



Yakima Health District

BULLETIN

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New Study Re-ignites Screening Mammography Controversy - But Has Anything Changed?

Background

Breast cancer is the second leading cause of cancer mortality among women, accounting in 2010 for 20 deaths in Yakima County, 815 deaths state-wide, and approximately 40,000 deaths nationally. For over a decade, the Yakima Health District (YHD) has received federal and state funding to assist uninsured and under-insured low-income women throughout south central Washington in securing access to screening mammography. In 2012, YHD's Breast, Cervical & Colon Health Program served over 1400 women in Yakima, Kittitas, Klickitat, Benton, Franklin, Walla Walla, and Columbia Counties in this manner.

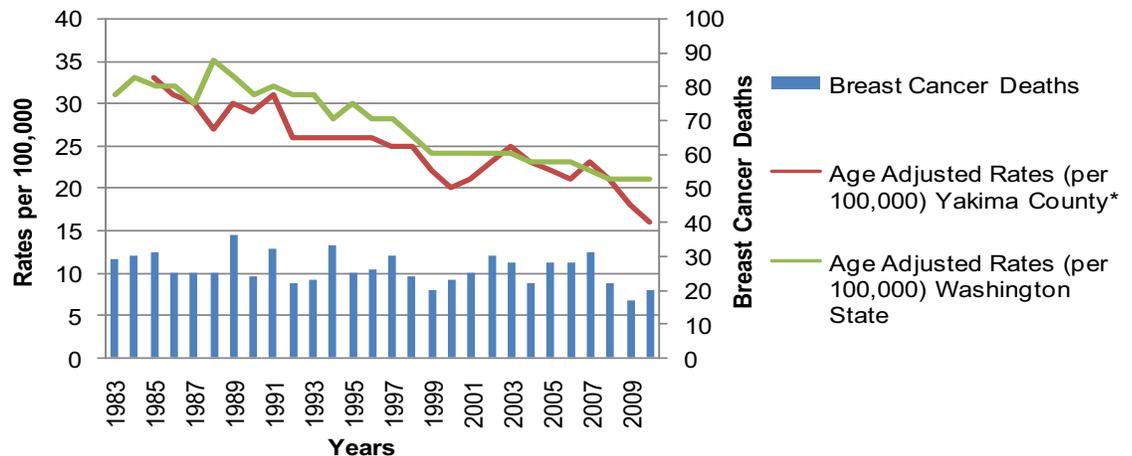
Breast cancer mortality rates have decreased approximately 50% over the past 30 years in Yakima County (see Figure below). Both screening mammography and advances in treatment are thought to have contributed to increased survival, but our understanding of the relative contributions of each to the overall decline is limited. Research into the benefits and risks of screening mammography is

ongoing; study results and their interpretation remain a source of controversy.

New Study Questions Benefits

Most Yakima County health care providers must have encountered at least some news coverage in late November addressing the *New England Journal of Medicine* article by Bleyer and Welch, who published their unsettling findings regarding the impact of three decades of screening mammography through the lens of national cancer registry data on breast cancer incidence from 1976-2008. They stratified results by early-versus-late stage at diagnosis and found that screening mammography increased detection of early stage cancer by 109% whereas late stage cancer diagnosis declined by only 8%. During that same interval, the breast cancer mortality rate declined 28%. The authors concluded that (1) screening mammography appears to be failing to lead to early detection of advanced cancers, (2) up to 30% of diagnosed early stage cancers may not necessarily warrant therapy or confer benefit to the diagnosed women (i.e., they

**Breast Cancer Deaths
Yakima County Residents, 1983-2010**



*rolling three year average

Source: Center for Health Statistics, Washington State Department of Health, 2012.

represent over-diagnosis), and (3) most of the gains in breast cancer survival must come from advances in therapy rather than from early detection. One of the chief assumptions underlying the analysis, that true secular incidence of breast cancer has been stable over time, was subjected to sensitivity analysis. The authors reported that a worst-case scenario (incidence increasing 0.5% per year) only reduced their over-diagnosis estimate from 30% to 20%. The authors acknowledged that their macro-level study does not point to which patients are being over-diagnosed, but they did call for updated randomized screening trials that both incorporate advances in therapy and attempt to mitigate over-diagnosis.

