NATIONAL COUNCIL OF CHIEF CLINICAL CONSULTANTS

CCC Corner

Focus on the Health of American Indians and Alaska Natives

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A new diagnostic category: 'First Trimester GDM'

Here is a common question

Does my patient have gestational diabetes or did she have previously undiagnosed diabetes?

Your patient just came in for a prenatal visit in the first trimester. She has risk factors for diabetes in pregnancy, e. g., previous macrosomic infant, previous GDM, etc… (see other risk factors below*). As per your facility's guidelines, you obtain an initial diabetes screen which is elevated. The subsequent 3 hour 100 g OGTT also comes back abnormal. You manage her pregnancy as a previously undiagnosed diabetic patient. After pregnancy her follow-up 2 hour 75 g OGTT is normal. Did your patient really have pre-existing diabetes or just gestational diabetes? The answer is important to know because it has long term implications for her entire lifetime.

Background

In our Native American/Alaska Native pregnant populations, where diabetes mellitus is so common, it is often difficult to decide if a pregnant woman has gestational diabetes mellitus (GDM), or type 2 pre-gestational diabetes mellitus (PGDM) e.g., pre-existing DM. While the usual GDM screen is 24-28 weeks, many service units screen women at their first prenatal visit. This is probably more common if the woman has other risk factors besides her ethnicity.

- What are the pros and cons of making the diagnosis early?
- How do we decide if our client was actually diabetic between pregnancies?

Consider this case

A 34 y/o Native American G_4P_3 presents for her first prenatal visit at 10 weeks by dates. Her BMI is 34.7 kg/M_2. Her three prior children all weighed over 9 pounds, but her deliveries were uncomplicated. She thinks she may have been told she had GDM with her last pregnancy, but never followed up after the baby was born. Her mother is a type 2 diabetic, as are several other family members. She admits to being thirsty a lot, but she doesn't have to get up at night to go to the bathroom more than once.

- Should she be screened now for GDM?
- Might she have undiagnosed PGDM?

This is more than a matter of semantics

How we decide on a specific diagnosis has long term health implications for the individual involved. A review of the definitions is probably in order at this point. Using the American Diabetes Association (ADA) definition, "A fasting plasma glucose level >126 mg/dL (7.0 mmol/L), or a casual plasma glucose level >200 mg/dL (11.1 mmol/L), meets the threshold for the diagnosis of diabetes, if confirmed on a subsequent day, and precludes the need for any glucose challenge." The woman who meets those criteria quite clearly has PGDM. Likewise, the woman with a history of type 2 diabetes between pregnancies, on medical therapy, is easy to classify.

Women with type 1 diabetes are also usually quite obvious by history. But how about the pregnant woman found to have two fasting glucose values >100 mg/dL?

Or two post prandial values >140 mg/dL? Are such women "pre-diabetic", or "gestational diabetics" or "PGDM"?

Do they need any further glucose challenge now during early pregnancy?

(continued on page 14)

THIS MONTH

Due to required summer hiking activities there will be no CCC Corner arriving in your mailbox in July. The next CCC Corner will be August.

The Native Women's Health and MCH Conference in Albuquerque, August 15–17, 2007. This meeting happens only every 3 years. It has internationally known speakers and benchmark organizations, e. g., Institute for Healthcare Improvement. nmurphy@scf.cc

This is different from than the ACOG / IHS Postgraduate course, held every September in Denver to rave reviews. The Denver meeting is an excellent 4.5 day primer on basic obstetrics, gynecology, and neonatal care, plus a clinical update. YMalloy@acog.org.

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

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

"Far and away the best prize that life offers is the chance to work hard at work worth doing"
—Teddy Roosevelt

Articles of Interest

A randomized, controlled trial of acetaminophen, ibuprofen, and codeine for acute pain relief in children with musculoskeletal trauma.

Pediatrics. 2007 Mar;119(3):460-7.

The goal of this study was to determine which of 3 oral analgesics given as a single dose provided the best pain control in children presenting with an acute musculoskeletal injury. The final diagnoses of injuries were contusions, sprains or fractures. Patients were excluded if they required an intravenous line which biased the study towards less severe injuries. The outcome was decrease in pain at 60 minutes and 120 minutes after treatment. Patients in the ibuprofen group had significantly greater relief from pain compared to patients receiving acetaminophen or codeine.

Editorial Comment

"Yankees versus Red Sox" … "Dodgers versus Giants" … "Paper versus plastic"… "Miller versus Budweiser"

The list of timeless debates is nearly endless. A longstanding issue was whether acetaminophen or ibuprofen offered the best pain relief. It was usually assumed that codeine was superior to the non-prescription pain relievers. This study looked only at acute pain relief but showed superiority of ibuprofen compared to acetaminophen and, surprisingly, codeine, also. It is of note that even though ibuprofen was superior to acetaminophen and codeine that 48% of patients receiving ibuprofen failed to get adequate analgesia at 60 minutes. Ibuprofen may be the best first choice for acute musculoskeletal pain but many patients may require further medication for adequate pain relief.

Infectious Disease Updates.

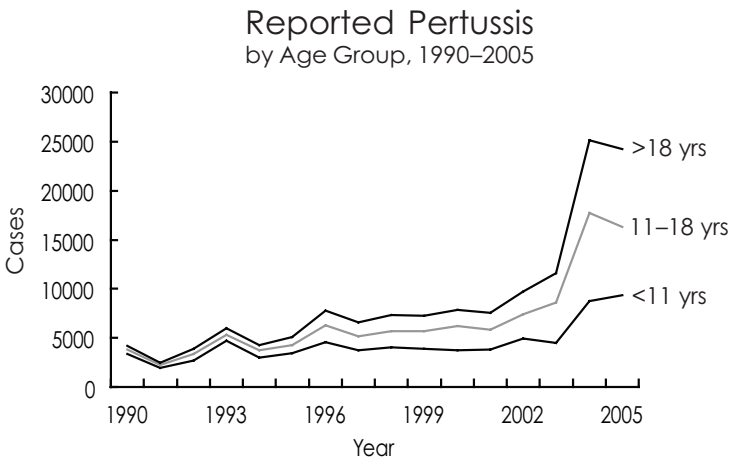
Rosalyn Singleton, MD, MPH

Pertussis: Secular Trends in the United States

In the pre-vaccine era, an average of 175,000 cases of pertussis was reported annually in the United States. After vaccination, the average annual number decreased to a low of 2,900 in the 1980s. However, since 1990 the number of cases has increased until it reached a high of 25,827 in 2004. The reasons for the increase are not entirely clear, but one contributing factor has been waning immunity in adolescents and adults. In 2004-5, 60% of reported pertussis cases were in persons 11 years or older. Although pertussis leads to significant disease in adults, they also transmit disease to vulnerable young infants. An estimated 75% of infants got their disease from a household contact.

Will Tdap vaccine have an impact on pertussis disease rates in AI/AN infants? The jury is still out, but the inexorable rise in pertussis cases in the United States was finally reversed in 2005, when the number of cases declined below 25,000.

What is known about pertussis infection rates in American Indian and Alaska Native (AI/AN) children? Recently, CDC and IHS authors described trends in AI/AN infants. During 1980-2004, 483 pertussis hospitalizations were documented among AI/AN infants (132/100,000 /year). The rate declined during the 25 year period to 100/100,000/year in 2000-2004, but remains higher than the rate estimates in the general US infant population (69/100,000/year).



Recent literature on American Indian/ Alaskan Native Health

Doug Esposito, MD

Pressley JC, Barlow B, Kendig T, Paneth-Pollak R. Twenty-year trends in fatal injuries to very young children: the persistence of racial disparities. Pediatrics. 2007 Apr;119(4):e875-84.

Summary

The authors embark on a 20 year odyssey through injury data in order to assess the effectiveness of injury prevention strategies in minority populations. To accomplish this, they rely on the National Vital Statistics registration system, which is based on death certificate data, and on census data with inter-census population estimation. The data evaluated was for the years 1981 through 2003. Deaths from all-cause, unintentional, and intentional injuries occurring in children 0-4 years of age were examined. Mechanism-specific mortality rates (motor vehicle traffic (separated to include occupant, pedestrian, and unspecified), drowning, residential fires, suffocation, poisoning, falls, and firearms) are also reported for white, black, American Indian/Alaska Native (AI/AN), and Asian/Pacific Islander children. The Hispanic designation only became available in 1990, and so is missing for prior years. In order to assess relative change over the 20 year time period, mortality rate ratios are reported for each minority group, with white children serving as the comparison group.

