THE IHS PRIMARY CARE PROVIDER

A journal for health professionals working with American Indians and Alaska Natives

September 2006 **Volume 31 Number 9**

APHA Publishes New Indian Health Guide to Cultural Competency

Patricia (Pat) D. Mail, MPH, PhD, President, American Public Health Association, Tacoma, Washington

The American Public Health Association (APHA), headquartered in Washington, DC, represents the near half-million public health practitioners throughout the United States. This includes members of the public health workforce who work with American Indian and Alaska Native peoples. In affiliation with APHA is the American Indian, Alaska Native, and Native Hawaiian caucus. Members of this caucus are active in the association and mount a strong scientific program every year at the annual meetings.

This year, the APHA published an excellent volume entitled *Strategies for Cultural Competency in Indian Health Care* by Mim Dixon and Pamela E. Iron. The book contains a series of case studies of model reservation, rural, and urban American Indian and Alaska Native programs providing cultural competency training for clinical staff. The case studies illustrate how each group arrived at its own unique approach. The authors then summarize the salient commonalities across programs. In addition, the book contains a CD that highlights the programs and their spokespersons.

The authors recognize that many health professionals serving Native people have little culture-specific history or background. In order to foster more sensitive providers, model programs in Alaska, California, Michigan, Oklahoma, and Washington State have been established and are here described. The ability to understand cultural values and traditions as well as a people's history helps providers become more fully integrated into their communities. For many tribal employees, knowledge of their history is empowering and contributes to their understanding of their survival and self-worth. Key elements in cultural competency are explained.

The book is an excellent resource for those public health practitioners, Native and non-Native alike, who need to better understand cultural competency. The model programs each approached the training and institutionalization of cultural content in different ways. Included in the case studies are Inupiat people from the Arctic Slope Native Association; two California programs (a rural clinic and a state-wide smoking cessation program); an urban Indian clinic in Detroit, Michigan; the Cherokee Nation program in Tahlequah, Oklahoma; and the Puyallup Tribe of Indians in Tacoma, Washington.

In the case of the California Rural Indian Health Board, CRIHB developed cultural training for individuals manning a state-wide quit line for smoking cessation. This made helpline staff more aware of Indian styles and needs, and helped to increase the number of Indians who called in to the helpline. The statewide program was also reinforced in urban and tribal clinics by local providers.

Another collaborative program that saw tribal members working closely with community programs and statewide

In this Issue...

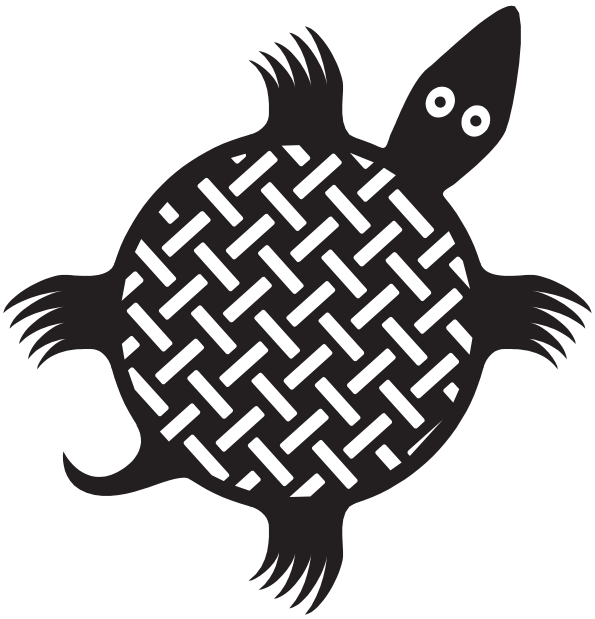
foundations was the Urban Indian Health Services Potawot Health Village, established near Arcata, California. The village consists of a series of traditional appearing houses with gardens and walking trails. The holistic approach to care includes western medicine practitioners (medicine, oral health, mental health, nutrition, etc.), traditional healers, gathering spaces for families, room for education and meetings, and restoration of native trees and plants on the 40 acre site acquired by nine tribal governments.

The Detroit, Michigan urban health center is an example of developing a culturally congenial program in donated space without great resources. The Puyallup Nation demonstrates how vision and tribal commitment can create a new facility from the ground up and involve the total staff in traditional activities and learning. Having a funded cultural coordinator as a part of the staff is critical to maintaining focus and planning events.

The authors observe that successful programs are structured around courses with an established curriculum that is required of staff and regularly scheduled. Providers are encouraged to experience tribal culture in community settings, and health care facilities should reflect local cultural environments. This might include the Cherokee nation's 40-hour course on history and culture, or the Puyallup's annual all-staff potlatch put on by the various clinic "clans." Other examples of this are provided throughout the book. Important to Native people is the integration of traditional medicine with western medicine. Potawot Village's gardens grow herbs that can be used in native treatments. Finally, training should be documented in employee evaluations. To be sustained, the programs need to be fully incorporated in the clinic's programs and schedule. A specific time needs to be dedicated to cultural competency training.

People contributing to this volume indicated that there is no single definition of cultural competency, but all agreed that the hallmarks include respect and acknowledgement of Native history and traditions. Indian humor plays a role as well, as teasing is a part of Indian culture, and you are teased if people like you. This book is an easy read and very informative, and the accompanying CD highlights key concepts.

This series of case studies is accompanied by a 30-minute CD that highlights key concepts and introduces many of the spokespeople for the model programs. The book may be obtained through the APHA website (*www.aphabookstore.org*) at $26.95 for non-members and $18.85 for members of APHA; or call 1-866-320-2742. The book is *Strategies for Cultural Competency in Indian Health Care* by Mim Dixon and Pamela E. Iron. (2006). Washington, DC: American Public Health Association. ISBN 10-0-87553-070-2.



Editor's Note: The following is a digest of the monthly Obstetrics and Gynecology Clinical Consultant's Newsletter (Volume 4, No. 8, August 2006) available on the Internet at http://www.ihs.gov/MedicalPrograms/MCH/M/OBGYN01.cfm. *We wanted to make our readers aware of this resource, and encourage those who are interested to use it on a regular basis. You may also subscribe to a listserv to receive reminders about this service. If you have any questions, please contact Dr. Neil Murphy, Chief Clinical Consultant in Obstetrics and Gynecology, at* nmurphy@scf.cc.

OB/GYN Chief Clinical Consultant's Corner Digest

Abstract of the Month
Jean Howe, Chinle
The rate of uterine rupture hasn't changed for 20 years – why have our practices changed?

The rate of symptomatic uterine rupture has been quoted at 0.5% - 1.0% for the last 20 years. The constant data have been very discordant with the changes in practice that we have seen recently, and the increased concentration/discussion regarding a increasing risk of rupture.

Luckily, several recent publications add significant information to our understanding of vaginal birth after cesarean (VBAC) and suggest that a reversal of the dramatic move away from VBAC may be in order. Nationally, the number of hospitals offering VBAC services has decreased dramatically over the past several years. Of those facilities that do offer VBAC, some allow a trial of labor for women in spontaneous labor but will not offer augmentation or induction of labor. Also, some hospitals restrict a trial of labor to women with only one prior cesarean delivery, even for those women who have had a previous vaginal birth. As IHS facilities with full scope Ob/Gyn departments have largely continued to offer VBAC services, it is encouraging to see VBAC re-evaluated from a more balanced and evidence-based perspective.

Induction of Labor

This month ACOG issued a new Committee Opinion addressing the safety of induction of labor for patients who have had a prior cesarean delivery. The abstract states, "Induction of labor in women who have had cesarean deliveries may be necessary because of fetal or maternal indications. The potentially increased risk of uterine rupture should be discussed with the patient and documented in the medical record. Selecting women most likely to give birth vaginally and avoiding the sequential use of prostaglandins and oxytocin appear to offer the lowest risks. Misoprostol should not be used in patients who have had cesarean deliveries or major uterine surgery."

This Committee Opinion offers a concise review of recent studies of VBAC and induction of labor and points out that previous studies may have overestimated the risk of uterine rupture with induction. For example, the study by Lydon-Rochelle et al was a retrospective, population-based study relying on ICD-9 codes for diagnosis of uterine rupture. Lydon-Rochelle reported the following rupture rates: 0.16% for repeat cesarean delivery, 0.52% for spontaneous labor, 0.77% for labor induced without prostaglandins, and 2.4% for labor induced with prostaglandins. The Committee Opinion notes that there was no significant difference in the rates of uterine rupture with spontaneous labor or labor induced without prostaglandins in this study.

More recent literature about induction is also presented. This includes the prospective, multi-center observational study by Landon, et al, where the outcomes experienced by 33,699 women with previous cesarean deliveries were analyzed. Chart review confirmed 124 cases of uterine rupture in the 17,898 women undergoing a trial of labor, with the following rates: 0.4% for spontaneous labor, 0.9% for augmentation of labor, and 1% for induction of labor. Additionally, this study reports a risk of rupture of 1.1% with oxytocin alone, 0.9% with mechanical dilation (+oxytocin), and 1.4% when prostaglandins and oxytocin were used in combination. The odds ratio of rupture, in comparison to the women who labored spontaneously, was 2.42 for augmentation of labor and 2.86 for induction of labor, with the highest risk associated with prostaglandins and oxytocin used in combination (O.R. 3.95). Misoprostol was one of the prostaglandins used in this study. Interestingly, there were no cases of rupture in women induced only with prostaglandins, which they suggest is due to these women going into labor "easily."

