



How to increase usage of the HPV vaccine? Let's ask our patients and their families

Alaska Native parental attitudes on cervical cancer, HPV, and the HPV vaccine

In June 2006, the U.S. Food and Drug Administration's Advisory Panel approved Merck's HPV vaccine (GARDASIL[®]) against the four strains of HPV that are responsible for 70 percent of cervical cancer cases and 90% of genital warts. The Advisory Commission on Immunization Practices voted to recommend that the HPV vaccine be given routinely to girls aged 11-12 years old. In an effort to roll out the new vaccine in Alaska, the CDC Arctic Investigations Unit and the Alaska Native Tribal Health Consortium designed and implemented a qualitative study to assess Alaska Native parents' knowledge and attitudes on cervical cancer, HPV, and the new HPV vaccine. Findings from this study were used to design a tailored educational campaign focused on promoting the HPV vaccine.

We recruited a convenience sample of Alaska Native parents from three different size communities in Alaska (one urban area, two rural towns, and a remote village). All participants were Alaska Native/American Indian, English speaking, and had a 9-18 year old daughter/ward. The focus groups, each lasting approximately 60 minutes, were carried out between January through March, 2007. At this time the Merck educational campaign was underway in Alaska, however, the vaccine was not widely available in the Alaska Native Tribal Health System. Participants received a \$25 incentive payment for their participation.

Prior to each focus group, each parent filled out a quantitative survey that collected demographic information and asked knowledge questions. During the focus groups, a moderator used a guide that consisted of twelve open-ended questions inquiring about parents' perceptions of cervical cancer, HPV, vaccines in general, and the new HPV vaccine. All of the participants were Alaska Native parents or guardians of girls between the ages of 9-18 yrs. Eighty percent of those involved in the focus groups were mothers. Approximately 30% of parents were

between the ages of 31-40 years and 38% were 41-50 years old. Thirty-five percent of participants had worked in or had a relative who worked in a medical setting.

Quantitative Survey Findings—Knowledge about Cervical Cancer, Vaccines, HPV, and the HPV Vaccine

The majority of parents (70%) knew that the Pap test is used to screen for cervical cancer. Parents were asked what came to mind when they heard the word "vaccine." Common themes that emerged in all focus groups were a shot, prevention, protection, and a requirement for school. The majority of participants (65%) knew that a vaccine prevents disease and can stop the spread of a disease. Overall, only 56% of parents knew that there was a vaccine for HPV and far less (20%) associated the vaccine with the prevention of cervical cancer. Although many of the parents had heard about HPV before, many were unaware that there was a link between HPV and cervical cancer. Those who had heard about it said they had seen a commercial or heard a news report, learned about it from working in a medical setting, or from a visit to a clinic. Few village-based parents knew how HPV is transmitted (36%) as compared to those from the urban area (63%) and the rural towns (74%). In both the urban and rural communities, a similar percentage of parents (38%) knew there was an association between HPV and genital warts and only 6% of village-based parents were aware of this association.

Qualitative Focus Group Findings—Attitudes and Perceptions about Cervical Cancer, Vaccines, HPV, and the HPV Vaccine

When asked what came to mind when they heard the words "cervical cancer" the comments from par-

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ACOG / IHS Course in Salt Lake City, Utah this year

Obstetric, Neonatal and Gynecologic Care
September 14-18, 2008
Salt Lake City, Utah

This annual women's health update for Nurses, Advanced Practice Clinicians, and physicians provides four days of lectures, workshops, and hands-on sessions. The course is a good foundation for those who are new to women's health care or new to the Indian health system. Many faculty members are from IHS and Tribal facilities. A Neonatal Resuscitation Program is also available. Details on page 4.

Early registration holds your place, and puts you in line for a possible scholarship. Contact 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.”

—Chinese Proverb

Quote of the month

“If you are late, you are a thief of my time.”

—Anonymous

Articles of Interest

Identification and Evaluation of Children with Autism Spectrum Disorders.

Pediatrics 120: 5; 1183-1213 November 2007

Management of Children with Autism Spectrum Disorders.

Pediatrics 120:5; 1161-1182 November 2007

These two clinical reports published in *Pediatrics* in November 2007 provide a complete summary for the clinician on autism spectrum disorders (ASDs). This month’s review will highlight the first article that covers identification and evaluation of children with autism spectrum disorders. The review next month will describe management strategies.

The authors emphasize that ASDs are not rare. The most recent epidemiology shows that 1/150 children in Europe and North America have an ASD, which is a 10-fold increase in the past few decades. Much debate has focused on whether the increased diagnosis of ASDs represents a true increase in disease and how this may relate to immunizations, especially the MMR vaccine and mercury containing vaccines.

Good evidence show that the increase in diagnosis is due to expanded diagnostic criteria and diagnostic “substitution”. The disease category of autism also now includes Asperger syndrome and pervasive development disorder-not otherwise specified making the disease now a spectrum disorder with a much broader range of presentations. Secondly, many children who were previously given a diagnosis of “mental retardation” or “emotional disturbance” and even “speech impairment” are now more appropriately placed in the ASD.

There is an excellent discussion on etiology. The evidence for/against vaccines as a potential cause of ASDs is reviewed. Often overlooked is that 10% of ASD are part of identified medical conditions such as fragile X, Down Syndrome, phenylketonuria and FAS. The heritable nature of ASD is emphasized in that there is a 5-6% recurrence risk of ASD in subsequent siblings.

Primary care providers are the key to identifying patients with ASD at an early age. The value of ongoing surveillance for delays in speech or emotional connectedness is reviewed. Screening using an ASD specific screening tool is recommended at ages 18-24 months and for any child in whom the diagnosis is entertained. If the diagnosis of ASD is felt likely then referral to a specialist who works with ASD is suggested along with enrollment in an early intervention program.

Editor's Note

This one article summarizes the literature of ASD for clinicians and supplies an algorithm for surveillance and screening that is straightforward. ASD is surprisingly common and it is our job to identify those children who may benefit from early intervention and structured programs at school. For many of us in remote, rural communities the first problem is how to obtain specialty consultation to confirm a diagnosis. The second and more formidable barrier to be discussed next month is how to find treatment services.

Infectious Disease Updates

Rosalyn Singleton, MD, MPH

Vaccine Safety Concerns:

The Price of Vaccine Success?

The Vaccine Court under the National Vaccine Injury Compensation Program recently made a judgment in favor of parents of a child with autism. This has occurred despite the fact that HRSA and CDC and the AAP and Institute of Medicine have all reviewed the scientific information concerning the allegation that vaccines cause autism and have found no credible evidence to support the claim. Paul Offit offered perspective on how the court could make this award on behalf of a child with autism and an underlying mitochondrial disorder.

Opinion: Inoculated Against Facts

By Paul A. Offit,
Infectious Disease, Children’s Hosp Philadelphia
New York Times March 31, 2008

When the vaccine court was established in 1986 a preponderance of scientific evidence was required for compensation. Because no one could sue vaccine makers without going through this special court, the number of lawsuits against vaccine makers fell drastically. The system worked fine until a few years ago, when vaccine court judges turned their back on science by dropping preponderance of evidence as a standard. Now, petitioners need merely propose a biologically plausible mechanism by which a vaccine might cause harm — even if their explanation contradicts published studies. In 2000, when Hannah was 19 months old, she received five shots against nine infectious diseases. Over the next several months, she developed symptoms of autism. Subsequent tests showed that Hannah has a mitochondrial disorder and this

contributed to her autism. An expert who testified in court on the Polings' behalf claimed that the five vaccines had stressed Hannah's already weakened cells, worsening her disorder. Without holding a hearing on the matter, the court conceded that the claim was biologically plausible.

"There is no evidence that children with mitochondrial enzyme deficiencies are worsened by vaccines," Salvatore DiMauro, a professor of neurology at Columbia who is the nation's leading expert on the disorder, told me. Indeed, children like Hannah Poling who are especially susceptible to infections are most likely to benefit from vaccines.

