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What's Up With All the Antibiotics for Sinusitis?

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Introduction

Sinusitis is one of the most common illnesses for which children and adults seek medical care (and often receive antibiotics) in the Indian Health Service (IHS). Sinusitis is the inflammation of the mucosa of the paranasal sinuses and is invariably accompanied by inflammation of the adjacent nasal mucosa. Because of this, rhinosinusitis is the preferred term.[1] Rhinosinusitis can be of a viral or bacterial etiology, and it is difficult to differentiate between the two. Most episodes of acute rhinosinusitis are caused by uncomplicated viral upper respiratory tract infections (URIs). Children have six to eight viral URIs each year and will develop acute bacterial rhinosinusitis (ABRS) 5% to 13% of the time,[2] while adults have two to three viral URIs per year and develop ABRS 0.5% to 2% of the time.[3]

Sinusitis is the fifth most common diagnosis resulting in an antibiotic prescription, and it accounted for 9% and 21% of all pediatric and adult prescriptions written in 2002.[4] Primary care physicians prescribed an antibiotic in 85% to 98% of cases for sinusitis.[1] Some studies indicate 18% to 60% of patients receive antibiotics for a diagnosis of a cold.[5]

It is estimated that the spontaneous resolution rate (that is, no antibiotics) for ABRS in children and adults is 63% and 62% respectively.[4] Since rhinosinusitis is frequently caused by viruses and resolves without antibiotic treatment over 60% of the time, the case for a conservative approach in patients with sinusitis-like symptoms can be made. The inappropriate use of antibiotics for ABRS is contributing to the emergence and spread of antibiotic resistant bacteria.[1]

Results of chart reviews of 450 episodes of ABRS in children and adults, conducted on four Indian reservations in Montana during 2002 and 2003, showed providers prescribed antibiotics 95.3% of the time for a diagnosis of ABRS; amoxicillin/clavulanate, amoxicillin, trimethoprim/sulfamethoxazole (TMP/SMX), and azithromycin were the most commonly prescribed antibiotics. However, when a definition for ABRS was used that was published recently by the Sinus and Allergy Health Partnership in the journal *Otolaryngology Head and Neck Surgery* (January 2004), 71.2% of the Indian patients did not meet the definition for ABRS.

Definition

In 2000, the Sinus and Allergy Health Partnership published antimicrobial treatment guidelines for ABRS in children and adults. These guidelines were updated in January 2004. The

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guidelines present recommended antibiotic therapy for children and adults with ABRS. They distinguish between two groups of people. One group with mild disease and no antibiotics in the past four to six weeks, and the other group with mild disease with recent antibiotic use (past four to six weeks) or moderate disease (regardless of recent antibiotic exposure). Antibiotics in the guidelines include (in no specific order): Amoxicillin/clavulanate, amoxicillin, cefpodoxime proxetil, cefuroxime axetil, cefdinir, trimethoprim/sulfamethoxazole, doxycycline, azithromycin, clarithromycin, erythromycin, telithromycin, gatifloxacin, levofloxacin, moxifloxacin, ceftriaxone, clindamycin, and rifampin.

According to the Sinus and Allergy Health Partnership, a diagnosis of ABRS may be made in adults and children with a viral URI that has not resolved after ten days or which worsens after five to seven days and is accompanied by some or all of the following symptoms: nasal drainage, nasal congestion, facial pressure/pain (especially when unilateral and focused in the region of a particular sinus), postnasal drainage, hyposmia/anosmia, fever, cough, fatigue, maxillary dental pain, and ear pressure/fullness. ABRS may occur at any time during a viral URI, but the incidence is much greater if the illness has not resolved after ten days.[4] It is important to recognize that no particular sign or symptom,[6] including a change in the color or characteristic of nasal discharge,[4] is sensitive and specific for sinusitis.

Chart Review Results

ABRS is a very common illness seen in IHS clinics and emergency rooms. During the past two years, 450 episodes of ABRS were evaluated by a chart review done on four Indian reservations in Montana. The chart review focused on the definition of sinusitis, duration of symptoms, and antibiotics prescribed. See Table 1 below for a definition of ABRS and Table 2 (page 132) for the duration of symptoms. Sixteen different antibiotics were prescribed; Table 3 (page 132) includes a complete listing of antibiotics prescribed.

Out of 450 patients with ABRS, 429 received antibiotics (95.3%). Three people received two antibiotics. Chart documentation for 129 people (28.6%), clearly met the definition for ABRS (URI not resolved after ten days or worsened after five to seven days). However, 259 people had their URI less than ten days (57.5%) and 62 people (13.7%) had their symptoms for an undetermined time period (chart documentation did not note length of chief complaint or duration of symptoms). Combining people with a URI less than ten days (259) and a URI of an unknown duration (62), resulted in 321 patients who did not meet the definition for ABRS (71.2%). However, 95.3% of all patients received an antibiotic for ABRS.

Discussion

When using the definition for ABRS from the January 2004 supplement issue of *Otolaryngology Head and Neck Surgery*, IHS providers overdiagnosed ABRS in their patients. The chart review suggests that many patients were prescribed unnecessary and inappropriate treatment for ABRS: unnecessary, because most of the patients diagnosed with ABRS probably had a viral illness, and inappropriate because Amoxicillin, amoxicillin/clavulanate, TMP/SMX, and cefuroxime axetil could have been used more, while azithromycin, clarithromycin, keflex, cefaclor, tequin, and levofloxacin could have been used less.

