



## Within the Hidden Epidemic:

### Sexually Transmitted Diseases and HIV/AIDS Among American Indians and Alaska Natives.

**OBJECTIVES:** To review the epidemiology, research, and prevention programs for sexually transmitted diseases in American Indians and Alaska Natives (AI/ANs).

**STUDY DESIGN:** We reviewed the current national and regional trends in sexually transmitted diseases (STDs) for AI/ANs from 1998-2004, peer-reviewed studies from January 1996, through May 2006, and reports, unpublished documents, and electronic resources addressing AI/AN STD prevention and control.

**RESULTS:** STD prevalence among AI/ANs remains high. For example, the case rate of *C. trachomatis* in the North Central Plains AI/AN populations is 6 times the overall US rate. Trends for *C. trachomatis* also show sustained increases. Little research exists on STDs for this population, and most is focused on HIV/AIDS. Fear of compromised confidentiality, cultural taboos, and complex financial and service relationships inhibit effective surveillance, prevention, and management.

**CONCLUSIONS:** Recommendations for STD control in this population include improved local surveillance and incorporation of existing frameworks of health and healing into prevention and intervention efforts. Research defining the parameters of cultural context and social epidemiology of STDs is necessary.

*Kaufman CE, Shelby L, Mosure DJ, Marrazzo J, Wong D, de Ravello L, Rushing SC, Warren-Mears V, Neel L, Jumping Eagle S, et al; for the Task force on STD Prevention and Control Among American Indians and Alaska Natives. Within the Hidden Epidemic: Sexually Transmitted Diseases and HIV/AIDS Among American Indians and Alaska Natives. Sex Transm Dis. 2007 May 25*

#### OB/GYN CCC Editorial

**The IHS National STD Program: A great resource**  
You will recognize many of the authors' names in the abstract above from the IHS Division of Epide-

miology and Disease Prevention and the IHS National STD Program. Don't hesitate to utilize the expertise the IHS National STD Program has to offer on HIV prevention and control. Below is some background on the IHS National STD Program.

#### National IHS HIV/AIDS Consultant

Scott Giberson is another great resource. Scott is the National IHS HIV/AIDS Consultant in the Office of Clinical and Preventive Services, HQE and a regular contributor to the CCCC. [Scott.Giberson@ihs.gov](mailto:Scott.Giberson@ihs.gov)

#### Other AI/AN specific HIV resources:

The need for historically grounded HIV/AIDS prevention research among Native Americans

This is a brief report that summarizes the need for historically grounded HIV prevention research among Native Americans living in the United States. It illustrates the intersection of culture and history, showing that ethnic groups can respond to historical traumatic events for generations, often to the detriment of individual and collective health.

*Journal of the Association of Nurses in AIDS Care. 18(2):15-7, 2007 Mar-Apr.*

#### American Indian Women, HIV/AIDS, and Health Disparity

Data are presented regarding the prevalence of HIV/AIDS among American Indian women. Health disparities found among American Indians are discussed and biological, economic, social, and behavioral risk factors associated with HIV are detailed. Recommendations are suggested to alleviate the spread of HIV among American Indian women and, in the process, to diminish a culture of treatment malpractice and a weakening of treatment ethics, racism, and genderism.

*Substance Use & Misuse, Volume 42 Issue 4 2007*

*p. 741 - 752*

*Other References online*

#### THIS MONTH

Abstract of the Month . . . . .	1
Child Health Notes . . . . .	2-3
Hot Topics . . . . .	4-5
Features . . . . .	6-15
From Your Colleagues . . . . .	10

**It is not too late to sign up for either of these...**

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](mailto:nmurphy@scf.cc)

This is different from than the **ACOG/IHS Postgraduate course**, held every September in Denver to rave reviews. It will be September 16-19 this year. It is an excellent 3.5 day primer on basic obstetrics, gynecology, and neonatal care, plus a clinical update for new staff or experienced staff who want a complete brush up.

[YMalloy@acog.org](mailto: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](mailto: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 Hsiao P'ing (1904–1997)

## Quote of the month

*"Hypocrisy is the homage vice pays to virtue"*

—Oscar Wilde

## Articles of Interest

### Lactose intolerance in infants, children, and adolescents.

*Pediatrics*. 2006 Sep;118(3):1279-86.

Lactose intolerance is common, especially in non-white populations. The AAP has released a summary statement based on a systematic review of the literature.

The most important point is that while primary lactase deficiency is common in older children and adults it is uncommon in children < 3 years of age. Congenital lactase deficiency is extremely rare. Nearly all infants, including AI/AN infants, should be able to have lactose in their diets.

Transient secondary lactase deficiency after an acute viral gastroenteritis is common and nearly always resolves rapidly. Only very young children (< 3 months) or malnourished children will need a lactose free formula.

Most children, even if lactose deficient, can drink up to 8 ounces of milk in a day without symptoms. Formal testing is not needed. A trial of a lactose free diet followed by reintroduction of lactose containing milk and recurrence of symptoms is sufficient to make the diagnosis.

### Editorial Comment

We spend a lot of time worrying about cow's milk. Breast-feeding is best but most infants should be able to drink a lactose containing formula if needed. Older children can often drink some milk and can take partially digested products including cheese and yogurt and pretreated milk. It is the rare child who needs all lactose foods removed from their diet.

## Infectious Disease Updates.

Rosalyn Singleton, MD, MPH

### Flu News

2006-7 Influenza activity in the United States peaked in mid-February. In late May, 20 states reported sporadic activity, and 30 states reported no influenza activity. It was a mild Flu season and the percent of deaths due to pneumonia and influenza remained below baseline levels for the entire influenza season. Between Oct. 2006 – May 2007, CDC received 60 reports of influenza-associated pediatric deaths. Since October 1, 2006, of the 23,181 influenza viruses cultured, 18,392 (79.3%) were influenza A viruses and 4,789 (20.7%) were influenza B viruses. Among the influenza A viruses, 63.5% were H1 viruses and 36.5% were H3 viruses. Influenza

vaccine is expected to be in good supply for the 2007-8 season – The CDC says that the US should have a record 127 million flu vaccine doses for next season.

Live nasal flu vaccine (FluMist®) is currently licensed only for 5-49 year olds. Two FluMist® studies were published in October in Pediatric Infectious Disease Journal. The first indicated that FluMist® was well-tolerated in children with asthma. The second study showed that FluMist® was associated with fewer cases of flu from vaccines than the Flu shot in 6-71 month old children. MedImmune Inc. has applied for an age expansion of FluMist® down to 1 year of age.

Bird Flu cases among humans and birds have been declining since January. Although WHO officials think the current cycle of the H<sub>5</sub>N<sub>1</sub> strain is nearing an end, they remain concerned about "pockets" of the disease in Indonesia, Nigeria, and Egypt. Preparing for a global pandemic in the event that the virus mutates and passes from person to person should still be a major priority.

## Recent literature on American Indian/Alaskan Native Health

Doug Esposito, MD

### Article

Williams JF, Storck M, American Academy of Pediatrics Committee on Substance Abuse; American Academy of Pediatrics Committee on Native American Child Health. Inhalant abuse. *Pediatrics*. 2007 May;119(5):1009-17

### Editorial Comment

This Clinical Report was jointly authored by the AAP Committee on Substance Abuse and the Committee on Native American Child Health, and stands as a valuable reference for those working with AI/AN children. Unfortunately, children in the populations we serve are known to be at elevated risk for abusing inhalants, especially the volatile hydrocarbons. They are easy to obtain, being almost ubiquitous in homes and the local environment. They are legal (for their intended uses), easy to conceal, and inexpensive. Consequently, they tend to be more widely abused by younger kids than any other substance class. Furthermore, this problem does not respect national boundaries. First Nations populations in Canada widely report high rates of this malady, and I have seen first hand large numbers of Native children in

both Central and South America partaking of this form of “escape.” In the U.S., inhalant abuse occurs everywhere and among all ethnicities and socioeconomic classes. However, it tends to be more prevalent anywhere there is significant socioeconomic disadvantage, geographic isolation (code for rural), and social isolation; ergo Reservations.