The vaccine court should return to the preponderance-of-evidence standard. But much damage has already been done by the Poling decision. Parents may now worry about vaccinating their children, more autism research money may be steered toward vaccines and away from more promising leads and, if similar awards are made in state courts, pharmaceutical companies may abandon vaccines for American children.

Below are some additional links for more information on vaccine safety:

- www.cdc.gov/vaccinesafety/concerns/thimerosal.htm
- www.immunize.org/safety

Recent literature on American Indian/Alaskan Native Health

Michael L. Bartholomew, MD

Ride Safe: A child Passenger Safety Program for American Indian/Alaska Native Children.

Letourneau RJ, Crump CE, Bowling JM, Kuklinski DM, Allen CW. Maternal and Child Health Journal 2008 Mar 14. [Epub ahead of print]

The motor vehicle related death rate in AI/AN children is nearly 2 ½ times higher than the overall US rate. Data from the 2002 National Highway Traffic Safety Administration (NHTSA) show that almost 40% of children under 5 who died in car crashes were unrestrained. Less is known about the use of child safety restraints in AI/AN populations though available information suggests very low rates of restraint use in AI/AN infants and children.

In January 2008, the NHTSA released Child Restraint Use in 2007-Demographic Results. Their analysis indicates that the

US child restraint use for children less than 12 months of age was estimated at 98%, while children aged 1-3 years was 96%. For children aged 4-7 years, the estimated restraint use was 85%. Interestingly, the NHTSA grouped AI/AN into an "Other-Non-Hispanic" demographic along with Native Hawaiian and Pacific Islander due to insufficient numbers. The 2007 NHTSA child restraint use estimates for "Other Non-Hispanic" for infants, children 1-3 years, and children 4-7 years were 100%, 95% and 87% respectively. It is painfully apparent that these results do not reflect the child restraint use in Indian Country and is largely misleading.

This new study attempts to define rates of restraint use among AI/AN children before and after implementation of a car safety seat educational intervention program. The program called Ride Safe is an evidenced-based injury prevention program designed to increase child safety seat use in children ages 3-5 years who are enrolled in 14 different AI/AN Head Start Programs.

Fourteen AI/AN Head Start sites in six different states implemented Ride Safe over four academic school years. The Ride Safe program included education of Head Start staff, and parents, distribution and installation of child safety seats, child safety seat certification training, and study training and support. Results show that initially Ride Safe was an effective intervention. After implementation of the Ride Safe Program, children were 2 to 3 times more likely to be observed in a child safety seat. Unfortunately this increase was not sustained over the length of the intervention. Additionally, the rate of child safety seat use ranged from 29.8% to 70.8%, with an overall car seat use rate of 47.5%. This rate is "far below" the 2006 NHTSA published car seat use rates for infants and children.

Despite the lack of sustainability, the Ride Safe program did produce some positive outcomes. During the study period, 2,916 car seats were provided. 78 Head Start staff obtained child passenger safety seat certification training and 1,744 parents/family members and 358 Head Start staff participated in educational sessions. Parental reasons for not using child safety seats became known, thus allowing for program improvement by focusing on these areas.

Reference:

Glassbrenner, D., & Ye, T. Child Restraint Use in 2007-Demographic Results. Traffic Safety Facts Research Note DOT HS 810 897, National Highway Traffic Safety Administration, National Center for Statistics and Analysis [online] January 2008

From Your Colleagues

Obstetrics

New Evidence Report on Management and Postpartum Follow-Up of Gestational Diabetes Mellitus

A new AHRQ evidence report finds there are no substantial differences in maternal or neonatal outcomes associated with the use of glyburide or insulin analogues, as opposed to the use of insulin in women with gestational diabetes. The report also finds that further studies are needed to inform the development of evidence-based guidelines for elective induction or cesarean delivery in women with diabetes. Select to review an abstract of the report. A print copy is available by sending an e-mail to ahrqpubs@ahrq.hhs.gov.

Therapeutic Management, Delivery, and Postpartum Risk Assessment and Screening in Gestational Diabetes

www.ahrq.gov/clinic/tp/gestdiabtp.htm

Ben Garnett, ANMC

**Antimicrobial prophylaxis for surgery
An Advisory Statement from the National Surgical Infection Prevention Project:
Antimicrobial Prophylaxis for Surgery**

Vaginal or abdominal hysterectomy

- Cefazolin
- Cefotetan
- Cefoxitin
- Cefuroxime
- Ampicillin sulbactam

Other

If Beta lactam allergy: metronidazole monotherapy is recommended in the ACOG Practice Bulletin as an alternative to cephalosporin prophylaxis for patients undergoing hysterectomy. Trovafloxacin, although still available in the United States, is recommended only for serious infections.

Synthetic pubovaginal sling

- Cefazolin
- Cefotetan
- Cefoxitin
- Cefuroxime

Other

If Beta lactam allergy: aminoglycoside, clindamycin, or metronidazole

Bratzler DW et al Antimicrobial prophylaxis for surgery: an advisory statement from the National Surgical Infection Prevention Project. Clin Infect Dis. 2004 Jun 15;38(12):1706-15.

Elaine Locke, ACOG

ACOG/IHS Denver Course in Salt Lake City, Utah this year

**Obstetric, Neonatal and Gynecologic Care
September 14-18, 2008
Salt Lake City, Utah**

This annual women's health update for Nurses, Advanced Practice Clinicians, and physicians provides a four-day schedule of lectures, workshops, hands-on sessions, and team building. The large interdisciplinary faculty collaborates to teach clinical and practical topics as they apply in Indian health settings. Many faculty members are your colleagues in IHS and Tribal facilities; private sector faculty also bring a wide range of experience providing Indian health care.

Learn the latest evidence-based approaches to maternal and child health services, and share problems and solutions with your colleagues from across Indian country. The course can also serve as a good foundation for professionals who are new to women's health care or new to the Indian health system.

In addition to the basic course, you may sign up for the Neonatal Resuscitation Program, and come away with your certificate from this convenient pre-course program. The opportunity to fulfill continuing education requirements in a concentrated format is significant: With the optional NRP, we can document your participation in seven half-days of education.

Sign up early! You'll have first chance for support from your facility and coverage for your time in Salt Lake City. Getting these benefits lined up takes time, so don't delay and miss out! In addition, early registration holds your place, and puts you in line for possible availability of scholarship funds.

Watch your mail for the course brochure and registration form, or download it from here www.ihs.gov/MedicalPrograms/MCH/F/CN01.cfm?module=08&option=9#top

Contact Yvonne Malloy ymalloy@acog.org for additional information.

Hot Topics

Obstetrics

Grief subsequent to an early miscarriage

The paucity of clear information as to the incidence, characteristics, and duration of grief following miscarriage suggests that practitioners can offer only suggestive guidelines as to what constitutes an adaptive or typical reaction to miscarriage.

The author found that

- * The affective and behavioral reactions that typically occur following miscarriage seem similar to the affective and behavioral reactions that typically occur following other types of significant loss. At the same time, grief following miscarriage seems somewhat distinct from grief that typically occurs following other losses in the preponderant emphasis on times ahead rather than on remembered times.

- * With regard to the percentage of individuals who experience a grief reaction following miscarriage, no clear guidelines can be formulated.

The available literature does suggest that grief reactions are common and that the grief is similar in intensity to grief following other types of losses. In addition, like grief following other types of losses, grief after miscarriage seems to abate in intensity by about 6 months following the miscarriage.

- * Although many variables have been studied to determine their role as moderators of the intensity and duration of grief following miscarriage, few clear conclusions can be drawn.

The authors conclude that "the similarity in the results of studies examining the duration and intensity of grief following miscarriage and the duration and intensity of grief following other types of losses supports using the general literature on grief to help guide patient expectations."

Brier N. 2008. Grief following miscarriage: A comprehensive review of the literature. *Journal of Women's Health*

Pregnant Women Who are Obese Linked with Greater Health Care Services Use

Obesity during pregnancy is associated with greater use of health care services and longer hospital stays. The primary reasons for the increased utilization of these services were increases in Caesarean section and obesity-related high risk conditions. Caesarean delivery rates were 45.2 percent for extremely obese women, compared to 21.3 percent for normal weight women.

