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SCHIP Reauthorization Sparks Debate on Health Insurance

Plans for reauthorization of the State Children's Health Insurance Program (SCHIP), the popular state/federal program to insure children of families too well off for Medicaid but unable to afford private insurance, collapsed in confusion last month, as the Bush administration took steps to preempt congressional action and state governors vowed to overturn the administration's move.

Both the administration's and the states' positions were seen as predictors of future debates on publicly and privately funded health insurance in the United States.

Here are some of the developments in the controversial issue.

- The Census Bureau in a report released August 28 said the number of uninsured children in this country increased from 8 million (10.9 percent) in 2005 to 8.7 million (11.7 percent) in 2006.
- Both the House and Senate passed bills in late July reauthorizing the SCHIP program, which is slated to expire September 30 this year. The bills differ in some details, but both would provide increases of at least \$35 billion to \$50 billion over five years in federal matching funds to allow states to enroll more children in SCHIP.
- President Bush has said he will veto the SCHIP reauthorization if the bill exceeds his budget request for a more modest increase of \$5 billion over the next five years. That would be enough money to allow states to continue to serve children now enrolled in SCHIP, but with no expansion.
- At 4:30 on Friday afternoon, August 17, the Centers for Medicare and Medicaid in the U.S. Department of

Health and Human Services announced that it had sent a letter to state governors informing them of new conditions that must be met by SCHIP programs before they extend income eligibility levels beyond 250 percent of poverty. Specifically, the new directives require states to have enrolled at least 95 percent of all children in a state whose family incomes are below the 250 percent level before they expand enrollment beyond that level; they must show that employer-based coverage for children has not declined by more than 2 percentage points over the past five years; and there must be a 12-month waiting period before SCHIP enrollment for children who had employer-based coverage in the past.

- The HHS action was not announced in the *Federal Register* with an opportunity for public comment, as is usual when changes are proposed in federal regulations. State governors say they will challenge the procedure in court, and they have also asked congressional leaders to add language to the pending reauthorization bills negating the administration's directive.
- States are allowed under the SCHIP law as it now stands to set their own income eligibility levels, and both the House and Senate bills leave that policy intact though with minor adjustments.

What Does It All Mean?

As of August 1 this year, 19 states have SCHIP income eligibility levels at or near 300 percent of poverty, which in most states would be an annual income of approximately \$62,000 for a family of four. Those states and several other who are contemplating but have not yet implemented such income eligibility would be unable to expand their SCHIP enrollments under the administration's proposed rules and might have to roll back

Health & Health Care in Schools is a monthly journal published in html and PDF versions by The Center for Health and Health Care in Schools. The Center is located at:
School of Public Health and Health Services
The George Washington University Medical Center
Support for Health & Health Care in Schools is provided by The Robert Wood Johnson Foundation



children who have been insured for years, according to Cindy Mann, executive director of the Center for Children and Families at Georgetown University in Washington.

Robert Greenstein, executive director of the Center on Budget and Policy Priorities estimates that the administration's directive puts coverage for as many as "several hundred thousand" children at risk.

Pennsylvania Governor Edward Rendell, whose state is launching a major effort to insure children, warns that if Congress does not intervene to stop the new directives, the legislation already passed by the House and Senate will be meaningless. "SCHIP will wither on the vine," he said.

Critics of the administration's new initiative speculate that President Bush's vow to veto generous new SCHIP legislation may be seen in hindsight to put many Republican members of the House and Senate in an awkward position—either to part company with the President by voting to override the veto or having to explain to constituents when they stand for reelection in 2008 that they voted against health insurance for children. "The new rules may give the administration room to bargain about the final SCHIP bill," one observer commented.

Whatever happens in the next few weeks, it is unlikely that Congress will let SCHIP die when the current law expires September 30. If no agreement has been reached by that time, Congress is expected to resort to a time-honored device for keeping unauthorized programs going—a continuing resolution that funds the program at current levels until a new law is passed.

Also see: "SCHIP—The Second-Hottest Item on Congress' Agenda,"

www.healthinschools.org/News-Room/EJournals/Volume-8/Number-2.aspx.

Chronic Illness in Childhood

The prevalence of chronic diseases in children has increased since the 1980s and will likely increase further, according to the *Journal of the American Medical Association*, which devoted its entire June 27, 2007, issue to the subject of pediatric chronic illness.

For children with chronic illness, life can be complicated and difficult, the Journal points out. "A child with asthma may need to take daily medication, an obese youngster may endure taunts or stares, a child with cancer may be hospitalized for extended periods of time, and concern about bills and time and health are very real, at least for their parents."

