

Prevention Notes

Update on Obstetrics and Gynecology Related Prevention Issues

Following are systematic reviews, recently completed, related to health promotion and disease prevention in the fields of obstetrics and gynecology.

Interventions for promoting smoking cessation during pregnancy

Smoking remains one of the few potentially preventable factors associated with low birthweight, very low preterm birth and perinatal death. The objective of this review was to assess the effects of smoking cessation programs implemented during pregnancy on the health of the fetus and infant, on the mother and on the family. The reviewers concluded that smoking cessation programs in pregnancy appear to reduce smoking, low birth weight and preterm birth, but no effect was detected for very low birthweight or perinatal mortality.¹

Folate supplementation during pregnancy

Folate depletion may result in anemia during pregnancy. The objective of this review was to assess the effects of routine folate supplementation in pregnancy on hematological and biochemical parameters and measures of pregnancy outcome. This review does not address the role of periconceptual folate supplementation.

The reviewers concluded that routine folate supplementation during pregnancy appears to improve hemoglobin levels and folate status. There is not enough evidence to evaluate whether routine folate supplementation has any effect, beneficial or harmful, on pregnancy outcomes for mother and baby.²

Education for contraceptive use by women after childbirth

Postpartum education on contraceptive use is a routine component of discharge planning in many different countries with a wide variety of health care systems. This education is based on assumptions concerning women's receptivity to contraceptive education during the postpartum period and their presumed lack of access to such education after that time. The objective of this review was to assess the effects of education about contraceptive use to postpartum mothers. The reviewers concluded that the effectiveness of postpartum education about contraceptive use has not yet been established in randomized controlled trials. Such education may be effective in increasing the short-term use of contraception. However, there are only limited data examining a more-important longer-term effect on the prevention of unplanned pregnancies.³



Maternal iodine supplements in areas of deficiency

Iodine deficiency is the leading preventable cause of intellectual impairment in the world. Although iodine supplementation is generally considered to be safe, there is a possibility of high doses of iodine suppressing maternal thyroid function. The objective of this review was to assess the effects of iodine supplementation before or during pregnancy in areas of iodine deficiency. The reviewers concluded iodine supplementation in a population with high levels of endemic cretinism results in an important reduction in the incidence of the condition with no apparent adverse effects.⁴

Interventions for encouraging sexual lifestyles and behaviors intended to prevent cervical cancer

The aim of this review was to determine the effectiveness of health education interventions to promote sexual risk reduction behaviors among women in order to reduce the transmission of Human papillomavirus (HPV). The reviewers concluded that educational interventions targeting socially and economically disadvantaged women, for whom information provision is complemented by sexual negotiation skill development, can encourage at least short-term sexual risk reduction behavior. This has the potential to reduce the transmission of HPV, thus possibly reducing the incidence of cervical carcinoma.⁵

Interventions for treating bacterial vaginosis in pregnancy

Bacterial vaginosis has been associated with poor perinatal outcome. Since the infections are amenable to treatment, identification during pregnancy and treatment may reduce the risk of preterm birth and its consequences. The objective of this review was to assess the effects of antibiotic treatment of bacterial vaginosis in pregnancy. The reviewers conclude that the current evidence does not support screening and treating all pregnant women for bacterial vaginosis to prevent preterm birth and its consequences. For women with a history of a previous preterm birth, there is some suggestion that detection and treatment of bacterial vagi-

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From the Editor

Millennium Greetings! The new year ushers in a wonderful opportunity to review the past and plan for the future. This issue of the newsletter will try to accomplish that in some areas. Featured are reports on the new DOD/VHA Tobacco Cessation Guideline; preventive foot care; pharmacologic treatment for smoking cessation; the current status of clinical reminders in the VHA; and, initiation of a new interactive web page for veterans by the Office of Special Projects. The apex of activity for the new year will be in April with the hosting of the Fourth Annual Prevention Conference on successful strategies in preventive medicine, programs that really work! Join us in Anaheim, CA from April 11-13th for a "non-taxing" time to learn and network with other VHA health care staff.

Preventive Medicine Conference Call October 5

For those of you unable to attend the preventive medicine conference call on October 5, a brief synopsis of the call follows. More detailed minutes may be obtained from Dr. Mary Burdick at the National Center for Health Promotion (NCHP), ext. 227.