The new Committee Opinion also cites another large retrospective study (Macones) of 25,005 women conducted by medical record data abstraction at both tertiary and community hospitals. This study found an overall risk of rupture of 0.98% (0.4% in women who also had a prior vaginal delivery). The odds ratio of uterine rupture was three times higher in women who underwent induction or augmentation of labor, in comparison to those who labored spontaneously. However when specific methods were assessed in multivariate analysis, in comparison to spontaneous labor, the odds of uterine rupture was 1.61 with augmented labor, 0.85 induced without oxytocin or prostaglandin, 1.46 with oxytocin alone, 1.90 with prostaglandin alone, and 4.54 with oxytocin and prostaglandins used in combination. Only the increased odds of rupture associated with combined oxytocin and prostaglandin use was statistically significant. Misoprostol was not used in this study population.

Based on this information, the Committee Opinion concludes, "Induction of labor remains a reasonable option, but the potentially increased risk of uterine rupture associated with any induction should be discussed with the patient and documented in the medical record. Selecting women most likely to give birth vaginally and avoiding sequential use of prostaglandins and oxytocin appear to offer the lowest risks of uterine rupture. Misoprostol should not be used in patients who have had cesarean deliveries or major uterine surgery."

This committee opinion is firm in its recommendation to avoid the use of Misoprostol but supports the use of oxytocin augmentation and induction in selected patients with appropriate counseling, and does not mandate the avoidance of all prostaglandins. As the most recent (2004) ACOG Practice Bulletin on VBAC cautions against the use of any prostaglandins in women undergoing a trial of labor, widespread use of prostaglandins is not likely without further clarification from ACOG. Nonetheless, this additional information about the risks associated with augmentation and induction of labor will be helpful in counseling patients, and the data suggest that the overall increase in risk associated with augmentation and induction of labor is less than previously stated.

Two Prior Cesarean Deliveries

Two recent, large studies of VBAC also offer new data about the advisability of VBAC for woman with two prior cesarean deliveries who desire a trial of labor. ACOG addressed this situation briefly but emphatically in the 2004 Practice Bulletin. That recommendation was based primarily on a study by Caughey et al, which was a retrospective chart review of all patients undergoing a trial of labor at a single facility over a twelve year period. The 3757 women with a single prior scar experienced a rupture rate of 0.8%, while 3.7% of women with two prior scars experienced uterine rupture (5 of 134). They note that the risk of uterine rupture was nearly five times greater for women with two previous scars compared to one scar. In a multivariate regression analysis they also note that the risk of rupture with two scars was only one-fourth as great if the woman had also had a prior vaginal delivery. ACOG concluded that for women with two prior cesarean deliveries, only those with a prior vaginal delivery should be considered candidates for a trial of labor.

Macones et al have reviewed their retrospective data from both tertiary and community hospitals, which included 20,175 women with one previous cesarean delivery and 3,970 women with two previous cesarean deliveries. The rates of successful VBAC were similar (75.5% and 74.6% respectively). The risk of rupture was lower for women with one prior cesarean delivery (0.9% vs. 1.8% for the women with two prior cesarean deliveries). The history of a prior vaginal birth was associated with a lower risk of rupture (0.5% vs. 2.4% with no prior vaginal delivery history). The odds ratio of major morbidity was 2.26 for women with two prior cesarean deliveries who elected a trial of labor compared to a repeat cesarean delivery. As the absolute risk of major morbidity remains small, these investigators conclude that a VBAC attempt remains a reasonable option for women with two prior cesarean deliveries.

Landon et al have also analyzed the data from their study to address this issue. Their prospective, observational study found rates of uterine rupture of 0.7% (115 of 16,915 women with a single prior cesarean delivery) vs. 0.9% (9 of 975 women with a history of more than one prior cesarean delivery) for women undergoing a trial of labor. The VBAC success rate was 74% for those with one prior scar and 67% with two prior scars. The study also included 84 women with three prior scars and 20 women with four prior scars; these women experienced a 63% and 55% success rate respectively. The difference in the absolute rates of uterine rupture for the subset of women with multiple prior scars who had experienced a previous vaginal delivery (1%) and who had not had a previous vaginal delivery (0.85%) was not statistically significant. Prior vaginal delivery was protective in the overall analysis with an odds ratio of uterine rupture of 0.5 compared to those women who had not given birth vaginally in the past. The odds of major maternal morbidity associated with a trial of labor for women with multiple prior cesarean deliveries was 1.41.

Both studies demonstrate that the absolute risk of uterine rupture for women with a history of two prior cesarean deliveries is small. This information suggests that, with appropriate counseling and labor management, women with two prior cesarean deliveries and who are otherwise acceptable VBAC candidates may be allowed to proceed with a trial of labor. An absolute requirement for a prior vaginal delivery is not supported by these findings, although prior vaginal delivery is an additional predictor for success.

Resources for VBAC

All Navajo Area facilities with full-scope Ob/Gyn services continue to offer VBAC, as do a number of other IHS sites. For more information about strategies to optimize safety for women undergoing a trial of labor, the work of the Northern New England Perinatal Quality Improvement Network remains an excellent reference. NNEPQIN has put forth guidelines for risk stratification and resource development on their website. These guidelines classify as low risk women with one prior uterine scar presenting with spontaneous labor and without FHR abnormalities. Medium risk women are those undergoing induction or augmentation, with two or more previous scars, or with a <18 month inter-delivery interval. High risk women are defined as those with repetitive non-reassuring FHR abnormalities, bleeding suggestive of abruption, or two hours without cervical change in active labor despite adequate contractions. They then describe appropriate resources needed to manage each risk group. The NNEPQIN site also has model consent forms and patient information, as well as suggestions about conducting drills. Dr. Lauria, one of the leaders of the ACOG-award winning NNEPQIN VBAC project, will be returning to speak at the triennial IHS Ob/Gyn meeting in Albuquerque in August 2007.

OB/GYN CCC Editorial comment:

The VBAC pendulum is beginning to swing back toward a more reasonable approach. Clearly the national benchmark recommendations that women with two previous cesarean deliveries and no vaginal delivery should have a repeat cesarean delivery should be reexamined in light of this new information. Likewise, cervical ripening and induction of labor with oxytocin and foley bulbs can be considered, as the data suggest that the overall increase in risk associated with augmentation and induction of labor is less than previously stated.

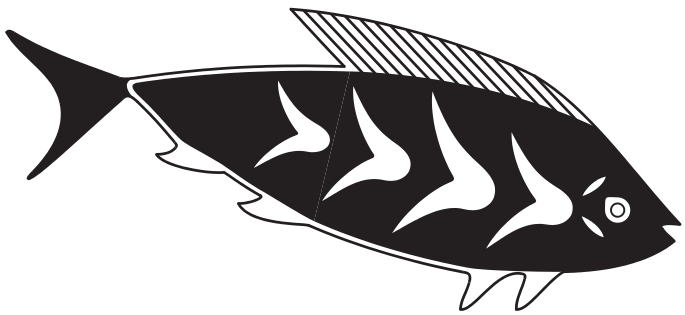
In addition, as we counsel our patients, we should not just speak in terms of odds ratios or relative risks, but in terms of attributable risk or marginal risks, above the baseline risk. For instance, the network data in the Landon study demonstrated that the rate of hypoxic ischemic encephalopathy was actually quite small, at approximately 1/2,000 trials of labor.

I encourage you to take advantage of a unique opportunity available to staff who provide care for Indian women and children. One of the foremost experts on this issue and how to implement reality based obstetric drills, Dr. Lauria, will be one of the keynote speakers at the next National Women's Health and MCH Meeting August 15 - 17, 2007. There will also be presentations on successful implementation of emergency obstetric drills from the staff of Phoenix Indian Medical Center.

References: see the online version of the Ob/Gyn CCCC newsletter.

From Your Colleagues: Carolyn Aoyama, HQE
New women's health workgroup forming: looking for interested volunteers

I want people for whom women's health is their true calling – people who are passionate about some part of women's health care – to join me in forming an IHS workgroup on women's health. There are people out there who are local experts on mobilizing women to come in for their Pap smears or their mammograms. There are others who care about access to high quality behavioral health services for women. Maternal/child health advocates who are especially interested in the "M" in MCH would be invaluable. How about chronic disease, or other health issues?



I am interested in forming a women's health workgroup with people who would be willing to serve in an advisory capacity to me. I value the advice of IHS staff who are passionately interested in expanding services that will improve access, quality, and health outcomes of AI/AN women. One of the first things I want to work on is an IHS women's health strategic plan. Please e-mail me at *carolyn.aoyama@ihs.gov* if you would be interested in serving in this advisory capacity.

