NATIONAL COUNCIL OF CHIEF CLINICAL CONSULTANTS

CCC CORNER

Focus on the Health of American Indian and Alaska Native Women and Children

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July 2006

Point/Counterpoint:

Refusals by pharmacists to dispense emergency contraception

Robert E. Pittman, PHS Chief Pharmacist Officer

I wanted to take the opportunity to respond to one of the articles in the June 2006 issue of CCC Corner. The article "Refusals by pharmacists to dispense emergency contraception: a critique" addresses an issue that has been in the news off and on for the last couple of years. Many of the leading pharmacy organization issued a response to the Obstetrics and Gynecology article. (see References)

Over the last 30 years, the IHS Pharmacy Program has worked with physicians and other providers to assure that our patients receive the medications they need.

On April 8, 2005, an e-mail was sent out on the Pharmacist and Physician listserv(s) discussing this issue.

Subject: Dispensing Birth Control and Emergency Contraception

Many of you may have read the articles this week about the Governor of Illinois directing pharmacists to fill prescriptions for birth control and emergency contraception. This issue was also discussed this week at the American Pharmacists Association Annual Meeting in Orlando, FL.

Over the years, IHS has tried whenever possible to accommodate pharmacists who do not feel they can ethically dispensing birth control or emergency contraception while still meeting our mission of providing needed pharmaceutical services to our patients.

At most sites, this issue is resolved by having another pharmacist who is willing to dispense the medication fill the prescription and counsel the patient. This solution is acceptable if the workload volume does not place an undue burden on the dispensing pharmacist. In clinics with only one pharmacist, the pharmacist can discuss this issue with the Clinical Director and see if there is a physician or other prescriber who would be available to dispense these medications. Policies and procedures need to be in place for when the pharmacist or prescriber is on vacation or unavailable so that the patients can receive medications without delay.

Other sites have looked at how they can assure that these medications are available 24/7 without violating any employee's ethical concerns nor causing any embarrassment for the patient (especially at sites that do not have 24 hour pharmacy coverage). Some sites provide pre-packed, pre-labeled Emergency Contraception in a controlled (for example Omnicell) location for providers that might be prescribing this medication. This allows the 24/7 option, allows first dose administration by the provider in the clinic or ER if desired, and automatically provides a work around for any pharmacist with ethical concerns. Most providers were very willing to work with us on this issue and patients are getting the care they are seeking.

Please discuss this issue at your site and if needed come up with a workable solution. If you have any questions, please contact me:

RADM Robert E. Pittman
PHS Chief Pharmacist Officer

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THIS MONTH

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Solstice

Males in the Hopi tribe dressed up as Kachinas—the dancing spirits of rain and fertility who were messengers between humanity and the Gods. At Midsummer, the Kachinas were believed to leave the villages to spend the next six months in the mountains, where they were believed to visit the dead underground and hold ceremonies on their behalf.

The Natchez tribe in the southern U.S. "worshiped the sun and believed that their ruler was descended from him. Every summer they held a first fruits ceremony." Nobody was allowed to harvest the corn until after the feast.

Also on-line....

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

Neil J. Murphy

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

IHS Child Health Notes

July 2006

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

"Knowledge is power"
—Francis Bacon

Articles of Interest

Antipyretic treatment in young children with fever: acetaminophen, ibuprofen, or both alternating in a randomized, double-blind study.

Arch Pediatr Adolesc Med. 2006 Feb;160(2):197-202.

Acetaminophen and ibuprofen have each demonstrated efficacy and safety in reducing fever in children. This study confirms what many practitioners have been doing for years; it is safe and effective to alternate acetaminophen and ibuprofen for maximal reduction in pain and fever.

Infectious Disease Updates.

Rosalyn Singleton, MD, MPH

HPV vaccine Licensed!

Human Papillomavirus (HPV) is the most common sexually transmitted infection, and can cause cervical cancer in women. American Indian and Alaska Native (AI/AN) women in several regions experience cervical cancer rates that are higher than other U.S. women. Although Pap smears and colposcopy have reduced the rate of invasive cancer, pre-cancerous lesions remain common and their diagnosis and treatment require substantial resources.

One of two investigational HPV vaccines, Gardasil™ (Merck) was licensed on June 8th, 2006 for use in females aged 9-26 years. In clinical studies, Gardasil™ had 100% efficacy in preventing infection from serotypes 16, 18, 6, and 11. Types 16 and 18 are responsible for 70% of cervical cancer and types 6 and 11 are responsible for 90% of genital warts. The Advisory Committee on Immunization Practices (ACIP) will vote on recommendations for this vaccine on June 29th, 2006 . The proposed recommendations are to provide routine vaccination for 11-12 year-old girls and catch-up vaccination for 13-26 year-old females. For more information about the proposed ACIP recommendations and the upcoming ACIP meeting, visit www.cdc.gov/nip/acip. ACIP will also vote on whether to include this vaccine in the Vaccines for Children (VFC) Program. The retail price of the vaccine is $120 per dose ($360 for full series), so we hope this vaccine will be covered under the VFC Program. More information on HPV and the vaccine can be found at: www.cdc.gov/std/hpv/STDFact-HPV-vaccine.htm

There are several questions about HPV vaccine of interest to AI/AN people, and CDC and tribal groups are planning ongoing research to address them. Among the many issues being looked at are determining the questions people have about this vaccine and the best way to educate them, and questions regarding the distribution of cancer-causing HPV serotypes in AI/AN populations and the efficacy of the current HPV vaccine for AI/AN populations.

THIS IS IMPORTANT

… to all Indian Health Service providers

Free access to full-text articles of the world's medical literature is available to all Indian Health Service providers at federal/tribal/urban programs via the Health Services Research (HSR) Library, a branch of the National Institutes of Health (NIH) library.

Recognizing the rural location of most clinics that serve American Indian and Alaskan Natives (AI/AN), the Indian Health Service has arranged access to the HSR Library. This service will allow you to conduct literature searches and to immediately download full text articles at no cost. Document delivery is also available for journal articles and books that are not in the online collection.

If you work at a federal site and are on the Wide Area Network (WAN) you can access this service at http://hsrl.nihlibrary.nih.gov. You can search by specific journal or use the *Pubmed* search engine via the National Institutes of Health.

For those at tribal or urban sites that are not on the WAN you can use this address:

http://nihlibrary.ors.nih.gov/ezproxy/ihs.htm. This address can be used at the workplace or at home using an id and password. To obtain an id and password contact, Diane Cooper at cooperd@mail.nih.gov. She can also help you with your literature searches or help you use the electronic resources that are available through the online library.

Contact Information:

Diane Cooper, MSLS
Informationist for the Indian Health Service
National Institutes of Health (NIH) Library
cooperd@mail.nih.gov
(301) 594-2449

Recent literature on American Indian/ Alaskan Native Health

Doug Esposito, MD

American Indian adolescents in substance abuse treatment: Diagnostic status.

J Subst Abuse Treat. 2006 Jun;30(4):275-84.

Summary

This study describes the prevalence of DSM-IV mental disorders among American Indian (AI) adolescents admitted to a Residential Substance Abuse Treatment Program (RSATP). It is the first such study combining DSM-IV diagnoses obtained through comprehensive structured interviews in AI adolescent RSATP patients. Results are compared with school based studies of AI adolescents in addition to similar studies of non-AI adolescents in substance abuse treatment settings.

