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PHYSICIAN NEWSLETTER

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HIGH STD RATES IN TEENAGE GIRLS

A paper recently presented by Centers for Disease Control and Prevention researchers at the 2008 National STD Prevention Conference in Chicago in March demonstrated the high rate of sexually transmitted infections among teenage girls. Previous studies have found similar rates; however, this is the first population-based study looking at the overall combined prevalence of several common STDs.

The paper analyzes a population-based sample of 14- to 19-year-old girls participating in the 2003-2004 National Health and Nutrition Examination Survey. Results showed 25.7% or approximately 3.2 million of the girls had at least one sexually transmitted infection. The human papillomavirus was the most common among (18.3%), followed by 3.9% with *Chlamydia trachomatis*, 2.5% with *Trichomonas vaginalis*, and approximately 1.9% with herpes simplex virus type II. About 15% of those who had an STD had more than one.

Officials are calling for action to control this crisis, but physicians say there are gaps in prevention and significant barriers blocking the way. For example, the HPV vaccine is expensive and not always covered by insurance, many adolescents do not regularly see a physician or become engaged in sexual activity before the opportunity to discuss it with their health care professional, and many young women are not receiving STD-related health care.

PHS RELEASES TOBACCO TREATMENT GUIDELINE

The U.S. Public Health Service recently released an updated clinical practice guideline to identify new counseling and medication treatments that are effective for helping people quit smoking. More than 40 organizations have endorsed the guideline, *Treating Tobacco Use and Dependence: 2008 Update*, and played a key role in its review. The review found evidence that counseling by itself or especially in conjunction with medication can greatly increase a person's success in quitting. In particular, quitlines were found to be effective and can reach a large number of people.

Among other recommendations issued in the 2008 PHS guideline:

- Clinicians, in their offices and in the hospital, should ask their patients if they smoke and offer counseling and other treatments to help them quit.
- Individual, group and telephone counseling are effective, and their effectiveness increases with treatment intensity. Counseling should include two components: practical counseling and social support.
- Tobacco cessation treatments also are highly cost-effective relative to other clinical interventions. Providing coverage for these treatments increases quit rates. Insurers and purchasers should ensure that all insurance plans include the counseling and medication treatments that have been found to be effective in the 2008 PHS guideline update.
- Counseling treatments have been shown to be effective for adolescent smokers and are now recommended. Additional effective interventions and options for use with children, adolescents, and young adults need to be determined.

The Guideline was developed by a 24-member, private-sector panel of leading national tobacco treatment experts that reviewed more than 8,700 research articles published between 1975 and 2007. The 2008 PHS guideline update and its companion products, which include a consumer guide and a pocket guide for clinicians, are available online at http://www.surgeongeneral.gov/tobacco/default.htm.

STUDY FINDS LACK OF INSURANCE INCREASES MORTALITY

Families USA, a leading voice for healthcare consumers, has released a study showing that in each of the 50 states and the District of Columbia uninsured individuals were sicker and encountered premature death sooner than their insured counterparts. The death toll from lack of health insurance was twice that from homicide. The study provides the first-ever, state-level estimates of the number of deaths due to lack of health insurance. The state estimates were derived using a methodology similar to that used for the Institute of Medicine's *Care without Coverage: Too Little, Too Late*, which estimated that 18,000 adults nationwide died in 2000 because they did not have health insurance, and to that used by the Urban Institute, which estimated 22,000 adults died in 2006 because they did not have health insurance.

Some of the reasons cited by Families USA for this observed association between uninsured status and mortality include: the uninsured are less likely to have a usual source of care; the uninsured are less likely to have undergone screening tests or received preventive care and are more likely to be diagnosed with advanced stage disease, which is often more difficult and more expensive to treat; and the uninsured more often have problems accessing needed medical care. To read more about individual state results visit: http://www.familiesusa.org/issues/uninsured/publications/dying-for-coverage.html.

NEW RESTRICTIONS ON BLOOD PRESSURE DEVICES CONTAINING MERCURY

Michigan's Public Act 493 of 2006 restricts the availability and use of mercury-based blood pressure measurement equipment and may require health professionals to revise office equipment and possibly clinical procedures.

Specific provisions in the law include:

- Beginning January 1, 2008, selling or receiving mercury manometers is prohibited in Michigan.
- Effective January 1, 2009, mercury manometers cannot be used by health care professionals to measure blood pressure in individuals.
- However, mercury manometers can be used in the State of Michigan after January 1, 2009 if the device was purchased prior to the effective date of the legislation (i.e., before 12/29/06), **and**
    - The mercury manometer is used exclusively in a private residence for assessing blood pressure, **or**
    - The mercury manometer is used exclusively for the purpose of checking the calibration of blood pressure equipment in a healthcare facility. When not in use, these manometers must be locked in an area not accessible to the public.

It is important that concerns regarding mercury and its waste be balanced with the importance of assuring accurate blood pressure measurements. Mercury-based blood pressure manometers are considered the gold standard for blood pressure measurement by the American Heart Association (AHA) because of their consistent accuracy. Public Act 493 does allow their continued use to check the accuracy of non-mercury blood pressure measurement equipment.

Because of the scope of hypertension and knowing that it is asymptomatic, the implications of inaccuracies of blood pressure measurement are cause for concern for all health care providers. To ensure proper technique is being used, national recommendations suggest a staff refresher session about every six months. A free training program addressing accuracy of blood pressure equipment and measurement entitled "Blood Pressure Measurement Quality Improvement Program," was developed by the MDCH Cardiovascular Health, Nutrition, and Physical Activity Section and is approved for contact hours. To obtain a free copy of the CD training program, contact Jill Scott-Gregus at scottj1@michigan.gov or 517-335-9596.