Hot Topics: Obstetrics
Update your standing post partum discharge orders: Tdap in pregnancy/postpartum

ACIP just came out with new provisional recommendations for pregnant women. The ACIP recommends that Tdap be given routinely in the postpartum period before discharge if two or more years have elapsed since the last Td. The reason for these recommendation is that mothers are the source of 32% of pertussis that occurs in infants.

Other recommendations:

- Tdap be given to health care workers if it's been two or more years since last Td.
- Tdap be given to adolescents up to 18 if it's been five or more years since last Td.
- Tdap be given to other adults <65 it's been ten years since last Td.

OB/GYN CCC Editorial comment

At some point soon, it would be worthwhile considering updating your standing orders for Tdap before postpartum discharge. The new provisional recommendations for pregnant women and the recommendations for Tdap in adults will become official when published in CDC's Morbidity and Mortality Weekly Report (MMWR).

Gynecology
ACOG releases HPV vaccine recommendations for ob-gyns

The ACOG has released clinical recommendations for females ages 9 to 26 for the human papillomavirus (HPV) vaccine in advance of their publication in the September 2006 issue of Obstetrics & Gynecology. A new committee opinion offers general information about the vaccine and addresses proper administration, precautions, and contraindications. "The approval of this vaccine represents a significant development in women's health and the fight against cancer. Obstetrician-gynecologists should be proactive in educating our patients about the vaccine so that as many women as possible are able to take advantage of this medical milestone," said ACOG President Douglas W. Laube, MD, MEd. "We must be prepared both to administer the vaccine and to answer patient and parent questions that will arise," Dr. Laube added. "Ob-gyns will play a critical role in the vaccine's widespread use in girls and women and we should discuss vaccination with our patients. Additionally, ob-gyns should stress the importance of continued cervical cytology screening regardless of vaccination status," Dr. Laube added.

Despite the protection the vaccine offers, ACOG emphasizes that the recommendations for cervical cytology screening remain unchanged. Pap screening should begin within three years of sexual intercourse (or by age 21) and then annually until age 30. After age 30, most women can continue annual testing or can choose to be tested every two to three years after three consecutive negative Pap tests. While the vaccine protects against HPV types 6, 11, 16, and 18, there are additional HPV strains that can cause cervical cancer. Pap testing can detect abnormal cervical cells caused by other HPV strains not covered by the vaccine.

The HPV vaccine is most effective when administered to girls and women before the onset of sexual activity. While the US Food and Drug Administration has approved the vaccine for girls and women ages 9 to 26, the federal Advisory Committee on Immunization Practices recommends that girls routinely receive the vaccine between the ages of 11 and 12. Although most ob-gyns are not likely to see many girls in this age group, ACOG recommends that teens first visit an ob-gyn between the ages of 13 and 15. This initial reproductive health visit is an ideal time to discuss the benefits of the vaccine and to offer it to teens.

Vaccination is also recommended for women up to age 26, regardless of sexual activity. Ob-gyns are encouraged to talk about the vaccine any time they see a patient within the target population and offer it to those who have not yet received it. However, women who are already sexually active should be counseled that the vaccine may be less effective if there has been prior HPV exposure.

Women who previously have had abnormal cervical cytology, genital warts, or precancerous lesions can be vaccinated. Those with suppressed immune systems also can be vaccinated, although the protection may be less than that of patients with normal immune function. The HPV vaccine is not a treatment for current HPV infection or genital warts. Patients undergoing treatment for HPV-related symptoms (cervical cytology abnormalities, genital warts) should continue with their prescribed medication and therapy.

While the vaccine has not been shown to have a harmful effect on pregnancy, it is not recommended that pregnant women be vaccinated. If a woman discovers she is pregnant during the vaccine schedule, she should delay finishing the series until after she gives birth. Women who are breastfeeding can receive the vaccine.

The recently approved vaccine shows great promise for controlling the spread of the main types of HPV that cause cervical cancer and genital warts. Given in a series of three shots over six months, the vaccine protects against four strains of HPV responsible for 70% of cervical cancers and 90% of genital warts cases. With widespread use, HPV vaccination has the potential to lower the occurrence of cervical cancer in future generations. Worldwide, cervical cancer is the second leading cause of cancer death in women with nearly half a million new cases and 275,000 deaths annually. An increase in routine Pap testing has led to a decrease in new cases and death (9,710 and 3,700 respectively) from cervical cancer in the US, but there is still a significant population of women who are not regularly screened.

OB/GYN CCC editorial comment

Will widespread human papillomavims prophylactic vaccination change sexual practices of adolescent and young adult women in America? Two human papillomavims (HPV) vaccines have been shown to be nearly 100% effective in preventing type-specific persistent HPV infections and associated type-specific high-grade cervical intraepithelial neoplasia (CIN). Recently, it has been hypothesized that the administration of this vaccine to young girls in the United States might increase sexual promiscuity among adolescent women and/or young adults. Thus, it has been suggested that focused vaccine strategies either based on the risk of CIN or gender might be more rational or cost-effective. However, such strategies are unlikely to completely eradicate the burden of this disease and decrease the cost of cervical cancer screening.

The same misguided rationale was used during implementation of the hepatitis B vaccine. The suggestion that widespread vaccination will alter sexual practices is refuted and the rationale for the vaccination of all girls and boys is outlined in a commentary by Monk and Wiley, as follows: “Seat belts do not cause reckless driving, tetanus shots do not cause children to seek out rusty nails, and hepatitis B vaccination has not altered sexual practices or increased injection-drug abuse in any population. Preventive measures do not always lead to high-risk behavior. It is naive to think that abstinence and monogamy will eradicate the morbidity and mortality of cervical cancer as suggested by some conservative organizations. Society needs to emphasize the benefits of HPV vaccination and find ways to increase its adoption and not create ill-founded barriers. Support and approval of HPV vaccination is not synonymous with support and approval of promiscuity, rather a cry to rally together to eradicate cervical cancer worldwide.”

References: see the online version of the Ob/Gyn CCCC newsletter.

Child Health

Emergency Contraception: A Primer for Pediatric Providers

Emergency contraception (EC) is a contraceptive method used safely and successfully by women for more than 30 years to prevent pregnancy. Nurses at all levels are often the first point of contact for a woman who is requesting EC; thus it is particularly important for them to stay abreast of both the facts regarding the use of this product and the current political controversies. It is particularly important for nurse practitioners (NPs) working in primary care with adolescents to remain cognizant of the significant barriers that remain for many women of all ages trying to access this important contraceptive tool.

Clements AL, Daley AM. Emergency contraception: a primer for pediatric providers. *PediatrNurs.* 2006 Mar-Apr;32(2): 147-53.

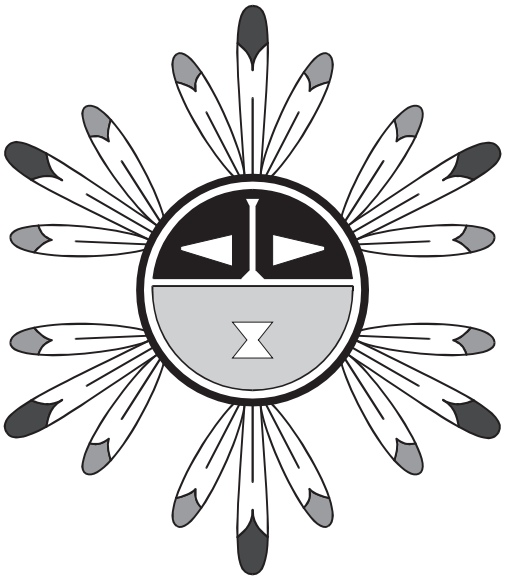
Chronic Disease and Illness
Antidepressant discontinuation syndrome

Antidepressant discontinuation syndrome occurs in approximately 20 percent of patients after abrupt discontinuation of an antidepressant medication that was taken for at least six weeks. Typical symptoms of antidepressant discontinuation syndrome include flu-like symptoms, insomnia, nausea, imbalance, sensory disturbances, and hyperarousal. These symptoms usually are mild, last one to two weeks, and are rapidly extinguished with reinstitution of antidepressant medication. The syndrome is more likely with a longer duration of treatment and a shorter half-life of the treatment drug. A high index of suspicion should be maintained for the emergence of discontinuation symptoms, which should prompt close questioning regarding accidental or purposeful self-discontinuation of medication. Before antidepressants are prescribed, patient education should include warnings about the potential problems associated with abrupt discontinuation. Education about this common and likely underrecognized clinical phenomenon will help prevent future episodes and minimize the risk of misdiagnosis.

Am Fam Physician. 2006;74:449-56, 457.

Features:
American Family Physician: Patient-Oriented Evidence that Matters (POEMS)
Norethindrone more effective for menses suppression

Do oral contraceptives containing norethindrone acetate or levonorgestrel differ in their effect on suppression of menses with continuous use?



