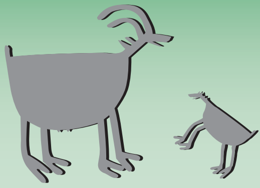
National Council of Chief Clinical Consultants



CCC Corner

Focus on the Health of American Indians and Alaska Natives

Vol 5, No 03
Mar 2007

Healing words:

The power of I'm sorry in medical practice

In 'Healing Words: The Power of Apology in Medicine', Dr Michael Woods addresses the intent of apology and disclosure programs. Dr. Woods later stated "I believe, and I'm speaking from a very physician-centric viewpoint, that we should be doing this because it's the right thing to do, not because it's going to lower our liability."

Patients are passive observers of behavior in the environment of care—in the clinics and the hospitals," he said. If an atmosphere of respect and apology is fostered, even for seemingly inconsequential matters, it becomes clear the provider really does care.

"Apology and disclosure are of equal importance, but they accomplish something very different. Both have to happen in the aftermath of an unanticipated outcome." Dr Woods cites a reference from an Archives of Internal Medicine article that said, "Data indicate that the likelihood of a lawsuit falls by 50% when an apology is offered and the details of the medical error are disclosed immediately."

The point is, apology isn't about causality," Dr Woods said. "Apology is about empathy, and understanding what the patient is going through and feeling badly for that. It's not about, 'Gee, I'm sorry I caused this.'"

"The apology itself, which I consider to be the front-end piece of maintaining the relationship and open communication, does not require any sort of admission of guilt," he said. "Even if there's a direct causal relationship on the part of the physician."

"Nobody needs to sue me to make me feel bad about a bad outcome. Every physician, or provider at least, understands that."

"The data," Dr Woods said, "seems to be suggesting that it's actually far greater than [50%]. ... [The insurance] program called the three Rs [regret, responsibility, and remedy,] has shown dramatic reductions in claims being filed in the group of people where they've had this process utilized. The number of patients who go through that process [of the three Rs] who actually end up filing claims is just a handful. It was essentially nothing, compared to the standard approach to this problem." Dr Woods has expanded the three Rs to five—the original regret, responsibility and remedy, plus recognition (of when an apology is needed) and remain (engaged, meaning don't just issue a quick apology and then disappear).

I've become convinced, even more than I was, that the major driver of medical malpractice [lawsuits] is not a litigious society, it is not physician ineptitude, it's anger," he said. "It's patient anger at not being provided with the information that they feel they need, and/or a sense that the physician is not respectful of them."

"Healing Words: The Power of Apology in Medicine, Second Edition," is published by Joint Commission Resources (JCR), an affiliate of Joint Commission on Accreditation of Healthcare Organizations. To order, call JCR customer service toll-free at 877-223- 6866, or www.jcrinc.com

OB/GYN CCC Editorial

Full disclosure and compassion are important Indian Health tenets

Our department has supported full disclosure with our patients for years. Not only is it respectful, on a very basic human level, but it is also the ethical approach. It may also be the most important conversation you will ever have with that patient, or their family. It will certainly be the one conversation you'll remem-

(continued on page 15)

THIS MONTH

Abstract of the Month . 1,15
Child Health Notes . 2–3,15
From Your Colleagues . . 4
Hot Topics 5–8
Features 9–14

Having trouble with sleep?

Do your elderly patients have trouble with sleep? One common recommendation is antihistamines, e. g., diphenhydramine. These drugs have 10 hour half-lives and may result in decreased alertness, daytime sedation, and prolonged reaction times on the day following use. Dizziness, dryness of the mouth, constipation, and blurring of vision may occur. Antihistamines make people feel sleepy, but do not improve sleep or insomnia. Antihistamines also negatively affect mentation in the elderly. A better approach might be environmental manipulation followed by Trazodone 25 mg, rather than all those new drugs on TV.

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

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

Quote of the month

""The most effective way to remember your wife's birthday is to forget it—once."
Anonymous

Editorial Comment

The essay below by Dr. Ratmeyer grew out of conversation at a Navajo Area Pediatric meeting this past fall. Dr. Ratmeyer makes an important plea for empathy and dialogue, not just criticism. This collaborative approach will allow health professionals to develop a successful working relationship with tribal employees that will benefit American Indian and Alaska Native children.

Understanding the Child Protection Role of Child Health Care Practitioners in Indian Country

Recently, pediatricians working on the Navajo Nation asked me to share my thoughts about our role in child protection. Although much of what I'll say comes out of my 15 years of experience at the Gallup Indian Medical Center, I suspect that many of my observations are applicable to doctors and other medical practitioners working elsewhere with Native American populations.

I have to start out by saying that I feel the pain of everyone tasked to interact with our social work and law enforcement agencies in Indian Country. We need to first acknowledge the reality of the professional environment in which we work. Although there are many examples of professional competence mixed with caring individuals doing the work of child protection, we tend to see agencies whose work product is the result of under funding, under training, and understaffing.

We have folks who have no training other than 'on-the-job', courtesy of the previous child protective service (CPS) worker or police officer. There are often minimal job requirements for these positions. Most tribal social work (SW) positions don't require a degree in social work. Many Family Court judges also may have little experience with the Navajo Nation's Children's Code, which is supposed to guide Family Court decision-making. We, in the medical profession, come from an entirely different world of expectations and experience in which we are not put "on the job" until after at least 7 years of intense training. That being said, we can only do the medical job for which we trained, with a bit of child advocacy to create and support a system that protects children. We cannot be social workers, and we cannot be law enforcement officers, and we cannot be officers of the court, either prosecutors or judges.

Our temptation is always to step out of our own discipline to point out the shortcomings of those in other disciplines, because of what we think they should be doing. A better and more effective approach is to come to understand what the folks in these agencies do. We need to learn about their reality, including what allows for such difficulty in responding to child maltreatment.

To do that, we have to stay in dialogue. We dehumanize people when we view them as equivalent to what they do (or, as we see it, what they fail to do). And it shows in how we talk to people. We — often unwittingly — paint ourselves as aloof, self-righteous, intolerant, and unapproachable when we go on our tirades of lambasting CPS staff for what we perceive as poor performance. It's a sure way to burn bridges. People will avoid us, refuse to speak with us, and work around us and at cross purposes to what we want to and need to do in these cases. We need to cooperate. We do that by talking, not just about work, but by getting to know one another by name and developing healthy personal relationships. They need to get to know us for who we are, as well as for what we do.

The only way to do that is by establishing a routine of regular meetings, always at the same time/day, in the same place, month after month, year after year. It requires that we commit to the process, as well as the entity, of the multi-disciplinary team. People need to understand we approach these situations from the perspective of 'diagnosis and treatment', just as we need to understand that they do so with a set of expectations imposed by the law and the courts. With have to be very objective in approaching this work within our own discipline, but we have to be more subjective about how people in other disciplines approach this work. We have to be aware of their shortcomings and the environment that allows those problems, while resisting the temptation to destructively criticize everything they do. Lastly, we need to do our job with a standard of excellence that makes us shine. People will look at us and say, there goes a real professional! He knows so much and understands so much. He's so good at sharing that knowledge with us. He's so good at listening to our concerns. He has such good suggestions about how to approach this problem. And he really cares about kids. If the CPS people can say things like this about us, then our stature grows. They trust us. They call us to ask about how to approach a particular problem, to discuss the urgency of an exam, to gain understanding about a chronic health condition of one of the kids in custody. That's collaboration and that's what we want.

