

# HEALTH WIRE AMERICANS AND DIABETES

# H E A L T H

By Anjetta McQueen

Diabetes has plagued mankind for centuries. Only recently have researchers discovered that diabetes plagues some groups of people more than others.

Physiologically, says Dr. Lester Henry, an endocrinologist who has extensively researched diabetes, "it's the same disease that whites have," but African Americans are 55% more likely than Caucasian Americans to develop the disease, said Henry, former chairman of Howard university's medical School.

Sociologically, according to Henry, other aspects of African American life—diet and economic disparity among them—change the playing field.

Barbara Holder, a professor of nursing at New York University was recently granted \$850,000 for an intervention study on families and chronic illness that focuses on diabetes. According to Holder, researchers have identified a type of diabetes, somewhere between type I and type II, that might be specific to African Americans.

Diabetes is a disease in which

the body does not produce or properly use insulin, the hormone needed to convert sugar, starches, and other foods into energy. There are two major types of diabetes. Type I diabetes is an insulin-dependent condition in which the body does not produce any insulin and most often strikes children and young adults. Type II diabetes is a non-insulin-dependent condition that is the result of the body's inability to make enough insulin properly. Type II afflicts most diabetics.

Obesity is a common reason for higher rates of African American diabetics, Henry said. "Statistically, black women are the heaviest group and black men are the consistently heavier than white men," he said. "They need to be encouraged to get back to normal weight and follow a diet that is responsible.

"Eating healthy is neither cure nor insurance against diabetes," says Holder, "but a good diet could increase a sufferer's quality of life." Another problem is that diabetes may not be taken seriously by African Americans. "People say they have 'a little sugar' all the time," says Holder. "They should take it seriously."

Savannah Burno, a copy editor at the Fort Worth Star-Telegram, had had diabetes for 16 years. As an African American, she points to what she sees as the roots of her illness: "I can see diet relating to me. We ate a lot of fried foods, when I was growing up." Burno acknowl-

edges that while she and other members of her family knew about diabetes, they tended to make doctor's visits low priorities.

Delayed diagnosis and poor health care will exacerbate most conditions, says Linda Geiss, a statistician in the Division of Diabetes Translation at the Atlanta-based Centers for disease Control and Prevention (CDC). But high health care costs, too little education, and general mistrust of the medical field can also keep a significant number of African Americans from being adequately tested, diagnosed and subsequently treated, she

says.

Six thousand people go blind and 300,000 people die every year from diabetes. But the nation's three million black diabetics also have higher rates of hospital stays, amputations and other related disabilities and deaths, said Linda Geiss. In addition to kidney failure, blindness and death, diabetes during pregnancy may cause premature delivery, birth defects, or even the baby's death.

Recent CDC research showed that minorities are at higher risk for diabetes during pregnancy because they don't get prenatal care to detect and

control the disease. The diabetes rate for African American women at 218.2 per 10,000 births was higher than whites at 207.4. And more African American women, 34.9%, compared to 16.3% for whites, lacked prenatal care until the second or third trimester of pregnancy.

While a survey showed that the diseases prevalence decreases as socioeconomic status rises, large numbers of African American and Hispanic households, regardless of income, showed higher levels of diabetes. For example, the "black enterprise" cluster, a group with (See Health Wire, Page 21)

## FAMILY HOME HOSPICE PRESENTS COURSE ON "GRIEF RECOVERY"

Family Home Hospice is pleased to announce that it is offering a series of classes on "Grief Recovery: Surviving the Loss of a Loved One." The classes will be offered at no charge. All individuals who have experienced the loss of a loved one are encouraged to become involved in this course which is designed to promote the successful reconciliation of grief resulting from death. Through group participation, the individual will have the opportunity to accept the reality of loss, experience the pain of the grief, adjust to an environment in which the deceased is missing, learn new ways of coping, and move toward new directions.

Topics shared in the classes include understanding grief, accepting memories, expressing and accepting feelings, adapting to new roles, stress and coping, planning for holidays and anniversaries, support systems, and reconciliation of grief.

Orientation is Monday, May 10, 1993, from 1PM until 3PM. Classes will begin on Monday, May 17, 1993, from 1PM until 3PM and will continue each Monday through August 2, 1993. Classes will be held in the conference room at Family Home Hospice, 1701 West Charleston Boulevard.

Pre-registration is required. For registration or more information, please contact Kathleen Bruttomesso or John Danks at 383-0887.

