



## Report on the Year 2004 by the Medical Officer of Health

*Adapted from a speech at the Board of Health Annual General Meeting, January 20th, 2005  
by Dr. Charles Gardner, MD,CCFP, MHSc, FRCPC, Medical Officer of Health*

This is our time to reflect on the year that has passed, on the challenges, successes and lessons learned. I would like to start by welcoming everyone, and by thanking you for being with us for our Annual General Meeting.

In many ways, the year 2004 marked the beginning of renewal in public health in Ontario. The SARS outbreak of 2003 prompted a profound scrutiny of public health and a tremendous increase in our public visibility. In June 2004, the provincial government released "Operation Health Protection", a three-year plan to renew public health, based on the recommendations of the reports of the Expert Panel on SARS (the Walker report) and the Campbell Commission. Their recommendations include:

- a review of the capacity of public health units and the Public Health Branch,
- a revision of the Mandatory Programs
- increasing the proportion of funding to public health units from the province to 75% by 2007
- increasing the authority of the Chief Medical Officer of Health (including having her or him report directly to the legislative assembly)
- the creation of a provincial Health Protection and Promotion Agency, and a Provincial Infectious Disease Advisory Committee (PIDAC)
- the creation of Regional Infection Control Networks throughout the province
- increasing infection control personnel in health care facilities.

By year-end, the province commenced its plan with the creation of PIDAC, increasing the powers of the Chief MOH within the *Health Protection and Promotion Act*, and increasing its funding to the health units to 55% in 2005. In 2004, the federal government also commenced the creation of the Public Health Agency of Canada and appointed a Chief Public Health Officer. Recently, the province announced the commencement of the public health capacity review. These are the kinds of sweeping changes that only occur once in a lifetime.

It has been very exciting to be a part of this change. I had the privilege of writing, on behalf of the Council of Ontario Medical Officers of Health, a submission for the Expert Panel on SARS on the topic: Regional Infection Control Networks, and our health unit has been active in developing such networks based out of Kingston and Ottawa. Within our district, we built on our experience with pandemic influenza planning and SARS, and worked with health care facilities to strengthen infection control measures. I am honoured to be a member of the Surveillance Subcommittee of the newly created PIDAC.

Our mission as the health unit for Leeds Grenville and Lanark is to "work with the community to protect, promote and enhance health through the identification of issues and the development of quality preventative health programs and services". The focus of the past year included a number of child health issues. To commence the year, Fraser Mustard, the guest speaker at our last AGM, challenged us to address the wellbeing of the very young in our society as the wisest of invest-

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ments. Our efforts to do so have included our Early Child Development programs, such as the Fetal Alcohol Spectrum Disorder prevention awareness activities, the initiation of a support program for mothers with Postpartum Depression, and our ongoing work within the community coalition Every Kid in Our Community (building assets for children).

The annual report of the Chief Medical Officer of Health called for action to address childhood obesity. Earlier in the year, the Board of Health supported the report of the public health dietitians of Ontario on this topic entitled [A Call to Action](#). As a health unit, our actions on this front in the past year included working with the Upper Canada School Board and other partners to include our high school cafeterias in the Eat Smart! Program, ensuring food safety and healthy food choices for our students. We continue working with our school boards on health promoting policies in schools.

Starting in September, the province commenced the rollout of three new vaccines, coming into full fruition with the beginning of this year. These vaccines serve to protect our children from meningococcal C meningitis, pneumococcal disease, and varicella (chickenpox). As a health unit, we continue to work through this transition to supply these vaccines to the physicians of our district and to vaccinate children in our clinics and schools. In the years to come, these new vaccines will prevent many serious cases of these diseases.

Late in the year, the province tabled the *Smoke-Free Ontario Act*. This legislation will serve to protect our children and ourselves from tobacco smoke by prohibiting smoking in all indoor public places and workplaces. Our Board of Health supported this concept with its approval of our Tobacco Strategic Plan in 2001.

The province also announced enhanced tobacco prevention education and enforcement activities for health units. With our Tobacco Strategic Plan, and our past tobacco bylaw campaigns, we are in a better position to respond to these program requirements.