This takes patience, self-insight, consistency, and commitment! This is what has worked for me over the years. But, I love

the work and I love the process. And I appreciate the people in CPS who struggle against great odds to deliver a 'good product'. Most of all, I want to protect kids. If we all truly want that, we'll realize that making incremental change over a long period of time is far more reasonable than tilting at windmills, while alienating entire agencies, to effectively lock us out of any influence over decision-making in the ultimate dispositions of these families embroiled in violence, abuse, and neglect. Building relationships between professionals and establishing continuity and consistency in our child protection processes may prove the most effective way to advocate for all our Native children and their families. And that may just bring us all some peace of mind.

John Ratmeyer, M.D., FAAP
Gallup Indian Medical Center
e-mail: **john.ratmeyer@ihs.gov**

Infectious Disease Updates.

Rosalyn Singleton, MD, MPH

Human Papilloma Virus (HPV) Vaccine Rollout Issues: Cost and Availability

Quadrivalent HPV vaccine (Gardisil®), which prevents two HPV serotypes associated with 70% of cervical cancer and two types of HPV serotypes associated with 90% of genital warts, promises to be an important tool in our prevention armamentarium. The vaccine is a 3 dose series and is licensed for 9–26 year old females. ACIP recommends routine vaccination of 11–12 year old females with catch-up vaccination for 13–26 year olds. This vaccine is available through the Vaccines For Children program (VFC), and some states have already started offering it to all VFC eligible (which includes American Indian and Alaska Native) females 9–18 years.

However, the cost of the vaccine (per dose costs are $120 private market, $96 federal contract) has put stress on the ability of states with universal vaccine programs like Washington, Alaska and New Mexico to provide HPV vaccine universally. Universal states combine VFC funding with other state and federal funding to provide free vaccines for all children <18 years old. As these states gear up to provide HPV vaccine, some may initially restrict HPV vaccine to a limited age group (e.g. 11-12 year old VFC-eligible), but eventually the vaccine should be available to all VFC-eligible females 9–18 years

There is a variation in the rollout of HPV vaccine in Indian Health Service and tribal facilities depending on the availability of the vaccine through state VFC programs. Because the vaccine is not yet available in some states, at least one tribal facility has purchased HPV vaccine and is seeking Medicaid and private insurance reimbursement. If you have concerns about how HPV vaccine will be rolled out in your state, please contact Amy Groom (Amy.Groom@ihs.gov).

HPV forecasting will be incorporated into the next version of the RPMS immunization package and will probably include options for forecasting for either 11-12 year old or 11-26 year old females.

Recent literature on American Indian/ Alaskan Native Health

Doug Esposito, MD

Early Obits Media Among Minnesota American Indians: The Little Ears Study. IS J Public Health? 2006 Dec 28; [E Pub ahead of print]

Summary

This study was designed to investigate the epidemiology of and risk factors for the development of early onset otitis media (OM) in a group of mostly Ojibwe infants living in a rural reservation or urban setting in Minnesota. Pregnant women 16 years and older were recruited into the study between June 1998 and April 2001. To be eligible, either the mother or the father had to self-identify as Native American.

Data was gathered through interviews conducted during the prenatal period and at 2 weeks and 6 months postpartum. Ears were examined by trained research nurses and tympanograms completed in enrolled infants at 2 weeks and 2, 4, and 6 months of age. In addition, hearing screenings were performed at least 4 times during the study and medical records were reviewed. A series of questionnaires were distributed at various intervals. Rigorous criteria were employed in the diagnosis of OM combining results from the ear examinations, tympanograms, and hearing screenings obtained during study visits. OM diagnoses were also tallied from clinic visit notes.

The study sample consisted of 408 women. This represented a participation rate of only 20%, a potential source of significant study error. Sufficient data for inclusion in the analysis was collected on a lesser number of participants.

Of the total universe of eligible study participants, 344 infants completed ear examinations in the first 6 months of life. Of those, 63% or nearly two thirds of the infants had at least 1 episode of OM and 34% had 2 or more episodes. OM occurred before 2 months of age in 25%, between 2 and 4 months of age in 40%, and between 4 and 6 months of age in 35% of these infants. Risk factors significantly associated with the development of early onset OM included a preceding URI and a maternal history of childhood OM. Risk factors found to be associated with OM in previous studies such as short breast-feeding duration and tobacco smoke exposure were not replicated here.

Editorial Comment

According to the authors, the incidence of early onset OM in this study exceeds that found in a similarly designed study of a White cohort of infants in Minnesota (63% vs. 48%). This study of mostly Ojibwe infants supports what many IHS pediatricians already know to be true: that Native American children have

(continued on page 15)

From Your Colleagues

Scott Giberson, HQE

Ryan White HIV/AIDS Treatment Modernization Act of 2006

New Language may improve AI/AN opportunities and clarify linkages of care

The Ryan White CARE Act (RWCA) was reauthorized (12/19/2006) as the "Ryan White HIV/AIDS Treatment Modernization Act of 2006 (RWMA)". The language is particularly remarkable for the Indian Health Service (IHS) and AI/AN in that it establishes opportunity for more seamless access to HIV/AIDS care and treatment. Although the intent of previous RWCA language was to assist AI/AN in access and eligibility to treatment and care of HIV/AIDS, this specific and reauthorized language certainly aims and succeeds in augmenting that intent.

The following RWCA provisions in the reauthorization affect the IHS and AI/AN population:

1. AI/AN individuals are/were always eligible for RWCA services if certain requirements were met (as any other person infected/affected by HIV/AIDS would need to meet various requirements – dependent upon the State of residence).
2. IHS federally operated Health Facilities will now be eligible to apply for services under Title III and IV through the RWMA (in addition to previously authorized Urban Programs and 638 Tribal Facilities under RWCA):
3. IHS facilities are exempt from the "Payer of Last Resort" restriction for Titles I, II and III. Although RWCA grantees are the payer of last resort, this amendment exempts I/T/U facilities from reimbursement, regardless of referral. In the past, RWCA grantees were asked to coordinate reimbursement of such funds with the tribes and with the IHS.
4. The new legislature supports access for all AI/AN under RWMA regardless of I/T/U utilization/affiliation or geographic location. (Previously, HRSA Policy 00-01 stated that AI/AN could not be turned away from RWCA services, but still held RWCA grantees as Payers of Last Resort. So, if patients were referred from IHS, RWCA grantees could technically go back to IHS for funding (whether or not this actually happened). Now, the RWMA codifies (that IHS is exempt from the Payer of Last Resort restriction) this language into law.
5. Planning council representation should include members from federally recognized Indian tribes as represented in the population.
6. Language surrounding AIDS Education and Training Centers (AETCs) now specifically names "Native Americans" as person(s) to be trained.

Editorial Comment: IHS HIV/AIDS Principal Consultant

It is a privilege to note that this revised language is due in large part to the hard work, diligence, and passion of community members and organizations that came from within our AI/AN communities. Some additional explanation may be helpful:

- The changes of eligibility as a grantee for Titles III and IV affect our IHS sites, but did not affect the eligibility that was already offered to Urban and 638 facilities. Here are links to services provided under Title III and IV
- Although I/T/U sites are eligible for Titles III and IV, this does not mean I/T/U sites are automatically grantees; they must go through the application and approval process. I am gathering information as best possible including information about grant application process or timelines.
- Previous RWCA language did not specify Native Americans or AI/AN when referring to AETCs ; however we have been working with the AETC leads at HQ for quite some time (prior to RWMA language) and are continuing this activity by integrating resources and ideas to maximize the benefit within our population.