The authors enrolled 89 AI patients between the ages of 13 and 18 years admitted to a RSATP in the southeastern United States. The 89 study subjects represented 27 different tribes. Data were collected from a combination of comprehensive structured diagnostic interviews using two validated instruments (DISC-IV-Y and CIDI-SAM) and review of treatment records.

As expected, substance use and substance use disorder rates were high. A mean of 5.26 substances were used by the aggregate group of study subjects in the year prior to interview. Marijuana was most commonly used (100%), followed by alcohol (96.6%), stimulants (57.3%), and cocaine (50.6%). In terms of substance use disorder, past year marijuana abuse/dependence prevalence was the highest (84.3%), followed by alcohol abuse/dependence (67.4%), stimulant abuse/dependence (22.5%), and cocaine abuse/dependence (15.7%). In fact, 20.4% of study subjects were found to have 4 or more substance use disorders. Due in part to limited sample size, the only statistically significant gender difference in substance use disorder was hallucinogens, with a rate in males of 16.7 % and females 0%. No gender difference was found for number of substances used.

Notably, 5.6% of study participants (5 individuals) did not meet diagnostic criteria for any substance use disorder. This is despite their being admitted to a RSATP! The authors offer a detailed and interesting discussion of several plausible explanations for this finding. It's worth taking a look!

Criteria for at least one DSM-IV non-substance mental disorder were met in 82% of study subjects. Twenty seven percent met criteria for 2 or more such disorders. The most commonly identified non-substance disorder was Conduct Disorder (CD) at 72.4%. Males were more likely to meet criteria for CD than female subjects (83.3% vs. 60.0%). This was the only statistically significant gender difference for non-substance mental disorders identified. Other disorders uncovered were ADHD (18%), Major Depressive Disorder (14.6%), Post traumatic Stress Disorder (10.1%), Oppositional Defiant Disorder (3.4%), and Generalized Anxiety Disorder (2.2%). These rates are high, but not surprising when compared to studies conducted in non-AI RSATP patients.

Findings from this study contrast studies of non-AI adolescents in one important way. AI adolescent RSATP patients appear to have higher relative rates of marijuana use and abuse/dependence as compared to alcohol. The opposite is true for non-AI RSATP patients, where alcohol use and abuse/dependence rates are found to be highest. Referral bias is a plausible confounder, however, marijuana and alcohol use patterns reported in this study parallel patterns found in school-based studies of substance use.

The authors caution that careful interpretation of heir findings is warranted. Limitations of their data are in part due to small sample size and study of a single treatment setting. Their results require replication and further validation. Other important limitations are described in detail in the paper. Please go to the article!

Finally, treatment strategies that have been developed for substance abusing non-AI adolescents in RSATPs might be of value to similarly situated AI adolescents. Careful and thoughtful scrutiny of these strategies, with thorough consideration of their cultural relevance and their feasibility given current resource limitations, is suggested.

Editorial Comment

It is appropriate that I am writing this review from a hotel room in Aurora, Colorado. The National Center for American Indian and Alaska Native Mental Health Research, University of Colorado Health Sciences Center, which is where the authors of this study work, is just down the road! The authors and the Center are prolific in the study of mental health-related issues among AI/AN populations. They are also highly skilled and experienced in the delivery of mental and behavioral health services to this same population. Take a look at the Center's website at www.uchsc.edu/ai/ncaianmhr/ncaianmhr_index.htm. They have a lot of interesting and exciting stuff going on. I really look forward to reviewing their next publication!

Announcements from the AAP Indian Health Special Interest Group

Sunnah Kim, MS

2006 Native American Child Health Advocacy Award Recipient Announced!

Each year, the AAP Committee on Native American Child Health presents the Native American Child Health Advocacy Award to recognize an individual who has made a major contribution to Native American child health.

The recipient of the 2006 award is Dr Bill Green, former chairperson of the Indian Health Special Interest Group. Dr Green was nominated by Dr Kelly Moore, who stated, "Dr Green has displayed exceptional leadership on behalf of Native American children through his distinguished service as Chief

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From Your Colleagues:

Judy Thierry, HQE

The Health Consequences of Involuntary Exposure to Tobacco Smoke

The Surgeon General's report, The Health Consequences of Involuntary Exposure to Tobacco Smoke, was released on June 27, 2006. The report is an evaluation and synthesis of evidence regarding the health effects of exposure to secondhand smoke. An update of the 1986 report, The Health Consequences of Involuntary Smoking, the report also adds information regarding secondhand smoke to the smoking and health database developed for the 2004 report, The Health Consequences of Smoking; the database link is available below

The six major conclusions of the latest report are as follows:

- Secondhand smoke causes premature death and disease in children and in adults who do not smoke.
- Children exposed to secondhand smoke are at an increased risk for sudden infant death syndrome (SIDS), acute respiratory infections, ear problems, and more severe asthma. Smoking by parents causes respiratory symptoms and slows lung growth in their children.
- Exposure of adults to secondhand smoke has immediate adverse effects on the cardiovascular system and causes coronary heart disease and lung cancer.
- The scientific evidence indicates that there is no risk-free level of exposure to secondhand smoke.
- Many millions of Americans, both children and adults, are still exposed to secondhand smoke in their homes and workplaces despite substantial progress in tobacco control.
- Eliminating smoking in indoor spaces fully protects nonsmokers from exposure to secondhand smoke. Separating smokers from nonsmokers, cleaning the air, and ventilating buildings cannot eliminate exposures of nonsmokers to secondhand smoke.

www.cdc.gov/tobacco

US Department of Health and Human Services. The health consequences of involuntary exposure to tobacco smoke: a report of the Surgeon General. Atlanta, GA: US Department of Health and Human Services, CDC; 2006.

Mark Traeger, Whiteriver

How to address health disparities? One story of success—Whiteriver, AZ

We recently published our influenza vaccination rates, showing how Whiteriver bridged the disparity often seen in influenza vaccination rates on reservations. The rates quoted are from 2002-3; since then we have increased our rates another 10% or so. (See abstract below)

OBJECTIVES: The Whiteriver Service Unit (WRSU) used proven effective methods to conduct an influenza vaccination campaign during the 2002-2003 influenza season to bridge the vaccination gap between American Indians and Alaska Natives and the US population as a whole.

METHODS: In our vaccination program, we used a multidisciplinary approach that included staff and community education, standing orders, vaccination of hospitalized patients, and employee, outpatient, community, and home vaccinations without financial barriers.

RESULTS: WRSU influenza vaccination coverage rates among persons aged 65 years and older, those aged 50 to 64 years, and those with diabetes were 71.8%, 49.6%, and 70.2%, respectively, during the 2002-2003 influenza season. We administered most vaccinations to persons aged 65 years and older through the outpatient clinics (63.6%) and public health nurses (30.0%). The WRSU employee influenza vaccination rate was 72.8%.

CONCLUSIONS: We achieved influenza vaccination rates in targeted groups of an American Indian population that are comparable to or higher than rates in other US populations. Our system may be a useful model for other facilities attempting to bridge disparity for influenza vaccination.

Traeger M et al Bridging disparity: a multidisciplinary approach for influenza vaccination in an American Indian community. Am J Public Health. 2006 May;96(5):921-5.

Short and Long…

Pregnancy Spacing Impairs Perinatal Outcomes

CONCLUSIONS: Interpregnancy intervals shorter than 18 months and longer than 59 months are significantly associated with increased risk of adverse perinatal outcomes. These data suggest that spacing pregnancies appropriately could help prevent such adverse perinatal outcomes.

Conde-Agudelo A et al Birth spacing and risk of adverse perinatal outcomes: a meta-analysis. JAMA. 2006 Apr 19;295(15):1809-23.

