

Nexus



Vol.5, No.1
March 2010

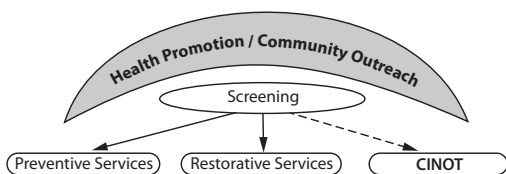
with the Health Care Community

Phase II of Ontario's Poverty Reduction Strategy:

Low Income Dental Program

– Rebecca Kavanagh, MPA, BScN, RN

On October 13th, 2009, the Ministry of Health and Long Term Care announced phase II of Ontario's Poverty Reduction Strategy. Within this phase is the provision of dental services for low income families, starting with children and youth as the first priority. This new strategy builds upon and links with current investments, such as the Children In Need of Treatment (CINOT) program, and ensures that every child from a low income family in LGL will have access to dental services at the onset of need. They will also receive health education to increase oral health awareness and be eligible for preventive services to maintain oral health. This program may reduce the need for invasive and costly emergency oral health services for children and youth over the long-term. The program will be built on a number of components, such as Health Promotion/Community Outreach, Preventive Services, Restorative Services, and the existing CINOT program.



Access to dental insurance is an issue for the population. According to the 2007 Canadian Community Health Survey, 59.4% (95% C.I.: 55.8, 63.1) of respondents from LGL reported having some form of insurance. This rate is significantly lower than Ontario overall at 64.8% (95% C.I.: 64.1, 65.5). This program will help those that meet the financial eligibility criteria of low income (still to be determined by the Ministry) and who are in need¹.

After consulting our dental partners, it was evident that health care providers should play an instrumental role in this new program. Therefore, the plan does include provisions to work closely with providers to include basic dental carries screening in their practice as well as fluoride varnish application to high risk children in some settings. These activities would be supported by dental staff from the Health Unit. Once our LIDP proposal has been approved for implementation by the Ministry, we will be seeking your input into how to reach these goals.

Each Health Unit in Ontario had been asked to submit a business case to the MOHLTC by January 29, 2010 seeking one-time start up funding to help set up the necessary infrastructure to support the program. We are expecting a response to Leeds, Grenville and Lanark District Health Unit's proposal by March 31st, 2010.

Reference

- 1 Leeds, Grenville and Lanark District Health Unit. "The Leeds, Grenville & Lanark District Health Profile." http://www.healthunit.org/profile/Community_Health_Profile.pdf. Accessed January 4, 2010.

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nexus ('nek-sus) noun,
Latin: bond, tie; from
nectere - to bind : a
connection or link

between things, persons, or events
esp. that is or is part of a chain of
causation

Source: Merriam-Webster's
Dictionary of Law, © 1996
Merriam-Webster, Inc.



Tuberculosis Update

– Martina Flanagan BScN, RN, CIC

The Leeds, Grenville and Lanark District Health Unit will be distributing TB resources to each Health Care Provider's office before World TB day. These resources include: the 2009 fourth edition of Tuberculosis Information for Health Care Providers that is published by the Lung Association; a poster titled Mantoux Tuberculin Skin test; a TB skin test ruler and the reporting forms required for positive Mantoux skin test and TB case reports. Positive Mantoux tuberculin skin test results and Tuberculosis must be reported to the Health Unit under the Ontario Health Protection and Promotion Act.



As we continue to develop new tests for Tuberculosis, all health care professionals look forward to the day that we achieve a world free of TB.

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8. Wobeser, Wendy. "The Challenge of Tuberculosis in Decline". TB Anywhere is TB Everywhere, March 28, 2007
9. The Lung Association. Tuberculosis Information for Health Care Providers, Ontario Lung Association, 2009
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12. Long, Richard, Ellis, Edward. Canadian Tuberculosis Standards, published by authority of the Minister of Health 2007, Public Health Agency of Canada, 2007

All TB medication for Pulmonary Tuberculosis and Latent Tuberculosis is provided free of charge from the Health Unit to patients who have a prescription from their health care provider.

Consider these Stats

- ▷ 1,600 new active and retreatment tuberculosis (TB) cases were reported in Canada in 2008 representing the lowest national TB rate ever recorded in Canada⁽¹⁾
- ▷ highest rate of TB (184.4 cases per 100,000) was reported in Nunavut⁽²⁾
- ▷ 62% of TB cases in Canada were attributed to foreign-born individuals⁽³⁾
- ▷ largest number of reported cases (18%) were between 25-34 years of age⁽⁴⁾
- ▷ individuals over 74 years of age had a higher age specific rate for TB⁽⁵⁾
- ▷ most frequently reported diagnostic site for TB was Pulmonary TB (68%)⁽⁶⁾
- ▷ Leeds, Grenville and Lanark had 0 cases of active TB in 2009⁽⁷⁾

Current testing:

Although the Mantoux method of skin testing continues to be the most common and reliable method used for TB screening, the skin test continues also to pose problems because it is user dependent and subject to interobserver variability.⁽⁸⁾ This test results in false positives due to cross reaction with other mycobacteria, including one of the most widely used vaccines worldwide, BCG (Bacille Calmette-Guerin). There are also false negatives due to patients with immunosuppression.⁽⁹⁾

What's new in testing:

Interferon-gamma release assays (IGRA) are registered in Canada as a test for the diagnosis of latent tuberculosis infection (LTBI).⁽¹⁰⁾ The Ministry of Health is presently examining the funding of IGRAs. Several logistical issues need to be resolved before this can happen.⁽¹¹⁾ IGRAs are in-vitro blood tests that are based on interferon-gamma (IFN- γ) release after stimulation by TB specific antigens. Two IGRAs are currently registered for use in Canada - the QuantiFERON-TB Gold[®] assay and the T-SPOT.TB[®] assay. IGRAs have greater specificity for LTBI than the tuberculin skin test (TST) in those who have received BCG. In addition, IGRAs may have higher sensitivity to detect LTBI in immunocompromised people than the TST.⁽¹²⁾

SMART Recovery Available in Tri-County Area

SMART Recovery is a non-profit organization that offers free support groups for people who want to change addictive behaviours including those involving alcohol, drugs and gambling. Through the use of weekly meetings and on-line support groups, SMART Recovery uses evidence based tools and techniques to teach people how to maintain the motivation to abstain, cope with urges, manage and solve problems, and maintain a balanced lifestyle.

Please see the enclosed pamphlet for local contact information or visit www.smartrecovery.org. This is another useful tool in your practice to assist clients ready to deal with their addictions and gain control of their lives.

"SMART Recovery Guide for Professionals and Commissioners." SMART Recovery Ontario, February 2009.

Case Management and Free Treatment of *C. trachomatis*, *N. gonorrhoeae* and *T. pallidum*

– Carolin Kaemmer, RN, BNSc, IBCLC, Public Health Nurse, and Gina Iacobucci, RN, BScN, Public Health Nurse

The control of communicable diseases in the population is one of the primary functions of public health practice. In Ontario, the Health Protection and Promotion Act (HPPA) is the legislation under which diseases are designated as reportable and under whose authority diseases are investigated and intervention undertaken. The HPPA requires the reporting of diagnosed infections of reportable diseases to local medical officers of health, including the sexually transmitted infections (STI's) involving the organisms *C. trachomatis*, *N. gonorrhoeae* and *T. pallidum*.

STI case management consists of appropriate treatment, counselling and eliciting the names of contacts. Management also includes determining how the contacts will be notified of their potential exposure, their need for evaluation and possible treatment. Cases need to be counselled about the nature and significance of their infection, including its implications for their own health, their need for treatment and follow up, and the need to ensure that their sexual contacts are informed of their exposure.

When treating patients for *C. trachomatis*, *N. gonorrhoeae* and *T. pallidum*, please advise them that a Public Health Nurse will call to do contact tracing and counselling. It

is beneficial to both Public Health Nurses and patients if patients are informed of the health unit role. If they anticipate a call from a Public Health Nurse regarding their diagnosis, they are generally more cooperative and forthcoming with providing information.

All patients can receive free treatment for *C. trachomatis*, *N. gonorrhoeae* and *T. pallidum*, as well as for bacterial vaginosis and trichomoniasis. All Health Unit sexual health clinics have medications available to provide to patients who have tested positive. Prescriptions can be brought to any clinic and medications will be dispensed free of charge.

Recommended treatment can be found in the Canadian Guidelines on Sexually Transmitted Infections, published by the Public Health Agency of Canada. An electronic version can be found at www.publichealth.gc.ca/sti.

Sexual health clinics can be found throughout Leeds, Grenville and Lanark Counties. Please see the schedule below for more information.

References

Government of Ontario. Health Protection and Promotion Act.(1990), http://www.e-laws.gov.on.ca/html/regs/english/elaws_regs_910559_e.htm

Public Health Agency of Canada.2008 "Sexual Health and Sexually Transmitted Infections" www.publichealth.gc.ca/sti (January 1010)

LOCATION	CLINIC DAY AND TIME
Almonte (613-283-2740)	Tuesday 10:30 am - 4:00 pm
Brockville (613-345-5685)	Monday 1:00 pm - 5:00 pm Thursday 2:30 pm - 7:00 pm
Gananoque (613-382-4231)	Thursday 11:00 am - 3:00 pm
Kemptville (613-258-5941)	Tuesday 11:00 am - 4:30 pm
Perth (613-283-2740)	Monday 10:30 am - 3:30 pm
Smiths Falls (613-283-2740)	Wednesday 10:30 am - 6:00 pm

New Pneumococcal Conjugate Vaccine

A new pneumococcal conjugate vaccine known as Synflorix™ by Glaxo SmithKline will be publicly funded for the routine immunization of infants and children up to 24 months of age and will replace Prevnar® vaccine for this age group.