Synopsis: There were 139 women enrolled in this double-blind, four-arm trial of oral contraceptives used continuously for 180 days for the purpose of suppressing menstrual periods. The estrogen used in all study arms was ethinyl estradiol (E2), which could be at a dose of 20 mcg or 30 mcg. The progestin was 1 mg norethindrone acetate (Loestrin) or 100 mcg levonorgestrel (Seasonale). The four study arms included: 1) norethindrone acetate plus 20 mcg ethinyl E2; 2) norethindrone acetate plus 30 mcg ethinyl E2; 3) levonorgestrel plus 20 mcg ethinyl E2; and 4) levonorgestrel plus 30 mcg ethinyl E2. All study participants had used cyclic oral contraceptives for at least three months before randomization. This study had an overall drop-out rate of 45 percent. More days of amenorrhea were recorded in the norethindrone acetate groups, with no difference between the lower versus higher estrogen dosing (mean days of amenorrhea during 180 days' use: norethindrone acetate plus 20 mcg ethinyl E2 = 164, levonorgestrel plus 20 mcg ethinyl E2 = 151; P = .02).

Bottom Line: In continuous dosing regimens, more days of amenorrhea can be achieved with oral contraceptives containing 1 mg norethindrone acetate than with oral contraceptives containing 100 mcg levonorgestrel. (Level of Evidence: 2b)

ACOG
Induction of labor for vaginal birth after cesarean delivery

Abstract: Induction of labor in women who have had cesarean deliveries may be necessary because of fetal or maternal indications. The potentially increased risk of uterine rupture should be discussed with the patient and documented in the medical record. Selecting women most likely to give birth vaginally and avoiding the sequential use of prostaglandins and oxytocin appear to offer the lowest risks. Misoprostol should not be used in patients who have had cesarean deliveries or major uterine surgery.

Induction of labor for vaginal birth after cesarean delivery. ACOG Committee Opinion No. 342. American College of Obstetricians and Gynecologists. *Obstet Gynecol.* 2006;108:465-67.

Breastfeeding
Suzan Murphy, PIMC
Early milk supply issues

Providers who work with new families usually hear lots of versions about "not enough milk" concerns. Phrases like:

- I don't think that I have enough milk
- I don't think I have any milk because I didn't leak while I was pregnant
- My breasts are flat
- There is nothing coming out
- The baby is hungry all the time

usually mean that the mom/family is worried, scared, and unaware of how to know if their baby is getting enough to eat. The following are ways to assess adequate intake and help guide families in the first weeks.

Reasonable expectations for intake and feeding behavior in a normal, healthy baby are as follows:

- Birth - 24 hours
  - Effective latch at birth, lots of sleep, and sleepy feeds; 2-3 feedings (including latch at birth) in the first 24 hours is success.
- 24 hours and until the white ("mature") milk comes in
  - The first milk, colostrum is thick (like honey), hard to suck out, and harder to see. The average amount consumed at each feeding is 5 cc (1 tsp). The baby's stomach size is 5 - l0cc at birth, expanding to about 60 cc (2 oz) at 1 week. The mother's colostrum and white milk production increases as the baby's stomach expands.
  - Feedings averaging every 2-3 hours – 8 - 12 times in 24 hours are important; they help insure adequate intake and stimulate the mom's milk supply. Wake the baby as needed.
  - Frequent feedings are normal. Babies often get fussy at feedings, perhaps because their mouths are tired from learning how to suck. They get stronger quickly. It will be easier once the white milk comes in.
  - Expect one diaper change for every day of life. For example if the baby is three days old, three diaper changes tells the mom that the baby is getting enough.
- By 2 - 5 days, the white milk is in.
  - Encourage the mom to feed every 2-3 hours to help prevent engorgement and insure adequate intake for the baby.
  - Watch for one diaper change for every day of life – up to six or more in 24 hours – this tells that mom that the baby is getting enough.
  - Once the baby is waking to eat, and diaper changes are six or more in 24 hours, the mom can relax a little and feed the baby on demand.
- Watch for:
  - < 7% weight loss in the first several days.
  - Birth weight re-gained by two weeks.
  - Weight gain of 1/2 oz to 1 oz per day in the first 3-6 months to double birth weight at 4 - 6 months and triple by one year.
- Growth spurts happen every couple weeks. The baby will suddenly want to eat more, all the time. The feeding frenzy will last 1-2 days, the mom's milk supply will increase to meet the need, and things will be fine.
- If the family wants to supplement, encourage them to use caution. Supplementing in the first weeks can undermine the mom's body's ability to maintain her supply.
- By 6 - 8 weeks, the baby' stomach is bigger, and the suck is much more efficient. Also the mom's body has become accustomed to the milk being there. The feedings are much shorter and less frequent, the mom's breasts are softer, and the leaking is almost gone. Breastfeeding is much easier.

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

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

Elder Care News

Is 75 years an appropriate upper age limit for mammography? A major finding of this study is that the screening participation among elderly women is high. The outcomes of our study suggest a steadily increasing sojourn time of breast tumours beyond the age of 69, leading to a strong increase in detection of cancers, and therefore, disfavouring the balance with the benefits of screening. At present, 75 years of age can be regarded as an appropriate upper age limit for the Dutch programme.

Fracheboud J, et al. Seventy-five years is an appropriate upper age limit for population-based mammography screening. *Int J Cancer.* 2006 Apr 15;118(8):2020-5.

Elder Care Initiative editorial comment Bruce Finke, MD, Nashville

Fracheboud et al set out to better understand the risk/benefit ratio of screening mammography in women age 70-75 when the Dutch breast cancer screening program raised its upper age limit from 69 to 75 based on models suggesting benefit to these older women. It is well known that breast cancer incidence increases with increasing age, but that cancers in older women tend to progress more slowly and that death from other causes also increases with age.

While a screening program is more likely to detect cancer in these older women than in women younger than 69, the cancers detected are less likely, without early detection, to cause death. This study (by the authors' own admission) adds little to the existing understanding, but it certainly provides no evidence to argue against screening in these older women and does point out that screening was well accepted (65.6% of women aged 70 - 75 accepted appointments for screening mailed to them).

An upper limit of mammography screening is supportable on a population basis but much less so when faced with the particulars of an individual patient. Walter and Covinsky provide an approach that mimics (in a more formal way) the thought processes of many clinicians. They calculate the number needed to screen for women in the highest, middle, and lowest quartiles of life expectancy for selected age groups. The results can be quite striking: the number needed to screen to prevent one cancer death in an 80 year old in the highest quartile of life expectancy is quite close to that for a 50 year old woman in the lowest quartile (240 and 226 respectively). Women unlikely to benefit from mammography should not be subjected to the test or the inevitable cascade of medical events that follow, but age is not, by itself, a satisfactory indicator of likelihood of benefit. Walter and Covinsky provide an evidence-based approach for better advising our older patients.

Walter LC, Covinsky KE. Cancer screening in elderly patients: a framework for individualized decision making. *JAMA*. 2001 Jun 6;285(21):2750-6.

International Health Update: Claire Wendland, Madison, WI
HIV/AIDS in Latin America and the Caribbean

This month the sixteenth international AIDS conference will be held in Toronto. In a fascinating series of articles, science reporter Jon Cohen documents the state of the epidemic in Latin America and the Caribbean, where typical modes of transmission, economic and social conditions, and government response vary dramatically from country to country. In Puerto Rico, for instance, injection drug use is a major vector of HIV transmission; in the Caribbean sex tourism is a significant part of the problem. In Argentina, it's a primarily heterosexual epidemic, while in Mexico and much of the rest of Central America, men who have sex with men are the major group at risk.

Cohen's look at Brazil is particularly interesting. When expensive multi-drug regimens first proved effective at controlling HIV in 1996, Brazil's government inspired activists and troubled corporate leaders around the world by not only mounting a strong prevention campaign, but by promising free antiretrovirals to any citizen who needed them – in part by negotiating aggressively with BigPharma, in part by manufacturing cheap knockoffs of drugs domestically. At the time, Brazil had the worst epidemic in the region. Ten years later, HIV prevalence rates are less than half of what had been predicted, and the Ministry of Health says 90,000 deaths have been averted. But increasing drug resistance among patients on long-term antiretroviral treatment means the country is spending more and more on second-line patented medications. Many critics, both on the left and the right, believe Brazil's universal access program will not be sustainable for much longer. Will the country be the first to break patent restrictions under the so-called "compulsory licensing" clause of the World Trade Organization's intellectual property rights act? Although this clause was meant to ensure that countries could manufacture affordable medications in a public health emergency, no government has yet invoked it for fear of the trade sanctions that would likely follow. HIV-infected Brazilians, and health workers in poor and middle-income countries around the world, watched the Brazilian government take the lead on universal access ten years ago; they – and we – are now waiting to see what the next move will be.

Cohen J. Brazil: ten years after. *Science.* 313:484-7, 28 July 2006.

Medical Mystery Tour
First trimester screening: How would you counsel this patient?

Ms. L. is a 40 y/o G1P0 at 9 weeks gestation (by a 6 week ultrasound) and is aware of her age-related risks for fetal aneuploidy. She inquires about the possibility of early

screening. Which one of the statements below is the most accurate way to counsel her:

1. Ultrasonic measurement of fetal nuchal translucency combined with biochemical tests between 11 and 13 weeks may detect close to 90% of chromosomally abnormal fetuses
2. Early trimester screening has a better detection rate, but a higher false positive rate, than midtrimester screening
3. Women who have first trimester screening that is negative will not need further testing

Stay tuned till next month to find out more (or see comment below).