Blood pressure measurement equipment needs to be checked for accuracy before being put into service and then routinely every six months or if the device is damaged. The AHA recommends that electronic devices be validated using the Association of the Advancement of Medical Instrumentation (AAMI) guidelines.

To download a step-by-step procedure for the measurement of blood pressure and learn more about the correct steps for checking the accuracy of blood pressure measurement devices please visit the Cardiovascular Health Section website at www.michigan.gov/cvh on the Health Care page. Locations are needed in Michigan to provide health care facilities and professionals services to assess the accuracy of blood pressure measurement equipment. If you provide that service or know of an agency in your area that provides this service, please contact Patricia Heiler at heilerp@michigan.gov. For additional resources and material on high blood pressure visit www.nhlbi.nih.gov or www.americanheart.org.

ANIMALS RABIES EPIDEMIOLOGY AND EVALUATION OF INVOLVED BATS

Rabid bats have been documented in the 49 continental states, and bats are increasingly implicated as important wildlife reservoirs for variants of rabies virus transmitted to humans (1). Recent epidemiologic data suggest that transmission of rabies virus can occur from minor, seemingly unimportant, or unrecognized bites from bats. The limited injury inflicted by a bat bite (in contrast to lesions caused by terrestrial carnivores) and an often inaccurate recall of the exact exposure history might limit the ability of health-care providers to determine the risk of rabies resulting from an encounter with a bat. Human and domestic animal contact with bats should be minimized, and bats should never be handled by untrained and unvaccinated persons or be kept as pets.

In all instances of potential human exposures involving bats, the bat in question should be safely collected, if possible, and submitted for rabies diagnosis. Rabies postexposure prophylaxis is recommended for all persons with bite, scratch, or mucous membrane exposure to a bat, unless the bat is available for testing and is negative for evidence of rabies. Postexposure prophylaxis might be appropriate even if a bite, scratch, or mucous membrane exposure is not apparent when there is reasonable probability that such exposure might have occurred.

On the basis of the available but sometimes conflicting information from the 21 bat-associated cases of human rabies reported since 1980, in 1-2 cases, a bite was reported; in 10-12 cases, apparent contact occurred but no bite was detected; and in 7-10 cases, no exposure to bats was reported, but an undetected or unreported bat bite remains the most plausible hypothesis. Clustering of bat-associated human cases within the same household has never been reported.

Consequently, postexposure prophylaxis should be considered when direct contact between a human and a bat has occurred, unless the exposed person can be certain a bite, scratch, or mucous membrane exposure did not occur. In instances in which a bat is found indoors and there is no history of bat-human contact, the likely effectiveness of postexposure prophylaxis must be balanced against the low risk such exposures appear to present. In this setting, postexposure prophylaxis can be considered for persons who were in the same room as the bat and who might be unaware that a bite or direct contact had occurred (e.g., a sleeping person awakens to find a bat in the room or an adult witnesses a bat in the room with a previously unattended child, mentally disabled person, or intoxicated person) and rabies cannot be ruled out by testing the bat. Postexposure prophylaxis would not be warranted for other household members.

UPPER PENINSULA REPORTABLE COMMUNICABLE DISEASES FOR THE PERIOD MARCH-APRIL 2008 AND YTD

	Chippewa		Delta Menominee		Dickinson Iron		LMAS		Marquette		Western UP		UP Total	
Disease	Period	YTD	Period	YTD	Period	YTD	Period	YTD	Period	YTD	Period	YTD	Period	YTD
Campylobacter	0	0	0	2	1	1	1	1	2	2	0	1	4	7
Cryptosporidiosis	0	0	0	0	1	1	0	0	2	2	0	0	3	3
Escherichia coli 0157:H7	0	0	0	0	0	0	0	0	0	0	0	1	0	1
Giardiasis	0	2	0	1	0	0	0	0	0	0	4	5	4	8
Salmonellosis	1	1	1	2	0	0	1	1	2	2	0	1	5	7
Meningitis - Aseptic	0	0	0	0	1	2	0	0	0	1	0	0	1	3
Streptococcus pneumoniae, Inv	1	1	0	0	1	1	0	0	0	1	0	0	2	3
Blastomycosis	0	0	1	2	1	2	0	0	0	0	0	0	2	4
Creutzfeldt-Jakob Disease	0	0	0	0	0	0	0	0	0	0	1	1	1	1
Cryptococcosis	0	0	0	0	0	0	0	0	0	0	0	1	0	1
Flu Like Disease	59	155	748	1191	553	1123	130	168	264	490	752	1368	2506	4495
Influenza	0	3	1	1	3	6	0	3	2	5	5	6	11	24
Staphylococcus Aureus Infect.	0	0	0	0	0	0	0	0	0	0	1	1	1	1
Chlamydia (Genital)	7	18	5	14	15	25	2	4	11	24	9	23	49	108
Gonorrhea	0	1	0	1	2	4	0	0	0	1	0	0	2	7
Syphilis - Latent of Unknown Duratic	0	0	0	0	0	0	0	0	0	0	1	1	1	1
Tuberculosis	1	1	0	0	0	0	0	0	0	0	0	0	1	1
Chickenpox (Varicella)	0	0	2	2	2	6	0	1	2	6	0	1	6	16
Mumps	0	0	1	5	0	1	0	0	0	0	0	0	1	6
Hepatitis A	0	0	0	0	0	0	0	0	0	0	1	1	1	1
Hepatitis B, Chronic	1	2	0	0	0	0	0	0	1	2	0	1	2	5
Hepatitis C, Acute	0	0	0	0	0	0	1	1	0	0	2	4	3	5
Hepatitis C, Chronic	9	20	7	14	2	3	2	6	5	13	12	16	37	72
Hepatitis C, Unknown	0	0	1	1	2	3	0	0	0	0	3	4	6	8