The diagnosis and treatment of uncomplicated ABRS is straightforward and simple. The history and duration of symptoms is crucial in diagnosing ABRS, as the physical examination provides limited information. Plain film radiographs, computed tomography, and magnetic resonance imaging scans are not

Table 1. Symptoms associated with acute bacterial rhinosinusitis (ABRS)

- Nasal drainage
- Nasal congestion
- Facial pain/pressure (especially when unilateral and focused in the region of a particular sinus group)
- Postnasal drip
- Hyposomia/anosmia
- Fever
- Cough
- Fatigue
- Maxillary dental pain
- Ear fullness/pressure

A diagnosis of ABRS may be made in adults or children with a viral URI that is no better after ten days or worsens after five to seven days and is accompanied by some or all of these symptoms.

Reprinted from *Otolaryngology-Head and Neck Surgery*, volume 130, number 1, Sinus and Allergy Health Partnership, Antimicrobial Treatment Guidelines For Acute Bacterial Rhinosinusitis 2004, pp. 1-50, 2004, with permission from the American Academy of Otolaryngology – Head and Neck Surgery Foundation, Inc.

necessary for most cases of uncomplicated ABRS. Implementation of treatment guidelines based on scientific evidence helps providers diagnose and treat ABRS more effectively, use antibiotics more judiciously, and increase the quality and cost effectiveness of care given.

Guidelines are not always easy to implement or readily endorsed by providers. ABRS treatment guidelines focusing on antibiotic selection were implemented in 2003 at one IHS facility studied and are being followed 66% (per chart review three to five months after guidelines adopted) of the time. However, only 36% of the cases met the definition for ABRS. When treatment guidelines were not followed (34% of the time), 44% of the failures were because amoxicillin/clavulanate was prescribed inappropriately, 29% because azithromycin was prescribed inappropriately, 24% because levofloxacin was prescribed inappropriately, and 3% because cefuroxime axetil was prescribed inappropriately.

Chart reviews and developing treatment guidelines for ABRS is an excellent Quality Improvement (QI) activity. QI activities related to treatment guidelines and use of antibiotics are encouraged by hospital accreditation agencies. ABRS treatment guidelines in the form of an algorithm can be developed from the article referenced.

Summary

According to the literature, ABRS is treated with antibiotics about 85% to 98% of the time, even though spontaneous resolution of ABRS without antibiotics occurs in around 62% of cases. In an IHS chart review, done during 2002 and 2003, providers prescribed antibiotics 95.3% of the time for ABRS even though only 28.6% of the time did documentation support the diagnosis of ABRS.

The Centers for Disease Control and Prevention (CDC) launched a nationwide campaign in September 2003, "Get Smart: Know When Antibiotics Work." More information regarding this excellent campaign can be found at *www.cdc.gov/drugresistance/community* or *www.cdc.gov/getsmart*. The goal of this campaign is to decrease inappropriate antimicrobial use and slow the rise in bacterial resistance. The keys to appropriate antibiotic use are as follows:

- Prescribe antibiotics only when treatment is likely to benefit the patient
- Select antibiotics that target the likely pathogens
- Use antibiotics at the appropriate dose and for the correct duration[6]

IHS providers can improve the quality of care given to patients with ABRS, at a reduced cost, and can utilize antibiotics more judiciously by:

1. Developing and implementing ABRS guidelines for children and adults that focus on evidenced-based information from the January 2004 ABRS article in the journal *Otolaryngology Head and Neck Surgery*.
2. Preferentially prescribing antibiotics in a first line therapy approach, then second line therapy, etc.
3. Monitoring the treatment of ABRS with QI activities.

Treatment guidelines and/or QI activities can reduce the overtreatment of ABRS with unnecessary antibiotics and slow the rise in bacterial resistance. Consider the following questions in QI activities for ABRS. Does your facility have ABRS treatment guidelines? How is ABRS being defined at your facility? Which antibiotics are being prescribed? The January 2004 journal article in *Otolaryngology-Head and Neck Surgery* on antimicrobial treatment guidelines for ABRS is an excellent resource for all health care providers who evaluate children or adults.

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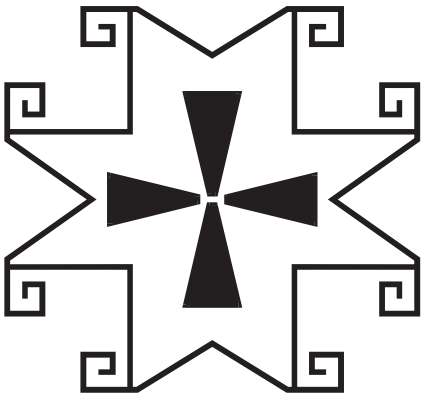

Table 2. Duration of symptoms for 450 patients seen at IHS facilities

Less than 10 days	Worse after 5 to 7 days	10 days or more	Duration ?
259 (57.5%)	5 (1.1%)	124 (27.5%)	62 (13.7%)

Adjustment for unknown duration of symptoms: Subtracting 62 people with symptoms of unknown duration from the total of 450, leaves 388 people. One hundred twenty nine out of 388 people meet the definition for ABRS (33.2%), and 259 out of 388 people did not meet the definition for ABRS (66.8%).

Table 3. Antibiotics prescribed (432 prescriptions)

Antibiotic	Frequency	Percent	Cost/Dose Children	Cost/Dose Adults
Amoxicillin	137	32%	$ 0.03	$ 0.05
Amoxicillin/clavulanate	96	22%	2.25	3.20
TMP/SMX	83	19%	0.01	.01
Azithromycin	24	6%	3.50	4.10
Doxycycline	23	5%	0.08	0.03
Erythromycin	15	3%	0.16	0.05
Levofloxacin	14	3%	5.37	5.37
Cephalexin	12	3%	0.05	0.04
Cefuroxime axetil	6	1%	1.75	8.04
Clarithromycin	6	1%	1.47	1.47
Cefaclor	4	1%	0.46	2.84
Cefprozil	4	1%	2.06	4.78
Gatifloxacin	3	1%	1.32	1.32
Ceftriaxone	2	<1%	14.97	23.15
Penicillin IM	2	<1%	3.90	2.87
Erythromycin/sulfisoxazole	1	<1%	0.01	0.01

- 432 antibiotics prescribed
- Three people received 2 antibiotics
- Cost per dose according to VA pricing to IHS pharmacies as of March 2004.