In August, raccoon rabies was discovered to be present in our district, despite a one-year hiatus in positive animal tests. Our response included the education of children in the schools in the affected areas.

Our Health Unit website is an essential communication tool that is being constantly modified. Since October, it includes a calendar of the program activities that we conduct in the schools of the Upper Canada District School Board, posted for the benefit of students, parents, teachers and health unit staff. In the fall, we also posted our newly updated Community Health Status Report to provide our communities with information on our health needs.

The Haines Report made many recommendations to improve food safety in the province. The Board of Health supported this report, and in keeping with this, we initiated an enhancement to our Food Handler Training Course with the inclusion of a Home Study program. The year also saw ongoing progress on drinking water safety legislative requirements. As a health unit, we responded to water safety concerns, including the issuing of a boilwater advisory in Gananoque in September.

As a health unit we are on a journey to understand and implement the principles of continuous quality improvement. We have been guided by the Strategic Plan of the Board of Health since 2001. This Plan has included, as a priority, that we determine and pursue sufficient resources to meet our mandate, always with the requirement for the efficient use of these resources. We had the unique challenge of developing budgets for two years, specifically for 2004 and 2005. The 2004 budget required us to gap a number of positions with a resultant impact on program delivery. With the arrival of Operation Health Protection, and the increased provincial funding to 55%, the Board approved a budget for 2005 that will allow us to fill these gapped positions and to fill others later in the year in keeping with the surplus from 2004. Through monthly reporting, the Board has been kept informed of gaps in our compliance with the requirements of the Mandatory Health Programs and Services Guidelines.

Our Strategic Plan has served us well as a roadmap. The future of public health is dynamic, very hopeful, but still profoundly unpredictable. Our relationship with the Local Health Integration Networks is an example of the unknown. In September, at the commencement of the review and revision of our Strategic Plan, we had the pleasure and the privilege to hear Andy Papadopoulos, former Executive Director of the Association of Local Public Health Agencies, speak to us.

At that time, Andy expressed the view that this is the best of times to do strategic planning. With faith in those words, we have continued on with this task, which we intend to complete in the present year.

I wish to take this moment to commend the staff of the Health Unit for your excellent, intelligent, imaginative and often inspiring service to the well being of our communities. To the Board, I thank you for your guidance and for taking on the challenging and very serious responsibility of public health. And to our partners and clients, I say that we look forward to working with you to protect and promote health in the year to come.

# Modest Weight Loss has Health Benefits

Submitted by Krystal Taylor, BSc, Dietetic Intern and Heather Deegan, MSc, RD, Registered Dietitian/Public Health Nutritionist

A recommendation to lose weight can be perceived as a daunting task for patients who are overweight. In fact, a goal to achieve “ideal” body weight may not be the best goal for all patients. Studies show that modest weight loss, in people who are overweight, can improve health. Achieving and maintaining modest weight loss has long-term health benefits and is recommended to reduce the risk factors associated with overweight.

## More is not better

Modest weight loss, defined as **5% to 10% of baseline weight**, has beneficial health effects even without reaching ideal body weight (1-3). The American Expert Panel on the Identification, Evaluation, and Treatment of Overweight in Adults has established guidelines for weight loss of 10% baseline weight as the initial goal for treatment of overweight. This weight reduction can be achieved within six months at a reasonable rate of one to two pounds per week by modifying eating and physical activity habits.

## Health benefits of modest weight loss

Overweight substantially increases the risk of morbidity from numerous obesity-related chronic diseases, such as hypertension, cardiovascular disease, and type 2 diabetes. Modest weight loss produced by lifestyle modification has been shown to positively affect blood pressure, serum and plasma lipid levels, and blood glucose levels.

Hypertension is one of the most common obesity-related complications. Several studies have confirmed that modest weight loss has a blood pressure lowering-effect in hypertensive and non-hypertensive patients (2). The risk of cardiovascular disease morbidity and mortality is positively related to the concentration of low-density lipoprotein cholesterol (LDL-C) and triglycerides and inversely related to high-density lipoprotein cholesterol (HDL-C). Modest weight reduction, when maintained, reduces total cholesterol, LDL-C, and triglycerides. HDL-C decreases during active weight loss but increases when a stabilized reduced weight is achieved (2-3). Complications associated with type 2 diabetes result from poor glycemic control and insulin resistance. Modest weight loss has been shown to improve glycemic control and insulin sensitivity (2).

