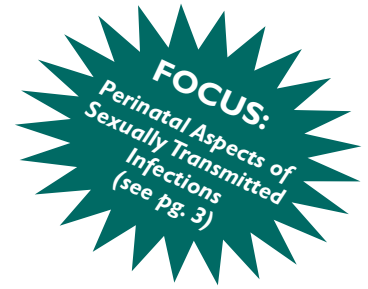


PERINATAL Perspectives



Volume 8, Issue 3

Quarterly news from the Indiana Perinatal Network

Summer 2004

Baby First Tops Helpline Calls; New Resources to be Unveiled



Local recording artist Jennie DeVoe lends her voice to a new *Baby First* educational video aimed at consumers.

Indiana State Department of Health (ISDH) reports indicate that the *Baby First...Right from the Start!* campaign topped calls to the Indiana Family Helpline during 2003.

Launched in 1999, the *Baby First* multi-media campaign promotes awareness of the need for prenatal care and a healthy lifestyle. The messages (TV and radio PSAs, billboards and posters) urge expectant mothers to call the toll-free Helpline for information and assistance. 🐾

Exciting new *Baby First* resources will soon be unveiled! Watch here for details and also visit IPN's website: www.indianaperinatal.org.

Johnson County Conference Promotes Breastfeeding

Health care professionals and consumers alike participated in Johnson County's Breastfeeding Conference—held August 5 at the Dietz Center on the campus of Franklin College in Franklin.

The all-day conference explored how to:

- ▶▶ Successfully promote and initiate breastfeeding;
- ▶▶ Assess common problems;
- ▶▶ Understand and overcome obstacles to long-term breastfeeding; and
- ▶▶ Determine practical solutions.

The agenda featured **Sherri Burton, RN, IBCLC, CLE**, lactation consultant, St. Francis Hospital and Health Centers, who discussed how to initiate breastfeeding and described the most common problems encountered in establishing the practice.

Taking a long-range look at the practice, **Joyce Bermes, RN, IBCLC**, IPN Breastfeeding Subcommittee member, explored obstacles to long-term breastfeeding with an emphasis on practical solutions.

Joining in a panel discussion that closed the day were **Lorie Hagner, RN, IBCLC**, Johnson County prenatal care coordinator, ACT Services; **Kathy Robertson, IBCLC**, breastfeeding counselor, Johnson County WIC program; **Angie Turnmire**, doula; and **Monica Luehrmann**, publicity representative



Improving our community, one baby at a time

for the Couple to Couple League.

Sponsored by the **Johnson County Breastfeeding Alliance**, **Johnson Memorial Hospital** and the **Indiana Perinatal Network**, attendees praised the scope of the information covered during the conference and its applicability. 🐾

For more information, contact Tracy Smith, Johnson County WIC office, 317.736.6628.



The Indiana Perinatal Network is an alliance of hundreds of individuals and organizations across Indiana committed to the beliefs that:

- Every mother deserves a healthy and safe pregnancy; and
- Every baby deserves to be born into a safe and nurturing home.

INDIANA
PERINATAL
NETWORK

LAST CHANCE!

Register NOW at
www.indianaperinatal.org

October Conference: Eliminating Perinatal Health Disparities

An upcoming IPN conference will explore disparities in maternal and child health outcomes and focus on strategies to begin closing the gap.

Eliminating Perinatal Health Disparities, Friday, October 1 at Embassy Suites Indianapolis North, will promote awareness of the multi-faceted aspects of perinatal disparities. Participants will:

- ▶ **Employ data to formulate the “big picture”** of perinatal disparities in Indiana.
- ▶ Identify **contributors to health disparities and their relationships to risk factors** for poor perinatal health outcomes.
- ▶ Confront the **challenges of eliminating disparities and develop strategies for building a framework that reduces and eliminates them**, including preterm labor.
- ▶ **Engage consumers/communities** in the process of reducing and eliminating disparities.
- ▶ Discuss the **roles of state and local health departments** in reducing disparities.

Registration for the conference is \$30 per person by September 20. Nurses completing this offering will be eligible for 7.5 contact hours. 🐾

For a registration form, visit www.indianaperinatal.org, phone IPN at 317.924.0825 or e-mail ipn@indianaperinatal.org.

HIGHLIGHTS OF THE AGENDA

9AM	Welcome —VIRGINIA CAINE, MD; Director, Marion Co. Health Dept; President, American Public Health Assoc.
9:20	State of the State: Perinatal Health in Indiana —JUDITH GANSER, MD, MPH; Director, ISDH Maternal & Child Health
9:40	Developing State Leadership in Maternal & Child Health to Reduce Perinatal Disparities —RICHARD A. ARONSON, MD, MPH; Maternal & Child Health Medical Dir., Maine Bureau of Health
10:40	Implementing Effective Strategies to Eliminate Disparities in Preterm & Low Birth Weight Delivery —VIJAYA HOGAN, MPH, DRPH; Clinical Associate Professor, Univ. of North Carolina (UNC) School of Public Health, Medicine-Child Health, and Dept. of Obstetrics & Gynecology; Dir. of Curriculum on Health Disparities, UNC School of Public Health
11:25	Q & A: Morning Speakers
1:15	The Consumer Voice: Indiana Access Survey Results —LARRY HUMBERT, MSSW, PG DIP; Director, <i>Indiana Access</i>
2:15	Connecting with Consumers: Building Community Relationships —LORETTA JONES, MCI, BA; Executive Director, Healthy African-American Families
3	Q & A: Afternoon Speakers
3:20	Closing & Evaluation
3:45	Technical Assistance for Five County (Allen, Elkhart, Lake, Marion, St. Joseph) Projects
4:45PM	Adjourn

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IPN thanks these individuals for their contributions to *Perinatal Perspectives* and its editorial standards.

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PUBLISHING SCHEDULE

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Winter	February	Dec. 15
Spring	April	Mar. 15
Summer	September	July 15
Fall	November	Oct. 15

The views and opinions expressed herein are those of contributing authors and do not necessarily reflect those of the Indiana Perinatal Network (IPN).