The Map to LOINC Project

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Introduction

Public health information systems are increasingly moving toward automated capture and analysis of data, use of data that are already electronic, and integration of public health and health care information systems. Laboratory data is becoming an increasingly valuable tool for public health agencies[1] for electronic laboratory-based reporting and public health surveillance.[2] However, code sets for laboratory test names may be different from one information system to another, complicating data aggregation. A solution is to map the local test names from these systems to an accepted standard set of codes, the Logical Observation Identifier Names and Codes (LOINC) code set.[3,4]

A collaborative pilot project was undertaken by the Centers for Disease Control and Prevention (CDC) and the Indian Health Service (IHS) to design and test a semiautomated process to standardize local laboratory tests names to LOINC at five IHS medical facilities. IHS facilities use an electronic medical record integrated clinical and administrative information system, the Resource Patient Management System (RPMS). This system consists of more than 35 different applications. The "Lab Package," which is used for laboratory records, is based on the Veterans Administration (VA) laboratory system (VISTA).

Objective

The objective of this project was to develop a semiautomated process to standardize local laboratory test files by mapping to LOINC.

Methods

The laboratory test files (test names, synonyms, units, and specimens for the tests) of four of the five participating medical facilities were combined into one "IHS master LOINC file." In addition, laboratory tests from file #60 distributed with the lab package version 5.2 and laboratory entries from a Test System database were added to the IHS master LOINC file. Tests that were incomplete or contained incorrect information were marked as "uncodeable." Panel tests were also excluded from the master file. Using the Regenstrief LOINC Mapping Assistant (RELMA), two scientists assigned LOINC codes to the 10,033 tests in the master file.

A mapping tool was developed for comparing each facility's laboratory test file to the IHS master LOINC file and automatically assigning a LOINC code to the test if a match was found in the master file. The mapping tool followed a two-step process. LOINC codes were assigned to the laboratory tests if there was an exact match between the laboratory test name in the facility's laboratory test file and the master file. If no match was found during the first pass, all typographic characters (non-alpha numeric characters) were removed and the matching process tried a second time. If a match was found during the second pass, a LOINC code was assigned; otherwise no LOINC code was assigned to the test. Tests not assigned a code by the mapping tool were reviewed manually and codes were assigned.

The process was designed to accommodate future changes in laboratory test names/codes; to meet all data security and confidentiality standards; and to be easily expandable to other IHS medical facilities in future.

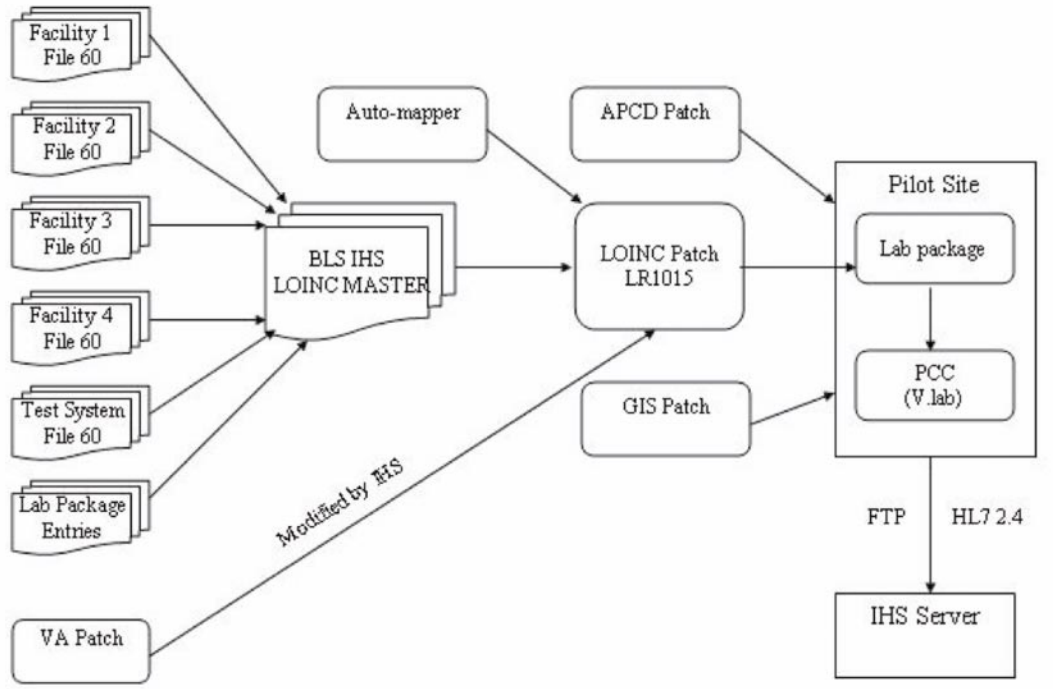
To integrate the mapping tool into RPMS, the following steps were taken (outlined in Figure 1 on the next page): the mapping tool, IHS master LOINC file, and the LOINC patch originally developed by the VA were combined to create the IHS lab patch (LR1015). The five pilot sites installed LR1015, and two additional RPMS patches, the "APCD" Patch and the Generic Interface System (GIS) Patch, used for aggregating the data of interest, standardizing it into Health Level Seven (HL7) format, and exporting it to a server at the IHS headquarters. Monthly exports of the data (test names, LOINC codes, and test results) are performed at each of the five pilot sites.