Overall, modest weight loss can help to manage the risk factors associated with chronic diseases, as well as reduce the risk of long-term complications for patients with existing conditions. More weight loss, beyond 5% to 10% of baseline weight, is not always better. After the initial six months of weight loss, the rate of weight loss and magnitude of the benefits often plateau. Once modest weight loss is achieved, prevention of weight gain should be the focus (1).

## Set realistic goals to improve health

It is not necessary for patients to reinvent their body size. Unrealistic goals for weight loss are often unachievable and may ultimately result in weight gain. Modest weight loss is more attainable and more likely to be maintained over the long term (1). Re-evaluate your patients’ goals for weight loss and help them adopt a healthy lifestyle approach to achieve and maintain a healthy weight. Encourage smaller goals that focus on healthy eating and being active. Some possible goals are: increase the number of daily servings of vegetables; reduce the number of desserts each week; or add 10 minutes of activity to the daily routine. Re-evaluate goals regularly and establish new goals once previous ones are achieved. Maintenance of weight loss is best achieved with sustained behaviour change.

## Value modest weight loss

The majority of overweight patients still do not value modest weight loss. A new definition of successful weight reduction, highlighting the health benefits of modest weight loss, should be adopted and applied when counselling patients. Realistic weight loss that can be maintained is a valuable treatment goal for patients who are overweight or obese. Physicians are influential in helping patients redefine successful weight loss and can assist with the establishment of realistic goals.

### References

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2. Goldstein DJ. Beneficial health effects of modest weight loss. *Int J Obes Relat Metab Disord.* 1992 Jun;16(6):397-415.
3. Case CC et al. Impact of weight loss on the metabolic syndrome. *Diabetes Obes Metab.* 2002 Nov;4(6):407-414.

# Ontario Fecal Occult Blood Test (FOBT) Project

Submitted by Melinda Billett, BScH, BScN, RN, Public Health Nurse, Colorectal Screening Project Coordinator

Since April 2004, the Leeds, Grenville and Lanark District Health Unit worked with Cancer Care Ontario on the Ontario FOBT Project. This project was a pilot study to investigate two approaches to promoting screening for colorectal cancer using the Fecal Occult Blood Test (FOBT). The strategies compared were promotion through primary health care physicians and through public health. The study proposed to include 220,000 patients from the primary care physician group and 220,000 clients from six public health units. The project targeted asymptomatic average-risk men and women ages 50 to 75.

The sensitivity and specificity of the FOBT to detect colorectal cancer has been under debate recently in the media and in academic circles. The Health Unit has heard from the community, both medical and lay persons, regarding the research. A report from CBS News on January 18, 2005 reported that the digital FOBT performed in the doctor's office detected possibly cancerous growths in the colon only five percent of the time<sup>1</sup>. The February 8, 2005 issue of *The Medical Post* reported the same research<sup>2</sup>, which was first published in the *Annals of Internal Medicine* on January 18, 2005. The researchers found that the one-time FOBT done during rectal exam at the doctor's office was inadequate as the sole screening for colorectal cancer. The researchers recommended that if the single digital FOBT was used, that the at-home 6-sample FOBT (2 samples from each of 3 bowel movements) should still be recommended for patients even when the result was negative from the digital sample<sup>3</sup>.

For the Colorectal Screening Project at the Health Unit, it has been recommended that the 6-sample FOBT be utilized every one to two years to screen asymptomatic adults age 50 and older. The 6-sample FOBT has been shown to reduce the mortality rate due to colorectal cancer by at least 16%, as studied through randomized control trials<sup>4</sup>. The FOBT will not detect all colorectal cancers, and it is not a perfect screening test. There are no perfect screening tests. Yet through utilization of this screening test, our population's health can improve. Using an imperfect screening test is better than no screening test at all.