We are working diligently with leadership from HRSA to discuss ramifications and implementation of this language and to disseminate the message of these changes to help with care of our AI/AN persons at risk and living with HIV/AIDS. Additionally, we hope to focus current and future initiatives and collaborations with HRSA around RWMA opportunities and efficient models and linkages of care between our clients, I/T/U facilities, and Ryan White grantees, service providers, and services. We are in the process of renewing and enhancing a Memorandum of Agreement (MOA) between IHS and HRSA that will speak to any potential opportunities and care that may come with the new RWMA Titles I, II, III, and IV. These 'services' (via RWMA) also include but are not limited to, AETCs, Special Projects of National Significance -SPNS, the AIDS Drug Assistance Program-ADAP, etc.). We will also be working with HRSA to identify and clarify each agency's comparative advantage in collaborating on this language to best assist AI/AN.

Given these provisions, it is imperative that all AI/AN clients and facilities eligible for these provisions are made aware and assisted in removing any barriers to effective and seamless access and care. It may be advisable for each health facility to contact a RWMA grantee in your respective area/state to link this new language to an action plan and discuss potential linkages or improve existing ones. If there are any significant needs or anecdotal evidence (from the field) that illuminates a specific challenge of implementation with RWMA grantees or services, comments are welcome and appreciated. If you would, please assist in passing this information along to appropriate personnel

Reference: Online

Hot Topics

Obstetrics

GDM Guidelines: Major discrepancies to identify GDM and predict pregnancy outcome

CONCLUSIONS: The guidelines of the various professional committees, being based on consensus and expert opinion, show major discrepancies in their ability to identify women with GDM and their capacity to predict adverse pregnancy outcome. Only evidence-based criteria derived from reliable and consistent scientific data will eliminate the confusion caused in clinical practice.

Agarwal MM et al Gestational diabetes: dilemma caused by multiple international diagnostic criteria. Diabet Med. 2005; 22(12):1731-6

OB/GYN CCC Editorial

If the criteria has shown improved outcome, then change to it

Two different classification schemes of GDM based upon results of the three-hour GTT results have been proposed. The Fourth International Workshop-Conference on Gestational Diabetes GTT values cited above are based upon the Carpenter and Coustan modification of earlier value. They are lower than those proposed by the Expert Committee on the Diagnosis and Classification of Diabetes Mellitus and the National Diabetes Data Group (NDDG), which used cutoff values of 105, 190, 165, and 145 mg/dL (5.8, 10.6, 9.2, and 9.1 mmol/L), respectively. The values are lower because the thresholds derived from the older Somogyi-Nelson method of glucose analysis were corrected to account for the enzymatic assays currently in use.

However, Schwartz 1999 have suggested that this classification scheme diagnosed more women with GDM at very little benefit and potentially high cost. In this retrospective review of 8857 pregnant women screened for GDM, 284 (3 percent) met the NDDG criteria while 438 (5 percent) met the Fourth International Workshop criteria. Thus, application of the more stringent Fourth International Workshop criteria to all women with positive screening test results would at best have reduced the prevalence of infants weighing 4000 grams from 17.1 to 16.9 percent, and the prevalence of infants weighing 4500 grams from 3.0 to 2.9 percent. Others have come to similar conclusions. (Ricart 2005)

ACOG considers use of either the Fourth International Workshop or the National Diabetes Data Group criteria acceptable for diagnosis of GDM. The ADA recommends use of the Fourth International Workshop-Conference on Gestational Diabetes criteria.

At this point Naylor et al reported that simply carrying the diagnosis of diabetes in pregnancy has been shown to increase the rate of cesarean delivery with no difference in pre-op clinical characteristics or post-op improvement in outcome. (Naylor 1996) Other factors to consider are the increased fetal monitoring and blood testing associated with a diagnosis of diabetes in pregnancy, e. g., 4 fingersticks / day for 6 months = 672 fingersticks.

Until the HAPO Study is complete the argument above is largely one of conjecture. In the short term due to the increased morbidity just associated with the diagnosis of diabetes in pregnancy should be made as accurately as possible based on clinical outcome. (HAPO 2006) Some would argue that simply identifying a patient for potential glucose intolerance after pregnancy is a benefit from public health standpoint. At this writing there is no evidence of improved outcomes with the large number of extra patients diagnosed by Carpenter and Coustan criteria.

As we use ACOG as our benchmark in Indian Country, either criteria is acceptable. In Indian Country we suggest each center decide on one set of criteria within that facility. At this point there is not clinical benefit to either the mother or infant to the large increase in patients diagnosed with diabetes in pregnancy by Carpenter and Coustan criteria. Hence one would need some other compelling rationale to change from those criteria.

Resources: Online

Benefit of cesarean for macrosomic infants weighing 4,000-4,999 g questioned

CONCLUSIONS: Although cesarean delivery may reduce the risk of death for the heaviest infants (5,000+ g), the relative benefit of this intervention for macrosomic infants weighing 4,000-4,999 g remains debatable. Thus, policies in support of prophylactic cesarean delivery for suspected fetal macrosomia may need to be reevaluated.

Boulet SL, et al Mode of delivery and the survival of macrosomic infants in the United States, 1995-1999. Birth. 2006 Dec;33(4):278-83

Gynecology

Cystocoele Repair: The Mesh Controversy by John Heusinkveld, Shiprock

After more than a century of improvements in pelvic surgery techniques, the cystocoele continues to be one of the most vexing problems for gynecologic surgeons. Recurrence rates for cystocoeles repaired with the traditional fascial plication technique are reported as high as 40%, with approximately half of the patients undergoing additional surgical procedures. Several explanations have been proposed for the high objective failure rate of the fascial plication as a treatment for anterior compartment prolapse. The first is that connective issue that has stretched or torn once is likely to do so again under the same stresses. Proponents of this explanation point to relatively high recurrence rates for other types of hernia when repaired using traditional techniques.

Proponents of an alternative explanation for the high rate of cystocoele recurrence believe that the primary defect responsible for cystocoeles is not a central defect in the fascia supporting the bladder, but a lateral detachment of this "pubocervical fascia" from the pelvic sidewall. Members of this school of thought believe that plicating the fascia centrally may ultimately do more harm than good, by drawing the lateral edges of the fascia further away from their attachments and thereby predisposing the patient to a larger cystocoele in the future.

In the early 1980s, the repair of inguinal and ventral hernias was revolutionized by the introduction of artificial graft materials, which drastically lowered the recurrence rate. To many gynecologic surgeons it seemed logical that the same materials and techniques might be applied to pelvic support surgery; however, early attempts to reinforce cystocoele repairs with materials such as Goretex met with very limited success and very high complication rates, mostly from infection and extrusion of graft material into the vagina. At the same time, improvements in abdominal techniques such as sacrocolpopexy provided good alternatives for patients with recurrent prolapse.

Interest in vaginal mesh techniques was rekindled by the introduction of the mid-urethral sling by Ulmsten and colleagues in the mid-1990s. Using a sling made from monofilament, macroporous prolene mesh, these surgeons were able to achieve excellent results in the treatment of urodynamic stress incontinence associated with urethral hypermobility. Unlike previous artificial materials used in the vagina, the prolene mesh was well tolerated, and problems with infection and extrusion were rare. Inspired by this success, other gynecologists began to attempt to use the same material to reinforce cystocoele repairs. Almost immediately it become apparent that the larger meshes required for cystocoele repair were associated with significant rates of mesh exposure; in contrast to earlier materials, however, the prolene meshes rarely needed to be removed, as the erosions were generally small and relatively easily treated with topical estrogen or minor surgical revisions. What was lacking, however, was consistent evidence of a benefit in the form of a reduction in the rate of cystocoele recurrence. A 2004 review by the Cochrane group found no basis to recommend the use of artificial meshes in the treatment of primary cystocoeles.