This article and its relatively high-profile news coverage sparked rebuttals and debate in-print and on-the-air among experts and advocates.

<http://www.npr.org/blogs/health/2012/11/21/165668987/with-routine-mammograms-some-breast-cancers-may-be-overtreated>

<http://www.npr.org/2012/11/22/165696183/study-questions-mammograms-overdiagnosis>

Although potentially disturbing to women and confounding to clinicians attempting to implement evidence-based guidelines, this publication's findings do not stand in isolation. The discussion in the *NEJM* article cites 13 other peer-reviewed European and North American studies from 2004-2012 that found over-diagnosis rates ranging from 5% to 47% (median 33%).

A 2011 Cochrane systematic review of seven trials including 600,000 women found a 19% (95% CI: -13 to -26%) reduction in breast cancer mortality at 13 years among women undergoing mammography and a 30% over-diagnosis rate. However, when only randomized trials were included in the analysis, the reduction in breast cancer mortality was only 10% and it was

of only borderline statistical significance (95% CI: -21% to +2%). In the randomized trials, all-cause mortality was no different than among unscreened women. The Cochrane reviewers concluded that screening mammography does indeed probably decrease the *relative* risk of breast cancer mortality by about 15% compared to unscreened women, but the *absolute* reduction is 0.05%. Conversely, the 30% *relative* risk of over-diagnosis carries an *absolute* risk increase of 0.5% for unnecessary treatment, resulting in a ratio of needing to treat 10 women for every one whose life is prolonged.

Impact on Clinical Practice

These studies could be perceived as undercutting the screening mammography recommendations of even the most conservative body (e.g., USPSTF; see Table below). Acceptance and participation in screening mammography is now widespread and a central part of women's health care culture. The Centers for Disease Control and Prevention's 2010 Behavioral Risk Factor Survey found that 74% of women ≥40 years and 78% of women ≥50 years of age in the Yakima metropolitan statistical area had undergone screening mammography within the preceding two years (<http://apps.nccd.cdc.gov/BRFSS-SMART/index.asp>; accessed 10 Dec 2012). What are the implications of these findings for women's health care in that context?

First, the disappointing news must be placed in context. Across multiples studies, consensus seems to exist that women who do undergo screening mammography are about 15% less likely to die from breast cancer than women who do not participate in such screening. As stated above, breast cancer mortality has declined 50% in Yakima County during the era of mammography; it would seem too parsimonious to attribute all of that benefit to treatment advances alone. On the other hand, that reduction in mortality comes at a cost for other women who have cancers diagnosed and treated that may not

Body	Routine Screening Mammography by Age			Mammography Interval	Clinical Breast Examination	Breast Self Examination
	40-49	50-74	≥75			
USPSTF ¹ & AAFP ²	No	Yes	No	Biennial	Inconclusive evidence	Not recommended
CTPH ³	No	Yes	No	Bi- or triennial	Not recommended	Not recommended
ACS ⁴ , AMA ⁵ , ACSurg ⁶	Yes	Yes	Yes	Annual	Recommended	Permissive
ACOG ⁷	Yes	Yes	Yes	Biennial 40-49 Annual ≥50	Recommended	Recommended

¹United States Preventive Services Task Force; <http://www.uspreventiveservicestaskforce.org/uspstf09/breastcancer/brcanrs.htm>
²American Academy of Family Physicians; <http://www.aafp.org/online/en/home/clinical/exam/breastcancer.html>
³Canadian Task Force on Preventive Health Care <http://canadiantaskforce.ca/guidelines/2011-breast-cancer/>
⁴American Cancer Society; <http://www.cancer.org/cancer/breastcancer/moreinformation/breastcancerearlydetection/breast-cancer-early-detection-ac-s-recs-mammogram>
⁵American Medical Association
⁶American College of Surgery
⁷American Congress of Obstetrics & Gynecology http://www.acog.org/About_ACOG/News_Room/News_Releases/2009/Interpreting_the_US_Preventive_Services_Task_Force

Note: all cited urls accessed 10 Dec 2012

result in prolongation of life. Focusing solely on mortality, though, may fail to account for total benefits of cancer treatment if net quality-adjusted life years are gained—even if life is not prolonged. However, it also seems conceivable that the degree of over-diagnosis and treatment reported in these studies could in fact lead to a net reduction in quality-adjusted life years across the screened population. None of the studies cited herein reported on quality-of-life, nor do they answer the fundamental question of whether a woman should choose to be screened or not. Various bodies interpret this evidence differently and craft their recommendations depending on how they weigh gradations in quality of evidence, analytic methodology, competing mortality risks, and clinical judgment, among other influences and interests (see Table on page 2).