Results

A total of 4,967 test names were in use at the five participating health care facilities. Results of mapping to LOINC are presented by facility in Table 1. We were able to map 63% to 76% of the local active laboratory tests to LOINC using the mapping tool; 11% to 27% of the tests were mapped manually. We could not assign LOINC codes to 7% to 19% of the laboratory tests due to incomplete or incorrect information about these tests.

To validate the performance of our mapping tool, we tested it on a laboratory test file from a facility that did not participate

Figure 1. Process Flow



in the pilot project. Of 703 laboratory tests in the facility's file, we were able to map 569 (81%) of the tests to LOINC.

Table 1. Mapping Results

Site	Total Active Tests	Automated Mapping No. (%)*	Manual Mapping No. (%)*	Uncodeable Tests No. (%)*
1	1,050	800 (76)	111(11)	139 (13)
2	1,098	687 (63)	204 (19)	207 (19)
3	1,315	872 (66)	360 (27)	83 (6)
4	1,213	765 (63)	244 (20)	204 (17)
5	291	205 (70)	36 (12)	50 (17)
Total	4,967	3,329 (67)	955 (19)	683 (14)

* Percentages do not add to 100% due to rounding

Conclusions:

- At each of the five participating facilities, we were able to standardize approximately two-thirds or more of the laboratory test names to LOINC using the automated mapping process, approximating other similar reported efforts.[5]
- The results from the facility that did not participate in the tool development phase suggest that this semi-automated process will achieve comparable results if expanded to other IHS medical facilities.
- Improvement in quality of data will increase the percentage of tests mapped in future.
- Standardization of laboratory names will allow IHS to aggregate laboratory data more easily for disease surveillance and clinical and administrative reporting efforts.

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The editors of *The IHS Primary Care Provider* welcome articles that facilitate communication and share timely information which is relevant to the clinical practice of Indian Health Service and tribal health care providers.

The editors are frequently asked for information on how to prepare an article for publication. In an effort to meet this expressed need, the following guidelines were developed. These are merely suggestions; articles that do not meet these guidelines will *not* be turned down just because the format is not as suggested.

For more information, contact Editor, IHS Clinical Support Center, Two Renaissance Square, Suite 780, 40 North Central Avenue, Phoenix, AZ 85004 (telephone (602) 364-7777; fax (602) 364-7788).

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Journals

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Blondin B. Traditional use of tobacco among the Dine. *Artic Med Res*. 1990;49(suppl 2):51- 53.

2. Corporate Author

The Committee on Enzymes of the Scandinavian Society of Clinical Chemistry and Clinical Physiology. Recommended method for the determination of gamma-glutamyltransferase in blood. *Scand J Clin Lab Invest*. 1976;36:119-25.

Books and Other Monographs

3. Personal Author(s)

Hawton K, Catalan J. *Attempted Suicide: A Practical Guide to its Nature and Management*. New York, NY: Oxford University Press; 1987:125-146.

4. Editor, Compiler as Author

Dausset J, Colombani J, eds. *Histocompatability Testing 1972*. Copenhagen: Munksgaard; 1973:12-18.

5. Agency Publication

Ranofsky AL. *Surgical Operations in Short-Stay Hospitals: United States, 1975*. Hyattsville, MD: National Center for Health Statistics; 1978. DHEW publication no. (PHS) 78-1785. (Vital and health statistics; series 13; no. 34).

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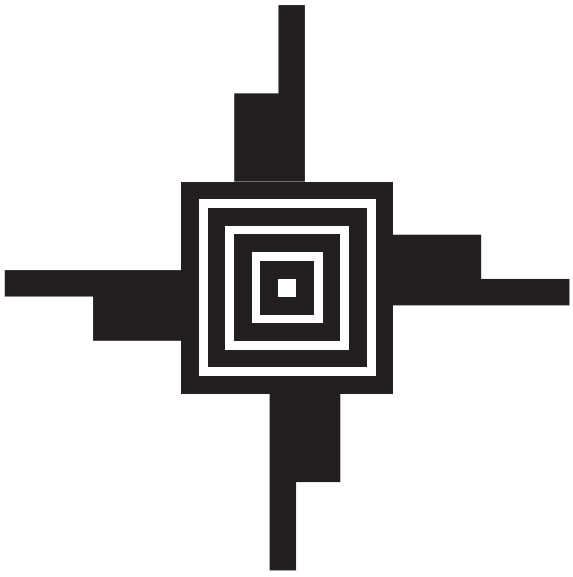
*Adapted from: Iverson C, Dan BB, Glitman P, et al. *American Medical Association Manual of Style*. 8th ed. Baltimore, MD: Williams and Wilkins; 1989.



Editor's Note: The following is a digest of the monthly Obstetrics and Gynecology Chief Clinical Consultant's Newsletter (Volume 2, No. 5 , May 2004) available on the Internet at http://www.ihs.gov/MedicalPrograms/MCH/M/OBGYN01.cfm. *We want 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@anmc.org.

OB/GYN Chief Clinical Consultant's Corner Digest

News flash

It's not too late to sign up for the 2004 Native Maternity Care and Women's meeting: Prevention in Native Women's Health to be held August 4 - 6, 2004 in Albuquerque, New Mexico. The national and international faculty will cover domestic violence, breastfeeding, and adolescent health, among other things. This will be great continuing education, as well as good networking for leaders of Women's Health/MCH. Go to *http://www.ihs.gov/MedicalPrograms/MCH/M/CN01.cfm#August2004*. For more information, contact: Kathy Breckenridge at *KBreckenridge@salud.unm.edu* or *nmurphy@anmc.org*.