To many gynecologists, the lack of a consistent benefit from the use of mesh was confirmation of the theory that the principal problem leading to a cystocoele was lateral detachment rather than a central defect. Impressed by the efficacy and safety of the transobturator route for mid-urthral sling placement, a consortium of French surgeons attempted to develop a similar procedure for cystocoele repair. The resulting technique, often referred to as TVM or Transvaginal Mesh, utilizes a double transobturator tension-free method of mesh fixation, with two straps of mesh on each side passing through the obturator membrane to recreate the lateral attachments of the pubocervical fascia; a larger, central portion of the mesh supports the bladder. Another mesh is sometimes placed posteriorly to support the vaginal vault, with supporting straps passing through the sacrospinous ligaments. The procedure can be performed with or without concurrent hysterectomy, and many surgeons report a lower incidence of erosions if the uterus is left in place.

Several kits based on the TVM technique are currently available in the United States, and early data indicates a low recurrence risk for cystocoeles repaired using these kits. The problem of mesh exposure, however, continues to be significant with most centers reporting erosion

Burt Attico, Phoenix

Consumer Reports has withdrawn its study on infant safety seats

This story appeared in the Feb 2007 issue of the periodical and was noted in the CCC Corner. The CR press release states that a "substantive issue" affecting results was brought to their attention by NHTSA. NHTSA reports that side impact tests conducted by Consumer Reports did not simulate 38.5 mph as stated in the report, but instead simulated speeds in excess of 70 mph. When NHTSA tested the same seats at a simulated 38.5 mph, seats did not detach from their bases. Both Consumer Reports and NHTSA stress that car seats are the safest place for infants in automobiles.

rates between 5 and 10%. A less common, but potentially more serious problem which sometimes leads to mesh removal is dyspareunia, occasionally accompanied by what Dr. Linda Brubaker of Loyola University succinctly terms "his-pareunia."

The need to find a balance between efficacy and potential complications has led to a vigorous debate among pelvic sugeons, who seem to be gathering into distinct pro-mesh and anti-mesh factions. This debate was the lead topic of discussion at the 2006 meetings of both the American Urogynecologic Society and the International Continence Society, with no consensus emerging as of yet. In the abscence of such a concensus, however, there are several situations in which the use of mesh seems reasonable to consider:

Recurrent cystocoele or vault prolapse: Most urogynecologists feel that the gold standard for this condition is abdominal sacrocolpopexy; however, this is a large abdominal operation with significant morbidity, and many of the patients suffering from the condition are older women who may welcome a less invasive option.

Patients considering an obliterative procedure: since these women are, by definition, not expecting to be sexually active in the future, the problem of possible dyspareunia is less of a consideration; the transvaginal mesh technique avoids the psychological problems of vaginal obliteration and also avoids potential complications associated with displacement of the rectum and bladder. In addition, most TVM patients will be able to resume sexual relations should their circumstances change unexpectedly.

Patients desiring uterine conservation: the problem of mesh exposure seems to be closely tied to the size and orientation of the vaginal incisions used to place the mesh. Multiple investigators have reported that erosions are very rare when the uterus is left in place and a small mucosal incision is used to place the mesh. Total procidentia may be corrected via the placement of both anterior and posterior meshes. Some mesh advocates believe that removal of a normal uterus in order to facilitate the correction of pelvic support defects may one day be viewed as archaic.

Other indications for the use of artificial mesh are the subject of controversy and ongoing clinical trials. It should be noted that at least one company has introduced a biological mesh (non-crosslinked porcine dermis) which can be secured by the same tension-free methods developed by the French group in an attempt to reduce the indicidence of erosions and dyspareunia. This material may provide a more attractive option for younger patients who wish to minimize the possibility of dyspareunia. Several trials are also currently in progress to compare the efficacy and total morbidity of the TVM technique with abdominal sacrocolpopexy. Stay tuned.

Reference: Online

OB/GYN CCC Editorial

The Rest of the Story: Find out at the Albuquerque Meeting

I would like to thank John Heusinkveld for this valuable contribution. John will be giving an in depth presentation on this and related topics at the National Indian Women's Health and MCH Conference August 15-17, 2007 in Albuquerque, NM. Please plan on attending

John welcomes correspondence with other IHS providers who are interested in this subject. **John.Heusinkveld@ihs.gov**

Strong evidence for the efficacy of physical therapy for the treatment for SUI in women

Results: Twenty four studies, including 17 RCTs and seven non–RCTs, met the inclusion criteria. The methodological quality of the studies varied but lower quality scores did not necessarily indicate studies from lower levels of evidence. This review found consistent evidence from a number of high quality RCTs that PFMT alone and in combination with adjunctive therapies is effective treatment for women with SUI with rates of 'cure' and 'cure/improvement' up to 73% and 97% respectively. The contribution of adjunctive therapies is unclear and there is limited evidence about treatment outcomes in primary care settings.

Conclusion: There is strong evidence for the efficacy of physical therapy for the treatment for SUI in women but further high quality studies are needed to evaluate the optimal treatment programs and training protocols in subgroups of women and their effectiveness in clinical practice.

Women's Health Headlines

Carolyn Aoyama, HQE

Menstrual Cycle is a Vital Sign

NIH will convene a workshop or conference to facilitate public and professional education about menses in girls and women, keeping in mind the "Menstrual Cycle is a Vital Sign" as what will probably be the theme. The summary of a previous workshop that he helped to organize on this topic with the Society for Menstrual Cycle Research and the New York Academy of Sciences in NYC can be seen at: **http://www.medicalnewstoday.com/medicalnews.php?newsid=13805**

Office of Women's Health, CDC

Indian Health Surveillance Report —Sexually Transmitted Diseases 2004

This report presents statistics and trends for sexually transmitted diseases (STDs) among American Indians and Alaska Natives (AI/AN) in the United States. This inaugural report represents a unique collaboration and partnership between CDC and the Indian Health Service (HIS).

Most of the AI/AN-specific data provided in this report are the result of a new surveillance methodology, whereby existing nationally notifiable STD data reported to CDC were analyzed using standard IHS populations and methods. In 2004, reported rates of chlamydia, gonorrhea, and primary and secondary syphilis among AI/AN were 2 to 6 times higher than comparable rates for whites.

http://www.cdc.gov/std/stats-ihs-2004/toc.htm

Neumann PB, et al Pelvic floor muscle training and adjunctive therapies for the treatment of stress urinary incontinence in women: a systematic review. BMC Womens Health. 2006 Jun 28;6:11.

OB/GYN CCC Editorial

Strongly consider a women's health physical therapist at your facility

Neumann et al confirm the previous data that greater than 70 % of patients improve with pelvic physical therapy. Without proper training, Kegel exercises are most frequently done incorrectly. I suggest that one of your physical therapist get the extra training available in this growing field.

In addition, many insurance companies now require formal physical therapy before considering a patient to be a candidate for surgical reimbursement. There are numerous special courses available for your staff to choose from. For further questions **nmurphy@scf.cc**

Here are two successful pelvic physical therapy stories from Indian Country **http://www.ihs.gov/MedicalPrograms/MCH/W/MatPT.cfm**

Child Health

Review and Comment: Newborn record form IHS-298 and its revision

Diana Hu and pediatricians in the Navajo Area have developed a revised newborn exam form.

We have included the old version (3/04) and the new version (8/06) Please contact Diana directly* The form revision process per the forms chapter guidance is briefly as follows:

- Clinical field review (2 to 4 weeks for sizeable response)
- Trial use of the new form to work the 'bugs' out is also acceptable
- Change title to IHS Newborn Form or
- Route through originating area, etc….

