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CCC CORNER
Maternal Child Health for American Indians & Alaska Natives

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Family cohesion and conflict
in an American Indian Community

Guest Editorial from Peter Stuart, M.D., Chinle

This American Indian sample reflects a support-oriented family profile despite the coexistence of high conflict. Despite the recognized importance of family environment in influencing health behaviors, few studies have attempted to assess or address distinctive attributes of American-Indian families. The article presents findings from an assessment of specific characteristics of the family environment within one American-Indian community.

Study Design

The study was conducted as part of a formative assessment of diet, activity, and family behaviors prior to the implementation of a community-based family wellness program. Members of one American-Indian community were trained to administer the assessment instrument by random household sample to participants ages 16 and older. The assessment analyzed responses to a survey instrument composed of a food and physical activity frequency questionnaire as well as four subscales of the Family Environment Scale (FES). Use of the FES with American-Indian families has not been previously reported in the published literature.

Methods

The present analysis assessed the following four dimensions of the family environment: (1) cohesion, defined as the degree of commitment, help, and support family members provide for one another; (2) expressiveness, defined as the extent to which family members are encouraged to express their feelings openly; (3) conflict, defined as the amount of openly expressed anger among family members; and (4) active-recreational orientation, defined as the amount of participation in social and recreational activities. Results from the survey were compared to nationwide scores reported for individuals from non-native, nondistressed, and distressed families and from nondistressed non-native minority (African-American and Latino) families.

Results

- In comparison to the non-native, nondistressed family sample, American -Indian families were comparable in expressiveness and cohesion, higher in conflict, and lower in participation in social and recreational activities.
- In comparison to the national sample of distressed families, the American-Indian family sample was more cohesive and expressive but no different in conflict and in participation in social and recreational activities.
- In comparison with nondistressed minorities, the American-Indian sample scored higher in expressiveness and conflict but lower in cohesion.

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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

October 2005

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

"The time to read is anytime: no apparatus, no appointment of time or place is necessary."
John Aikin (1747-1822)

Articles of Interest

Relationships between poverty and psychopathology: a natural experiment.

JAMA. 2003 Oct 15;290(15):2023-9.

Summary

Social causation (adversity and stress) versus social selection (downward mobility due to mental illness) are competing theories about the origins of mental illness. Halfway through an ongoing longitudinal psychiatric study, a casino opened on an Indian reservation that gave families an income supplement. A significant number of Indian families moved out of poverty while non-Indian families in the study had no change in economic status. There was a marked decrease in the number of Indian children diagnosed with conduct and oppositional defiant disorder but no change in anxiety or depression symptoms. The results suggest a social causation explanation for conduct and oppositional defiant disorder but not for anxiety or depression.

Editorial Comment

This article is two years old but raises lots of interesting questions. Many of us have strong feelings about gambling in general and Indian gaming in particular. This study takes the issue out of the moral arena and asks about health effects of Indian gaming with some surprising results. It touches on the larger question of the relationship between health and economic status.

Infectious Disease Updates.

Rosalyn Singleton MD MPH

Menactra®: Addressing a rare but deadly killer

Neisseria meningitides infects a small proportion of the general population (<1-5 per 100,000); however, despite its rarity, meningococcal disease is important because of its high mortality rate – 10 to 25%. A quadrivalent polysaccharide vaccine (A, C, Y and W-135) has been available; however, polysaccharide vaccines are poorly immunogenic in children < 2 years and do not induce immunologic memory. Serogroup prevalence varies widely. In the US, serogroups C (28%), Y (34%), and B (33%) were the most prevalent serogroups during 1995-1998. The highest rate of meningococcal disease (5:100,000) occurs in infants; however, a peak also occurs in 15-19 year olds.

In January the FDA licensed a new meningococcal quadrivalent (A, C, Y, and W135) conjugate vaccine (Menactra®, Sanofi-Pasteur). Studies in children showed superior immunogenicity and similar side effects compared with the older polysaccharide vaccine (Menimmune®). In February 2005 the Advisory Committee on Immunization Practices (ACIP) voted to recommend routine vaccination with Menactra® at pre-adolescent (11-12 year olds) with catch-up before high school entry (15 year olds), and for college freshmen living in dorms, and other groups at highest risk (eg. asplenia, terminal complement deficiency, military recruits, travelers to or residents in countries with epidemic disease). Since boarding schools pose similar risks of transmissions as dormitories, individual Areas may want to extend vaccination recommendations to include students between 11 and 18 years entering boarding schools. The vaccine was added to the list of Vaccines For Children (VFC) eligible vaccines.

Recent literature on American Indian/ Alaskan Native Health

Doug Esposito, MD

Confronting oral health disparities among American Indian/ Alaska Native children: The Pediatric Oral Health Therapist.

Am J Public Health. 2005;95(8):1225-29.

Summary

The authors outline the historical development and recent deployment of Pediatric Oral Health Therapists in rural Alaska as a means of addressing the disparities that exist with regard to dental health and access to dental services in isolated Native communities. American Indian/Alaska Native children suffer from the highest rates of tooth decay and the poorest dental health in the Nation. For many, access to dental service is severely limited. In Alaska, geographic isolation serves as a significant barrier. Additionally, it has been extremely difficult to attract dentists to rural and isolated areas, but not for want of trying! The authors make a cogent moral and public health argument in support of the Dental Health Aide and the Pediatric Oral Health Therapist Program as it is currently being planned.

Editorial Comment

The interested reader will want to review the American Dental Association's (ADA) negative view of the Pediatric Oral Health Therapist Program as outlined in the May 2005 issue of the American Journal of Public Health "Improving the Oral Health of Alaska Natives." Also of interest is the Anchorage Daily News article "Dental Training Rouses Protest from Dentists," which appeared on June 1, 2005. The integrity of this rational and innovative approach to reduce dental health disparities by increasing access to quality care for isolated communities is ➔

➔ jeopardized as a result of this ADA attack. Can valid programs serving the greater good ever succeed when pitted against the economic interests and controlling tendencies of relatively small professional groups in a democratic capitalist society (yikes!)? Efforts to develop oral health therapist programs have failed before in the United States at the hand of such attacks, despite documented efficacy and safety from other countries. Will this brave attempt also fail? Only time will tell.

Additional Reading

Improving the oral health of Alaska Natives.
Am J Public Health. 2005 May;95(5):769-73.

Dental training rouses protest from dentists.
Anchorage Daily News. June 1, 2005.

Developing a pediatric oral health therapist to help address oral health disparities among children.
J Dent Educ. 2004 Jan;68(1):8-20.

Article

Community-onset methicillin-resistant Staphylococcus aureus associated with antibiotic use and the cytotoxin Panton-Valentine leukocidin during a ferunculosis outbreak in rural Alaska.
J Infect Dis. 2004;189(9):1565-73.

Highlights

Despite its cumbersome (and perhaps frightening) title, it's a wonderful, relevant, and timely paper, and well worth reading.