The implications of childhood chronic illness for institutions that serve children, including schools, are immense and grow-

ing, the Journal says in an accompanying editorial. Journal editor Catherine DeAngelis cites conditions for which prevalence has increased in the last two decades, including the three that have grown most—obesity, asthma, and attention deficit disorder. It also appears that physician-diagnosed diabetes mellitus among children and adolescents has increased, with type 2 diabetes becoming common especially among minority adolescents. Added to these are other illnesses of childhood, including cancer, cerebral palsy, juvenile rheumatoid arthritis, cystic fibrosis, and cardiovascular disease, for which we still do not fully understand the effects of treatment on children's physical and psychological development.

The Journal examines in detail two of the chronic diseases that are commanding new attention—diabetes and childhood obesity.

Diabetes

Diabetes occurring early in life has devastating effects on the ability of young patients to live full lives, researcher Rebecca Lipton points out. But diagnosing the condition is changing. "Before 1997, virtually all diabetes in young individuals was thought to be autoimmune type 1 diabetes mellitus (DM). Now there is widespread recognition that insulin-resistant type 2 DM can occur in childhood. Furthermore, evidence is accumulating that type 2 DM in young individuals is qualitatively different from that in older adults, often resulting from an interplay of insulin resistance and autoimmunity."

A World Health Organization-sponsored study that began in the 1980s has found major increases in diabetes in children in all areas of the world, and the Centers for Disease Control and Prevention (CDC) estimates that the risk of diabetes before age 20 in the United States is 24.3 per 100,000 per year, overall.

Almost simultaneous with the increase in diabetes, there has been an unprecedented increase in childhood obesity during the past two decades, and it's tempting to assign the growing incidence of diabetes to obesity alone, but that may miss important contributing factors such as genetic susceptibility that are not yet clearly identified, the research report notes.

Obesity

An epidemic of childhood obesity and overweight threatens long-term medical, psychosocial, and financial consequences beyond U.S. society's current capacity to respond, according to researcher Rita Lavizzo-Mourey.

"Current evidence indicates a worst-case trend. In just over a generation, rates of overweight have approximately tripled among children aged 6 to 11 years, and in 2004 17.1 percent of children and adolescents in the United States were overweight." The researcher notes that children in certain demographic subsets, including African American adolescents, are particularly vulnerable to overweight and its adverse health effects, "adding to the burden of populations that are already disproportionately uninsured and experiencing disparities in health care."

Programs to change the food and physical activity environment of children exist in some schools, including a Healthy Schools Program created by the Alliance for a Healthier Generation, a joint project of American Heart Association and the William J. Clinton Foundation that aims to help schools set and implement standards for nutrition, physical activity, and staff wellness. “The program started with 230 pilot schools in 13 states, and more than 900 schools signed up to use the programs online tools. In its first year, the program reached approximately 750,000 students and is providing further evidence that school-based interventions are a powerful tool for reaching large numbers of at-risk youth.”

School-based interventions alone may not be enough to reverse the upward trend in obesity rates, however. Recent research has suggested that to succeed, school-based programs must be accompanied by family and community interventions.

Defining ‘Chronic Illness’

Understanding the true scope and impact of childhood chronic illness on schools, physicians, and the public health system requires agreement on what, exactly, the term means, and such agreement is currently lacking, the Journal says. Various programs and services for children use differing ways of identifying those who are chronically ill, based on factors such as a patient’s ability to function normally in life or school, the need for supportive medical service on a part- or full-time basis, and the need for accommodation to a disability.

A comprehensive review of medical literature came up with a range of concepts, from “medically fragile” to “children with special health care needs.” The Journal researchers do not mention the definitions used by federal agencies, which differ, for example, between the Individuals with Disabilities Education Act (IDEA) and Social Security Supplemental Income (SSI), but they make clear that some kind of international consensus is needed if we are ever to know how many children are “chronically ill,” and what the term means for their care and treatment.

What everyone can agree on, says Journal editor DeAngelis, is that chronic illness steals childhood, and that stemming the growth of chronic illness in children calls for major efforts to understand causation and means of prevention.

Prevention and Control of Influenza

As another flu season approaches, the Advisory Committee on Immunization Practices (ACIP) has published a comprehensive guide to preventing and controlling outbreaks of the illness. The report notes that in the United States, annual epidemics of influenza occur typically during the late fall and winter seasons, with rates of infection highest in children.