IPN welcomes stories, art and photo contributions. All such material must be accompanied by a self-addressed, stamped envelope for return. Send submissions to IPN, 2835 North Illinois St., Indianapolis, IN 46208, Attn: *Perinatal Perspectives* Editor, or e-mail: ipn@indianaperinatal.org. For advertising information, e-mail: jfoster@indianaperinatal.org

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Perinatal Aspects of Sexually Transmitted Infections

Screening & Treatment Key Perinatal Care Components

By: Tina D. Groat, MD
Assistant Professor of Clinical Obstetrics & Gynecology
Indiana University School of Medicine

Sexually transmitted infections are relatively common during the perinatal period, especially among low-income women. These infections can result in complications that affect the health of the expectant mother and the baby, including pelvic inflammatory disease (PID), ectopic pregnancy, spontaneous abortion, stillbirth, prematurity, and perinatal infections. For women at increased risk, education, screening, identification and treatment are especially critical components of perinatal care.



The most common sexually transmitted infections include **Syphilis, Chlamydia, Gonorrhea, Hepatitis B Virus, Human Immunodeficiency Virus (HIV)** and **Human Papilloma Virus (HPV)**. Since the incidence of many of these infections is increasing, it is important for providers to know how to screen for and treat these infections.

The Centers for Disease Control & Prevention (www.cdc.gov/std) provides up to date information and treatment schedules. Data and information on occurrences of STDs in Indiana can be found by visiting the Indiana State Department of Health (www.in.gov/isdh/programs/hivstd/quarterly/2004/mar/index.htm).

Sources of Clinical Information

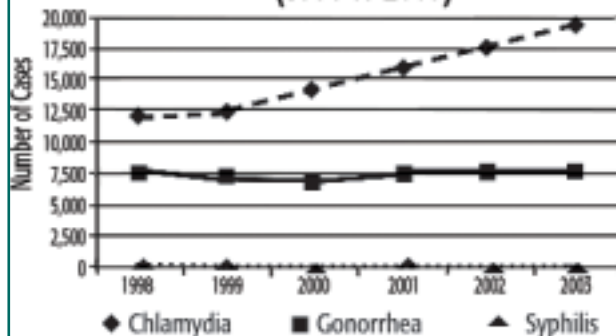
Information on forms of STDs excerpted from *UpToDate*, a subscription-based clinical information resource (www.uptodate.com or ph: 800.998.6374). Upon request, IPN (ipn@indianaperinatal.org) can furnish the original citation(s) for a particular statement in the articles that appear here.

IPN thanks **Tina D. Groat, MD**, Assistant Professor of Clinical Obstetrics and Gynecology, Indiana University School of Medicine, ph: 317.630.6082, fax: 317.630.6524, for her assistance in compiling this information.

We also recognize *Perinatal Perspective's* Clinical Consultants for their diligent review: **Lauren Dungy-Poythress, MD**, St. Vincent Indianapolis Hospital; **Howard Harris, MD**, NICU Medical Director, Methodist Hospital, Indianapolis; **Michael Hogan, MD**; Pediatrician, retired; and **Mureena Turnquest Wells, MD**, Maternal Fetal Medicine, St. Mary's Hospital, Evansville.

Indiana Overview: Sexually Transmitted Infections

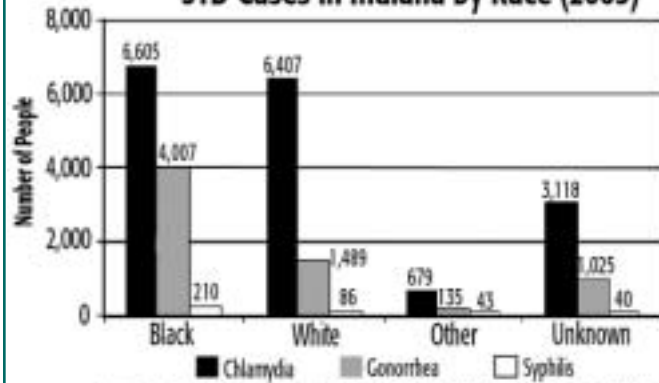
Indiana Cases of Chlamydia, Gonorrhea & Syphilis (1998 to 2003)



Source: www.IN.gov/isdh/programs/hivstd/Epidemiological%20Profile/2003/images/image146.gif

Year	Chlamydia	Gonorrhea	Syphilis
1998	11,800	7,098	511
1999	12,351	6,546	840
2000	14,012	6,520	750
2001	15,421	7,031	528
2002	17,343	7,469	317
2003	17,009	6,656	379

STD Cases in Indiana by Race (2003)



Source: ISDH, www.in.gov/isdh/programs/hivstd/Epidemiological%20Profile/2003/images/image144.gif

The most frequently reported sexually transmitted infection in Indiana is **Chlamydia**, followed by **Gonorrhea** and **Syphilis**.

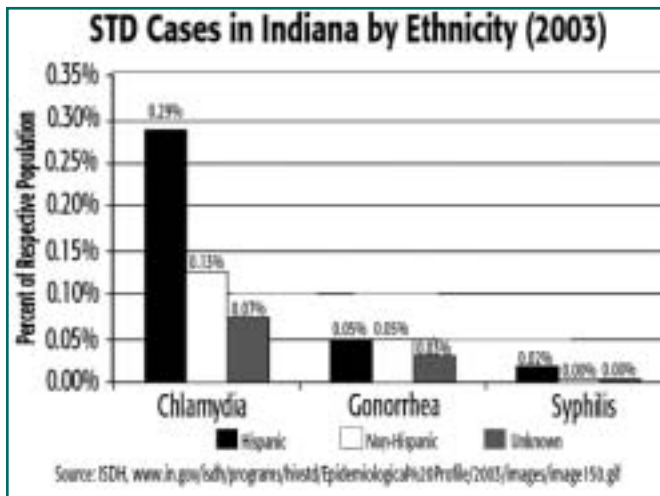
The incidence of new Chlamydia and Gonorrhea infections declined from 2002; while Syphilis increased slightly.

The occurrence of Chlamydia is split almost equally between African-Americans and whites, while Gonorrhea and Syphilis are more widespread among African Americans. ▶

Continues on page 4.

Perinatal Aspects of Sexually Transmitted Infections

Indiana Overview (con't from pg. 3)



Females outnumber males for both Chlamydia and Gonorrhea; Syphilis is more prevalent among males.

In 2002, Indiana had 85 cases of acute **Hepatitis B**, and out of 128 reported cases of TB, 11 persons were also found to be **HIV positive**. 🦋

Source: ISDH Epidemiologic Profile for HIV/AIDS in Indiana 2003, May 18, 2004 from Executive Summary. For STD cases by county, visit www.IN.gov/isdh/programs/hivstd/Epidemiological%20Profile/2003/q3_stds.htm#Figure%2053

Chlamydia

With about four million cases of **Chlamydia** (*C. trachomatis*) occurring every year in the U.S., Chlamydia is the most common sexually transmitted infection.

