FAST TRACK

"Infants who bedshare with their mothers exclusively breastfeed longer than infants who do not."

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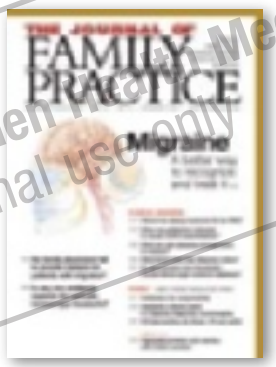
Co-sleeping discussion omitted breastfeeding

To the editor:

As a lactation consultant, I am always amazed by the omission of the vast amount of research done by James J. McKenna, PhD (www.nd.edu/~jmckenn1/lab/) that shows the beneficial aspects of co-sleeping to the newborn when discussing the co-sleeping issue ("What are safe sleeping arrangements for infants?" *J Fam Pract* 2006; 55: 1083–1087). Rarely do we hear about the physiological benefits to the baby, such as respiration regulation, heartbeat regulation, and temperature regulation when the baby is near her mother. Isn't a newborn more stable and at less risk of SIDS when near her mother and these physiological processes are in check?



Obviously, substance abuse (including tobacco), type of bed, and bedcovers need to be discussed with the parents. But in my view, these are secondary to the benefits of co-sleeping.

Debra Kyler, MS, RD, IBCLC
Board-Certified Lactation Consultant

The authors respond:

We can appreciate the concern over the omission of breastfeeding from our response to this question. A number of studies have been conducted demonstrating a significant association between bedsharing and breastfeeding.[1–5] A 1997 study by McKenna et al showed that infants who routinely bedshare breastfeed twice as much at night as infants who routinely sleep in a separate bassinette. The duration of breastfeeding episodes was also 39% longer.[1] A 2005 study by the International Child Care Practices Study Group showed that infants who bedshare with their mothers exclusively breastfeed longer than infants who do not bedshare (relative risk [RR]= 0.43; 95% confidence interval [CI], 0.30–0.61).[2]

While we do not dispute the potential benefits of bedsharing on breastfeeding, our task was to answer a question about the safety of various infant sleep arrangements. The outcomes we included were accidental asphyxiation, SIDS, injury, and death of unknown cause. We decided not to report on the relationship between breastfeeding and SIDS because breastfeeding did not meet inclusion criteria as a "sleep arrangement."

A 2006 trial conducted by Ball et al demonstrated that infants who sleep in sidecars attached to a mother's bed breastfeed as frequently as bedsharing infants and were observed in potentially adverse situations less frequently.[3] Given the potential benefits of bedsharing on breastfeeding, and the fact that side-cars are not a financially viable or culturally appropriate option for many families, it's fair to say that the question, "Does bedsharing improve breastfeeding?" probably deserves its own Clinical Inquiry.

Michelle R. Adler, MD MPH
Department of Family Medicine,
Oregon Health & Science University

Abbas Hyderi, MD, MPH
Department of Family Medicine,
University of Illinois at Chicago

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Talking about HPV has its challenges

To the editor:

Thanks to new treatments to prevent cervical cancer and the public information campaign accompanying it, people are talking about the human papilloma virus (HPV). We can check to see if women are infected with HPV and we can offer many of the women with this infection a vaccine to prevent cervical cancer.

What we can't do is give our patients a good coherent story that makes sense to them regarding how they became infected with the virus. We tell our patients that HPV is a sexually transmitted disease. Then we say that we can't culture for the virus in men, and we don't treat it in men. But it's OK to continue to have sex with the partner who may have infected them after they have been treated. It is difficult for a person to wrap their minds around having unprotected sex with an infected and untreated partner. With 90% of all women said to be positive for the virus, was it all sexually transmitted?

Needless to say this creates a lot of stress for the patients involved. If it is sexually transmitted, then shouldn't both partners be treated? And if a person does not plan to be sexually active, does this person have the option of not being treated?

Risk factors for cervical cancer include the presence of HPV, but 10% of women who have never had sex are HPV positive. And why do some people who have the virus develop cervical cancer, while others have no ill effects at all? The answers are still unknown. It is my feeling that the virus is normal flora in the body, but may be sexually activated.