Abstract of the Month

What is the trend in offering vaginal birth after cesarean (VBAC)? The American College of Obstetricians and Gynecologists (ACOG) has awarded the annual Wyeth Pharmaceuticals Section Award to its Vermont and New Hampshire Sections in recognition of their leadership of the VBAC Project. Concerned with the decline in the number of hospitals offering vaginal births after cesarean (VBAC), ob-gyns from both states worked together to develop a project to improve the safety and delivery of VBACs in their region.

The Vermont/New Hampshire VBAC Project led to the development of guidelines for the management of VBAC. The guidelines are used to reinstitute VBACs in hospitals that no longer offer them. While VBAC availability has declined in Vermont and New Hampshire, many patients who have had previous cesarean sections prefer to attempt to deliver their babies vaginally but have difficulty finding hospitals who perform VBACs, says Peter H. Cherouny, MD, chair of the Vermont Section. "There's still clearly a demand for VBACs."

The project's risk profile of VBAC patients showed that VBACs could be offered in a safe environment, Dr. Cherouny says. After identifying the clinical characteristics of patients with low, medium, and high risk for uterine rupture, a regional institutional classification was developed that included specific recommendations for the care of VBAC patients at the different risk levels. Dr. Cherouny points out that the group at low risk showed fetal and maternal risks similar to what all hospitals deal with every day with obstetric patients.

Three documents were developed and disseminated from the project: a patient VBAC education form, a patient consent form for VBAC, and regional guidelines for hospital management of VBAC. The support for the project data and new documents is leading to the reinstitution of VBAC in some hospitals, while others are considering the option, according to Dr. Cherouny.

More than 200 health care professionals and 35 of the 37 hospitals in Vermont and New Hampshire were involved in the project. Input came from ob-gyns, nurse managers, certified nurse midwives, anesthesia personnel, administrators, and insurers throughout the region. Based on the successful collaborative project, the hospitals have decided to create the Northern New England Perinatal Quality Improvement Network, a consortium that will develop other projects geared toward improving perinatal care in the region. The network's first project will be to collect patient outcome data on VBAC. "This award gives national recognition to the work of many people, showing that you can start at a grassroots level and have a significant impact on patient care," Dr. Cherouny says. For more information, go to *www.acog.com/from_home/publications/press_releases/nr05-02-04.cfm*. Northern New England Perinatal Quality Improvement Network: *http://www.nneob.org/index.php?option=displaypage&itemid=50&op=pagemenu*. VBAC Documents: Consents, Patient Education, Protocol: *http://www.nneob.org/index.php?option=displaypage&Itemid=52&op=page&SubMenu*. Emergency Cesarean Delivery: Simulations, Drills, Q/A: *http://www.nneob.org/index.php?option=displaypage&Itemid=71&op=page&SubMenu*.

OB/GYN CCC Editorial comment

What is the trend in offering VBAC? There has been a slight swing of the pendulum back to offering selected VBAC in small and rural hospitals. Since 1999, the overall trend had been away from VBAC, especially since the July 1999 Practice Bulletin, No. 5 that recommended that emergency delivery be "immediately available." In the last few years that swing of the pendulum may be making small iterative steps back toward VBAC for selected VBAC candidates.

This process involves recognizing different risk levels for VBAC candidates. e.g., low risk versus high risk, and triaging

patients in small rural hospitals accordingly. In fact the trend just reached national prominence when ACOG recognized Vermont and New Hampshire OB/GYNs for VBAC Project.

The above approach to prenatal risk assessment requires the entire facility to change some basic paradigms. One approach to this is the use of emergency delivery simulations and efforts to develop effective teamwork. As symptomatic uterine rupture is an infrequent event (0.7%), one could argue that any facility providing any delivery, no matter how low risk, should use a similar system-wide approach to careful risk triage if they plan to offer vaginal delivery, much less cesarean delivery.

As luck would have it, the Indian health system is on the forefront of this issue and will have a keynote presentation from Michele Lauria, Professor of Maternal Fetal Medicine, Dartmouth University, at the upcoming Women's Health and Maternity Care: Biennial IHS, Tribal, and Urban (ITU) Meeting in August in Albuquerque. The IHS MCH website offers the Dartmouth Hitchcock VBAC consent as an example in our Perinatology Corner VBAC CME/CEU module. Go to *www.ihs.gov/MedicalPrograms/MCH/M/VB01.cfm*.

From Steve Holve, Pediatric Chief Clinical Consultant

Bronchiolitis systematic review with Peds CCC Comments. Many other updates. Go to *www.ihs.gov/MedicalPrograms /MCH/C/CHdownloads/IHSPedsMay41504.doc*.

From Jane Powers, Ft. Duchesne, Utah

Check out the Child Abuse Website from the Office for Victims of Crimes: Child Abuse Training. The Project is a coordinated effort between two government agencies (the Office for Victims of Crime and the Indian Health Service) to provide equipment, training, and resources to medical providers within the Indian Health Service and tribal programs on the medical evaluation of child abuse. It is an example of a successful partnership between two federal agencies that evolved from a pilot project implemented on the Northern Ute Indian Reservation in Utah in 1995. The site offers training, course requirements, forms, policies and procedures, and links of interest. Go to *http://www.ovccap.ihs.gov/index.asp*.

Breastfeeding

Is Varicella Vaccination Safe During Lactation? The authors conclude that no evidence was found of varicella virus excretion in breast milk or of other transmission of virus to infants when mothers were vaccinated postpartum. They encourage physicians to identify susceptible women during pregnancy and ensure postpartum vaccination.

Bohlke K, et al. Postpartum varicella vaccination: is the vaccine virus excreted in breast milk? *Obstet Gynecol* November 2003;102:970-7._*www.ncbi.nlm.nih.gov/entrez-query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=14672472*.