Thanks to Diana for bringing this forward

*Diana Hu, MD
Acting MCH Consultant: NAIHS, Pediatrics
Tuba City Regional Health Care Corporation
diana.hu@tcimc.ihs.gov

Does Swaddling Reduce Excessive Crying in Infants?

Conclusion: For older babies, swaddling did not bring any benefit when added to regularity and stimuli reduction in baby care, although swaddling was a beneficial supplementation in excessively crying infants <8 weeks of age

van Sleuwen BE, et al Comparison of behavior modification with and without swaddling as interventions for excessive crying. J Pediatr. 2006 Oct;149(4):512-7

Chronic disease and Illness

Does Delay in Diagnosis of Breast Cancer Impact Prognosis?

Results: The mean delay was 14.2 months with a range of three to 36 months. The most common reason for delay in diagnosis was failure to biopsy a palpable mass when mammography and or ultrasonography results were negative. Pathology data were available for 39 of the women, and axillary node information was available for 38.

No significant correlations were demonstrated between the delay of diagnosis, the natural log of tumor diameter, or the number of positive axillary nodes. Diagnostic delay also did not correlate with tumor grade or metastatic stage. Six patients died of breast cancer, and death was associated with stage III or stage IV of the disease but not with the length of diagnostic delay.

Conclusion: Despite common fears that a diagnostic delay enables the progression of the disease and signifies lost opportunities for a better outcome, the authors conclude that delays in diagnosis of 36 months or less do not appear to worsen the prognosis of breast cancer or patient survival.

Hardin C et al The relationships among clinician delay of diagnosis of breast cancer and tumor size, nodal status, and stage. Am J Surg. 2006 Oct;192(4):506-8

OB/GYN CCC Editorial

This is still the number one source of malpractice suits: Failure to diagnose

The authors do stress that delays are undesirable and negatively impact patient and provider confidence. They also reference "the triad of error" components of a young woman, a self-detected breast mass, and a normal mammogram, which they describe as the patient most likely to be associated with delay in diagnosis

Features

American College of Obstetricians and Gynecologists

ACOG Opposes Sex Selection for Family Planning Purposes

Abstract: In this Committee Opinion, the American College of Obstetricians and Gynecologists' Committee on Ethics presents various ethical considerations and arguments relevant to both pre-fertilization and post-fertilization techniques for sex selection. The principal medical indication for sex selection is known or suspected risk of sex-linked genetic disorders. Other reasons sex selection is requested are personal, social, or cultural in nature. The Committee on Ethics supports the practice of offering patients procedures for the purpose of preventing serious sex-linked genetic diseases. However, the committee opposes meeting requests for sex selection for personal and family reasons, including family balancing, because of the concern that such requests may ultimately support sexist practices. Because a patient is entitled to obtain personal medical information, including information about the sex of her fetus, it will sometimes be impossible for health care professionals to avoid unwitting participation in sex selection.

Sex Selection. ACOG Committee Opinion No. 360. American College of Obstetricians and Gynecologists. Obstet Gynecol 2007;109:245–8.

Featured Website

David Gahn, IHS MCH
Portal Web Site Content Coordinator

The MCH Coordinators Site has a clean new look, plus new functionality

The MCH Coordinators Site now has a wide open approachable format that streamlines the reader's navigation to get to the important links. To that end, there is now a schematic map of Indian Country so that one can simply click on the area of the country you want to learn more about.

In addition, there is an easy to read MCH Headlines box at the top of the page which gives you access to all the recent headlines generated by Judy Thierry's new MCH Headlines Column in the monthly CCC Corner Newsletter. The combination of these two items increases the user friendly nature of the page, plus makes it timely. http://www.ihs.gov/MedicalPrograms/MCH/F/MCHC01.cfm

What has not changed is the encyclopedic nature of the resources available especially through the National MCH Coordinator's 'More Links of Interest' site. This page serves in many ways as a resource for Child Health links missing after the demise of the Indian Child Health page. Please contact Judith.Thierry@ihs.gov for questions or additions.

Frequently asked questions

Q. How many rubella vaccines does a mother really need to get?
A. If negative, then revaccination with one dose of MMR, and no further serologic testing

Question

What is the current recommendation from CDC for post partum women who are non-immune and who have had 2 previous document MMR's? At my past facility we didn't give any further vaccine but at my new facility, it seems to be a mystery. Can you point me in the right direction? Thanks

Answer

The CDC "Pink Book", in the section on Rubella, p. 165* the CDC briefly addresses the issue of a patient who has a documented vaccination for rubella, but still has a negative serum IgG by ELISA. In this case, they recommend revaccination with one dose of MMR, and do not recommend further serologic testing. It seems that if you don't have an immune response after two doses of MMR, you do not need to administer another dose.

Background

In reality the 'titer' is more like a "+ or -", depending on whether it's >1:10 or <1:10, getting a repeat titer is often unhelpful.... Most women nowadays have been vaccinated in childhood, and the booster we give them in pregnancy should provoke a satisfactory anamnestic response. It's a good question, but more of a hassle issue at present when the disease is so rare! Even women from Mexico and Central America usually get immunized in childhood now, mostly because measles is such a big public health problem as a cause of childhood mortality, but the vaccine currently comes as MMR, so they get covered for all 3.

The Redbook states on page 578 that "routine prenatal screening for rubella immunity should be undertaken. If a women is found to be susceptible than rubella vaccine should be administered in the postpartum period."

However, on page 576 of the Redbook it states "some people in whom antibody has been absent by hemagglutination inhibition testing have been found to be immune when more sensitive testing has been done."

So the practical answer is that his patient is immune for all practical purposes. In theory each vaccine administration is 95% effective so after two vaccines the chance of being truly non-immune is 0.05 X 0.05 = 0.0025 or 2.5/1,000 women with two MMR on record.

For more information, you could send this question to CDC at NIPINFO@cdc.gov, and get access to other resources.

Reference: Online

International Health Update

Claire Wendland, Madison, WI

Sexual behavior in context: A public health perspective

Here's the international health column, sent to you from a very green, very rainy, very mosquito-abundant Malawi. Cheers, Claire

Since the 1980s, and especially since the recognition of sex as an important route of HIV transmission, research into sexual behavior has flourished nearly worldwide. (The Middle East and some parts of Asia represent exceptions where proposed research on sexual behavior is rarely approved or funded, while there is a disproportionate amount of data from Africa.) In a recent Lancet article, Kaye Wellings and international colleagues analyze datasets from 59 countries' surveys on sexual behavior, using research conducted 1996-2006. When possible, they compare this data with reports from the 1970s. Most datasets were part of the standard Demographic and Health Surveys, conducted by trained interview teams in developing countries on a regular basis, so the comparability of data is unusually good. The resulting report busts some myths about sexual behavior while leaving other questions unanswered.

Contrary to popular opinion, there is no overall trend toward earlier intercourse. Though considerable intraregional and some inter-gender variability exists, worldwide first intercourse continues to be typically between ages 15 and 19. Premarital sex has increased; however, it appears that this trend is linked to later marriage in many countries and not to increased early sex. Most people are married (in this report cohabitation was counted as marriage since legal standards of marriage vary substantially). Single people have much less sex than married people, especially in Africa, and marriage is not protective against acquisition of HIV; for women in much of Africa and Asia, it is actually a risk factor. The proportion of people using a condom at most recent sexual encounter was higher for men than women worldwide, and this difference appears to be because women were having sex with their husbands and were unwilling or unable to negotiate safe sex. Overall condom use at last intercourse was low worldwide, particularly in developing countries. It is encouraging to note, however, a substantial increase in condom use in both sexes over the past decade, especially dramatic in much of Africa and among women in the US. Ten to fifty percent of women worldwide report they cannot always say no to sex, and first intercourse in young girls was forced in about a third of cases. Multiple partnerships are more common in industrialized countries, and globally more common among men than women. They were especially common where the distance between work and home was substantial. Nonetheless, monogamy remains the dominant pattern worldwide.