Here are some of the points most relevant to those of us who care

for AI/AN children:

1. Overall, the all-cause injury mortality rate declined over the 20 year period, but remained approximately twice that of white children (i.e. fewer Native kids are dying of injury now than before but the AI/AN-to-white disparity remains static). The decline can be attributed to a decline in unintentional injury alone.
2. Intentional injury mortality rates remained static over time and almost three-fold higher for AI/AN children than for white children.
3. Overall, the all-cause motor vehicle injury mortality rate (occupant, pedestrian, and unspecified) declined, but remained nearly three times that of white children. Additionally, there appears to be a recent trend toward increased mortality for AI/AN children and a widening of the disparity due to all-cause and occupant motor vehicle injury mortality. We are losing ground in the car seat/booster seat battle in Indian country!
4. AI/AN children still have the highest overall mortality rates of any other racial designation for all-cause injury, unintentional injury, motor vehicle (all-cause) injury, motor vehicle occupant injury, firearm injury, and drowning.
5. There has been longitudinal improvement in mortality rates and a narrowing of the AI/AN-to-white disparity with regards to pedestrian motor vehicle injury, drowning, residential fires, poisonings, and falls over the 20 year period.
6. Firearm injury mortality declined, but remained three-fold higher among AI/AN children and as noted above, was higher for AI/AN children than for any other racial designation.
7. No significant trend in mortality from suffocation was observed over the 20 year time period except for a slight worsening toward the end of the study period, with a nearly two-fold disparity being maintained between AI/AN and white 0-4 year old children.

Editorial Comment

This article reports important trends over a 20 year time period in injury mortality for minority children 0-4 years of age. Unfortunately, this important study appears in the e-pages of the journal *Pediatrics*, making it particularly hard to find and doomed to a life in relative obscurity. Please take the time to read this paper for yourself. It is well worth the effort of anyone interested in better understanding the number one killer of children and loss of productive life-years in our Native communities.

One important comment should be made about an issue that was unfortunately left out in the authors' discussion of study limitations. The reader of this article must understand that there exists a significant bias that shifts the reported injury rates downward (they look better than they actually are) in the AI/AN population. The database from which these statistics originate is constructed from death certificate data that is highly susceptible to the effect of racial misclassification.[1,2,3] This issue was introduced in some detail in the September 2007 issue of the *IHS Child Health Notes* related to cancer incidence and survival in AI/AN adolescents and young adults.[4] It might be worth a look, just to refresh your memory.

The authors are keenly aware of this issue, and had a section on racial misclassification, ethnicity, and missing e-codes in the original manuscript (Personal communications with Dr. Pressley, May 2007). However, due to space constraints, they had to remove this element from the final paper. They had considered removing Native American-specific reporting in its entirety from the final manuscript, but went ahead anyway, "because we felt it did not overstate the problem and that it would inform injury prevention health personnel of areas where additional efforts are needed." I am glad they did. Despite the fact that the true situation is likely at least a little worse than suggested, I believe the data as presented offer an important glimpse into the successes and failures of injury prevention efforts targeting AI/AN communities. The bottom line: health disparities exist and persist and despite some notable achievements, the disparities are actually worsening in some arenas. As for the number one killer of AI/AN children, we have come a long way, but we certainly have an even longer way to go.

References

1. *Sugarman JR, Soderberg R, Gordon JE, Rivara FP. Racial misclassification of American Indians: its effect on injury rates in Oregon, 1989 through 1990. Am J Public Health. 1993;83(5):681-4.*
2. *Epstein M, Moreno R, Bacchetti P. The underreporting of deaths of American Indian children in California, 1979 through 1993. Am J Public Health. 1997;87(8):1363-6.*
3. *Stehr-Green P, Bettles J, Robertson LD. Effect of racial/ethnic misclassification of American Indians and Alaskan Natives on Washington State death certificates, 1989-1997. Am J Public Health. 2002;92(3):443-4.*
4. *Cancer in 15- to 29-year-olds by primary site. IHS Child Health Notes, September 2006. http://www.ihs.gov/medicalprograms/MCH/M/documents/IHSchildnotesSept06.doc*

Adolescent sexual behavior and strategies for reducing early pregnancy and childbearing

With One Voice 2007: America's Adults and Teens Sound Off About Teen Pregnancy assesses public opinion on adolescent pregnancy. The survey is the fifth in a series of nationally representative surveys conducted by the National Campaign to Prevent Teen Pregnancy that have asked adolescents (ages 12-19) and adults (ages 20 and older) a consistent, core set of questions about adolescent pregnancy and related issues.

Topics include parental and other adult influence; abstinence and contraception; regret, virginity, older partners, and attitudes about adolescent sex; gender differences; religion; social norms and beliefs; and media. Data are presented in charts and, where available, results from previous surveys (2001-2006) are included. A description of the survey methodology and a summary are also provided. The survey is intended to provide insights for policymakers, program administrators, families, and others about adolescent pregnancy and factors that influence adolescents' decisions about sex.

www.teenpregnancy.org/resources/data/pdf/WOV2007_fulltext.pdf

Hot Topics

From Your Colleagues

Ben Garnett, Anchorage

Control over schedule: Most important predictor of staff work-life balance and burnout

RESULTS: Both women and men report being highly satisfied with their careers (79% compared with 76%, P<.01), having moderate levels of satisfaction with work-life balance (48% compared with 49%, P=.24), and having moderate levels of emotional resilience (51% compared with 53%, P=.09). Measures of burnout strongly predicted career satisfaction (standardized beta 0.36-0.60, P<.001). The strongest predictor of work-life balance and burnout was having some control over schedule and hours worked (standardized beta 0.28, P<.001, and 0.20-0.32, P<.001, respectively). Physician gender, age, and specialty were not strong independent predictors of career satisfaction, work-life balance, or burnout. CONCLUSION: This national physician survey suggests that physicians can struggle with work-life balance yet remain highly satisfied with their career. Burnout is an important predictor of career satisfaction, and control over schedule and work hours are the most important predictors of work-life balance and burnout. LEVEL OF EVIDENCE: II.

Keeton K, et al Predictors of physician career satisfaction, work-life balance, and burnout. Obstet Gynecol. 2007 Apr;109(4):949-55.

Obstetrics

Placental problems with previous caesarean delivery: Abruptio, previa

Research shows a link between the development of placenta praevia and placental abruption during the subsequent pregnancies of women who previously had a caesarean delivery.

CONCLUSION: Caesarean delivery for first live birth is associated with a 47% increased risk of placenta praevia and 40% increased risk of placental abruption in second pregnancy with a singleton.

Yang Q, et al Association of caesarean delivery for first birth with placenta praevia and placental abruption in second pregnancy. BJOG. 2007 May;114(5):609-13.

Late Pregnancy Bleeding (ALSO serialization)

Effective management of vaginal bleeding in late pregnancy requires recognition of potentially serious conditions, including placenta previa, placental abruption, and vasa previa. Placenta previa is commonly diagnosed on routine ultrasonography before 20 weeks' gestation, but in nearly 90 percent of patients it ultimately resolves. Women who have asymptomatic previa can continue normal activities, with repeat ultrasonographic evaluation at 28 weeks. Persistent previa in the third trimester mandates pelvic rest and hospitalization if significant bleeding occurs. Placental abruption is the most common cause of serious vaginal bleeding, occurring in 1 percent of pregnancies. Management of abruption may require rapid operative delivery to prevent neonatal morbidity and mortality. Vasa previa is rare but can result in fetal exsanguination with rupture of membranes. Significant vaginal bleeding from any cause is managed with rapid assessment of maternal and fetal status, fluid resuscitation, replacement of blood products when necessary, and an appropriately timed delivery. Am Fam Physician 2007;75:1199-206.

Gynecology

Discharge 24 Hours After Vaginal Hysterectomy Safe, Acceptable

CONCLUSIONS: Vaginal hysterectomy performed as a 24-hour day case procedure appears to be as safe as traditional inpatient management, with a high rate of early discharge and a low rate of readmission. This may have additional advantages for the woman and healthcare provider alike.

Penketh R, et al prospective observational study of the safety and acceptability of vaginal hysterectomy performed in a 24-hour day case surgery setting. BJOG. 2007 Apr;114(4):430-6

Child Health

Forty percent of 3-month-olds watch TV, DVDs, or videos

CONCLUSIONS: Parents should be urged to make educated choices about their children's media exposure. Parental hopes for the educational potential of television can be supported by encouraging those parents who are already allowing screen time to watch with their children.