Infection rates are most prevalent among adolescent women and drop off steeply after the early 20s. Risk factors for infection include young age, black race, multiple sexual partners, recent new sex partner, low rates of barrier contraception and a history of STDs.

In infants born to mothers through an infected birth canal, conjunctivitis and pneumonia can occur.

Although the majority of women with Chlamydia are asymptomatic, cervical infection is the most common syndrome with symptoms such as vaginal discharge, poorly differentiated abdominal pain, or lower abdominal pain.

Approximately 30 percent of women with Chlamydia will develop pelvic inflammatory disease (PID) if left untreated.

Traditionally, cervical swabs were the diagnostic technique of choice—thus requiring a full pelvic examination. Now, new testing methods can utilize urine or self-administered vaginal swabs.

During pregnancy, recommended regimens include Erythromycin and Amoxicillin. Alternative regimens include Azithromycin, Erythromycin base, or Erythromycin Ethylsuccinate. Doxycycline, the Fluoroquinolones, and Erythromycin Estolate are contraindicated for pregnant women. 🦋

Gonorrhea

Gonorrhea infection (*N. gonorrhoeae*) remains a significant cause of preventable and treatable morbidity in women. Although its incidence rate in Indiana declined dramatically, rates of infection increased in 1995 before declining again and remaining stable through 2001.

Expectant mothers can expose their newborn infants to the infection during delivery, causing neonatal ophthalmia. The infection increases a woman's risk of ectopic pregnancy along with PID and scarring that obstructs fallopian tubes and interferes with fertilization.

About 50 percent of women with cervical infection are asymptomatic; symptomatic infection typically manifests as vaginal pruritis and/or purulent discharge.

Given the high incidence of asymptomatic gonococcal infection in women, PID can be the first presenting complaint. Significant scarring and inflammation may be present with PID symptoms such as pelvic/abdominal pain, abnormal vaginal bleeding, and dyspareunia.

Although approximately 50 percent of patients with PID have fever, this sign may be more common in patients with PID caused by *N. gonorrhoeae*.

N. gonorrhoeae can be identified using several diagnostic modalities. The "gold standard" is culture using a modified Thayer-Martin medium. Testing by culture is readily available, costs are moderate, and it also allows the determination of antibiotic resistance.

Pregnant women with uncomplicated infection should be treated with a recommended Cephalosporin, or if allergic, a single, 2 gram dose of Spectinomycin. Either Erythromycin or Amoxicillin can be used for treatment of presumptive or confirmed Chlamydial co-infection.

All pregnant women with PID should be hospitalized and given parenteral antibiotics, due to the potential complications of infection resulting in adverse pregnancy outcomes.

Quinolones and Tetracyclines should not be used to treat Gonorrhea in pregnant women. 🦋

Perinatal Aspects of Sexually Transmitted Infections

Hepatitis B Virus (HBV)

During the past decade, the rate of hospitalizations, cancers and deaths in the U.S. related to Hepatitis B virus (HBV) has more than doubled. Approximately 1.2 million Americans have chronic HBV and can infect others.

The infection rate among infants born to HBsAg-positive mothers is as high as 90 percent. Maternal-infant transmission can occur in utero, at the time of birth or after birth. The high protective efficacy of (95 percent) of neonatal vaccination suggests that infection occurs predominantly at or after birth.

Among all pregnant women, maternal carrier testing should be performed at the first prenatal visit. For women at high risk for HBV infection, testing should be repeated late in pregnancy. The current recommendation is to administer the Hepatitis B vaccine to all infants at birth. All infants born to HBsAg-positive mothers should receive the Hepatitis B vaccine and Hepatitis B Immune Globulin (HBIG) at birth.

Indiana law requires physicians and hospitals to immediately report pregnant women with Hepatitis B, acute or chronic, and perinatally exposed infants to the local health department. Laboratories must report HBsAg-positive findings to the Indiana State Department of Health (ISDH). Note: Laboratory reporting does not nullify physician or hospital obligations to report (Communicable Disease Reporting Rule for Physicians, Hospitals & Laboratories, 410 Indiana Code 1-2.3, Sec. 46, October 2000). Case reports of HBsAg-positive pregnant women are forwarded to **Beverly Sheets, RN**, Perinatal Hepatitis B Case Coordinator, ISDH.

Three PHB field investigators, assigned to specific sectors of the state, assume the case management of pregnant women who are infected with Hepatitis B virus and oversee the immunization of infants and case contacts with Hepatitis B vaccine. These investigators partner with obstetrical care and immunization providers, along with local health departments, to help ensure that all pregnant women are tested for HBV and their infants and contacts are managed appropriately.

For more information about the Perinatal Hepatitis B program, contact **Beverly Sheets, RN**, ph: 317.501.5722, e-mail: hepbbev@aol.com

Perinatal Hepatitis B Cases Reported in Indiana

Year	No. of Cases	Note:
1999	50	Field investigation and case-management activities under
2000	58	ISDH's Perinatal Hepatitis B
2001	81	Program (as it's known today)
2002	113	were first developed and
2003	131	implemented in 2000.

Herpes Simplex Virus

Herpes simplex virus (HSV) infection is prevalent worldwide and is a major source of morbidity and mortality for newborns.

HSV-2 causes most cases of genital HSV disease, spread through sexual contact. The highest rates of HSV-2 occurred in black women (55 percent) and black men (35 percent).

HSV-1 can also cause genital herpes. However, primary HSV-1 infection generally involves the mucosal surfaces of the mouth, pharynx, lips and eyes.

In the largest epidemiologic study in pregnancy to date, more than 7,000 pregnant women underwent serologic tests for HSV prior to and during pregnancy. About two percent of initially seronegative women acquired HSV-2. The implication of these studies is that the ability to identify the disease by patient history and symptoms is limited and diagnostic testing is required.

The gold standard for diagnosis of acute HSV infection is viral culture that becomes positive two to three days after inoculation.

The clinical designations of HSV infection are: *primary genital*, *nonprimary first-episode*, and *recurrent*. Nonprimary first-episode genital HSV refers to patients with preexisting antibodies to one of the two types of virus who acquire the other virus and develop genital lesions due to the newly acquired strain.

The hallmark of the primary episode of genital HSV is multiple painful vesicles in clusters on an inflamed surface.