For anyone working with Native populations for any length of time, if you haven’t run into this problem yet, then you haven’t been looking. It’s out there! For those of us on the Navajo Nation, all you have to do is look around the Bashes’ parking lot or in the adjacent weeds and drainage ditches to find the ubiquitous cans of AquaNet hairspray used to make “ocean.” Although a reasonably common practice among adults, kids partake of this concoction as well. And, its use (or misuse) can be fatal. I’ve seen it!

I would encourage everyone to at least skim this article, or better yet, read it thoroughly and in its entirety. I am sure you will find it to be either a valuable review of or an excellent introduction to a prevalent and dangerous problem. Please, be on the look out.

## Article

Centers for Disease Control and Prevention. **Fatal Injuries Among Children by Race and Ethnicity – United States, 1999-2002. Surveillance Summaries, May 18, 2007. MMWR 2007;56(SS-5).**

## Editorial Comment

The last time I wrote to you all, I reviewed an article by Pressley, et al<sup>1</sup> on early childhood injury.<sup>2</sup> In that review, I pointed out an important study limitation related to the racial misclassification that occurs on death certificates and the impact racial misclassification has on reported mortality and disease rates that are derived from death certificate-dependent databases. The resultant effect of this bias is to underestimate mortality and disease rates for Native Americans.

Well, as luck would have it, the very week I submitted my review to Dr. Holve a similar study was published in the MMWR! In this report, the

authors referenced a CDC study that quantifies the net effect of this error. They state that “adjusting for misclassification would increase reported rates for AI/ANs by approximately 20.6%.”<sup>3</sup> Wow!!

So, what does this all mean? Injury mortality rates for AI/AN children are significantly worse and the disparities significantly greater than reported. This renders the progress that appears to have been made far less impressive. Although progress is certainly being made, much remains to be done if we are to successfully eliminate injury as a health disparity for AI/AN children by 2010. **Healthy People 2020, anyone?**

1. 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.*

2. IHS Child Health Notes, June/July 2007.

3. Rosenberg HM, Maurer JD, Sorlie PD, Johnson NJ, MacDorman MF, Hoyert DL, Spittler JF, Scott C. *Quality of death rates by race and Hispanic origin: a summary of current research, 1999. Vital Health Stat 2. 1999 Sep;(128):1-13.*

## 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](mailto:indianhealth@aap.org)

or complete the on-line locum tenens form at <http://www.aap.org/nach/locumtenens.htm>

## Child Health

### Obese Young Adults Face High Diabetes Risk

People who are obese at age 18 will more likely than not develop type 2 diabetes at some point.

#### CONCLUSIONS:

Cardiometabolic abnormalities are present in nearly 68% of young, healthy, Asian-Indian adolescents and even among those with normal weight. Insulin resistance is associated with individual cardiometabolic factors, and plasma insulin showed association with clustering of some variables

Ramachandran A, *Insulin resistance and clustering of cardiometabolic risk factors in urban teenagers in southern India. Diabetes Care. 2007 Jul;30(7):1828-33.*

# Hot Topics

## Obstetrics

### VBAC: Smaller attributable risk than previously reported

**OBJECTIVE:** To compare pregnancy outcomes in women with one prior low-transverse cesarean delivery after induction of labor with pregnancy outcomes after spontaneous labor.

**METHODS:** This study is an analysis of women with one prior low-transverse cesarean and a singleton gestation who underwent a trial of labor and who were enrolled in a 4-year prospective observational study. Pregnancy outcomes were evaluated according to whether a woman underwent spontaneous labor or labor induction

**RESULTS:** Among the 11,778 women studied, vaginal delivery was less likely after induction of labor both in women without and with a prior vaginal delivery (51% versus 65%,  $P < .001$ ; and 83% versus 88%,  $P < .001$ ). An increased risk of uterine rupture after labor induction was found only in women with no prior vaginal delivery (1.5% versus 0.8%,  $P = .02$ ; and 0.6% versus 0.4%,  $P = .42$ ). Blood transfusion, venous thromboembolism, and hysterectomy were also more common with induction among women without a prior vaginal delivery. No measure of perinatal morbidity was associated with labor induction. An unfavorable cervix at labor induction was not associated with any adverse outcomes except an increased risk of cesarean delivery.

**CONCLUSION:** Induction of labor in the study population is associated with an increased risk of cesarean delivery in all women with an unfavorable cervix, a statistically significant, albeit clinically small, increase in maternal morbidity in women with no prior vaginal delivery, and no appreciable increase in perinatal morbidity.

**LEVEL OF EVIDENCE:** II.

### OB/GYN CCC Editorial

#### VBAC: The pendulum needs to swing back

After peaking in 1996, the vaginal birth after cesarean delivery (VBAC) rate has steadily declined to 13% in 2004. This decline has been accompanied by a number of articles that have questioned whether a trial of labor is equally suitable for all women with a prior low-transverse cesarean delivery. Correspondingly, investigators have tried to identify factors predictive of a lower chance of a successful trial of labor as well as a greater chance of uterine rupture, and thereby identify the specific women for whom a trial of labor is less safe and appropriate.

In contrast to the declining rate of VBAC, the rate of labor induction has been steadily increasing, more than doubling over the last decade to a frequency of more than 20%. Thus, the effect of induced versus spontaneous labor in women attempting VBAC is of particular interest. Initial reports suggested that women who underwent labor induction were no more likely than their spontaneously laboring

counterparts to have a cesarean delivery or a uterine rupture. More recent studies, however, have challenged both conclusions, showing a higher rate of both cesarean delivery and uterine rupture among women undergoing labor induction with a prior cesarean delivery.

The 2001 Lydon-Rochelle et al in the NEJM raised questions about a possible higher rate of uterine rupture during induction of labor after previous cesarean delivery and temporally was related with a further erosion of the VBAC rate. The current prospective observation study above further illuminates the weakness of the Lydon-Rochelle et al article which was based on ICD 9 codes alone, a method known for ascertainment bias.

Women who desire a VBAC and are confronted with the decision to undergo labor induction can be counseled that their risk for most serious adverse outcomes is not significantly increased, the adverse outcomes that are increased have a small attributable risk associated with induction, and that even this small attributable risk appears limited to women without a prior vaginal birth.

*Reference: Online*

### New CDC/ACIP Recommendation for Varicella Vaccination in Women

#### Prenatal Assessment and Postpartum Vaccination

Prenatal assessment of women for evidence of varicella immunity is recommended. Birth before 1980 is not considered evidence of immunity for pregnant women because of potential severe consequences of varicella infection during pregnancy, including infection of the fetus. Upon completion or termination of their pregnancies, women who do not have evidence of varicella immunity should receive the first dose of vaccine before discharge from the health-care facility. The second dose should be administered 4–8 weeks later, which coincides with the postpartum visit (6–8 weeks after delivery). For women who gave birth, the second dose should be administered at the postpartum visit. Women should be counseled to avoid conception for 1 month after each dose of varicella vaccine. Health-care settings in which completion or termination of pregnancy occurs should use standing orders to ensure the administration of varicella vaccine to women without evidence of immunity. ...”

Prevention of Varicella: Recommendations of the Advisory Committee on Immunization Practices (ACIP)

### OB/GYN CCC Editorial

#### Update the clinical guidelines at your hospital to include the above recommendations

Please add prenatal screening and postpartum vaccination, as per CDC/ACIP to your practice and guidelines.

[www.cdc.gov/mmwr/preview/mmwrhtml/rr5604a1.htm?s\\_cid=rr5604a1\\_e](http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5604a1.htm?s_cid=rr5604a1_e)

## Gynecology

### LEEP doubles risk of preterm delivery: Patients need to be informed

**CONCLUSION:** Our study showed an almost 2-fold increase in the risk of preterm delivery after LEEP treatment. Thus, women in their reproductive age should be informed about the increased risk of preterm delivery, if treated with LEEP.

