Physicians' Newsletter

Leeds, Grenville & Lanark District
HEALTH UNIT

From the Medical Officer of Health

November—February 2002

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Season's Greetings

On behalf of the staff of the Leeds, Grenville and Lanark District Health Unit, and the members of the Board of Health I would like to wish you one and all a wonderful holiday season and good health throughout New Year.

Sincerely,
Dr. Charles Gardner, Medical Officer of Health

Tobacco Bylaw Advocacy Update

Submitted by Dr. Charles Gardner, Medical Officer of Health

The Health Unit is continuing to work with the communities throughout Leeds, Grenville and Lanark for the development of bylaws prohibiting smoking in all indoor public places and workplaces. In September we presented at a public consultation forum for the municipalities of Perth, Bathurst/Burgess/ Sherbrook, and Drummond/North Elmsley. Presently we are working with a public committee whose mandate is to develop recommendations for a tobacco bylaw to the municipal councils of Brockville and Elizabethtown/Kitley.

It is very important that physicians make their support for strong tobacco bylaws known publicly to municipal councils, to the media, and to tobacco bylaw review committees such as the one presently working for Brockville and Elizabethtown/Kitley. There has been a great deal of support for this from our community partners, including hospital boards, community health centers, member agencies of the Tri-Health Team (the heart health coalition for the tri-county), and from the medical societies and medical advisory committees of our district.

I urge all health care workers to actively support the development of tobacco bylaws to protect citizens and workers from environmental tobacco smoke in public and workplaces. Your support has been and will continue to be essential to the successful implementation of smoke free bylaws.

Please visit our website for more information at www.healthunit.org, or contact me or Yves Decoste, the Health Unit Tobacco Coordinator at 345-5685, or 1-800-660-5853.

*************************ATTENTION*************************

The Health Unit is asking for your help in Tuberculosis Surveillance.

As newcomers to the tri-county, immigrants who require surveillance for latent tuberculosis often have difficulty accessing primary health care. BY LAW, they must be monitored on a regular basis by a family physician. We are seeking physicians who would be willing to provide this service. If you are interested in assisting the Health Unit, please contact me at 613-345-5685 or 1-800-660-5853. Thank you.

Dr Charles Gardner

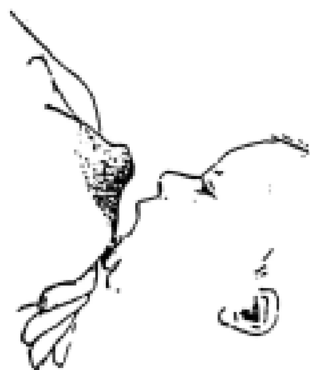
POSITION, POSITION, POSITION and Breastfeeding

Submitted by Lois Byington, Public Health Nurse

As in real estate, where the buzz-word is location, location, location, in breastfeeding, the focus is position, position, position.

- Mother has sore nipples? - check position and latch.
- Mother complaining of pain during feeding? - check position and latch.
- Baby not reaching expected weight gain? - check position and latch.
- Baby having trouble latching on? - check position and latch.
- Baby pulls off during feed? - check position and latch.

We have included a patient information sheet which shows mom a latch-on from her perspective, as well as some tips on how to attain it. Contact the Health Unit (Health Action Line 1-800-660-5853) for copies of the hand out if you would like to use them in your practice.



Baby's nose is near your left nipple. You support him with your right arm, your right hand cradling his neck, so that his front is held snugly against your torso, probably with his lower body wrapped around your waist and held by your elbow. You may be using pillows to support your arm, but it is your arm, not a pillow, that supports and hugs the baby against you. Hold your left breast with your left hand. Your thumb points toward the ceiling on the outer (left) side of your breast, your fingers point toward the ceiling on the inner (right) side of your breast. This shapes your breast in a U, not a C - it is a sideways "sandwich" for your sideways baby.
If you're small-breasted, your hand is on your rib cage more than on your breast, to make sure your fingers stay well out of his way. Baby's lower lip touches your breast, farther away from your nipple than it will end up. It's as if the baby's lower lip is about to climb a mountainside, with the nipple at the peak. The nipple is aimed slightly away from the baby.