Generally, a nonprimary first-episode is less severe with fewer systemic symptoms, decreased local pain and reduced viral shedding. However, it can be difficult to clinically distinguish a nonprimary first-episode of genital HSV from a primary infection. In these instances, serologic testing and viral isolation are required for confirmation.

Symptomatic recurrent HSV episodes are characterized by a prodrome (such as local pain or paresthesia) followed by vesicular lesions.

The most common mode of maternal-fetal transmission is contact with infected vaginal secretions during delivery. Studies show that the rate of maternal-fetal transmission is 10 times higher among infants of women with recently acquired first episode infection than those with recurrent disease.

Major categories of neonatal disease are:

- ▶▶ **Localized disease** of the skin, eyes and mouth (SEM)
- ▶▶ **Central nervous system (CNS)** disease with or without SEM involvement
- ▶▶ **Disseminated disease**

Neonates usually become sick during the first four weeks of life with two-thirds of cases presenting within the first week and ▶

Continues on page 6.

Perinatal Aspects of Sexually Transmitted Infections

Herpes Simplex Virus (con't from pg. 5)

as many as 25 to 30 percent on the first day of life. Most infants present initially with SEM disease, but 60 to 70 percent progress to CNS involvement or disseminated disease.

The outcome of neonatal HSV is highly variable. One study evaluated the predictors of morbidity and mortality in neonates with HSV and found no deaths among children with SEM disease. In comparison, the mortality rate was 15 percent among children with CNS disease and 57 percent with disseminated disease.

A large registry of acyclovir use in pregnancy for both HSV and varicella pneumonia suggests this drug is safe in pregnancy. As a result, it is recommended that acyclovir be administered to pregnant women experiencing a first episode of HSV during pregnancy to reduce the duration of active lesions and viral

shedding. Suppressive therapy for the remainder of pregnancy should also be considered.

Cesarean delivery should be offered to women who have active lesions and to women with a history of genital herpes who have symptoms of vulvar pain or burning at the time of delivery. However, delivery by cesarean birth does not prevent all infections. Approximately 20 to 30 percent of HSV-infected infants are born by cesarean and as many as 8 percent of those are born with intact membranes.

Mothers with active lesions, regardless of site, should be careful when handling their infants; lesions should be covered and hands should be washed before touching the baby.

Perinatal HIV Transmission: Counseling & Care Management

Perinatal HIV Transmission in Indiana

Cumulative Children Born to HIV-Infected Mothers

Race	Exposed*	HIV	AIDS	Definitely Not Infected	TOTAL	Percent Total
White	16	16	19	103	154	34%
Black	45	26	28	134	233	51%
Hispanic	5	0	0	8	13	3%
Multiracial	6	4	3	39	52	11%
Other	0	0	1	1	2	1%
TOTAL	72	46	51	285	54	100%

* Includes children lost to follow-up. Their progression to other categories is unknown at this time. Source: Indiana State Dept. of Health (ISDH)

About 7,000 HIV-infected women give birth in the U.S. each year. With no intervention to reduce transmission, 1,750 newly infected babies would be born every year.

In 1994, Pediatric AIDS Clinical Trials Group (PACTG) protocol showed that a three-part regimen of Zidovudine (ZDV) administered during pregnancy, labor and to the newborn, could reduce the risk of perinatal transmission by nearly 70 percent (see next page). To be effective, the care of the HIV-infected pregnant woman must also involve an ongoing collaboration between her HIV specialist, obstetrician, and the woman herself.

Important components of the initial evaluation include assessment of the status of the patient's HIV disease; recommendations about beginning or altering antiretroviral treatment; and discussion of interventions to reduce the risk of perinatal HIV transmission.

The assessment should evaluate:

- ▶ **The degree of existing immunodeficiency** determined by CD4 cell count and percent.
- ▶ **The need for prophylaxis** against *Pneumocystis carinii pneumonia* (PCP) or *Mycobacterium avium complex* (MAC), or for treatment of any HIV-related illnesses.
- ▶ **History of prior or current antiretroviral therapy.**
- ▶ **Provision of support services, mental health services, and drug abuse treatment** as needed.

Management of HIV-infected pregnant women during labor should focus on minimizing the risk for both perinatal transmission of HIV and the potential for maternal and neonatal complications. Interventions that prevent infant exposure to infectious maternal blood and secretions in the birth canal during delivery could provide some protection against transmission.

The American College of Obstetrics and Gynecology (ACOG) issued an opinion that elective cesarean delivery should be discussed and recommended for all HIV-infected pregnant women with viral loads above 1000 copies/mL. If the decision is made to perform an elective cesarean delivery, ACOG recommends it be performed at 38 weeks gestation.

If vaginal delivery is chosen, artificial rupture of membranes and invasive procedures that may cause a break in the infant skin, such as scalp electrodes, should be avoided.

ZDV prophylaxis should be provided regardless of the mode of delivery.

Perinatal Aspects of Sexually Transmitted Infections



HIV Testing in Indiana

By: Terry Jackson, RN BS
ISDH HIV Perinatal Nurse Consultant

This year marks the 10th anniversary of the Pediatric AIDS Clinical Trials that documented the effectiveness of Zidovudine (ZDV or AZT) in reducing perinatal HIV transmission. Since then, many new antiretroviral agents have set the stage for further advancements.

While pregnancy is not a reason to forgo treatment, it may dictate a change in the expectant mother's medication, since some antiretroviral medications may be harmful to the fetus. Consequently, early prenatal care is critical to the health and well-being of both the mother and the baby.

As HIV Perinatal Nurse Consultant for ISDH, author Terry Jackson, RN, BSN, aids in the implementation of the new law and monitors compliance. "I look forward to working with hospitals and health care providers to allow our newest Hoosiers the opportunity to be born free of HIV," says Jackson. Direct questions or comments to her by calling 317.233.7743 or emailing tjackson@isdh.state.in.us. View the legislation at www.ai.org/legislative/ic/code/title16/ar41/ch6.html

HIV Legislation

In 2003, the Indiana legislature passed HB 1630 that requires an HIV test to be offered by physicians (licensed under IC 25-22.5) or advanced practice nurses (licensed under IC 25-23) who diagnose the pregnancy or are primarily responsible for providing prenatal care (IC 16-41-6-5). Additionally, an educational component must explain the risks and benefits of the test.

At the time of labor and delivery, if no written evidence indicates that an HIV test was performed, the physician or advanced practice nurse in attendance at the delivery must offer the test (IC 16-41-6-6).