In Leeds, Grenville and Lanark, the Health Unit promoted the screening program through many avenues. Physicians were a major part of the promotion campaign; 4600 patient information packages were distributed to physicians' offices.

Nurse practitioners and occupational health nurses were also involved in promotion. A large media campaign including radio and print ads and displays at banks, flu clinics, libraries and other venues were components of the campaign. Com-

munity education presentations to the target audience were also completed. Over 12,000 patient information packages were distributed throughout the community, and as of the end of January 2005, 504 patients in Leeds, Grenville and Lanark completed the FOBT.

Physicians have an incredible ability to impact patient screening. In a study investigating colorectal screening behaviours in relatives of colorectal patients, physician encouragement was found to have the strongest relationship to screening behaviour<sup>5</sup>. With this in mind, the Health Unit hopes physicians will continue to encourage their patients 50 years of age and older to be screened for colorectal cancer.

The project officially ended February 28, 2005. Data collection continues until May 31, 2005. Patients who have received the signed laboratory requisition or the FOBT kit can still be included in the study if they return their completed kit by May 31<sup>st</sup>. The information collected from this study will help the Ontario Ministry of Health and Long Term Care plan for a provincial screening program for colorectal cancer.

Although the Health Unit will no longer provide patient information packages, adapted patient FOBT pamphlets can be ordered from Cancer Care Ontario by faxing 416-971-6888 (Attn: Lorna Dobi). Project updates, reports, and educational materials will be posted on the Cancer Care Ontario website ([www.cancercare.on.ca](http://www.cancercare.on.ca)).

The Leeds, Grenville and Lanark District Health Unit wishes to thank physicians for their support of the Ontario FOBT Project and colorectal screening. Without the support of physicians, patients in Leeds, Grenville and Lanark would not be able to access this important screening.

## References

- <sup>1</sup> CBS News January 18, 2005. *Common Colorectal Test Often Fails*. Retrieved January 20, 2005 from [www.cbsnews.com](http://www.cbsnews.com)
- <sup>2</sup> Hodges, D. (2005) Cancer screening tool fails the test: Single in-office exam for colorectal CA found to have no validity. *The Medical Post*, 41(6). Retrieved February 18, 2005 from [http://www.medicalpost.com/mpcontent/article.jsp?sessionid=GCMEMDHCNJNA?content=20050207\\_211040\\_5320](http://www.medicalpost.com/mpcontent/article.jsp?sessionid=GCMEMDHCNJNA?content=20050207_211040_5320)
- <sup>3</sup> Collins, J. F., Lieberman, D. A., Durbin, T. E., Weiss, D. G., and the Veterans Affairs Cooperative study #380 Group. (2005) Accuracy of screening for fecal occult blood on a single stool sample obtained by digital rectal examination: A comparison with recommended sampling practice. *Annals of Internal Medicine*, 42(2), 81-85.
- <sup>4</sup> Cancer Care Ontario. *Colorectal Pilot Project*. Retrieved February 1, 2005, from [http://www.cancercare.on.ca/prevention\\_colorectalScreening.htm](http://www.cancercare.on.ca/prevention_colorectalScreening.htm)
- <sup>5</sup> Madlensky, L., Esplen, M. J., Gallinger, S., McLaughlin, J. R., & Goel, V. (2003) Relatives of colorectal cancer patients: Factors associated with screening behaviour. *American Journal of Preventative Medicine*, 25(3), 187-194.

# World TB Day

## March 24, 2005

Submitted by Bonnie Erwin, RN, BScN, Public Health Nurse

World TB Day is an opportunity to focus attention on the massive challenge of defeating the TB epidemic at the global regional, national and community level. Governments have pledged to detect 70% of all infectious TB cases and cure 85% of these cases by the end of 2005. Meeting these “process” targets is essential to achieve the 2015 “Millennium Development Goals” of reducing TB prevalence and deaths by half relative to the year 1990.