Zimmerman FJ, et al Television and DVD/Video Viewing in Children Younger Than 2 Years. Arch Pediatr Adolesc Med. 2007 May;161(5):473-9

Chronic disease and Illness

Malabsorption of Oral Antibiotics in Pregnancy after Gastric Bypass Surgery

Gastric bypass surgery, by definition, changes the absorption capabilities of the stomach and small intestine. The use of oral medications in patients post gastric bypass may need to be adjusted by medical providers to account for this absorption change. The following case exemplifies this dilemma in a pregnant patient status post gastric bypass surgery with a complicated urinary tract infection.

Magee SR et al Malabsorption of Oral Antibiotics in Pregnancy after Gastric Bypass Surgery J Am Board Fam Med 2007;20 310-313

Features

ACOG, American College of Obstetricians and Gynecologists

Endometrial ablation. ACOG Practice Bulletin No. 81

Summary of Recommendations and Conclusions

The following recommendations and conclusions are based on good and consistent scientific evidence (Level A):

- For women with normal endometrial cavities, resectoscopic endometrial ablation and nonresectoscopic endometrial ablation systems appear to be equivalent with respect to successful reduction in menstrual flow and patient satisfaction at 1 year following index surgery.
- Resectoscopic endometrial ablation is associated with a high degree of patient satisfaction but not as high as hysterectomy.

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

- Hysterectomy rates associated with both resectoscopic endometrial ablation and nonresectoscopic endometrial ablation are at least 24% within 4 years following the procedure.
- Women undergoing endometrial ablation with previous or concomitant laparoscopic sterilization are at low risk for the development of cyclic or intermittent pelvic pain subsequent to the procedure.
- Patient satisfaction and reduction in menstrual blood flow after endometrial ablation in women with normal endometrial cavities is similar to that experienced by women using the levonorgestrel-secreting intrauterine system.

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

- Patients who choose endometrial ablation should be willing to accept normalization of menstrual flow, not necessarily amenorrhea, as an outcome.
- Premenopausal patients undergoing endometrial ablation should be counseled to use appropriate contraception.
- in women with endometrial cavities that exceed device limitations.
- The endometrium of all candidates for endometrial ablation should be sampled, and histopathologic results should be reviewed before the procedure.
- Women with endometrial hyperplasia or uterine cancer should not undergo endometrial ablation.
- Performance of nonresectoscopic endometrial ablation in patients with prior classic cesarean delivery or transmural myomectomy may increase the risk of damage to surrounding structures. If endometrial ablation is to be performed in such patients, it may be best to perform resectoscopic endometrial ablation with laparoscopic monitoring. Safety of nonresectoscopic endometrial ablation in women with low transverse cesarean delivery has not been adequately studied.
- For resectoscopic endometrial ablation, it is recommended that a fluid management and monitoring system that provides "real-time" output of fluid balance be used.

Endometrial ablation. ACOG Practice Bulletin No. 81. American College of Obstetricians and Gynecologists. Obstet Gynecol 2007; 109:1233–48.

Breastfeeding Suzan Murphy, PIMC

FAQs—Breastfeeding and maternal illness

Is breastfeeding okay if mom the gets sick? Most of the time, the answer is yes. The following review is from CDC and references listed below.

When breastfeeding is not recommended:

- The baby is diagnosed with galactosemia, a rare genetic metabolic disorder occurring in 1 in 47,000 births. There is little data on the prevalence of galactosemia in AI/AN communities.
- The baby's mother:
  - ◊ Has been infected with or recently exposed to the human immunodeficiency virus (HIV)
  - ◊ Is taking antiretroviral medications
  - ◊ Has untreated, active tuberculosis
  - ◊ Is infected with human T-cell lymphotropic virus type I or type II
  - ◊ Is using or is dependent upon an illicit drug
  - ◊ Is taking prescribed cancer chemotherapy agents, such as antimetabolites that interfere with DNA replication and cell division
  - ◊ Is undergoing radiation therapies; however, such nuclear medicine therapies require only a temporary interruption in breastfeeding

What about stomach flu?

Yes, moms with diarrhea from food and water sources can keep breastfeeding. The recommendations to increase fluid intake and use oral rehydration salts work well with breastfeeding.

If medication is needed consider kaolin-pectin (Kaopectate) or loperamide (Immodium, Maalox) . Both are described by the American Academy

Fetal or infant death is a traumatic event for parents

Measures to assist grieving parents

CONCLUSION: Although care after perinatal death often adheres to published guidelines, substantial room for improvement is apparent. Parents with perinatal losses report few choices during labor and delivery and inadequate communication about burial options and autopsy results. Hospitals, nurses, and doctors should increase parental choice about timing and location of delivery and postpartum care, encourage parental contact with the deceased infant, and facilitate provision of photos and memorabilia.

Gold KJ, et al Hospital Care for Parents After Perinatal Death. Obstet Gynecol. 2007 May;109(5):1156-1166.

of Pediatrics (AAP) as "usually compatible with breastfeeding," with kaolin-pectin being preferable to loperamide.

Avoid suggesting anitdiarrheal medications that have bismuth subsalicylate compounds (Pepto-Bismol). They are considered by both AAP and Hale to be of concern because the baby can absorb significant levels of salicylates and pose a theoretical risk of Reye's syndrome.

Can a mom breastfeed if she contracts hepatitis A?

Yes, she can continue and gamma globulin treatment is compatible with breastfeeding. Encourage the mom to use effective hand washing techniques and food safety recommendations to protect her baby, whether she is breastfeeding or bottle-feeding.

What if she has hepatitis B (HBV) ?

Is it safe for a mom infected with HBV to breastfeed her baby right after birth?

Yes. HBV transmission through breastfeeding was not reported. CDC recommends:

- All babies born to HBV-infected moms need to receive hepatitis B immune globulin and the first dose of hepatitis B vaccine within 12 hours of birth, the second dose of vaccine at aged 1–2 months, and the third dose at aged 6 months.
- The infant needs to be tested after completing the vaccine series, at aged 9–18 months to confirm that the vaccine worked and the infant is not infected with HBV through exposure to the mother's blood during the birth process.

What if the mom's nipples are cracked and bleeding?

Like hepatitis C, both viruses are spread by infected blood. There is not enough data to make recommendations at this point. Until more information is available, the wisest course is to encourage the mom to temporarily interrupt breastfeeding her baby until she is healed. Although sore nipples seem to last forever, they usually heal quickly, often within 24 hours. It is helpful to pump and dump during this time. Since both hepatitis b and c are resilient viruses, it would be prudent to discard the breast pump when through.

What about HBV vaccinations for a breastfeeding mom?

It is okay for a breastfeeding mom to receive HBV vaccinations. The vaccines contain noninfectious HBsAg particles and are given to newborns also.

For more information, refer to CDC. A Comprehensive Immunization Strategy to Eliminate Transmission of Hepatitis B Virus Infection in the United States. MMWR, Recommendations and Reports, December 23, 2005/54(RR16);1-23

What about mom with hepatitis C (HCV)—is it safe for her to breastfeed?

Yes, like HBV, there is no evidence that breastfeeding spreads HCV.

What if the mom in infected with HCV and has cracked and bleeding nipples?

See recommendations above for HBV and cracked and bleeding nipples.

For more information, refer to CDC. Recommendations for prevention and control of Hepatitis C virus (HCV) infection and HCV-related chronic disease. MMWR, October 16, 1998, 47(RR-19):1–39.

What if a mom becomes infected with West Nile Virus, is it safe for her to breastfeed her baby?

So far, there is no evidence that it is harmful for a mom infected with West Nile Virus to breastfeed infant. In According to CDC, there have been 4 documented cases of West Nile Virus transmission through breast milk (1 in 2002 and 3 in 2003) with no recognizable illness in the baby. As a result, CDC recommends that moms with West Nile Virus illness continue breastfeeding because the benefits of breast milk are thought to outweigh the theoretical risk of harm to the baby.

Domestic Violence

Denise Grenier, Tucson/Rachel Locker, Warm Springs

The failure to protect Indigenous women from sexual violence in the USA

The Amnesty International report entitled "Maze of Injustice—The failure to protect Indigenous women from sexual violence in the USA" is an important and timely reminder for all individuals and agencies that provide services to American Indian and Alaska Native (AI/AN) women. The Amnesty International report calls attention to the disproportionate impact on Indian women, focusing on three disparate communities that vary with respect to law enforcement, jurisdiction, and health care and support services. This report helps remind us that no one is immune from sexual violence.