*Nøhr B et al Loop electrosurgical excision of the cervix and the subsequent risk of preterm delivery. Acta Obstet Gynecol Scand. 2007;86(5):596-603*

### Clinic management of early pregnancy failure: Safe, cost-effective

Early pregnancy failure and induced abortion are often managed differently, even though safe uterine evacuation is the goal in both. Early pregnancy failure is commonly treated by curettage in operating room settings in anesthetized patients. Induced abortion is most commonly managed by office vacuum aspiration in awake or sedated patients. Medical evidence does not support routine operating room management of early pregnancy failure. The University of Michigan initiated office uterine evacuations for early pregnancy failure treatment. Patients previously went to the operating room. These changes required faculty, staff, and resident education. Our efforts blurred the lines between spontaneous and induced abortion management, improved patient care and better utilized hospital resources

*Harris LH, et al; Surgical management of early pregnancy failure: history, politics, and safe, cost-effective care Am J Obstet Gynecol. 2007 May;196(5):445.e1-5*

## Child Health

### Physical Activity Alone May Not Reduce Obesity in Children

**CONCLUSION:** The authors conclude that this program to increase physical activity resulted in improvement in motor skills of children four to five years of age but had no demonstrable impact on obesity. They suggest that the program may have provided inadequate levels of physical activity to produce a measurable effect, and that several factors may need to be addressed simultaneously to impact body mass index. They suggest that future intervention programs for obesity in early childhood should incorporate attention to diet, more behavioral approaches, and greater involvement of parents.

*Reilly JJ, et al. Physical activity to prevent obesity in young children: cluster randomised controlled trial. BMJ November 18, 2006;333:1041-3.*

### Increased risk of autism: associated with parental age and obstetric conditions

**CONCLUSIONS:** Evidence to suggest that parental age and obstetric conditions are associated with an increased risk of autism and autism spectrum disorders is accumulating. Although not proven as independent risk factors for autism,

these variables should be examined in future studies that use large, population-based birth cohorts with precise assessments of exposures and potential confounders.

*Kolevzon A et al Prenatal and perinatal risk factors for autism: a review and integration of findings. Arch Pediatr Adolesc Med. 2007; 161(4):326-33*

## Chronic disease and Illness

### Rosiglitazone: seeking a balanced perspective

**CONCLUSIONS:** Rosiglitazone was associated with a significant increase in the risk of myocardial infarction and with an increase in the risk of death from cardiovascular causes that had borderline significance. Our study was limited by a lack of access to original source data, which would have enabled time-to-event analysis. Despite these limitations, patients and providers should consider the potential for serious adverse cardiovascular effects of treatment with rosiglitazone for type 2 diabetes

*Nissen SE, Wolski K. Effect of rosiglitazone on the risk of myocardial infarction and death from cardiovascular causes. N Engl J Med. 2007 Jun 14;356(24):2457-71.*

### Editorial Comments:

#### British Analysis Does Not Confirm Rosiglitazone (Avandia) MI Risk

After weighing all options and reviewing data from both the NEJM article and information sent out from GlaxoSmithKline, most do not presently believe it rational to have a blanket policy of taking patients off of rosiglitazone. No other major professional entity has recommended that up to this time. Rather, we recommend three possible options in consultation with the patient either by phone or at an appointed clinic visit.

- The patient and provider may choose to continue rosiglitazone with careful attention to possible symptoms of either ischemia or congestive heart failure.
- The patient and provider may negotiate a change in medication to pioglitazone if that is available on the pharmacy formulary. 15 to 30 mg of pioglitazone is roughly equivalent to 4 mg of rosiglitazone and 45 mg roughly corresponds to the 8mg dose.
- The patient and provider may choose to take the patient off rosiglitazone. This requires careful blood glucose monitoring for 2 – 3 months as the effect of the TZD class is not lost immediately on discontinuing this medicine. Titration of insulin or adding another agent may be necessary depending on the response to discontinuing the medicine.

*Lancet Editorial: Reference Online*

# Features

## ACOG, American College of Obstetricians and Gynecologists Management of Herpes in Pregnancy: Practice Bulletin

### Summary of Recommendations and Conclusions

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

- Women with active recurrent genital herpes should be offered suppressive viral therapy at or beyond 36 weeks of gestation.
- Cesarean delivery is indicated in women with active genital lesions or prodromal symptoms, such as vulvar pain or burning at delivery, because these symptoms may indicate an impending outbreak.

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

- In women with premature rupture of membranes, there is no consensus on the gestational age at which the risks of prematurity outweigh the risks of HSV.
- Cesarean delivery is not recommended for women with a history of HSV infection but no active genital disease during labor.
- Routine antepartum genital HSV cultures in asymptomatic patients with recurrent disease are not recommended.
- Routine HSV screening of pregnant women is not recommended

*Management of Herpes in Pregnancy. ACOG Practice Bulletin No. 82. American College of Obstetricians and Gynecologists. Obstet Gynecol 2007; 109:1233–48.*

## Ask a Librarian

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

### Scopus™: A New Database

Scopus™ is an interdisciplinary, bibliographic database that indexes the contents of more than 15,000 journals in the physical sciences, engineering, earth and environmental sciences, life and health sciences, social sciences, psychology, business, and management. Scopus coverage includes 535 open access journals, 12,850 academic journals, conference proceedings, trade publications, 13 million patents, and more than 200 million scientific web pages. The coverage of Scopus is strongest from 1996 to the present and it is updated daily.

In terms of functionality, Scopus:

- provides the ability to view search results and refine them to the most relevant hits,
- offers an email alerting service that notifies you when a new publication matches your search terms, and when a new publication cites a selected publication,
- presents patent search results from four patent offices,

- includes seamless links to full-text articles and other library resources.

### Search Functions

Function	Symbol/Method	Example
Freetext searching	Select "All fields"	
Spelling	Use all variations	colour, color
Phrases	use quotation marks - "m"	"avian flu"
Truncation	*	arter* gives artery or arteries
Wildcard	*	wom*n gives woman or women
Optional wildcard	?	p?ediatric gives pediatric or paediatric
Controlled vocabulary	none	
Boolean	AND, OR, AND NOT	human AND NOT rat

You can access Scopus via Research Tools Databases on the green menu bar on the HSR Library webpage. For more information about using Scopus email me at cooperd@mail.nih.gov

## Breastfeeding

Suzan Murphy, PIMC

What to do when: Mom says,

"My newborn likes the bottle better."

Why does it happen?

In a normal, healthy newborn, bottle preference is usually from overuse of a bottle and/or pacifier. However, it is helpful to rule out unusual newborn issues that can effect sucking like a short frenulum or thrush.

What is the cause?

Formula or breast milk comes out of the bottle quickly, just a little tug. Also, the plastic nipple can rub the roof of the mouth, stimulating the suck. It is not much work for the baby—and there is no waiting for let down. It is easy. Breastfeeding takes more work. Often, but not always, a baby will begin to favor the bottle and avoid breastfeeding. Unfortunately, it is hard to know which baby will be influenced by frequent bottles/pacifiers.

In the first couple weeks, there is probably still time for the mom's supply to bounce back.

To get mom and baby back to breastfeeding:

- Assure the mom that her baby is getting enough
- Have her count diaper changes—if her baby has least 6 in 24 hours, her baby is probably has an adequate intake.
- Check her baby's weight gain—½ oz—1 oz per day, 3.5–7 oz per week is normal
- Tell the mom to breastfeed about 2 hours—8 to 12 times

in 24 hours. The baby's suck muscles and mom's milk supply will get up to speed together and the frequency will slow down within a couple days.

- Discourage the “pump and feed” method—it has a near 100% burn out rate.
- Tell the mom to praise her baby for sucking well. The baby knows mom’s happier voice and will respond appropriately.
- Recommend less use of the bottle. If the bottle can be weaned down to once or twice a day, the mom’s milk supply will probably be protected. Less is best in the first 4 – 6 weeks.
- Suggest that the pacifier be avoided—and saved for difficult times like car trips with screaming a baby or challenging moments.

If it looks like it really is a supply issue, or the “bounce back” is not happening, consider medication. Clinical studies indicate that metoclopramide can increase milk supply in difficult situations. For more information, refer to Thomas Hales’ text, Medications and Mother’s Milk or sources like the San Diego Breastfeeding Coalition web page, below.