- The authors report their findings of risk factors associated with a particular community-onset MRSA (CO-MRSA) skin infection outbreak in a rural Alaska Native village.
- Though causality could not be definitively established due to study design, use of antibiotics in the 12 preceding months was strongly associated with MRSA skin infection.
- The Panton-Valentine leukocidin (PVL) genes were present in 97% of MRSA isolates, and in none of the methicillin-sensitive Staph aureus (MSSA) isolates. PVL is a virulence factor that has been associated with skin and soft tissue infection, and appears to play a significant role in the development of skin infections in Alaska as well.
- "The emergence of MRSA strains that cause skin infections in rural Alaska appears attributable to the selective pressure of antibiotic use for drug-resistant strains expressing PVL." In other words, antibiotic use selected for more virulent PVL-containing strains of MRSA. The more exposure to antibiotics, the more likely a person was to have a MRSA skin infection. Ahhh, the judicious use of antibiotics issue yet again rears its ugly head in daily clinical practice!

Editorial Comment

Community-onset/community-acquired MRSA (CO-MRSA) is emerging as a significant health problem across the nation, and has been extensively reported in the literature. This paper, although not specifically related to child health, is relevant and timely. It serves as a reminder to all of us that antibiotics have real and measurable costs, both from an individual patient and a public health perspective. Although antibiotics are indispensable aides in the control of infections, more use results in more, and measurable, resistance.

CO-MRSA represents a problem of particular concern for Native communities. Given the prevalence of certain socioeconomic factors, many AI/AN populations experience a relatively high background rate of skin infections. Additionally, AI/AN populations tend to experience a greater burden of deep and invasive infections than the general population. These and other realities could serve to lower the threshold for antibiotic use among providers, and translate into additional selective pressure on microbes within Native communities.

As always, judicious use of antibiotics is warranted. Many of us who work in Native communities are well positioned to put into practice rational approaches to antibiotic use, given our inclination toward public health practice.

In Alaska, given the high prevalence of CO-MRSA, an effort was made on the part of the CDC Arctic Investigations Program to encourage appropriate antibiotic use when confronted with suspected Staphylococcal infections. Efforts were designed to limit the development of inducible clindamycin resistance among MRSA strains, and to use vancomycin with the utmost caution. Cotrimoxazole became the first-line antibiotic, used only if local care of infection was unsuccessful or impracticable. Although the effect of this effort is unknown, the time is ripe for all of us to look critically at this issue and develop rational approaches to antibiotic use for suspected Staphylococcal infections within our own clinical settings and communities, in an effort to further limit the development of microbial "super strains."

Additional Reading

Community-acquired methicillin-resistant Staphylococcus aureus in a rural American Indian community.
JAMA 2001;286(10); 1201-5.

Community-acquired methicillin-resistant Staphylococcus aureus in southern New England children.
Pediatrics. 2004;113(4):347-52.

Community-associated methicillin-resistant Staphylococcus aureus in pediatric patients.
Emerg Infect Dis. 2005 Jun;11(6):966-8.

From Your Colleagues

Carolyn Aoyama, HQE

Children and Teens Told by Doctors That They Were Overweight

The percentage of children and teens aged 6-19 years in the United States who are overweight nearly tripled to 16% during 1980-2002. To determine what percentage of overweight children (or their parents) and teens were ever told their weight status by doctors or other health-care professionals, CDC analyzed data from the 1999-2002 National Health and Nutrition Examination Survey. This report summarizes the results of that analysis, which determined that: 36.7% of overweight children and teens aged 2-19 years had been told by a doctor or other health-care professional that they were overweight, and teens aged 16-19 years were more likely to be told than parents of children aged 2-11 years. **www.cdc.gov/mmwr/preview/mmwrhtml/mm5434a3.htm**

CDC Childhood Obesity Fact Sheets Youth Risk Behavior Survey (YRBS) and School Health Profiles (Profiles)

PARAMETERS: overweight, engage in unhealthy dietary behaviors, or are physically inactive.

The Profiles results describe characteristics of health education, physical education, opportunities for physical activity, and the school environment among middle/junior and senior high schools that may help address the problem. **www.cdc.gov/healthyyouth/obesity/facts.htm**

Judy Thierry, HQE

Maternal Mortality in Indian Country: Follow-up to September Abstract

With the RPMS analysis of maternal Morbidity ICD 9 codes gleaned from over 6,000 files over a two year period from 5 IHS sites with surgical obstetric capacity now provides MCH health care providers, epidemiologists, researchers and program planner's access to data not previously available.

Maternal morbidity figures prominently in IHS admissions, outpatient services, lab assessment and medical imaging. Outcomes must be framed in both maternal and infant indicators. Hidden morbidities of injury and mental health while queried were found to be universally underreported. This was not unexpected, but we need the data to tell us what we could observe. Data quality is being addressed through several ventures. One of these is with the Office of Information Technology and the analysis of reported data entered at the service unit and captured through exports to the national data warehouse. Ultimately a MCH Data Mart will be able to frame key MCH health issues and protective factors as we advance in both quantity and quality of data entry and timeliness.

The goal of a MCH Data Mart would is a perinatal data set of real time clinical utility for service units and one that in the aggregate could reliably describe AI/AN maternal trends in health. Just as we rely on timely information for medical action, so to for health care planning and health policy. Census data, mid-census data, mortality vital statistics are essential public health data sets but cannot describe the MCH population here and now. Delivery log aggregate information, contract health referred patients aggregate information placed in a registry of some sort can and will meet the needs of those providing the health care and those seeking to improve MCH health care at the population level.

The development of the RPMS data query and resultant poster presentation entitled Maternal Morbidity during Delivery Hospitalizations in American Indian and Alaska Native Women sought to address several underlying questions. The basic morbidity questions which are addressed in the poster and which will be presented in manuscript in draft for publication are nicely laid out in tables and correlated with intervention of cesarean section and length of stay. Back to the underlying questions.

1 Could we get reliable data from RPMS using ICD9 codes to describe maternal morbidity? Would there be consistency in the use of codes.
2 Would the data quality hold up across area and between service units? Were we indeed seeing and documenting the same morbidities across facilities?
3 Could we describe somewhat the workforce parameters and provision of care by professional category i.e. midwife and obstetrician?

(continued on page 6)

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 sites find pediatricians to fill permanent vacancies. Contact AAP staff member Sunnah Kim at (847) 434-4729

Hot Topics

Obstetrics

Do Pregnant Women Require Rectal Swabs for GBS?

CONCLUSION: The group B streptococci detection rate from vaginal-perianal specimens is not significantly different from the detection rate from vaginal-rectal specimens. Therefore, pregnant women do not need to be subjected to the discomfort of collection of a rectal specimen. LEVEL OF EVIDENCE: II-2.

Jamie WE, et al. Vaginal-perianal compared with vaginal-rectal cultures for identification of group B streptococci. Obstet Gynecol November 2004;104:1058-61.