The best way to prevent flu and its possible serious complications is vaccination, the report advises, and vaccination is recommended for all children six months to four years of age and for schoolchildren up to 18 years of age. Vaccination is also recommended for some special groups, including:

- Children and adolescents receiving long-term aspirin therapy who therefore might be at risk for developing Reye syndrome after influenza virus infection;
- Adults and children who have chronic pulmonary or metabolic disorders (including asthma and diabetes);
- Adults and children who have immunosuppression caused by medication or by HIV;
- Adults and children who have any condition (e.g., cognitive dysfunction, spinal and cord injuries, seizure disorders, or other neuromuscular disorders) that can compromise respiratory function;
- Health care personnel;
- Healthy household contacts, including children, and caregivers of children up to five years of age, with particular emphasis on vaccinating contacts of children under six months of age.

The ACIP offers a refresher on the background and epidemiology of influenza. The report notes that there are two types of viruses that cause human infection, A and B, subtypes of which circulate globally. Annual vaccinations are required because new influenza variants regularly emerge, as the result of mutations that occur during viral replication

As for the epidemiology--influenza spreads from person to person primarily through “large-particle respiratory droplet transmission” as when an infected person coughs or sneezes near a susceptible person. Droplets do not remain suspended in air and usually travel only a short distance. It’s also possible to come into contact with droplets on a contaminated surface. The typical incubation period for the flu is one to four days, with an average of two days. Adults can be infectious from the day before symptoms begin and through approximately five days after illness onset. Young children also might shed virus several days before illness onset, and children can be infectious for as much as ten days after onset of symptoms.

The clinical signs of influenza are well known to most people—fever, headache, malaise, nonproductive cough, sore throat, and a runny nose, for example. But there are considerable variations in symptoms, and studies of adults and children who were thought to have the flu have shown that laboratory confirmation is needed in many cases. That could be important, because an attack of influenza can result in hospitalization or death. For children, rates of hospitalization are higher among young children than older children; and while influenza-related deaths are uncommon among children, they represent a substantial proportion of all flu-associated deaths and often occur in children who have no known risk factors for complications.

Prevention Strategies

Stressing that annual vaccination is far and away the best way to avoid getting the flu, the report also mentions some other prevention strategies, including two that are reasonable and inexpensive—frequent handwashing and “improved respiratory hygiene,” which might include teaching children to cough or sneeze into tissues. Antiviral drugs used to treat influenza are no substitute for vaccination, and it’s not clear if community-level interventions such as closing schools do much to control viral transmission during typical flu seasons, though school closings are always mentioned as a first line of defense against any widespread influenza epidemics.

Comprehensive information about annual influenza season is available as a Recommendation and Report from the Advisory Committee on Immunization Practices, July 13, 2007, at www.cdc.gov/mmwr.

Gaps in Vaccine Financing for Underinsured Children

For childhood and adolescent vaccination, having private insurance may be worse than having no insurance at all, according to reports in the August 8, 2007, issue of the *Journal of the American Medical Association*.

As many as 14 percent to 20 percent of children in the United States are “underinsured,” meaning they have private insurance that covers some, but not all, of the vaccines recommended for children by the Advisory Committee on Immunization Practices (ACIP). And at a time of rising vaccine costs and state and local budget constraints, the children and their parents may find it hard or impossible to get public help to make up the shortfalls, especially for newly recommended vaccines.

The situation is ironic, researchers say, because children who have no insurance at all or who have public insurance such as Medicaid can receive their vaccines free of charge, at any site, under a federal entitlement, the Vaccines for Children Program.

To start with, researchers point out that the number of new vaccines recommended for children and adolescents has nearly doubled during the past five years, and the cost of fully vaccinating a child has increased dramatically in the past decade. “New or expanded recommendations for meningococcal conjugate, tetanus-diphtheria-acellular pertussis (Tdap), hepatitis A, influenza, rotavirus, and human papillomavirus vaccines have led to a 7.5-fold increase from \$155 in 1995 to \$1170 in 2007.”

In interviews with immunization program managers from 48 states, researchers found that underinsured children were ineligible for publicly purchased vaccines such as meningococcal

or pneumococcal conjugates in most states, and 10 states had changed their policies for providing selected new vaccines between 2004 and 2006, to restrict access by underinsured children. “The most commonly cited barriers to implementation in underinsured children were lack of sufficient federal and state funding to purchase vaccines.”