If the baby won’t latch, refer the mom to WIC or a Lactation Consultant. It is OK to call us for over-the-phone-ideas at 1-877-868-9473. It is toll-free—best times are 7 am – 10 pm, Mountain Standard Time.

What about extra fluids?

Clinical studies have not agreed with the common practice of encouraging fluids to increase milk supply. Unfortunately the studies were small, each with less than 30 participants, and did not correct for climate issues—such as excessive heat/cold, or the typical amount of outdoor exposure the mother experienced. So while encouraging water is a healthy practice, excessive fluids are not necessary. A reasonable recommendation is to keep water nearby and drink to thirst.

*Please note:* If it is believed that a specific (safe) beverage will help, it probably will. Confidence is a powerful tool with parenting, especially breastfeeding.

[www.breastfeeding.org/articles/reglan.html](http://www.breastfeeding.org/articles/reglan.html)

**New IHS Breast feeding Family Support web page: Have pictures to share?**

When family and friends support breastfeeding, it makes the challenges easier.

**Your encouragement will touch a lifetime.**

- Tell mom that she is doing great.
- Let dad know that his patience is beautiful.
- Let the new family how proud you are of them.
- Praise grandparents/aunts/uncles/cousins/friends- for their wonderful care and wisdom.

**Give the new family a boost:**

- Tackle some household chores
- Bring a meal over
- Change some diapers
- Make the trip to the grocery store
- Give the baby a bath
- Take the new siblings to the park
- Read a book or watch TV with the new siblings
- Keep mom resting, bring the baby to her

If you have pictures to share, please email them to [suzan.murphy@ihs.gov](mailto:suzan.murphy@ihs.gov)

[www.ihs.gov/MedicalPrograms/MCH/M/bfFamily.cfm](http://www.ihs.gov/MedicalPrograms/MCH/M/bfFamily.cfm)

**International Health Update  
Claire Wendland, Madison, WI  
Maternal survival redux:**

**a view from Malawi—Failure of justice**

Last November this column reviewed the Lancet’s recent series on maternal survival, which assessed the progress and pitfalls of the Safe Motherhood movement. This month I want to revisit the issue of maternal survival from a more personal perspective. I spent the first five months of 2007 in Blantyre, Malawi, the largest city in a country in which a woman’s lifetime chance of dying from childbirth complications is around one in eight. While there I spent part of each week working clinically in a busy public referral and teaching hospital, alongside many of the nation’s new nurse midwives—and doctors-in-training. During these five months we averaged two to three maternal deaths every week in the hospital. I also spent time out in the community, interviewing nurse midwives at area health centers, and speaking with traditional midwives (TBAs in the biomedical lexicon). Many health workers—both within and outside of the formal medical sector—shared their perceptions of maternal risk in Malawi. Some thoughts based on these experiences:

- Birth in a safe facility, attended by a skilled health worker, is just a start. And it doesn’t necessarily equate with “birth in a hospital with a biomedically trained doctor or nurse midwife.” Can a referral hospital be considered a “safe facility” if it has no sutures, runs out of all antibiotics except penicillin G, or has such poor staffing that one nurse covers a ward of eighty patients? Can a government health center be considered safe if there is no equipment to start an IV, nor any blood pressure cuff? What if the “skilled health worker” is demoralized and apathetic because he hasn’t been paid in two months? What if she is a brand new intern – poorly trained and supervised – who learned how to do a Cesarean from another

**Family Planning**

**Waiting until the menses to start hormonal contraceptives: Needless Obstacle**

CONCLUSION: Protocols that require a woman to wait until the next menses to start hormonal contraceptives are an obstacle to contraceptive initiation. Directly observed, immediate initiation of the pill improves short-term continuation

*Westhoff C, et al Initiation of oral contraceptives using a quick start compared with a conventional start: a randomized controlled trial. Obstet Gynecol. 2007 Jun;109(6):1270-6.*

## STD Corner

### Sexually active women benefit from HPV vaccine

INTERPRETATION: Administration of HPV vaccine to HPV-naive women, and women who are already sexually active, could substantially reduce the incidence of HPV16/18-related cervical precancers and cervical cancer

*Ault KA Effect of prophylactic human papillomavirus L1 virus-like-particle vaccine on risk of cervical intraepithelial neoplasia grade 2, grade 3, and adenocarcinoma in situ: a combined analysis of four randomised clinical trials. Lancet. 2007; 369(9576):1861-8*

intern and isn't too sure how to use oxytocin? Making motherhood safer won't happen simply by bringing women into the hospital. It is going to require detailed attention to sector-wide issues like supply chains, health sector funding, training and brain drain.

- Infection is playing a huge role in maternal deaths, at least in countries with high HIV prevalence, and the role of Cesarean section needs to be investigated carefully in these settings. Since I first worked in Malawi, the pattern of maternal deaths has shifted. In 1990, deaths from septic unsafe abortion were common, as was death from hemorrhage. In 2007, both of these have declined, but postpartum—and especially postoperative—infection deaths have skyrocketed. HIV-positive women are especially (but not exclusively) at risk. HIV treatment and prevention are crucial. And in this setting, the increased morbidity and mortality attendant upon surgical intervention should affect the risk/benefit analysis for Cesarean: the adoption of First World standards like surgical delivery for breech needs careful re-evaluation.
- We should rethink—AGAIN—the question of traditional birth attendant training. TBA training has all but vanished from international funders' priorities, based on conflicting data on effectiveness. This despite the fact that TBAs continue to be the attendants at many births in the developing world; half of Malawi's births are outside of formal-sector health facilities. TBAs I spoke with in Malawi very strongly advocated for a restoration of training programs that they felt provided them not only with valuable information and skills, but perhaps even more importantly enabled them to forge mutually respectful connections with district health offices and staff at local hospitals. These proved invaluable when it came time to manage difficult cases together.
- Women's empowerment is more than a buzzword. In too many families, a woman's value is in her capacity to bear children. In too many places, a girl's ability to access schooling or employment depends on her willingness to trade sex for the patronage of an older male. In too many countries, women do not make the policy decisions that affect their lives. When a fifteen-year-old dies after an unsafe abortion, when a woman who knows she has AIDS dies of postpartum sepsis after her third attempt in three years to bear a son, maternal death is not just a biomedical problem, remediable by technical interventions. It is a failure of justice.

## MCH Alert

### Who needs liquor stores when parents will do?

The present study findings “highlight the need for alcohol prevention efforts to address ... social sources of alcohol, particularly before high school; a major challenge for alcohol prevention efforts. The authors found that

- At the beginning of 6th grade, parents and guardians were the most common source of alcohol (32.7%), followed by another adult age 21 or older (15.7%) and someone age 20 or younger (9.7%).
- By the end of 8th grade, another adult age 21 or older (22.7%) surpassed parents and guardians (18.9%) as the most prevalent source reported.
- Consistent users followed a pattern similar to that of the entire sample, with social sources outstripping commercial sources.
- Over time, student reports of taking alcohol from home or a friend's home, receiving alcohol from a friend's parent or guardian, and purchasing alcohol from commercial sources were lower in prevalence compared to accessing alcohol from parents or guardians, another adult age 21 or older, or someone age 20 or younger.
- Among the entire sample of alcohol users, increases over time were observed across the following sources of alcohol: another adult age 21 or older, someone age 20 or younger, took it from home, and commercial.
- Parents as a source of alcohol use decreased over time.
- Males were more likely than females to get alcohol from commercial sources. Among consistent users, males were more likely than females to get alcohol from a friend's parent.

“Recognizing the importance of social sources of alcohol and how social sources change as children age offers an ideal opportunity for primary prevention,” the authors conclude.

*Hearst MO, Fulkerson JA, Maldonado-Molina MM, et al. 2007. Who needs liquor stores when parents will do? The importance of social sources of alcohol among young urban teens. Preventive Medicine 44(6):471-476.*

## MCH Headlines

Judy Thierry HQE

### Taking a harder line on blood transfusions

Hospitals trying to zero in on the key factors that put patients at risk for blood transfusions might start by looking within.