Given the health and economic costs, the importance of preventing obesity in women of child-bearing age in order to enhance health during pregnancy and throughout the course of life still remains a vital public health concern.

CONCLUSIONS: Obesity during pregnancy is associated with increased use of health care services

Chu SY et al Association between obesity during pregnancy and increased use of health care. *N Engl J Med*. 2008 Apr 3;358(14):1444-53.

Gynecology

Non-surgical treatment of urinary incontinence and prevention of urinary and fecal incontinence

A recent AHRQ-sponsored review of published evidence on the non-surgical treatment of urinary incontinence in women included the following estimates of efficacy, based on a review of the available randomized controlled trials:

BACKGROUND: Urinary incontinence in women is a common problem that adversely affects quality of life.

CONCLUSIONS: Moderate levels of evidence suggest that pelvic floor muscle training and bladder training resolved urinary incontinence in women. Anticholinergic drugs resolved urinary incontinence, with similar effects from oxybutynin or tolterodine. Duloxetine improved but did not resolve urinary incontinence. The effects of electrostimulation, medical devices, injectable bulking agents, and local estrogen therapy were inconsistent.

Specific estimates of efficacy from available randomized controlled trials included that pelvic floor muscle training would resolve 490 cases of stress incontinence per 1000 cases treated.

This article was accompanied by an NIH "state of the science" statement addressing prevention of urinary and fecal incontinence. Conclusions included that "routine episiotomy is the most easily preventable risk factor for fecal incontinence" and that pelvic floor muscle training may prevent or reduce incontinence in older women and lifestyle changes, such as weight loss and exercise, may prevent both urinary and fecal incontinence.

Shamliyan TA, Kane RL, Wyman J, Wilt TJ. Systematic review: randomized, controlled trials of nonsurgical treatments for urinary incontinence in women. *Ann Intern Med*. 2008 Mar 18;148(6):459-73.

Ultrasound differentiated between benign and malignant: Improved outcomes

BACKGROUND: The diagnostic accuracy of ultrasonography for differentiating between benign and malignant adnexal masses is proportional to the expertise of the operator. However, we do not know whether improved diagnostic accuracy will affect the management of these tumours. We assessed the effect of the quality of gynaecological ultrasonography on the management of patients with suspected ovarian cancer in a randomised controlled trial.

INTERPRETATION: Improved quality of ultrasonography has a measurable effect on the management of patients with suspected ovarian cancer in a tertiary gynaecology cancer centre, and results in a significant decrease in the number of major staging procedures and a shorter inpatient hospital stay.

Yazbek J et al Effect of quality of gynaecological ultrasonography on management of patients with suspected ovarian cancer: a randomised controlled trial. *Lancet Oncol.* 2008 Feb;9(2):124-31

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Child Health

Is Short-term Therapy Effective for Treating Latent TB in Children?

CONCLUSION: The authors conclude that a three- to four-month course of isoniazid/rifampin combination therapy is well tolerated in children and is as effective as the traditional nine-month course of isoniazid monotherapy. In addition, the shorter treatment courses are associated with higher compliance rates.

Spyridis NP, et al. The effectiveness of a 9-month regimen of isoniazid alone versus 3- and 4-month regimens of isoniazid plus rifampin for treatment of latent tuberculosis infection in children: results of an 11-year randomized study. *Clin Infect Dis.* 2007;45:715-722.

Cognitive and Neuromotor Impairments Seen at 5 Years in Children Born Preterm

Follow-up of a large cohort of children born before 33 weeks' gestation shows that, despite improvements in treatment and survival, many of these children have cognitive and neuromotor impairment and require specialized care by 5 years of age

INTERPRETATION: In children who are born very preterm, cognitive and neuromotor impairments at 5 years of age increase with decreasing gestational age. Many of these children need a high level of specialised care. Prevention of the learning disabilities associated with cognitive deficiencies in this group is an important goal for modern perinatal care for children who are born very preterm and for their families.

Larroque B et al Neurodevelopmental disabilities and special care of 5-year-old children born before 33 weeks of gestation (the EPIPAGE study): a longitudinal cohort study. *Lancet.* 2008 Mar 8;371(9615):813-20.

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Chronic disease and Illness

FDA Approves Alternative Dosing Schedule for Combined Hepatitis Vaccine

In April 2007, the U.S. Food and Drug Administration (FDA) approved an alternative schedule for the combined hepatitis A and hepatitis B vaccine Twinrix (GlaxoSmithKline). The vaccine was first licensed in 2001 for vaccination of persons 18 years and older with a schedule of three doses adminis-

tered at zero, one, and six months. An alternative four-dose schedule can now be used, with doses administered at zero, seven, and 21 to 30 days, and at 12 months.

Studies showed that the first three doses of the four-dose schedule provide equivalent protection to the first two doses in the three-dose series, as well as to a single dose of monovalent hepatitis A vaccine and to two doses of monovalent hepatitis B vaccine. The FDA suggests that the four-dose schedule may be useful if vaccination with the combination vaccine has been initiated but potential exposure (e.g., through travel) is expected before the second dose is due, according to the standard three-dose schedule. Additional information is available from the manufacturer's package insert and GlaxoSmithKline Vaccines (telephone, 800-366-8900).

Morbidity and Mortality Weekly Report, October 12, 2007

Effect of lower targets for blood pressure and LDL cholesterol on atherosclerosis in diabetes: The SANDS randomized trial

CONCLUSIONS: Reducing LDL-C and SBP to lower targets resulted in regression of carotid IMT and greater decrease in left ventricular mass in individuals with type 2 diabetes. Clinical events were lower than expected and did not differ significantly between groups. Further follow-up is needed to determine whether these improvements will result in lower long-term CVD event rates and costs and favorable risk-benefit outcomes

Howard BV et al Effect of lower targets for blood pressure and LDL cholesterol on atherosclerosis in diabetes: the SANDS randomized trial.

JAMA. 2008 Apr 9;299(14):1678-89.

www.ncbi.nlm.nih.gov/pubmed/18398080

Menopause Management

Estrogen therapy doubles rate of benign breast lumps

The concern not only because of the extra biopsies and worry those lumps cause, but benign proliferative breast disease may be associated with cancer development in approximately 10 years.

CONCLUSION: Use of 0.625 mg/d of CEE was associated with a statistically significant increased risk of benign proliferative breast disease

Rohan TE et al Conjugated equine estrogen and risk of benign proliferative breast disease: a randomized controlled trial. *J Natl Cancer Inst.* 2008 Apr 16;100(8):563-71

Features

ACOG American College of Obstetricians and Gynecologists

Use of Psychiatric Medications During Pregnancy and Lactation

Summary of Recommendations and Conclusions:

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

- Lithium exposure in pregnancy may be associated with a small increase in congenital cardiac malformations, with a risk ratio of 1.2–7.7.
- Valproate exposure in pregnancy is associated with an increased risk of fetal anomalies, including neural tube defects, fetal valproate syndrome, and longterm adverse neurocognitive effects. It should be avoided in pregnancy, if possible, especially during the first trimester.
- Carbamazepine exposure in pregnancy is associated with fetal carbamazepine syndrome. It should be avoided in pregnancy, if possible, especially during the first trimester.
- Maternal benzodiazepine use shortly before delivery is associated with floppy infant syndrome.

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

- Paroxetine use in pregnant women and women planning pregnancy should be avoided, if possible. Fetal echocardiography should be considered for women who are exposed to paroxetine in early pregnancy.
- Prenatal benzodiazepine exposure increased the risk of oral cleft, although the absolute risk increased by 0.01%.
- Lamotrigine is a potential maintenance therapy option for pregnant women with bipolar disorder because of its protective effects against bipolar depression, general tolerability, and a growing reproductive safety profile relative to alternative mood stabilizers.
- Maternal psychiatric illness, if inadequately treated or untreated, may result in poor compliance with prenatal care, inadequate nutrition, exposure to additional medication or herbal remedies, increased alcohol and tobacco use, deficits in mother–infant bonding, and disruptions within the family environment.