Hot Topics:

Obstetrics

The return of the vaginal breech delivery

ABSTRACT: In light of recent studies that further clarify the long-term risks of vaginal breech delivery, the American College of Obstetricians and Gynecologists recommends that the decision regarding mode of delivery should depend on the experience of the health care provider. Cesarean delivery will be the preferred mode for most physicians because of the diminishing expertise in vaginal breech delivery. Planned vaginal delivery of a term singleton breech fetus may be reasonable under hospital-specific protocol guidelines for both eligibility and labor management. Before a vaginal breech delivery is planned, women should be informed that the risk of perinatal or neonatal mortality or short-term serious neonatal morbidity may be higher than if a cesarean delivery is planned, and the patient's informed consent should be documented.

OB/GYN CCC Editorial

This is a significant shift in opinion based on the increasing literature supporting the return to vaginal breech delivery in those centers with providers who can display current competence and in which the facility has hospital-specific protocol guidelines. Oxytocin induction or augmentation was not offered. Here are some of the criteria used in the studies analyzed:

- gestational age greater than 37 weeks
- frank or complete breech presentation
- no fetal anomalies on ultrasound examination
- adequate maternal pelvis
- estimated fetal weight between 2,500 g and 4,000 g.
- fetal head flexion
- adequate amniotic fluid volume, defined as a 3-cm vertical pocket
- normal labor progress

ACOG issued the following recommendations

- The decision regarding the mode of delivery should depend on the experience of the health care provider. Cesarean delivery will be the preferred mode of delivery for most physicians because of the diminishing expertise in vaginal breech delivery.
- Obstetricians should offer and perform external cephalic version whenever possible.
- Planned vaginal delivery of a term singleton breech fetus may be reasonable under hospital-specific protocol guidelines for both eligibility and labor management.
- In those instances in which breech vaginal deliveries are pursued, great caution should be exercised, and detailed patient informed consent should be documented.
- Before embarking on a plan for a vaginal breech delivery, women should be informed that the risk of perinatal or neonatal mortality or short-term serious neonatal morbidity may be higher than if a cesarean delivery is planned.
- There are no recent data to support the recommendation of cesarean delivery to patients whose second twin is in a non-vertex presentation, although a large multicenter randomized controlled trial is in progress

Mode of term singleton breech delivery. ACOG Committee Opinion No. 340. American College of Obstetricians and Gynecologists. Obstet Gynecol 2006;108:235–7.

VBAC pendulum is posed to swing back

CONCLUSION: A history of multiple cesarean deliveries is not associated with an increased rate of uterine rupture in women attempting vaginal birth compared with those with a single prior operation. Maternal morbidity is increased with trial of labor after multiple cesarean deliveries, compared with elective repeat cesarean delivery, but the absolute risk for complications is small. Vaginal birth after multiple cesarean deliveries should remain an option for eligible women. LEVEL OF EVIDENCE: II-2.

Landon MB et al Risk of Uterine Rupture With a Trial of Labor in Women With Multiple and Single Prior Cesarean Delivery.

OB/GYN CCC Editorial

Multiple prior cesarean deliveries are not associated with uterine rupture in VBAC

Landon et al joins a growing literature that shows there is not a consistent trend to limit VBAC to those patients with only 1 previous cesarean delivery as reported in a 2004 ACOG Practice Bulletin. Macones GA, et al published 2 large studies that support Landon et al, above. In retrospect the ACOG Practice Bulletin was essentially based on one study, Caughey AB, et al 1999.

Macones GA, et al Obstetric outcomes in women with two prior cesarean deliveries: is vaginal birth after cesarean delivery a viable option? Am J Obstet Gynecol. 2005 Apr;192(4):1223-8; discussion 1228-9.

Macones GA, et al Maternal complications with vaginal birth after cesarean delivery: a multicenter study. Am J Obstet Gynecol. 2005 Nov;193(5):1656-62.

Caughey AB, et al Rate of uterine rupture during a trial of labor in women with one or two prior cesarean deliveries. Am J Obstet Gynecol. 1999 Oct;181(4):872-6.

Vaginal birth after previous cesarean delivery. ACOG Practice Bulletin No. 54. American College of Obstetricians and Gynecologists. Obstet Gynecol 2004;104:203–12.

Gynecology

CDC's Advisory Committee Recommends Human Papillomavirus Virus Vaccination

Vaccine considered highly effective in preventing infections that are the cause of most cervical cancers.

Elder Care News

When in doubt—Involve a geriatrician in your elderly female patient's care

CONCLUSIONS: Outpatient geriatric interventions emphasizing collaboration between geriatricians and primary care physicians, chronic disease self-management, and physical activity may reduce hospitalization risk and total health care costs among vulnerable elders.

Fenton JJ et al Bringing Geriatricians to the Front Lines: Evaluation of a Quality Improvement Intervention in Primary Care J Am Board Fam Med 2006;19 331-339

➔The Advisory Committee on Immunization Practices (ACIP) voted to recommend that a newly licensed vaccine designed to protect against human papillomavirus virus (HPV) be routinely given to girls when they are 11-12 years old. The ACIP recommendation also allows for vaccination of girls beginning at nine years old as well as vaccination of girls and women 13-26 years old. HPV is the leading cause of cervical cancer in women.

According to the ACIP's recommendation, three doses of the new vaccine should be routinely given to girls when they are 11 or 12 years old. The advisory committee, however, noted that the vaccination series can be started as early as nine years old at the discretion of the physician or health care provider.

OB/GYN CCC Editorial
ACIPs recommendations: Some of the final steps before roll out of this HPV vaccine

Each Indian Health, Tribal, and Urban facility should be making active plans now on how best to implement this vaccine for their clientele. In general most states will make the quadravalent vaccine available to our AI/AN patients at no cost in January 2007. There are many major issues to anticipate while we maintain a highly effective screening program in the meantime.

Here are just a few:

- how to implement as a cancer vaccine while addressing the sexually transmitted infection issues head on
- how to address 'catch up' vaccination for those patients over the age of 19 years who will not qualify for Vaccines For Children coverage
- how to monitor the quadravalent vaccine effectiveness (patients may be infected with more than one HPV sub-type), and possible adverse vaccine reactions.

Three Questions Distinguish Urge From Stress Incontinence

CONCLUSIONS: The 3IQ questionnaire is a simple, quick, and noninvasive test with acceptable accuracy for classifying urge and stress incontinence and may be appropriate for use in primary care settings. Similar studies are needed in other populations. We also need a clinical trial comparing the outcomes of treatments based on the 3IQ and the extended evaluation.

1. During the last 3 months, have you leaked urine (even a small amount)?
2. When performing physical activity; When an urge occurred and could not reach the toilet quickly enough; Without physical activity or sense of urgency?
3. When urine leakage occurs most often and provides a list of four circumstances. The subjects are asked to try to pick one that most often applies.

The answer to this last question determines the type of incontinence: most often with physical activity indicates a diagnosis of stress incontinence; most often with a sense of urgency indicates urge incontinence; without physical activity or urgency suggests another cause; and about equally with physical activity and urgency indicated mixed type (a combination of stress and urge incontinence).

Brown JS et al The sensitivity and specificity of a simple test to distinguish between urge and stress urinary incontinence. Ann Intern Med. 2006 May 16;144(10):715-23

Child Health

Boyfriends, girlfriends, and Adolescents' risk of sexual involvement

We have found that having had a boyfriend or girlfriend by seventh grade is both a predictor of having sex in the ninth grade and a marker of prior risks for sex.