This fascinating report has several serious limitations. Data on use of sex workers was so poor, in part due to vexing variations in the definition of sex work, that it cannot be compared properly. Data on same-sex behavior, similarly, is minimal – entirely absent in some regions – and when it exists at all addresses men only. The authors did not correlate sexual risk with socioeconomic status (though they do refer to other studies that have done so). Probably most seriously, sexual health surveys are of course even more vulnerable than other surveys to reporting bias: respondents may tend to report what they think is acceptable behavior, rather than what they actually do. The authors suggest that male over-reporting and female under-reporting may contribute to the substantial gender differences seen here.

Despite its limitations, however, the report is also useful from a public health perspective. On the positive side, it reassures us that there is no pandemic of adolescent promiscuity to worry about. However, it also shows that self-reported sexual behavior does not seem to correlate well with HIV: with the exception of patterns of condom use, sexual behaviors in high-transmission areas are, if anything, less risky than those in low-transmission areas.

Wellings K et al. Sexual behaviour in context: a global perspective. The Lancet 368:1706-28, November 2006

Navajo News

Jean Howe, Chinle

Clomiphene "bests" Metformin in a NEJM study

This and similar headlines were used to describe the results of a recent multicenter study published in The New England Journal of Medicine. As the treatment of anovulatory infertility is a routine part of our clinical practice, it seemed worthwhile to find out more…

The study, titled "Clomiphene, Metformin, or Both for Infertility in the Polycystic Ovary Syndrome", enrolled women with polycystic ovarian syndrome and infertility. A total of 626 women were enrolled and randomized to one of 3 groups: clomiphene + placebo, metformin + placebo, and clomiphene + metformin. Each woman received the assigned treatment until pregnancy was achieved or for up to 6 cycles or 30 weeks. The live birth rates were as follows: clomiphene 22.5% (47/209), metformin 7.2% (15/208), and clomiphene plus metformin 26.8% (56/209). Although the highest absolute live birth rate was in the group receiving combination therapy, the difference between combination therapy and clomiphene alone was not statistically significant. The study used live births (appropriately) as the primary outcome measure; however the secondary outcome measures are also of interest. The mean number of ovulations per subject was 2.2 in the clomiphene group, 1.4 in the metformin group, and 2.8 in the group receiving combination therapy. The conception rates were 39.5% with clomiphene, 21.7 with metformin, and 46.0 with combination therapy. The multiple gestation rate was 6.0% with clomiphene, 0% with metformin, and 3.1% with combination therapy. Additional material included on-line provided stratification by BMI. Those with a BMI <30 had live birth rates of 36.8% (clomiphene), 8.8% (metformin), and 36.9%

(combination therapy). This decreased to 16.4% (clomiphene), 3.8% (metformin), and 22.9% (combination therapy) for those with a BMI >35. BMI was noted to increase during the course of the study in women treated with clomiphene alone but decreased in those receiving metformin, either alone or in combination with clomiphene. The study population included many women with high BMI and longstanding infertility (40 months on average, with over half having previously received one or both study drugs in the past). Over 10% of the study participants were American Indian or Alaska Native.

Polycystic ovarian syndrome (PCOS) is a common cause of female infertility. PCOS is characterized by the formation of multiple small ovarian cysts, high androgen levels, high LH levels, and insulin resistance. Obesity is a common finding. It has been proposed that correcting the underlying metabolic abnormalities of PCOS may lead to improved fertility. This premise, and success in small trials, has led to the widespread use of metformin for the treatment of PCOS-related infertility. This study is the first large-scale attempt to rigorously examine this approach. It is important because it demonstrates that clomiphene is actually more effective than metformin in treatment of PCOS-related infertility. What is less clear is if there is still a role for metformin use in combination with clomiphene; although the overall live birth rate was higher with combination therapy the difference achieved was not statistically significant. A review of the treatment of anovulatory infertility by Up to Date Online describes a sequential approach to infertility treatment, with weight loss as the first intervention, followed by clomiphene, then a course of metformin if clomiphene is unsuccessful, followed by resumption of clomiphene after 8 – 12 weeks of metformin use. An update to these recommendations is anticipated later this month.

As I review this literature, I am struck by the central role of weight issues in the treatment of anovulatory infertility. Up to Date Online cites several studies about PCOS and weight loss and concludes that, in women with PCOS and a BMI over 27, loss of 5-10 percent of body weight will restore ovulation in over half of women within six months. Women who can achieve this goal benefit from improved fertility without the increased risk of multiple gestation associated with clomiphene use. For those unable to achieve this weight loss or still requiring treatment, the efficacy of treatment remains higher for those with healthier BMIs. Addressing weight issues is challenging for both patients and health care providers. Attention to healthy diet and increased physical activity remain the core interventions in this endeavor. It will be interesting to see if metformin is abandoned completely in the treatment of PCOS-related infertility or if its use will continue, not necessarily as a primary therapy for ovulation induction, but in an effort to combat the metabolic abnormalities and obesity associated with PCOS.

Resources: Online

Medical Mystery Tour

Prolonged second stage with an epidural

A primigravida at 41 3/7 weeks presented after 2 days of outpatient vaginal misoprostol cervical ripening 1 hour after spontaneous rupture of membranes. The patient's past history was significant for polycystic ovarian syndrome. The patient had a 41 lb. weight gain through 8 visits and one abnormal result on a 3 hour glucose tolerance test.

The patient was contracting every 1 – 4 minutes was noted to be 2 cm dilated, and 80% effaced with an estimated fetal weight of "9 + lbs" and reassuring fetal heart tones in cephalic presentation. Initially the patient was managed expectantly, but after 4 hours of no progress, oxytocin augmentation was begun. The patient was beta strep positive and received IV penicillin IV. The patient subsequently received epidural anesthesia.

Stage I lasted 8 hours. At 5-6 cm dilation the patient was noted to have temperature of 100.6 F and started on intravenous gentamicin and ampicillin.

In Stage II the patient was noted to have 'labored down' due a dense epidural status without active pushing for some of Stage II. The patient ultimately regained the sensation to push and the caput descended to +2. As Stage II neared 4 hours the risks and benefits of vacuum assistance were discussed with the patient and it was agreed to proceed. The vacuum extractor was placed during 3 contractions. Subsequently, the fetal presenting part descended to +3/5 with the scalp visible without pushing. The fetal heart tones were reassuring throughout. The patient is noticeably beginning to tire and subjectively seems to be pushing less effectively.

What do you want to do now?

- Allow the patient to push for 30 minutes more and re-evaluate
- Notify the OR team and discuss cesarean delivery
- Wait for the epidural to completely wear off
- Apply the vacuum for a second trial
- Add clindamycin
- Other….

MCH Headlines

Judy Thierry, HQE

Scrub Club

Scrub Club is a KID friendly website and as the name implies it gets kids to wash their hands and think about why this is important. IT is also for health care providers and definitely for teachers who must engage students (K to 5th grade) and those in early childhood settings and their administrators in having a healthy environment, halting spread of disease, URI, influenza – starting with effective hand washing. http://www.scrubclub.org/home.php?fuseaction=main

STD Corner

Lori de Ravello, National IHS STD Program

A First: STD Rates Available by IHS Area

A new STD surveillance report is the first to present STD rates by IHS Area. The report—a collaborative effort between IHS and CDC—uses an innovative methodology, whereby existing nationally notifiable STD data reported to CDC were analyzed using standard IHS populations and methods. The plan is to update this report every two years.