Dr. Kristen Nichol, Chief of Medicine, Minneapolis VA has been appointed chairperson of the selection committee for hiring a new NCHP Director. Dr. Nichol is a former chair of the Preventive Medicine Field Advisory Group (PMFAG). An announcement should be made soon concerning Dr. Gebhart's successor in the role of Chief Consultant, Primary/Ambulatory Care.

There will be no *Veterans Health Survey* conducted by the NCHP in FY 2000. Dr. Lew Kazis is conducting a *Health Survey of Veterans* which includes prevention modules dealing with nutrition, physical activity, alcohol moderation and smoking cessation. It was felt that two surveys would be unnecessary and confusing to the veteran population.

The Fourth Annual Preventive Medicine Conference will be held April 11-13, 2000 in Anaheim, CA (see announcement p.8). Networks and/or facilities will fund participant travel. Target audience for the meeting will be the Preventive Medicine Program Coordinators (PMPCs), Patient Health Education Coordinators (PHECs), quality management officers, clinical managers and network preventive medicine coordinators. There will be a poster session at the conference to which you are invited to submit abstracts concerning prevention programs. Priority will be given to those abstracts that deal with the topics of cholesterol and hypertension checks; immunizations; breast, prostate and colorectal cancer screening; alcohol moderation and control counseling; diet and physical activity counseling as well as community-based interventions and partnerships with other community groups. Questions concerning the conference can be addressed to Dorothy Gagnier at the NCHP, ext. 226.

To facilitate communication of issues in prevention that bring about workable solutions, Dr. Mary Burdick has been contacting the field to discover what barriers interfere with providing health promotion and disease prevention services to veterans. A number of issues have been identified.

Dr. Gagnier, NCHP Education Director, is still soliciting generic patient education materials in prevention from the field. We are interested in samples of

materials that have been developed "in-house," and only a list of those that are purchased from vendors. List the name of the vendor in case we want to obtain samples of their product later. So far, approximately 60 medical centers have responded. A final reminder will be mailed within the next few weeks and follow-up telephone calls made to Directors of Primary/Ambulatory Care. We are soliciting PMPCs and PHECs to take the lead in this project. Objectives of the survey are to 1) facilitate sharing of information between medical centers; 2) identify areas where shortages exist; and, 3) collaborate with other groups within and outside the VHA, in the development of education materials not currently available to veterans.

Anne Joseph, MD, and PMFAG member mentioned that a draft of the combined VHA/DOD clinical practice guideline is nearing completion (see related article, p.5). It will differ from the AHCPR Guideline in that VA places more emphasis on referrals to tobacco cessation specialists. Another difference, based on recent evidence, is the use of pharmacologic aids such as Bupropion, nicotine nasal spray and inhaler (see related article, p. 4). The AHCPR will be issuing a revised guideline in January 2000.

Ellen Yee, MD, MPH, PMFAG member reported on womens' health in the VHA. The VA standard benefit package for enrollees, now includes pregnancy care and counseling regarding birth control. Both male and female

partners may be counseled about alcohol abuse and the effects of cigarette smoking on pregnancy. Some changes have occurred in sterilization; a woman can now request tubal ligation without three referrals from other providers.

The next PMCC (Preventive Medicine Conference Call) will be held **March 8 at 2:00 pm**. NB: new day of the week and time **Wednesday at 2:00 pm**. The call in number is **800.767.1750**. This over-rides the information printed in the Fall issue of the newsletter (*Prevention Notes, Fall 1999, Vol. 4 #3, p. 8*). See that issue of the newsletter for posting of the three remaining calls for the year.

Be sure to check out the "Healthy Happenings Calendar," a new addition to our newsletter, which reminds you of national dates observed related to health. Hope that you

find this new feature helpful. I will continue to send quarterly updates of these events.



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National Meeting Involvement

NCHP recently represented the Veterans Health Administration, at a number of national prevention activities. These included the United States Preventive Services Task Force, which is reviewing the evidence for community-based preventive services and Partnership for Prevention, a Washington, DC-based public/private organization, whose aim is to promote disease prevention at a national level.

Current Status of Clinical Reminders in the VHA (Letting Computers Do the Work For You!)

Clinical Reminders are VISTA software tools that are able to assess any coded data in a patient's chart. The reminders can evaluate a patient's history, as it is recorded in CPT and ICD codes, as well as any other type of information that is recorded in a data field. That means that almost any information in VISTA on a patient (that is NOT in just text) can be used to trigger or satisfy a reminder.