All interested parties in the debate do appear to agree that potential candidates for screening mammography should be clearly presented with the risks, benefits, and alternatives to screening mammography prior to participating. Such informed consent might include but not necessarily be limited to the following talking points for average-risk women:

- screening mammography decreases the overall chances of dying from breast cancer by about 0.05% (15% lower than for a woman who does not undergo screening);
- some data suggests screening mammography may not be effective in substantially reducing the incidence of aggressive cancers;
- false positive mammography may lead to anxiety and unnecessary biopsy or unnecessary treatment more often than it leads to a life-saving cancer diagnosis (estimate: 0.5% overall risk, 30% higher than for women who do not undergo screening);
- some breast cancers diagnosed by screening mammography may not affect longevity if they were to go undiagnosed (estimated range: 5-47%; median 33%); and
- we currently have a low ability to discriminate between which early stage cancers do require treatment and which do not.

Most women will still choose to follow one of the recommendation frameworks set forth in the table on page 2, but transparency with patients in our evolving and imperfect understanding of the risk-benefit analysis of such interventions seems to be a patient-centered, trust-building approach that is also in the best interests of the clinician and the health care system. Another guiding principle can be to focus limited resources on groups most likely to experience net benefit in an efficient manner (e.g., women 50-74 years of age).

The old saying that “an ounce of prevention is worth a pound of cure” only applies when the benefits do indeed outweigh the risks and/or costs. That seems too obvious to warrant writing down, but the anticipated benefits from preventive health interventions are often prone to overstatement. Helping patients navigate rhetoric, mis-information, and nuances is both a challenge and an opportunity in today’s ever-changing healthcare landscape. For more background on judicious application of preventive health care interventions, visit <http://www.ahrq.gov/clinic/uspstfix.htm> (*What Not to Do in*

Primary Care: Overuse of Preventive Services – 2009; Agency for Healthcare Research and Quality).

Cited Articles:

Bleyer A, Welch HG. Effect of three decades of screening mammography on breast cancer incidence. *NEJM* 2012;367:1998-2005.

Gøtzsche PC, Nielsen M. Screening for breast cancer with mammography. *Cochrane Database of Systematic Reviews* 2011, Issue 1. Art. No.: CD001877. DOI: 10.1002/14651858.CD001877.pub4.

Notice to Begin Reporting Infections Caused by Certain Multiple Drug Resistant Organisms

YHD repeats this announcement as a reminder in follow-up to the November 7, 2012, fax which launched the implementation of this surveillance effort.

Responsible Entity	Reporting Obligation
Health care providers Health care facilities	Notify YHD at (509) 249-6541 within 24 hours when the following multidrug resistant organisms are identified from patient specimens: <ul style="list-style-type: none"> • Carbapenem-resistant Enterobacteriaceae (CRE)¹ • Vancomycin-resistant <i>Staphylococcus aureus</i> (VRSA)
Laboratories	Submit all VRSA and CRE isolates to the Washington State Public Health Laboratories (PHL) for confirmation. Submission instructions will follow under a separate communication.

¹The Washington State Department of Health (DOH) requests that health care providers, health care facilities and laboratories report CRE as an “other rare condition of public health significance” and/or “emerging condition with outbreak potential” set forth in Washington Administrative Code 246-101-101 and WAC 246-101-301.

If infection or colonization with a multidrug-resistant organism (MDRO--e.g., MRSA, VRE, VISA/VRSA, extended spectrum beta-lactamases [ESBLs], CRE, resistant *Streptococcus pneumoniae*) is suspected in a patient, implement contact precautions immediately and consult an infectious diseases specialist. Laboratories, facility infection control practitioners, and infectious disease specialists will receive additional background information and instructions addressing this reporting request. If you have any questions related to this request, please call YHD Communicable Diseases Control at (509) 249-6541.