Report Highlights:

- Despite their small numbers, AI/AN are disproportionately affected by STDs
- Chlamydia:
  - Chlamydia remains the most commonly reported STD for all races and ethnicities
  - There are large disparities between IHS and US chlamydia rates: 2.3 times greater for AI/AN than US
  - 3 IHS Areas—Aberdeen, Alaska, and Billings—had chlamydia rates 4.9 to 6 times higher than the US rate
  - Compared to men, chlamydia rates are higher among women and reflect the fact that women are far more likely to be screened
- Gonorrhea:
  - Gonorrhea rates for the overall IHS population are stable and similar to US rates
  - 3 IHS Areas—Aberdeen, Alaska, and Phoenix—were 1.6 to 2.4 times higher than the US rate
  - IHS gonorrhea rates were higher for women than for men
- Primary & Secondary Syphilis (P&S)
  - Both the US and IHS have experienced increases in P&S in the past 4 years, however increases have been greater in AI/AN
  - IHS P&S cases are primarily occurring in 3 Areas in the southwest: Albuquerque, Navajo, and Phoenix
  - IHS P&S cases are evenly distributed between men and women (this is in contrast to US cases, where many more cases are among men than women)

Reference: Online

Nurses Corner

Sandra Haldane, HQE

A “Small Fall” and a Trip to the Emergency Department

“Prepare yourself: this is the beginning of the end — your mother will go through a gradual decline and, most likely, never regain her previous level of function.”

The above sentence, with infinite variations, was repeated many times during the past year as my family attempted to cope with the sudden transition of my mother’s health from that of a 91-year-old, independent, New England woman, living by herself and driving her car in a city where there were no family members living, to a dependent ward of the healthcare system. The transition began one day as I listened to my voice mail and heard the small voice of my mother saying that she had suffered a “small fall” and that the “nice men in the ambulance” had taken her to an unspecified emergency department. I stared at my phone, unable to internalize the message for a moment. I was then flooded with terror as I contemplated what she (and we) would have to endure.

For the rest of this story of elders in the 21st century, go here

The Cycle of Relocation:
One Family’s Experience With Elder Care
www.medscape.com/viewarticle/549625

Breastfeeding

Suzan Murphy, PIMC

ACOG Calls on Ob-Gyns, Health Care Professionals, Hospitals and Employers for Increased Support for Breastfeeding

Washington, DC — In an effort to help increase the rate of breastfeeding in the US, today The American College of Obstetricians and Gynecologists (ACOG) issued a Committee Opinion, "Breastfeeding: Maternal and Infant Aspects," emphasizing ACOG's strong support for breastfeeding and urging ob-gyns, other health care professionals, hospitals, and employers to support women in choosing to breastfeed their infants.

Breastfeeding is the preferred method of feeding for newborns and infants, and nearly every woman can breastfeed her child, according to ACOG. ACOG continues to recommend exclusive breastfeeding of infants until approximately 6 months of age, with longer periods being beneficial. Some exceptions to breastfeeding include women who take illegal drugs, have high alcohol intake, have HIV, have an infant with galactosemia, or have certain other infections.

Research that shows the many health benefits of breastfeeding to infants, women, families, and society continues to accumulate. Education and support for breastfeeding can improve breastfeeding rates for all women and would be a positive economic investment for both health plans and employers because there are lower rates of illness among infants who are breastfed.

Committee Opinion #361, "Breastfeeding: Maternal and Infant Aspects," is published in the February 2007 issue of Obstetrics & Gynecology. More detailed information on breastfeeding can be found in

ACOG Clinical Review (Vol. 12, Issue 1 (supplement), Jan-Feb 2007) "Special Report from ACOG, Breastfeeding: Maternal and Infant Aspects"

Domestic Violence

Health Care-Based Interventions for Women Who Have Experienced Sexual Violence

Thirty publications that evaluated health care-based interventions for women who experienced sexual violence were reviewed. The findings highlight that clinicians often need training in the provision sexual assault care, and that not all emergency departments have sexual assault care protocols. Studies examining effectiveness found that Sexual Assault Nurse Examiner programs are very helpful, that health care-based sexual assault treatment settings attract more women than do forensic-based settings, that sexual assault survivors often prefer a combination of medication and counseling treatment, and that preexam administration of a video explaining the collection of forensic evidence may reduce women's stress during the procedure. Studies on postexposure HIV prophylaxis found that many women did not complete the treatment regimen, often because of side effects. Emergency contraception to prevent postrape pregnancy is not consistently offered to women. Only one study reported on abortion as part of the range of sexual assault services.

Martin, Sandra L., Young, Siobhan K., Billings, Deborah L., Bross, C. Christopher Health Care-Based Interventions for Women Who Have Experienced Sexual Violence: A Review of the Literature. Trauma Violence Abuse, Jan 2007; vol. 8: pp. 3-18

What's New on the MCH Website?

Second methamphetamine issue of the IHS Primary Care Provider now available online!

Note that we received more articles than anticipated so some of them will appear in a third issue to come out later this Spring.

Thanks again for your collaboration and support

—Lori de Ravello

www.ihs.gov/PublicInfo/Publications/HealthProvider/issues/PROV0107.pdf

Family Planning

Abstinence counseling vs family planning: Which is more effective?

Adolescent pregnancy rates in the United States declined by 27% from 1991 to 2000. Our data suggest that declining adolescent pregnancy rates in the United States between 1995 and 2002 were primarily attributable to improved contraception use.

- Rates of sexual activity did not decline significantly among adolescents ages 15-19 or among those ages 18-19; the decline in sexual activity among adolescents ages 15-17 was of borderline significance.
- The contraceptive risk index declined by 34% among adolescents ages 15-19, by 46% among those ages 15-17, and by 27% among those ages 18-19.

* Pregnancy risk declined by 38% among adolescents ages 15-19, by 55% among those ages 15-17, and by 27% among those ages 18-19.

- Fourteen percent of the change in pregnancy risk among adolescents ages 15-19 was attributable to a decrease in the percentage of sexually active young women, while 86% was attributable to changes in contraceptive method use; among adolescents ages 15-17, the corresponding percentages were 23% and 77%, respectively. All of the change in pregnancy risk among adolescents ages 18-19 was the result of increased contraceptive use.

In comparison with our school-based study, this analysis of the NSFG showed a larger contribution of contraceptive use to declines in adolescent pregnancy rates. Our findings raise questions about current US government policies that promote abstinence from sexual activity as the primary strategy to prevent adolescent pregnancy.

Midwives Corner

Lisa Allee, CNM, Chinle

Maternal positioning and pain relief measures and promoting effective pushing technique

Conclusions: The primary findings of our review indicated that most of the studies are flawed and do not answer the important questions for maternity caregivers to safely manage prolonged second stage. Meanwhile, approaches for promoting a normal second stage of labor are available to caregivers, such as maternal positioning and pain relief measures and also promoting effective pushing technique.

Altman MR; Lydon-Rochelle MT Prolonged second stage of labor and risk of adverse maternal and perinatal outcomes: a systematic review. Birth. 2006; 33(4):315-22

Perinatology Corner

Planned cesarean delivery doubles NICU rates and the risk for pulmonary disorders

Results: Compared with planned vaginal deliveries, planned cesarean delivery increased transfer rates to the neonatal intensive care unit from 5.2% to 9.8% ($P < .001$).

Conclusion: A planned cesarean delivery doubled both the rate of transfer to the neonatal intensive care unit and the risk for pulmonary disorders, compared with a planned vaginal delivery.