“One of the biggest risks in the U.S. of being transfused is which doors you happen to walk through on the day of surgery,” anesthesiologist Timothy Hannon, MD, MBA, said in a recent G-2 Reports audioconference on blood management. Even within a group of surgeons or anesthesiologists, he said, you see considerable variation in blood use, with some ordering quite a bit and others very little.

In fact, he told College of American Pathologists (CAP) TODAY, a hospital is a “quantifiable risk factor for transfusion” for all patients, whether or not they have surgery. That’s because the hospital tends to have a “culture” for how it approaches transfusion therapy, says Dr. Hannon, medical director of the blood management program at St. Vincent Hospital, Indianapolis, and president and CEO of Strategic Healthcare Group, which offers, among other services, blood management consultation.

It has been known for some time that a restrictive transfusion strategy may be better for adult patients than a liberal strategy. Now, a new study has found that a restrictive strategy (hemoglobin threshold of 7 g/dL) for red-cell transfusion can decrease transfusion requirements without increasing adverse outcomes in stable, critically ill children (Lacroix 2007). The mounting more-may-be-less data is why some hospitals are implementing conservative, evidence-based blood management programs.

Lacroix J, et al. *Transfusion strategies for patients in pediatric intensive care units. N Engl J Med. 2007;356:1609-1619*

## Medical Mystery Tour

### Nausea and Vomiting in Pregnancy

#### Case 1

MTB is a 24 y/o G1P0 at 10 weeks by her dates who presents to her first prenatal visit complaining of morning sickness. Her symptoms are not incapacitating, but she would like to feel better. She has tried various herbal teas without much relief. Your most useful recommendation at this initial visit would be:

- reassurance, small frequent intake, pyridoxine (vitamin B-6)
- prescribe a cholinomimetic agent (e.g., metoclopramide)
- prescribe a 5-HT-3 receptor inhibitor (e.g., ondansetron)
- clear liquid diet and bismuth subsalicylate (Pepto-Bismol)

#### Case 2

HB is a 30 y/o G3P2 at 9 weeks by her dates who presents for her first prenatal visit complaining of nausea with vomiting that lasts pretty much all day, but she is able to keep some food down. She says this has occurred with each of her pregnancies, but this time it is especially troublesome. She has had a small amount of spotting but no cramping. She appears to be well hydrated. Your initial work up at this time should include:

- complete metabolic panel, thyroid functions, amylase and lipase
- electrolytes, alanine aminotransferase, pelvic ultrasound
- upper abdominal ultrasound, H. pylori antigen testing, stool guaiac testing
- no laboratory studies are indicated at this time

#### Case 3

EP is a 19 y/o G1P0 at 11 weeks by her dates who presents to the emergency department complaining of severe nausea and vomiting. She is wretching, appears ill, and is only able to produce a small amount of concentrated urine that is strongly positive for ketones. Your initial management should include:

- oral hydration, mental health consult
- intravenous hydration, admit for parenteral alimentation
- intravenous hydration, nasogastric tube, H2-blocker drip
- intravenous hydration, parenteral anti-emetics

#### What do you think?

Stay tuned for the discussion in next month’s CCC Corner

## Osteoporosis

### Dietary calcium is better than supplements at protecting bone health

Women who get most of their daily calcium from food have healthier bones than women whose calcium comes mainly from supplemental tablets

CONCLUSION: Calcium from dietary sources is associated with a shift in estrogen metabolism toward the active 16 alpha-hydroxyl metabolic pathway and with greater BMD and thus may produce more favorable effects in bone health in postmenopausal women than will calcium from supplements.

Napoli N, et al *Effects of dietary calcium compared with calcium supplements on estrogen metabolism and bone mineral density. Am J Clin Nutr. 2007 May;85(5):1428-33*

## Midwives Corner

Lisa Allee, CNM, Chinle

### Midwifery's approach to pre-labor SROM supported by professional organization's journal

Morwitz and Jordan present a review of the literature on pre-labor rupture of membranes at term. Most significantly, they point out some of the flaws in the TERMPROM study by Hannah et al. The biggest problem was that there was no control of the number of vaginal exams, which have been shown to be directly correlated with increased risk of infection by Hannah et al. and others. Speculation has been made that if the number of vaginal exams had been limited in the study pool the results may have been different. Another problem has to do with GBS-positive management being very different and inconsistent during the study time period as compared to today. The authors' concluding statements support the time-honored midwifery practice of having options in the management of pre-labor SROM tailored to the individual patient and setting and the integral role played by the woman herself in the decision making process.

'Two practices supported by current research findings should be incorporated into midwifery care of women with term PROM. The first is to strictly limit vaginal examinations. There is considerable evidence documenting the increased risk of perinatal infection related to digital vaginal examination, yet little change has occurred in this aspect of practice. Despite ACOG's recommendation that vaginal examination should be deferred during the initial evaluation, doing a "baseline vaginal exam" is common practice. Requiring vaginal examinations at set intervals to prove labor progression is another entrenched habit. A speculum examination to determine initial cervical status is sufficient in most cases, and digital examinations should be done only when the information is needed to make management decisions. The second practice is to consistently provide information

about the options of expectant management and immediate induction to women with term PROM, and to involve them in the decision-making process. This is congruent with midwifery hallmarks and philosophy of care. In addition, it is explicitly supported by Cochrane reviewers and the TERMPROM researchers.

In an editorial accompanying the publication of the term PROM study, Duff stated his view that the practice of expectant management should be abandoned. An unquestioning acceptance of this view is not justified based on available evidence. Women should be fully informed on the risks and benefits of induction and expectant management, and offered both options. Midwives should strive to remain champions of a care approach that involves women in decision making and supports the value of nonintervention.'

### Editorial Comment by Lisa Allee, CNM

I couldn't have said it better myself. But I will add my two cents, too. I think the ACOG statement that induction should be started immediately upon SROM is over interventionist, not evidence based, and disrespectful of the inherent wisdom and intelligence of women's bodies and minds. I encourage midwives to feel supported by our professional organization's journal in continuing evidence-based approaches to pre-labor SROM by offering options of induction or awaiting spontaneous labor. AND most importantly keep your fingers out of there!!! (Really folks, the vaginal exam does not make much difference—her cervix is what is and her labor goes as it goes no matter if we check the cervix or not AND there are other ways to tell how her labor is progressing—tune in and labor sit.)

Reference: *Online*

## From Your Colleagues

Scott Giberson, HQE

### American Indian/Alaska Native (AI/AN) population has the shortest timeline HIV to AIDS

The American Indian/Alaska Native (AI/AN) population has the 3rd highest rate of HIV/AIDS, the shortest timeline between diagnosis and death and the highest percentage of 'late' diagnosis (determined by progression of disease at time of diagnosis) of any race/ethnic group.

This suggests the critical preventive component of missed screening opportunities. Reports of the percentage of AI/AN tested for HIV range anywhere from below 50% to roughly 75%. Given the risk factors and population vulnerabilities, it is imperative we screen individuals at

every opportunity. The impact of screening early and often is easily justifiable as treatment and care is available. Screening also serves as a preventive measure since it is estimated that over half of newly infected individuals acquire HIV from those unaware of their status.

With the revised CDC testing guidelines, states are changing requirements and attempting to adjust policy to effectively implement more broad-based screening efforts. The IHS supports these CDC recommendations and have removed any potential barriers (at the Agency level) to increase screening efforts. It is a responsibility that each of us attempts to take on the role of an advocate, supporter, facilitator, or provider of prevention and care, to include advocacy for HIV screening. [www.ihs.gov/medicalprograms/hivaids/](http://www.ihs.gov/medicalprograms/hivaids/)

## Navajo News

Jean Howe, Chinle

### The evolution of management of Actinomyces on a Pap report

Actinomyces is an anaerobic Gram-positive bacterium that may be found as normal flora in the mouth and GI tract. It can also colonize the female genital tract and, in rare cases, cause pelvic abscesses.

