

## Current and Classic Resources, January-February 2011

### Current Resources

**Berg CJ, Callaghan WM, Syverson C, Henderson Z. Pregnancy-related mortality in the United States, 1998 -2005. *Obstetrics and Gynecology*. 2010;116(6): 1302–08.**

Aims: To describe the risk of women dying from pregnancy complications in the United States.

Sample: This study uses data from the Pregnancy Mortality Surveillance System that includes voluntary reporting of deaths occurring within one year of pregnancy regardless of the cause of death or duration of pregnancy. It includes data for 1998-2005 from 52 reporting areas including all 50 states, New York City and Washington, DC.

Methodology: An ecological trend study based on surveillance data. Clinically experienced epidemiologists code the data the outcomes of pregnancy, cause of death and associated conditions.

Results: “The aggregate pregnancy-related mortality ratio for the 8-year period was 14.5 per 100,000 live births, which is higher than any period in the previous 20 years of the Pregnancy Mortality Surveillance System. African-American women continued to have a three- to four-fold higher risk of pregnancy-related death. The proportion of deaths attributable to hemorrhage and hypertensive disorders declined from previous years, whereas the proportion from medical conditions, particularly cardiovascular, increased. Seven causes of death—hemorrhage, thrombotic pulmonary embolism, infection, hypertensive disorders of pregnancy, cardiomyopathy, cardiovascular conditions, and noncardiovascular medical conditions—each contributed 10% to 13% of deaths.”

Discussion: While it is not clear why there has been an increase in pregnancy related mortality, it should be a concern both for clinicians and healthcare quality initiatives. This study also confirms a continued disparity in a sentinel event that of often a measure of population health.

**Neuner B, Miller P, Wand KK, Weiss-Gerlach E, et al. Socioeconomic factors, hazardous alcohol consumption, smoking in patients with minor trauma in an inner-city emergency department. *J Emer Med*. 2010;39(5):554-560.**

Aims: “The aim of the present study was to investigate whether socioeconomic factors may aid in providing a simple screening algorithm for Hazardous Alcohol Consumption (HAC) in young ED patients with minor trauma.”

Sample: Consecutive patients over age 18 with acute trauma admitted in an Emergency Department from December 2001 to February 2003. The final sample included 2562 patients. Exclusion criteria including patients unable to give informed consent, escorted to ED by police, homeless or not fluent in the German language.

Methodology: Convenience sample, computerized version of the Alcohol Use Disorders Identification Test (AUDIT)

Results: ED patients with minor trauma showed a high prevalence of Hazardous Alcohol Consumption (HAC) and smoking.

Discussion: Age, gender and smoking status may be relevant variables for stratifying screening for HAC in patients with minor trauma.

**Waterbrook AL, Southall JC, Strout TD, Baumann MR. The knowledge and usage of complementary and alternative medicine by emergency department patients and physicians. *J Emer Med*. 2010;39(5):569-575.**

Aims: “In this study, we evaluated ED patients desire to discuss CAM [Complementary and Alternative Medicine] with their emergency physicians, as well as their willingness to try CAM for their presenting complaint”

Sample: English speaking patients presenting to the ED in four predetermined 4 hour blocks over a 1 week time period. Exclusion criteria including those deemed medically inappropriate (severity of illness) and those unable to communicate.

Methodology: Convenience sample, thirteen item structured surveys

Results: 54.7 % of patients currently used or had use CAM in the past, most frequent were herbal supplements, massage, Chinese medicine/acupuncture, homeopathy and biofeedback. Only 24% of patients using CAM would discuss it with an ED physician.

Discussion: Patients presenting for acute care may be using CAM and are reluctant to volunteer that information. ED on other physicians should seek that information from patients.

### Classic Resources

**Oaks JM, Kaufman JS. *Methods in Social Epidemiology*. San Francisco, CA: Jossey-Bass; 2006.**

“We define social epidemiology as the branch of epidemiology that considers how social interactions and collective human activities affect health.” Much of the study of health disparities depends on the methodology of social epidemiology. This book addresses a broad definition of social epidemiology and provides and introduction and history of this field in Part One: Background. The second part is measures and measurement including socioeconomic position, race, poverty, health inequalities and residential community context. The best measures of these concepts are much more complex than simple demographics and often require multiple types of measurements. The final section of the book provides insights into a variety of social epidemiology research methodologies and strategies for analysis.

If you would like to contribute an annotated reference contact: [Timothy P. Hickman, MD, MEd, MPH](#) or [Fariha Shafi, MD](#)