When baby gapes wide, you s-t-r-o-k-e his lower lip toward his chin, using the inner part of your breast to pry his mouth open a bit further. This also buys a little extra time and helps ensure that his lower lip is folded back toward his chin. At the end of this motion, his upper lip will go "over the mountain top", and you will snug his shoulders extra close.
You need to be careful that you don't start this motion with his lower lip close to your nipple, or he will over shoot the mountaintop and end up with his upper lip well past your nipple, his lower lip right at the base of the nipple, and his chin tucked so that he can hang on. He should end with his lower lip still far from your nipple and his upper lip just past it.

Here, the baby has been snugged close at the end of the latch. You can't see his mouth because his cheek is against your breast. If you could see it (don't peek), you'd see that the angle at the corner of his mouth is about 140 degrees - much more than the 90 degrees typical of a "cliff hanging" baby who isn't on the breast far enough.
The baby's nose is probably not touching your breast. This picture shows the baby looking straight into the breast; more likely, he'd have his chin slightly lifted.
Notice that there's more areola (ah-REE-oh-lah),or dark skin around the nipple, showing beyond his upper lip than beyond his (invisible) lower lip. He's off-center, so that his working jaw is stroking your breast, not chewing on your nipple.
Don't relax your left hand until after he starts the long, slow (1 per second) jaw motions of active nursing.

Immunization Records: Dear Doctors – We need your help!

Submitted by Margaret Hendriks, Public Health Nurse

The Immunization Program would like to thank all physicians in offices and community health centers who regularly share their immunization records with the health unit. We need this information to update our records, as required by the Ministry of Health and Long-Term Care, and to ensure that all children have the required immunization.

Many parents do not realize that it is their responsibility to inform the health unit regarding their child's immunization. When records are not up to date, we send letters to parents to get this information. The letters include warnings of suspension from school unless the necessary immunization is given or proof of immunization is provided. In many cases the immunization requested is up-to-date but the information has not been provided These letters often generate unnecessary visits or calls to your office, as well as distress and anxiety in the families who receive them. In order to reduce this we ask that you do the following:

Three things we ask of you to help the system run more efficiently:

Poster – A colourful poster for your office can be obtained when you order your vaccine by calling the Vaccine Line at 1-800-660-5853 or 613-345-5685 Ext 2267. Please put the poster in a place where parents can see it and will be reminded of their responsibility to provide this information to the Health Unit.

Notice of Immunization Given – Use the immunization reporting sheets (provided with the poster) to send us the information. This could be done by the parents or by your office by faxing 1-613-345-7038 or by mailing:

The Leeds, Grenville & Lanark District Health Unit
Department of Clinical Services
458 Laurier Blvd.
Brockville, Ontario K6V 7A3

Immunization Schedule – A copy of the immunization schedule is also available for your office. Parents may have the opportunity to read it while they are in your waiting room. This may remind them to review the child's, and their own, immunization. Booster shots for tetanus are needed every 10 years, and many adults forget that they need this too. Working together, with parents, we can ensure that the families in our community are immunized.

Tattooing and Body Piercing

From the Immunization Action Coalition's (IAC) Website - Link through the Physicians' / Health Professionals' page on the Health Unit's web-site. www.healthunit.org

Because tattooing and body piercing have become popular even in mainstream American culture, and because these procedures can be associated with increased risk for blood-borne infectious diseases such as hepatitis B and hepatitis C, the Immunization Action Coalition (IAC) has created a web page containing links to relevant articles from medical journals and publications from national sources such as the Centers for Disease Control and Prevention (CDC).

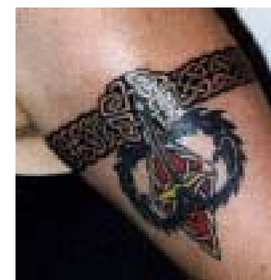


Photo courtesy of socrates.berkeley.edu

Theoretically, tattooing and body piercing carry the risk of transmitting blood-borne infections; however, in practice it has been difficult to isolate the risk associated with tattooing and body piercing from other risk factors. We hope this page will help you advise patients who are considering one or both of these forms of body art.