OB/GYN CCC Editorial

While this article is of interest, it is Level II-2 evidence based on a small study of 200 patients in a prospective cohort. The current CDC Guidelines still recommend a combined vaginal rectal swab

First Validated Model Predicts Risk of Failed Vaginal Birth After Cesarean

The factors that were predictive of emergency c-section were increasing maternal age, decreasing maternal height, male fetus, no previous vaginal birth, prostaglandin induction of labor, and birth at later than 40 weeks' gestation.

CONCLUSIONS: We present, to our knowledge, the first validated model for antepartum prediction of the risk of failed vaginal birth after prior cesarean section. Women at increased risk of emergency caesarean section are also at increased risk of uterine rupture, including catastrophic rupture leading to perinatal death

Smith GC et al Predicting cesarean section and uterine rupture among women attempting vaginal birth after prior cesarean section. PLoS Med. 2005 Sep;2(9):e252

Gynecology

Paroxetine Curbs Premenstrual Dysphoric Disorder

CONCLUSION: For the treatment of PMDD, luteal phase dosing with 12.5 mg and 25 mg of paroxetine CR is effective and generally well tolerated

Steiner M, et al Luteal phase dosing with paroxetine controlled release (CR) in the treatment of premenstrual dysphoric disorder. Am J Obstet Gynecol. 2005 Aug;193(2):352-60.

Social and cultural barriers to Pap test screening: Fatalistic attitudes, lack of support

Fatalistic attitudes, lack of family support, and low levels of information about cervical cancer are associated significantly with lack of Pap screening in women with cervical cancer, as are the previously identified risk factors of recent immigration and low levels of education. The authors argue that attitudinal, financial, and cultural barriers must be overcome to improve cervical cancer screening in the United States, and that development of home testing may have only limited acceptability. The authors recommend mobilization of community resources to address attitudinal barriers to cervical cancer screening.

Behbakht K, et al. Social and cultural barriers to Papanicolaou test screening in an urban population. Obstet Gynecol December 2004;104:1355-61.

Child Health

#1 cause of pediatric deaths!!!

The number one cause of death for children younger than 14 years is vehicular injury. Child safety seats and automobile safety belts protect children in a crash if they are used correctly, but if a child does not fit in the restraint correctly, it can lead to injury. A child safety seat should be used until the child correctly fits into an adult seat belt. It is important for physicians caring for children to know what child safety seats are available and which types of seats are safest. Three memory keys will help guide appropriate child safety seat choice:

1 Backwards is Best;
2 20-40-80; and
3 Boost Until Big Enough.

"Backwards is Best" cues the physician that infants are safest in a head-on crash when they are facing backward. "20-40-80" reminds the physician that children may need to transition to a different seat when they reach 20, 40, or 80 lb. "Boost Until Big Enough" emphasizes that children need to use booster seats until they are big enough to fit properly into an adult safety belt.

Biagioli F. Child safety seat counseling: three keys to safety. Am Fam Physician. 2005 Aug 1;72(3):473-8.

Broad portrait of what adolescents are doing and thinking

Freeze Frame: A Snapshot of America's Teens presents data on a wide variety of topics, from adolescents' sexual behavior to their religious beliefs. The chart book, produced by the National Campaign to Prevent Teen Pregnancy in conjunction with Child Trends, groups data into seven areas of influence -- health, family, peers and partners, school, community, media and consumer behavior, and religious and spiritual beliefs. The chart book is intended to help correct many common misconceptions about adolescents as well as to provide adults and those working directly with adolescents with a more textured understanding of adolescents.

Chronic disease and Illness

Native Americans with highest rates of major depressive disorder

Findings from the largest survey ever mounted on the co-occurrence of psychiatric disorders among U.S. adults afford a sharper picture than previously available of major depressive disorder* (MDD) in specific population subgroups and of MDD's relationship to alcohol use disorders (AUDs) and other mental health conditions. The new analysis of data From the 2001-2002 National Epidemiologic Survey of Alcohol and Related Conditions (NESARC) shows for the first time that middle age and Native American race increase the likelihood of current or lifetime MDD, along with female gender, low income, and separation, divorce, or widowhood. Among race-ethnic groups, Native Americans showed the highest (19.17 percent) lifetime MDD prevalence.

Major depression is a prevalent psychiatric disorder and a pressing Public health problem. That it so often accompanies alcohol dependence raises questions about when and how to treat each diagnosis. These data both inform clinical practice and provide researchers with information to advance hypotheses about common bio-behavioral factors that may underlie both conditions.

The NESARC results demonstrate a strong relationship of MDD to substance "dependence" and a weak relationship to substance "abuse", a finding that suggests focusing on dependence when studying the relationship of Depression to substance use disorders. This research direction is supported by earlier genetic studies that identified factors common to MDD and alcohol Dependence and at least one epidemiologic study that demonstrated excess MDD among long-abstinent former alcoholics.

Coexisting substance dependence disorder and MDD predict poor outcome among clinic patients. A decade ago, many treatment leaders discouraged Treating MDD in patients with substance dependence on the grounds that arresting substance dependence was the more immediate need and that its resolution well might also resolve MDD. Results from foregoing epidemiologic surveys and several clinical trials over time altered that picture, so that treating both disorders simultaneously is today common practice.

Grant BR et al Epidemiology of Major Depressive Disorder 2005 Archives of General Psychiatry October 3 National Institute on Alcohol Abuse and Alcoholism (NIAAA) Laboratory of Epidemiology and Biometry, NIH

(From Your Colleagues, continued from page 4)

4 Could we capture such elements as length of stay (LOS), health factors (tobacco, alcohol), patient education, injuries (E&M codes) and outpatient visits?

5 We wanted the data to answer questions that OB department chiefs, as well as MCH committee's, Directors of Nursing, Health Educators, and IHS leadership would want to know.

The RPMS data required statistical software to provide percent prevalence from this non random sample population. We wanted a workable number of files. We wanted direct IHS and tribal hospitals to participate – they did. The basic question of could we obtain useable data to make sense of maternal morbidity was answered in the 4 tables presented. Could we do this for all area's, tribal, direct and contract health care program – perhaps. Our CHS data was nil to nonexistent and would require a specific query and follow-up. Insurance data was obtained through a second query. Nashville United South and Eastern Tribes Tribal Epidemiology Center is currently developing and testing a prenatal registry working directly with CHS personnel in the entry and tracking of prenatal care as rendered to AI/AN patients in the private sector. This will have great impact as only 10,000 of the near 40,000 AI/AN births each year are delivered in IHS facilities.

This brings us to the denominator issue and what this study can say about prenatal care and maternal morbidity and what it cannot. We have insufficient information from our participating facilities to say what occurs around patients transferred antenatally or intrapartum and how this might have altered the picture of maternal morbidity. Fetal maternal issues that may drive transfer cannot be described here. A fundamental issue arises in our inability to link maternal parameters with fetal and infant outcomes. Prematurity, low birth weight, infant complications are not to be found in this data. The individual sites can be expected to use their individual files for further secondary analysis. Linkage of files to a chart audit sampling type methodology is required. I look forward to these secondary analyses as they are important and necessary next steps in using this data to inform local care, staff training, community awareness and the women themselves.