The Vaccine

Synflorix™ is a 10 valent pneumococcal conjugate vaccine that protects against serotypes: 1,4,5,6B,7F,9V,14,18C,19F,23F. The serotypes 1, 5 and 7F are not in Prevnar. The number of doses and schedule for Synflorix™ is the same as for Prevnar®. Synflorix can be administered concomitantly with other childhood vaccines.

The Ministry of Health is recommending that infants who begin their series with Prevnar® should complete it with Synflorix, or should complete at least the primary series with Prevnar® whenever possible.

High Risk

Children 24 to 59 months of age with medical conditions/risk factors that put them at increased risk for Invasive Pneumococcal Disease should continue to receive two doses of Prevnar® two months apart.

Vaccine Supply

The vaccine will be supplied in a single dose syringe package without needles. The plunger contains rubber butyl, and the syringe components contain latex. Vaccine providers can request the vaccine from the Health Unit as part of their regular vaccine order starting in February 2010 for delivery in March 2010.

For additional information:

A pneumococcal conjugate vaccine fact sheet is available on the Ministry's website at: http://www.health.gov.on.ca/english/public/pub/immun/pnem_conjugate.html

For more detailed information about Synflorix™ see the product monograph at http://www.gsk.ca/english/docs-pdf/Synflorix_PM_20090505_EN.pdf

Adapted from the MOHLTC letter to HCP dated October 6, 2009

REVISED Practice Guidelines for Nutrition in Pregnancy and Infant Feeding Related to the Prevention of Atopic Disease among Infants

– Dianne Oickle, MSc, RD, Registered Dietitian/Public Health Nutritionist

Guidelines for nutrition in pregnancy, lactation and infancy, related to the prevention of allergic disease among infants have changed.

Previous guidelines outlined separate recommendations for the introduction of complementary foods to infants based on an infant's status as low or high allergy risk ^(1, 2). More recent research has pointed recommendations in a different direction.

The American Academy of Pediatrics (AAP) released a review and recommendations in January 2008 ⁽³⁾, on nutritional options during this period that may affect the development of atopic disease in early life. The European Society of Pediatric Gastroenterology, Hepatology, and Nutrition (ESPGHAN) Committee on Nutrition ⁽⁴⁾ released a medical position paper in January 2008 which summarized the evidence for health effects of complementary foods. Other papers that support the recommendations of the AAP and ESPGHAN include documents from EuroPrevall ⁽⁵⁾ and the European Academy of Allergology and Clinical Immunology (EAACI) ⁽⁶⁾. The following revised Health Unit guidelines incorporate the recommendations of these groups.

Guidelines for Nutrition in Pregnancy and Lactation

No food restrictions recommended for women during pregnancy or lactation, other than a mother's own food allergies, regardless of allergenic risk of the fetus/infant ^(7, 8, 9).

Studies generally have not supported a protective effect of a maternal exclusion diet (including the exclusion of cow's milk and eggs) during pregnancy on the development of atopic disease in infants ^(8, 9).

Even if the infant's biological father is allergic to specific foods, there is no need for the mother to avoid those foods to which the father is allergic.

Guidelines for the Introduction of Complementary Foods for Infants at LOW or HIGH Risk of Food Allergies ^(7, 8)

Exclusive breastfeeding for 6 months
After 6 months of age, no solid food restrictions.

There is little risk to introducing foods after the age of 6 months, including those foods that are commonly allergenic.

Therefore, the following foods are safe to introduce after the age of 6 months: grains, vegetables, fruit, meat (beef, poultry, fish), meat alternatives, egg yolk, egg white, cow's milk products, soy, goat's milk, sesame, peanut, nuts, shellfish/seafood.

Although foods such as peanuts and other nuts are considered safe after six months of age for allergy reasons, **caution needs to be used to prevent choking**. Hard, small and round, smooth and sticky solid foods can block a young child's airway.

Regardless of allergy risk, **honey should still be delayed until after 1 year of age** to avoid risk of infant botulism.⁽¹⁰⁾

Guidelines for the Feeding of Infant Formula for Infants at HIGH Risk of Food Allergies ^(7, 8)

In infants who are not exclusively breastfed for 6 months:

There is good evidence that extensively hydrolyzed formulas, compared with formulas made with intact cow's milk proteins, may delay some allergic symptoms.

There is moderate evidence that partially hydrolyzed formulas, compared with formulas made with intact cow's milk protein, may delay some allergic symptoms.

There is no convincing evidence for the use of soy-based formula for the purpose of allergy prevention.

Guidelines for Introducing Solid Foods to the Infant with Diagnosed Food Allergies

If any infant begins to show signs of allergy, a physician or nurse practitioner needs to be consulted. When signs of allergy appear, there may be recommendations for the delay of certain foods in addition to what is stated above ⁽⁷⁾.

Full Health Unit guidelines are available at: www.healthunit.org/professionals

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