## NEW GUIDELINES ISSUED FOR THE DIAGNOSIS AND TREATMENT OF SICKLE CELL

A federally sponsored panel recently issued new guidelines for diagnosis and treatment of sickle cell disease, an inherited disorder that makes children susceptible to infections and other potentially fatal complications.

The guidelines include a recommendation for universal screening of newborns, protective doses of penicillin to ward off infection and follow-up medical care. Universal screening is correctly performed in 34 states and jurisdictions, and targeted screening is done in others.

Sickle cell disease is marked by crescent-shaped red blood cells. The most common form, sickle cell anemia, affects one out of 375 African-Americans, causing jaundice and abdominal, muscular and joint pain, skin ulcerations and gallstones.

But the disease also occurs in people whose ancestors came from areas such as the Mediterranean basin, Arabian Peninsula, the Caribbean and Central and South America.

The new guidelines are part of a series of medical advisories being developed by independent expert panels, with the support of the Agency for Health Care Policy and Research, to help improve the effectiveness of medical care.

The guidelines call for screening of all newborn babies for sickle cell disease. Panel co-chair Jeanne Smith, M.D., associate professor of clinical medicine at Columbia University and director of the Comprehensive Sickle Cell Center at Harlem Hospital, said screening programs targeted to a specific racial or ethnic group will not identify all infants with sickle cell disease. "Because of mixing of the

gene pool, it's not always possible to be certain of an individual's racial or ethnic background by physical appearance, surname or self-report," Dr. Smith said.

"Universal screening is the best and most reliable method of casting the broadest possible net to identify affected infants," Dr. Smith said, "and it ensures that all babies benefit equally from state and federal funding for neonatal screening."

The test can be done in conjunction with other neonatal screening tests that are also performed universally for conditions such as phenylketonuria—a relatively rare disease that causes mental retardation—and hypothyroidism, a thyroid condition.

The guidelines also call for infants whose initial test reveals sickle cell anemia to be given prophylactic penicillin within two months of birth, even if the diagnosis has not been confirmed.

"Administration of penicillin can significantly reduce the number and severity of infections and pneumonia-related deaths," said the panel's other co-chair, Thomas Kinney, M.D., professor of pediatrics at Duke University Medical Center in Durham, N.C.

The guidelines also recommend improved genetic counseling for couples with the sickle cell trait, which increases the risk of offspring being born with sickle cell anemia. Eight percent of all African-Americans—2.5 million individuals—carry the trait; when both parents have it, their offspring have a one in four chance of being born with sickle cell anemia.

Furthermore, the guidelines

call on screening laboratories to relay test results promptly to the infant's physician and hospital of birth.

The infant's physician should promptly establish a definitive diagnosis and the parents should be taught about the disease, routine child care (including body temperature measurement, and signs of life-threatening complications, such as fever, unusual sleepiness or irritability, rapid respiration, or vomiting), and how to reach medical help quickly.

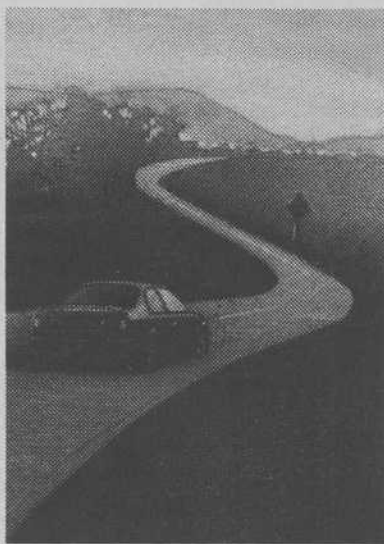
The guidelines also emphasize the importance of regular visits to assess the child's medical status, administration of age-appropriate immunizations, and the provision of other infant-specific health services.

The 13-member private-sector panel of physicians, nurses, social workers and consumer representative reviewed more than 7,000 studies before writing the guidelines. The documents then underwent rigorous review by other experts in sickle cell disease.

According to AHCPRA Administrator J. Jarrett Clinton, M.D., the agency, which is a part of the Public Health Service within HHS, will distribute the guidelines widely to physicians, nurses, hospitals, consumer groups and others.

Sickle Cell Disease: Screening, Diagnosis, Management, and Counseling in Newborns and Infants, a quick reference guide for clinicians and a guide for parents are available without charge by sending a post card or letter to: Sickle Cell Disease, P.O. Box 8547, Silver Spring, MD. 20907, or calling 1-800-358-9295.

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