



HALDIMAND-NORFOLK HEALTH UNIT

PHYSICIAN'S NEWSLETTER

Haldimand and Norfolk Pandemic Response Plan

The Haldimand-Norfolk Health Unit has put together an Influenza Pandemic Response Plan which is now available as a working document on the Health Unit website www.hnhu.org.

We are taking this opportunity to ask you to think about how you would like to be kept informed in the event of a pandemic. It is understood that you will be overwhelmed with patients at this time and therefore would need timely and accurate information delivered to you in a way that accommodates you best, ie, fax, email, etc.

The Health Services and Public Health Measures Subcommittee and the Anti-virals and Vaccine Subcommittee both have a community physician on the list of possible members to ensure this sector is well represented during a health emergency such as a pandemic. Please contact the Health Unit if you

have questions regarding these sub-committees.

It is important for your office to be considering its own contingency plan in the event of a pandemic. This contingency plan would address such issues as how (if) you would keep operating with 30-50% fewer staff, which services do you provide that could be defined as "non-essential", which staff would be considered non-essential who could be re-trained for other essential services within your practice.

As we've all heard before, it's a matter of "when" not "if" the pandemic will be arriving and the Health Unit will be doing its best to assist the community agencies in pandemic planning.

Submitted by Leslee Wilson, Public Health Inspector, 519.426.6170 Ext. 3254



Stuttering

Stuttering, or dysfluency, is a communication disorder that disrupts the natural flow of speech. Common characteristics of stuttering include sound repetitions (p-p-please), part-word repetitions (be-be-bean), whole-word repetition (my my my truck), phrase repetitions (Can I Can I Can I go?), prolongations (mmmmmy name is), and blocks. Stuttering can also be accompanied by secondary behaviours such as eye blinking and facial grimacing.

Stuttering occurs in approximately 1% of the population and begins between

2-4 years of age. Most children will go through a period of normal developmental dysfluency during the preschool years as language acquisition occurs. Normal developmental dysfluency differs from true stuttering by the types of dysfluencies the child is exhibiting, the number of repetitions the child is displaying and the percent of syllables stuttered in the child's speech. In normal developmental non-fluencies children are likely to repeat whole words or phrases two to three times. They are also likely to stutter on less than 10% of syllables spoken. True stuttering is characterized by

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SIDS, Pacifiers and Co-Sleeping / Co-Bedding

The “Back to Sleep” campaign has dramatically reduced the incidence of Sudden Infant Death Syndrome.

Using a supine position for infant sleep has resulted in reduction of about two thirds in the numbers of SIDS deaths from 332 in 1990¹ to 138 in 1999². Research further showed that back-lying does not increase risk of milk aspiration³. All of the agencies stopped recommending side-sleeping as an alternative. Research shows that it commonly reverts to prone and has nearly the same SIDS risk as prone sleep. SIDS deaths in Canada further declined to 111⁴ in 2002 as side-lying was abandoned.

In 1999, the American Product Safety Council offered the recommendation that the only safe place for babies to sleep is in their crib⁵. The American Academy of Pediatrics and the Canadian Pediatric Society followed with similar recommendations. In 2004-05, both agencies renewed the guidelines and specifically recommended against any bed-sharing⁶. In addition they suggested use of pacifiers for SIDS prevention. Both also included a recommendation that babies share their parents' rooms, a practice known to decrease SIDS risk by 50%⁷.

A steady stream of criticism has followed. The breastfeeding communities have been particularly vocal. Exclusive breastfeeding for six months is now the recommenda-

Risk Factors for SIDS

All of the following increase the risk of SIDS:

1. **Tummy (prone) or side sleeping**
2. **Soft sleep surfaces**
Waterbed, couch, sofa, or pillows
3. **Loose bedding**
Pillows, comforters, quilts, blankets
4. **Overheating**
Overdressed or very warm room increases risk by 5 times
5. **Smoking**
Mothers who smoked during pregnancy; any exposure to smoke at home increases risk by 11.3 times
6. **Bed sharing**
Sharing a bed with anyone other than the parents or caregivers