OB/GYN CCC editorial comment

For more background on this and other prenatal genetic screening questions, please go to the free CME module, which is also just a great resource: Prenatal genetic screening: serum and ultrasound, at *http://www. ihs.gov/MedicalPrograms/MCH /M/TMO1.cfm.*

Midwives Corner, Lisa Allee, CNM, Chinle
VBAC: pendulums and ecstasy

The first article I'll review is yet another nudge for the pendulum to swing back to sanity for VBACs in this country, and the second article has some thought-provoking information on ways to enhance the natural birth process, VBAC or not, but certainly incredibly relevant to supporting women in achieving successful VBACs.

Landon, et al, in a large multi-center prospective observational study found that women with histories of multiple cesarean deliveries are not at higher risk for uterine rupture than women with single prior cesarean deliveries, 0.9% and 0.7% respectively. Notice how low these rates are – less than 1%. They also found that while having had a prior vaginal delivery was protective for uterine rupture, it was not significant enough to warrant requiring this in order to be a VBAC candidate.

They did find that "the risk of other adverse maternal events (hysterectomy and transfusion) is increased in women with multiple prior cesarean deliveries, but the absolute level of

these risks is small" (3.2% and 0.6% respectively). Another finding was that pitocin induction or augmentation, epidural, and less than two years since the cesarean delivery were associated with higher rates of uterine rupture. Perinatal outcomes of term infants were no different in women with one or multiple prior cesarean deliveries and in women with trials of labor or elective repeat cesarean.

Ecstatic Birth

In the second article, Sarah Buckley, MD writes eloquently and informatively about the hormonal aspects of labor, birth, postpartum, and breastfeeding. She covers oxytocin, the love hormone and mediator of all the ejection reflexes – sperm, baby, placenta, and milk; beta-endorphins, our naturally occurring analgesics, levels of which rise during labor; catecholamines that inhibit oxytocin and blood flow to the uterus when stimulated by fear and anxiety; and prolactin, the milk and protection hormone. She discusses the ways in which this hormonal mix is essential to the normal processes of giving birth, breastfeeding, and bonding, and ways that it can be supported and enhanced. She draws the parallel of the hormones of birthing a baby being the ones involved in making the baby and, thus, the possibility of ecstatic birth. She also reviews the ways in which interventions such as induction or augmentation of labor, analgesia or anesthesia, cesarean delivery, and early separation can wreak havoc on this beautifully crafted hormonal milieu.

She closes the article with a beautiful quote from Dutch professor of obstetrics, G. Kloosterman, who says, "Spontaneous labour in a normal woman is an event marked by a number of processes so complicated and so perfectly attuned to each other that any interference will only detract from the optimal character. The only thing required from the bystanders is that they show respect for this awe-inspiring process by complying with the first rule of medicine – nil nocere (do no harm)".

Buckley, S. Ecstatic birth: The hormonal blueprint of labor. *Mothering.* 2002 March-April; 111: 51-61.

Editorial Comment, Lisa Allee, CNM

Landon's article is yet more evidence that VBAC should be available and encouraged for most women with a prior cesarean delivery, or deliveries. This research was reported in USA Today, and in the article the chairman of the ACOG practice committee was quoted as saying that he expects his group to revise their VBAC recommendations. Let's hope they even change that fateful wording "immediately available" back to the much more helpful "readily available" so even women in rural and small towns and cities can have VBACs again.

The second article is not from a peer reviewed journal, but check out the references and see that many of these are. This article gives scientific backing to the ancient art of midwifery – supporting women in their natural processes of giving birth. I included it here because while all women deserve us knowing and thinking about ways we can support, enhance, and, hopefully, not trample on their hormonal cascade for birth, women having a VBAC need us to do so even more. I fully admit that creating truly undisturbed births in most of our practice settings is difficult, if not impossible, but there are many, many things that we can do to move closer to that goal: speak softly and gently; make the surroundings comforting and soothing to all the senses; use words that induce calm and confidence, not fear and doubt; keep the sounds of other women giving birth to a minimum (close the door); turn down the lights; turn down the monitor; use touch and voice for relaxation; use relaxation, movement, water, massage, heat/cold, etc. for helping with pain instead of medications; welcome the people the woman loves; keep mothers and babies together....

These oxytocin-friendly procedures can help women undergo VBAC successfully and decrease (dare I say prevent?) the need for the interventions Landon and others have found to increase the risk of uterine rupture, namely pitocin and epidurals. Our own hormones rock, let them flow!

Landon, M, et al. Risk of uterine rupture with a trial of labor in women with multiple and single prior cesarean delivery. *Obstetrics & Gynecology.2006* Jul;108(l):12-20.
Buckley, S. Ecstatic Birth: The hormonal blueprint of labor. *Mothering.* 2002 March-April; 111:51-61.

Nurses Corner

Native Alaskan and American Indian nurses scholarship opportunity

I am writing to you about a scholarship opportunity for American Indian and Native Alaskan (AI/NA) Commission Corps officers through the Native Nurses Career Opportunity Program. We are a small grant-based scholarship program funded by IHS at the University of Minnesota - School of Nursing. We award scholarships to AI/NA registered nurses pursuing their master's degree at the University of Minnesota School of Nursing. It is our goal to increase the number of master's prepared AI/NA nurses. We have several scholarship recipients who are currently Commission Corps officers and would like to get the word out to other officers who might also benefit from our program.

The U of MN offers courses online and we encourage our students to stay and serve in their current communities. We also understand the nature of being a Commission Corps officer and understand that our students need to respond when called to duty. Please share this information with any American Indian and Native Alaskan officers looking to further their education. Contact *NativeRN@umn.edu* or *www.nursing.umn.edu/NNCOP.*

Oklahoma Perspective, Greggory Woitte, Hastings Indian Medical Center

The indications for IUD use have vastly expanded

Intrauterine devices are the most common reversible method of contraception worldwide. However, here in the US, less than 1% of contraceptive users use an IUD. Due to the Dalkon Shield controversy, many different forms of IUDs were

removed from the market. Today, there are only two IUDs on the market here in the US, the copper T380A (Paraguard) and the Levonorgesterel intrauterine system (Mirena). Today's IUDs have corrected a design flaw that was unique to the Dalkon Shield, and recent research has shown that they are safe and very effective, with pregnancy rates approaching that of tubal sterilization. The Levonorgesterel intrauterine system offers the non-contraceptive benefit of reducing menstrual flow and can be used for idiopathic menorrhagia. Recent evidence suggests that IUDs can be used in the Adolescent population and that 75% of adolescents that had IUDs placed were very happy with their contraceptive choice at one year. IUD use in the properly selected adolescent could be a useful weapon in the prevention of teenage pregnancy. One of the largest concerns with IUD use is the increased risk of pelvic infections, which appears to be greatest at the time of insertion but returns to the background rate one month after insertion. Candidates for IUDs include:

- Multiparous and nulliparous women at low risk for STDs
- Women who desire long-term, reversible contraception
- Women with the following medical conditions: diabetes, thromboembolism, menorrhagia/dysmenorrhea, breastfeeding, breast cancer, and liver disease

When your next patient is searching for a contraceptive option, and isn't absolutely certain she does not want to have more children, an IUD is an excellent option.

References: see the online version of the Ob/Gyn CCCC newsletter.

Perinatology Picks, George Gilson, MFM, ANMC
Glyburide flows from fetus to mother by placental transport system

Results: There was highly significant transfer of glyburide against concentration gradient from the fetal to the maternal circulation. Fetal-to-maternal concentration ratio was 0.92 +/- 0.23 at the start of the experimental period and 0.31 +/- 0.47 3 hours later (P = .01) (n = 5). Verapamil did not modify glyburide transport.

Conclusion: This is the first direct evidence of active glyburide transport from the fetus to the mother and, in general, of any medicinal drug used during pregnancy. These experiments suggest that glyburide is actively effluxed by a transporter other than P-glycoprotein. Alternatively, it is possible that a minority of glyburide is carried by P-glycoprotein, but most of the fetal load is pumped to the mother by a yet-unidentified placental transport system.

Kraemer J et al. Perfusion studies of glyburide transfer across the human placenta: implications for fetal safety. *AmJObstet Gynecol.* 2006 Jul;195(l):270-4.

STD Corner, Lori de Ravello, National IHS STD Program
Condom use and the risk of genital human papillomavirus infection in young women

Results: The incidence of genital HPV infection was 37.8 per 100 patient-years at risk among women whose partners used condoms for all instances of intercourse during the eight months before testing, as compared with 89.3 per 100 patient-years at risk in women whose partners used condoms less than 5 percent of the time (adjusted hazard ratio, 0.3; 95 percent confidence interval, 0.1 to 0.6, adjusted for the number of new partners and the number of previous partners of the male partner). Similar associations were observed when the analysis was restricted to high-risk and low-risk types of HPV and HPV types 6, 11, 16, and 18. In women reporting 100 percent condom use by their partners, no cervical squamous intraepithelial lesions were detected in 32 patient-years at risk, whereas 14 incident lesions were detected during 97 patient-years at risk among women whose partners did not use condoms or used them less consistently.