To visit IAC's new Tattooing and Body Piercing Information web page, go to:
http://www.immunize.org/tattoos/index.htm

"Preconception Health: Folic Acid for the Primary Prevention of Neural Tube Defects" by Health Canada 2002.

Prepared by The Folic Acid Alliance of Ontario.
Adapted by Barbara Guthrie, Public Health Nurse and Julie Lenk, Public Health Dietitian.

Background

Neural Tube Defects (NTDs) are congenital anomalies that place the families of infants with these conditions under a considerable burden of care and carry significant monetary costs for society. The national birth prevalence has been decreasing: from 11.6 per 10,000 total births (live and stillbirths) in 1989 to 7.5 per 10,000 in 1997 (260 births per year). Most NTDs are multifactorial in origin: a combined effect of genetic and environmental factors, resulting in the improper development and closure of the neural tube during the third and fourth weeks of pregnancy. Ninety to ninety-five percent of NTDs occur in families where there is no family history of NTDs.

Can neural tube defects be prevented?

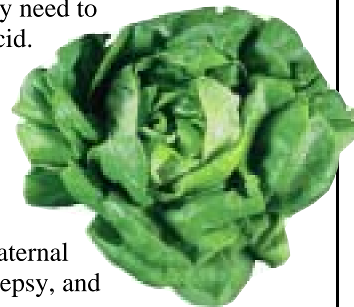
There is clear evidence that periconceptional use of supplements containing folic acid substantially reduces the risk of occurrence and recurrence of this condition, and possibly of other congenital anomalies. Studies have shown that at least half the number of cases of NTDs can be prevented if women consume sufficient amounts of folic acid before conception and during early pregnancy. Although the specific effect of folic acid on the developing fetus is not clear, we do know that this micronutrient is necessary for the synthesis of nucleic acids and amino acids, and for cell division.

What to advise

Daily folic acid supplementation should be started at least 2 to 3 months before conception and continued throughout the first trimester of pregnancy. Since many pregnancies are unplanned, women who *could* become pregnant should also take this daily supplement. The supplements are recommended in addition to eating foods high in folate and foods fortified with folic acid. The following points need to be communicated when recommending a supplement:

- Choose a multivitamin-multimineral supplement that contains 0.4 mg folic acid in a daily dose.
- The use of products labelled "For therapeutic use only" is unnecessary.
- Avoid supplements that contain herbs and other "non medicinal ingredients".
- Try to select a product containing vitamin A as beta-carotene rather than retinol (high doses of retinol have been found to cause several types of birth defects).
- Women should not take more than one daily dose, as indicated on the product label.
- Folate–rich foods include: asparagus, broccoli, brussels sprouts, spinach, romaine lettuce, orange juice, beans, lentils, peas, peanut butter, corn, avocado.
- Folic Acid fortified foods include: white flour, enriched pasta and cornmeal, breakfast cereals, fruit-flavoured drinks, plant beverages such as soy-milk, pre-cooked rice.

Does this advice apply to all women?



Women in high-risk groups may need to take a higher amount of folic acid. Those with close relatives who have an NTD are at greater risk, as are women with a previous child with this condition (3% to 5% risk for another affected pregnancy). Other risk factors are poorly controlled maternal diabetes mellitus, maternal epilepsy, and obesity.

Research has shown that among women with a previous NTD-affected pregnancy, 4.0 mg per day of folic acid (by prescription) taken in the periconceptional period reduces the risk of recurrence by 72%. For women with diabetes mellitus, the benefits of higher doses of folic acid (i.e. > 0.4 mg) are unknown; optimal glycemic control is recommended. There is evidence that women with epilepsy may benefit from a dose of 4.0 mg folic acid daily in the periconceptional period, and if they are taking carbamezapine or valproic acid as anticonvulsant medication (both considered to be related to a higher risk of NTDs). These drugs might be replaced with others. Although low maternal vitamin B12 status is a risk factor for NTDs, this cannot be remedied with folic acid.

How safe is folic acid?

There are few safety concerns, however, folic acid may adversely affect untreated vitamin B12 deficiency. For this reason, physicians need to be on the alert for undiagnosed B12 deficiency arising from particular diets, pernicious anemia, celiac sprue and inflammatory bowel disorder. All women given high doses of folic acid (i.e. > 1.0 mg daily) need to be evaluated for possible vitamin B12 deficiency.