Kolas T, et al Planned cesarean versus planned vaginal delivery at term: comparison of newborn infant outcomes. Am J Obstet Gynecol. 2006 Dec;195(6):1538-43

Amniotic Fluid Promising Source of Stem Cells

Stem cells capable of differentiating to multiple lineages may be valuable for therapy. We report the isolation of human and rodent amniotic fluid-derived stem (AFS) cells that express embryonic and adult stem cell markers. Undifferentiated AFS cells expand extensively without feeders, double in 36 h and are not tumorigenic. Lines maintained for over 250 population doublings retained long telomeres and a normal karyotype. AFS cells are broadly multipotent. Clonal human lines verified by retroviral marking were induced to differentiate into cell types representing each embryonic germ layer, including cells of adipogenic, osteogenic, myogenic, endothelial, neuronal and hepatic lineages. Examples of differentiated cells derived from human AFS cells and displaying specialized functions include neuronal lineage cells secreting the neurotransmitter L-glutamate or expressing G-protein-gated inwardly rectifying potassium channels, hepatic lineage cells producing urea, and osteogenic lineage cells forming tissue-engineered bone.

De Coppi P, et al Isolation of amniotic stem cell lines with potential for therapy. Nat Biotechnol. 2007 Jan;25(1):100-6

(Healing Words, continued from page 1)

ber for the rest of your career, or whole life for that matter, so please make the most of it. The Indian Health system is exploring a Disclosure policy at this time. In the meantime, just be honest with your patients and their families and recall an apology is not a statement of causality, rather one of empathy.

On a personal note, I had such conversations and they are the hardest conversations I have ever had to initiate. I also wish I would have done a better job. Perhaps if I had read "Healing Words: The Power of Apology in Medicine', prior that conversation, then I wouldn't have as many things I wished I would have said.

(Child Health Notes, continued from page 3)

more OM at an earlier age than other U.S. populations. Other studies exist that thoroughly validate this perception.1

Unfortunately, the authors tread on dangerously thin ice when they allude to a possible genetic predisposition of Ojibwe infants to early onset OM. The authors base this conclusion solely on a statistically significant association between early onset OM in study infants and a maternal history of childhood OM. They also suggest that a poorly done study of Apache infants published in the late 80s also supports this contention. 2 No such conclusion can be reasonably drawn from either study design, in my opinion, and the authors of the Apache study make no such assertion.

As any regular reader of my reviews knows, I flatly reject the notion that genetics can in any way explain the significant health disparities suffered by minority populations (please refresh your memories by reviewing two previous editions of the IHS Child Health Notes: www.ihs.gov/MedicalPrograms/MCH/M/documents/ICHN107.doc, www.ihs.gov/MedicalPrograms/MCH/M/documents/ICHN306.doc), although variation between individuals within a population can occur on a genetic basis. Yes, "race" does in fact exist, but it is a purely human invention, born entirely out of the human psyche.

The paper under review is particularly rife with uncontrolled bias and confounding on many fronts, and independent of my own perhaps quirky personal prejudice, no reasonable conclusion invoking genetic factors as a source of disparities in early onset OM in the studied population can be drawn. This is yet another unfortunate example of the ongoing medical institutionalization and ratification, or "biologification," of racism. C'mon guys, more critical thought processes are surely in order!

Let's no longer scapegoat the biology of minority populations as the source of their own suffering. Ample scientific evidence compels the conclusion that health disparities derive in their largest part from socially imposed inequities and injustices in exposure and access to resources (i.e. poverty and all its trimmings and trappings). Although it is easier, more convenient, and more comfortable to blame the victim than to blame society and ourselves, we must trash junk science and finally take responsibility for the existence of health disparities in the U.S. We need look no further than five hundred years of exploitation and domination of a "race" of people for answers. Accepting this, I believe, is the critical first step that will free a just society to make hard choices and truly end health disparities once and for all.

Additional Reading

1. Todd, NW. Familial predisposition for otitis media in Apache Indians at Canyon Day, Arizona. Genet Epidemiol. 1987;4(1):25-31.

2. Curns AT, Holman RC, Shay DK, et al. Outpatient and hospital visits associated with otitis media among American Indian and Alaska native children younger than 5 years. Pediatrics. 2002 Mar;109(3):E41-1.

Announcements from the AAP Indian Health Special Interest Group

Sunnah Kim, MS

Locums Tenens and Job Opportunities

If you have a short or long term opportunity in an IHS, Tribal or Urban facility that you'd like for us to publicize (i.e. AAP Web site or complimentary ad on Ped Jobs, the official AAP on-line job board), please forward the information to indianhealth@aap.org or complete the on-line locum tenens form at www.aap.org/nach/locumtenens.htm

Perinatology Picks

George Gilson, MFM, ANMC

Ultrasound is better at finding NTD than AFP

For instance, if one performs 1st trimester screening, then one does not also need to obtain a 2nd trimester AFP if you have obtained an ultrasound in the interim

CONCLUSION: Standard ultrasound improved NTD detection over AFP screening alone, by improving AFP test sensitivity and identifying NTDs in low-risk pregnancies

Dashe JS, et al Alpha-fetoprotein detection of neural tube defects and the impact of standard ultrasound Am J Obstet Gynecol. 2006 Dec;195(6):1623-8

SAVE THE DATES

IHS Colposcopy Update & Refresher Course

- April 16–18, 2007
- Albuquerque, NM
- DRAFT Brochure
  www.ihs.gov/MedicalPrograms/MCH/F/CN01.cfm#Apr07
- Contact AWaxman@salud.unm.edu

2nd 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

National Indian Women's Health and MCH Conference, 2007

- August 15–17, 2007
- Albuquerque, NM
- DRAFT Brochure
  www.ihs.gov/MedicalPrograms/MCH/F/CN01.cfm#Aug07
- Contact nmurphy@scf.cc

Abstract of the Month

- Healing words: The power of I'm sorry in medical practice

IHS Child Health Notes

- Understanding the Child Protection Role of Child Health Care Practitioners
- Human Papilloma Virus (HPV) Vaccine Rollout Issues: Cost and Availability
- Early Obits Media Among Minnesota American Indians: The Little Ears Study

From Your Colleagues

- Scott Giberson, HQE—Ryan White HIV/AIDS Treatment Modernization Act of 2006

Hot Topics

Obstetrics—

- GDM Guidelines: Major discrepancies to identify GDM and predict pregnancy outcome
- Consumer Reports has withdrawn its study on infant safety seats

Gynecology—

- Cystocoele Repair: The Mesh Controversy by John Heusinkveld, Shiprock
- Strong evidence for the efficacy of physical therapy for the treatment for SUI
- Menstrual Cycle is a Vital Sign
- Strongly consider a women's health physical therapist at your facility
- Does Delay in Diagnosis of Breast Cancer Impact Prognosis?

Features

- ACOG—ACOG Opposes Sex Selection for Family Planning Purposes
- The MCH Coordinators Site has a clean new look, plus new functionality
- International Health Update—Sexual behavior in context
- Medical Mystery Tour—Prolonged second stage with an epidural
- STD Corner—A First: STD Rates Available by IHS Area
- Nurses Corner—A "Small Fall" and a Trip to the Emergency Department
- Family Planning—Abstinence counseling vs family planning: Which is more effective?
- Perinatology Corner—Planned cesarean delivery doubles NICU rates and the risk for pulmonary disorders

Neil Murphy, MD
SCF
PCC–WH
4320 Diplomacy Drive
Anchorage, AK 99508

Non-Profit Org.
US Postage
PAID
Anchorage, AK
Permit #1022