Sharing a bed with people who smoke or are under the influence of alcohol or drugs increases an infant's risk for SIDS
7. **Preterm and low birth weight infants**
Infants born premature or low birth weight
8. **Formula feeding**
Increases risk by 5 times

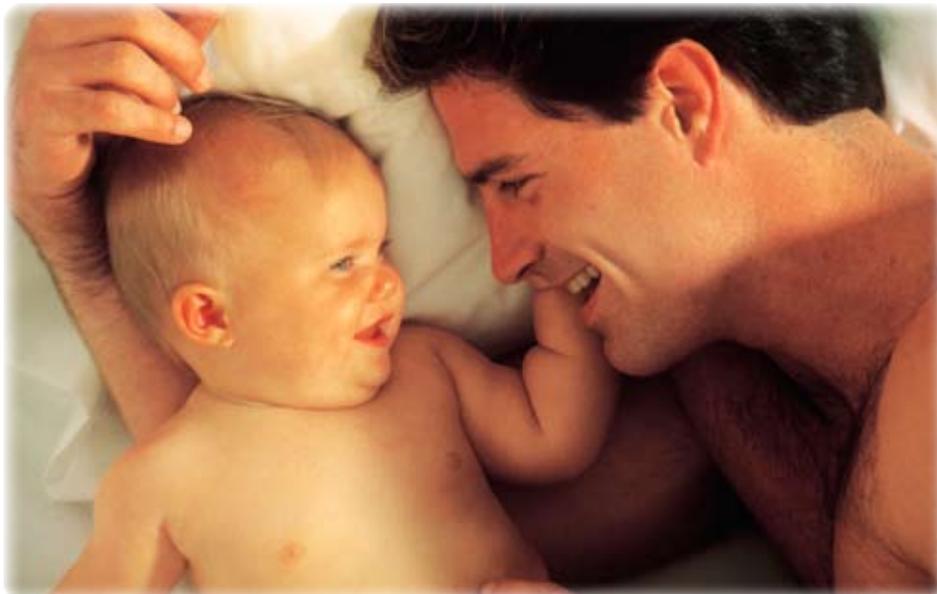
tion from health agencies, from World Health Organization to the Canadian Pediatric Society. Among its many other positive attributes, breastfeeding in and of itself is thought to protect against SIDS. There is no definitive research on that yet but some studies show decreased levels of arousal in formula fed infants⁸.

The CPS and AAP Statements went on to note that pacifier use seemed effective in SIDS prevention⁹. Pacifiers do in fact encourage baby to breathe by maintaining a higher state of arousal during sleep. However they are less effective than a baby's own fingers, or actually being fed, in maintaining higher level arousal. And pacifiers tend to lead to fewer feeds (and full arousals) than no pacifier¹⁰. The use of pacifiers is discouraged in the first month or two until breastfeeding is established. This proviso is included in the recommendations by the AAP and the CPS but is not usually mentioned in the press releases and news reports of the publications

Sleeping next or close to mom facilitates breastfeeding—making frequent nighttime feeds easier—and is adopted by the vast majority of breastfeeding women, for a time at least¹¹. The discussion has been so heated that the CPS recently acknowledged that it is useless to make recommendations that 50-90% of people [parents] refuse to follow¹². They further note that offering information on making bed-sharing as safe as possible may need to follow.

The initial data used by the Product Safety Council is thought to be flawed by some. Dr. James McKenna, pre-eminent researcher in the area of Mother Baby Sleep, flatly states that no bed-sharing deaths have occurred that aren't related to a known risk factor like sleeping on a couch or other inappropriate surface, mother being drugged or drunk, or sleeping with siblings rather than parents. When such risky sleeping is factored out, SIDS deaths in co-sleeping situations drops to near zero¹³. His position has also been supported by the AAP's own Section on Breastfeeding Medicine¹⁴.