- Males who reported a girlfriend by seventh grade were more likely than those who had not to be sexually active in ninth grade.
- Females who reported a same-age boyfriend in seventh grade were more likely than those reporting no boyfriend in seventh grade to be sexually active in ninth grade, and those reporting an older boyfriend in seventh grade were more likely than those reporting a same-age boyfriend to be sexually active in ninth grade.
- For males, sixth-grade peer norms favoring sex, Hispanic ethnicity, and eighth-grade situations that could lead to sex predicted ninth-grade reports of sexual activity.
- For females, menarche in sixth grade was associated with ninth-grade reports of sexual activity, as were peer norms favoring sex and situations that could lead to sex in eighth grade. ➔

➔ Helping girls to handle the social changes related to early pubertal development, deemphasizing social activities that may pave the way for risky behavior and encouraging parental supervision may help reduce early involvement with a boyfriend or girlfriend.

Marin BV, Kirby DB, Hudes ES, et al. 2006. Boyfriends, girlfriends and teenagers' risk of sexual involvement. Perspectives on Sexual and Reproductive Health 38(2):76-83.

OB/GYN CCC Editorial

Lori de Ravello, National IHS STD Program, offers a focus on adolescent sexual behavior this month in the STD Corner. Lori highlights 5 articles from the June 2006 Perspectives on Sexual and Reproductive Health on findings and strategies in adolescent reproductive health.

In addition Sulak et al below reports a successful sex education program in an academic center

Sulak PJ, Herbelin SJ, Fix DDA, et al. 2006. Impact of an adolescent sex education program that was implemented by an academic medical center. American Journal of Obstetrics and Gynecology 195(1):78-84.

Chronic Disease and Illness

Driving, Other Erratic Behaviors Reported After Taking Zolpidem (Ambien)

Zolpidem (Ambien), a nonbenzodiazepine, sedative-hypnotic prescribed for the short-term treatment of insomnia, has been associated with increased numbers of impaired driving incidents in Wisconsin during the past several years. Although the label directs patients to take zolpidem only when able to devote a full 8 hours to sleep, and cautions against operating heavy machinery or motor vehicles, the patients involved in these incidents have driven while under the influence of zolpidem. Some of these drivers have expressed their belief that they were "sleep-driving," saying they have no memory of the driving incident.

A 'typical' Ambien driver will demonstrate erratic, unsafe driving, often with wide lane deviations, many crashes or near–head on collisions, or unpredictable, bizarre driving maneuvers according to staff at the Toxicology Section at the Wisconsin State Laboratory of Hygiene (WSLH) in Madison.

Erratic behaviors reported after taking zolpidem are not limited to impaired driving, but have included sleepwalking, eating, drinking alcohol, belligerent outbursts, urinating in inappropriate places, agitation, confusion, dazed appearance, slurred speech, incoordination, and poor balance. Usually patients have no memory of these incidents and are at a loss to explain subsequent events, such as why food is missing from the refrigerator or why alcohol bottles are half empty.

Factors associated with zolpidem-impaired driving include not going to bed immediately after taking the drug, attempting to drive too soon after taking it, high blood levels, or ingestion with other drugs and/or alcohol.

Special concerns that patients should be aware of include memory loss or amnesia. Patients are advised to take Ambien only when they are able to get a full night's sleep (7-8 hours) before they need to be active again.

Coitus is…

associated with reduced requirement for labor induction at 41 weeks

CONCLUSION: Reported sexual intercourse at term was associated with earlier onset of labor and reduced requirement for labor induction at 41 weeks. LEVEL OF EVIDENCE: II-2.

Tan PC, et al Effect of coitus at term on length of gestation, induction of labor, and mode of delivery. Obstet Gynecol. 2006 Jul;108(1):134-40.

Coitus During…

Early Pregnancy Not Linked to Recurrent Preterm Birth

CONCLUSION: Self-reported coitus during early pregnancy was not associated with an increased risk of recurrent preterm delivery. There was an association between increasing number of sexual partners in a woman's lifetime and recurrent preterm delivery.

Yost NP, et al Effect of coitus on recurrent preterm birth. Obstet Gynecol. 2006 Apr;107(4):793-7

Features:

Breastfeeding

Suzan Murphy, PIMC

Pain is one of the reasons that moms quit breastfeeding in the first 2 weeks

For common sore nipples, there are quick fixes that can help reverse the problem.

For early sore nipples:

Look for the root problem

Check positioning points

- The baby is "belly to belly" so the baby's face and body face the mom's body.
- The baby's mouth is open wide, on the breast, and snuggled close. The baby's nose can be squished up against the mom's breast—it is ok, the baby will pull back or let go if breathing is hard.

Latch

- Check that both lips out and at least ½ inch past the nipple onto the areola (more is better).
- Check the internal mouth and nipple connection:
  - o Is the baby's lower lip folded under?
  - o Does the mom feel the baby's lower gum bumping her when the baby sucks?
  - o Is the sucking rhythm jerky, snappy, not smooth?

"Yes" to any of these usually means the nipple isn't deep enough in the mouth and the baby's tongue isn't out far enough to cover the gums and effectively milk the nipple.

So, show the mom how to gently push the chin down through a couple suck cycles. The baby's mouth will open a little more, the lower lip pops out, and the tongue will drop down to cover the gums—viola! Less pain and the baby gets more milk—and it usually takes just a couple "fixed" feedings for the baby to automatically latch appropriately.

- Sometimes in the first couple days, as the baby is learning how to suck effectively, the baby will chomp on mom enough to cause tender nipples. Moms usually describe it as pain at the beginning of the feeding that goes away after the first 15-30 seconds. It usually helps for the mom to know that the discomfort will get better each day.
- If the mom is compressing or pushing down on the breast - so she can see the baby breath—it can disrupt latching and lead to sore nipples. It can help to reassure her that the baby instinctively knows that breathing important and will pull away if breathing is hard.
- If the baby is using a pacifier often, it can alter the sucking process and lead to sore nipples. Encourage the mom to use the pacifier carefully—less (and later) is more.
- To help the mom while the nipples are healing, encouragement is magic. She will feel better soon—a day or two, sometimes less. Also consider suggesting:
  - o Let the nipple air dry before putting the bra flap or breast pad on.
  - o If the nipple sticks to clothing or a breast pad, wet it first so it peels off gently without new skin.
  - o Topical treatments like lanolin ointment, gel pads, and tea bags. Moms often say they help. Effective positioning/latch and time help too.
- If the mom says that it hurts all the time and nothing seems to help, check with a breastfeeding consultant.

If the pain starts after the first couple weeks, thrush is likely. Both mom and baby need to be treated.

Schanler R et al. Breastfeeding Handbook for Physicians, American Academy of Pediatrics and American college of Obstetricians and Gynecologists. 2006

Biancuzzo M. Breastfeeding the Newborn: Clinical Strategies for Nurses, Mosby Publishing, 2003.

Information Technology

Hospital Computer Keyboards Should Be Disinfected Daily

CONCLUSIONS: Our data suggest that microbial contamination of keyboards is prevalent and that keyboards may be successfully decontaminated with disinfectants. Keyboards should be disinfected daily or when visibly soiled or if they become contaminated with blood.

Rutala WA, et al Bacterial contamination of keyboards: efficacy and functional impact of disinfectants. Infect Control Hosp Epidemiol. 2006 Apr;27(4):372-7.