OB/GYN CCC Editorial

This dataset is available to 5 Areas now, but if your Area isn't one of them, then you can request a review data from your Area data. This is a great opportunity for you to tease out trends in maternal mortality that might save future 'near misses' or actual fatalities in your own patient population.

Contact **Judith.Thierry@ihs.gov**

Maternal Mortality in AI/AN Women:
Abstract in September CCCC

www.ihs.gov/MedicalPrograms/MCH/M/obgyn0905_Coll.cfm
(scroll down to Dr. Thierry in alphabetical order)

Features

ACOG

Racial and Ethnic Disparities in Women's Health
ACOG Committee Opinion No. 317

ABSTRACT: Significant racial and ethnic disparities exist in women's health. These health disparities largely result from differences in socioeconomic status and insurance status. Although many disparities diminish after taking these factors into account, some remain because of health care system-level, patient-level, and provider-level factors. The American College of Obstetricians and Gynecologists strongly supports the elimination of racial and ethnic disparities in the health and the health care of women. Health professionals are encouraged to engage in activities to help achieve this goal.

Racial and Ethnic Disparities in Women's Health. ACOG Committee Opinion No. 317. American College of Obstetricians and Gynecologists. Obstet Gynecol 2005;106:889-92.

OB/GYN CCC Editorial

ACOG has long been dedicated to the improvement of AI/AN women's health disparities through the many projects of the ACOG Committee on American Indian Affairs. The AAP has also had a strong commitment to the care of AI/AN children.

Just a few of the ACOG projects include:

- ACOG /IHS Postgraduate Course on Obstetric, Neonatal, and Gynecologic Care
- ACOG Fellows in Service Program
- ACOG Committee on American Indian Affairs –see for many activities
- ACOG Annual IHS Area Site Visits
- Liaison Relationship – AAP, Committee on Native American Child Health (CONACH)

I strongly encourage other professional organizations to consider matching or exceeding the above two organizations efforts, e.g., Family Medicine organizations need to seriously reconsider their commitment to Native Health.

Ask a Librarian

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

Help Us Establish a Free Electronic Patient Education Resource Center

Studies show that Native Americans react more favorably when educational materials include Native Americans in the pamphlets, videos, and posters. While there is an abundance of patient educational materials out there, few of them on Native American-specific. But now a new project will collect Native American oriented patient education materials for IHS clinicians. You can help.

The goal is to have an electronic resource that is available IHS-wide. Clinicians will be able to download and print materials in the clinic or hospital setting, at the point-of-care. Providing patient education materials in conjunction with the clinician's advice strengthens the message and improves health behavior.

This project is the joint effort of Mary Wachacha, IHS Health Education Consultant and Dr. Charles (Ty) Reidhead, Internal Medicine Chief Clinical Consultant. If you have any questions, please contact Mary Wachacha, Dr. Reidhead or myself, Diane Cooper, via email. We are all on the Global Outlook email system.

Help build this IHS-wide electronic National Patient Education Library. Send me any patient education materials that you are using now and have found useful in your patient care. If they are in electronic format you can send by email. If not just mail a copy and, it can be scanned to make it an electronic version. Please note in your correspondence if the material is copyrighted. I will get the permission from the originating organization if it is used.

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Hot Topics Chronic Disease

"Menopausal Arthritis" May Develop in Women Receiving Aromatase inhibitors

Estrogen deprivation may be associated with increased arthralgias in women secondary to greater sensitivity to nociceptive stimuli, which is mediated by NO and prostaglandin E2; production of enkephalin in the spinal cord; and opioid effects on the CNS.

The arthralgias of estrogen deprivation are typically characterized by joint pains in the hands, knees, hips, lower back, and shoulders, and by early morning stiffness.

Felson DT, Cummings SR. Aromatase inhibitors and the syndrome of arthralgias with estrogen deprivation. Arthritis Rheum. 2005 Sep;52(9):2594-2598.

Domestic Violence

October is Domestic Violence Awareness Month

Every October, Domestic Violence Awareness Month activities are planned across the country. National, state, and community-based domestic violence prevention and victim service organizations, corporations, health care providers, faith-based groups, and other organizations. To keep up to date with the latest events, news, and materials, go to **www.ncadv.org**

The Impact of Disaster on Battered Women

Battered women and their children are less safe than ever in the wake of a disaster. When hurricane Katrina struck the Gulf Coast on August 29th, at least seven domestic violence shelters, transitional housing programs, and outreach organizations were impacted by the storm's severity.

VAWA

The Violence Against Women Act (VAWA) of 2000 expires in September of 2005 and the remarkable gains we've made in ending domestic and sexual violence could come to a halt if Congress does not act quickly. During the past decade, VAWA of 1994 and 2000 have provided tremendous resources and protections for victims of domestic violence and sexual assault.

Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA)

Primary prevention is the cornerstone of the DELTA Program. Program activities are guided by a set of prevention principles including:

- Preventing first-time perpetration and first-time victimization;
- Reducing risk factors associated with IPV perpetration or victimization;
- Promoting protective factors that reduce the likelihood of IPV;
- Evidence-based program planning;
- Using behavior and social change theories in prevention program planning and evaluation; and
- Evaluating prevention programs and using results to inform future program plans.

Indian Health Violence Against Women web site

A large number of helpful AI/AN resources
http://www.ihs.gov/MedicalPrograms/MCH/W/DV00.cfm

Elder Care News

Cancer screening in elderly patients: a framework for individualized decision making

Most cancers increase in incidence with age, while the benefit of screening for elders is diluted by competing mortality from age and chronic disease. How do we properly counsel elders about the benefits and risks of cancer screening in advanced age? In this article the authors suggest an interesting strategy for evaluating the value of screening for cancer in the elderly. They note that the likelihood of benefit from screening to detect cancer depends on several quantifiable factors, including the risk of death from the specific cancer, life expectancy, and screening factors (how well the screening test works). Based on this data, they calculate the number needed to screen (NNS) to prevent one cancer death at selected ages for the highest, middle, and lowest quartiles of life expectancy.

The results of this analysis can be quite striking. For women in the highest quartile of life expectancy at age 80 (vigorous, health octogenarians without chronic disease), 240 mammograms would be needed to prevent one death from breast cancer, comparing favorably to 226 mammograms needed to prevent a single death by breast cancer in women at age 50 in the lowest quartile of life expectancy. For men in the highest quartile of life expectancy at age 85 the benefits of colorectal cancer screening (NNS=554) are greater than for men in the lowest quartile of life expectancy at age 50 (NNS=630). Tables published in the paper outline these relationships in selected ages in very useful ways.