McKenna has gathered a mass of informa-





tion about the synergistic accommodation that happens between parent and child when they routinely co-sleep. Their breathing synchronises, as do sleep cycles. In general the mother actually gets more sleep, and sleeps more soundly, than the mother whose child is down the hall. In addition the baby feeds more often – approximately twice as often as when the child is in a separate bed – and the mother does not remember waking to feed^{15, 16}. Dr. Nils Bergman has done parallel research demonstrating that better growth and development is achieved in both premature and term infants when babies are held skin to skin, literally attached to mother, for as long as they need that¹⁷. Both McKenna and Bergman note that proximity of mother and baby are the evolutionary standard and separation is a very Western, 20th Century notion. While both support co-bedding, both also support other forms of co-sleeping.

Co-Sleeping vs. Bed-Sharing

Bed-sharing = infant and mother sleeping in the same bed

Co-Sleeping = infant and mother sleeping in the same room

Co-Sleeping includes co-bedding, but also includes a specialized baby bed that attaches to the parents' bed (a.k.a. "co-sleeper"), a bassinet beside the bed, a bassinet or crib near the bed.

All this is confusing to professionals let alone to consumers and patients. As the CPS found, there are families who will share beds with infants, regardless of guidelines. Therefore it's only common sense to be mindful of what these are. The first point is that sharing a room with an infant is co-sleeping and includes having the baby on a separate surface that is attached or close to the parental bed.

Several sets of guidelines have already been developed for safely bed-sharing. Australia and the United Kingdom both have defined policies and recommendations for safe sleeping with baby. Dr. Aurore Cote, of McGill University, Montreal has published an excellent guide to sleeping with babies called *Back to Sleep for Life, Sleeping in a safe environment*¹⁸ which includes suggestions in the box.

The crib-sleeping baby has similar guidelines: firm, flat mattress, no blankets, no stuffed animals, no soft toys, quilts, or bumper pads. The child should wear sufficient night-clothes to need no blanket. If needed, one thin blanket tucked in at the side and reaching only to the waist should be used. And the crib should be in the parent's room.

With breastfeeding being the new norm in Canada, including locally, many parents of breastfeeding infants will wonder about bed-sharing. It should only be done if ALL the criteria noted above are met, because those define whether it can be safe or not. Parents who choose not to meet the criteria should have the infant in a safe baby bed, close at hand.

And, of course, all of the safe sleeping for baby guidelines apply for both bed-sharing and crib-sleeping infants. No one wants to see another SIDS death, ever.

Submitted by Judith Hayman, Public Health Nurse, 905.318.5367 Ext. 312

Guidelines for Safe Bed-Sharing

These include:

- Neither parent should smoke. Chemicals exhaled during sleep can affect baby.
- Neither parent should be impaired with alcohol, drugs, medication, or illness. (Anything that impairs awakening.)
- The sleep surface should be flat and firm. Lounges and couches are never considered safe as entrapment may occur.
- One light blanket and pillow for each parent. Baby should wear sufficient nightwear to not need a blanket.
- Parents have baby in bed with them routinely, not occasionally.

Occasions when the parents are ill, have consumed alcohol, or medications that make them sleep, etc. are times when baby should sleep in his own bed.

From Back to Sleep for Life, Sleeping in a safe environment by Dr. Aurore Coté

¹ Canadian Foundation for the Study of Infant Deaths. Number of SIDS Deaths in Canada. http://www.sidscanada.org/Number_of_SIDS_Deaths_in_Canada_1990-2003.pdf. Accessed March 15, 2006.

² Public Health Agency of Canada. Sudden Infant Death Syndrome (Canadian Perinatal Surveillance System Fact Sheet). http://www.phac-aspc.gc.ca/rhs-ssg/factshts/sids_e.html. Accessed March 15, 2006.

³ Task Force on Sudden Infant Death Syndrome. The changing concept of sudden infant death syndrome: diagnostic coding shifts, controversies regarding the sleeping environment, and new variables to consider in reducing risks. *Pediatrics*. 2005, 166(5):1245-1255.

⁴ Statistics Canada. Causes of Death, 2002. <http://www.statcan.ca/english/freepub/84-208-XIE/84-208-XIE2004002.htm>. Accessed March 15, 2006.