Contrasting that with the Vaccines for Children Program, the researchers pointed out that funding in that program is available for all recommended vaccines for eligible children, including the uninsured and children on Medicaid.

And it’s also true, they said, that there are some limited and hard-to-access options for underinsured children in the Vaccines for Children Program. The Vaccines for Children law says underinsured children can receive vaccines at federally qualified health centers or rural clinics, but such clinics do not exist in every community because of requirements that the clinics must be located in medically underserved geographic areas. More typically, the researchers report, funding for underinsured children who seek vaccines in public health clinics has been provided by other federal sources, such as Section 317 discretionary grants of the Public Health Service law.

Immunization program managers interviewed for the study described growing discomfort about their inability to give state-purchased vaccines to underinsured children “Being forced to turn away underinsured children or asking families to pay out-of-pocket for expensive vaccines is creating significant ethical dilemmas, particularly for public health practitioners whose role is to serve vulnerable populations.”

A research report, “Gaps in Vaccine Financing for Underinsured Children in the United States,” and an editorial, “Reasons and Remedies for Underinsurance for Child and Adolescent Vaccines,” appear in the August 8, 2007, issue of the Journal of the American Medical Association.

WORTH NOTING

Infant Immunizations at Record Levels, but Adolescent Vaccinations Lag

Three-quarters of U.S. children 19 to 35 months of age received the recommended series of childhood vaccines in 2006, meaning they had four doses of diphtheria, tetanus and pertussis vaccine; three doses of polio vaccine; one or more doses of measles, mumps, and rubella vaccine; three doses of Haemophilus influenzae type b vaccine (Hib); three doses of hepatitis B vaccine; and one or more doses of varicella or chickenpox vaccine. There were substantial state and regional differences in the percentages of children who were fully immunized, ranging from 83.6 percent in Massachusetts to 59.5 percent in Nevada and from 81.4 percent

in Boston to 65.2 percent in Detroit. For the first time this year, the Centers for Disease Control and Prevention (CDC) also looked at how many adolescents had ever received the full range of vaccinations and found that rates for 13- to 17-year-olds were lowest for the most recently recommended vaccines; only 11.7 percent had received a meningococcal vaccination, for example. “We have more work to do to protect older children from vaccine preventable diseases,” said Dr. Melinda Wharton, deputy director of CDC’s National Center for Immunization and Respiratory Diseases.

Perceived Lactose Intolerance Found to Affect Bone Mineral Content

A study reported in the September 2007 issue of the journal *Pediatrics* indicates that children as young as 10 years who believe themselves to be lactose-intolerant tend to avoid milk, the major source of calcium essential to adolescent bone development. Studies of a cross-section of ethnic groups in middle schools in California and Indiana found that many of the girls who thought themselves to be lactose-intolerant were not actually “lactose-maldigesters” (meaning that their bodies do not process calcium). But the failure of self-identified lactose-intolerants to consume milk resulted in damage to bone development, leading researchers to urge that education programs and focus groups address misconceptions surrounding lactose intolerance at an early age, to prevent it from reducing calcium intake.

AUGUST NEWS ALERTS

The following information appeared during the month of August 2007 in the News Alerts section of the website of the Center for Health and Health Care in Schools, at www.healthinschools.org.

August 1, 2007 Senate Begins Debate on SCHIP Reauthorization

Debate began yesterday on a bill now before the Senate that would reauthorize the State Children’s Health Insurance Program, which is set to expire next month. As expected, in hours of debate, Senators differed on whether the program that provides health insurance to children in working-poor families should be reined in or expanded, though all Senators who spoke favored continuing the program at some level. A bill reported by a large majority in the Senate Finance Committee last week calls for increasing federal spending for SCHIP by \$35 billion over the next five years, to enable states to bring additional children into the program, while the Bush administration in its proposed budget for next year calls for an increase of only \$5 billion over five years, which would limit SCHIP largely to children already being covered. In the Senate, the debate triggered questions about whether adults and parents should also be covered by SCHIP, and how high states should be allowed to set the income levels at

which families are eligible for the program. It was also pointed out that there is wide diversity between states in the way SCHIP operates, as the result of waivers that have been granted to states by the federal Department of Health and Human Services. Debate on the bill is expected to continue all of this week.