These findings match our clinical understanding that it is the overall health and vigor of the elder, not his or her age, that is important in these decisions and provide real information to bolster and clarify that understanding. The authors take pains to point out that the decision to screen or not screen, at any age, should be driven by the individual's health goals, values and preferences, informed by the best information we can offer.
Walter LC, Covinsky KE. Cancer screening in elderly patients: a framework for individualized decision making. JAMA. 2001 Jun 6;285(21):2750-6.

Guest Comment: Bruce Finke, IHS Elder Care Initiative

It does no one any good (and can do significant harm) to urge cancer screening for frail elders who are unlikely to benefit. At the same time, we do a disservice to vigorous, health elders if we underestimate the possible benefit of screening based on age alone. The tables provided in this paper allow us give our elders real and specific information about the possible benefit of cancer screening to help them make their decisions.

Family Planning

ParaGard® Approved for Nulliparous Women in Stable Relationships from Age 16

The U.S. Food and Drug Administration (FDA) has approved an updated label for its intrauterine device (IUD), ParaGard® T 380A Intrauterine Copper Contraceptive.

The new prescribing information for ParaGard excludes nulliparity as a contraindication, confirming that the risk of pelvic infection is more related to a patient's sexual behavior than her contraceptive choice. Hormone-free ParaGard is also no longer contraindicated for women with a history of sexually transmitted diseases or pelvic inflammatory disease unless a patient currently has acute PID or engages in sexual behavior suggesting a high risk for PID. Finally, mutual monogamy is no longer a user requirement, although use by women is a stable relationship is encouraged.

"The FDA's approval of a less restrictive patient profile for ParaGard confirms what many health care providers have known for years," said Dr. Laura MacIsaac, director of family planning at Albert Einstein Medical College and chief medical officer at FEI Women's Health. "ParaGard is safe, effective and the most appropriate contraceptive for many women to use throughout their reproductive lives – from age 16 through menopause."

www.ParaGard.com

Forwarded by Tony Ogburn, M.D., University of New Mexico

Information Technology

Still doing GYN surgery the old fashioned way? Robotic surgery in remote settings

Although still in its infancy, robotic surgery is a cutting-edge development in surgery that will have far-reaching implications. While improving precision and dexterity, this emerging technology allows surgeons to perform operations that were traditionally not amenable to minimal access techniques. As a result, the benefits of minimal access surgery may be applicable to a wider range of procedures. Safety has been well established, and many series of cases have reported favorable outcomes. However, randomized, controlled trials comparing robotic-assisted procedures with laparoscopic or open techniques are generally lacking.

Robotic surgery has successfully addressed the limitations of traditional laparoscopic and thoracoscopic surgery, thus allowing completion of complex and advanced surgical procedures with increased precision in a minimally invasive approach. In contrast to the awkward positions that are required for laparoscopic surgery, the surgeon is seated comfortably on the robotic control consol, an arrangement that reduces the surgeon's physical burden. Instead of the flat, 2-dimensional image that is obtained through the regular laparoscopic camera, the surgeon receives a 3-dimensional view that enhances depth perception; camera motion is steady and conveniently controlled by the operating surgeon via voice-activated or manual master controls. Also, manipulation of robotic arm instruments improves range of motion compared with traditional laparoscopic instruments, thus allowing the surgeon to perform more complex surgical movements.

In a relatively short time, robotic procedures spanning the whole spectrum of surgery have been successfully executed. Initial results show that mortality, morbidity, and hospital stay compare favorably to conventional laparoscopic operations. However, only a limited number of randomized, prospective studies that compare outcomes of robotic techniques with conventional methods exist. More procedure-specific, randomized trials need to be performed before robotic surgery can find its way into everyday surgical practice

Telerobotic surgery stands out as a way of delivering surgical care to patients who have no direct access to a surgeon; however, costs are prohibitive to the spread of such technology to underserved areas that need it most. Even in the United States, surgical robots are mainly available in large academic centers. The issues of cost, technical drawbacks, and clinical effectiveness need to be resolved before robotic procedures can become mainstream, everyday surgical procedures.

OB/GYN CCC Editorial comment:

These technologies could have tremendous benefit in Indian Country in time. New technologies, such as virtual reality, haptics (i. e., systems that recreate the "feel" of tissues through force feedback), and telementoring, can powerfully ally with surgical robots to create a new medium for acquisition and assessment of surgical skills through simulation of all operations that can be done via the robot. Performance of robotic procedures requires specialized training. However, the majority of residency programs in the United States do not provide formal training in robotic surgery skills. Students, residents, and residency programs should strive to keep up with this new development in surgical technology that is likely to reshape the way we practice surgery.

Medical Mystery Tour

HCG curves redefined: Symptomatic patients with an early viable intrauterine pregnancy

Just to review, last month we described a patient with an early pregnancy with symptoms of pelvic pain and bleeding. Pelvic ultrasound performed 2 days prior revealed a 3 cm right adnexal structure thought to be a possible an ovarian cystic structure with complex elements or a curved hydrosalpinx. The structure had the appearance of a donut. The radiologist's dictation stated that the study was consistent with a hydrosalpinx or corpus luteum cyst, but that ectopic pregnancy needed to be considered clinically. There were also indistinct intrauterine contents not unlike a gestational sac, but no distinct fetal pole or yolk sac. The radiologist could not rule out a pseudosac. The radiologist's DRAFT report suggested appropriate medical/surgical intervention depending the patient's condition. Her lab values were:

QUANTITATIVE HCG

	Value	Percent increase
6 days prior	850	-
4 days prior	1400	54% increase
2 day prior	2142	53% increase

The patient said that Emergency Department (ED) provider told her that you would know what dose of methotrexate to prescribe in this particular situation. She said she heard the ED physician was concerned that her HCG had not increased by 66% during the previous serial 2 day intervals. She said the ED physician said that you might want to call a specialist to find out, because this was her third ectopic pregnancy.

What dose of methotrexate would you prescribe to this patient?

The answer is zero

The clinical pearl here is that normal pregnancies can be associated with a 53 percent HCG rise over 48 hours. If clinically stable, this particular patient should have a repeat HCG in 48 hours.

The patient's HCG was 2142, e.g., slightly over a discriminatory zone of 2000. Shouldn't we be able to demonstrate an intrauterine pregnancy in all cases by an HCG of 2000?

Actually, some would argue that the discriminatory zone should be an HCG up to 2,500. Or better yet, each institution should determine their own discriminatory zone based on their local HCG lab techniques and ultrasound capability.

Background

The beta-hCG concentration in a normal intrauterine pregnancy rises in a curvilinear fashion until 41 days of gestation at which time it plateaus at approximately 100,000 IU/L and the mean doubling time for the hormone is from 1.4 to 2.1 days. Studies in viable intrauterine pregnancies have demonstrated that in 85 percent of these gestations the beta-hCG concentration rises by at least 66 percent every 48 hours during the first 40 days of pregnancy; in only 15 percent of viable pregnancies is the rate of rise less than this threshold.