Clinical Reminders are designed to: 1) provide timely information about patients' health maintenance schedules, 2) assist in compliance with VHA performance measures, 3) assist in compliance with health promotion and disease prevention guidelines, 4) assist in targeting patients with particular diagnoses and procedures or site-defined criteria. Clinical reminders can be time-saving tools for patient care providers by quickly presenting information that is appropriate or due in a summary format that obviates the need for difficult chart reviews (e.g., searching the old orders on a patient for the last pneumovax or Td).

A reminder can be made to apply to a group of patients based on any of the following findings: age, sex, diagnosis, procedure, health factor, computed finding or location. For example, a mammogram might be due for women over the age of 30 who have not had the procedure of bilateral mastectomy. Health factors are any type of patient characteristic that you want to collect as a data element e.g., family history of breast cancer, positive depression screen, life expectancy <1 year, history of positive PPD. Computed findings are computer codes that go out and find other information in VISTA, e.g., Race, LDL >130, and HCV Ab positive.

The reminders can be set to recur at a defined frequency or can be set to be due only once. They can be made NOT APPLICABLE by any of the findings that make them apply to a group of patients (age, sex, diagnosis, etc.). In addition, reminders can be satisfied by any of the following: lab tests, imaging studies, immunizations, skin tests, and education topics.

Examples of complex reminders that might be useful in some clinics are:

- 1) A reminder that is due for any patient with diabetes whose most recent LDL is >130. The reminder might not be applicable or appropriate if the patient has a life expectancy of <1 year. The reminder could be satisfied by a repeat LDL that was <130.
- 2) A reminder that is due for patients with hepatitis C to get educated about the disease, treatment options and the transmission of the disease. The reminder would be applicable only for patients with a diagnosis of Hepatitis C and would be satisfied by entry of the education topic or an entry of a health factor "REFUSES HEPATITIS C EDUCATION."
- 3) A reminder that finds all patients with diabetes, who have a normal creatinine, a HbA1c of >8 on last check and no proteinuria might be used to find a cohort of potential candidates for a research protocol.

Reminders can be displayed to a user in 3 ways: 1) on the cover sheet of the CPRS GUI, 2) in Health Summary and 3) on the AICS encounter forms. All three of these displays can be customized for the clinic or even for an indi-

vidual user to display the reminders that are useful for that particular area or individual. This customization of reminders for a site, clinic or specific user is an important feature that makes the Clinical Reminders very flexible tools for finding information and presenting it at the right time.

Reports are now also available based on Clinical Reminders. A report can be generated from a reminder on a clinic, a stop code, a PCMM team, a PCMM provider or on an inpatient ward. The report gives the number of patients for whom the reminder applies and how many have the reminder due. For example, a reminder report on a HbA1c reminder would display the number of diabetics and how many had not had a HbA1c in the past year.

I can run a report on my clinic or on my PCMM panel that shows me who needs a pneumovax or a HbA1c and when those patients have their next appointment with me or even all their future appointments at the Medical Center. We now routinely run reports on our Nursing Home patients to get lists of patients who need their pneumovax, influenza and PPD updated. This is a great timesaver compared to doing chart reviews or trying to keep a logbook.

I no longer have to look through old notes to see when I last did foot care education on my diabetic patients or to see when I last evaluated a patient for major depressive disorder – the reminder tells me when it is due and the health summary tells me when it was last done if I need to know. And I can tell how I am doing with my panel of patients and their preventive health:

PCE Reminders Due Report - Summary Report on PCMM panel

Reminders due for XXXX.XXX MD for 10/24/1999

	# Patients with Reminder Applicable	Due
Preventive Health Education	966	205
Depression Screen in past 1yr	966	300
Diabetes HbA1c	173	23
Diabetes Creat	173	12
Diabetic with last BP>140/85	173	77
Diabetes Urine Protein	171	24
Diabetes Urine Microalbumin	89	27
Diabetes Foot Inspection	172	44
Pneumococcal Immunization	732	224
Tetanus/Diphtheria	966	232
Smokers not educated in past 6 mo	224	93

Clinical Reminders can be time-saving useful tools if set up correctly. The next version of the Clinical Reminders software, expected to be out in the next 6 months, will make the reminders much more powerful and flexible.

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Update

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nosis early in pregnancy, may prevent a proportion of these women from having a further preterm birth. It is not known whether this is associated with an improvement in neonatal well-being.⁶ (Screening for bacterial vaginosis in pregnancy is one of the topics currently being considered by the United States Preventive Services Task Force).