Such abscesses tend to be slow-growing, are typically described as “woody”, and may be mistaken for a neoplasm. Actinomyces grows preferentially on foreign bodies such as the intrauterine device (IUD) and the likelihood of colonization increases with duration of use. For women using an IUD, the finding of actinomyces on a pap report can be a common and perplexing challenge, especially as the vast majority will be without symptoms and at very low risk for serious disease.

I am intrigued by the management of actinomyces because it also serves as a reminder about the evolution of medical knowledge and the importance of common sense in clinical practice. Perhaps I’m revealing my age but, when I was in training, a report of Actinomyces on a pap inevitably led to a recall of the patient for removal of her IUD. This caused a great deal of contraceptive consternation and an urgent search for an acceptable alternative method. Soon after my training was completed it became more acceptable to leave the IUD in situ, but only if a relatively long course of penicillin-based antibiotics was administered. More recently, awareness is growing that it is no longer necessary to remove the IUD or treat in most cases.

A recent review article by Westhoff in the journal *Contraception* provides useful background information. Studies of the Pap smear results of IUD users reported a prevalence of 0 to 31% of actinomyces-like-organisms noted on pap, with an average of 7%. (For women without IUDs the rate of positive paps remained close to 0%). Interestingly, the review also states that, in studies of women with Actinomyces pelvic abscesses, only half of pap tests performed were positive for the bacteria. Given the lack of specificity of this test result, the author endorses the position of the UK Faculty of Family Planning and the Planned Parenthood Federation of America that such patients can continue IUD use. They should be informed of the potential risk

of subsequent pelvic abscess, which is not precisely known but is believed to be substantially less than 1/1000. This review also notes the finding that rate of actinomyces-positive pap results is lower with levonorgestrel IUDs than with Paraguard IUDs.

Both UpToDate and ACOG provide a similar perspective. UpToDate recommends that the patient be notified of the finding and examined. In the absence of symptoms, the finding of actinomyces likely represents colonization and IUD removal or antibiotic treatment is unnecessary. The patient should be given instructions to seek medical care if symptoms of PID are noted. If she is symptomatic, then removal of the IUD would be an important part of management due to the heightened growth of actinomyces on foreign bodies. This position is also endorsed by the ACOG Practice Bulletin on IUDs, published in 2005, which states that “The options for management of asymptomatic IUD users with actinomyces on Pap test are expectant management, an extended course of oral antibiotics, removal of the IUD, and both antibiotic use and IUD removal.”

A recent CME article of IUD use in *Contemporary Ob/Gyn* by IHS alumni Tony Ogburn and Eve Espey seeks to dispel many misconceptions about IUD use. Amongst other helpful recommendations, they make note of the changes to the Paraguard package insert which endorses IUD use in nulliparous women. This same revision removed genital actinomycosis from the list of contraindications to Paraguard use.

This evolution of recommended medical practice, from a very conservative management plan that undoubtedly increased the risk of unwanted pregnancy for some women, to a more practical and evidence-based approach encouraging symptom evaluation and ongoing IUD use for almost all women, is refreshing.

Reference: *Online*

## Gynecology

### Treatment of bleeding irregularities induced by progestin only contraceptives: Effective

#### AUTHORS' CONCLUSIONS:

Some women may benefit from the interventions described, particularly with cessation of an ongoing bleeding episode. Several regimens offer promise in regulating bleeding, but findings need to be reproduced in larger scale trials. Intermittent treatment with an agent may help some women to continue the use of a progestin-only contraceptive. The results of this review do not support routine clinical use of any of the regimens included in the trials, particularly for long-term effect.

Abdel-Aleem H et al *Treatment of vaginal bleeding irregularities induced by progestin only contraceptives*. *Cochrane Database Syst Rev*. 2007; (2):CD003449

**Oklahoma Perspective**  
**Greggory Woitte—Hastings Indian**  
**Medical Center**

**Preconception Health of Women Delivering**  
**Live-Born Infants—Oklahoma, 2000–2003**

The U.S. Public Health Service recommends that all women of childbearing age consume >400 µg of folic acid daily through either supplementation or fortified foods. CDC recommends offering, as a component of maternity care, one pre-pregnancy visit to a health care provider for women planning pregnancy to enable women to receive risk assessment, health education, and specific interventions to address identified risks before conception. Analysis of data collected from women in Oklahoma during 2000–2003 from the Pregnancy Risk Assessment Monitoring System (PRAMS) indicated that 21.5 percent of women with a recent live birth were not aware of folic acid benefits before they became pregnant, 73.5 percent did not consume multivitamins at least four times per week during the month before pregnancy, and 84.8 percent did not receive preconception counseling from a health-care provider. Although pre-pregnancy awareness of the benefits of taking vitamins with folic acid in the prevention of some birth defects was high among Oklahoma women with a recent live birth, actual consumption of multivitamins during the month before pregnancy was low. Promoting preconception health of women is a key public health strategy in the United States to decrease morbidity and mortality associated with negative maternal and infant outcomes. Increased folic acid consumption before conception and during the first trimester of pregnancy can reduce the incidence of neural tube defects by 50–70 percent.

**Editorial comment: Greggory Woitte**  
**Preconception Counseling**

I am sure that most of your patients are similar to mine in that your first visit with them is after they have become pregnant. They show up at the clinic for a confirmatory pregnancy test, to schedule their first prenatal visit and to get started on prenatal vitamins (or as I am frequently seeing to start Flintstones vitamins). However, as I am sure you are aware, by the time the patient reaches our doorstep, we have missed a very important part of the pregnancy that we may have had some dramatic affect upon.

Between 2000 and 2003, the state of Oklahoma developed and administered a preconception survey. (See above) They found that 84.8% of women did not have any preconception counseling by a provider. 21.5% of women did not know about the benefits of preconception folic acid and equally disturbing

was that 73.5% did not take vitamins before trying to become pregnant.

In accordance with the ACOG Committee Opinion No. 313, patients who are in the reproductive ages should be questioned about the possibility of becoming pregnant, especially if they are not on contraception. Women should be encouraged to formulate a reproductive health plan. We, as practitioners of Women’s Health, should be encouraging women to take steps to get as healthy as possible at every visit. This is especially important in women of reproductive ages where we have the opportunity to provide education regarding the benefits to the fetus, as well as to identify patients at high risk for adverse pregnancy outcomes.

We also need to remind our colleagues from other disciplines of medicine to ask their patients about potentially becoming pregnant and refer those who may be in need of pre-conceptual counseling or those in need of contraceptive counseling.

*Reference: Online*

**STD Corner**

**Lori de Ravello, National IHS STD Program**  
**Updated Screening for Chlamydial Infection**  
**Recommendations, USPSTF**

- The U.S. Preventive Services Task Force (USPSTF) recommends screening for chlamydial infection for all sexually active non-pregnant young women aged 24 and younger and for older non-pregnant women who are at increased risk . This is a grade A Recommendation.
- The USPSTF recommends screening for chlamydial infection for all pregnant women aged 24 and younger and for older pregnant women who are at increased risk . This is a grade B Recommendation.
- The USPSTF recommends against routinely providing screening for chlamydial infection for women aged 25 and older, whether or not they are pregnant, if they are not at increased risk . This is a grade C Recommendation.
- The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for chlamydial infection for men . This is a grade I Statement.

[www.ahrq.gov/clinic/uspstf/uspstfchl.htm](http://www.ahrq.gov/clinic/uspstf/uspstfchl.htm)

**Primary Care**  
**Discussion Forum**

September 1, 2007

**Moderator: Andrew**  
**Narva, MD**

**Chronic Renal Disease:**  
**How is Primary Care**  
**Effectuated?**

- What is an appropriate work up?
- Anticipated benefits of acting now
- What is the impact of diabetes on chronic renal disease?

How to subscribe/unsubscribe to the Primary Care Discussion Forum?

Subscribe to the Primary Care listserv  
[www.ihs.gov/cio/listserver/index.cfm?module=list&option=list&num=46&startrow=26](http://www.ihs.gov/cio/listserver/index.cfm?module=list&option=list&num=46&startrow=26)

## Alaska State Diabetes Program

Barbara Stillwater

### (How) can we prevent type 2 diabetes?

Our knowledge base in this field is still quite rudimentary, and we have no information about truly long-term (ie, for decades) prevention of type 2 diabetes.