The Indian Health Service (IHS) and our health care providers need to be aware of the prevalence of sexual assault and the need to address acute injuries as well as the long term negative health effects of sexual violence. As a result of this report,

Sexually transmitted infections in preadolescent children

Pediatric nurse practitioners may be called on to conduct an assessment for sexual abuse of a young child. Depending on the type of sexual contact, a decision may have to be made to obtain cultures for sexually transmitted infections (STIs). Recognizing the symptoms of STIs in preadolescent children, along with having knowledge of the modes of transmission, diagnostics, and treatment, are part of the clinical decision. The impact of STI in preadolescent children has physical and emotional consequences for the child and family, along with legal consequences for an accused perpetrator. Knowledge about types of sexual contact that necessitate STI cultures, incubation periods, and symptomatology is essential. Accurate techniques and appropriate selection of culture materials are necessary. Proper positioning of the child for obtaining cultures can decrease the potential for discomfort during the examination. Gonorrhea, Chlamydia trachomatis, herpes simplex virus, human papillomavirus virus, syphilis, Trichomonas vaginalis, hepatitis B, and HIV are reviewed.

Lewin LC.Sexually transmitted infections in preadolescent children. J Pediatr Health Care. 2007 May-Jun;21(3):153-61.

the IHS will help develop a prototype policy on sexual assault that can be used by facilities to help ensure the provision of best practices and culturally appropriate medical and supportive care for victims.

The health care response to intimate partner violence (IPV) has been improved by the existence of policies and procedures at all IHS facilities. Screening for IPV has improved as well, with aggregate national rates exceeding Agency targets. IPV policies and procedures, screening and education for health care providers are the result of Agency clinical performance measures developed to improve care.

The Indian Health Service and the Administration for Children and Families (ACF) jointly fund activities at twenty IHS, Tribal and Urban facilities to help improve the health care response to domestic violence. This work is led by multidisciplinary teams of health service staff and tribal and community domestic violence advocates. The IHS-ACF project seeks to build a sustainable response to domestic violence that prioritizes safety and autonomy for victims and provides outreach and education, utilizing the experience and commitment of community members. Partners in this collaborative effort include the Family Violence Prevention Fund (FVPF), Mending the Sacred Hoop Technical Assistance (MSHTA) Project and Sacred Circle. MSHTA and Sacred Circle specialize in developing sexual assault and domestic violence policies and programs in Indian Country.

Sexual assault has long been recognized as a dynamic of domestic violence. In response to the alarming statistics of sexual assault experienced by AI/AN women, several of the project sites, including the Cherokee Indian Hospital and Zuni Comprehensive Community Health Center, have trained sexual assault nurse examiners (SANE) who are on call and available for emergency room care. For other sites, identifying and cooperating with pre-existing sexual assault community resources have been key to strengthening their response. At the Kanza Health Center in Oklahoma, the Dearing House, a nearby child advocacy center, was instrumental in improving exams for pediatric/adolescent sexual assault cases identified in the clinic. The Warm Springs Health and Wellness Center's Domestic Violence team leaders collaborated with the local Victims of Crime office to assist high school students in the production of a film about sexual assault against children and teens. This effort complements the efforts at the Warm Springs facility and community hospital where SANE nurses are available for follow-up. Both institutions maintain policies and procedures on sexual assault. Many of the domestic violence project sites expanded their work beyond the walls of the health care facility, and the focus has increasingly moved toward prevention.

The experience of the IHS-ACF project sites demonstrates that chances for success for improving the health care response to domestic violence are greatest when health care teams and local domestic violence advocacy groups collaborate in the delivery of services to women. This model of care can be combined with existing best practices to improve the health care response to victims of sexual assault. Clinical guidelines have been shown to improve the quality of care for a number of health conditions, such as type 2 diabetes. Similarly, the incorporation of guidelines and policies concerning domestic violence and sexual assault will strengthen the ability of our providers and health care system to address sexual violence against American Indian and Alaska Native women. Our expectation should be that the health care response will be consistently safe, professional, timely, accessible, culturally and personally respectful, and coordinated with law enforcement and legal and community services. We must not re-victimize women who seek care in our hospitals and clinics.

IHS-ACF Domestic Violence Project
Project Faculty, IHS and FVPF

Information Technology

Brigg Reilley/John Redd, HQW

How can we improve HIV screening in pregnancy? Preliminary GPRA Related Results

As you read the following, think about the classic '3 things you should take away from a presentation,'

1. Prenatal HIV screening is the responsibility of all clinics whether we like it or not
2. Most service units have a prenatal HIV screening problem, but we are not aware of it
3. There are gaps that that staff can identify and fix, improving both actual screening rates and reported screening rates.

In some clinics, there can be a 'not my job' syndrome.

People say things along the lines of: 1) We refer the women out anyway; 2) We don't have an HIV counselor, and it's not my role to counsel and 3) What if it IS positive? We can't do anything about it anyway.

All of these reasons are essentially irrelevant—and, as noted below, the successful small clinics

MCHB Launches Web Site to Increase Awareness of Perinatal Depression

Depression During and After Pregnancy: A Resource for Women, Their Families, and Friends contains tips on identifying depression in mothers and offers steps to help treat it successfully. The Web site was launched by the Health Resources and Services Administration's Maternal and Child Health Bureau to increase awareness among women and health professionals of the impact and pervasiveness of perinatal depression.

Selected topics include steps a woman can take if she believes she is at risk of, or is experiencing, perinatal depression. A section of the Web site is devoted to information for families and friends. A list of print and electronic resources is also provided.

www.mchb.hrsa.gov/pregnancyandbeyond/depression

Menopause Management

Earlier hormone therapy closer to menopause tended to have reduced CHD risk

CONCLUSIONS: Women who initiated hormone therapy closer to menopause tended to have reduced CHD risk compared with the increase in CHD risk among women more distant from menopause, but this trend test did not meet our criterion for statistical significance. A similar nonsignificant trend was observed for total mortality but the risk of stroke was elevated regardless of years since menopause. These data should be considered in regard to the short-term treatment of menopausal symptoms.

Rossouw JE, et al
Postmenopausal hormone therapy and risk of cardiovascular disease by age and years since menopause
JAMA. 2007 Apr 4;297(13):1465-77

assume responsibility for the first few PN visits, which includes getting the lab panels done, even if the woman will eventually be referred out.

Background

Current national standards of care for prenatal care specifically recommend that all pregnant women be routinely screened for a variety of diseases for which early detection is beneficial to the mother or child. Routine infectious disease screening includes tests for HIV, syphilis, gonorrhea, chlamydia, and hepatitis B surface antigen. Early detection of HIV is critical because it can reduce the risk of mother-to-child transmission from approximately 25% with no intervention to less than 1% with intervention.

National IHS policy is that prenatal HIV screening in IHS should be conducted on all women in IHS through "opt-out" testing. The IHS 2005 Executive Summary states "The Indian Health Service has issued guidance recommending universal prenatal HIV testing using the "opt-out" approach. In "opt-out" testing, HIV tests are included in the standard battery of prenatal tests and women are informed that an HIV test is being conducted and that they have a right to refuse it. Information regarding HIV is included as part of a patient's prenatal education. As more practitioners adopt opt-out testing, prenatal HIV screening rates should increase."

IHS considers prenatal HIV screening an important indicator of the quality of care provided by the Agency. As a result, HIV screening during prenatal care is one of the core Government Performance and Results Act (GPRA) measurements, with the IHS goal being to reach 100%. GPRA considers a service unit 'responsible' for HIV screening if there is >1 visit during the time frame of pregnancy.

For the most recent year, GPRA statistics show that percentage of IHS prenatal patients tested during pregnancy for HIV varies considerably by IHS Area, from 17% to 84%. The national IHS rate is about 65%.

Clearly, these rates can and should improve.

The IHS Division of Epidemiology & Disease Prevention Prenatal HIV Screening Project

In response to these results, IHS, through the Minority AIDS Initiative and the IHS Division of Epidemiology & Disease Prevention, has funded the ongoing IHS Prenatal HIV Screening Project. In brief, this is the methodology of this phase of the project:

Charts that were considered 'misses' by GPRA (i.e. prenatal care but no HIV screening) are being reviewed in 20 IHS sites (thus far, charts have been reviewed at 12 sites) across the country. The misses were identified by running a simple logic (a set of commands that we can give to any service unit that is interested).