Conclusions: Among newly sexually active women, consistent condom use by their partners appears to reduce the risk of cervical and vulvovaginal HPV infection.

Winer RL et al. Condom use and the risk of genital human papillomavirus infection in young women. *New England Journal of Medicine.* June 22, 2006;354:2645-2654.

Steiner MJ et al. Commentary: condoms and sexually-transmitted infections. *New England Journal of Medicine.* June 22, 2006;354:2642-2643.

Latest 2006 STD treatment guidelines just released by CDC

These guidelines for the treatment of persons who have sexually transmitted diseases (STDs) were developed by CDC after consultation with a group of professionals knowledgeable in the field of STDs who met in Atlanta, Georgia, during April 19 - 21, 2005. The information in this report updates the Sexually Transmitted Diseases Treatment Guidelines, 2002 (MMWR 2002;51[No. RR-6]).

Included in these updated guidelines are an expanded diagnostic evaluation for cervicitis and trichomoniasis; new antimicrobial recommendations for trichomoniasis; additional data on the clinical efficacy of azithromycin for chlamydial infections in pregnancy; discussion of the role of *Mycoplasma genitalium* and trichomoniasis in urethritis/cervicitis and treatment-related implications; emergence of *Lymphogranuloma venereum* protocolitis among men who have sex with men (MSM); expanded discussion of the criteria for spinal fluid examination to evaluate for neurosyphilis; the emergence of azithromycin resistant *Treponema pallidum;* increasing prevalence of quinolone-resistant *Neisseria gonorrhoeae* in MSM; revised discussion concerning the sexual transmission of hepatitis C; postexposure prophylaxis after sexual assault; and an expanded discussion of STD prevention approaches.

Barbara Stillwater, Alaska State Diabetes Program
Obese girls: threefold risk for early death than slim counterparts

Among more than 100,000 women in the Nurses' Health Study II, those with a body mass index (BMI) greater than 30 kg/m^2 when age 18 had a nearly threefold risk for premature death compared with women with BMIs below 18.5 kg/m^2 at age 18. Effects of childhood overweight on quality of life at younger ages may be substantial, and higher mortality rates in middle age may represent "the tip of the iceberg" of detrimental health consequences. Our findings support preventive action in children aimed at reducing their risk for becoming overweight.

Women with higher BMIs in their late teens were at greater risk of premature death. Compared with women who had a BMI between 18.5 and 21.9 kg/m^2 at age 18, the hazard ratio for premature death for women between the ages of 22 and 44 at baseline was 0.98, for those with a BMI less than 18.5 kg/m^2, 1.18 for a BMI of 22.0 to 24.9 kg/m^2, 1.66 for a BMI of 25.0 to 29.9 kg/m^2 , and 2.0 for a BMI of 30 kg/m^2 or greater. During adolescence, women with a higher BMI at age 18 years had higher levels of alcohol consumption, were more likely to smoke cigarettes, and were less likely to engage in physical activity or use oral contraceptives.

This paper underscores the importance of efforts to prevent excessive weight gain in children, not only to prevent obesity but also to prevent moderate overweight. Given the prevalence of overweight, large-scale preventive strategies aimed at increasing physical activity and stimulating healthy eating habits in US children and adolescents are warranted.

Practice Pearl: Explain to interested patients that this study adds to the substantial body of evidence indicating that excessive weight in childhood is associated with significant negative health consequences later in life, including increased risk for premature death.

van Dam RN et al. The relationship between overweight in adolescence and premature death in women. *Ann Intern Med.* 2006 Jul 18;145(2):91-7.

Call For Abstracts: Journal Of Aboriginal Health

This is a call for abstracts of papers for emerging knowledge in the area of First Nations, Inuit, and/or Métis women's health to be submitted for consideration for publication in the fourth issue of the Journal of Aboriginal Health, published by the National Aboriginal Health Organization. Some general Aboriginal health research abstracts will be accepted to complement the theme, as these abstracts may also fit into future issues of the Journal. The Journal of Aboriginal Health is seeking abstracts of papers that enhance our understanding of Aboriginal women's health issues from a variety of writers including academics and scholars, students, community health professionals, traditional healers, and community members. Contributions are encouraged from Aboriginal community-based practitioners and/or researchers whose work may involve innovative, preventative or traditional approaches to Aboriginal women's health.

The Journal of Aboriginal Health strives to provide Aboriginal health research excellence with community relevance, and follows a double-blind peer review process by both academic and community scholars. To that end, the Journal shares success stories in Aboriginal health, discusses issues and opportunities, and provides the latest information and research of interest to First Nations, Inuit, and Métis Peoples. Abstracts are welcome in either official language; however articles will only be published in the language of submission.

Submit original, unpublished abstracts of 250 words, of papers approximately 20 pages or 5,000 words, suitable for peer review, by October 15, 2006 to:

Journal of Aboriginal Health
National Aboriginal Health Organization
220 Laurier Ave. W., Suite 1200, Ottawa, ON K1P 5Z9
Telephone 1-877-602-4445/Fax (613) 233-1810/E-mail *dsoucy@naho.ca*

Electronic submissions are preferred. Be sure to consult the Journal of Aboriginal Health style guidelines at *www.naho.ca/english/communications_journal.php*. View the full call for abstracts at *www.naho.ca*.

Electronic Subscription Available

You can subscribe to *The Provider* electronically. Any reader can now request that he or she be notified by e-mail when the latest issue of *The Provider* is available at the Clinical Support Center website (*http://www.ihs.gov/MedicalPrograms/ClinicalSupportCenter/*). To start your electronic subscription, simply go to *The Provider* website (*http://www.ihs.gov/publicinfo/publications/healthprovider/provider.asp*) and complete the subscription form. This address can easily be reached from the Clinical Support Center website by clicking the "Publications" link and then clicking the "How To Subscribe" link. You are encouraged to try downloading the current issue to see how well this works at your site.

If you also want to discontinue your hard copy subscription of the newsletter, please contact us by e-mail at *the.provider@phx.ihs.gov*. Your name will be flagged telling us not to send a hard copy to you. Since the same list is often used to send other vital information to you, you will not be dropped from our mailing list. You may reactivate your hard copy subscription at any time.

This is a page for sharing "what works" as seen in the published literature, as well as what is being done at sites that care for American Indian/Alaskan Native children. If you have any suggestions, comments, or questions, please contact Steve Holve, MD, Chief Clinical Consultant in Pediatrics at sholve@tcimc.ihs.gov.

IHS Child Health Notes

Quote of the month

"Never eat more than you can lift"

Miss Piggy

Articles of Interest

Intake of sugar-sweetened beverages and weight gain: a systematic review. Am J Clin Nutr. 2006 Aug;84(2):274-88. *http://www.ajcn.org/cgi/content/full/84/2/274*.

The authors reviewed English language articles from 1966 - 2005 on the relationship of consumption of sugar sweetened beverages and the risk of weight gain. Findings from large cross-sectional studies with long periods of follow-up show a positive association with greater intake of sugar sweetened beverages and weight gain in both children and adults. Short-term feeding trials in adults also support an induction of positive energy balance and weight gain with sugar sweetened sodas. The authors believe the weight of epidemiological and experimental evidence supports the need for public health strategies to discourage consumption of sugary drinks.

Obesity — the new frontier of public health law. *N Engl J Med*. 2006 Jun 5;354(24):2601-10. *http://content.nejm.org/cgi/content/extract/354/24/2601*.

The law can be a powerful instrument of public health. The authors mention decreased lead exposure, improved workplace safety, the mandate of seatbelts and airbags, and even increased immunization rates as the result of legislation and litigation. One of the newest targets of public health law is obesity.

Increased regulation or taxing of food raises issues about the appropriate balance between personal freedoms and the potential public health benefits. The authors do an excellent job of pointing out that such regulations were rejected in the past. They go on to show that restrictions on food advertising now are far more likely to be accepted given the documented increase in obesity. Various pending legislation and litigation around food advertising, distribution, and taxation are discussed.

Editorial Comment

These two articles complement one another: identification of a problem and a set of possible solutions. Beyond one-on-one counseling of patients (which appears to be fairly ineffective), what public health strategies involving courts or legislatures might work? An interesting angle is that tribes are sovereign nations and have the power to set their own laws and taxes. A Navajo Nation tax on soda pop? A Hopi Nation tax on any soda larger than 12 ounces? An Apache ban Twinkies®? Or would this lead to bootlegging of Big Gulps® and Twinkies®? There are lots of intriguing possibilities. Read the articles and dream.

Infectious Disease Updates
Rosalyn Singleton, MD, MPH

Outpatient visits associated with otitis media and tympanostomy tube placement among young American Indian and Alaska Native children in the age of pneumococcal conjugate vaccine.