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

- Whenever possible, multidisciplinary management involving the patient's obstetrician, mental health clinician, primary health care provider, and pediatrician is recommended to facilitate care.
- Use of a single medication at a higher dose is favored over the use of multiple medications for the treatment of psychiatric illness during pregnancy.
- The physiologic alterations of pregnancy may affect the ab-

sorption, distribution, metabolism, and elimination of lithium, and close monitoring of lithium levels during pregnancy and postpartum is recommended.

- For women who breastfeed, measuring serum levels in the neonate is not recommended.
- Treatment with all SSRIs or selective norepinephrine reuptake inhibitors or both during pregnancy should be individualized.
- Fetal assessment with fetal echocardiogram should be considered in pregnant women exposed to lithium in the first trimester.

ACOG Practice Bulletin No. 92: Use of Psychiatric Medications During Pregnancy and Lactation. Obstet Gynecol. 2008 Apr;111(4):1001-20

Breastfeeding

Kendra Carter, Northern Navajo Medical Center What Do High Performance Cars and Near Term Neonates Have In Common?

Infants like high performance cars, require consistent care and unique fuel. Many people understand the car scenario when educated on the characteristics of near-term infants who by definition are of a gestational age between 34–37 weeks. These late premature infants are at higher risk for the following:

- hypothermia due to less body fat and low weight (may actually weigh 1-1.5 pounds less than full term infants.)
- hypoglycemia and even dehydration can occur if infants miss feedings.
- infection related to an immature immune system
- hyperbilirubinemia related to immature liver
- uncoordinated ability to feed due to suck, swallow, breathe pattern when breastfeeding adding to fatigue.
- become easily over stimulated, resulting in an unorganized state compounding feeding difficulty.

It is vital that the nursing plan reflect understanding of the above risks and sometimes subtle signs, especially if the infant rooms-in and is breastfeeding.

- Feed baby every three hours and be aware that these infants can rapidly move from a hyper-alert to a deep sleep state and may require waking up techniques to feed.
- Limit total feeding time to thirty minutes to allow infant to rest.
- Allow the mother time to pump afterward as baby sleeps on her lap.
- Teach mothers and family members to look for signs of an effective latch and feeding of the infants. Families can help, awaken infant, change infant's diapers, and provide mothers with a snacks, water and uninterrupted time for breastfeeding.
- Vigorous, rhythmic sucking burst with brief pauses between sucking bursts is a sign of effective suck. No dimpling in baby's cheeks should be seen during sucking. Audible swallows and listen for soft "k" sound
- Supplement five to ten ml of pumped breast milk using a special nurser or syringe feeding techniques.

- Mother is relaxed and comfortable. Like the car scenario, the pit crew is a mom's lifeline. She may need to be reminded to take care of herself and accept help.
- Moms need to drink to thirst- keep healthy drinks, water, and natural juice, watch out for caffeinated drinks. Drink to thirst- keep healthy drinks, water, and natural juice, watch out for caffeinated drinks. Eat to hunger- keep healthy snacks of veggies and protein snacks. This is not the time to diet to lose weight. Let someone else take care of the household chores for the first day or two at home. Nap when baby naps, do not forget sleep is important to you as well.
- Lactation consultants brought in early can anticipate discharge instructions and home follow-ups.
- Use of infant feeding records can reassure and be used for emphasis.
- Baby is having adequate numbers of wet and soiled diapers
- Baby regains birth weight between days ten and fourteen of life.

Domestic Violence

Denise Grenier, Tucson
Rachel Locker, Warm Springs

Intimate Partner Violence and Sexual Violence Victimization Assessment Instruments for Use in Healthcare Settings

Intimate Partner Violence and Sexual Violence Victimization Assessment Instruments for Use in Healthcare Settings is a compilation of existing tools for assessing intimate partner violence (IPV) and sexual violence (SV) victimization in clinical/healthcare settings. The purpose of this compilation is to provide practitioners and clinicians with the most current inventory of assessment tools for determining IPV and/or SV victimization and to inform decisions about which instruments are most appropriate for use with a given population.

This document will aid in the selection of assessment instruments to identify victims requiring additional services. This can help practitioners make appropriate referrals for both victims and perpetrators. www.cdc.gov/ncipc/dvp/IPV/IPVandSV-Screening.pdf

Other resources

Below is the link to CDC's Injury publications that also has some useful resources.

www.cdc.gov/ncipc/pub-res/pubs.htm

This is a successful CDC resource called "Choose Respect" which also provides useful information.

www.chooserespect.org/scripts/index.asp

Elder Care News

Bruce Finke, Elder Care Initiative

Landmark Study on Treatment of Hypertension in the Very Old

This international randomized controlled trial addresses the important unanswered question of the value of treatment for

hypertension in men and women aged 80 and older. Although treatment of elevated systolic and diastolic blood pressure has clearly been shown to benefit younger elders, prior to this study the data in the older elderly has been inconclusive.

Nearly 4000 elders aged 80 and older with systolic blood pressures of 160mm Hg or higher were randomized to receive either placebo or a diuretic similar to HCTZ. An ACE-I was added to the diuretic as needed to reach the target blood pressure of 150/80.

Over a 2 year study period active treatment was associated with a 30% reduction of stroke (fatal and nonfatal), a 39% reduction in death from stroke, a 21% reduction in death from any causes, a 23% reduction in death from cardiovascular causes, and a 64% reduction in heart failure. There were fewer serious adverse events in the active treatment group than in the placebo group.

Elder Care Initiative Editorial comment:

This is a landmark study that makes clear the benefit of treatment of hypertension, diastolic and systolic, in the very old. I was especially interested in the marked reduction in stroke and heart failure, two conditions with huge implications for the function and quality of life of older people. Treatment of high blood pressure is not just about preventing death, but also about preserving quality of life.

Beckett NS, Peters R, Fletcher AE, Staessen JA, Liu L, Dumitrascu D, Stoyanovsky V, Antikainen RL, Nikitin Y, Anderson C, Belhani A, Forette F, Rajkumar C, Thijs L, Banya W, Bulpitt CJ; the HYVET Study Group. Treatment of Hypertension in Patients 80 Years of Age or Older. N Engl J Med. 2008 Mar 31

Family Planning

Contraceptive agents when initiating breastfeeding

Nonhormonal methods of contraception (barrier contraception, copper intrauterine device) are preferred in nursing mothers because hormonal contraception may interfere with lactation and transfer of hormones into milk poses a theoretical risk to the infant.

Progestin only—If hormonal methods are to be used, progestin-only contraceptives are the preferred method for breastfeeding women, although timing of initiation of therapy is somewhat controversial. Because falling progesterone levels trigger lactogenesis, early initiation of progestin-containing contraceptives theoretically could interfere with this process, particularly if injection contraception is given in the first 72 hours after delivery. The immature metabolism of neonates theoretically could lead to accumulation of progesterone and its metabolites in the infant.

Due to these concerns, manufacturers' package inserts recommend starting progesterone-containing oral contraceptives six weeks postpartum if the mother is exclusively breastfeeding, and three weeks postpartum if she is supplementing with formula. However, there are no data on the impact of earlier initiation of progestin-only contraception. The American College of Obstetricians and Gynecologists (ACOG) recommends that breast-

feeding women initiate progestin-only oral contraceptives at two to three weeks postpartum, and depot medroxyprogesterone acetate at six weeks postpartum. In certain clinical situations, such as concern about patient follow-up, ACOG states that it may be appropriate to start progesterone-containing contraception earlier.

The levonorgestrel releasing intrauterine device is recommended for insertion six weeks postpartum in breastfeeding women.