In all instances, the expectant mother has the right of refusal.

To establish implementation procedures, ISDH adopted rule 410 IAC 1-7. A brochure on HIV testing and pregnancy is being developed to help health care providers inform and educate consumers.

Syphilis Legislation

IC 16-41-15-6: Infant eye examinations; treatment

A person in professional attendance at a birth shall carefully examine the eyes of the infant and if there is reason for suspecting infection in one (1) or both eyes, the person in professional attendance at the birth shall apply such prophylactic treatment as may be prescribed by the state department.

IC 16-41-15-7: Birth certificates; ophthalmia neonatorum precaution information

The state department shall require in each birth certificate, in addition to information otherwise required in the certificate, an answer to the question "Were precautions taken against ophthalmia neonatorum?"

IC 16-41-15-10: Syphilis testing during pregnancy; duty of physician

A physician who diagnoses a pregnancy of a woman shall take or cause to be taken a sample of blood: 1) at the time of diagnosis of pregnancy; and 2) during the third trimester of pregnancy, if the woman belongs to a high risk population for which the Centers for Disease Control "Sexually Transmitted Diseases Treatment Guidelines" recommend a third trimester syphilis testing; and shall submit each sample to an approved laboratory for a standard serological test for syphilis.

IC 16-41-15-12: Syphilis testing at time of delivery

If at the time of delivery positive evidence is not available to show that standard serological tests for syphilis have been made in accordance with section 10 of this chapter, the person in attendance at the delivery shall take or cause to be taken a sample of the blood of the woman at the time of the delivery and shall submit the sample to an approved laboratory for a standard serological test for syphilis.

Source: <http://www.in.gov/legislative/ic/code/title16/ar41/ch15.html>

Syphilis

Syphilis, a chronic infection caused by the spirochete *Treponema pallidum*, is of particular concern during pregnancy because of the risk of transplacental infection. In the neonate, congenital infection is associated with perinatal death; premature birth; low birth weight; congenital anomalies; and active congenital Syphilis.

In the absence of treatment, the infection occurs in a series of stages usually within the first year after infection.

Latent Syphilis is an asymptomatic infection, with positive serology and a negative physical examination. If latent infection arises after one year or the time of initial infection is unknown, it is defined as late latent Syphilis or latent Syphilis of unknown duration.

Late or tertiary Syphilis can arise as soon as one year after initial infection or up to 25 to 30 years later. During this stage, the central nervous system, cardiovascular system, or the skin and subcutaneous tissues are typically affected.

The incidence of Syphilis dropped dramatically after the discovery of penicillin in the 1940s and bottomed out during the following decade. However, the number of cases of early Syphilis subsequently rose due to an increase in injection drug use and the human immunodeficiency virus (HIV).

Syphilis is transmissible during the early stages of disease (primary and secondary Syphilis) and requires exposure to

Continues on page 8.



Perinatal Aspects of Sexually Transmitted Infections

Syphilis (con't from pg. 7)

open lesions in which organisms are present. The incubation period varies from 10 to 90 days.

PRIMARY

The first manifestation of Syphilis is a painless papule that soon ulcerates to produce the classic chancre(s) of primary Syphilis. Chancres heal spontaneously within three to six weeks.

SECONDARY

A disseminated systemic process begins six weeks to six months after the appearance of the chancre in approximately 25 percent of untreated patients. Characteristic of this stage is a generalized maculopapular skin rash involving the palms, soles and mucous membranes. The rash of secondary Syphilis typically resolves spontaneously within two to six weeks.


LATENT

Latent disease is usually subclinical, although clinical relapses may occur. With the exception of perinatal transmission, Syphilis is rarely transmitted during the latent phase.

The problems associated with Syphilis in pregnancy can be almost completely eliminated by universal early antepartum screening and antibiotic treatment. Seventy to 100 percent of infants born to untreated mothers will be infected compared to one to two percent of those born to women adequately screened and treated during pregnancy.

Most congenital cases of Syphilis are due to lack of prenatal care, but a negative test result in early pregnancy that is not repeated later in pregnancy and suboptimal maternal treatment are also contributing factors. While the number of cases of congenital Syphilis decreased in all ethnic groups, minority ethnic populations still have the highest rates of this congenital infection.


Penicillin is the gold standard for the treatment of Syphilis in both pregnant and nonpregnant individuals. No penicillin-resistant strains of *T. pallidum* have been identified to date. Penicillin therapy in pregnancy is effective for treating maternal disease, preventing transmission to the fetus, and treating established fetal disease.

For expectant mothers who are allergic to penicillin, alternative antibiotics are either ineffective (eg, Erythromycin), contraindicated (eg, Tetracycline) or lack sufficient data regarding efficacy (eg, Ceftriaxone). Therefore, the only satisfactory treatment for is desensitization followed by penicillin therapy. 

Anogenital Warts

Anogenital warts (*condylomata acuminata*) are the most common viral STDs in the U.S. Caused by Human Papilloma Virus (HPV), most infections are transient and cleared within two years. Disease in women is primarily caused by vaginal intercourse, and the risk increases with the number of sexual partners. Symptoms vary depending upon the number of lesions and their location. Patients with a small number of warts are often asymptomatic. Other patients may have pruritus, bleeding, burning, tenderness and vaginal discharge.

Diagnosis is usually made by visual inspection of the affected area. The lesions, which are skin-colored or pink, range from smooth flattened papules to a verrucous, papilliform appearance.

Treatment involves chemical or physical destruction, immunologic therapy, or surgical excision. The preferred approach depends on the number and extent of the lesions. In general, all therapies for genital warts are somewhat unsatisfactory due to recurrence rates of 30 to 70 percent within six months of treatment. 