The full text of these systematic reviews is available in the *Cochrane Library* at <<http://www.update-software.com/ccweb/cochrane/revabstr/ccabout.htm>>

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Recent Advances in Pharmacological Treatment for Smoking Cessation

In April 1996, the Agency for Health Care Policy and Research (AHCPR) released a comprehensive *Guideline* for the treatment of smoking. The main conclusions of the *Guideline* were: 1) all smokers should be identified and offered treatment; 2) nicotine replacement therapy (NRT) should be encouraged for virtually all smokers; and 3) there is a positive relationship between the intensity of behavioral treatment and long-term smoking cessation.¹ Since the publication of this guideline, numerous clinical trials of innovative treatments for smoking cessation have been published. Nicotine patch and gum have become available over-the-counter, and investigations of alternative ways to deliver nicotine (such as nicotine spray, nicotine inhaler, and combination therapies) have been conducted. Clinical trials of bupropion and nortriptyline have been reported, as well as novel approaches to the delivery of behavioral therapy such as telephone and Internet access to counseling. The *AHCPR Guideline* is currently undergoing revision to include these data; and will be available in April 2000. The purpose of this article is to review recent advances in pharmacological treatments for smoking cessation.

Over-the-Counter (OTC) Nicotine Replacement Therapy (NRT)

Seven studies have examined the efficacy of nicotine gum and patch OTC. These studies find quit rates similar to NRT that is delivered in a prescription setting. However, access to telephone and other forms of non-face-to-face counseling are frequently included with OTC manufacturer packages. Gum and patch approximately double quit rates compared to placebo (odds ratios (OR) 1.6-2.8).² Although OTC availability has raised concerns about long-term use of NRT, there are no data available concerning this practice.

Nicotine Nasal Spray

Of the NRTs available, nicotine spray most closely duplicates nicotine delivery from cigarettes. It is assumed to have more abuse liability because of its rapid onset of action, and remains a prescription drug. Smokers are told to use 1-2 doses per hour for up to 3 months. In four clinical trials, quit rates in active treatment groups are approximately double the rates in placebo groups (25-29%).² Throat, nose, and eye irritation and coughing are common with this treatment, although tolerance to these effects develops in about one week.

Nicotine Inhaler

The nicotine inhaler supplies nicotine through a plug that delivers a vapor. Nicotine is absorbed through the buccal mucosa rather than the lungs, so it is not actually an inhaler. Absorption kinetics, therefore, are similar to nicotine gum, however, the inhaler more closely duplicates smoking behavior. Early studies show the odds of quitting with active treatment compared to placebo to be 1.0-3.5.²

Combination Nicotine Therapy

Studies on high dose transdermal nicotine replacement therapy have been inconclusive to date, showing improvement in long but not short-term quit rates. These studies have, however, supported the safety of high dose NRT. There is some promising data on combination therapies with patch and gum, or patch and nasal spray.² The combination of patch and gum has been found to reduce withdrawal symptoms compared to either therapy alone. Other studies have found small improvements in 6 month quit rates with patch plus supplemental nicotine gum or spray. On the basis of these data, many clinicians prescribe 15 or 21 mg. patches with gum, to use on an as-needed basis to manage nicotine and oral cravings, up to 10 pieces per day.

Safety of Nicotine Replacement Therapy

Since publication of the AHCPR Guideline, new data on the safety of NRT in patients with cardiac disease have become available. A clinical trial of nicotine patches vs. placebo conducted in 10 VA hospitals enrolled 584 patients with cardiac disease, and there was no difference in the rates of adverse events, supporting the safety of NRT in patients with cardiac disease. A surprising result from this trial was that there was no improvement in smoking cessation rates in the active treatment group.³ This may be attributable to the brevity of the behavioral intervention, which might not have been appropriate for the duration of smoking and prevalence of psychiatric comorbidity in this veteran population. The safety of NRT in pregnancy has not been established, although the dangers of smoking in pregnancy are well-documented.