August 2, 2007 House Passes CHIP Reauthorization

As the Senate continued debate yesterday on a reauthorization of the State Children’s Health Insurance Program (SCHIP), the House of Representatives abruptly passed its own bill, the Child Health Care and Medicare Protection Act of 2007, which authorizes an increase of almost \$50 billion over the next five years for CHIP and makes school-based health centers eligible for reimbursement. The House voted 225 to 204 on party lines for the bill, which will now go to conference with whatever legislation the Senate finally passes, with supporters hoping to retain at least \$35 billion in new money for the child health program. That would far exceed the \$5 billion increase President Bush asked for SCHIP in his budget and the President has said he will veto any bill that provides the program more new money. The House bill would fund its proposed \$50 billion increase by raising the federal tax on cigarettes 45 cents a pack, to 84 cents. The House bill in addition to the CHIP reauthorization includes a number of changes in the federal Medicare program aimed at reducing the role of private Medicare plans and reversing expected cuts in Medicare reimbursements to doctors.

August 3, 2007 Senate Passes SCHIP Extension

The United States Senate passed a bill August 2 that reauthorizes the State Children’s Health Insurance Program (SCHIP) for another five years, with a funding increase of \$35 billion that is expected to enable states to add 3 million more children to current SCHIP enrollment. A reauthorization bill passed by the House August 1 would allow \$50 billion in added funding, and a conference is expected to reconcile differences on the money figure and other details of the two bills when Congress returns from an August recess. The state/federal children’s health insurance program was enacted in 1997 and is slated to expire September 30th.

August 6, 2007 Three Vaccines Urged for Preteens

The Centers for Disease Control and Prevention (CDC) is urging parents whose children are entering the teen years to protect them against some of the most serious health threats to adolescents. In recommendations released August 1, the CDC and the American Academy of Pediatrics stress the importance of health checkups for 11- and 12-year-olds and the importance of preteen vaccinations, including MCV4, which protects against meningitis and its

complications; Tdap, which is a booster against tetanus, diphtheria, and pertussis; and, for girls, the newly developed vaccine against human papillomavirus (HPV), the most common sexually transmitted infection in the United States. “Many parents do not realize that some childhood vaccines, such as those for tetanus and whooping cough, wear off over time and, as they get older, young people are at risk for different diseases at school, camp, or in other new situations,” said Dr. Anne Schuchat, director of the CDC’s Center for Immunization and Respiratory Diseases. Detailed information for parents is available in English and Spanish at a new website, www.cdc.gov/vaccines/preteen.

August 8, 2007

School Breakfast Seen Reducing Nurse Visits

Eating breakfast at school before classes begin has been found to improve children’s learning and behavior, but it may also offer health benefits, including reduced numbers of visits to the school nurse, according to the Food Research and Action Center (FRAC). In a report released yesterday, FRAC detailed the experiences of 23 school districts across the country where breakfast was available to students in the form of sit-down eating in the cafeteria, “grab and go”(packaged meals picked up from serving carts and eaten elsewhere on school grounds), or regularly scheduled time to eat breakfast in the classroom. In some of the surveyed districts, breakfast was a “universal” option, meaning it was free to all students, and in other districts it was offered free of charge to low-income students and at reduced price or full price to those able to pay. A new option called “Second Chance Breakfast,” usually implemented in middle and high schools, allows students time after the first period of the day to eat breakfast either in the cafeteria or from carts in the hallway. The full FRAC report, which details the various ways schools are handling breakfast and the obstacles to breakfast programs, can be accessed online at www.frac.org/pdf/urbanbreakfast07.pdf.

August 10, 2007

ACIP Reminds about Meningococcal Vaccination

The Advisory Committee on Immunization Practices called attention today to the advisability of vaccinating all persons aged 11-18 years against meningococcal disease. That would include routinely vaccinating children at their 11-12 years health visits, the ACIP said, and vaccinating young people at the time of entry into high school (approximately age 15) if they missed the earlier immunization. It is also important, the ACIP pointed out, that college freshmen be vaccinated at the time of entry into college, where they will be at increased risk for meningococcal disease as the result of living in dormitories. The ACIP expects this year’s supply of the vaccine, MCV4 to be sufficient to meet the peak in demand that occurs when children are returning to school after summer vacation. The committee advises that MCV4 and Tdap (tetanus toxoid, reduced diphtheria toxoid, and acellular

pertussis) vaccines be administered during the same visit, but if simultaneous vaccination is not possible, MCV4 and Tdap can be administered in any order. “The goal is routine vaccination of all adolescents with MCV4 beginning at age 11,” the ACIP said. The revised recommendations of the Advisory Committee on Immunization are available as part of the Morbidity and Mortality Weekly Report for August 10, 2007, at www.cdc.gov/mmwr.