Combined estrogen-progestin—Combined estrogen-progestin contraceptives are known to

- suppress milk production in the early post-partum period, and have even been used to treat
- engorgement. Clinical trials examining the effect of combined oral contraceptives on milk
- supply and infant growth have reported mixed results. A large review of the literature concluded
- that the data were of such poor quality that no evidence-based recommendation could be made
- regarding use of combined contraceptives in lactating women.

Expert recommendations vary:

- ACOG recommends delaying the initiation of combined estrogen-progestin contraceptives until at least six weeks postpartum, and then only if lactation is well-established and the infant's nutritional status can be closely monitored.
- The World Health Organization (WHO) recommends delaying the initiation of combined contraceptives until six months postpartum. Between six weeks and six months, WHO states that the theoretical or proven risks usually outweigh the advantages.

Helpful resources

Combined hormonal versus nonhormonal versus progestin-only contraception in lactation: Cochrane Review

www.cochrane.org/reviews/en/ab003988.html

National Guidelines Clearinghouse

www.guidelines.gov/summary/summary.aspx?ss=15&doc_id=7098&nbr=004270&string=contraceptive+AND+choices+AND+breastfeeding+AND+women

Faculty of Family Planning & Reproductive Health Care.

Contraceptive choices for breastfeeding women. J Fam Plann Reprod Health Care 2004 Jul;30(3):181-9

Frequently asked questions

First Trimester Down Syndrome Testing

1. Q. Who should be offered first trimester Down syndrome (DS) screening?

A. Women presenting for prenatal care at less than 14 weeks gestation.

2. Q. Should only high-risk women (over 35 y/o) be offered

1st trimester DS screening?

A. No, all women who desire the testing are candidates.

3. Q. At what gestational age should first trimester DS screening be scheduled?

A. Between 11 weeks 0 days and 13 weeks 6 days (by ultrasound).

4. Q. What are the components of the 1st trimester DS screen?

A. Ultrasound measurement of the nuchal translucency (NT) + blood for PAPP-A (pregnancy-associated plasma protein-A) and free beta HCG.

(Most ultrasound exams at ANMC will also include the fetal heart rate, nasal bone, and ductus venosus or tricuspid waveform, if able to be obtained, which increase the sensitivity and reduce the false positives.)

5. Q. I'm pretty good at office ultrasound. Can I do my own NT measurements?

A. Without certification, unfortunately no. Accurate NT measurements are difficult to obtain without special training. A lot is riding on the results. NT measurement requires a certificate of competency which can be obtained by attending a one-day didactic course, taking a written examination, and submitting 10 ultrasound images for critique and/or acceptance. Following certification, annual certification of competency needs to be accomplished by submitting more images. If interested, the certification process can be initiated at this website: www.ntqr.org.

6. Q. I'm happy with our usual 2nd trimester screening. What's the advantage to offering first trimester DS screening?

A. The advantages are earlier diagnosis, increased sensitivity (91%), and fewer false positives (4%).

(This is compared to 2nd trimester screening that has a 78% sensitivity and a 5% FPR for screening in younger women (<35 y/o), and an 85% sensitivity but an 11% FPR in women >35 y/o. Many women will present too late for 1st trimester screening, so 2nd trimester screening will continue to be an appropriate option.)

7. Q. What is "integrated screening"?

A. Integrated screening is a screening strategy which relies on the results of both the 1st and 2nd trimester testing to give a final risk assessment.

(The ANMC contract with our reference lab, NTD Laboratories, is currently not set up to do integrated screening. Also, we felt that most women would want to have the results of an abnormal 1st trimester screen divulged to them right away, and not wait for another several weeks.)

8. Q. What is "sequential contingent screening"?

A. Sequential contingent screening is the strategy that we are currently using at ANMC. If women have an abnormal 1st trimester result, they are informed, and offered the option of immediate invasive testing, or subsequent 2nd trimester testing.

If they have a normal result, their DS screening is considered to have been completed.

9 Q. What are the cut-off values used for 1st trimester screening?

A. A 1st trimester cut-off of 1:50 or higher is used to counsel about immediate invasive testing, if the woman so desires.
 -A 1st trimester cut-off of 1:300 or higher is used to recommend a detailed 2nd trimester anatomic ultrasound, and/or possible amniocentesis.
 -According to our current ANMC protocol, women with a screening result of less than 1:300 have completed DS screening. (If the pregnancy is 13 weeks or less, ANMC patients may be referred to Seattle for chorionic villus sampling [CVS], if they so desire. If a woman is beyond 13 weeks, or does not wish CVS, or would prefer amniocentesis, she will need to wait 2 weeks and be referred for amnio after 15 weeks. "Early amnio", between 12-15 weeks, has a high [2.6%] pregnancy loss rate, and is not recommended.)

10 Q. If my client's 1st trimester DS screen is negative, is any further testing necessary?

A. If the woman's 1st trimester DS screen is less than 1:300, our strategy of contingent sequential screening does not require any further testing for fetal aneuploidy. However, testing for fetal open neural tube defects (ONTD) still needs to be carried out. (In the current ANMC system, it is unfortunately currently not possible to order a maternal serum alpha fetoprotein (MSAFP) for ONTD screening alone, apart from a quad screen. Following negative 1st trimester screening, 2nd trimester serum screening, if not "integrated", has an unacceptably high false positive rate (17%) for fetal Down syndrome, and is not recommended. However, we are fortunate to be able to order routine fetal anatomic surveys at 16-20 weeks, which have a high sensitivity (96%) for fetal ONTD and fetal abdominal wall defects. MSAFP screening only has an 80% sensitivity for ONTD in ultrasound-dated pregnancies (only 65% in LMP-dated pregnancies), so ultrasound is superior in this regard. In order to follow ACOG guidelines, some sort of ONTD screening needs to be done.)

11 Q. At 12 weeks 2 days, a woman undergoes 1st trimester screening and has a nuchal translucency (NT) of 2.9 mm, which is >95th percentile for this crown rump length. How should she be counseled?

A. The NT alone does not determine the screening result. It needs to be combined with the PAPP-A and free beta HCG for a final risk assessment. The NT alone only has a sensitivity for fetal DS of 72%, with a (high) false positive rate of 19%. The NT combined with the biochemistries has a sensitivity of 91% and a FPR of 4%. The full screen result requires both, and it is not prudent to act on the NT measurement alone. (Important exception: If the NT measurement is over 3.5 mm (+3 SD), it is considered a cystic hygroma, and the woman may be counseled about having invasive testing right away, if she so desires. A cystic hygroma raises the risk of aneuploidy to as high

as 1:2.)

12 Q. I've heard that an enlarged NT can also signal fetal heart defects. How large does the NT have to be to be considered a marker for potential heart defects?

A. About 1% of patients have an NT >3.5 mm (>99th percentile), which is used as the cutoff for making a referral for fetal echocardiography after 20 weeks. Even if the fetus is found to have a normal karyotype, it should still be screened for cardiac defects. (The sensitivity of a NT >3.5 mm for congenital heart disease is about 40%, but the positive predictive value is only about 4%.)

13 Q. What about multiple gestations? Can they undergo 1st trimester screening?

A. Twins can be screened for fetal aneuploidy in the 1st trimester since nomograms are available to calculate their overall risk. Higher order multiples however are not able to be accurately screened at present, although an NT >3.5 mm should always raise suspicion.

14 Q. Does 1st trimester screening only screen for fetal Down syndrome, or can other fetal trisomies also be detected?

A. First trimester combined screening tests screen for trisomy 21 (Down syndrome) and trisomy 18. Trisomy 13 and sex chromosome aneuploidies (Turner syndrome, XO, and Klinefelter syndrome, XXY, etc.) are not efficiently screened with this test. (However, remember, over 50% of fetuses with Turner syndrome will have a cystic hygroma, i.e., NT >3.5 mm.)

15 Q. My client has a negative 1st trimester DS screening result, and a normal 2nd trimester ultrasound, but she still desires amniocentesis. Is that indicated?