Bupropion

Bupropion (Zyban) was FDA-approved for smoking cessation in 1998. Two clinical trials have been reported on the effectiveness of this antidepressant for smoking cessation. The first trial compared placebo to 100 mg., 150 mg., and 300 mg. per day. At 12 months, rates of point-prevalent abstinence were 12%, 20%, 23%, and 23%, respectively.⁴ The second trial compared placebo, nicotine patch, bupropion, and nicotine patch plus bupropion. Treatment with bupropion alone or in combination with nicotine patch yielded significantly higher long-term quit rates than either nicotine patch or placebo.⁵

Recommendations

There are multiple pharmacotherapies for smoking cessation, including nicotine patch, gum, spray, inhaler and bupropion that are effective for smoking cessation. Each roughly doubles quit rates in comparison to placebo. There are very few data that compare therapies head-to-head, therefore there is no basis for initial recommendations of one therapy over another. Early drug trials are more likely to be conducted in more motivated quitters and to include more intensive behavioral intervention. Therefore, results may be more promising than those observed in later studies. Given this scenario, patient preference and experience with past quit attempts become important determinants of drug choice.

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VHA/DOD Clinical Practice Guideline to Promote Tobacco Use Cessation in the Primary Care Setting

Tobacco use is a major health problem for both military and veteran populations. In recent years, the military has established a goal of reducing tobacco use among its active duty personnel to improve readiness for service. Unfortunately, the legacy of untreated nicotine dependence after discharge, remains a health hazard in addition to a financial burden to the annual budget for the Veterans Health Administration (VHA).

For these reasons, designees from the Department of Defense (DOD) and the VHA formed a Working Group in 1998, to create a uniform *Clinical Guideline* for the treatment of nicotine dependence in both agencies. Final VHA approval occurred in November 1999. The official version will be distributed to all networks and local facilities in early 2000. When reading the protocol it will be evident, that the *Guideline* had to be written not just for adult male veterans, but for active duty military, their families and dependents as well. The document deals with the prevention of tobacco use, not just the treatment of nicotine dependence.

The term tobacco, not cigarette smoking, is the key word in the *Guideline*. No matter what form of tobacco is used, any tobacco delivery device (pipe, cigar, chewing tobacco, spit tobacco or cigarettes) can lead to nicotine dependence. By design, this is not called a *Smoking Cessation Guideline* that only deals with cigarette smoking. The term "cessation" is commonly linked to smoking, but is not used with other chemical dependencies. One seldom hears the phrase, for example, "I am going to refer you to an alcohol, or cocaine cessation clinic." The committee defined the concept that nicotine dependence is a treatable addiction which requires anticipation, recognition, intervention and follow-up for all veterans.

This *Clinical Guideline* views nicotine dependence as a disorder that should be identified in every veteran's medical record by all primary care clinicians in the VHA, and that appropriate treatment should be offered routinely. A consistent message from all primary care and specialty providers about the harmful effects of tobacco and the use of effective treatment, can reduce veterans' tobacco use. The tailored approach of the algorithm contained in the *Guideline*, can be matched to the tobacco users' current situation (recently stopped tobacco user, current smoker, etc.). Counseling suggestions that are appropriate for common situations encountered in treating nicotine dependence (denial, relapse, nicotine withdrawal symptoms, etc.) have been incorporated into the decision points of the algorithm.

An important concern at the local level is the frequency of counseling for tobacco use that needs to be documented. The *Guideline* reads, that after documenting the smoking status of the veteran, "Repeated assessment is not necessary in the case of the adult who has never used tobacco or has not used tobacco for many years, and for whom this information is clearly documented in the medical record. The clinician can proceed further, based on clinical relevance and appropriateness."

In many cases, there needs to be some training for health care providers to fully implement the interventions recommended in the *Clinical Guideline*. Most nurses and physicians are not adequately trained to assist tobacco users. (*JAMA*. 1999;282:825-9 and *JAMA*. 1993;270:1035-40). This situation presents an excellent opportunity for the Preventive Medicine Program Coordinator (PMPC) to organize in-service sessions or grand rounds, on tobacco counseling and pharmacotherapy.

The recommendations in the *Guideline* were based on the best literature published in the tobacco control field, and compared with the *Agency for Health Care Policy and Research (AHCPR #18) Guideline* from 1996, which will be revised in the spring of 2000.

The *DoD/VHA Guideline* is not intended to set a standard for the operation of a comprehensive nicotine dependence treatment program in your facility. These suggestions are designed for use by primary care clinicians, in treating veterans on a one-to-one basis, in the ambulatory care clinic. When treatment is not successful in assisting a veteran to become tobacco free, a referral to a tobacco cessation treatment specialist is the next step. This action directs the

patient encounter beyond the scope of this protocol, and into more intensive behavioral and pharmacologic therapy.