Sources:
Folic Acid It's never Too Early. Folic Acid Awareness Community Action Guide 2002. Folic Acid Alliance of Ontario.
Members of the Folic Alliance of Ontario include: The Easter Seal Society of Ontario; The Fetal Centre at The Hospital for Sick Children; The Spina Bifida and Hydrocephalus Association of Ontario; Best Start- Ontario's Maternal, Newborn and Early Child Development Resource Centre; The Ontario Society of Nutrition Professionals in Public Health.
Nutrition for a Healthy Pregnancy: National Guidelines for the Childbearing Years. Health Canada. 1999

Infant Hearing Program – IHP comes to Leeds, Grenville and Lanark

Submitted by Marsha Houlahan, Speech and Language Coordinator.
and Erin McLean, Public Health Nurse

The Government of Ontario has initiated a province wide program that will ensure that infants born deaf, hard of hearing, or at risk of developing hearing loss in early childhood will be identified and have access to services and supports as early as possible. The Southeastern Infant Hearing Program, sponsored by the Kingston-Frontenac-Lennox & Addington (KFLA) District Health Unit will be responsible for coordinating the implementation of the IHP in Leeds, Grenville and Lanark.

The IHP Model involves several stages. Each stage of hearing screening involves more advanced screening equipment and techniques. During hearing screening, infants will hear soft tones, and IHP Screeners, with the use of automated technology will record the hearing sensitivity of the Middle, Inner Ear and Brainstem responses.

In Stage I, hospitals with a postpartum unit will offer hearing screening for all newborns. Infants will receive either a 'pass' or refer' result from this screening. Infants receiving a "refer" result will be scheduled for Stage II screening at a community clinic. In Leeds, Grenville and Lanark, community clinics will be provided in both Smiths Falls and Brockville, and will be staffed by public health nurses. Once again, infants may receive either a 'pass' or 'refer' result. After a 'refer' result at the community clinic, the infant will be referred for a full assessment with an audiologist. Families living in Leeds, Grenville and Lanark will be able to see an audiologist from the Hotel Dieu Hospital, Kingston in the Smiths Falls offices of the Language Express, next to the Health Unit.

Certain infants may be designated 'high risk' for developing hearing loss because of family history, physical anomalies, infections or other conditions present at birth. Babies spending time in a Neonatal ICU represent half of the children at risk. They will be screened before leaving the NICU, and those with a 'refer' result will be referred directly to the audiologist for a complete assessment.

Any infant designated 'high risk', but receiving a 'pass' result, will be offered a follow-up hearing screening by 12 months of age to ensure that hearing difficulties have not developed.

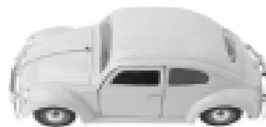
This quick, non-invasive process will be available all across Ontario in the Fall 2002. The Infant Hearing Program has already started in Leeds, Grenville and Lanark in August this year.

For more information, call the Southeastern Regional Infant Hearing Program at 1-800-267-7875.

How knowledgeable are you when it comes to car seats? Take a minute to complete this true or false quiz.

Submitted by Erin McLean, Public Health Nurse

How knowledgeable are you when it comes to car seats?
Take a minute to complete this true or false quiz.



1. Car seats are designed to protect children in a head on collision.
2. Any car seat that has been dropped more than one meter or has been in a collision, should be destroyed.
3. Car seats can be used for up to 10 yrs, unless they have an expiry date.
4. Babies should continue to ride rear facing until they are at least 9 or 10 months old, are at least 20 lbs. and can pull themselves to a standing position.
5. Head huggers are necessary to support an infant's head when in the car seat.
6. It is a good idea to insert padding in the car seat, under the baby, for comfort and warmth.
7. Toddlers are protected more with a car seat that has a fold down armrest.
8. Preschoolers can come out of their car seat when they are too tall for their car seat.
9. Car seat clinics are a good way for a parent to ensure that they are using their car seat correctly.
10. Physicians play an important role in protecting children from injury.

How did you do? Check the answers below!