### Consider these facts:

1. Every second someone in the world is newly infected with TB.
2. Untreated, each person with TB disease will infect an average of 10-15 people annually.
3. Approximately one quarter of people with TB disease in the developing world will die.
4. The global incidence of TB is increasing at a rate of about half a percent each year, but is rising much faster in sub-Saharan Africa and countries of the former Soviet Union.
5. In Eastern Europe and Africa, TB deaths are increasing after almost forty years of decline.
6. In terms of total cases, the largest TB burden in the world is in south-east Asia.
7. Treatment using directly observed therapy strategy (DOTS) produces cure rates of up to 95% even in the world's poorest nations.
8. Approximately 60% of the world's population has access to DOTS programs.
9. A six-month supply of drugs for DOTS costs about US \$10.
10. The World Bank has ranked the DOTS as “one of the most cost-effective of all health interventions”.

Reference: [www.who.int/mediacentre/factsheets/fs104/en](http://www.who.int/mediacentre/factsheets/fs104/en)

### Consider these issues:

Multi-drug resistant TB is a manufactured problem resulting when infected person with a non-resistant strain do not take or receive appropriate antibiotics. For this reason, DOTS has become the global treatment standard to ensure patient adherence to therapy. Provision of DOTS to populations in need has risen from one in ten to one in three over the last 15 years. There has been progress! However, it remains unavailable to many in the developing and industrialized world alike.



Please mark on your calendar

Wednesday, April 20, 2005

**Dr. Wendy Wobeser** from Queen's University will present a **lecture from 12:30 pm to 1:30 pm** at Brockville General Hospital. This lecture will focus on recent information for the treatment of Latent Tuberculosis and it will also address the issues involved with patients referred from Immigration Canada for TB medical surveillance. “Care Connect” will be available to institutions that have access.

TB and HIV co-infection is a globally explosive combination. Persons with latent tuberculosis infection (LTBI) and HIV have an extremely high risk of developing TB disease as their immune systems become progressively incapable of containing the TB bacterium. In many regions of the developing world, TB has become the most common opportunistic infection among persons with HIV/AIDS.

Smoking is emerging as a potent risk factor for tuberculosis deaths. A study in India led by Dr. Vendhan Gajalakshmi, suggested that smoking causes half the male tuberculosis deaths in India. Not only in Asia and Africa, but also throughout America and Europe, smoking appears to increase the number of people who develop clinical TB themselves and who can then infect others, unless properly treated and cured.

### The Globalization of Diseases - Why TB is Important to Industrialized Countries

In early 2003, Toronto experienced the impact of the devastating infectious disease known as SARS. Shortly before that we were introduced to West Nile virus, which has since become a permanent inhabitant in North America. These experiences have focused our attention on the global realities of 21<sup>st</sup> century – that within a matter of hours, an infectious disease in one corner of the globe can leap across continents and directly affect the lives of people thousands of miles away. This new reality highlights the fact that infectious diseases like TB have both local and global relevance.

For Canada, protecting our nation from global infectious disease threats has traditionally involved screening of high-risk individuals at our national borders. However, in an era of globalization, where tens of millions of individuals annually cross borders that are highly permeable to infectious diseases, this “Ellis Island” model has become an anachronism. A new paradigm could call upon the world's industrialized nations to look beyond their borders and reduce global disparities in the burden of infectious diseases, and in doing so protect their own health and economic interest.

Reference: Centre for Global Health Research

### Key Contacts:

Dr. Kamran Khan, Research Scientist, Inner City Health Research Unit, St. Michael's Hospital, Toronto, Ontario.

Dr. Chris Dye, Surveillance and Monitoring Department, World Health Organization, Geneva, Switzerland.

# Breast Health / Breast Cancer

Submitted by Bonnie Schmittker RN PHN, Public Health Nurse

## Current books of reliable information are now available at all local libraries for patients to use.

The **Leeds Grenville & Lanark Counties Library Project** was made possible by the generous support of the



Rural women from our area attended a forum in Sharbot Lake and identified the need for access to reliable and current information on breast health and breast cancer. This project is modelled after a similar project developed and implemented in the Kingston area. Funding was provided to purchase books that will be placed in each public library in Leeds, Grenville and Lanark counties.

