing should be specifically discussed with the client. For a discussion of HIV testing in pregnant women, consult the guidelines for HIV screening of pregnant women "

IHS uses the IOM, ACOG and CDC as best practice benchmarks and Chapter 13 of the IHS Manual does not require an additional separate written IHS consent for HIV screening in pregnancy.

Those benchmarks call for 'opt out testing'. The basic idea with 'opt out' testing is to remove barriers to what constitutes life saving therapy for fetuses, e.g., the 076 Protocol significantly reduces infant mortality.

The specifics of 'opt out' testing require that the patient be informed about HIV and its consequences, plus that the patient will be universally screened unless she specifically opts out, or declines screening. There is no longer a need to complete the two sided IHS-509, 8/93, HIV Screening form out on each patient.

Most centers that have successfully implemented 'opt out' have done so by informing the patient in her initial prenatal teaching session about HIV (and that she will be screened as a course of her routine care) along with the standard compliment of important prenatal teaching content.

The rest of this Frequently Asked Question is continued, with many other resources, on the MCH web page.

*(cont. from page 6 sidebar)*

## OB/GYN CCC Editorial

Indian Health can be a very rewarding career. We have the privilege to work with wonderful patients. We can develop relationships with our patients and fellow staff members that last a lifetime. Indian Health is also a great career for those who want a part time, full time, or locum tenens position. See these sites on the MCH webpage:

- Frequently Asked Questions
  What are some of the opportunities to provide care in Indian women's health?
- IHS staff in the news
- Locum Tenens and Job Opportunities
- ACOG Fellows in Service Program

We are curious…. Do you know which IHS provider was prescribing Clomid in 1978 in rural Alaska?

For extra credit—please contact **nmurphy@scf.cc** with your answer.

## Start planning now

**Prevention of Cardiovascular Disease & Diabetes Among AI/AN**
- May 16—19, 2005
- Denver, CO

**Native American Women's Health: Leadership for Change Conference**
- May 19—20, 2005
- Denver, CO

**IHS / ACOG. Postgraduate Course: Obstetric, Neonatal, and Gynecologic Care.**
- June 19—23, 2005
- Denver, Colorado

*The basics of all AI/AN women's health, plus a good update.*

**Contact Yvonne Malloy at YMalloy@acog.org or (202) 863-2580**



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## *Abstracts of the Month*
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- Early epidural provided shorter labor and did not increase cesarean delivery

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- Sandra Dodge—How many deliveries does a provider need to maintain active privileges?

## *Hot topics*
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- Gynecology—Vaginal pH for Diagnosing Status of Menopause
- Child Health—Pregnancy and Birth Rates Decline for Teenagers Aged 15–17 Years, 1976-2003
- Chronic disease and Illness—Low-dose aspirin can prevent cardiovascular disease in older women

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