In general, most service units have said they are sure that they have tested every prenatal patient for HIV, and usually express surprise at their low GPRA scores.

Results

These results are part of an ongoing study and are considered preliminary.

The two main categories of 'misses' as 1) data and 2) clinical. Sites that have < 80% reported HIV screening rates generally have some sort of data or clinical gap in screening, or often both.

On the clinical side, the main misses were:

- not using opt-out, including still using a consent form
- not testing at all, mainly among women who are late presenters, or skip appointments, or have otherwise 'non-routine' prenatal care, although it is arguable that this group is actually at highest risk
- a provider determining that an HIV test is not needed because there are 'no risk factors' or -carrying over an HIV test from a previous pregnancy
- assuming that the test was done (or will be done) at the previous (or next) service unit to see the patient.

In the data category, the main errors were:

- not entering HIV tests results from a contract lab into the facility's computer
- not entering HIV tests results done by an another facility
- not entering HIV test refusals into the facility's computer

(note: to enter refusals in the EHR takes a couple extra steps, which should be fixed in the next version).

Preliminary Recommendations to IHS Service Units

- Review the policy of universal prenatal HIV testing via "opt-out" with all clinicians, whether or not they usually see prenatal patients.
- Run the SU's patient list to find charts that are misses and 'diagnose' the SU's gaps.
- Bundle HIV and the other routine prenatal ID serum tests into a "prenatal panel" that can be ordered in one step by clinicians. Tests done 'a la carte' result in greater misses for HIV and other IDs, especially in patients with complications and

missed appointments.
- Perform prenatal testing before transferring to a higher level of care. Small facilities should remember that GPRA will consider them responsible for prenatal HIV testing if the patient is seen by them. Transfers out with no lab tests done, and with no follow up to obtain results on test done elsewhere, result in low scores.
- Make prenatal opt-out HIV screening absolutely routine, both in policy and in practice. Sites with lower scores tend to 'bottleneck' testing in a way that makes it an exceptional event rather than the rule. For example, a provider may be unable to test without a specific consent form (and the form isn't easily available), and without using a specific person to obtain consent (and that person isn't in clinic today). These reasons for low testing rates are no longer acceptable in the world of universal prenatal opt-out HIV screening.

OB/GYN CCC Editorial

Act now: Make HIV screening a routine test in pregnancy

Brigg Reilley and John Redd emphasize that the above results are just part of an ongoing investigation, but felt strongly in the importance of this data to allow a preliminary release. The full analysis will follow.

In the meantime, there are clear 'provider related' and 'system related' obstacles to routine prenatal HIV screening and documentation that can be addressed now. Pending the final results, these simple statements are true:

- All pregnant patients should be educated about and offered HIV screening in pregnancy
- HIV screening in pregnancy is your responsibility. Don't wait for the next provider or facility to do perform the screening
- HIV screening in pregnancy is a routine part of care. It does not need a separate written consent and can be 'bundled' in with the other initial prenatal labs
- Many of the patients who miss the initial screen, e.g., due to missed appointments etc… are those patients at highest risk. Please continue to try to obtain the HIV screen right up to and including the time of delivery.

International Health Update

Claire Wendland, Madison, WI

Social context of maternal deaths and morbidity

Fair warning: the three pieces I'm recommending here are not freely available online. But all should be available through your librarian, and for providers who are interested in the social context of maternal deaths and morbidity, they are well worth seeking out.

A northern Nigerian proverb tells us "the world is a pregnant woman"—suggesting that life, like pregnancy, is uncertain and perilous. But why is it so much more perilous in some places than others? Biomedical and public health perspectives on the problem have tended to identify shortfalls in clinical care, and have led to interventions designed to improve skills training: not long ago the training of TBAs was the flavor of the day, and more recently the focus has shifted to the improvement of emergency obstetric care in health centers. Anthropologists Craig Janes and Lewis Wall (also an Ob/Gyn) bring a different perspective to their studies of pregnancy-related mortality in the disparate settings of Nigeria and Mongolia, both arguing that rising maternal death rates reflect not just health sector deficiencies, but larger social upheavals and overarching economic structures.

In Mongolia, for example, herders have been organized since the 13th century into collective structures—first feudal, then socialist—that regulated access to valued resources including land, livestock and water (and under the socialists, health care and education). These collective structures were rapidly dismantled when Mongolia initiated the so-called "shock therapy" program of economic reforms in 1990. Food shortages, widespread unemployment and localized famine, growing inequality, and deterioration of the public health sector rapidly followed. Though this initial shock has now stabilized, reproductive health and maternal mortality statistics continue to be poorer than they were under socialism. Women, Janes suggests, appear to be particularly vulnerable to the economic stresses occasioned by de-collectivization, household food insecurity, and migration, in part because the deconstruction of the collective has isolated women—economically and socially—at the single-household level.

Nigeria has had similar problems with a deteriorating public health sector and economy. Wall's article demonstrates how highly patriarchal social and religious structures compound these national problems, resulting in rising rates of maternal death, obstetric fistula disease and perhaps even peripartum cardiomyopathy. Where women depend on powerful men for both the social permission and the economic resources required to travel to the hospital, tragedy can all too easily follow.

For a more intimate narrative take on issues of gender, maternity and risk in North Africa, consider Kris Holloway's new book Monique and the Mango Rains. Holloway was a Peace Corps

Chronic Illness

Sleeping Poorly ... and Maybe Depressed: Co morbidity in Formal Sleep Studies

In this survey of 100 patients referred to our sleep center, we found that a very high proportion (53%) of them had also been diagnosed with depression. This is consistent with other estimates of co morbidity between depression, insomnia, and obstructive sleep apnea.6 This high concordance serves as a reminder that when primary care physicians diagnose depression, they should question their patient closely about sleep complaints, especially obstructive breathing patterns and insomnia.

When patients present, as they frequently do, with hypersomnolence, fatigue, irritability, low energy, or diminished cognitive function, the provider's antennae likely will be raised to diagnose and treat depression. These findings serve as a small reminder that they need to be aware that common primary sleep pathologies such as obstructive sleep apnea or insomnia may also account for these symptoms.

Sorscher AJ Sleeping Poorly ... and Maybe Depressed: Co morbidity in Patients Referred for Formal Sleep Studies J Am Board Fam Med 2007;20 320-321

volunteer in Mali 1989-1991, where she worked closely with Monique Dembele, a Malian community health worker and midwife. Monique had minimal training and even more minimal facilities but a burning drive to improve health care—and particularly childbirth safety—in a rural village. This nicely written, extremely accessible book (requiring no clinical background to enjoy) neither pathologizes nor romanticizes Malian village life, and deals in a fair and approachable way with issues of sexuality and patriarchy.

All three of these readings challenge conventional medical wisdom by suggesting that a narrow focus on improving one or another aspect of formal health sector care—absent an understanding of and attention to the larger social and political contexts of women's lives—will not be enough to substantially reduce maternal deaths in the Third World.

Interventions to Reduce Hemorrhage During Myomectomy for Fibroids

(ACOG Cochrane Update)

AUTHORS' CONCLUSIONS: There is limited evidence from a few RCTs that misoprostol, vasopressin, bupivacaine plus epinephrine, tourniquet, and mesna may reduce bleeding during myomectomy. There is no evidence that oxytocin and morcellation have an effect on intraoperative blood loss. There is need for adequately powered RCTs to shed more light on the effectiveness, safety, and costs of different interventions in reducing blood loss during myomectomy.

Kongnyuy EJ, Wiysonge CS. Interventions to reduce hemorrhage during myomectomy for fibroids. Cochrane Database of Systematic Reviews 2007, Issue 1. Art. No.: CD005355. DOI: 10.1002/14651858.CD005355

MCH Headlines

Judy Thierry HQE

Improve the system—Improve the care: Underpinnings

The title of the American Native Women's Health and Maternity Care Conference to be held August 15—17, 2007 at the Marriott—Louisiana, Blvd., Albuquerque, NM has as one of its three objectives to "outline the underpinnings of an optimal WH and MCH health care system/environment in the ITU".

- Underpinnings like a foundation, like the joists in a floor are about strength and unity.
- Underpinnings like the lining of a coat or jacket provide durability, form and fit.