Singleton R, Holman R, Yorita K, Cheek J. Outpatient visit rates with otitis media (OM) and with tympanostomy (PE) tube placement were evaluated in American Indian and Alaska Native (AI/AN) children.

Methods. Records for all outpatient visits with OM listed as one of the diagnoses and with myringotomy and insertion of tube listed as a procedure for AI/AN children <5 years of age were obtained from the Indian Health Service National Patient Information Reporting system for 2000 - 2004. Rates for OM visits were obtained for the general population of US children by using the National Ambulatory Medical Care Survey.

Results. Outpatient visit rates associated with otitis media for AI/AN children <5 years old (97/100/year) in 2000 - 2004 were less than those previously reported for 1994 - 1996[1] (138); however, the rate remained higher than that for the US population in 2000 - 2004 (71; 95% confidence interval 64-77). The OM visits rate for AI/AN infants <1 year of age (204) was more than twice as high as that for US infants (93). The OM visit rate in AI/AN children varied by region, and was highest for the Alaska region (157 for children < 5 years of age) and lowest for the Oregon and Washington areas (76 for children < 5 years of age). The PE tube placement rate for AI/AN children <5 years of age also varied by region; the rate was highest for the Alaska region (23/1,000/year) and low (0.5 to 2.2) for each of the other regions.

Comment. The OM outpatient visit rate in AI/AN children, as well the rate for the general population of US children, has decreased since routine pneumococcal conjugate vaccination. The rate of OM and PE tube placement for AI/AN children

varied widely by region; the PE tube placement rate may be affected by the OM rates, as well as availability of and referrals to otolaryngologists.

1. Curns AT, Holman RC, Shay DK, et al. Outpatient and hospital visits associated with otitis media among American Indian and Alaska Native children younger than 5 years. *Pediatrics*. 2002;109:e41.

Special thanks to Bob Holman, statistician from CDC Division of Viral and Rickettsial Disease, Atlanta, GA.

Recent literature on American Indian/Alaskan Native Health

Doug Esposito, MD

Cancer in 15- to 29-year-olds by primary site. *Oncologist*. 2006 Jun;11(6):590-601. *http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=pubmed&cmd=Retrieve&dopt=Abstract&list_uids=16794238&query_hl=11&itool=pubmed_DocSum*.

This report represents an adaptation of a larger, more detailed 205 page document (*http://seer.cancer.gov/publications/aya/*). According to the authors, this is the first report detailing cancer epidemiology specifically in the 15 - 29 year-old age group.

Cancer incidence and survival rates reported by the authors derive from data collected through the Surveillance, Epidemiology, and End Result (SEER) program of the National Cancer Institute. Population estimates are from US Census data. SEER collects data on all invasive malignancies occurring in defined geographic areas. Although these areas represent a relatively small portion of the entire US population (approximately 13%), they are chosen to be representative of the nation as a whole with regard to ethnic/racial make-up. The data are then generalized to the rest of the country. Mortality rates are derived from analysis of data provided by the CDC's National Center for Health Statistics (NCHS). A more detailed description of the statistical manipulations of the data is beyond the scope of this review. For a full description of methods, the interested reader should refer to the full monograph referenced above.

Cancer in the 15 - 29 year-old population comprises only 2% of all malignancies in the US. An estimated 21,400 cancer diagnoses occurred in the year 2000 in this age group. By way of comparison, only 0.75% of all malignancies occur prior to age 15. Due to the fact that cancer incidence increases exponentially with age, half of all cancers in the 15 - 29 year age group actually occur in 25 - 29 year-olds. SEER reports cancer incidence to be lowest for AI/ANs at all ages, and highest for non-Hispanic whites in the first 40 years. African Americans/blacks have the highest cancer incidence over age 40.

The distribution of cancer type in the 15 - 29 year-old age group is unique and changes over time so that the distribution of cancer type seen at age 15 years is very different from that seen by age 30. The five most frequent invasive malignancies in 15 - 29 year-olds are lymphomas (20%), invasive skin cancers (15%, with 76% of these being melanoma), male genital system cancers (11%), endocrine system cancers (11%, with 96% of these being thyroid), and female genital system cancers (9%). These cancers account for 66% of all malignancies in this age group. CNS cancers and leukemias account for only 6% each. Significant gender differences exist. For females, genital system cancers account for 18%, while lymphomas and thyroid cancers account for 17% each, melanoma 15%, and breast cancer 7% of all malignancies (representing 74% of all female cancers in this age group). For males, genital system cancers account for 22%, lymphomas 21%, melanoma 17%, CNS cancers 8%, and leukemias 8% (representing 76% of all male malignancies in this age group).

Perhaps of more interest to pediatricians, for 15 - 19 year-olds, the five most frequent malignancies are lymphomas (26%), leukemias (12%), CNS cancers (10%), endocrine system cancers (9%, with 87% of these being thyroid), and invasive skin cancers (8%, with 84% of these being melanoma). These five account for 65% of all malignancies in this age group.

Cancer incidence increased in all age groups younger than 45 years between 1975 and 2000. However, it appears that this rise has leveled off for 15 - 24 year-olds, with a decrease in incidence for 25 -29 year-olds over the last five years.

With regard to mortality, the authors conclude that age-dependent cancer death rates generally reflect the incidence profile; i.e., the more patients diagnosed with cancer, the higher the expected death rate. As such, Native Americans are reported to have the lowest death rate from cancer for all age groups. Trends in mortality have been positive over time. Between 1975 and 2000, mortality due to invasive cancers has declined in all age groups younger than 45 years. However, the rate of reduction in mortality for African Americans/blacks was reported to be significantly lower than the reduction observed in other racial groups.

The authors report cancer survival to be best for non-Hispanic whites and worst for African Americans/blacks in the 15 - 29 year-old age group. AI/ANs had intermediate survival rates. However, AI/ANs had a more rapid death rate in the first two years following diagnosis than non-Hispanic whites, Hispanics, and Asians/Pacific Islanders. This high death rate in the first two years following diagnosis was then followed by a unique and unexplained plateau or leveling off not seen in any other ethnic or racial group. During the 1990s, 15 - 29 year-old AI/ANs experienced more than twice the death rate of non-Hispanic whites. For the age group <15 years, AI/AN survival was worse than any other ethnic/racial group until approximately 3.5 years after diagnosis, at which point the survival rate met and subsequently paralleled the rate for African Americans/blacks. Overall, AI/ANs appear to experience the second worst cancer survival rates below 45 years of age.

Progress toward improving 1 and 5 year survival rates for 15 - 29 year-old cancer patients over time has occurred, but only fractionally as compared to older and younger age groups. Males faired far worse than females overall.

Finally, the authors contend that the patterns and trends observed in cancer incidence suggest the sporadic nature of cancer in 15 - 29 year olds: "In general, there are relatively scant data to support either an environmental causation or an inherited predisposition to cancer in this age group. The vast majority of cases of cancer diagnosed before age 30 appear to be spontaneous and unrelated to either carcinogens in the environment or family cancer syndromes."

Editorial Comment

Fortunately, invasive malignancies are relatively rare in the pediatric age group. That being said, they are obviously among the most devastating set of conditions for our patients and their families. This report affords a valuable perspective on cancer epidemiology in young adults.

The authors report incidence rates for invasive malignancies among 15 - 29 year-old AI/ANs to be the lowest of any ethnic/racial group. On the one hand, that American Indian/Native Alaska young adults as a group seem to be somehow protected from malignancy is encouraging. However, it is well known and has been amply reported that racial misclassification occurs frequently among individuals of AI/AN heritage. This racial misclassification often results in an underestimate of disease burden. The methods employed by the authors of this report are highly susceptible to such errors in racial classification. In fact, SEER data and other disease registries have been extensively criticized on this point. Additional inaccuracies arise when trying to lump together a highly diverse ethnic/racial group such as AI/AN.

This report also suggests that AI/AN groups tend to have worse cancer survival as compared to other ethnic/racial categories. True disparities in cancer survival for AI/AN populations do appear to exist, and have been reported in a number of studies employing a variety of research methodologies. I cannot definitively say that I understand the exact cause of these disparities, but I would wager a guess that it has something to do with the source of most of the health disparities afflicting vulnerable populations the world over: socially imposed inequities and injustices in exposure and in access to resources. And so, the struggle continues.