1. **True**. Car seats are designed to absorb the impact of a head on collision. They are tested by the manufacturer to meet standards set by Transport Canada. Testing also includes crushing and inverting the car seat to see that the child is protected. Car seats are not tested for side or rear impact collisions.
2. **True**. Car seats are like bike helmets, designed to absorb the forces of a single impact, which includes being dropped. In a subsequent impact, the car seat may fail to protect the child, and the child may be ejected from the seat in a collision. Many families will choose to use a second hand seat, not realizing that their child may be at risk. Knowing the history of a second hand seat is vital.
3. **True**. Car seats have a 10-year life span, but in recent years, some manufacturers have decided to become more cautious and are stamping an expiry date into the hard plastic shell of the seat.
4. **True**. Although many babies reach 20 lbs before they are 9 or 10 months old, they do not have the same upper body strength as a baby who can crawl and pull himself up. When rear facing, the baby's entire body is supported by the seat in a collision. When forward facing, the harness of the seat is the only support for the baby. They are more likely to sustain head, neck and spinal cord injuries in a collision.
5. **False**. Head huggers are not recommended to be used with a car seat. If the baby's head has a tendency to lean to one side or another, a rolled up receiving blanket can provide the necessary support. Unless the head hugger came as an original part of the car seat, it will interfere with the harness and the baby may be ejected in a collision.
6. **False**. Car seats are tested with the existing padding. During an impact, this padding is compressed. If you insert any additional padding, you may create an extra 'space' between the baby and the harness, and the baby may be ejected from the car seat.
7. **False.** The fold down armrest that comes on some car seats is a comfort feature, not a safety feature. There is a greater potential for injury if a child is playing with hard plastic toys during a collision when using this type of car seat.
8. **True**. However, they should be in some form of a child restraint. Seat belt systems in vehicles are designed for a minimum weight of 90 lbs. and they will not protect a child in a collision. They may in fact cause more injuries. There are seats available now on the market that go up to 80 – 100 lbs.
9. **True**. There are trained people at a car seat clinic who will assist the parent in learning how to properly use their own car seat. The car seat can also be checked to see if it is under recall and if it is appropriate for their child's height, weight and level of development. In between car seat clinics, parents can get assistance from trained Public Health Nurses, 1-800-660-5853 or 1-613-345-5853, Transport Canada's Info line, 1-800-333-0371 and at some of the fire departments in Leeds, Grenville and Lanark.
10. **True.** Parents rely on their physician to provide them with accurate information that will help to keep their child safe from harm. You do make a difference!

Looking for more information on car seats? Look on our website, www.healthunit.org in the Babies-Children section.

Recruiting Women for Breast Screening The Family Practice Model

Submitted by Susan LaBrie, Public Health Nurse

Evidence from randomized clinical trials indicates that mortality from breast cancer can be reduced by up to 40% through regular mammography screening among women age 50-74. Based on this research, the Ontario Ministry of Health and Long-Term Care began funding the Ontario Breast Screening Program (OBSP) in 1989. Today, there are 90 OBSP sites across the province. For the OBSP to achieve a 40% reduction in mortality from breast cancer, 70% of women over age 50 would need to be screened. Paradoxically, research has shown that while the incidence of breast cancer increases with age, women's participation in breast screening decreases with age.

In an effort to determine factors affecting compliance with screening mammography, research has continued to show that physician prompting or recommendation is *the* most important factor affecting the participation of older women. An Australian study found that the most cost-effective personal recruitment strategy was an invitation letter without a specified appointment time, followed by a second letter to non-attenders. Together these findings support the implementation of the Family Practice Model (FPM) recruitment strategy into physician's practices.

The FPM is a collaborative effort between the OBSP and family physicians to reach all eligible women in the physician's practice, encouraging them to participate in breast screening. Major components of this model include:

- Compiling a list of women eligible for screening (either manually or by computer)
- Sending personalized letters of invitation for breast screening from the physician to their eligible patients.
- Sending reminder letters to those women who have not responded to the first letter.

The OBSP provides physicians with any assistance needed to generate the list of eligible women and also assumes all mailing costs.