RESOURCES

- ▶ **THE INDIANA FAMILY HEALTH COUNCIL, INC. (IFHC)**—Receives and administers Title X federal funds from the U.S. Dept. of Health and Human Services for family planning services. The Council contracts with non-profit and/or public agencies to provide family planning services for low-income working poor and teens. IFHC provides contraception, STD testing and treatment, screening for cervical and breast cancer, screening for testicular and prostate cancer, pregnancy testing, counseling and referral for other health services. Special initiatives and programs include:
 - **CONDOM DISTRIBUTION PROGRAM** Provides condoms to individuals as a form of prevention for sexually transmitted diseases and unintended pregnancies in every county in Indiana. Since the program began in 1998, IFHC has distributed more than *one million condoms annually* to 139 agencies statewide.
 - **CHLAMYDIA & GONORRHEA TESTING PROGRAM** in conjunction with ISDH conducts a chlamydia and gonorrhea screening program for non-profit medical agencies.
 - **MALE INVOLVEMENT PROGRAMS** address topics such as sexual responsibility, family values, decision-making, reproductive anatomy and sexually transmitted diseases.
 - **TITLE X CLINICS & UPCOMING TRAININGS**—For a complete list, visit: www.ifhc.org or contact Gayla Winston, ph. 317.247.9151, fax: 317.247.9159 or email: ifhc@iquest.net
- ▶ **PLANNED PARENTHOOD OF INDIANA, INC.**—With 40 health centers and nearly 125,000 clients, Planned Parenthood serves all who need quality health care and accurate information on sexual health. To reach a local Planned Parenthood clinic, call 800.230.PLAN. To reach administration or education services, call 800.421.3731 or 317.926.4662. For a listing of Indiana Planned Parenthood Health Centers, trainings, and more information, visit www.ppin.org/index.cfm

Perinatal Aspects of Sexually Transmitted Infections

Bacterial Vaginosis (BV)


Bacterial Vaginosis (BV), the most common cause of vaginal discharge, results from an overgrowth of certain bacteria that occur naturally in the vagina. Although the main symptom is an increased thin, white vaginal discharge with a strong fishy odor, *approximately 50 percent of women have no symptoms.*

Women who douche at least once a month have higher rates of infection, according to a study published in *Obstetrics & Gynecology*.

All symptomatic pregnant women should be tested and treated. BV is associated with spontaneous abortion, post-gynecologic surgery infection, PID that can lead to infertility, an increased risk of preterm birth, premature rupture of membranes, chorioamnionitis and endometritis.

Recommended regimens (www.cdc.gov/STD/treatment/5-2002TG.htm#): Metronidazole, 250 mg orally, three times a day for seven days; or Clindamycin, 300 mg orally, twice a day for seven days.

Clinical considerations, according to The U.S. Preventive Services Task Force (www.guideline.gov/summary/summary.aspx?doc_id=2659):


- ▶ **For women with a history of pre-term delivery, screening for bacterial vaginosis is an option.** Studies demonstrated a benefit of screening and treatment among women at especially high risk of preterm birth (35 to 57 percent). Consider previous history of preterm delivery, other risk factors, and time of presentation in making the decision whether to screen.
- ▶ **The optimal screening test is uncertain.** Accepted clinical criteria for BV include vaginal pH > 4.5, amine odor on the application of KOH (potassium hydroxide), appearance of a homogeneous vaginal discharge, and presence of clue cells on a microscopic examination of a wet mount. Presence of at least three of these criteria is generally considered diagnostic of BV.
- ▶ **Neither the optimal time to screen high-risk pregnant women nor the optimal treatment regimen for them is clear.** Three trials demonstrated a reduction in preterm birth with screening in the second trimester and use of various regimens of oral Metronidazole alone or oral Metronidazole and Erythromycin.
- ▶ **Treatment is appropriate for pregnant women with symptomatic BV.** These women may be at higher risk than those without symptoms. Treatment can relieve symptoms such as vaginal discharge. 

Group B Streptococcal Disease (GBS)

The incidence of Group B Streptococcal (GBS) disease in babies less than a week old declined by more than 70 percent in the 1990s—coinciding with increased use of intrapartum antibiotic prophylaxis.

In 1999, the incidence of GBS disease began to plateau. Subsequent studies by the Centers for Disease Control (CDC) & Prevention prompted a re-evaluation of prevention strategies.

In 2002, compelling evidence led the CDC to recommend *universal prenatal screening for GBS colonization* by vaginal-rectal culture at 35 to 37 weeks gestation. In light of emerging Clindamycin and Erythromycin-resistant GBS, second-line agents for penicillin-allergic women were revised. A number of additional issues were addressed, including: management of threatened preterm delivery; planned cesarean section deliveries in GBS-colonized women; GBS bacteriuria; management of newborns exposed to intrapartum chemoprophylaxis; and culture collection and processing methods.

The American College of Obstetricians and Gynecologists (ACOG) and American Academy of Pediatrics (AAP) support the CDC's revised guidelines that a screening-based approach for the prevention of early-onset GBS disease in the newborn be adopted. 

HELPFUL HOTLINE NUMBERS

(www.in.gov/isdh/programs/hivstd/about/hotline.htm)

- ▶ **Centers for Disease Control and Prevention (CDC) National AIDS Hotline:** 800.342.AIDS (2437); Spanish Service: 800.344.7432; TTY Service for the Deaf: 800.243.7889
- ▶ **CDC National STD Hotline:** 800.227.8922
- ▶ **Indiana State Department of Health (ISDH) Division of HIV/STD**
 - Division Information: 317.233.7499
 - Prevention Program: 317.233.7840
 - CTR Program: 317.233.7840
 - STD Program: 317.233.7426
 - Clinical Data and Research: 317.233.7506
 - Care Coordination Program: 317.233.7672
 - Community Planning: 317.233.7197
 - CAB and Planning Council: 317.234.1811
 - HIV Services: 317.233.7486
- ▶ **INDIANAPOLIS HELP (HERPES SUPPORT)—Ph:** 317.221.8313; e-mail: IndyHELP@yahoo.com or visit <http://www.indyhelp.com>. Also **FORT WAYNE HELP**, ph: 219.481.2890.
- ▶ **NATIONAL HERPES HOTLINE—Ph:** 919.361.8488
- ▶ **NATIONAL SEXUALLY TRANSMITTED DISEASE (STD) HOTLINE—Ph:** 800.227.8922.

LAST CHANCE!

Register NOW at
www.indianaperinatal.org

Conference Will Explore Safe Sleep, Infant Loss and Support

An October IPN conference will focus on sleep practices across cultures, infant loss and grief-support resources.

What You Need to Know About Safe Sleep, Infant Loss and Support, to be held Wednesday, October 6, at ISDH's Rice Auditorium, 2 North Meridian, Indianapolis, aims to enhance awareness of safe-sleeping practices across cultures, deepen understanding of the infant-loss experience; and identify a wide range of available grief-support resources.

Registration for the conference is \$35 per person for professionals

(with an additional \$25 per person for nursing CEUs) and \$25 per family (regardless of family size) by September 24. Nurses, EMS personnel, firefighters and law-enforcement officials completing this offering will be eligible for 5.0 credit hours. 🐸

The event is sponsored by **ISDH's Community Council on Infant Health & Survival and ISDH Maternal and Child Health Services.**

For more information, contact IPN at **317.924.0825** or e-mail ipn@indianaperinatal.org.

