LETTERS FROM MAINE

A Fat-Fighting Stimulus

The bad news is that the global economy has gone in the toilet. The good news is that most economists agree on something. They suggest that to winch ourselves out of this abyss, we (or our government) must do some serious spending. As a lifelong fiscal conservative, this notion makes me nervous.

BY WILLIAM G. WILKOFF, M.D.

However, a New York Times column by recent Nobel Prize recipient Paul Krugman helped me to realize that in a depression economy, we must operate by a different set of rules. Mr. Krugman feels that appropriately targeted spending in huge chunks is the best and only answer. If the economy overheats to the point of inflation, he says that we will have plenty of room to cool things down by increasing interest rates.

So … I'm ready to chime in with my own suggestions about how we should spend all that money we are going to print. It's hard to argue with the value of repairing and improving our roads, bridges, airports, etc. Maybe those of us who prefer to commute by bicycle will get a few more lanes of our own as part of this rehab of our infrastructure.

A comprehensive and totally federally funded immunization program also would be a nice addition. However, I suggest that we invest some of our stimulus package in something less tangible than bridges and vaccines—a plan that will stimulate our children to become more physically active.

The origins of our national epidemic of obesity are many and, in some cases, poorly defined, but it is clear that a sedentary lifestyle is a contributor. Although there are too few valid studies to draw a solid conclusion, intuition tells me that programs including increased physical activity must be beneficial. While I would like to see us take the simple and direct approach and blow up half the televisions in the United States, somehow I don't think Congress will buy it.

Although my friends who are educators have become increasingly frustrated as our public schools have become dumpsters for our society's ills, I am afraid it's time to toss our epidemic of physical inactivity on the pile.

A few primary school educators that I know have cleverly integrated physical activity into their curricula. However, I think the severity of the problem demands the more drastic step of adding an hour to the school day for every kindergarten-through-fifth-grade student in America. Obviously, this is a change with a big price tag. So this is where the stimulus bundle comes in. In the plan, each school that added an hour to the school day would receive a sizeable chunk of change to fund the cost of staff and building maintenance. The only stipulation would be that during that hour the students must be kept physically active.

Each school could use the money as its needs dictate. Upgrade playgrounds, modify classrooms to be activity friendly, pay stipends for teachers who wanted to work more hours—or even better, pay underemployed community members to be supervisors. Each school would be supplied with voluminous educational materials to stimulate creative solutions to fill that hour. For some schools, it may simply mean adding another and longer recess that promotes free play. For others, it could be adding nontraditional school activities such as dance and martial arts.

Presumably, the biggest health payoff for our investment would be a few decades away. For a quicker feedback, one could measure BMIs anonymously and compare them before and after initiating the program. Regardless of how much it bumps up our GDP, one less hour of inactivity will be good for our children. ■

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POINT/COUNTERPOINT

Is universal vaccination of boys the next step in fighting HPV?

Boys and girls should be vaccinated.

Widespread immunization of girls and boys against the human papillomavirus could fully eradicate types 16 and 18 of the virus. If we miss half the equation by leaving the boys out of our vaccination strategy, that type of public health success will not be possible.

BY ELLEN ROME, M.D.

The benefits of HPV vaccination in boys are numerous. While protecting women from HPV and the morbidity and mortality associated with cervical cancer is a significant motivation for male vaccination, males would also accrue their own health benefits through vaccination. For example, approximately 12% of oral pharyngeal cancers are caused by HPV types 16 and 18, which also causes some penile and anal cancers. Also, 90% of genital warts are caused by HPV types 6 and 11, which can occur in boys as well as in girls; while not life-threatening, genital warts are certainly anxiety provoking. In addition, one out of four girls and one out of six boys is the victim of sexual abuse by age 20. That's a high number of young people for whom prevention would be relevant.

With respect to public health, if we want to achieve herd immunity with HPV, we really need to vaccinate both sexes. There's also a larger message from society in how we choose to formulate our vaccination strategy. If we don't vaccinate boys, we are saying as a society that women and girls alone have the responsibility for society's sexual health.

Men also have a stake in the health of their future sexual partners. While boys may be only 11 or 12 years old when their parents consent to HPV vaccination on their behalf, these boys and their parents will not want their future partners or offspring to be exposed to life-threatening HPV.

The cost-effectiveness estimates for vaccinating boys are not compelling at this point. However, the public health benefit is clear and the medical risks associated with vaccination are extremely low. In fact, the experience with girls in the United States has been excellent, with fewer adverse events reported for the HPV vaccine than for most other common immunizations.

Making sure that all girls and women worldwide get the vaccine is the first priority. But vaccinating boys and young men would also help us more broadly prevent disease, especially in areas where vaccination is not universal. In a perfect world, boys and girls would receive this vaccine at a young age and both would be able to reap its preventive benefits from the start. ■

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The evidence needs time to mature.

The issue of immunizing males against HPV often comes down to whether they should receive the vaccine to protect females. Doing so is honorable and even reasonable, but at this point there is little evidence suggesting that this is cost-effective.

BY KENNETH ALEXANDER, M.D.

Early cost-benefit analyses of this idea showed that a large number of males would need to be immunized to achieve even a minimal increase in protection for females. At the same time, adding males to the equation would significantly increase the cost of the immunization program. For the time being, we need to focus on getting a high number of women and girls immunized, and then we can start thinking about what to do with men and boys.

This said, there are other compelling reasons to consider vaccinating males. Newer data are beginning to show that HPV does more in men than might have been appreciated just a decade ago. A significant portion of head and neck cancers, anal cancers, and cancer of the larynx are caused by HPV. When you start adding up the number of cases of cancers in males attributable to HPV, you end up with roughly the same number as the amount of cervical cancer cases in the United States. Not to be forgotten is the significant morbidity associated with genital warts. So the reasons to immunize males will likely have more to do with protecting males against the diseases they get, rather than protecting women from cancer.

The catch with male immunization is that the studies showing that HPV vaccines prevent these cancers in men do not yet merit changing our vaccination strategy. When the data are available, I expect we will have sound reasons to immunize males against HPV.

Although we are not yet in a position to offer routine HPV immunization to males, physicians still have a few tasks to consider. First, we need to ensure that all the women who are eligible for this vaccine have the opportunity to receive it. Second, depending on the maturity of the patient, physicians can begin a discussion about issues of sexuality and sexually transmitted diseases at the 11- to 12-year-old visit. This means talking to the parent and child together, then with the parent alone, and finally with the child alone. Third, we must give children honest, accurate information before they become sexually active so they can make good decisions. Even if we don't yet give young males a vaccine, we must give them the facts. ■

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