Type 2 diabetes is a progressive disease. It develops over years as a result of declining pancreatic  $\beta$ -cell compensation for chronic and often worsening insulin resistance. Preventing type 2 diabetes requires modification of the underlying disease biology to slow, stop, or reverse the decline in  $\beta$ -cell compensation. Data from six randomized trials reveal several interventions that reduce the number of high-risk people who develop diabetes during relatively short periods of treatment. Interventions that reduce body fat or that mitigate the effect of excess fat to cause insulin resistance provide the greatest risk reduction and the best evidence for real disease modification. At least two studies indicate that disease modification is possible soon after glucose levels enter the diabetes range. These findings, combined with the fact that falling  $\beta$ -cell compensation leads to rising glycemia, provide a rationale for an intervention strategy that begins with lifestyle modification and progresses to pharmacological therapy aimed at reducing insulin resistance if lifestyle approaches fail to prevent glucose from rising to the diabetes range. Our knowledge base in this field is still quite rudimentary, and we have no information about truly long-term (i.e., for decades) prevention of type 2 diabetes. Even for the short to intermediate term, additional work is needed to determine optimal application of the general strategy described above, to examine combination approaches to prevention, and to test new interventions as they become available. Such work should focus on disease modification, not just cases of diabetes, as a major outcome.

Reference: Online

## Frequently asked questions

### Q. Can oral or sublingual misoprostol be used for postpartum hemorrhage (PPH)?

A. Yes and both have a more rapid onset of action than rectal administration

The doses are smaller than some of the rectal doses that are being used. The sublingual and oral doses of misoprostol mentioned in the articles below are: 400, and 600 microg.

Sublingual and oral doses reach a peak concentration much more rapidly, so sublingual or oral dosing may have more of a role in the acute management of PPH, rather the mid and long term management as with rectal misoprostol. (The time to peak concentration (Tmax) was similar in both the sublingual (26.0 +/- 11.5 min) and oral groups (27.5 +/- 14.8 min) and was significantly shorter than those in both vaginal groups.)

Reference: Online

### Q. How should you greet your patients?

A. Most patients prefer their physicians to greet them with a handshake and introduction

CONCLUSIONS: Physicians should be encouraged to shake hands with patients but remain sensitive to nonverbal cues that might indicate whether patients are open to this behavior. Given the diversity of opinion regarding the use of names, coupled with national patient safety recommendations concerning patient identification, we suggest that physicians initially use patients' first and last names and introduce themselves using their own first and last names.

Makoul G, et al An evidence-based perspective on greetings in medical encounters. *Arch Intern Med.* 2007 Jun 11;167(11):1172-6

## Women's Health Headlines

Carolyn Aoyama, HQE

### Why do Native American women have the poorest 5-year survival rate for breast cancer?

Encourage American Indian/ Alaska Native women to join the Sister Study TODAY!

#### The Sister Study needs your help

Please help the Sister Study recruit more AI/AN women.

- So far, less than 500 AI/AN women have enrolled out of a total of (37,000) in the Sister Study
- Breast cancer is the 2nd leading cause of cancer death among Native women.
- Their 5-year survival rate is lower than that of white women.
- Scientists have very little information on cancer histories in American Indian/Alaska Native communities.

#### Please help recruit patients into this study.

Eligibility criteria include the following:

- 35 and 74 years old
- AND the patient has never had breast cancer
- AND the patient lives in the U.S. or Puerto Rico
- AND the patient (living, deceased), is a blood relative and had breast cancer.

[https://sisterstudy.niehs.nih.gov/webscreener/DisplayPage.asp?\\_PageNumber=1](https://sisterstudy.niehs.nih.gov/webscreener/DisplayPage.asp?_PageNumber=1)

## MCH Headlines—Judy Thierry, HQE

### Are you interested in the bigger picture of Indian Health care?

Perhaps you should join an Indian Health list serve on your topic(s) of interest?

Centering prenatal care, breastfeeding, primary care discussion forum, CCC newsletter ... elder care. The IHS List Server site (address below) is a great place to start. It has general information and, the "Available Lists" page displays all lists on the Indian Health Service list serv.

[www.ihs.gov/cio/listserver/index.cfm](http://www.ihs.gov/cio/listserver/index.cfm) or contact [Judith.Thierry@ihs.gov](mailto:Judith.Thierry@ihs.gov)

## Perinatology Picks

George Gilson, MFM, ANMC

### Anemia in Pregnancy Briefly:

#### The Common to the Unusual—including IV therapy

##### BACKGROUND:

Anemia is very common in pregnant women, and 99% of such women (in non-malarious areas) are iron deficient. Iron deficiency is seen frequently because of prior menstrual losses, prior pregnancy related losses, and nutritional factors. As a result of a dilutional effect, the normal hematocrit for third trimester pregnant women at sea level is 33+3 %. Women with a hematocrit over 30% should not be considered anemic.

##### DIAGNOSIS:

Sophisticated studies are usually not needed in the work up of a woman with pregnancy associated anemia. The CBC that revealed the low hemoglobin/hematocrit will usually also reveal a low MCV (microcytosis), a low MCH (hypochromia), and an increased RDW (anisocytosis), characteristic of iron deficiency. Women with mild (or acute) anemia may not yet have these typical red cell morphologic changes however. The most sensitive and specific test for iron deficiency during pregnancy (even prior to overt anemia) is a low serum ferritin, which reflects total body iron stores. Normal values are 40-200 ng/mL. Serum iron, TIBC (transferrin), and the per cent transferrin saturation, are all less accurate indices during pregnancy. Hemoglobin electrophoresis should be reserved for women who, on the basis of their ethnicity or family history, are suspected of having a hereditary hemoglobinopathy (e.g., thalassemia, sickle cell disease, etc.).

##### TREATMENT:

###### a. Oral iron therapy

Most women with iron deficiency can be treated with oral iron. Ferrous sulfate 325 mg contains 57 mg of elemental iron, and is the most efficient form. The evidence is unclear as to the value of adding ascorbic acid. Oral iron commonly causes gastrointestinal symptoms however. These are usually dose dependent, but may be severe enough that women will not, or cannot, adhere to their regimen, even with stool softeners and/or acid reducing agents. Slow-release iron formulations may prevent gastric irritation, but not constipation, and are significantly more expensive. Stools will become black after taking iron, and asking about stool color is a good way to check adherence to therapy. To see if the patient is responding to (or taking) therapy, a reticulocyte count may be obtained 7 days after starting treatment, but a rise in the hemoglobin or hematocrit will usually not occur until 3-4 weeks. It may also be prudent to prescribe supplemental folic acid, at least 1 mg daily, as this nutrient will also commonly be deficient in women who are iron deficient.

###### b. Parenteral iron therapy

Anemia may become severe enough to cause symptoms (fatigue, tachycardia, etc.). Since acute post partum hemorrhage is such a common event (approximately 5 per cent of births), this has the potential to becoming a life-threatening condition. Women with a known placenta previa are at special risk. Fetal growth and oxygenation will usually not be affected until the maternal hemoglobin is less than 5 g/mL however. In such symptomatic or worrisome cases, where adherence is a limiting factor, parenteral iron therapy may be considered.

There are 3 parenteral iron therapy options available in the United States at the present time: iron dextran, ferric gluconate, and iron sucrose. Iron dextran is no longer widely used because of its significant risk of anaphylaxis (0.6%), or other hypersensitivity reactions (0.2-3%). It is also usually given intramuscularly, and is painful, can cause skin discoloration, and is unpredictably absorbed. Ferric gluconate and iron sucrose are both given intravenously, and are safe and effective alternatives, although they are somewhat more expensive. Iron sucrose has the lowest rate of serious adverse reactions (anaphylaxis 0.002%, hypersensitivity 0.005%), and so is our drug of choice.