August 16, 2007

Survey Reports U.S. Schools ‘Infested with Drugs’

“This fall, more than 16 million teens will return to middle and high schools where drug dealing, possession, use, and students high on alcohol or drugs are part of the fabric of their school,” according to the twelfth back-to-school survey conducted by the National Center on Addiction and Substance Abuse (CASA) at Columbia University. Responding to survey questions, students reported increases since 2002 in the numbers of classmates they have seen high on drugs at school and the ease with which illegal drugs are sold and kept on school campuses. “Too many of our nation’s high and middle schools have become marijuana marts and pill palaces,” said CASA president and former Secretary of Health, Education and Welfare Joseph Califano, Jr. In other survey findings, 37 percent of 12- to 17-year-olds said they can buy marijuana within a day at school and 17 percent said they can buy it in an hour or less. Being popular seems to add to the risk of drug abuse, with popular teens at drug-infested schools found 10 times likelier to abuse prescription drugs, 9 times likelier to use illegal drugs other than marijuana or prescription drugs, 5 times likelier to get drunk monthly, and 4 times likelier to smoke or chew tobacco. Information about the 2007 back-to-school survey is available at www.casacolumbia.org.

August 22, 2007

Hypertension Often Missed in Children

Hypertension—elevated blood pressure—is a common chronic disease of children and adolescents that is often underdiagnosed and untreated, according to a research report in today’s issue of the *Journal of the American Medical Association*. Researchers who studied a group of children 3 to 18 years of age in outpatient clinics at a large academic urban medical system found that a number of factors, including patient age, height, obesity, and the difficulty of getting consistent readings of blood pressure over time, make it hard to diagnose hypertension, even though taking blood pressure is often part of a well-child visit. Stressing the importance of following up on readings of elevated blood pressure, the researchers noted that one form of hypertension—“secondary” hypertension, meaning the high blood pressure results from some other condition such as renal disease—is more common in children than in adults. And although the majority of children with mild to moderate hypertension have the “primary” form, in which a cause is not identifiable, the increased prevalence of childhood weight problems calls for increased attention to

weight-related problems such as high blood pressure, the researchers stress. An article, “Underdiagnosis of Hypertension in Children and Adolescents,” appears in the August 22/29, 2007, issue of the *Journal of the American Medical Association*.

August 23, 2007 FDA Approves Drug for Psychiatric Conditions in Children, Adolescents

A statement issued August 22 by the U.S. Food and Drug Administration (FDA) notes that the FDA has approved Risperdal (risperidone) for the treatment of schizophrenia in adolescents ages 13 to 17, and for the short-term treatment of manic or mixed episodes of bipolar 1 disorder in children and adolescents ages 10 to 17. This is the first FDA approval of an atypical antipsychotic drug to treat either disorder in these age groups. Until now, there has been no FDA-approved drug for the treatment of schizophrenia for pediatric use and only lithium is approved for the treatment of bipolar disorder in adolescents age 12 and up. The statement points out that evidence to support the new recommendations was collected through studies requested by the FDA as part of its pediatric drug development initiatives. “Schizophrenia is a serious and disabling psychiatric disorder,” the statement says. “Symptoms may include hallucinations, delusions, and disorganized thinking. Bipolar disorder, also known as manic-depressive illness, is a serious psychiatric disorder that causes wide shifts in a person’s mood, energy, and ability to function.” Risperdal is manufactured by Janssen, L.P. of Titusville, New Jersey.

August 29, 2007 New Asthma Guidelines Emphasize Children

The National Heart, Lung, and Blood Institute (NHLBI) in the National Institutes of Health today issued the first comprehensive update in a decade of clinical guidelines for the diagnosis and management of asthma, including an expanded section on childhood asthma. Calling asthma one of the most common health problems in the United States, the new guidelines note that 22 million people in this country have asthma, including 6.5 million children under age 18. Key features of the guidelines include a new approach to assessing and monitoring asthma by using multiple measures of a patient’s current impairment and future risk; new emphasis on the importance of teaching patients skills to self-monitor their asthma; control of environmental factors and other conditions that can affect asthma; and continued use of a “stepwise approach” to control asthma in which medication and dosages are stepped up when needed and stepped down when possible. The stepwise management charts are revised to specify treatment for three age groups: 0-4 years, 5-11 years, and 12 years and older. The NHLBI said the 5-11 age group was added as the result of emerging evidence that children respond differently than adults to asthma medication. The guidelines are available online at www.nhlbi.nih.gov/guidelines/asthma/index.htm.

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