Domestic Violence

In the Domestic Violence Track at Indian Health Conference on Women's Issues: August 4 - 6, 2004, Albuquerque, NM (see conference link above), Donald Clark and Rachel Locker will lead a series of sessions on violence against Native Women. In addition, Bonnie Duran, University of New Mexico, will also present on Child maltreatment prevalence and mental disorders outcomes among American Indian women in primary care.

Duran B, Malcoe LH, Sanders M, Waitzkin H, Skipper B, Yager J. Child maltreatment prevalence and mental disorders outcomes among American Indian women in primary care. *Child Abuse Negl*. 2004 Feb;28(2):131-45.*www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=15003398*.

Primary Care Discussion Forum

On May 1, 2004, Donna Perry in Chinle, began moderating a discussion of Adolescent Risk Taking Behavior on the Primary Care Discussion Forum. This will be a combined listserv discussion with the Special Interest Group – Indian Health of the AAP.

The Discussion Forum provides an e-mail listserv-based discussion moderated by national leaders or experts in a particular field. The discussion is captured and summarized online at: *www.ihs.gov/MedicalPrograms/MCH/M/PCdiscForum.asp*

Adult Asthma

On August 1, 2004, thanks to Charles (Ty) Reidhead, Whiteriver, we will start an Adult Asthma Discussion. Ty is the IHS Internal Medicine CCC. To subscribe, go this site and click the word 'subscribe' in the first paragraph: *www.ihs.gov/MedicalPrograms/MCH/M/MCHdiscuss.asp*, or contact Dr. Murphy.

International Health Update

Guidelines can save lives, according to the Royal College of Obstetricians and Gynaecologists. Recent reviews by the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI) and the Confidential Enquiry into Maternal Deaths (CEMD) have shown that following the RCOG guidelines may reduce maternal death. Two guidelines include thromboembolic disease (RCOG) and cesarean delivery (NICE). Royal College of Obstetricians and Gynaecologists Guidelines:*http://www.rcog.org.uk/mainpages.asp?PageID=106* Confidential Enquiry into stillbirths and Deaths in Infancy (CESDI) and the Confidential Enquiry into Maternal Deaths (CEMD):*http://www.cemach.org.uk/publications.htm*. National Institute for Clinical Excellence (NICE): *http://www.nice.org.uk/catcg2.asp?c=20034*.

From your colleagues

From Barbara Fine: Impaired Fasting Glucose now starts a 100 mg/dL: Millions More Have Pre-Diabetes; Native Women

with Heart Disease; HRSA Announces Perinatal Mental Wellness Grant; Scholarships for Native Health leaders, practitioners, and other individuals committed to promoting public health for Native American tribes

From Bill Green: Aggressive Lipid Lowering With Statins Better

From Elaine Locke: Free Job Postings: Indian Facilities on ACOG Career Connection

From Barbara Orcutt: Post-Coital Contraception: Differing opinions and options

From Laura Shelby: Chlamydial and gonococcal infections among young adults

From Barbara Stillwater: Short Women Are At Greater Risk for Gestational Diabetes; Diabetes doubled after gestational diabetes

From Judy Thierry: Breastfeeding and the Risk of Postneonatal Death in the United States; Patient education for prenatals: I specifically would like to know what…..; Please tell me how and if genetics clinics are being run in your area

From Mary Wachacha: Prenatal Patient Education Available in one click

Hot Topics:

Obstetrics

Skin-to-Skin Contact Beneficial in Healthy Term Newborns: Kangaroo care; Some treatments for cervical intraepithelial neoplasia increase risk of PROM; Prenatal exposure to fluoxetine (Sarafem, Prozac) results in poor neonatal adaptation; Maternal Physical Activity May Reduce Gestational Diabetes Risk; Potential Risk Factors for Gestational Hypertension Identified; Does Asthma Adversely Affect Pregnancy Outcomes? Multigene Association Study With Pregnancy Hypertension; Dental care use and self-reported dental problems in relation to pregnancy; Maternal dental x-rays linked to increased risk of infant low birth weight

Gynecology

Aromatase and Leiomyoma of the Uterus; Sacral nerve stimulation effective for fecal incontinence; In vitro-fertilization outcomes improving in U.S.; Emergency Contraception: Effectiveness of a telephone prescription service; Metformin Helps Patients with Polycystic Ovary Syndrome; Benefits and Risks of OCPs Beyond Contraception

Child Health

Adolescent Health Issues in Indian Health; Schools: Finding they can raise funds without undermining children's diets and health

Chronic Illness and Disease

Glucosamine Has a Disease-Modifying Effect on Osteoarthritis; ACS Guidelines Updated for Detection of Cancer: Cervical, breast, colorectal, endometrial; Reduce alcohol misuse by adults, including pregnant women - USPSTF; Pain-free efficacy with sumatriptan in the mild pain of menstrually associated migraine; Optimal Exercise Duration and Intensity in Women; Aromatase inhibitors - Use of Letrozole After Tamoxifen for Breast Cancer; Sibutramine Treatment for Binge-Eating Disorder

Features

AFP: Annual Proteinuria Screening Is Not Cost-Effective – POEM; Cochrane for Clinicians -Vaginal Estrogen Preparations for Relief of Atrophic Vaginitis; Abnormal Uterine Bleeding; Impaired Glucose Tolerance and Impaired Fasting Glucose; Diagnosis and Treatment of Acne

ACOG: Failure of the FDA To Approve OTC Status for Plan B®: Question of decision's motivation; Ginger Supplement Helps Relieve Pregnancy-Related Nausea and Vomiting

AHRQ: Do Me a Favor – Web Morbidity and Mortality

Elder Care News: Ultrasound bone assessment is a reliable predictor of fracture risk

Frequently asked questions: What should I do: Pregnant patient's varicella-like rash?