One thing has become clear about HPV: There is an association between HPV and cervical cancer, and that association can be blunted by giving at-risk patients a vaccine.

We need to encourage our patients to get vaccinated, and be honest with ourselves and our patients about what we truly know about this problem, and what is an educated guess.

Tyler Cymet, DO

Section Head, Family Medicine Sinai Hospital of Baltimore; Assistant Professor of Internal Medicine, Johns Hopkins School of Medicine, Baltimore, Md

Was caution the best advice?

To the editor:

I was quite disappointed with the October Clinical Inquiry on steatohepatitis that advised readers to "remain cautious in prescribing statins for those with nonalchoholic steatohepatitis" ("Can patients with steatohepatitis take statins? *J Fam Pract* 2006; 55:905–906).

None of the studies cited support this conclusion. Also, several randomized placebo-controlled trials of statins over the past decade—specifically in patients with conditions that predispose them to nonalcoholic steatohepatitis (NASH): obesity and type 2 diabetes—revealed no difference between statins and placebo in the incidence of liver problems.[1] In fact, in people with normal baseline transaminases, at least 1 professional organization's clinical practice guideline recommends that routine testing of transaminases is no longer necessary.[2]

Why is this important? Up to 80% of people with type 2 diabetes will develop or die from cardiovascular disease (CVD). Lipid therapy can reduce the in-

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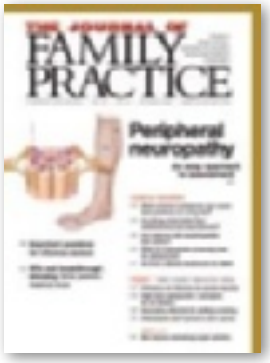
cidence of CVD in people with type 2 diabetes by 22% to 24%, according to a recent meta-analysis.[3] In fact, the Heart Protective Study suggests that *all* patients with type 2 diabetes benefit from statin use, regardless of baseline low-density lipoprotein (LDL) cholesterol levels.[4]

If one compares these result to those of the United Kingdom Prospective Diabetes Study (UKPDS), where tight control of glucose was not associated with a reduction in risk for CVD, we must ask ourselves why we spend so much of the encounter time focused on glucose control rather than lipid or blood pressure control.[5]



In a recent study of national data, only 33.8% of people with type 2 diabetes were at current guideline recommended level of LDL-cholesterol (<100 mg/dL).[6] Since 90% of patients with type 2 diabetes receive their diabetes care from primary care clinicians, the onus is on us to improve this number.[7]

Although the term "clinical inertia" in no way describes what occurs during my encounters with patients with Type 2 diabetes, if we use NASH as a "soft reason" to avoid statins or to discontinue them, then clinical inertia is the only term that accurately describes our behavior.[8] We must ask ourselves if our unfounded fear of statins in people with NASH is really in the best long-term interest of our patients with type 2 diabetes.

Michael L. Parchman, MD, MPH
Department of Family and Community Medicine, University of Texas Health Science Center, San Antonio

The author responds:

You've cited stimulating references that would compel any primary care clinician to review the current evidence on the management of lipids in diabetes and alter practice patterns as necessary to provide the best care possible to our patients. Regarding this clinical inquiry of statin use in steatohepatitis, you've noted that the studies presented did not discover significant complications from statin use. This is indeed very encouraging as steatohepatitis is also increasing in our practices, and understanding how to treat patients with this condition is important.

However, these studies were of short duration (six months or less) and had low patient numbers. Given the limited nature of published evidence on this topic, caution is prudent when prescribing statins for our patients with steatohepatitis.

Until larger and longer length studies are published, Dr. Oh's statement is a reasonable and responsible approach to the management of patients in this category. Hopefully, future larger studies will reinforce these early studies, and that could establish statin use in steatohepatitis as the standard-of-care. We are not there yet.

Dave Congdon, MD
University of Washington, Seattle

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FAST TRACK

"Is our unfounded fear of statins in people with NASH really in the best interest of patients with Type 2 diabetes?"

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