The 18.5 credit 2.5 day conference is YOUR conference. Workgroups, professional reports and updates, state of the art practice across ITU's and plenary discussions from national leaders and women's health advocates are designed to 'fit' your practice and the community you serve.

Wanda Jones, Deputy Assistant Secretary, Office for Women's Health (OWH) Department of Health and Human Services will identify the challenges for Women's Health in 2007 and the strategies for addressing those issues. She will describe OWH mission and initiatives impacting on AIAN women (underserved, women of color, health disparities and citizens of sovereign nations). http://www.4women.gov/owh/about/welcome.cfm

Ms. Stacy Bohlen, Executive Director National Indian Health Board will provide remarks on NIHB's educational and advocacy role, the key partnerships and collaborations that support American Indian and Alaska Native women and their families and communities. Recent testimony by a board member requested increased support for diabetes and chronic disease. www.nihb.org/index.php

Empowering women is a precept of Centering Pregnancy R. Evidence based group prenatal care taken up by Zuni, Chinle, Kayenta and Tuba, among other practice communities will present a paradigm shift in care that is client centered, founded on building trust among the women. www.centeringpregnancy.com/

A pre-meeting training on Monday and Tuesday will take place at the Marriot—please contact judith.thierry@ihs.gov if you are interested.

Special Care Program at PIMC presented by Judy Whitecrane, CNM serves A/OD at risk pregnant women 'where they are at' in a sensitive, confidential and behaviorally integrated health care approach.

Provider Self Care? Terese Grant from the Center on Human Development and Disability, University of Washington will engage participants in appreciating the importance of a system that values self-care, respite, retreats, networking and day-to-day support of staff who work with high-risk women.

"Improve the System—Improve the Care" planning committee has designed many workshops and plenary objectives to address the effects of violence on AIAN women and the clinical and community response. Domestic Violence and Sexual Assault strategies and potential alternatives for serving victims of sexual assault in direct Tribal and urban Indian locations will be addressed by—Connie Monahan, New Mexico Statewide Sexual Assault Nurse Examiner (SANE) Coordinator.

Please join us

Native Women's Health and MCH Conference, 2007

www.ihs.gov/MedicalPrograms/MCH/F/CN01.cfm#Aug07

Medical Mystery Tour

Which Indian Health facilities lead the entire U.S. in national obstetric benchmarks?

You saw the above question last month in the May CCC Corner.

Here is the rest of the story…

First, let me tell you two characteristics, common to both facilities. Both have strong certified nurse midwife programs and both are 638 facilities, e.g., operated by tribal Boards under Self Determi-

nation legislation.

…and now the envelope please….the winners are… the Tuba City obstetrical care unit and the Alaska Native Medical Center obstetrical care unit.

- Tuba City was recognized for cesarean delivery rate just under 14 percent—lowest in the State of Arizona for Arizona Perinatal Trust Level II Nurseries
- Alaska Native Medical Center was recognized for best practice in five categories of the American College of Nurse-Midwives (ACNM) 2005 Benchmarking Program for facilities its size.

The categories included

Successful vaginal after cesarean rate	84.1% (63 attempted VBACs)
Intact perineum	84.1% (1352 vaginal births)
Patients with prenatal care by 12 weeks	86.9% (1488 births)
Lowest pitocin induction rate	5.4% (1488 births)
Cesarean delivery rate	9.1% (1488 births)

As no one staff category can accomplish the above in isolation, I would like to offer congratulations to the entire women's health staff at both facilities for a job well done.

Now, how can we translate that success to other Indian Health sites?

The easiest way to start that process is to hear directly from the staff themselves. We have arranged to have members of their staff present at the upcoming **2007 National Indian Women's Health and MCH Conference** in Albuquerque, NM August 15- 17, 2007 so you can hear for yourselves.

The theme of the **2007 National Indian Women's Health and MCH Conference** is "Improve the System: Improve the Outcome" so it will explore how we can all work together to raise the AI/AN health status to the highest possible status.

There will be national benchmark organizations (Institute for Healthcare Improvement, American College of Nurse-Midwives, American College of Obstetricians and Gynecologists, Kaiser Family Foundation, etc…), internationally known speakers, and a rather extensive clinical Program.

The meeting is only every 3 years, so you and a team from your facility should try your best to attend. You can either use your local facility funds, because there is a program review function, or use your CME /CEU funds. In addition, limited scholarships are available.

It is not too late to sign up.

For registration information contact nmurphy@scf.cc

Navajo News

John Heusinkveld. Shiprock

Adjustable Urethral Slings Offer Hope for Patients with Complex Incontinence Problems

This month's Navajo News comes from Northern Navajo Medical Center, which has the highest gynecology surgery volume of the Navajo Area IHS facilities.

Over the past 10 years, various versions of the mid-urethral sling operation have dramatically improved the surgical treatment of urodynamic stress incontinence. The vast majority of patients, whose incontinence results from urethral hypermobility, can now be cured by a simple, minimally invasive procedure, preferably in combination with pelvic floor physical therapy.

Treatment of stress incontinence resulting from problems such as instrinsic sphincteric deficiency (ISD) and other neuromuscular problems remains more problematic. Urethral bulking procedures such as collagen or carbon bead injection can provide temporary relief, but have to be repeated at intervals in order maintain their effect. Mid-urethral slings placed via the suprapubic approach appear to be moderately effective for ISD; however, in order to be effective for this indication, a sling generally needs to be placed under greater tension than one placed for urethral hypermobility, and the difference between continence and retention can be quite small.

A new modification of the suprapubic sling technique appears to be well-suited for patients with complex problems such as ISD or recurrent incontinence after previous surgery. In this procedure, a small sling of mesh is placed under the mid-urethra and attached to 2 polypropylene threads which pass behind the pubic symphysis and through the lower extent of the abdominal wall, where they are attached to a small prosthesis, implanted directly above the rectus fascia via a two to three centimeter incision in the skin above the symphysis pubis. This prosthesis contains a tiny spool around which the traction threads are wound; rotating the spool to the right or left increases or decreases the level of tension on the threads, which correspondingly adjust the level of support for the urethra. A small plastic arm attached to the prosthesis containing the spool is left in place, protruding slightly through a small gap in the suprapubic incision. On postoperative day one or two, the bladder is filled, the indwelling catheter is removed, and the adjustment arm is rotated to the right, increasing support for the urethra until no leakage is observed with coughing. The cough test is then repeated with the patient standing, and the level of tension can be increased if necessary. The patient then voids and the tension can be reduced if retention occurs. Finally, the adjustment arm is removed and the gap in the incision is closed.

If a patient with an adjustable sling ever experiences recurrent leakage or retention, the level of urethral support can be adjusted via a simple procedure done under local anesthesia, in which the suprapubic incision is reopened and the adjustment arm is reattached to the prosthesis, allowing the spool to be turned to the right or left as needed to increase or decrease the level of urethral support. This procedure can be repeated as many times as needed throughout the patient's life.

In addition to patients with sphincter deficiency, adjustable slings appear well-suited for patients who have failed a conventional continence operation, or who present with recurrent leakage after previous surgical procedures. They can also be used with caution in patients who are not candidates for other surgical techniques due to neuromuscular problems affecting the detrusor muscle. These patients typically utilize the Valsalva maneuver during voiding, and are at high risk for retention using conventional surgical techniques. An

adjustable sling allows the surgeon to find a level of support that balances continence with retention.

To our knowledge there are two adjustable sling products currently approved by the FDA, only one of which is actively being marketed in the United States. The system described here was developed by the Neomedic corporation in Spain and is marketed in the US by Tri-Anim under the brand name Remeex™ (Regulacion Mecanica Externa). A somewhat different system using a trans-obturator route, Safyre-t™, manufactured by the South American company Promedon, has received FDA approval but is not yet being marketed in the US. The Neomedic product has been in widespread use in Europe since 1999 with an excellent safety record and good results.

Our early experience with the adjustable sling in Shiprock has been positive. The surgical technique is virtually identical to placement of a conventional mid-urethral sling via the suprapubic route. As expected, adjustable sling placement involves significantly more effort for the surgeon and the patient than a conventional sling, typically requiring several days hospitalization in order to implant and adjust the sling. Although we would not advocate the adjustable sling as a first-line treatment for most stress incontinence patients, we believe that it is an excellent option for patients with certain conditions.