The *Guideline's* Appendix includes the *Fagerstrom Nicotine Tolerance Questionnaire*, a brief comparison of pharmacologic agents and their respective prices, and a list of patient education resources for use in the clinical setting.

A valuable outcome of the *Guideline* is to assist in determining success in reaching the goals of reducing morbidity and mortality in the veteran population. By clearly documenting the tobacco use status of all veterans and advising tobacco users to quit, system-wide, we will send a consistent message to all veterans, about the detrimental effect of tobacco on their health.

The next challenge is to create a reliable standard for comprehensive treatment for nicotine dependence at all VHA facilities. Some VAMC pharmacy formularies in 1999, still do not have nicotine replacement therapy or bupropion available for nicotine dependent veterans. This is an unacceptable practice according to the AHCPR national guidelines. High quality care for veterans requesting help to stop tobacco use, should provide all the components for success, not a sub-standard, low-cost version.

The Loma Linda VAMC has initiated an E-mail group for any facility coordinator wishing to be in contact with others implementing this *Guideline*, or updating treatment protocols for behavioral and pharmacologic therapy in smoking cessation. Contact Mr. David Saville, Addiction Counselor at the J.L. Pettis Memorial VAMC, Loma Linda California (the only full-time nicotine dependence coordinator in the VHA) at phone number: (909) 825-7084, ext. 1869 or by E mail at: <SavilD@11.visn22.med.va.gov>

The anticipated outcome of the combined federal *Smoking Cessation Guideline*, is to reduce tobacco related morbidity and mortality in both active duty military and veteran populations. Your comments about the *Clinical Practice Guideline* can be directed to the Tobacco Control Health Systems Specialist at VACO, Oliver Parr (202) 273-8454 and the members listed below.

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**Check out this newsletter on the Web at the
Internet & Intranet addresses listed below!**

Internet: www.va.gov/nchp

Intranet: vaww.va.gov/nchp

Preventive Foot Care

Foot and ankle problems represent a significant amount of morbidity in patient populations. The incidence and prevalence of foot conditions increase in both numbers and severity with age. According to the *Analysis of Foot Care Data* from *The 1990 National Health Interview Survey*, the most common foot complaints were toenail problems, infections, corns, calluses, foot injuries, flat feet, bunions, arthritis of the toes and toe/joint deformities.

It is estimated that the average person walks over 65,000 miles in a lifetime, subjecting the foot to both micro and macro trauma. Although the human foot was designed to develop and function unshod on natural surfaces, most people in the United States ambulate on hard, flat, unyielding surfaces in shoes which are often chosen more for style and fashion than for comfort and function. As a consequence, the foot is vulnerable to progressive mechanical deformity, both acute and chronic trauma, and invasion from various bacterial, fungal and viral infections. In addition, chronic degenerative conditions, such as diabetes, peripheral vascular disease and the various arthritides, further complicate foot problems and increase the risk for morbid complications. From a public health perspective, primary, secondary and tertiary preventive interventions should be instituted early and continued throughout the patient's lifetime in order to prevent limb-threatening complications.

Primary Prevention

Foot hygiene principles are an absolute necessity in primary prevention and should never be presumed by the health care professional. Recommendations to the patient should include:

- washing feet daily with soap and water;
- drying feet thoroughly, especially between toes;
- using an antifungal spray powder on the feet daily or in shoes at least weekly;
- using an emollient to keep feet moist, if excessively dry;
- using a drying powder (antifungal) to keep feet dry, if they perspire excessively;
- changing socks daily.

Other Primary Prevention Interventions

- Inspecting feet daily for cuts, scrapes, abrasions, blisters, etc. (a mirror placed on the floor can be used for this task, if needed);
- Avoiding complications related to chronic degenerative conditions such as diabetes, peripheral vascular disease, arthritis, poor vision, dementia, immunodeficiency, etc., remembering :
 - not attempting to cut thickened toenails;
 - not attempting to cut hyperkeratotic skin such as corns and calluses;
 - not soaking feet in hot water; and
 - calling your primary care physician or podiatrist at the first sign of a problem

Shoes – Footgear

A recommendation for shoe gear is to select shoes primarily for comfort and function rather than fashion and style. Unfortunately, many patients view these points in reverse which adds a psychosocial component to this issue. Footgear serves both a protective and functional purpose. The normal aging process can result in mild neuropathy, ischemia, immunopathy and atrophy of the protective plantar fat pad. Patients suffering from chronic degenerative diseases such as diabetes, peripheral vascular disease and arthritis are at even greater risk. Shoes must accommodate osseous deformities and protect the foot from excessive pressure and friction. In addition, the medial longitudinal arch should be supported in order to assist in balancing the foot for ambulation

- Make sure shoes fit properly by identifying the longest toe (usually the first but commonly the second) and check the front of the shoe for at least a $1/2$ " of space. This should be done at least monthly or sooner if the patient complains.