Background

Multidrug resistant organisms (MDROs) pose a serious threat not only to individual patient welfare, but also to public health. Morbidity, mortality, costs and treatment failures are

all increased for infections due to antibiotic-resistant organisms. Furthermore, some antibiotic resistance is easily transmissible between bacterial species and even between genera. CRE are endemic in several eastern states, but are rare in Washington. As of October 2012, DOH is aware of only 11 CRE isolates detected in Washington. Only 13 cases of VRSA have been identified in the United States since 2002; none have been reported in Washington State. DOH conducts mandated surveillance for antibiotic resistance under WAC 246-101-630. Reasons for establishing surveillance for this set of organisms at this time include the following:

- Healthcare associated infections (HAIs) cause approximately 1.7 million infections, 99,000 deaths, and \$28-33 billion in excess healthcare costs each year nationwide.
- Although MDROs cause only about 16% of all HAIs each year, they do require special infection control precautions and active surveillance after identification to control and prevent further spread.
- Certain organisms, such as CRE, appear to be rare in our state. This impression, though, merits validation. Furthermore, prompt recognition and preventive actions can keep rare MDRO from becoming endemic.
- DOH can offer epidemiologic and laboratory assistance in HAI investigations, including consultation on infection control and providing molecular testing, if indicated.

Adapted from Highly Antibiotic Resistant Organisms: Reporting and Specimen Submission Requirements for Healthcare Facilities, Healthcare Providers and Laboratories in Washington State (DOH, October 23, 2012)

Influenza and RSV Laboratory Surveillance

During the last week of November, the first non-sporadic cases of seasonal influenza were detected locally in Yakima County. Activity was low statewide through November, but increased in early December. During the first week of January 2013, positive results were obtained from 60 (20%) of 298 local rapid antigen influenza tests submitted through YHD's collaborating laboratory surveillance network. Virtually all influenza isolates tested and subtyped to-date by the Washington State Public Health Laboratories have been A H3N2. Detection of respiratory syncytial virus activity in Yakima County was first noted during the initial days of November. Forty (35%) of 113 RSV specimens tested through the local laboratory surveillance network during the first week of January 2013 were positive. To track viral respiratory surveillance data, please visit the following websites:

Local data: <http://yakimahealthdistrict.org/w/home/community-health/rsv-flu-stats/>

Washington Influenza Update: <http://www.doh.wa.gov/PublicHealthandHealthcareProviders/PublicHealthSystemResourcesandServices/Immunization/InfluenzaFluInformation.aspx>

Pertussis Letter from State Health Officer

Dr. Maxine Hayes, Health Officer for Washington State, sent letters to Health Care Providers in December. The unfortunate death of a baby in King County due to pertussis prompted her response to again remind us of the importance of pertussis vaccination. She also shared information that the ACIP (Advisory Committee on Immunization Practices) recently approved a provisional Tdap vaccination recommendation to vaccinate pregnant women during **each** pregnancy. A copy of Dr. Hayes' letter is attached to the Bulletin. Through the last full week of December, 4,783 cases of pertussis had been reported statewide in 2012 (69 cases/100,000 population). Not since 1943 has a higher statewide annual case rate been recorded. In Yakima County, 468 cases were reported in 2012 (189 cases/100,000 population).

STD Update for Clinicians in Yakima, April 10, 2013.

The Seattle STD/HIV Prevention Training Center has again scheduled an update for clinicians in Yakima this year. The April 10, 2013 Save-the-Date flyer and program agenda are attached to the Bulletin. Please call David Miller at (509) 249-6532 if you have question.

National Birth Defects Prevention Month and Folic Acid Awareness Week — January 2013

From the Centers for Disease Control and Prevention...

January is National Birth Defects Prevention Month. Each year, birth defects affect approximately one in 33 newborns in the United States. Birth defects are a leading cause of infant mortality, accounting for approximately 20% of infant deaths. Babies who survive and live with birth defects are more likely to have life-long physical and cognitive challenges.

January 6–12, 2013, is National Folic Acid Awareness Week. CDC urges all women of childbearing age who are capable of becoming pregnant to consume 400 µg of folic acid every day, before becoming pregnant and during pregnancy, to help reduce the risk for neural tube defects. Health-care providers should encourage women to consume folic acid in fortified foods or supplements, or a combination of the two, in addition to a varied diet rich in folate. Additional information about folic acid is available at <http://www.cdc.gov/folicacid>.