Highlights of the Agenda

- 9:30AM **Welcome**—GREG WILSON, MD; State Health Commissioner, ISDH
- 9:45 **State of the State**—BETH JOHNSON, RN, MSN; Perinatal Consultant, State Liaison, ISDH
- 10 **Keynote**—JAMES KEMP, MD; Assoc. Prof. of Pediatrics, Saint Louis Univ. School of Medicine; Pediatrician, SSM Cardinal Glennon Children's Hospital, St. Louis
- 11 **Progress on Safe Sleep**—DEBORAH C. GIVAN, MD; Clinical Prof. of Pediatrics; Dir., Children's Apnea & Sleep Disorders Center, Riley Children's Hosp.
- 1PM **Resources & Referrals**—BARB HIMES; SIDS & Loss Support Coordinator, IPN
- 1:15 **Baby First Consumer Video**—JULIA TIPTON HOGAN, MPA; IPN
- 2 **Mosaic: Some Facts About Working with the Hispanic Community**—JOCELYN GONZALEZ, Child Abuse Prevention Program Coordinator, Wishard Hispanic Health Project
- 2:30 **Community Outreach Events**—MARY PAYTON, Outreach Coord./Health Educator, Indpls. Healthy Start, Marion County Health Dept.
- 3 **Grief Support**—JANE HEUSTIS, RN; Pathway Support Group Coordinator, Methodist Hosp.
- 3:30 **Resource Sharing**—BARBARA JOHNSON, MS; Coordinator, Indiana University Child Protection Program
- 4pm **Closing & Evaluation**

Don't Miss Exciting Resource-Sharing Opportunities!

Afternoon sessions focus on resources and referrals. The day concludes with attendees sharing their innovative home-grown programs and literature—as well as comments on what works (and doesn't work) in their particular communities. *If possible, come prepared to share your best information with 100 fellow participants!*



UPDATE



A national Friendly Access™ program with the Indiana Perinatal Network.

Consumer Survey Highlights*

ENTRY INTO PRENATAL CARE

- 46 percent took a home pregnancy test to make sure they were pregnant
- 12 percent saw provider seven or fewer times

25 percent *did not* get prenatal care as early as they wanted. Reasons cited:

- Didn't know I was pregnant (29 percent)
- Couldn't get an earlier appointment (20 percent)
- Not enough money or insurance (12 percent)
- Too many other things going on (11 percent)
- Didn't want to find out I was pregnant (five percent)
- No one to care for my other children (three percent)
- No other way to get to the doctor (two percent)
- Didn't want prenatal care (one percent)
- Couldn't find doctor or midwife to take me (one percent)
- Other (13 percent)

INTENT OF PREGNANCY

- Seven percent wanted to be pregnant sooner
- 18 percent wanted to be pregnant at that time
- 45 percent wanted to be pregnant later
- 27 percent did not want to be pregnant at that time or at any time in the future

FAMILY PLANNING

71 percent weren't using any kind of birth control at the time of pregnancy. Reasons cited:

- I wanted to be pregnant (27 percent)
- Side effects from birth control method (15 percent)
- Didn't think I could get pregnant (13 percent)
- Didn't want to use birth control (11 percent)
- Don't know/not sure (11 percent)
- Didn't think I would have sex (four percent)
- Husband/partner did not want me to use birth control (three percent)
- Declined to answer (two percent)

STRESS FACTORS DURING PREGNANCY

- Moved (52 percent)
- Argued with husband/partner more often (33 percent)
- Many bills I couldn't pay (33 percent)
- Close family member sick/hospitalized (31 percent)
- Death of someone close (31 percent)
- Lost job, but wanted to keep working (26 percent)
- Husband/partner lost job (25 percent)
- Someone close had problem with alcohol or drugs (21 percent)
- Moved more than once (18 percent)
- Separated/divorced (17 percent)
- Husband/partner or self went to jail (16 percent)
- Husband/partner did not want me to be pregnant (13 percent)
- Involved in a physical fight (eight percent)
- Homeless (seven percent)

Contact **Larry Humbert, MSSW, PG DIP, Director, Indiana Access**, ph: **317.924.0825**, Lhumbert@indianaperinatal.org

* Data gathered from face-to-face surveys of 520 women during their postpartum stays at Wishard and Methodist Hospitals from August 2003 through January 2004.


FOR YOUR INFORMATION

NEW WEBSITES & RESOURCES

- ◆ **New Clinical Practice Guidelines from AAP**—The American Academy of Pediatrics (AAP) released guidelines on the *Management of Hyperbilirubinemia in the Newborn Infant 35 or More Weeks of Gestation*. In its *Clinical Practice Guidelines* AAP states, "In every infant, we recommend that clinicians: 1. Promote and support successful breastfeeding; 2. Perform a systematic assessment before discharge for the risk of severe hyperbilirubinemia..."
 - ➔ Visit http://aappolicy.aappublications.org/practice_guidelines/index.dtl#M.
- ◆ **Manual Aids in Development of Smoking-Cessation Programs for Expectant Mothers**—A technical assistance manual from The Partnership for Smoke-Free Families Program (PSF) helps providers develop and implement pregnancy-specific smoking-cessation programs.
 - ➔ Download the manual (PDF) at helppregnant smokersquit.org/care/learn.asp. Hard copies of the executive summary and a limited number of full manuals are available by calling 919.843.7663 or e-mailing info@helppregnant smokersquit.org

Check Out NPA's Transcultural Aspects of Perinatal Health Care

To address the challenges of caring for an increasingly diverse population, the National Perinatal Association (NPA) released *Transcultural Aspects of Perinatal Health Care—A Resource Guide*. A copy of this resource is now available for loan from IPN's office.

Focusing on perinatal care, this new fifth edition raises awareness of cultural, ethnic, and religious issues related to health and illness; pregnancy and prenatal care; labor and delivery; postpartum and newborn care; and much more. 