Hormone Replacement Update: Estrogen Does Not Prevent Chronic Disease in Postmenopausal Women With Hysterectomy – Medscape CME

Information Technology: 2004 Technology Conference, Scottsdale, AZ

MCH Alert: Oral Health and Health in Women: A Two-Way Relationship

Medscape: Emergency Contraceptive Pills and Adolescents (Web Conference) CME

Office of Women's Health, CDC: Venous Thromboembolism after Air Travel

Osteoporos is: Higher Calcium Intake May Decrease Risk of Kidney Stones in Younger Women; Vitamin D Use Reduces Risk of Falls in Elderly

Patient Education: What Every Pregnant Woman Needs to Know About Cesarean Delivery; Vaginal Yeast Infections; Vaginal Discharge; Bacterial Vaginosis

Geriatric Dentistry

The New Mexico Geriatric Education Center for the past three years has held a Geriatric Dentistry Workshop for Dentists, Dental Assistants, and Hygienists with a track for Non-Dental participants. The IHS Clinical Support Center has provided the CDEs for this event, and we want to thank them.

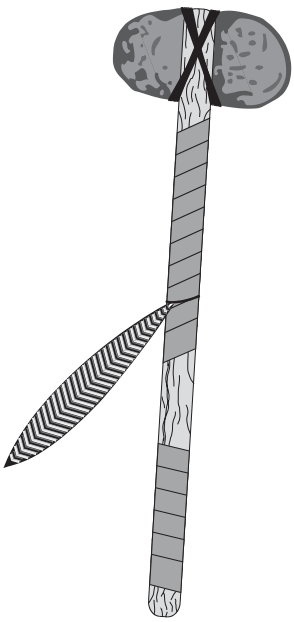
The workshop for dentists has focused on teaching a process for denture fabrication that involves less time and less expense for the dental clinic and fewer visits for the elder. The workshop has been enthusiastically attended by dentists who left with new knowledge and a desire to pursue the denture fabrication process. The non-dental participants learned about the importance of oral health and its effect on the body, and how disease and medications affect oral health for elders. A bonus was a visit to a skilled nursing facility caring for those with dementia. Both dentists and non-dental participants learned how to perform an oral health assessment on elders with challenging behaviors due to their dementia. Oral health assessment is a skill that all health care providers should know in order to provide the most complete health care for elders.

The NMGEC was awarded a grant to improve on the workshop and provide a more intensive hands-on involvement in the denture fabrication process. Eleven dentists arrived at Fort Defiance PHS Hospital in Arizona recently, ready to make dentures. Over the four-day workshop, the dentists, with the assistance of the skilled dental assistants at the Fort Defiance Dental Clinic, prepared dentures for 39 elders whose new smile told it all. For those attending the workshop, this gave them an opportunity to go back to their service units and share the process with the colleagues.

A videotape explaining the process was produced from the grant and will be available by the end of July 2004. If you would like to learn more about the process and interest those in your clinic setting, please contact the NMGEC for your complimentary copy by calling (505) 272-4934.

For one day of the workshop, health care providers were invited in from surrounding areas and Fort Defiance SU to attend a geriatric seminar on health care issues for elders. Over 75 providers attended to learn more about Geriatric Principles, Polypharmacy for Elders, Cultural Issues, Oral Health and Systemic Disease, and an Oral Health Assessment demonstration.

We urge health care providers to learn how to conduct an oral health assessment and its importance to an elder's overall health from the dentists and dental assistants at your facility. If you would like more information or training in the process, please contact the NMGEC at (505) 272-4934 or e-mail Darlene Franklin, Associate Director, at *dfranklin@salud.unm.edu*.

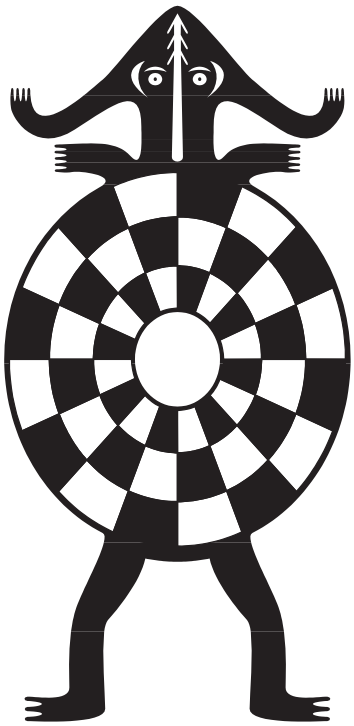


NIH Funding Community Networks to Reduce Cancer Health Disparities

The National Cancer Institute, through its Center to Reduce Cancer Health Disparities (CRCHD), invites cooperative agreement grant applications (U01) for Community Networks to Reduce Cancer Health Disparities Through Education, Research, and Training (Community Networks Program, CNP). The purpose of the CNP is to reduce cancer health disparities by conducting community-based participatory education, training, and research among racial/ethnic minorities (e.g., African Americans, Hispanics, Asians, Pacific Islanders, and Native Americans/Alaska Natives) and underserved populations (e.g., Appalachian, rural, low socioeconomic status, and other underserved populations). The overall goals of this program are to significantly improve access to and utilization of beneficial cancer interventions in communities with cancer health disparities, thereby reducing these disparities.

The CNP will be implemented in three phases. The goal of Phase I is to develop and increase capacity building to support community-based participatory education, research, and training to reduce cancer health disparities. The goal of Phase II is to develop community-based participatory research and training programs to reduce cancer health disparities. The goal of Phase III is to establish credibility and sustainability of the CNP.

Applications are due 7/13/04. The link to the full announcement is at *http://grants.nih.gov/grants/guide/rfa-files/RFA-CA-05-012.html*. For other resources on CBPR, visit *http://depts.washington.edu/ccph/commbas.html*.