Midwives Corner

Lisa Allee, CNM, Chinle

Nuchal cords, somersaults, and the value of a pulsing cord: Nuchal Cord Management

ABSTRACT: Nuchal cord, or cord around the neck of an infant at birth, is a common finding that has implications for labor, management at birth, and subsequent neonatal status. A nuchal cord occurs in 20% to 30% of births. All obstetric providers need to learn management techniques to handle the birth of an infant with a nuchal cord. Management of a nuchal cord can vary from clamping the cord immediately after the birth of the head and before the shoulders to not clamping at all, depending on the provider's learned practices. Evidence for specific management techniques is lacking. Cutting the umbilical cord before birth is an intervention that has been associated with hypovolemia, anemia, shock, hypoxic-ischemic encephalopathy, and cerebral palsy. This article proposes use of the somersault maneuver followed by delayed cord clamping for management of nuchal cord at birth and presents a new rationale based on the available current evidence.

Mercer, J, Skovgaard, R, Peareara-Eaves, J, Bowman, T. 2005. Nuchal Cord Management and Nurse-Midwifery Practice. Journal of Midwifery & Women's Health 50(5): 373-379

Editorial Comment: Lisa Allee, CNM

Judith Mercer, et al, present excellent evidence that leaving a nuchal cord alone and delivering the baby by the somersault maneuver is preferred over clamping and cutting the cord before the shoulders deliver. They also provide nice drawings showing how to do the somersault. I first learned the somersault many years ago from a locums midwife while I was working as an RN. Soon after, on a very, very busy shift, I walked into a room where two nurses were busily getting gloves on, but the head was crowning, so I stepped in and caught the baby noting a nuchal cord as he came out. I pointed him toward his mother's thigh and out he somersaulted! First baby I ever caught. I have used the somersault ever since except once when I mistakenly thought that a baby was slow to deliver due to the nuchal cord and clamped and cut it—it wasn't the cord it was the shoulders. Needless to say the seconds it took to get that baby out were long and the baby needed some help getting going. Lesson learned—the baby needs the cord intact. Mercer, et al, present research that shows cutting a nuchal cord can lead to problems (see above) and that in a survey of nurse-midwives 40% selected somersaulting as their best option for nuchal cords and 96% avoid immediate clamping and cutting of nuchal cords. They also provide a clearly stated description of cord anatomy and physiology and the "blood volume model of neonatal transition" that not only supports the suggested management of nuchal cords, but also the benefits of delayed cord clamping in general. Judith Mercer has written elsewhere about delayed cord clamping and its beneficial role in neonatal resuscitation. This is based on the blood volume the baby gets from the placenta preventing hypovolemia and this thinking is consistent with the new changes in CPR that emphasize circulation, circulation, circulation (who else just took the new class with all those compressions?) She proposes letting the cord pulse while giving PPV with baby between mom's legs. I know this is very different than the rush to the warmer and change is hard, but read and think about it—it makes sense.

I highly recommend her chapter, "Fetal to Neonatal Transition: First, Do No Harm" in *Normal Childbirth: evidence and debate*, edited by Soo Downe, Elsevier. 2004. p.141-160. Actually, read the whole book.

International Health Update:

Claire Wendland, Madison, WI

Where There is No Doctor & A Book for Midwives

Most of us have likely seen or used *Where There is No Doctor*, the community health worker's manual that is a staple of Peace Corps volunteers and others—and that has had ninety translations and adaptations made to date! The Hesperian Foundation, a non-profit organization famous for its publication of this and other low-cost low-technology health manuals, has now made several manuals available on line in English-language versions. OB providers will be especially interested in *A Book for Midwives*, just named "Notable Book of 2006" by the American College of Nurse-Midwives.

Medical Mystery Tour

Copious post operative mucous secretions: The rest of the story

Let's review last month's case history….

A 60 year old female heavy smoker underwent a staging laparotomy that ultimately revealed bilateral hydrosalpinges without complication. The patient developed a left lung collapse due to tenacious secretions and had a successful re-inflation of her left lung by bronchoscopy. The afebrile patient was then noted to have several dry small fatty nodules between her midline staples, but she was otherwise tolerating an advancing diet, voiding, and had bowel movements. The patient was encouraged to stop smoking and the nature of chronic obstructive pulmonary was discussed with the patient. On the day of discharge the provider began to replace of the slightly prolapsed subcutaneous fat and to place Steristrips over the otherwise clean and dry incision.

Did you think of any further discharge/wound care instructions you would give this patient?

If you said something along the lines of: take two hydrocodone(s) and call me in the morning, then you would have been ½ correct.

If you had said take a little general anesthesia and call me in the morning, then you would have been closer. Let me explain.

The provider initially removed the lower one half of the staples at the bedside and was surprised to find that the adipose protruding through the staples for the last 3 days had actually been the omentum. The patient was then taken to the operating room and received general anesthesia. The subcutaneous tissue was opened. There was omentum in the subcutaneous tissue with some omentum that was dried indicating that it had been there for a while. Most of the tissue was fresh in appearance and moist. There was no odor, discharge or purulent material. There was no devitalized tissue. The skin edges and the subcutaneous tissues looked normal and without significant need for debridement. At the fascial edge, the suture was identified and was in place, but had pulled through the fascia in the upper 1/2 of the wound allowing the omentum to herniate through.

The total area of dried omentum is less than 2 square inches. This is immediately moved away from the incision and a small partial omentectomy was performed by sequentially clamping, dividing and ligating the omentum away from the bowel. There is no bowel extravasated from the abdominal cavity. The prolapsed omentum was excised and the abdomen explored without further findings. The fascia was closed with a mass closure technique. The patient did well and was discharged 5 days later without further complication. The patient was re-admitted 2 weeks later with a partial small bowel obstruction that resolved with conservative therapy.

Of note, the patient went home with inhalers an incentive spirometer, and a pulmonary appointment, but she did stop smoking.

What can we learn from this case?

There are a number of facets to this case, but let's start with incidence, risk factors, and signs/symptoms. Please review what UpToDate says about 'Surgical incisions: Prevention and treatment of complications' for complete details.

The incidence of fascial disruption is 1 percent overall and 0.4 percent in gynecologic surgery. By comparison, incisional hernia develops in approximately 1 percent of uncomplicated surgical cases, 10 percent of patients with wound infection, and 30

(continued on page 14)

Perinatology Picks

George Gilson, MFM, ANMC

Only 29% of ACOG recommendations are level A: Good and consistent evidence

Results: The 55 practice bulletins contained 438 recommendations of which 29% are level A, 33% level B, and 38% level C. The 55 bulletins cite 3953 references of which 17% are level I, 46% level II, 34% level III, and 3% others. Level A recommendations were significantly more likely among the 23 gynecologic than 32 obstetric bulletins (37% versus 23%, odds ratios 1.95, 95% confidence intervals 1.28, 2.96). The study types referenced in obstetric and gynecologic bulletins were similar (P > .05 for comparison of levels I, II, and III and meta-analysis references).

Conclusion : Only 29% of the American College of Obstetricians and Gynecologists recommendations are level A, based on good and consistent scientific evidence.

Chauhan SP et al American College of Obstetricians and Gynecologists practice bulletins: an overview. Am J Obstet Gynecol 2006 Jun;194(6):1564-72; discussion 1072-5.