Extended Oral Contraceptives Decrease Premenstrual Symptoms

Conclusion: The use of a 168-day extended regimen of drosperinone in combination with ethinyl estradiol decreased premenstrual symptoms compared with a standard 21/7 regimen. This was particularly true for women who had more premenstrual symptoms during the 21/7 regimen.

Coffee AL, et al. Oral contraceptives and premenstrual symptoms: comparison of a 21/7 and extended regimen. Am J Obstet Gynecol November 2006;195:1311-9.

Perinatology Picks

George Gilson, MFM, ANMC

Placental cultures and histology poor predictors of infectious status of the amniotic fluid

RESULTS: Ninety-two percent of women with positive amniotic fluid cultures tested with at least one positive placenta culture. Eighty percent of women who had negative amniotic fluid cultures also tested with a positive placenta culture. The accuracy of placental cultures in predicting amniotic fluid infection varied from 44% to 57%. Placental pathology showed an accuracy of only 58% in diagnosing intraamniotic inflammation.

CONCLUSION: Placental microbiologic and histologic studies poorly reflect the infectious and inflammatory status of the amniotic fluid. Results of such studies should be interpreted with caution in the management and future counseling of women with preterm labor or preterm premature rupture of membranes

Pettker CM, et al Value of placental microbial evaluation in diagnosing intra-amniotic infection. Obstet Gynecol. 2007 Mar;109(3):739-49

STD Corner

Lori de Ravello
National IHS STD Program

Guidelines for School-Based STD Screening in Indian Country

I'm pleased to announce that our office has just released "Guidelines for School-Based STD Screening in Indian Country". A PDF of the document or hard copies are available, so please let me know if you would like one. Also, the link will be up on our website soon, url below.

Thanks so much to everyone who helped to put these together. We look forward to your feedback. Also, please let us know if you need our technical assistance to implement school-based STD screening in your area. Lori

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Fluoroquinolones No Longer Recommended for Treatment of Gonococcal Infections

In the United States, gonorrhea is the second most commonly reported notifiable disease, with 339,593 cases documented in 2005. Since 1993, fluoroquinolones (i.e., ciprofloxacin, ofloxacin, or levofloxacin) have been used frequently in the treatment of gonorrhea because of their high efficacy, ready availability, and convenience as a single-dose, oral therapy. However, prevalence of fluoroquinolone resistance in Neisseria gonorrhoeae has been increasing and is becoming widespread in the United States, necessitating changes in treatment regimens.

Beginning in 2000, fluoroquinolones were no longer recommended for gonorrhea treatment in persons who acquired their infections in Asia or the Pacific Islands (including Hawaii); in 2002, this recommendation was extended to California. In 2004, CDC recommended that fluoroquinolones not be used in the United States to treat gonorrhea in men who have sex with men (MSM). This report, based on data from the Gonococcal Isolate Surveillance Project (GISP), summarizes

data on fluoroquinolone-resistant N. gonorrhoeae (QRNG) in heterosexual males and in MSM throughout the United States. This report also updates CDC's Sexually Transmitted Diseases Treatment Guidelines, 2006 regarding the treatment of infections caused by N. gonorrhoeae. On the basis of the most recent evidence, CDC no longer recommends the use of fluoroquinolones for the treatment of gonococcal infections and associated conditions such as pelvic inflammatory disease (PID). Consequently, only one class of drugs, the cephalosporins, is still recommended and available for the treatment of gonorrhea.

MMWR Morb Mortal Wkly Rep. 2007 Apr 13;56(14):332-336.

www.cdc.gov/mmwr/preview/mmwrhtml/mm5614a3.htm

Alaska State Diabetes Program

Barbara Stillwater

High rate of diabetes among indigenous people not due to thrifty gene according to study

High rates of diabetes among indigenous people across the globe are rooted in social disadvantage rather than a genetic pre-disposition specific to indigenous populations.

This article examines one of the oldest gene-based theories of complex disease causation: the thrifty genotype hypothesis (THG). This hypothesis is emblematic of the way in which genetic research into complex disease attracts a high investment of scientific resources while contributing little to our capacity to understand these diseases and perpetuating problematic conceptions of human variation. Although there are compelling reasons to regard the high prevalence of type 2 diabetes mellitus as a by-product of our biological incapacity to cope with modern affluent and sedentary lifestyles, there is at present no consistent evidence to suggest that minority populations are especially genetically susceptible. Nor is it clear why such genetic differences would be expected, given the original pan-species orientation of the TGH. The limitations inherent in current applications of the TGH demonstrate that genetic research into complex disease demands careful attention to key environmental, social, and genetic risk factors operating within and between groups, not the simplistic attribution of between-group differences to racialized genetics. A robust interdisciplinary approach to genetic epidemiological research is proposed.

Paradies YC, et al Racialized genetics and the study of complex diseases: the thrifty genotype revisited Perspect Biol Med. 2007 Spring;50(2):203-27

Women's Health Headlines

Carolyn Aoyama, HQE

Women's Early Drinking Problems More Likely to Escape Diagnosis

Men are more likely than women to experience many of the problems commonly associated with nondependent drinking, according to a new study. But the authors suggest women are prone to different alcohol-related problems that are less likely to be diagnosed.

CONCLUSIONS: Significant gender differences were found in approximately one-third of the symptoms assessed and in the overall scale. Further examination of the nature of gender differences in alcohol problem symptoms should be undertaken to investigate whether a gender-neutral scale should be created or if men and women should be assessed with separate criteria for alcohol dependence and abuse.

Nichol PE, Krueger RF, Iacono WG. Investigating gender differences in alcohol problems: a latent trait modeling approach Alcoholism: Clinical and Experimental Research 31(5), 2007.

Laparoscopic and methotrexate in a fixed multiple dose regimen most effective for ectopic

AUTHORS' CONCLUSIONS: In the surgical treatment of tubal ectopic pregnancy laparoscopic surgery is a cost effective treatment. An alternative nonsurgical treatment option in selected patients is medical treatment with systemic methotrexate. Expectant management can not be adequately evaluated yet.

Hajenius PJ et al Interventions for tubal ectopic pregnancy. Cochrane Database Syst Rev. 2007 Jan 24;(1):CD000324

Family Planning

Reasons for unprotected intercourse

RESULTS: Of 7856 respondents, 33% felt they could not get pregnant at the time of conception, 30% did not really mind if they got pregnant, 22% stated their partner did not want to use contraception, 16% cited side effects, 10% felt they or their partner were sterile, 10% cited access problems and 18% selected "other." Latent class analysis showed seven patterns of response, each identifying strongly with a single reason. CONCLUSIONS: Almost half of women with viable unintended pregnancies ending in a birth felt they could not/would not get pregnant at the time of conception. Most women identified with a single reason for having unprotected intercourse.

Nettleman MD, Chung H, Brewer J, et al. 2007. Reasons for unprotected intercourse: Analysis of the PRAMS survey. Contraception 75(5):361-366.

(First Trimester GDM…, continued from page 1)

The effects of pregnancy on glucose metabolism

Here is why first trimester glucose results can be confusing. Evolution has set up the physiology of pregnancy to provide maximum substrate for the survival and development of the fetus. Post prandial glucose, fatty acid, and amino acid excursions are higher, thus readily enabling the fetus to siphon off maternal nutrients for its needs. This occurs, in the case of glucose, by active diffusion across the placental membrane. Nevertheless, especially during early pregnancy, a state of relative maternal hypoglycemia is customarily observed, especially in the pre-prandial state. In addition, the nausea and vomiting provoked by high human chorionic gonadotrophin levels leads to maternal catabolic state.

This situation may complicate the diagnosis of diabetes by the usual criteria. In the first trimester, fasting glucose are expected to be lower, and post prandial glucose values may or may not yet be elevated. Every woman may occupy somewhat different positions on this "bell curve" of responses. Dr. O'Sullivan set up the glucose challenge test we use today to be carried out in the early third trimester, when pregnancy has definitely shifted to a different, much more anabolic state, induced by high human chorionic somatomammotrophin, cortisol, and estrogen.

A first trimester glucose challenge may provide confusing results. In a woman with the risk factors below, seeing what her fasting and two-hour post meal glucose excursions are may be more helpful. If the values quoted above, comparable to those obtained in non-pregnant women, are obtained, PGDM is quite likely.