Call for Proposals: 2005 Catch Planning Funds Grants

The American Academy of Pediatrics (AAP) is offering you an opportunity to put your ideas into action by taking advantage of the funding available through the Community Access to Child Health (CATCH) Program. Grants of up to $10,000 are awarded on a competitive basis to pediatricians who want to plan innovative community-based child health initiatives that will ensure that all children, especially underserved children, have medical homes and access to health care services. A pediatrician must lead the project and be involved in proposal development and project activities. Resident CATCH grants of up to $3,000 also are offered during this cycle.

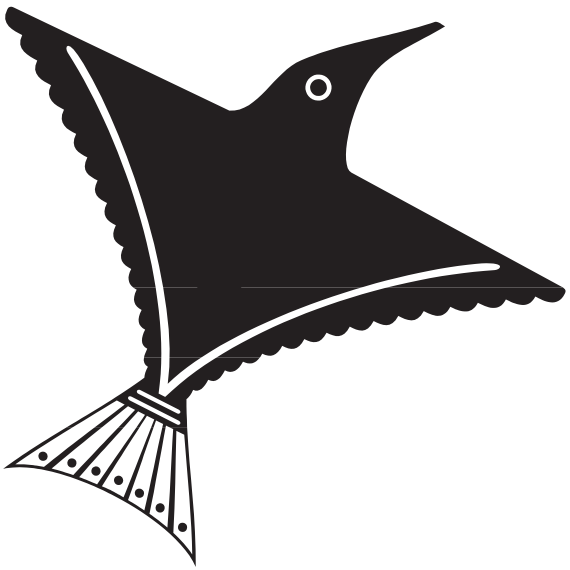
Planning project activities may include needs assessments and community asset mapping, feasibility studies, community meetings/forums, focus groups, planning meetings, and development of grant proposals for future project implementation after the planning phase is complete. Priority will be given to projects serving communities with the greatest health disparities.

Apply online at *http://www.aap.org/catch/planninggrants.htm*; application deadline is July 30, 2004. For more information and technical assistance, write to *catch@aap.org*, or call (800) 433-9016, ext 7632.

Apply early and take advantage of the technical assistance available to you from your Chapter CATCH Facilitator at *http://www.aap.org/catch/RosterChapterFac.pdf* or Resident CATCH Facilitator at *http://www.aap.org/catch/RosterResFac.pdf*, as well as CATCH staff. The deadline for requesting technical assistance for the 2005 CATCH Planning Funds application is July 12, 2004.

You may also want to save the date for the Community Access to Child Health (CATCH) and Medical Home National Conference, July 15 - 17, 2004, in Chicago, Illinois; visit *www.aap.org/catch/nationalconf.html*.

One pediatrician can make a difference!



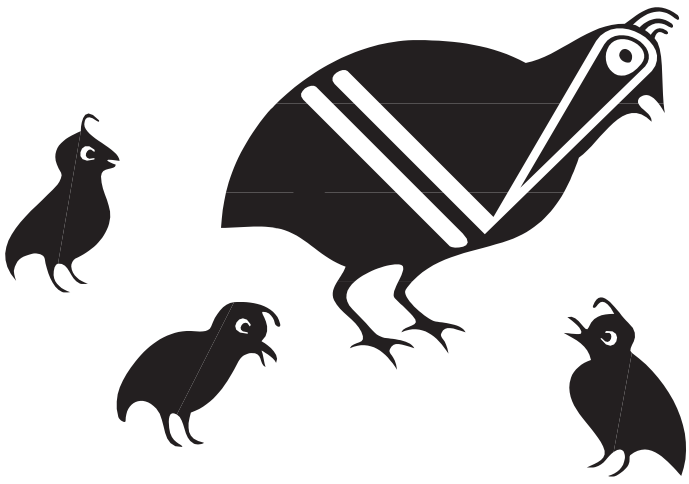
SIDS Risk Reduction Resource Kits Distributed

` On May 15, 2004, SIDS Risk Reduction Resource Kits were mailed out. Mail Groups identified in the IHS Headquarters mailing lists have been targeted to achieve a broad reach, and they include tribal leaders, Area Directors, service unit directors, tribal health boards, tribal health directors, and Indian organizations. Separate bulk mailings will go to leads for emergency medical services, community health representatives, public health nursing, maternal and child health coordinators, tribal day care programs, Early Head Start programs, tribal WIC programs, elder programs, and community health aides and community health providers in Alaska.

The Kit includes a letter from Dr. Grim, a 28 page training manual, and two VHS videos. "Sudden Infant Death Syndrome Awareness Project — A video to help reduce the risk of sudden infant death syndrome" is a seven minute video created through a partnership between the CJ Foundation for SIDS and the Great Lakes Inter-Tribal Council, Inc. The second video is seventeen minutes in length; it was created by a partnership between CJ and the Aberdeen Area Tribal Chairmen's Health Board.

Two accompanying CD-ROMs contain the videos, the 28 page training manual in PDF downloadable format, and numerous posters, brochures, and patient education materials, also downloadable. The training manual was created in partnership between the CJ Foundation and Dr. Larry Burd, Professor in the Department of Pediatrics, University of North Dakota School of Medicine. Two modules for education include one for the community and one for professionals. Included are for pre- and posttests, tools for assessment of services in American Indian communities, discussion of "who can do this training," basic facts on infant mortality and SIDS, and the approaches in conducting community education in American Indian communities. Additional power point slides are available in the kit to facilitate teaching in the community, clinic, or other settings.

For further information, contact Judith Thierry, DO, IHS Maternal Child Health Coordinator, at *jthierry@hqe.ihs.gov*; telephone (301) 443-5070.



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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 *(www.csc.ihs.gov).*

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.*

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