Editorial comment:

Please note this article is not meant to criticize ACOG's Practice Bulletin process, which is actually quite robust and we all appreciate. Rather, it is a reflection of what level of studies are available in the literature for ACOG to review. When in doubt, remember the Cochrane Library was initially a maternity oriented database and only reviews randomized clinical trials

ACOG

William H. J. Haffner American Indian/Alaska Native Women's Health Award

The ACOG Committee on American Indian Affairs would like to establish the William H. J. Haffner American Indian/Alaska Native Women's Health Award. This award recognizes an individual who has made a major contribution to raising the level of health and/or improving AI/AN women's health care.

Background:

In the Committee's role of visiting IHS Areas and providing on-site reviews it has a first hand look at the many dedicated clinicians working in the field of the IHS. These are men and women who have found innovative ways to provide excellent maternal and child health care with exceedingly limited resources and often in isolated and remote areas. They continue to show incredible fortitude and hope in trying circumstances. The committee felt that it should be commending these heroic efforts and shining a light on the many ways in which the IHS is succeeding.

The Committee wanted to name the award after someone who has been the living example of what the award stands for. The committee felt that Dr. William Haffner epitomizes this dedication and exceptional service to AI/AN women's health care. Dr. Haffner had a long career within the IHS and also has been involved with the ACOG Indian Health programs from the beginning. In many cases, he has been the link between ACOG and the IHS is the establishing of long history of cooperative efforts to improve the health and welfare of AI/AN woman. While Dr. Haffner enjoys recognition and service within the College through his years of service on many committees, he also brings recognition and legitimacy to the role that ACOG has played within the IHS. He is someone who has and does move between both worlds with ease. He therefore brings a certain prestige to the award for the IHS as well. The committee foresees the honoree being recognized at ACOG's ACM and also being recognized at the IHS's Annual National Combined Councils awards banquet. This increases the awareness of the role ACOG continues to play in increasing access and quality of health care to AI/AN women with the IHS and Tribes.

Criteria:

- A clinician who has been outstanding in AI/AN women's health care.
- The clinician could be but does not have to be an ob/gyn. Any health care professional such as family physicians, certified nurse midwives, nurse practitioners, registered nurses etc. could be eligible for the award.
- Awardees must demonstrate a commitment and dedication to providing exceptional health care to AI/AN women.
- They must be currently working within an IHS or Tribal position or recently retired.

Contact: Yvonne Malloy YMalloy@acog.org

Nurses Corner—Sandra Haldane, HQE

Are you aware of a school curriculum dealing with STI/HIV prevention activities?

#1—From Christine Benally, SHC, Coordinated School Health Education, Ft. Defiance Service Unit

There is a Curriculum developed out of the University of New Mexico specifically for Native Americans. **The Circle of Life: Native American HIV Prevention Curriculum**.

- University of New Mexico
- Center for Health Promotion and Disease Prevention
  MSC 11 6145
  Albuquerque, NM 87131
- For more information about the Center's activities, projects, community outreach or employment, please contact Leslie Trickey at 505-272-4462, or email her at LETrickey@salud.unm.edu

http://hsc.unm.edu/chpdp/projects/croflife.htm

#2—From Mary Wachacha, Lead Consultant IHS Health Education

Here is information on the **Be Proud, Be Responsible** curriculum. I am still waiting to hear where the electronic version of the Native American specific **Circle of Life HIV/AIDS** curriculum is physically located. **Be Proud, Be Responsible** can be ordered from Select Media at the website below

ETR has a great website of evidence-based programs. For each program they include:

- Overview of the Curriculum
- Unique Features of the Curriculum
- Theoretical Framework
- Costs and Training Information
- Evaluation Fact Sheet

www.selectmedia.org/curriculum.asp?curid=4

The Association of Nurses in AIDS Care—www.anacnet.org

This nursing organization offers many services including educational offerings that you may be interested in taking advantage of.

STD Corner

Lori de Ravello

National IHS STD Program Focus on adolescent sexual behavior this month

Boyfriends, Girlfriends and Teenagers' Risk of Sexual Involvement

CONCLUSIONS: To reduce the risk of adolescent sexual activity, parents and communities should encourage youth in middle school, especially females who experience early menarche, to delay serious romantic relationships.

Marin BV et al Perspectives on Sexual and Reproductive Health Volume 38, Number 2, June 2006 pages 76-83

Four other related articles available online.

Osteoporosis

Osteoporosis Guidelines Updated: North American Menopause Society

Specific recommendations for evaluation focus on assessment of risk factors for bone mineral density–defined osteoporosis and osteoporotic fracture are as follows:

- Lifestyle practices should be reviewed regularly, and those that reduce the risk for bone loss and osteoporotic fractures should be encouraged in all women. These include maintaining a healthy weight, eating a balanced diet, obtaining adequate calcium and vitamin D, participating in appropriate exercise, avoiding excessive alcohol consumption, not smoking, and using measures to prevent falls. Periodic reviews of calcium and vitamin D intake and lifestyle behaviors are useful in all adult women.
- A woman's risk for falls should be evaluated at least annually after menopause.
- The physical examination should include an annual measurement of height and weight, as well as an assessment for kyphosis and back pain.
- Bone mineral density testing is indicated for all postmenopausal women with medical causes of bone loss and for all postmenopausal women aged 65 years and older. The preferred technique is dual energy x-ray absorptiometry (DXA). The total hip, femoral neck, and posterior-anterior lumbar spine should be measured, using the lowest of the 3 bone mineral density scores.
- Bone mineral density testing should be considered for healthy postmenopausal women younger than age 65 years with at least one of the following risk factors: previous fracture (other than skull, facial bone, ankle, finger, and toe) after menopause; thinness (body weight < 127 lb [57.7 kg] or body mass index < 21 kg/m2); history of hip fracture in a parent; or current smoking.
- Routine use of biochemical markers of bone turnover is not generally recommended in clinical practice.
- If osteoporosis is diagnosed clinically or by bone mineral density, any secondary causes should be identified. However, there are limited data to define the most thorough or cost-effective workup.
- Vertebral fracture must be confirmed, either by a vertebral fracture assessment with DXA measurement of the spine or height loss greater than 20% (or 4 mm) of a vertebra on spinal radiograph.

Specific recommendations for treatment are as follows:

- The need for prescription osteoporosis therapy is determined based on a combination of bone mineral density and risk factors. Drug treatment of osteoporosis is recommended for all postmenopausal women who have had an osteoporotic vertebral fracture; who have bone mineral density values consistent with osteoporosis (ie, T-score worse than or equal to -2.5); who have a T-score from -2.0 to -2.5 plus at least one of the following risk factors for fracture: thinness, history of fragility fracture (other than skull, facial bone, ankle, finger, and toe) since menopause, and history of hip fracture in a parent.
- Treatment recommendations should be based on both efficacy data and clinical parameters. These include magnitude of fracture risk, adverse effect profile, tolerability of specific drugs, extraskeletal risks and potential benefits, confounding diseases, cost, and patient preference, including choice of dosing. Because head-to-head trials comparing the effectiveness of pharmacologic therapies to reduce fracture risk have not been conducted, selection of one therapy over another cannot be on the basis of clinical evidence.
- Bisphosphonates are the first-line drugs for treating postmenopausal women with osteoporosis. Alendronate and risedronate reduce the risk for both vertebral and nonvertebral fractures, but whether there are differences in fracture protection among the bisphosphonates is uncertain. It is probable that all bisphosphonates produce greater relative and absolute fracture risk reductions in women with more severe osteoporosis.
- The selective estrogen-receptor modulator raloxifene should be considered most often in postmenopausal women with low bone mass or in younger postmenopausal women with osteoporosis who are at greater risk for spine fracture than hip fracture. Although raloxifene prevents

(continued on page 14)

Navajo News

Kathleen Harner, Tuba City

Methamphetamine abuse among women on Navajo: Part IV

The "Drop-in" gravida

A 24yo G3A2 presents to labor and delivery at 34 weeks gestation having received no prenatal care. She is contracting every 5 – 6 minutes and is complaining of excruciating pain. She is very dramatic. She denies health problems or surgeries; she has had one elective and one spontaneous abortion. She denies drug or alcohol use and does not use any medications regularly. Her fetal monitoring strip is reactive and without decelerations. You order routine prenatal labs and a urine toxicology screen and it is positive for methamphetamine. Her fetal fibronectin test is negative, ultrasound confirms her dating, and her contractions stop with hydration. Now what are you to do with her?