The data on the old adage that normal pregnancies increase by 66 percent every 48 hours was based on studies of 29 and 36 patients. (Daya, Kadar) More recent data from 287 patients showed the slowest or minimal rise for a normal viable intrauterine pregnancy was 24% at 1 day and 53% at 2 days. (Barnhart)

The Barnhart et al data re-define the slowest rise in serial hCG values for a potentially viable gestation and will aid in distinguishing a viable early pregnancy from a miscarriage or ectopic pregnancy. The minimal rise in serial hCG values for women with a viable intrauterine pregnancy is "slower" than previously reported, suggesting that intervention to diagnosis and treat an abnormal gestation should be more conservative. The use of the more conservative data on HCG rise will hopefully lead to less need for invasive procedures and/or unnecessary use of methotrexate.

One thought to ponder for next month...

If the HCG curve has been redefined in symptomatic patients with an early viable intrauterine pregnancy…just how accurate is our other major diagnostic modality in diagnosing ectopic?

What it accuracy of ultrasound in this setting?

Resources

Daya S Human chorionic gonadotropin increase in normal early pregnancy Am J Obstet Gynecol 1987 Feb;156(2):286-90.

Kadar N; DeCherney AH; Romero R. Receiver operating characteristic (ROC) curve analysis of the relative efficacy of single and serial chorionic gonadotropin determinations in the early diagnosis of ectopic pregnancy. Fertil Steril 1982 Apr;37(4):542-7.

Kadar N, Caldwell BV, Romero R. A method of screening for ectopic pregnancy and its indications. Obstet Gynecol. 1981 Aug;58(2):162-6.

Barnhart KT et al Symptomatic patients with an early viable intrauterine pregnancy: HCG curves redefined Obstet Gynecol 2004 Jul;104(1):50-5.

Navajo News

Syphilis Treatment Issues—Azithromycin Use Not Encouraged for Syphilis Treatment

Navajo Area is continuing to cope with a syphilis outbreak. Over the past five years, more than 275 cases of syphilis have been documented in Navajo Area, leading to aggressive screening efforts in many care settings including emergency departments, detox facilities, and community outreach campaigns. All patients diagnosed with any STD are offered syphilis screening. In pregnancy, patients are screened on entry to care, early in the third trimester, and on admission to Labor and Delivery. Although progress has been made, more than 35 cases have been diagnosed in the first 8 months of 2005.

Concurrently, we have experienced intermittent shortages of penicillin G benzathine (LA-Bicillin), the treatment of choice for syphilis. Thus a recent article suggesting that Azithromycin may be an acceptable treatment alternative was of great interest locally. This article described a randomized trial of a 2 gram oral dose of Azithromycin vs. a 2.4MU IM dose of LA-Bicillin in 328 subjects in Tanzania. Patients were evaluated based on a two-fold dilution in titer by 9 months or by healing of the primary lesion. Cure rates are reported as:

97.7% in the Azithromycin group (CI 94–99.4%)
95% in the LA-Bicillin group (CI 90.6–97.8%)

Despite these findings, and the ease of use of a single-dose oral preparation, there may be cause to hold off on adopting this new treatment regimen. In a commentary accompanying the article, King Holmes points out that penicillin has been the mainstay of treatment for 5 decades with no demonstrated resistance. Azithromycin resistance has been documented. He suggests that the upcoming 2006 CDC STD treatment guidelines continue to recommend the use of Penicillin. Efforts to secure and maintain an adequate supply of LA-Bicillin are indicated and working with local pharmacies to assure appropriate use of limited supplies may be necessary.

Centers for Disease Control, Sexually Transmitted Diseases Treatment Guidelines 2002, MMWR, May 10, 2002, 51(RR-6)

Centers for Disease Control, Brief Report: Azithromycin Treatment Failures in Syphilis Infections---San Francisco, California, 2002-2003. MMWR, March 12, 2004, 53(09);197-198.

Reidner, G, Rusizoka, M, Todd, J., et al., "Single-Dose Azithromycin versus Penicillin G Benzathine for the Treatment of Early Syphilis", The New England Journal of Medicine, 2005;353:1236-44.

Holmes, K. "Azithromycin versus Penicillin G Benzathine for Early Syphilis", The New England Journal of Medicine, 2005;353:1291-93.

Midwives Corner

Jenny Glifort, CNM, ANMC

Paxil Use in Early Pregnancy May Cause Birth Defects

A study suggested an increase in the risk of overall major congenital malformations for paroxetine as compared to other antidepressants [OR 2.2; 95% confidence interval, 1.34-3.63]. Healthcare professionals are advised to carefully weigh the potential risks and benefits of using paroxetine therapy in women during pregnancy and to discuss these findings as well as treatment alternatives with their patients. GlaxoSmithKline (GSK) and FDA notified healthcare professionals of changes to the Pregnancy/PRECAUTIONS section of the Prescribing Information for Paxil and Paxil CR Controlled-Release Tablets to describe the results of a GSK retrospective epidemiologic study of major congenital malformations in infants born to women taking antidepressants during the first trimester of pregnancy.

www.fda.gov/medwatch

From your Colleagues

Mary Lynn Eaglestaff, Aberdeen

Preterm Labor: Signs and Symptoms - Patient Education Brochure

Aberdeen Area Women's Health Program
www.ihs.gov/MedicalPrograms/MCH/M/Pr01.cfm#preLabor

Oklahoma Perspective

Greggory Woitte—Hastings Indian Medical Center

Less quantity of prenatal visits with higher quality: Outcome based analysis

The natural disasters Katrina and Rita that have hit the coastal Gulf States hard are having an effect nationally. We have all heard about the affects on the offshore rigs and the refineries and how gas prices are going to affect the cost of living from food costs to cost of stamps. Here in Oklahoma we are beginning to see the affect on prenatal care. As the cost of gasoline has topped the $3 mark, we are seeing more patients missing appointments due to the gas costs. Additionally, I have had patients ask if they could space out some appointments in order to keep their gas costs down.

- We all know that prenatal care is vital to decreasing the maternal and neonatal morbidity, however, does missing a few visits really affect the patient?
- How about if my facility systematically looks into the content our prenatal care and intentionally decides to reduce our average number of visits to increase our overall access* to patients?

A systematic review of ten randomized trials (over 60,000 women) in the Cochrane Review by Villar et al revealed that decreasing the number of visits did not jeopardize health outcomes. A reduction in the number of antenatal care visits with or without an increased emphasis on the content of the visits could be implemented without any increase in adverse biological maternal and perinatal outcomes.

OB/GYN CCC Editorial

The Cochrane Review by Villar et al confirms the tenets of the 1989 Public Health Service Expert Panel on the Content of Prenatal. The Panel looked carefully at the data supporting the quantity and quality of prenatal care and suggested 9 visits. This is reduction of approximately 3-6 visits depending on many facilities current pattern. That reduction represents a decrease of 25-40 percent of appointments per patient with no change in outcome. McDuffie et al. RCT reported a decrease of 2.7 visits per patient with good patient outcomes and patient satisfaction.