A. Both 1st and 2nd trimester screening is just that, screening, not diagnostic. Screening is able to lower risks, but only an invasive diagnostic test can definitively diagnose fetal aneuploidy. If a woman still wishes invasive testing and understands the risks of pregnancy loss following testing (which are quoted in the literature as ranging from 1:200 to 1:1600), that is her choice. (It would have been more cost-effective if she had decided that earlier and been referred before having any screening!)

**OB/GYN CCC Editorial comment:
First trimester screening is a reality**

Though first trimester screening a reality, please note that these comments are from George Gilson, MFM, at the Alaska Native Medical Center so are based on the resources available in tertiary care center. You may wish to do something different in your service unit, but it is helpful to be aware which direction your clinical care will be heading when the resources are available.

International Health Update

Claire Wendland, Madison, WI

Is health a human right?

In the arena of international development and health, the use of human-rights language to advocate for the health of the poor is increasingly popular. This language raises many serious questions, yet it also historically and morally powerful. The two articles referenced at the end of this column give those who are interested a place to start with this rights-and-ethics discussion.

What can a “right to health” possibly mean? If we interpret the phrase as “a right to be healthy,” it’s a difficult proposition to swallow. Everyone dies, and nearly everyone contracts a serious disease at some point in life: in that light, a right to be healthy seems positively nonsensical. In practice, though, the phrase “right to health” usually serves as a shorthand for a right to the conditions necessary to produce the best attainable standard of health – conditions including basic education and access to information, adequate health care, food security, a safe environment, protection from severe poverty, decent sanitation and clean water. Public health research has consistently shown these factors to be strong social determinants of health; many have been enshrined in the Millenium Development Goals as keys to world human development.

In fact, the right to the conditions necessary for health has been part of the Universal Declaration of Human Rights (to which the US is one of many signatories) since 1948. An expanded version became international law in the 1970s. Though a US ambassador to the United Nations derided this law as a “letter to Santa Claus” the decade after that, soon a terrible epidemic was to draw the world’s attention to the conjunction of health and human rights. In the 1990s, the devastating spread of HIV/AIDS exposed to the view of wealthy countries the links between inequality and disease, marginalization and disease, poverty and disease, lack of adequate health care and disease. In this context, the work of Jonathan Mann called for human rights to be the foundation of public health ethics, an idea that has spread widely in the new millennium.

This framework is not without problems. First, it does not address the issue of competing priorities. Why is health a priority over all other communal values, or is it? What happens in situations of extreme scarcity? What about when one country’s priorities (for national security, for instance, or for intellectual property rights) cause damaged health in other countries? Second, it carries an ambiguity between judicial and moral claims. Rights in the legal sense are things a person may reasonably expect to have satisfied by the force of the law. Is a decent standard of living really this kind of right? Is access to health care? If so, how much health care? (Those in the Indian Health Service, where treaty rights really did establish legal claims to health care and education, will recognize some of these debates.) Even if the “right to health” is not thought of as a legal right, but a moral one, whose responsibility is it? Finally, what about transnational or supra-national institutions? Mechanisms of international accountability remain fairly thin. If the World Bank’s policies, or Chevron’s, or Pfizer’s, hurt the health of the Third-World poor, who holds them accountable and how?

Despite these serious concerns, thinking about health as a human right does have an impact in the international health arena. I see it as having two major functions. It creates a right to assistance – and a duty to intervene – in the name of health. This right and duty have been established for decades in humanitarian conflicts (though they are not completely without controversy); what’s new here is their use in the setting of severe disease. Again, the HIV/AIDS epidemic, especially in Africa, was paramount in shifting this discussion. More broadly, health as a human right rhetorically establishes a framework of ethics, a language of moral urgency that does not depend on religious creed and therefore opens the way to international consensus on public health issues. In this sense, it is an important counter-discourse to the dominant argument of neo-liberal economics: that the invisible hand of the market, working through economic growth, is alone enough to improve human well being. In this realm human rights as a framework for public health ethics meets social justice movements. The powerful language of rights moves the disciplines of medicine and public health away from narrow disease-specific intervention programs, away from a preoccupation with individual genetics and behavioral choices and into the realm of social determinants of health.

Here’s how I see Jonathan Mann’s project, Paul Farmer’s project, the project of those who work within this model: they are calling us to a passion for social justice. They are getting public health up beside them on the soapbox in defense of a set of values embedded in human rights talk. Their language has echoes of Mandela and Gandhi, Jefferson and Lincoln, Tiananmen Square, Birmingham and Martin Luther King. They marshal deep history and moral force to move us forward – with genuine partnerships and a shared vision of the future – into a struggle for the human commonwealth.

Sounds good, doesn't it?

Buchanan, DR. Autonomy, paternalism, and justice: ethical priorities in public health. American Journal of Public Health 98(1):15-21, 2008

MCH Headlines

Judy Thierry HQE

CDC Releases Study on Abuse & Neglect of Infants

CDC released a study today entitled “Nonfatal Maltreatment of Infants—United States, October 2005–September 2006.” The study, published in CDC’s Morbidity and Mortality Weekly Report, found that in the year studied, there were 91,278 babies less than 1 year old who were documented victims of child abuse or neglect. Of those, 29,881 were victims of abuse or neglect before they were 1 week old.

Almost 70% of babies less than 1 week old were reported for neglect and 13.2% were reported for physical abuse. The study also found that medical professionals, such as doctors, nurses, and other hospital staff were most likely to report child abuse and neglect of babies. The study was authored by researchers from CDC’s National Center for Injury Prevention & Control and the Administration for Children & Families (ACF).

The study is available at www.cdc.gov/mmwr.

Medical Mystery Tour

You know how to treat yeast infections, right?

Which of these are true about vulvar pruritus?

Here are the answers to last month's questions

- 1 It is important to ask patients presenting with vulvar pruritus if symptoms vary with their cycles

True

Discussion

When did the symptoms start in relation to menses? *Candida* vulvovaginitis often occurs in the premenstrual period, while trichomoniasis often occurs during or immediately after the menstrual period.

- 2 *Candida glabrata* tends to respond to intravaginal boric acid therapy

True

Discussion

C. glabrata has low vaginal virulence and rarely causes symptoms, even when identified by culture. Every effort should be made to exclude other co-existent causes of symptoms and only then treat for yeast vaginitis. Treatment failure with azoles is not uncommon (around 50 percent) in patients with *C. glabrata* vaginitis. Moderate success (65 to 70 percent) in women infected with this organism can be achieved with intravaginal boric acid (600 mg capsule once daily at night for two weeks). Better results (>90 percent cure) have been achieved with intravaginal flucytosine cream (5 g nightly for two weeks); however, flucytosine cream is not readily available and must be made by a compounding pharmacy. There are no good data regarding use of oral voriconazole for *C. glabrata* vaginitis. Anecdotal reports suggest poor response and rare if any success, and the potential for toxicity.

Sobel JD; Chaim W Treatment of Torulopsis glabrata vaginitis: retrospective review of boric acid therapy. Clin Infect Dis 1997 Apr;24(4):649-52.

- 3 Nystatin successfully treats the majority of patients with tinea cruris.

False

Discussion

Tinea cruris (jock itch) is a special form of tinea corporis involving the crural fold. It is a specific fungal infection, but it's a dermatophyte infection, unlike *Candida*, which is a yeast form. In North America the most common cause is *T rubrum*. A few cases are caused by *E floccosum* and occasionally *T mentagrophytes*.

Tinea cruris is far more common in men than women. The disease often begins after physical activity that results in copious sweating, and the source of the infecting fungus is usually the patient's own tinea pedis. Obesity predisposes to tinea cruris.

Topical antifungal treatment will suffice for the ordinary

case. Failure to treat concomitant tinea pedis usually results in prompt recurrence. Lesions resistant to topical medications can be treated with griseofulvin by mouth, 250 mg three times daily for 14 days, or any of the other systemic agents.

Daily application of talcum or other desiccant powders to keep the area dry will help prevent recurrences. Itching can be alleviated by over the counter preparations such as Sarna or Prax, although these can be irritating if applied to inflamed or excoriated skin. Patients should also be advised to avoid hot baths and tight-fitting clothing, and to wear boxer shorts rather than briefs.