Additional Reading

Measuring the health status gap for American Indians/Alaska Natives: getting closer to the truth. *Am J Public Health*. 2005 May;95(5):838-43. *http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=pubmed&cmd=Retrieve&dopt=AbstractPlus&list_uids=15855463&query_hl=14&itool=pubmed_DocSum*

Childhood cancer among Alaska Natives. *Pediatrics*. 2003 Nov;112(5):e396. *http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=pubmed&cmd=Retrieve&dopt=AbstractPlus&list_uids=14595083&query_hl=23&itool=pubmed_docsum*

Improving American Indian cancer data in the Washington State Cancer Registry using linkages with the Indian Health Service and tribal records. *Cancer*. 1996 Oct1;78(7 Suppl):1564-8. *http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?itool=abstractplus&db=pubmed&cmd=Retrieve&dopt=abstractplus&list_uids=8839571.*

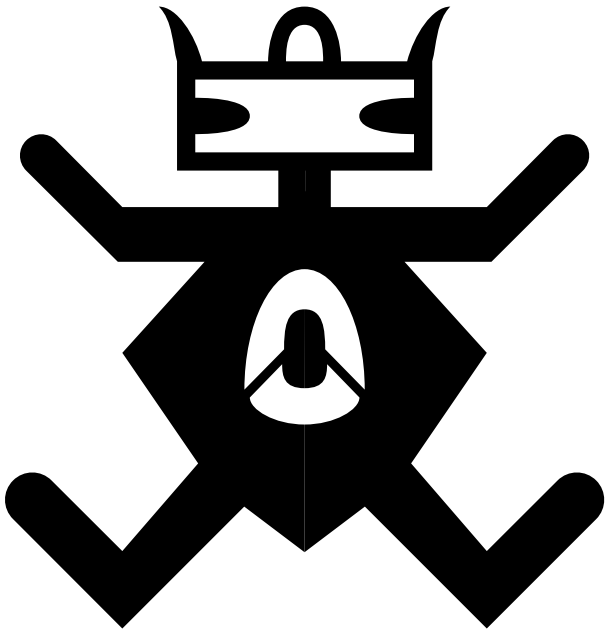
Announcements from the AAP Indian Health Special Interest Group

Sunnah Kim, MS

The AAP Committee on Native American Child Health (CONACH) recently received notification of a financial contribution from the estate of Demaree Low Jackson. Little is known about Ms. Jackson, other than the fact that she was born in Nevada, and that her father worked very hard on behalf of Native American populations in Nevada many years ago, particularly related to education for children.

The CONACH will receive approximately $100,000 from Ms. Jackson's estate. Members of the CONACH will be meeting in September 2006 to discuss plans for utilizing these funds. The CONACH hopes to maximize these funds to make a significant impact on the health of American Indian and Alaskan Native (AI/AN) children.

We welcome your suggestions on programs that could be set up by the CONACH. Please submit your ideas to *indianhealth@aap.org*.



NNAAPC Headquarters to Move to Denver

After months of consideration, the National Native American AIDS Prevention Center (NNAAPC) Board of Directors has unanimously decided to move its headquarters from Oakland, California to Denver, Colorado. The decision to relocate was conceived in response to the evolution and spread — different from previous periods — of the HIV/AIDS epidemic in Native American communities into more rural areas. By moving the headquarters from its original location in the San Francisco bay area, the Board of Directors hope to be better positioned to address current HIV/AIDS needs in Native communities.

Although San Francisco is central to the development of NNAAPC and overall HIV/AIDS awareness, educating the rural populations currently facing the greatest risks of infection must now be the chief focus of the organization's efforts. In a letter addressed to the Indian community and NNAAPC's Invested Partners, the Board of Directors emphasized the need for relocation in order to fully comply with the mission to serve Indian Country and provide the best services possible.

Denver was chosen as the new location for the NNAAPC headquarters because of its history in providing a professional and inspiring locale for national, Native American organizations. "It is with great excitement that we commence this relocation process," said NNAAPC Board President Yvonne Davis. "The Board of Directors is convinced that the new setting will allow for a period of reorganization to better direct our services to the many Indigenous Nations infected with or affected by HIV/AIDS."

NNAAPC was founded in the late 1980s by caring and interested Native people who began to address why and how the lack of awareness on the part of the US federal government impacted the effects of HIV/AIDS within the Native American population. NNAAPC will continue to address the evolving HIV/AIDS epidemic. The mission of NNAAPC is twofold: To address the impact of HIV/AIDS on American Indians, Alaska Natives, and Native Hawaiians through culturally appropriate advocacy, research, education, and policy development in support of healthy indigenous people.

Over the past 20 years, NNAAPC services have expanded to include, among a host of offerings, tailored capacity building services, media development, and public policy. NNAAPC is the only US national organization devoted to HIV/AIDS prevention for Native communities across the country.

Correction

The new url address for The Provider, where you can find back issues and other information, is *http://www.ihs.gov/PublicInfo/Publications/HealthProvider/Provider.asp*.

October is Domestic Violence Awareness Month
October 11 is Health Cares About Domestic Violence Day

October is national Domestic Violence Awareness Month (DVAM). This is an annual observance sponsored by the National Coalition Against Domestic Violence. Every October, across the country, domestic violence survivors and advocates, health care providers, elected officials, law enforcement and public safety personnel, business leaders, faith-based groups, and many others are organizing and participating in domestic violence memorial activities, public education campaigns, and community outreach events. If you would like more information about DVAM activities and how your facility can participate, visit *www.ncadv.org.*

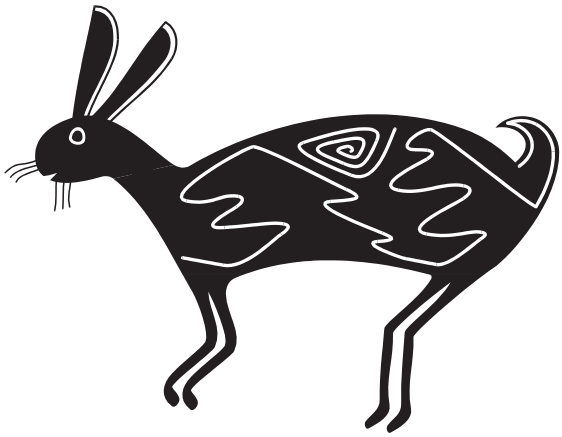
Join thousands of other health care providers for the eighth annual Health Cares About Domestic Violence Day (HCADV Day) on October 11, 2006!

Sponsored by the Family Violence Prevention Fund (FVPF). HCADV Day is a nationally recognized awareness campaign that takes place annually on the second Wednesday of October. HCADV Day aims to educate members of the health care community about routine domestic violence (DV) assessment and the long term health implications of DV. If you would like more information about how your facility can participate in Health Cares About Domestic Violence Day as well as additional information about Domestic Violence Awareness Month, visit *hltp://endabuse.org/hcadvd/.*

Health care providers are in a unique position to identify and assist victims of domestic violence. If you would like more information about how to improve the response of your facility to domestic violence visit *www.endabuse.org/health.*

Sample hospital and clinic domestic violence policies and procedures and guidelines for providers can be found on the IHS Maternal and Child Health Domestic Violence website at *http://www.ihs.gov/MedicalPrograms/MCH/V/index.cfm.*

If you are a victim of domestic violence, call the National Domestic Violence Hotline at 1-800-799-SAFE; TDD: 1-800-787-3224.



Change of Address or Request for New Subscription Form

Name _____ **Job Title** _____

Address _____

City/State/Zip _____

Worksite: ☐ **IHS** ☐ **Tribal** ☐ **Urban Indian** ☐ **Other**

Service Unit (if applicable) _____ **Social Security Number** _____

Check one: ☐ **New Subscription** ☐ **Change of address**

If change of address, please include old address, below, or attach address label.

Old Address _____

THE IHS PRIMARY CARE PROVIDER

A journal for health professionals working with American Indians and Alaska Natives

THE IHS PROVIDER is published monthly by the Indian Health Service Clinical Support Center (CSC). Telephone: (602) 364-7777; fax: (602) 364-7788; e-mail: *the.provider@phx.ihs.gov.* Previous issues of THE PROVIDER (beginning with the December 1994 issue) can be found on the CSC Internet home page *(http://www.ihs.gov/PublicInfo/Publications/HealthProvider/Provider.asp).*

Opinions expressed in articles are those of the authors and do not necessarily reflect those of the Indian Health Service or the Editors.

Circulation: The PROVIDER (ISSN 1063-4398) is distributed to more than 6,000 health care providers working for the IHS and tribal health programs, to medical schools throughout the country, and to health professionals working with or interested in American Indian and Alaska Native health care. If you would like to receive a copy, send your name, address, professional title, and place of employment to the address listed below.

Publication of articles: Manuscripts, comments, and letters to the editor are welcome. Items submitted for publication should be no longer than 3000 words in length, typed, double-spaced, and conform to manuscript standards. PC-compatible word processor files are preferred. Manuscripts may be received via e-mail.

Authors should submit at least one hard copy with each electronic copy. References should be included. All manuscripts are subject to editorial and peer review. Responsibility for obtaining permission from appropriate tribal authorities and Area Publications Committees to publish manuscripts rests with the author. For those who would like more information, a packet entitled "Information for Authors" is available by contacting the CSC at the address below or on our website at www.csc.ihs.gov.

Dept. of Health and Human Services
Indian Health Service
Clinical Support Center
Two Renaissance Square, Suite 780
40 North Central Avenue
Phoenix, Arizona 85004

PRESORTED STANDARD
POSTAGE AND FEES PAID
U.S. DEPT. OF HEALTH & HUMAN SERVICES
PHOENIX, AZ
PERMIT NO. 5691

CHANGE SERVICE REQUESTED

_____

OFFICIAL BUSINESS
PENALTY FOR PRIVATE USE $300