Source: *MMMR* 2013;62(01):14 (http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6201a4.htm?s_cid=mm6201a4_e)

Additional Reference

CDC. Recommendations for the use of folic acid to reduce the number of cases of spina bifida and other neural tube defects. *MMWR* 1992;41(No. RR-14).

YAKIMA HEALTH DISTRICT

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Union Gap, WA 98903



Reporting Line: (509) 249-6541
After hours Emergency: (509) 575-4040 #1
Toll Free: (800) 535-5016 x 541



Confidential Fax: (509) 249-6628



<http://www.yakimapublichealth.org>



André Fresco, MPA, Administrator
Christopher Spitters, MD, MPH, Health Officer
Devika Singh, MD, MPH Deputy Health Officer
Sheryl Di Pietro, Director of Community Health
Gordon Kelly, Director of Environmental Health
Marianne Patnode, Supervisor of Communicable Disease Services

Notifiable Condition <i>(includes confirmed and probable cases)</i>	Cases			Total Cases by Year	
	Jan- Nov	Jan- Nov	Jan- Nov	Total Cases by Year	Total Cases by Year
	2012	2011	2010	2011	2010
Campylobacteriosis	80	121	119	122	128
Chlamydia	1202	1138	1018	1224	1109
Cryptosporidiosis	2	1	4	1	4
Genital Herpes - Initial	58	71	46	74	51
Giardiasis	13	16	21	16	27
Gonorrhea	76	92	28	99	33
Hepatitis A acute	2	0	0	0	0
Hepatitis B acute	0	0	0	0	0
Hepatitis B chronic	*NA	8	4	8	4
Hepatitis C acute	0	0	1	0	1
Hepatitis C chronic	*NA	185	175	205	230
HIV/AIDS Cumulative Living	**185	**178	**177	182	173
HIV/AIDS Deaths	**6	**4	**5	4	6
HIV/AIDS New	**9	**8	**11	12	11
Meningococcal Disease	2	0	2	0	2
Pertussis	439	7	10	10	11
Salmonellosis	24	18	50	18	54
Shigellosis	1	10	2	11	2
STEC (enterohemorrhagic E. coli)	7	10	9	10	10
Syphilis - Primary and Secondary	6	8	6	9	6
Tuberculosis	5	6	9	6	9
*NA=Not Available					
**= Stats from January - October Only					

**Notifiable
Conditions
Summary
Jan - Nov,
2012**



STATE OF WASHINGTON
DEPARTMENT OF HEALTH

PO Box 47890 • Olympia, Washington 98504-7890
Tel: (360) 236-4030 • FAX: (360) 586-7424 • TDD Relay Service: 1-800-833-6388

December 21, 2012

Dear Colleague:

I'm saddened by the news I have to share with you about a baby in our state who recently died from whooping cough and another child who died from the flu. These are somber reminders of how vulnerable babies and children are to these and other diseases that vaccines can prevent. You can help prevent the spread of whooping cough and flu by making sure to stock and offer both vaccines to all of your patients.

While the whooping cough epidemic is slowing, the disease will always be present at some level in our communities. We're also seeing increasing flu activity in Washington – so it's important to keep vaccinating against both diseases.

Research shows that a recommendation from you plays a crucial role in a person's decision to vaccinate. Protect your patients and help create a protected community by:

- Educating them about the benefits and risks of immunization.
- Recommending and offering vaccinations to them, their family members, and your staff.
- Referring patients to their local health agency or pharmacy if vaccines are not available in your practice.

Adults should get a one-time Tdap booster and kids should get the whooping cough vaccinations on schedule – a five-dose DTaP series that starts when they're two months old and is complete before age seven, and one Tdap booster between 11 and 12 years old.

The Advisory Committee on Immunization Practices recently approved [provisional Tdap vaccination recommendations](#) to vaccinate pregnant women during *each* pregnancy, even if they were previously been vaccinated. It should be given between 27 and 36 weeks gestation. Flu vaccine can be given at any time during pregnancy.

For adults without insurance that covers Tdap vaccine, it may be available through your [local health agency](#) or the [Give Immunity, Fight Transmission \(GIFT\) program](#) for public and community health facilities. If you do not stock or have Tdap or flu vaccine in your practice, it's important that you refer patients to another provider.