- Make sure that the shoe has the following characteristics:
 - Front of the shoe is wide enough and high enough to accommodate all of the toes and metatarsal heads;
 - The counter of the shoe (portion that grips the heel) should be firm; extended counters into the arch area are preferred;
 - Supportive sole which is strong enough for use on hard, flat, and unyielding surfaces;
 - The shoe should also be able to accommodate either a built-in, over-the-counter, or custom orthotic device;
 - Made of breathable upper materials and shock absorbent soling materials;
 - Although slippers may feel comfortable on the foot for the initial few moments, they do not have enough padding and support to protect the foot from flat, hard, and unyielding surfaces. Slippers are meant to be worn for the short walk from the bed to the bathroom. Patients should not be walking out of the house or standing for long periods of time in them.

In addition to advice for all patients, the following interventions are important for at-risk populations, as well:

- Make sure shoes are correctly sized and are appropriate for the activity being undertaken. (keep in mind that a lengthy walk can produce significant trauma if done in the wrong shoes; this is especially true for high heeled shoes);
- Purchase shoes in the late afternoon or early evening when feet and ankles are at their maximum size (secondary to orthostatic edema);
- Do not expect shoes to "stretch to size." Remember that different companies use different sizes so that a 10-D by one manufacturer may be a 9 $1/2$ -C by another. New shoes should fit comfortably.

Secondary Prevention

In the form of screening for disease precursors, secondary prevention should also be performed through the continuum of life with a foot examination for signs and symptoms of:

- ingrown toe nail/Onychocryptosis;
- fungal disease of the nails and skin (which is often the locus of infection for the nails);

- verruca plantaris and other viral skin lesions;
 - excessive pronation; and
 - structural and mechanical deformities:
 - hallux valgus;
 - hammer toe deformity and associated hyperkeratosis and sublesional bursitis;
 - metatarsal deformities and associated hyperkeratosis and sublesional bursitis; and,
 - excessive pronation.
 - vascular disease
 - pedal pulses – dorsalis pedis and posterior tibial
 - neuropathy
 - protection sensation – 5.07 monofilament
- The 5.07 monofilament is used to screen for protection sense in diabetic patients or other patients with peripheral neuropathy. The monofilament is placed on the skin until the filament bends. This applies 10 grams of pres-

sure to the skin that should be felt by the patients. The absence of this sensation indicates that the patient does not have protection sensation and is at risk for the development of limb-threatening ulceration and infection.

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Dr. Robbins is a Diplomate of the American Board of Podiatric Public Health, the Board of Podiatric Orthopedics and Primary Podiatric Medicine, as well as Professor of Podiatric Medicine at the Ohio College of Podiatric Medicine.



VA Launches Health Resource Homepage

The Veterans Health Administration - Office of Special Projects, in partnership with the VA Learning University, hosted the Veterans Affairs Health Resource Pilot-Testing Conference on July 28 - 29, 1999, in Silver Spring, Maryland. The VA Health Resource is the new patient health information and education web site, developed by the VHA Office of Special Projects. The objective is to create a "world-class," customer-driven web site, that will serve as a "one-stop," just-in-time health resource for veterans, their families and their caregivers.

The purpose of the conference was to pilot-test the web site and obtain information for improvement. Specific questions included, "Is the web site consumer-focused, user-friendly, and capable of meeting veterans' educational needs? Is the site fun to use?"

20 veterans and 30 staff tested the 13 health components of the program and provided feedback. Ideas regarding the functionality and graphic design of the home page were also solicited.

Criteria for selecting veteran participants were: experience using a computer and the Internet, articulate, any age, and able to drive or commute to the education site. Staff participant selection criteria included: comfortable using a computer and the Internet, articulate, and willing to be an organizational and field champion for the new program.

Faculty attending the meeting were: Susi Lewis, MA, RN, C., CPHQ; Nancy A. Thompson, Ph.D., FACHE; Victor S. Wahby, MD, Ph.D.; and Laura Warfield, MS, RD.