This is the "drop-in" gravida, positive for methamphetamine and having had no prenatal care. You are far more likely to see a gravida positive for meth in labor and delivery than in your prenatal care clinic. She comes in, not because she is concerned about her pregnancy but because she is in excruciating pain. Meth abusers do not perceive pain, joy or sadness the same way non abusers do. At TCRHCC this patient would be immediately identified as being at risk for drug or alcohol abuse and she would be informed that a urine toxicology screen would be performed.

Our clinical guideline on drug screening in labor and delivery includes the following conditions:

- Positive Substance Abuse Questionnaire
- No Prenatal Care
- Late Prenatal Care
- Scant Prenatal Care
- Multiple DNKA's (missed appointments)
- Abruptio Placenta
- Intrauterine Fetal Demise
- Prior History of Substance Abuse
- Preterm Labor
- Intrauterine Growth Restriction
- Unexplained Congenital Abnormalities
- Current Sign and Symptoms of acute intoxication
- Domestic Violence

Patients should be informed that screening will be performed based on clinical guidelines. Written consent is not required. Providers should strive to protect the integrity of the provider-patient relationship treating patients with dignity and respect. Providers should communicate honestly and directly about what information can and cannot be protected. Positive screens are reported to child protective services and the staff pediatricians are notified.

The patients are offered counseling services prior to discharge from the hospital. If the patient is undelivered at discharge she is offered the same combination of regular drug screening, continuity of prenatal care, and mental health counseling that drug dependant mothers identified in the clinic setting are offered. If the patient is delivered and either she or the baby will have a positive urine drug screen, child protective services are notified and they determine the appropriate disposition of the infant. The mother is still offered counseling services and close follow-up.

Unfortunately, we often don't see these moms until late in their prenatal course, as with the gravida in the example. Ideally, these patients should receive extra support from their prenatal care providers but this is impossible when they are not identified until late in pregnancy. But, however and whenever they are identified, they must be offered comfort, hope and support.

References: Online

OB/GYN CCC Editorial comment:

I want to offer special thanks to Kathleen Harner, MD, from Tuba City for this very helpful 4 part series on Methamphetamine abuse among women on Navajo. The previous 3 editions can be found in the CCCC dating from April 2006.

In addition, the Primary Care Discussion Forum had a particularly helpful discussion on the topic of Methamphetamine Abuse in Indian Country moderated by Steve Holve, MD, also from Tuba City. Please find that captured discussion, as well as many other resources at this site. **http://www.ihs.gov/MedicalPrograms/MCH/F/PCdiscForumMod.cfm#meth**

Alaska State Diabetes Program

Barbara Stillwater

Diabetes Is The Clinical Equivalent of Aging 15 Years

INTERPRETATION: Diabetes confers an equivalent risk to aging 15 years. However, in general, younger people with diabetes (age 40 or younger) do not seem to be at high risk of CVD. Age should be taken into account in targeting of risk reduction in people with diabetes.

Booth GL et al Relation between age and cardiovascular disease in men and women with diabetes compared with non-diabetic people: a population-based retrospective cohort study. Lancet 2006; 368:29-36.

(Medical Mystery Tour, continued from page 10)

percent of patients who underwent repair of dehiscence. More than one-half of hernias appear within six months of the original operation, approximately three-quarters are present by two years, and 97 percent are present by five years.

Wound disruption results from increased intraabdominal pressure or abdominal wall muscle tension overcoming suture strength, knot security, and tissue strength or holding power. Factors that enable mature collagen to stretch and allow incisional hernia after apparently adequate healing remain obscure. Often no obvious cause or precipitating factors are identified.

Problems with slow or delayed healing are rare in young and healthy patients, while a number of factors contribute to the problem of fascial failure in other patients:

UNDERLYING CONDITIONS: Risk factors for fascial disruption are numerous, but excessive coughing is listed along with poor nutrition, advanced age, pulmonary disease, obesity, and several others.

CLINICAL MANIFESTATIONS AND DIAGNOSIS: Signs and symptoms of a complete dehiscence include profuse serosanguinous drainage, often preceded by a popping sensation and an incisional bulge exacerbated by Valsalva maneuvers. The absence of a healing ridge in a laparotomy incision by postoperative day 5 can be a sign of impaired healing and impending disruption. In one series, none of 17 patients with dehiscence had a palpable ridge prior to rupture whereas 1,240 of 1,249 patients without dehiscence had a palpable ridge.

Most dehiscences occur 4 to 14 days after surgery, with a mean of 8 days. The diagnosis can be made based upon clinical grounds in the majority of cases. Imaging studies, such as ultrasonography, magnetic resonance imaging, or computed tomography, have been used when the diagnosis was unclear.

OB/GYN CCC Editorial

Appropriate wound reclosure will improve the care of our AI/AN patients

While the above wound dehiscence is a relatively uncommon event, superficial wound disruption is much more common. The American Board of Obstetricians and Gynecologists Annual Board Certification materials recently referenced a systematic reviewed on the reclosure of the disrupted laparotomy wound by Wechter et al 2005.

The review found that reclosure of disrupted laparotomy wounds was successful in over 80% of patients. Failed reclosure resulted in no life-threatening complications. Reclosure of disrupted laparotomy wounds is safe and decreases healing times. Compared with healing by secondary intention, reclosure resulted in faster healing times (16–23 days versus 61–72 days), and in the one study that evaluated it, 6.4 fewer office visits. The optimal timing and technique for reclosure and the utility of antibiotics were inconclusive.

Wechter ME, et al Reclosure of the disrupted laparotomy wound: a systematic review. Obstet Gynecol. 2005 Aug;106(2):376-83.

(Osteoporosis, continued from page 12)

bone loss and reduces the risk for vertebral fractures, its effectiveness in reducing other fractures is uncertain. When considering raloxifene therapy, extraskeletal risks and benefits are important.

- Teriparatide (parathyroid hormone 1 - 34) should be reserved for treating women at high fracture risk, including those with very low bone mineral density (T-score worse than -3.0) with a previous vertebral fracture. Parathyroid hormone improves bone mineral density and reduces the risk for new vertebral and nonvertebral fractures, but dosage requirements of daily subcutaneous injections may limit use.
- The primary indication for systemic ET/EPT is to treat moderate to severe menopause symptoms, such as vasomotor symptoms. When these symptoms abate, continued hormone therapy can still be considered for bone effects, weighing its benefits and risks against those of other treatment options.
- Calcitonin is not a first-line drug for postmenopausal osteoporosis treatment because its fracture efficacy is not strong and its bone mineral density effects are less than those of other agents. However, it can be considered in women with osteoporosis who are more than 5 years beyond menopause. Although calcitonin may reduce vertebral fracture risk in women with osteoporosis, the evidence documenting fracture protection is not strong. Calcitonin is not recommended for treating bone pain other than that resulting from acute vertebral compression fractures.
- At present, available data do not allow making definitive recommendations concerning combination or serial antiresorptive and anabolic drug therapy.
- Treatment goals and the choice of medication should be reevaluated on an ongoing basis through periodic medical examination and follow-up bone mineral density testing during therapy. Measuring bone mineral density has limited use in predicting the effectiveness of antiresorptive therapies for reducing fracture risk; an appropriate interval for repeat bone mineral density testing is 2 years. Adherence to the treatment plan should be encouraged, in part by providing clear information to women regarding their risk for fracture and the purpose of osteoporosis therapy.
- Drug-related adverse effects may require switching to another agent.
- In most women, treatment of osteoporosis needs to be long term.