- 4 Topical steroid ointments at the correct treatment for lichen sclerosis

True

Discussion

The treatment with the best evidence of efficacy from randomized trials is superpotent topical corticosteroid ointment. Approximately 95 percent of women will achieve complete or partial relief of symptoms. No specific superpotent steroid or regimen has been shown to be superior to another. We use clobetasol or halobetasol propionate 0.05 percent ointment daily at night for 6 to 12 weeks and then one to three times per week for maintenance. The ointment is applied sparingly in a thin film over the affected area. A 15 g tube of ointment should be prescribed.

Diakomanolis ES et al Vulvar lichen sclerosis in postmenopausal women: a comparative study for treating advanced disease with clobetasol propionate 0.05%. Eur J Gynaecol Oncol. 2002;23(6):519-22.

- 5 Classic psoriasis occurs often on the vulva

False

Discussion

Classic psoriasis rarely presents primarily on the vulva. If it does present on the vulva, it is usually in patients with psoriasis primarily present in the classic psoriasis positions elsewhere on the body.

Patients with plaque type psoriasis usually present as young adults with symmetrically distributed plaques involving the scalp, extensor elbows, knees, and back. The plaques are erythematous with sharply defined margins that are raised above the surrounding normal skin. A thick silvery scale is usually present, although recent bathing may remove the scale. The lesions can range from less than 1 to more than 10 cm in diameter. The plaques typically are asymptomatic, although some patients complain of pruritus. Close inspection may reveal pitting of the nail plates and involvement of intertriginous areas such as the umbilicus and intergluteal cleft.

Navajo News

Jean Howe, Chinle

Sexual Assault Nurse Examiner (SANE) Training Course, June 9-13, 2008

Navajo Nation Museum, Window Rock, Arizona.

This 5-day intensive training course will focus on the basic forensic medical examination techniques and issues in providing care for adult and adolescent victims of sexual assault. It will provide nurses and other licensed healthcare professionals with the didactic training necessary for certification as a Sexual Assault Nurse Examiner (SANE) or a Sexual Assault Forensic Examiner (SAFE) and discuss next steps after training. Strategies for developing a multi-disciplinary Sexual Assault Response Team (SART) will also be reviewed.

This course provides the classroom curriculum portion of SANE/SAFE training. For nurses or other healthcare professionals who do not routinely perform pelvic examinations, practical experience to acquire pelvic examination skills should be arranged outside of this course. It would be beneficial to begin this process prior to attending the course if possible. After completion of the course, proctoring is also strongly recommended for the initial forensic examinations performed.

This course is open to Indian Health Service healthcare professionals, including nurses, advanced practice nurses, PAs, and physicians. A brochure and registration forms will be available soon, as well as information on lodging. There is no fee to attend the course. Transportation, lodging, and per diem are the responsibility of the home health system or individual.

This course is being co-sponsored by Carolyn Aoyama, Senior Consultant for Women's Health and Advanced Practice Nursing Program at IHS Headquarters and by the Chinle Family Violence Prevention Task Force and the Navajo-Hopi-Zuni SANE/SART Work Group. For questions about content, please contact Sharon Jackson (Sharon.jackson@ihs.gov) or Sandra Dodge (Sandra.dodge@ihs.gov). For questions about registration or logistics, please contact Alberta Gorman (Alberta.gorman@ihs.gov).

IHS and Tribal sites throughout the Four Corners area are working with the Northern Arizona Center Against Sexual Assault to formulate an integrated approach to sexual assault. This training is a part of that effort. The goal is to have SANE and SART services available throughout the Four Corners area.

Office of Women's Health, CDC

Factors Associated with Elevated Risk of Postneonatal Mortality Among Alaska Native

Objective Compared to non-Natives in Alaska, the Alaska Native population has a postneonatal mortality rate 2.3 times higher (95% CI 1.9, 2.7). The objective of the study was to identify variables that account for this elevated risk.

RESULTS: In stratified analysis, race remained associated with postneonatal mortality within most categories of marital status, maternal education, maternal age, prenatal tobacco or alcohol use, prenatal care utilization, parity and residence. The odds

ratio between race and postneonatal mortality was reduced to 1.3 (95% CI 1.0, 1.6) by controlling for education, a composite variable of marital status and the presence of father's name on the birth certificate, and prenatal tobacco or alcohol use.

CONCLUSIONS: A small number of potentially modifiable factors explain most of the postneonatal mortality disparity between Alaska Natives and non-Natives, leaving a relatively small increase in risk. These findings suggest that by targeting Alaska Native women who display these characteristics, the postneonatal mortality gap may be reduced.

Blabey MH, Gessner BD. Three Maternal Risk Factors Associated with Elevated Risk of Postneonatal Mortality Among Alaska Native Population. *Matern Child Health J.* 2008 Apr 4

Perinatology Picks

George Gilson, MFM, ANMC

Maternal Fetal Medicine Editorial Comment:

Clarification for 'What is this all about the 'minor markers' for Down Syndrome?'

We would like to clarify a few points from the April Perinatology Picks story entitled: What is this all about the 'minor markers' for Down Syndrome?

If women undergo first trimester Down syndrome (DS), and the results are negative (risk <1:300), the system set up at ANMC, "contingent sequential screening", considers them as not requiring further second trimester screening for DS. This is because second trimester quadruple marker screening will increase the number of false positive results if first trimester results are not taken into account. Other screening systems, such as "integrated screening" do use both first and second results to compute a final risk estimate, but this is not the strategy we have chosen to use at ANMC. Despite negative first trimester DS screening, women still need to be screened for open neural tube defects (NTD). We accomplish this at ANMC by having all women undergo a comprehensive fetal anatomic survey at 16-20 weeks. Ultrasound has a 96% sensitivity for NTD, whereas quadruple screening with maternal alpha fetoprotein (AFP) only has an 80% sensitivity (only 65% in pregnancies not ultrasound dated!). If your service unit is unable to do routine second trimester ultrasounds however, you still must offer women NTD screening with AFP testing, even if they have had negative first trimester DS screening results.

If you have further questions, please contact Neil Murphy at nmurphy@scf.cc

What is this all about the 'minor markers' for Down Syndrome? April 2008 CCC Corner

www.ihs.gov/MedicalPrograms/MCH/M/ob.cfm?module=4_08ft#peri

Do We Need to do MSAFP Testing after First Trimester Down Syndrome Screening?

A recent Fetal Medicine Foundation newsletter (Vol.2, Issue 3, July 2006) discussed this topic and reached some interesting

conclusions that may be pertinent to our practices. The current standard of care in the United States has been in place since the early 1980's, and is to offer maternal serum alpha fetoprotein (MSAFP) testing to all pregnant women in order to screen for fetal open neural tube defects (ONTD), including anencephaly and meningomyelocele. Other important abnormalities suggested by an elevated MSAFP are the abdominal wall defects, including gastroschisis and omphalocele. Most MSAFP determinations are done between 15 and 20 weeks gestation, and are now part of either the "triple" or "quad" screens, which are also done to screen for fetal Down syndrome (DS). Unfortunately, MSAFP has less than optimal sensitivity and specificity for ONTD, with a detection rate of about 80% (MSAFP >2.5 MoM) at a fixed false positive rate of 5%.

Second trimester ultrasound on the other hand has sensitivity and specificity for ONTD that are >95%. The diagnosis of anencephaly is usually immediate. The diagnosis of spinal defects is also excellent. In addition to vertebral column defects, the cranial findings of an abnormal cerebellum, the "banana" sign (Chiari type II malformation), and the resultant cranial deformity of the "lemon" sign, have been well described for several decades. Fetal abdominal wall defects are usually also easily diagnosed with ultrasound. The more rare fetal problems, such as the genitourinary abnormalities, bowel obstruction, and teratomas, which are also associated with elevated MSAFP, are also usually apparent on ultrasound.