The Planning Group was comprised of: Susi Lewis, MA, RN, C, CPHQ; Rose Mary Pries, MSPH, CHES; Nicheole Amundsen, RN, RMS; Iris Renner, MLS; Nancy A. Thompson, Ph.D. FACHE; Gwen Waddell-Schultz, RN, MSN, ONC, CS; Victor S. Wahby, MD., Ph.D.; and Laura Warfield, MS, RD.

The meeting generated enthusiastic responses from veteran participants. Seated at computer stations, participants provided written feedback to staff, concerning their likes and dislikes.

Major components of the proposed web site include:

- patient health education materials that stress prevention and wellness;
- an interactive "story-telling" approach to health information;
- links to other sources of health information;
- locating the nearest VA facility;
- late-breaking stories related to veterans, and;
- a daily health message.



"Chat rooms" for various health conditions, moderated by professionals, are also being considered.

After analyzing the feedback from both veterans and staff, the Office of Special Projects has incorporated many changes. Meeting participants will receive a summary of the revisions.

Select components of the web site will be available this winter. Others will be added later.

You may contact Susi K. Lewis, Clinical Program Manager at the Office of Special Projects if you have questions or comments at 202-745-2200 or via e-mail: susi.lewis@med.va.gov.

Susi K. Lewis, MA, RN, C., CPHQ

Nancy A. Thompson, Ph.D., FACHE

Laura J. Warfield, MS, RD

Victor S. Wahby, MD, Ph.D.

Office of Special Projects, Washington, DC



Program Manager Laura Warfield questions veteran David Gordon on his reaction to the new web site.

Healthy Happenings

January – April, 2000

Date	Event	Sponsoring Agency
January	National Eye Care Month	American Academy of Ophthalmology www.eyenet.org
January	National Glaucoma Awareness Month	Prevent Blindness America 800.331.2020 • www.preventblindness.org
February	Low Vision Awareness AMD (Age-related Macular Degeneration) Month	Prevent Blindness America 800.331.2020 • www.preventblindness.org
February 14-18	National Eating Disorders Screening Program	National Mental Illness Screening Project 781.239.0071
February 20-27	Eating Disorders Awareness Week	Eating Disorders Awareness & Prevention, Inc. 206.382.3587 • www.nmisp.org
March	National Nutrition Month	American Dietetic Association (ADA) National Center for Nutrition and Dietetics 312.899.0040 • www.eatright.org
March 5-11	Save Your Vision Week	American Optometric Association 314.991.4100
April	Alcohol Awareness Month	National Council on Alcoholism and Drug Dependence (NCADD) 212.206.6770 • www.ncadd.org
April 3-9	National Public Health Week	American Public Health Association (APHA) www.apha.org/news/press/nphw.htm Anne Cahill 202.293.2270 x499
April 6	National Alcohol Screening Day	National Mental Illness Screening Project 781.239.0071 • www.nmisp.org
April 7	World Health Day	American Association for World Health Karen Moran • 202.466.5883

*Contact organizations for promotional materials.

Preview of Coming Attractions!

**Disneyland and Disneyland
Pacific Hotels • Anaheim,
CA • April 11-13, 2000**

Featuring

*David Satcher, MD, Ph.D. (Invited)
Assistant Secretary for Health and
Surgeon General, US Department of
Health and Human Services*

*Thomas L. Garthwaite, MD
Acting Under Secretary for Health,
Department of Veterans Affairs*

as well as other leaders in preventive medicine, within and outside of the VHA, including the Centers for Disease Control and Prevention and Department of Defense. The meeting will highlight "best practices/successful strategies" in prevention, proven to be effective and exportable to other sites. The program will emphasize activities that work in the delivery of preventive care. Plenary and concurrent sessions will focus on stages of change, clinical reminders, internet resources, evidence-based practices, research in prevention, the preventive services task force, immunizations, screening for colorectal cancer, diabetes education, and counseling techniques on alcohol, nutrition and exercise.

We are soliciting abstracts for a poster session on prevention programs at local medical centers. Watch for details regarding this within the next few weeks. Contact Dorothy Gagnier at the National Center for Health Promotion for more information concerning the conference.

National Center for
Health Promotion (NCHP)
Veterans Affairs Medical Center
508 Fulton Street
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Address Correction Requested



Putting Prevention Into Practice in the VA