Locally, Dr. W.J. Wyatt, a family physician in Brockville, has implemented the FPM into his practice for the past 2 years. Marion Taylor, a Registered Nurse who works with Dr. Wyatt, reports on how the FPM has worked for them; "We find that most patients who receive a letter inviting them to use the OBSP are very receptive. The reporting process is very clear and complete; the physician is provided with a copy of the report with details of the examination and mammogram. The patient is also sent a written report with results and appropriate follow-up".

Other benefits of the FPM include:

- Reaching women in the physician's practice that are not seen regularly
- Improves routine participation in screening and decreases "opportunistic" screening
- Provides the physician with feedback on the screening compliance of their patients
- Encourages patients to see their physician regularly about all health issues

For more information about the FPM and how it can work in your practice, please contact Bonnie Schnittker at (613) 283-2740 or 1-800-267-7918 or send an email to bonnie.schnittker@healthunit.org.

Sources:

Bass, B., Pross, D., Bell, P. (1994). Recruitment for breast screening in a rural practice: Trial of a physician's letter of invitation. Canadian Family Physician, 40, 1730-1739.

McAuley, R. G., Rand, C., Levine, M. (1997). Recruiting women for breast screening: Family Physician Model Strategy. Canadian Family Physician, 43, 883-888.

Beaulieu, M. D., Beland, F., Roy, D., Falardeau, M., Hebert, G. (1996). Factors determining compliance with screening mammography. Canadian Medical Association Journal, 154(9), 1335-1343.

Web: Physicians' / Healthcare Professionals Resources

http://www.healthunit.org/physicians/publications.htm

Physicians' / Healthcare Professionals Resources
Leeds, Grenville and Lanark District Health Unit

Search Directory
- Medical Libraries

Topics
- Adult Vaccination Recommendations
- Anthrax
- Childhood Vaccination Recommendations
- Emergency Contraception
- Guidelines
- Infection control practices
- Needle-stick injuries management
- Publications/Reports/Articles
- Reportable Diseases
- Sexually Transmitted Disease Management
- Travel Medicine

Contribute
- Be an editor
- Suggest a site

Publications/Reports/Articles/Links

- The Canadian Task Force on Preventive Health Care has just recently produced an "EVIDENCE BASED RESOURCE SHEET" for health professionals. You may also want to include some of the links from this resource on to your own website.
- Contingency Plan for Pandemic Influenza
- West Nile Virus: A Primer for the Clinician 297 kb from the Annals of Internal Medicine www.annals.org
- Infectious Mononucleosis Outbreak Investigation (Perth/Smiths Falls) 16.2 kb
- Leeds, Grenville and Lanark District Health Unit Publications

Journals and Information links

- Annals of Family Medicine
- American Family Physician
- Archives of Family Medicine
- Australian Family Physician
- BMC Family Practice (Online)
- British Journal of General Practice
- British Medical Journal
- Canada Communicable Disease Report
- Canadian Family Physician
- Canadian Journal of Rural Medicine
- CMAJ: Canadian Medical Association Journal
- HIV - by JAMA
- Chronic Diseases in Canada
- Family Medicine
- Family Practice
- Family Practice Management
- Handheld Resources for Family Physicians University of Toronto
- Hong Kong Practitioner
- JAMA: Journal of the American Medical Association
- Journal of Family Practice
- Journal of the American Board of Family Practice
- The Lancet
- Le Médecin du Québec
- Karolinska Institutet is one of Europe's largest medical universities. List of Databases in Medicine and Related Areas
- Morbidity and Mortality Weekly Report MMWR
- New England Journal of Medicine
- New Zealand Family Physician
- Physician Education Services -The Doctors' Page Calgary Health Region
- Scandinavian Journal of Primary Health Care
- South African Family Practice
- Medical Education Journals and Databases
- Links to PubMed/Medline Journals
- Free Medical Journals
- Medical Electronic Journals and Newsletters at Medical Matrix

Dr. Charles Gardner

As the Medical Officer of Health for Leeds, Grenville and Lanark I feel that one of the essential roles of the Health Unit is to make available to physicians and other health care providers timely, accurate and helpful information on issues related to public health. The internet has increasingly become a means of providing members of the public, as well has health care providers, with information in general.
If you wish to contribute with content or if you have any suggestions for our resource site please email me at moh@healthunit.org