If your patient has chosen first trimester "combined" screening for Down syndrome (measurement of the fetal nuchal translucency (NT) and determinations of pregnancy associated plasma protein A [PAPP-A] and free beta HCG between 11 and 13 weeks), does she also need to undergo MSAFP screening in the second trimester? Does she need a second trimester anatomic survey to look for the abnormalities detailed above? Ultrasound at 11-13 weeks should easily be able to diagnose anencephaly, as well as abdominal wall defects. At the present time however, there are no studies that have looked at the accuracy of screening for spinal defects at this gestational age.

In our system in Alaska, those women who have had negative first trimester screening for fetal DS receive a second trimester sonographic anatomic survey, and are thus screened for ONTD with the modality with the best detection rate. If a woman has had a negative first trimester screen, we have elected not to do "integrated" DS screening with a quad screen in the second trimester, and thus we do not get an MSAFP. Women who present after 13 weeks can elect multiple marker screening, with MSAFP, and may also require second trimester ultrasound as indicated. However, this scheme may not be most cost-effective in your setting, especially if "level II" ultrasound services are not readily available. Likewise, remember that ACOG guidelines continue to recommend MSAFP screening for women who have had first trimester screening, despite the above evidence. As this is a continuously evolving field, remember to "stay tuned for further details..."

Primary Care Discussion Forum

Ann Bullock, Cherokee, NC

The conclusion of the adolescent behavioral health on-line discussion:

This month's discussion on adolescent behavioral health will be terminated prematurely due to the non-negotiable demands of Spring Break – certainly an imperative that all self-respecting adolescents would endorse enthusiastically.

I hope that the case discussed shed at least some light on issues bearing on the diagnosis and management of behavioral health disorders in adolescents. Precision in psychiatric diagnosis of children and teens is problematic to say the least. A major proportion of drug prescriptions in this population are off-label, which is perhaps appropriate, as I am not sure we have an exact label for many struggling kids. Many DSM diagnoses are derived from adult criteria, and often fail to encompass the nuances of child and adolescent disorders. No better example exists than the diagnosis of PTSD, which works pretty well when applied to an adult after a discrete trauma, but doesn't capture the wide spectrum of behavioral and emotional responses we see in children exposed to early life stress, whether chronic or acute. Adult derived criteria for bipolar disorder, major depression, and even substance abuse all leave room for "diagnostic orphans", and conversely, can stretch-to-fit some youth who may not meet the classic definition, but need help nevertheless.

We always need to remember that we in IHS are dealing with a population that has been subjected to massive amounts of psychosocial deprivation. It is well demonstrated that kids who grow up in such circumstances are far more likely to exhibit signs and symptoms of emotional dysregulation, disruptive behavior disorders, ADHD, substance use disorders, and the whole gamut of psychiatric disorders – whatever the formal diagnosis may entail. Given the complexities and controversies in medication management for these youth, the primary care provider needs to develop a feel for when and how to refer teens and their families to specialty care. And although child and adolescent psychiatrists are in extremely short supply in IHS, thankfully we have a few, and have attracted more in recent years. Most adult psychiatrists – particularly if they've been in IHS for a while – do the best we can, and inevitably acquire a lot of experience with youth. The American Academy of Child and Adolescent Psychiatry has published guidelines for referral (link below)

Adolescents and their families can and do respond to our efforts, although of course, not uniformly. But much of the success is built on the foundation of our primary care providers who take the time, even when there is no time, to try and bring order out of chaos.

1 Moreno C et al. Natural trends in the outpatient diagnosis and treatment of bipolar disorder in youth. Archive General Psychiatry. 2007; 64:1032-1039.

www.aacap.org/cs/root/physicians_and_allied_professionals/when_to_seek_referral_or_consultation_with_a_child_and_adolescent_psychiatrist

(HPV vaccine, continued from page 1)

Participants centered around the following themes: death; personal experiences with cancer; fear; pap smears; hysterectomy; ability to reproduce; and older women. The majority of mothers said that they alone make the decision to vaccinate their child against a disease. Some said that they make the decision in conjunction with their spouse and a few said that they involve their daughter and spouse in the decision-making. Many of those who said that they involve their daughters had older teenage daughters. For example, one mother stated “My daughter is 17, and she’s the one who went out, did her research on the shot, and she’s been patiently waiting for it.” The majority of the fathers said that the decision is a joint decision between them and their spouse.

The majority of participants want to vaccinate their daughter due to: health and safety concerns; a positive belief that vaccines work; personal experience with the cancer/HPV; or a belief that their daughter is susceptible to HPV. One mother described it this way, “I see it as just part of being a mom and wanting to protect your child against cancer.” Another parent stated “For me, having a strong history of all kinds of cancers in my family, one less cancer - the vaccine could protect my daughter from at least that.” Another theme that was mentioned by at least one parent in each community is that often a sexual exposure is not under the control of the young woman, as in the case of rape, and this vaccine would offer the young woman protection from HPV. Reasons that participating parents would refuse vaccination include general concerns about vaccines, need for more information, fear of side effects, wanting more research studies, wanting to wait to see if problems develop, and fear of being in an experimental trial. A typical comment about the newness of the vaccine came from a mother who stated, “I don’t like to be the first to use a new vaccine. That makes me uncomfortable that it hasn’t been used by a lot of people yet. Some side effects may turn up that they don’t know about until they vaccinate a whole bunch of kids.”

In all the communities, when parents were asked what information should be included in an educational campaign on the new vaccine, parents stressed a focus on prevention, the importance of describing HPV, cervical cancer, and the vaccine and letting people know that the vaccine is safe. Parents said to keep it simple, to talk about side effects, the shot schedule, the need for continued Pap smears, and how HPV is transmitted. When asked “Who should deliver the message about the vaccine?” the same answers came up in all regions: providers (nurses, doctors, health aides, children services workers, tribal health workers) and teachers. The parents specified that the faces they want to see on posters should be Alaska Native and some suggested having a girl in the target age for the vaccine, a family oriented picture, an elder, or a multi-generational picture with a grandmother, mother, and daughter.

This study has several limitations. The sample was small and selected in a non-random manner. Thus, the results, including the survey data, should not be generalized to the whole Alaska Native population. Rather, the results should be interpreted as an array of possible findings that are present among some Alaska Native parents.

The findings of this study have been used to design a poster and flyer on the new vaccine oriented towards Alaska Native parents. The pictures on these materials show an Alaska Native teenage girl, her mother, and grandmother and the text stresses the safety of the vaccine and the testing that has occurred. The theme of “protection” is present in the headline that reads, “Love her, protect her....with a vaccine against cervical cancer.” This research is unique in that it was undertaken prior to widespread vaccine introduction and was used to guide educational material development. This approach should be considered for other vaccines or for other populations where vaccine introduction may be controversial or require special attention to cultural or religious sensitivities. Copies of the brochure and poster can be requested by emailing Tania Smallenberg, Immunization Nurse Specialist, ANTHC, at tsmallenberg@anmc.org.

Toffolon-Weiss M; Hagan K; Leston J; Peterson L; Provost E; Hennessy T.

OB/GYN CCC Editorial comment: How to institutionalize a ‘well adolescent’ visit that previously did not exist

Melissa Toffolon-Weiss and her colleagues offer a very helpful paradigm on how to query our patients and their families to explore possible barriers to instituting what could be a life saving vaccine intervention. Each facility should consider similar projects for HPV vaccine implementation or other health strategies.

In the meantime we all have been struggling on how to encourage our young women to actually get this vaccine, largely because there is not a common ‘well adolescent’ visit. Many of these young women get their first HPV vaccine injection at a volleyball physical or similar visit. It is an even greater struggle to make sure our adolescents get the subsequent next two injections to complete the 3 dose series.

We may not be able to lift a direct cookie cutter approach from the successful the infant oriented vaccine strategies, but we need to learn from that approach. Call back lists, tickler files, or just apply your best public health experience to whatever works.

Please let me know if you develop a particularly successful approach to start and complete the HPV vaccine series at your facility. nmurphy@scf.cc