Glycosylated hemoglobin levels (HbA1C) levels offer limited assistance in non-type 1 pregnant diabetics. Because of the physiologic hemodilution of pregnancy, which will also dilute HbA1C, they almost always look great! However, this "physiologic anemia" does not develop until the mid second trimester, and an elevated early trimester HbA1C value (>6.5%) may be an important clue to the woman's pre-gestational carbohydrate metabolism. Likewise, since embryogenesis is complete by 9 weeks gestation, interventions aimed at lowering glucose after that time are not likely to have a significant impact on the prevention of hyperglycemia-induced teratogenesis. It would have been great to have found this woman pre-conceptually, established good control, and put her on folate, but now, our interventions may not be timely at all. Conversely, women with a first trimester HbA1C >8.5% have an incidence of fetal anomalies of upwards of 20 per cent. Such women certainly deserve referral for a second trimester comprehensive ("level 2") targeted ultrasound to carry out a detailed survey of the fetal anatomy.

Our recommendation would be against labeling women as pre-gestational diabetics if they don't meet the ADA criteria > 126 mg/dL fasting and/ or >200 mg/dL post prandial glucose. (See First trimester GDM below)

We have searched extensively and have not been able to find a single evidence-based recommendation as to the validity of first trimester glucose screening, just textbook "expert opinions". Please note the usual criteria are only based on giving our clients their 50 g 1-hour glucose challenge (and possible 3-hour diagnostic 100 g glucose tolerance test) at the recommended interval of 24-28 weeks, during "the anabolic phase" of pregnancy.

We should avoid labeling women as pre-existing diabetic, and instead care for them as they have GDM just with a slightly higher level of suspicion. They may have GDM which can be controlled with diet and exercise (class A1), or need medical therapy (insulin or glyburide), i.e., GDM, class A2. Perhaps a significant number of the latter group actually do have PGDM which can be determined post partum.

A new diagnostic category: First Trimester GDM

We suggest patients whose first diagnosis of glucose intolerance is in the first trimester simply be called 'First Trimester GDM'. Here is an approach to last part of her Progress note:

Assessment:

1. IUP, 8 wks.
2. 1st Trimester GDM
   —possible pregestational DM, status to be determined pp

Plan:

- monitor for development of GDM-A2
- will require increased surveillance if becomes GDM-A2
- otherwise manage as GDM-A1
- need to re-test for glucose intolerance postpartum

We would manage the First trimester GDM patient according to their and their fetus' needs now, and establish a definitive diagnosis later. If you have a high level of suspicion initially, you can order a spot urine Protein/ Creatinine ratio, or a

24-hour urine for creatinine clearance and total protein, as well as arrange a baseline dilated retinal exam. If the patient requires medical therapy, she will also need fetal surveillance after 32 weeks. There are also psychological benefits with more accurate diagnoses.

Those patients with abnormal OGTTs diagnosed after completion of the first trimester should simply be diagnosed with 'gestational diabetes mellitus'.

From a public health standpoint, it will behoove us to assiduously follow up such a woman as presented in the case vignette at six weeks post partum. Significant numbers of Native American women with GDM will become overt type 2 diabetics within five years of the index pregnancy. Post partum we need to be sure she gets her 75 g 2-hour screen, or fasting glucose evaluated by the usual adult criteria, in order to establish the level of abnormal carbohydrate metabolism. If normal, then she should be re-screened with a fasting glucose every 3 years.

When the results of the large international multi-center Hyperglycemia and Pregnancy Outcomes (HAPO) study, which is using the 75 g glucose tolerance test to diagnose GDM, are published, we will have the evidence to enable us to simplify the whole process.

In summary, the term 'First Trimester GDM' raises the appropriate level of suspicion among your fellow providers, while providing the patient the most accurate diagnosis for the rest of her lifetime.

Your comments on what works for you at your service units are welcome.

George J. Gilson, MD (ANMC)
John B. Miller, M.D. (Zuni)
Neil Murphy, M.D. (ANMC)

Deputy OB/GYN CCC Editorial

Drs. Gilson, Miller, and Murphy raise a excellent point about the challenges of managing an early diagnosis of gestational diabetes.

Their proposed new diagnostic category, First Trimester GDM, highlights the increased risk status of these women, without making a diagnosis of pre-gestational diabetes until confirmatory testing has been conducted after delivery. We have seen a number of women in similar circumstances in our practice and find that they benefit greatly from intensive education during pregnancy, although assuring completion of postpartum testing remains challenging.

The use of this new diagnostic category would help identify these women for intensified efforts for postpartum follow-up and provide efficient communication of risk to other members of the health care team. It would be worthwhile to consider adding this new diagnostic category in your facility's Diabetes in Pregnancy guidelines when you next update them.

—Jean Howe, MD

Reference: Online

Risk factors triggering a GDM screen at the first prenatal visit

History

- macrosomic infants over 4000g (8 lbs. 14 oz.)
- family history of first degree relatives with diabetes
- gestational diabetes in a previous pregnancy
- overweight
  (pre-pregnancy weight ≥ 110 % of ideal body weight
  (pre-pregnancy weight BMI ≥ 27)
- prior term intrauterine fetal demise
- prior infant with a birth defect or congenital anomaly
- habitual abortion (≥ 3 consecutive SAB)

Current pregnancy:

- age over 35 years
- unexplained polyhydraminos
- persistent glycosuria

Child Health

Urinary symptoms in adolescent females: STI or UTI?

RESULTS: In the full sample, prevalence of UTI and STI were 17% and 33%, respectively. Neither urinary symptoms nor UTI was significantly associated with STI. Further analyses are reported for the 154 (51%) with urinary symptoms: Positive urine leukocytes, more than one partner in the last three months and history of STI predicted STI. Urinalysis results identified four groups: (1) Normal urinalysis-67% had no infection; (2) Positive nitrites or protein-55% had UTI; (3) Positive leukocytes or blood-62% had STI; and (4) Both nitrites/protein and leukocytes/blood positive-28% had STI and 65% had UTI. Those without a documented UTI were more likely to have trichomoniasis than those with a UTI, and 65% of those with sterile pyuria had STI, mainly trichomoniasis or gonorrhea.

CONCLUSIONS: Adolescent females with urinary symptoms should be tested for both UTI and STIs. Urinalysis results may be helpful to direct initial therapy.

Huppert JS, Biro F, Lan D, Mortensen JE, Reed J, Slap GB. Urinary symptoms in adolescent females: STI or UTI? J Adolesc Health. 2007 May;40(5):418-24. Epub 2007 Mar 9.

SAVE THE DATES

Native Women's Health and MCH Conference

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

3rd Annual American Indian and Alaska Native Long Term Care Conference

- September 5–6, 2007
- Albuquerque, New Mexico
- Visit www.aianlongtermcare.org
- Contact Bruce.Finke@ihs.gov

IHS/ACOG Obstetric, Neonatal, and Gynecologic Care Course

- September 16–20, 2007
- Denver, Colorado
- Contact Yvonne Malloy at 202-863-2580 or YMalloy@acog.org

Abstract of the Month

- A new diagnostic category: 'First Trimester GDM'

IHS Child Health Notes

- A randomized, controlled trial of acetaminophen, ibuprofen, and codeine for acute pain relief in children with musculoskeletal trauma.
- Infectious Disease Updates—Pertussis: Secular Trends in the United States
- Recent literature on American Indian/Alaskan Native Health—Adolescent sexual behavior and strategies for reducing early pregnancy and childbearing

From Your Colleagues

- Ben Garnett, Anchorage—Control over schedule: Most important predictor of staff work-life balance and burnout

Hot Topics

- Obstetrics—Placental problems with previous caesarean delivery: Abruptio, previa
- Gynecology—Discharge 24 Hours After Vaginal Hysterectomy Safe, Acceptable
- Child Health—Forty percent of 3-month-olds watch TV, DVDs, or videos
- Chronic disease and Illness—Malabsorption of Oral Antibiotics in Pregnancy after Gastric Bypass Surgery

Features

- Breastfeeding—Breastfeeding and maternal illness
- Menopause Management—Earlier hormone therapy closer to menopause tended to have reduced CHD risk
- International Health Update—Social context of maternal deaths and morbidity
- Medical Mystery Tour—Which Indian Health facilities lead the entire U.S. in national obstetric benchmarks?
- Navajo News—Adjustable Urethral Slings Offer Hope for Patients with Complex Incontinence Problems
- Perinatology Picks—Placental cultures and histology poor predictors of infectious status of the amniotic fluid
- STD Corner—Guidelines for School-Based STD Screening in Indian Country
- Alaska State Diabetes Program—High rate of diabetes among indigenous people not due to thrifty gene according to study

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