Our current protocol is to give iron sucrose 200 mg in 100 mL of normal saline IV over 1 hour. A test dose (25 mg IV slow push) is not necessary, but may be considered at the discretion of the provider. The woman's exact dose can be calculated, taking into account her weight and the current and desired hematocrit, but, since most women who will be receiving the drug are severely anemic, we have elected to empirically give 5 doses of 200 mg (total of 1000 mg) at 24-48 hour intervals. The patient should be observed and vital signs and fetal heart rate documented prior to her discharge. The hemoglobin or hematocrit may be repeated 7 days after the last dose, as hematopoiesis proceeds rapidly after intravenous iron administration. If you wish to see if total iron stores have been replenished, a serum ferritin may provide guidance, and a second course of iron sucrose considered.

In the rare event of a serious adverse reaction, the infusion should be stopped, the patient hydrated with normal saline, and preparations for possible need for respiratory support (endotracheal intubation) initiated. The following drugs should be administered: epinephrine 0.3-0.5 of 1:1000 SQ every 5 minutes, diphenhydramine 50 mg IV, and methylprednisolone 125 mg IV.

Reference: *Online*

## Domestic Violence

Denise Grenier, Tucson

Rachel Locker, Warm Springs

IHS-ACF DV Project: Conference CD

I want to make you aware that you can obtain a copy of the National Conference on Health and Domestic Violence Conference – Presenter CD by clicking on the URL:

<http://fvpfstore.stores.yahoo.net/2007-conference-presentation2008.html>

You may find the CD content helpful as you work towards improving your DV screening, patient education and patient safety planning

Carolyn Aoyama Carolyn

Aoyama@ihs.gov

## Family Planning

**One In Four with Unplanned Pregnancy Experience Gaps In BCM Or Do Not Use A Method**

Fifteen percent of U.S. women in a recent survey who were at risk of unplanned pregnancy had had a gap in contraceptive use of one or more months during the previous year, while 8% had not used any method

**CONCLUSIONS:** Providers could better help women avoid unintended pregnancy by initiating regular assessments of method use difficulties, improving counseling on method choice and pregnancy risk, and identifying and assisting women at higher risk for inconsistent method use because of disadvantage, relationship characteristics or ambivalence about pregnancy prevention. In addition to providers' efforts, broader societal commitment is critical for increasing contraceptive knowledge and expanding access to contraceptive care for all women who are at risk of having an unintended pregnancy

*Frost J et al Factors associated with contraceptive use and nonuse, United States, 2004. Perspect Sex Reprod Health. 2007 Jun;39(2):90-9*

## MCH Alert

**Home visiting associated with decreased infant death**

Infant death may be considered the 'tip of the iceberg' in which children of families at risk experience suboptimal care, poor health outcomes, and the possibility of lifelong disability; some die before their first birthday.

**The authors found that**

- After controlling for race, prenatal care, maternal

smoking, maternal education, and maternal age, enrollment in greater Cincinnati's Every Child Succeeds (ECS) was associated with a 60% decrease in the likelihood of infant death.

- Among all the independent variables identified, adequacy of prenatal care had the strongest association with the likelihood of infant death.
- \* Black mothers enrolled in ECS before birth were more likely to received adequate prenatal care, compared with control subjects.
- The largest association between ECS participation and reduced infant mortality rate was seen for black infants.
- No influence of ECS enrollment on gestational age at birth was observed.

The authors conclude that "our study findings are consistent with the findings from randomized, controlled trials and suggest that home visiting reduces the risk of infant death."

*Donovan EF, Ammerman RT, Besl J, et al. 2007.*

*Intensive home visiting is associated with decreased risk of infant death. Pediatrics 119 (6):1145-1151.*

## Midwives Corner

**Upright position during the first stage of labor did not contribute towards a shorten labor**

**CONCLUSIONS:** The upright position during the first stage of labor did not contribute towards a shorter duration of labor; however, it proved to be a safe and well-accepted option for the women of this study.

*Miquelutti MA, et al Upright position during the first stage of labor: a randomised controlled trial. Acta Obstet Gynecol Scand. 2007;86(5):553-8*

**Cesarean rate can be reduced by health workers in analyzing and modifying their practice**

**CONCLUSIONS:** The cesarean rate can be safely reduced by interventions that involve health workers in analyzing and modifying their practice. Our results suggest that multifaceted strategies, based on audit and detailed feedback, are advised to improve clinical practice and effectively reduce cesarean section rates. Moreover, these findings support the assumption that identification of barriers to change is a major key to success.

*Chaillet N; Dumont A Evidence-based strategies for reducing cesarean section rates: a meta-analysis.*

*Birth. 2007; 34(1):53-64*

## Perinatology

**Down Syndrome—Contingent sequential screening is the most cost-effective method**

**CONCLUSION:** Analysis of this actual data from the FASTER Trial demonstrates that the Contingent Sequential test is the most cost-effective. This information can help shape future policy regarding Down syndrome screening.

*Ball RH, et al First – and Second-Trimester Evaluation of Risk for Down Syndrome. Obstet Gynecol. 2007 Jul;110(1):10-17*

**Aspirin during pregnancy could reduce risk of pre-eclampsia**

Women who receive aspirin or other antiplatelet drugs during pregnancy are at lower risk of pre-eclampsia. **INTERPRETATION:** Antiplatelet agents during pregnancy are associated with moderate but consistent reductions in the relative risk of pre-eclampsia, of birth before 34 weeks' gestation, and of having a pregnancy with a serious adverse outcome.

*Askie LM, et al Antiplatelet agents for prevention of pre-eclampsia: a meta-analysis of individual patient data. Lancet. 2007 May 26;369(9575):1791-8*

## 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](http://www.ihs.gov/MedicalPrograms/MCH/F/CN01.cfm#Aug07)
- Contact [nmurphy@scf.cc](mailto:nmurphy@scf.cc)

### 3<sup>rd</sup> Annual American Indian and Alaska Native Long Term Care Conference

- September 5–6, 2007
- Albuquerque, New Mexico
- Visit [www.aianlongtermcare.org](http://www.aianlongtermcare.org)
- Contact [Bruce.Finke@ihs.gov](mailto: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](mailto:YMalloy@acog.org)

### 2<sup>nd</sup> National Summit on Preconception Health

- October 29–31, 2007
- Oakland, California
- CDC, March of Dimes
- [www.marchofdimes.com/california/4947\\_24789.asp](http://www.marchofdimes.com/california/4947_24789.asp)

## Abstract of the Month

- Within the Hidden Epidemic: Sexually Transmitted Diseases and HIV/AIDS Among American Indians and Alaska Natives.

## IHS Child Health Notes

- Lactose intolerance in infants, children, and adolescents.
- Infectious Disease Updates—Flu News
- Recent literature on American Indian/Alaskan Native Health—Inhalant abuse.
- Locums Tenens and Job Opportunities

## Hot Topics

- Obstetrics—VBAC: Smaller attributable risk than previously reported
- Gynecology—LEEP doubles risk of preterm delivery: Patients need to be informed
- Child Health—Physical Activity Alone May Not Reduce Obesity in Children
- Chronic disease and Illness—Rosiglitazone: seeking a balanced perspective

## Features

- ACOG—Management of Herpes in Pregnancy: Practice Bulletin
- Ask a Librarian—*Scopus™*: A New Database
- Breastfeeding—What to do when: Mom says, "My newborn likes the bottle better."
- International Health Update—Maternal survival redux: a view from Malawi
- Family Planning—Waiting until the menses to start hormonal contraceptives: Needless Obstacle
- STD Corner—Sexually active women benefit from HPV vaccine
- MCH Alert—Who needs liquor stores when parents will do?
- MCH Headlines—Taking a harder line on blood transfusions
- Medical Mystery Tour—Nausea and Vomiting in Pregnancy
- Midwives Corner—Midwifery's approach to pre-labor SROM supported by professional organization's journal
- Navajo News—The evolution of management of *Actinomyces* on a Pap report
- Child Health—Obese Young Adults Face High Diabetes Risk
- Oklahoma Perspective—Preconception Health of Women Delivering Live-Born Infants
- STD Corner—Updated Screening for Chlamydial Infection Recommendations, USPSTF

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

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