North American Menopause Society. Management of osteoporosis in postmenopausal women: 2006 position statement of The North American Menopause Society. Menopause. 2006 May-Jun;13(3):340-67

(Point/Counterpoint, continued from page 1)

OB/GYN CCC Editorial

This is another in our series of Point/Counterpoint topics that allows our readers to fully explore various sides of complex issues. I want to thank James Bresette, HQE, for helping facilitate this Point/Counterpoint.

The June 2006 CCC Corner noted increasingly numerous instances have been reported in the United States media of pharmacists refusing to fill prescriptions written for emergency postcoital contraceptives. These pharmacists have asserted a "professional right of conscience" not to participate in what they interpret as an immoral act.

Above, the PHS Chief Pharmacist Officer in a simple, yet elegantly worded response makes it clear that policies and procedures need to be in place for when the pharmacist or prescriber is on vacation or unavailable so that the patients can receive medications without delay.

The PHS Chief Pharmacist Officer's comments are especially important because some of our AI/AN patients may be a thousand miles by airplane away from the nearest alternative pharmacy provider.

The American Pharmacists Association (APhA), the national professional society of pharmacists, has actually been a strong advocate for women. The APhA has been active in facilitating pharmacists to prescribe emergency contraception directly to women in need in a number of states. Please see the APhA Special Report below.

It may not only be the individual provider or pharmacist's approach that creates barriers to our patients. In some cases there can be systematic issues that can also lead to impaired access. Another article posted in the CCC Corner on this topic was co-authored by 2 former Indian Health staff who are now on the faculty of the University of New Mexico. Espey et al reported that Plan B and Preven were not in stock at the majority of pharmacies in a moderately sized metropolitan area. Lack of availability at the pharmacy constitutes a major barrier to emergency contraception access.

Lastly, it is my experience that pharmacists tend to be much more organized than most providers, hence are much more likely to have an effective policy or procedure for something like this. I think an individual patient is much more likely to have her choices limited by a provider. The Indian Health Primary Care Discussion Forum referenced below provides a variety of views on this topic. If a provider does not feel she/he can offer the full range of services to a patient, then they should make similar arrangements to those described by our pharmacy colleagues. Just like our pharmacy colleagues, we should honor that provider's opinion while we continue to provide the highest level of care to our patients.

I encourage continued dialogue on this and other topics. I find we can learn best if we can truly listen to those we think we disagree the most. Please consider the 'walk a mile in my shoes' concept before you begin to you make any final decision. Once we completely understand all the variables, then we can better serve our patients.

References: Online

(IHS Child Health Notes, continued from page 3)

Clinical Consultant in Pediatrics for the Indian Health Service from 1996 to 2002…Dr Green remains widely recognized by his peers as one of the nation's leading experts and advocates for Native American child health." The award will be presented during the 2006 AAP National Conference and Exhibition on October 8, 2007 in Atlanta, GA.

Please join us in extending our congratulations to Dr Green!

International Meeting on Indigenous Child Health: Call for Presentations

Join the American Academy of Pediatrics and the Canadian Paediatric Society, in cooperation with the Indian Health Service and the First Nations and Inuit Health Branch, Health Canada, for the International Meeting on Indigenous Child Health, which will be held on **April 20-22, 2007 in Montreal, Quebec**. This will be an opportunity for child health providers and researchers dedicated to working with American Indian, Alaska Native, First Nations, Inuit, and Métis children and families to join together and share their experiences and successes in providing health care to indigenous children and their families.

The theme of this conference is "Solutions, Not Problems", and the goal will be to have much of the conference's educational program focused on model programs, research in indigenous communities, and skills-building. A Call for Presentations has been released, and is designed to discover the innovative programs that have been implemented and found to be successful at improving the health of indigenous children in the US or Canada. Proposal submissions will be accepted from any individual working with indigenous children and youth, and is not limited to medical providers. The Call for Presentations can be found at: www.aap.org/nach/2InternationalMeeting.htm

Please note that IHS employees will need to obtain a federal passport in order to receive reimbursement for attending the International Meeting due to the Canadian location. For more information on passport requirements and for updated conference information, visit www.aap.org/nach.

SAVE THE DATES

IHS/ACOG Obstetric, Neonatal, and Gynecologic Care Course

* September 17–21, 2006
* Denver, CO
* Contact YMalloy@acog.org or call Yvonne Malloy at 202-863-2580
* Neonatal Resuscitation Program available
* Brochure www.ihs.gov/MedicalPrograms/MCH/F/documents/ACOG_06brochR1_1.pdf

International Meeting on Indigenous Child Health

- April 20–22, 2007
- Montreal, Quebec, Canada
- Solutions, not Problems
- Joint meeting of IHS, AAP-CONACH, First Nations and several other stakeholders
- www.aap.org/nach/2InternationalMeeting.htm

2007 Indian Health MCH and Women's Health National Conference

* August 15–17, 2007
* Albuquerque, NM
* For anyone involved in care of women and children
* Internationally recognized speakers
* Save the dates. Details to follow

Abstract of the month

- Point/Counterpoint: Refusals by pharmacists to dispense emergency contraception

IHS Child Health Notes

- Antipyretic treatment in young children with fever: acetaminophen, ibuprofen, or both alternating in a randomized, double-blind study.
- Infectious Disease Updates—HPV vaccine Licensed!
- American Indian adolescents in substance abuse treatment: Diagnostic status.
- 2006 Native American Child Health Advocacy Award Recipient Announced!

From Your Colleagues

- Judy Thierry, HQE—Health Consequences of Involuntary Exposure to Tobacco Smoke
- Mark Traeger, Whiteriver—How to address health disparities? One story of success

Hot Topics

- Obstetrics—The return of the vaginal breech delivery
- Gynecology—CDC's Advisory Committee Recommends Human Papillomavirus Virus Vaccination
- Child Health—Boyfriends, girlfriends, and Adolescents' risk of sexual involvement
- Elder Care News—When in doubt, Involve a geriatrician in your elderly female patient's care

Features

- Breastfeeding—Pain is one of the reasons that moms quit breastfeeding
- Information Technology—Hospital Computer Keyboards Should Be Disinfected Daily
- International Health Update—Where There is No Doctor & A Book for Midwives
- Midwives Corner—Nuchal cords, somersaults, and the value of a pulsing cord: Nuchal Cord Management
- Medical Mystery Tour—Copious post-op mucous secretions: The rest of the story
- Perinatology Picks—Only 29% of ACOG recommendations are level A
- Osteoporosis—Guidelines Updated: North American Menopause Society
- Navajo News—Methamphetamine abuse among women on Navajo: Part IV
- Alaska State Diabetes Program—Diabetes Is The Clinical Equivalent of Aging 15 Years

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