In addition, the PHS Panel suggested an emphasis on use of proven screening techniques vs traditional testing methods with little supporting data, e. g., discontinue practice of routine urine testing for glucose and protein at each visit.

When a facility changes to the more effective prenatal system, I would suggest that patients' expectations be managed from the outset to maintain patient satisfaction. This can include a careful setting of expectations starting at their first appointment, or first prenatal educational session. The nature of what to expect should be reinforced throughout the gestation.

Villar J, Carroli G, Khan-Neelofur D, Piaggio G, Gülmezoglu M. Patterns of routine antenatal care for low-risk pregnancy. The Cochrane Database of Systematic Reviews 2001, Issue 4. Art. No.: CD000934. DOI: 10.1002/14651858. CD000934.

McDuffie RS Jr et al Effect of frequency of prenatal care visits on perinatal outcome among low-risk women. A randomized controlled trial. JAMA. 1996 Mar 20;275(11):847-51.

Public Health Service Expert Panel on Prenatal Care. Caring for our Future: The Content of Prenatal Care. Washington, D.C.: Public Health Service, US Dept of Health and Human Services, NIH Publication No. 90-3182, 1989

**(See Open access can work for any type of practice, OB/PEDS Chief Clinical Consultants' Corner, Volume 3, No. 8, August 2005)*

Perinatology Picks

George Gilson

Newly Released Perinatology Corner Module—Shoulder Dystocia

A great resource of information and/or free CEU/CME

www.ihs.gov/MedicalPrograms/MCH/M/shdyst.cfm

Thyroid-stimulating hormone decreases significantly during the first trimester

OBJECTIVE: To estimate a normal reference range for thyroid-stimulating hormone (TSH) at each point in gestation in singleton and twin pregnancies.

METHODS: All women enrolling for prenatal care from December 2000 through November 2001 underwent prospective TSH screening at their first visit. Separate nomograms were constructed for singleton and twin pregnancies using regression analysis. Values were converted to multiples of the median (MoM) for singleton pregnancies at each week of gestation.

RESULTS: Thyroid-stimulating hormone was evaluated in 13,599 singleton and 132 twin pregnancies. Thyroid-stimulating hormone decreased significantly during the first trimester, and the decrease was greater in twins (both $P < .001$). Had a nonpregnant reference (0.4–4.0 mU/L) been used rather than our nomogram, 28% of 342 singletons with TSH greater than 2 standard deviations above the mean would not have been identified. For singleton first-trimester pregnancies, the approximate upper limit of normal TSH was 4.0 MoM, and for twins, 3.5 MoM. Thereafter, the approximate upper limit was 2.5 MoM for singleton and twin pregnancies.

CONCLUSION: If thyroid testing is performed during pregnancy, nomograms that adjust for fetal number and gestational age may greatly improve disease detection. Values expressed as multiples of the median may facilitate comparisons across different laboratories and populations.

LEVEL OF EVIDENCE: II-2

Dashe JS et al Thyroid-Stimulating Hormone in Singleton and Twin Pregnancy: Importance of Gestational Age–Specific Reference Ranges. Obstetrics & Gynecology 2005;106:753-757

OB/GYN CCC Editorial

This article presents more evidence that we must remember that thyroid-stimulating hormone decreases significantly early in pregnancy. This is clinically significant because many patients have their TSH level checked for various clinical indications during the first trimester and early second trimester, e.g., hyperemesis gravidarum. Though the TSH is physiologically decreased some clinicians assume the decreased TSH is related to true hyperthyroidism and the patient is begun on antithyroid agents.

If the patient is not clinically hyperthyroid, then a better approach is not to consider treatment based on TSH levels until after 20 weeks gestation. See pseudohyperthyroidism below.

PEARL: The best way to screen/evaluate a pregnant woman for thyroid disease is to look at the free T4. The free T4 tells you directly what amount of thyroid hormone she and the fetus are seeing. If it's normal, and you still suspect hyperthyroidism, then get a free T3. In the woman with known hypothyroidism, the free T4 may still be low normal, but a then a high TSH may clue you that you need more L-thyroxine replacement.

The Indian Health system continuing education module (free CEU/CME) on this topic offers many more details and resources.

Thyroid Disorders in Pregnancy Module

www.ihs.gov/MedicalPrograms/MCH/M/THYR01.cfm

Hyperemesis Gravidarum "Pseudohyperthyroidism" page

www.ihs.gov/MedicalPrograms/MCH/M/THYR05.cfm#top

Primary Care Discussion Forum

November 1, 2005

Morbidity and Mortality Rounds—Web Based*

Rectal bleeding: Is it hemorrhoids?

40 year old American Indian female presents to a remote ambulatory care clinic with intermittent blood in her stool for the last 3 months.

- She has had chronic constipation.
- She believes that the blood is due to her hemorrhoids.

Moderator: Terry Cullen

STD Corner

Laura Shelby's exciting opportunity

Laura Shelby will be leaving her Centers for Disease Control assignment with the IHS Division of Epidemiology Program as STD Program Manager after 9 years of dedicated service to Indian Country. Laura leaves IHS with a heavy heart as she will miss all the wonderful people she has been working with throughout the years. However, the IHS STD Program will be left in very capable hands. Lori de Ravello will be acting STD Program Manager until Laura's position is filled by CDC.

Laura was accepted to a Master of Public Health program at the London School of Hygiene and Tropical Medicine. She is looking forward to this new adventure. If you would like to contact her while she is in London, her e-mail address is laurakaye42@yahoo.com.

Welcome Lori de Ravello

Lori de Ravello will be Acting Program Manager of the IHS national STD Program until Laura's replacement is hired. Like Laura, Lori is a CDC Public Health Advisor assigned to the IHS National STD Program in Albuquerque, New Mexico. Since December 2003, Lori has been jointly-funded by CDC's Divisions of STD Prevention and Reproductive Health to support the efforts of the STD Program and to promote integration of STD, HIV, and reproductive health services.

Lori has worked for CDC since 1993, both domestically and internationally. She has worked on a wide range of projects addressing women's health issues, including family planning, managed care, Safe Motherhood, HIV prevention, services integration, training-related efforts, information technology, informatics, and surveillance. During her assignment to the IHS, she has worked with the STD/HIV Prevention Training Centers to support the development and delivery of provider training in Indian Country, represented the program at regional and national Infertility Prevention Project meetings, and developed and disseminated tribal jail STD screening guidelines, among other things.

Lori has a bachelors degree in international relations from the University of New Mexico (1989) and a masters degree in international public health from the University of Alabama at Birmingham (1993). She served as a Peace Corps Volunteer in Honduras (1990-1991).