To preview the resource guide on loan from IPN, call 317.924.0825 or e-mail ipn@indianaperinatal.org. The publication is available from NPA for \$49.95 (non-members) or \$44.95 (members) at www.nationalperinatal.org/Announcements/2003TransculturalBookFlyer.pdf

2004 Calendar


OCTOBER

- 1 **Eliminating Perinatal Health Disparities**—Embassy Suites Indianapolis North. Contact: ipn@indianaperinatal.org
- 4 **IPN 4th Annual Birdies for Babies Golf Outing**—Hillcrest Country Club. Proceeds benefit IPN. Arrival, lunch and silent-auction bidding start at 11 am. Shotgun start at 1 pm. Auctions and awards begin at 6 pm. Contact IPN, ph: 317.924.0825 or e-mail: ipn@indianaperinatal.org.
- 6 **ISDH Immunization Program Fall Awards Conference**—Indianapolis Marriott North, 3645 River Crossing Parkway, Indianapolis 46240. For details visit www.IN.gov/isdh/programs/immunization/events.htm or contact Jennifer McCarthy, Perinatal Hepatitis B Field Investigator, Immunization Program, ISDH, ph: 317.435.1319
- 6 **What You Need to Know About Safe Sleep, Infant Loss & Support**—ISDH, Auditorium, 2 North Meridian, Indianapolis. Contact: IPN, ph: 317.924.0825 or e-mail: ipn@indianaperinatal.org
- 8 **ISDH Immunization Program Fall Awards Conference**—Primo South Banquet & Conference Center, 2615 East National Ave., Indianapolis 46227 For details visit www.IN.gov/isdh/programs/immunization/events.htm or contact Jennifer McCarthy, Perinatal Hepatitis B Field Investigator, Immunization Program, ISDH, ph: 317.435.1319
- 13 **Resolve Through Sharing**—Ball Memorial Hospital, Muncie Room OMPI. Contact: Margie Pyron RN, MS, LCCE, MCH Clinical Nurse Specialist Perinatal Center Manager, Ball Memorial Hospital, ph: 765.747.4222 MPyron@chs.cami3.com
- 27-28 **Preventing Prematurity Conference (SWRPAB) Southwestern Indiana Regional Perinatal Advisory Board Conference**, Evansville, Indiana. For

more information, contact Susan Bonhotal, ph: 812.760.9923 sbonhotal@hotmail.com

NOVEMBER

- 4 **Community Health Network Perinatal Symposium 2004**—PPD Revisited with Birdie Meyer and Marcia Boring, 7 pm, CHN OB Classroom Contact: Jonell Allen, MSN, CNS, Clinical Nurse Specialist Obstetrics, Community Health Network, pager: 317.904.1770 or e-mail: jallen@ecommunity.com
- 6 **March of Dimes Prematurity Summit**—Adam's Mark Hotel, Indianapolis. Contact: March of Dimes, Indiana Chapter, ph: 317.262.4668 or visit www.marchofdimes.com/indiana
- 10 **NRP Recertification**—8 am, Ball Memorial Hospital & Rehab CR, Muncie, Room 4000. Contact: Margie Pyron RN, MS, LCCE, MCH Clinical Nurse Specialist, Perinatal Center Manager, Ball Memorial Hospital, ph: 765.747.4222 MPyron@chs.cami3.com

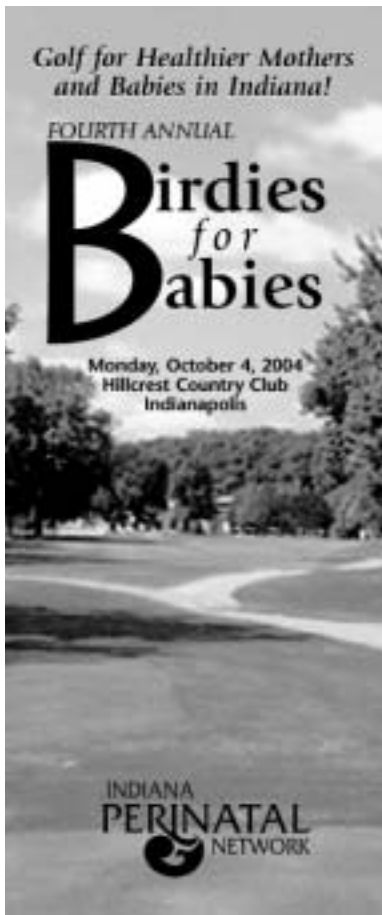


Going the Extra Mile!

IPN thanks **Britt & Jeff McDermott** for their generous donation of a meeting room and food for IPN's 2004 Strategic Planning Retreat held September 1 at Woodland Country Club in Carmel.

Classifieds

PART-TIME HELP WANTED—Looking for an opportunity to work with childbearing families in a truly family-centered setting? Birthroot Midwifery Service seeks an RN, LPN or EMT to join our staff of Birth Assistants who assist the CNM at area home births. Must have current CPR and NRP certification, Indiana and Michigan licensure plus an interest in family-centered birth alternatives. Experience in L&D and/or nursery preferred. Scheduling is flexible, but you must be available to be on call at least 4 days per month and to travel within a one-hour radius of South Bend. Pay is \$250 per birth plus a modest amount per day for call time. For more information, please call Lynn McDonald, CNM, MSN at 574.255.6182. Visit the website at www.birthrootmidwifery.com



The Golf Outing that Benefits Indiana's Babies!

October 4, 2004

Hillcrest Country Club • Indianapolis

Every week in Indiana, 126 babies are born too small, too soon; and 13 babies die before their first birthdays.

The Indiana Perinatal Network (IPN) is an alliance of hundreds of individuals and organizations with a vision for Indiana that:

- Every mother deserves a healthy and safe pregnancy; and
- Every baby deserves to be born healthy and into a safe and nurturing home.

SPONSORSHIP OPPORTUNITIES STILL AVAILABLE:

Platinum Sponsor—Two foursomes; four hole sponsorships; and special recognition throughout the event (including the beverage cart).

Gold Sponsor—One foursome; two hole sponsorships; and special recognition throughout the event .

Awards Reception Sponsor—One foursome; special recognition at the awards reception; and additional recognition throughout the tournament.

- 11AM Arrival, Lunch & Silent Auction Bids Begin
- 1PM Shotgun Start Followed by Auction & Awards Reception

Proceeds help to support the Indiana Perinatal Network in its efforts to save Indiana's babies!

LAST CHANCE!
Sign up NOW at
www.indianaperinatal.org

Openings remain for Foursomes AND Single Players!



A community approach to improving health care for Indiana's Mothers & Babies

Indiana State Department of Health,
Maternal and Child Health Services
2 North Meridian St., 8-C
Indianapolis, IN 46204



Funded by Title V through the Indiana State Department of Health Maternal Child Health Services.