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- ⁵ U.S. Consumer Product Safety Commission. Recommendations Revised To Prevent Infant Deaths from Soft Bedding. Press release, April 9, 1999. <http://www.cpsc.gov/CPSC/PUB/PREREL/PRHTML99/99091.html>. Accessed March 15.
- ⁶ Community Paediatrics Committee. Recommendations for safe sleeping environments for infants and children. *Paediatrics & Child Health* 2004; 9(9), 659-663.
- ⁷ Hauck FR, Heman SM, Donavan M, et al. Sleep environment and the risk of Sudden Infant Death Syndrome in an urban population: The Chicago Infant Mortality Study. *Pediatrics* 2003; 111:1207-14.
- ⁸ Horne, R S C, Parslow, P M, et al. Comparison of evoked arousability in breast and formula fed infants. *Arch. Dis. Child.* 2004;89;22-25.
- ⁹ Task Force on Sudden Infant Death Syndrome & Community Paediatrics Committee.
- ¹⁰ Smith, L. The co-sleeping controversy. National Breastfeeding Seminar, 2005.
- ¹¹ Ball, H. Breastfeeding, bed-sharing and infant sleep. *Birth*, 2003, 3(3), 181-88.
- ¹² Pediatric group to soften bed-sharing stand, *The London Free Press*, Feb 14, 2006. Also in *Toronto Star, Globe and Mail*, etc, same day.
- ¹³ McKenna, J. Why babies should never sleep alone: A review of the co-sleeping controversy in relation to SIDS, bed-sharing and breastfeeding. *Paediatric Respiratory Reviews*, 2005, 6: 134-152.
- ¹⁴ AAP Section on Breastfeeding. SIDS Policy Statement Response. *Breastfeeding: Best for Baby and Mother*, Winter 2005/2006.
- ¹⁵ McKenna J, Mosko S, Richard C. Bed-sharing promotes breastfeeding. *Pediatrics*. 1997; 100:214-219.
- ¹⁶ Mosko S, Richard C, McKenna J. Infant arousals during mother-infant bed sharing: implications for infant sleep and sudden infant death syndrome research. *Pediatrics*. 1997; 100:841-849.
- ¹⁷ Anderson, GC, Moore E, Hepworth, JT, Bergman, NJ. Early skin-to-skin contact for mothers and their newborn infants. Cochrane Collaborative Systematic Review. Cochrane Library, April 2003.
- ¹⁸ Cote, A. *Back to Sleep for Life, Sleeping in a safe environment*. Available for order as PDF at: www.backtosleepforlife.ca/

Stuttering *continued from page 1*

multiple sound repetitions, prolongations, blocks and secondary behaviours.

Spontaneous recovery of stuttering is estimated to occur in 60% of cases with girls much more likely to recover than boys. Children who have a family history of stuttering are at an increased risk of persistent stuttering. As well, those children who have good speech and language skills have been shown to have a higher recovery rate without treatment than those who have other speech and language difficulties.

The aetiology of stuttering has long been debated. Recent research shows that approximately 25-80% of stuttering cases are the result of genetics. Alterations in anatomy and function of the central nervous system may also play a role in stuttering. Positron Emission Tomography and Magnetic Resonance Imaging have revealed that people who stutter have decreased activation of the auditory cortex in the left hemisphere and increased activity in the right hemisphere compared to people who do not stutter. As well, people who stutter show an overactivation of the Supplementary Motor Area (SMA) and reduced activation of the primary speech motor area (Broca's area).

The cause of stuttering is biological; however, the environment plays a key role in severity. In other words, although stuttering is determined biologically, a person's emotional reaction to their stuttering can cause an increase in severity. As one reacts to their stuttering, anxiety can build causing them to stutter more which in turn increases anxiety. This creates what is known as the stuttering-fear cycle. Successful treatment focuses on counteracting the fragility of the left hemisphere through fluency enhancing techniques and altering the environment to remove fear and apprehension.

The Haldimand-Norfolk Preschool Speech and Language Program is offering workshops (including one on fluency), for parents, educators, professionals and anyone interested in learning about the communication skills of children age 0-5 years.

Refer to the enclosed insert for dates of workshops.

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