Lori is looking forward to continuing the great collaboration and networking that Laura has perfected over the years. Please contact her for any STD-related questions, ideas, suggestions, or needs: lori.deravello@ihs.gov, 505-248-4202.

OB/GYN CCC Editorial

The Indian Health system will very much miss Laura Shelby's help and energy that she added to our system. Laura innovations and networking have transformed our approach to the care of sexually transmitted infections in Indian Country. Though we are very excited about Laura's new opportunities, she will be sorely missed. Good luck and thanks very much for all the help over the years, Laura

From Lori de Ravello

Which Comes First in Adolescence—Sex and Drugs or Depression?

BACKGROUND: The notion that adolescents "self-medicate" depression with substance use and sexual behaviors is widespread, but the temporal ordering of depression and these risk behaviors is not clear. This study tests whether gender-specific patterns of substance use and sexual behavior precede and predict depression or vice versa.

RESULTS: Overall, sex and drug behavior predicted an increased likelihood of depression, but depression did not predict behavior. Among girls, both experimental and high-risk behavior patterns predicted depression. Among boys, only high-risk behavior patterns increased the odds of later depression. Depression did not predict behavior in boys, or experimental behavior in girls; but it decreased the odds of high-risk behavior among abstaining girls (RRR=0.14) and increased the odds of high-risk behavior (RRR=2.68) among girls already experimenting with substance use.

CONCLUSIONS: Engaging in sex and drug behaviors places adolescents, and especially girls, at risk for future depression. Future research is needed to better understand the mechanisms of the relationship between adolescent behavior and depression, and to determine whether interventions to prevent or stop risky behaviors will also reduce the risk of later depression.

Hallfors DD et al. Which comes first in adolescence-sex and drugs or depression? Am J Prev Med. 2005 Oct;29(3):163-70

(Family Cohesion…, continued from page 1)

Summary

In comparison to these national samples, the American Indian sample projects a distinctive family profile, FES results can be useful in establishing a baseline assessment of family strengths and challenges and could serve as an evaluation tool in tracking the impact of social and public health services within Native communities.

Teufel-Shone NI, Staten LK, Irwin S, et al. 2005. Family cohesion and conflict in an American Indian community. American Journal of Health Behavior 29(5):413-422.

Guest Editorial comment

Peter Stuart, Chinle

What exactly does "being culturally sensitive" mean?

Someone somewhere will certainly take a study such as this and say "We need to develop programming for American Indian families to help them reduce conflict, and participate more in social and recreational activities".

This study demonstrates well some of the hazards in research involving American Indians/Alaskan Natives. When does a study reflect conditions for "American Indians" as a whole, and when should we be particularly sensitive to the unique cultural, economic, social, and environmental contributors to distress and wellness? The most one can argue from a study of this nature is that a particular community demonstrated a particular constellation of family environmental processes. Even calling the study a study of American Indians is problematic as it conflates all of our communities under that label despite their incredible diversity.

The study also raises issues around the construction of goodness and the assigning of precedence to culturally-moderated perceptions of behavior in a scale such as the FES. Is "expressiveness" as defined by the study a universal good? Is "conflict" a universal negative? What are the risks involved using research such as this in the design of community interventions? What types of processes need to be in place to respect the perspectives of the communities involved and to avoid the neo-colonialist error of attributing ascendance to the researcher's community norms? How can providers and health managers involved in funding and program priority issues acknowledge their own inherent biases and make balanced and respectful decisions?

Some helpful resources

Relationships between poverty and psychopathology: a natural experiment

CONCLUSIONS: An income intervention that moved families out of poverty for reasons that cannot be ascribed to family characteristics had a major effect on some types of children's psychiatric disorders, but not on others. Results support a social causation explanation for conduct and oppositional disorder, but not for anxiety or depression.

Costello EJ, et al Relationships between poverty and psychopathology: a natural experiment. JAMA. 2003 Oct 15;290(15):2023-9.

Socioeconomic disparities in health change in a longitudinal study of US adults

The results suggest that the higher prevalence of major health-risk behaviors among those in lower socioeconomic strata is not the dominant mediating mechanism that can explain socioeconomic disparities in health status among US adults.

Lantz PM et al Socioeconomic disparities in health change in a longitudinal study of US adults: the role of health-risk behaviors. Soc Sci Med. 2001 Jul;53(1):29-40.

Socioeconomic factors, health behaviors, and mortality

CONCLUSION: Although reducing the prevalence of health risk behaviors in low-income populations is an important public health goal, socioeconomic differences in mortality are due to a wider array of factors and, therefore, would persist even with improved health behaviors among the disadvantaged.

Lantz PM et al Socioeconomic factors, health behaviors, and mortality: results from a nationally representative prospective study of US adults. JAMA. 1998 Jun 3;279(21):1703-8

Featured Website

David Gahn, Tahlequah

Newly Released Perinatology Corner Module— Shoulder Dystocia

This is a great resource of information on one of the modest devastating (an unpredictable) problems in maternity care. You can also use the module for free CEU/CMEs

www.ihs.gov/MedicalPrograms/MCH/M/shdyst.cfm

SAVE THE DATES

21st Annual Midwinter Indian Health OB/ PEDS Conference

- For providers caring for Native women and children
- January 27-29, 2006
- Telluride, CO
- Contact Alan Waxman
  AWaxman@salud.unm.edu

Advances in Indian Health, 6th Annual

- May 2-6, 2006
- Albuquerque, NM
- **www.ihs.gov/MedicalPrograms/MCH/M/CN01.cfm#May06**

Native Peoples of North America HIV/AIDS Conference

- May 3–6, 2006
- Anchorage, Alaska
- Embracing Our Traditions, Values, and Teachings
- **www.embracingourtraditions.org**

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Abstracts of the Month

- Family cohesion and conflict in an American Indian Community

IHS Child Health Notes

- Relationships between poverty and psychopathology: a natural experiment
- Menactra®: Addressing a rare but deadly killer
- Dental training rouses protest from dentists

From Your Colleagues

- Children and Teens Told by Doctors That They Were Overweight
- Youth Risk Behavior Survey (YRBS) and School Health Profiles (Profiles)
- Maternal Mortality in Indian Country: Follow-up to September Abstract

Hot Topics

- Do Pregnant Women Require Rectal Swabs for GBS?
- First Validated Model Predicts Risk of Failed Vaginal Birth After Cesarean
- Paroxetine Curbs Premenstrual Dysphoric Disorder
- #1 cause of pediatric deaths!!!
- Native Americans with highest rates of major depressive disorder

Features

- ACOG—Racial and Ethnic Disparities in Women's Health ACOG Committee Opinion No. 317
- Ask a Librarian—Help Us Establish a Free Electronic Patient Education Resource Center
- Domestic Violence—October is Domestic Violence Awareness Month
- Elder Care News—Cancer screening in elderly patients: a framework for individualized decision making
- Oklahoma Perspective—Less quantity of prenatal visits with higher quality: Outcome based analysis