Thank you for your continued effort to fight these diseases and protect those who are especially vulnerable. Find up-to-date information on [whooping cough](#) and [flu](#) on our website, including free education materials. You can also join our public health conversations on [Facebook](#) and follow us on [Twitter](#).

Sincerely,


Maxine Hayes, MD, MPH
State Health Officer



STATE OF WASHINGTON
DEPARTMENT OF HEALTH

PO Box 47890 • Olympia, Washington 98504-7890
Tel: (360) 236-4030 • FAX: (360) 586-7424 • TDD Relay Service: 1-800-833-6388

December 21, 2012

Dear Colleague:

I'm saddened at the news I have to share with you about a baby in our state who recently died from whooping cough and another child from the flu. These are somber reminders of how vulnerable babies and children are to these and other diseases that vaccines can prevent. You can help to protect pregnant women and infants by making sure to stock and offer Tdap and flu vaccines to all of your patients.

While the whooping cough epidemic is slowing, the disease will always be present at some level in our communities. We're also seeing increasing flu activity in Washington – so it's important to keep vaccinating against both diseases.

Advice from you plays a crucial role in a pregnant and postpartum woman's decision to get vaccinated. Women who are offered vaccine at the time of their visit are more likely to get vaccinated than women who are not. More information is available in our September 2012 Issue Brief, [Influenza Vaccination Among Pregnant and Postpartum Women in Washington: The Importance of the Prenatal Care Provider](#).

Research shows that getting vaccinated against whooping cough and flu can protect mom and baby against severe illness and complications during and after pregnancy. Vaccination reduces the risk of the mother infecting the baby and can protect the baby in the first few months of life – when they're the most vulnerable, and too young to be vaccinated themselves.

Most babies get these diseases from family members and close contacts. Be sure to recommend vaccination to their family members and your staff. This creates a protected community and everyone, especially babies, benefits.

The Advisory Committee on Immunization Practices recently approved [provisional Tdap vaccination recommendations](#) to vaccinate pregnant women during *each* pregnancy, even if they've previously been vaccinated. It should be given between 27 and 36 weeks gestation. Flu vaccine can be given at any time during pregnancy.

For adults without insurance that covers Tdap vaccine, it may be available through your [local health agency](#) or the [Give Immunity, Fight Transmission \(GIFT\) program](#) for public and community health facilities. If you do not stock or have Tdap or flu vaccine in your practice, it is vital that you refer patients to another provider.

Thank you for your continued effort to fight these diseases and protect those who are especially vulnerable. Find up-to-date information on [whooping cough](#) and [flu](#) on our website, including free education materials. You can also join our public health conversations on [Facebook](#) and follow us on [Twitter](#).

Sincerely,

Maxine Hayes, MD, MPH
State Health Officer



The Seattle STD/HIV Prevention
Training Center presents

STD UPDATE

FOR CLINICIANS

SAVE THE DATE!

April 10, 2013

***Yakima Convention Center
10 North 8th Street
Yakima, Washington 98901***



Seattle
STD/HIV

PREVENTION TRAINING CENTER

For more information please contact
Ronnie Staats, PTC Training
Coordinator:

rstaats@uw.edu or **206-685-9848**

www.seattlestdhivptc.org

**STD Update
April 10, 2013**

**Yakima Convention Center
10 North 8th Street
Yakima, Washington 98901**

8:30 – 8:45 a.m.	Welcome, ARS orientation and Pre-course test	Dana Kubilus, PTC Training Assistant
8:45 – 9:45 a.m.	Update on Viral Hepatitis	Speaker to-be-announced
9:45 - 10:00	<i>Break</i>	
10:00 – 11:00	Diagnosis and Management of Chlamydia	Devika Singh, MD, MPH
11:00 – 11:15	<i>Break</i>	
11:15 – 12:15	Gonorrhea: Changes and Challenges	Devika Singh, MD, MPH
12:15 – 1:00	<i>Lunch (Provided)</i>	
1:00 – 2:00	Contraception Update	Lisa Callegari, MD
2:00– 2:15	<i>Break</i>	
2:15 – 3:00	Genital Dermatology: Part 1	Sue Szabo, PA-C
3:00 – 3:15	<i>Break</i>	
3:00 – 3:45	Genital Dermatology: Part 2	Sue Szabo, PA-C
3:45 – 4:00	Post-course test/Evaluations	
4:00	<i>Adjourn</i>	