The following books were purchased and are being distributed now:

Dr. Susan Love's Breast Book *General information on breast health – an excellent resource book.*

B.O.O.B.S.: A Bunch of Outrageous Breast Cancer Survivors *tell their stories of Courage, Hope and Healing in dealing with breast cancer. Written with humour, insight, raw emotion and honesty.*

I'm Too Young to Have Breast Cancer *Intimate and detailed anecdotes from 16 real women under the age of 40 who encounter breast cancer.*

Breast Cancer Husband *Helpful information for men on how to cope and be a support for their partner.*

After Breast Cancer: A Common Sense Guide to Life after Treatment *Information on a wide range of practical issues women face after treatment.*

A bookplate is being placed in the cover of each book directing women to further information:

|  |                |
|--|----------------|
| Canadian Cancer Society<br><a href="http://www.cancer.ca">www.cancer.ca</a>                                  | 1 888 939-3333 |
| Ontario Breast Screening Program<br><a href="http://www.cancercare.on.ca">www.cancercare.on.ca</a>           | 1 800 668-9304 |
| Leeds, Grenville & Lanark District Health Unit<br><a href="http://www.healthunit.org">www.healthunit.org</a> | 1 800 660-5853 |

Year 2 of the project allows additional books to be purchased for children and placed in the public elementary schools within Leeds, Grenville and Lanark counties.

### The partners in this project are:

- ◆ Survivors of Breast Cancer
- ◆ Rideau Lakes Public Library
- ◆ Country Roads Community Health Centre
- ◆ Regional Cancer Program for Southeastern Ontario
- ◆ Canadian Cancer Society
- ◆ Leeds, Grenville and Lanark District Health Unit
- ◆ Breast Health Coalition of Leeds, Grenville and Lanark

Take a look for these books the next time you are at your local library.

**Please make your clients aware of these excellent books within their communities. We have enclosed a poster that may assist in making clients aware of these books. Please post it in a public area of your facility.**



**Recognize & respond to preterm labour**

**Signs and Symptoms:**

- bad cramps or stomach pains that don't go away
- bleeding, trickle or gush of fluid from your vagina
- lower back pain/pressure, or a change in lower backache
- a feeling that the baby is pushing down
- contractions, or change in the strength or number of them
- an increase in the amount of vaginal discharge

.....  
Some women may feel that 'something is not right'.

If you have any of these signs  
**GO TO THE HOSPITAL RIGHT AWAY!**

For more information call the HealthAction line at 1-800-660-5853 or 345-5685 or visit [www.healthunit.org](http://www.healthunit.org).

Ontario  
Early Years  
Advertising paid for by Early Years Reproductive Grant from the Ministry of Health and Long Term Care

## Preterm Labour – Signs and Symptoms

*Submitted Lois Dewey, RN, BScN, Public Health Nurse*

Preterm birth accounts for almost 8% of all births in Leeds, Grenville and Lanark. The *Canadian Perinatal Health Report (2003)* cites preterm birth as the single most important cause of perinatal mortality and morbidity in industrialized countries.

The Health Unit is conducting a campaign during late February/early March to raise awareness of the signs and symptoms of preterm labour. This campaign includes the provision of booklets and posters to assist professionals in health teaching as well as a media campaign focused on newspaper submissions and radio spots.

Please watch your mail for a supply of booklets, which can be ordered free of charge from the Health Unit, as well as posters for waiting room display.

## Lymphogranuloma Venereum (LGV) in Ontario

*Submitted by Dr. C. Gardner, MD, CCFP, MHSc, FRCPC, Medical Officer of Health*

We have received notification from the Ministry of Health and Long-Term Care of a resurgence of LGV in Europe and the United States among men who have sex with men associated with concurrent STI including HIV, and who engage in casual sex gatherings. There has been recent confirmation of one case of LGV in Ontario.

Personnel from the Ministry have provided the health units of the province with an information package on the diagnosis and management of LGV and requested that this information be made available to physicians who work with high risk populations. If you wish to receive a copy of this information package please contact Dr. Gardner, Medical Officer of Health, or Jane Fletcher, Director of Clinical Services at 345-5685 or at 1-800-668-5853.