THE CSTE WASHINGTON REPORT

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June 17, 2004 Volume 8, Number 12

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EDITOR'S NOTE: Scientists at the National Institute of Environmental Health Science (NIEHS), one of the National Institutes of Health (NIH), have found that detectable levels of mouse allergen exist in the majority of U.S. homes. NIEHS researchers analyzed dust samples, asked questions, and examined homes in the first National Survey of Lead and Allergens in Housing, a survey of 831 homes. Allergen levels were studied and related to demographic factors and household characteristics. 82 percent of U.S. homes were found to have mouse allergens. The findings by Cohn et al. appear in the June 2004 issue of the Journal of Allergy and Clinical Immunology -- additional details are provided in this Washington Report.

The CSTE Washington Report is provided as an information resource for members of the Council of State and Territorial Epidemiologists on federal legislation and regulation

affecting public health and epidemiology in the U.S. Legislation cited in the report can be accessed via http://www.thomas.loc.gov Regulations cited can be accessed via http://www.gpo.gov

LEGISLATIVE UPDATE -- On June 15th, a Subcommittee of the House Energy and Commerce Committee voted out the **Asthmatic Schoolchildren's Treatment and Health Management Act (**H.R. 2023). Introduced last year by Rep. Cliff Stearns (R-FL), the bipartisan bill directs the Secretary of Health and Human Services, in making any asthma-related grant to a State educational agency or a local educational agency, to give preference to any such agencies in States that require schools to allow students to self-administer medication to treat that student's asthma or anaphylaxis. It also expresses: (1) the sense of Congress regarding the strategies identified by the Centers for Disease Control and Prevention for addressing asthma within a coordinated school health program; and (2) the support of Congress for the goals and ideals of such strategies. The bill has also been referred to the House Committee on Education and the Workforce. There is no corresponding Senate legislation. On June 2nd, Rep. Roybal-Allard (D-CA) introduced the **Newborn Screening Saves Lives Act (H.R. 4493)** which authorizes $15 million in grants in FY 2005, and such sums as necessary in FY 2006-2009, to assist health care professionals and State health department laboratory personnel with education in newborn screening and training in relevant and new technologies in newborn screening as well as congenital, genetic, and metabolic disorders. The bill is designed to correct the lack of uniformity in newborn screening procedures and follow-up education and counseling with parents. The grant program would be administered by the Health Resources and Services Administration. The bill has bipartisan support. **Tobacco regulation** – The House corporate tax bill that is now moving through Congress includes a $9.6 billion tobacco farmer buyout provision. The House approach is likely to receive opposition in the Senate where many Senators are committed to pairing a buyout with strong FDA authority to regulate tobacco products and others fear the controversial buyout will bog down the tax bill. Bipartisan bills in both the House and Senate to give FDA tobacco regulatory authority were recently introduced with the backing of public health organizations.

BRIEFING ON CITIES READINESS INITATIVE (CRI) -- The U.S. Department of Health and Human Services provided a briefing June 15th to relevant partners on the new Cities Readiness Initiative which is being funded at a level of $39 million via the reprogramming of FY 2004 CDC State and Local Preparedness funding. Briefers noted that new information has been obtained that al Qaeda has experimented with easily created aerosolized *Bacillus anthracis* that can be widely spread using commercially available means. This new understanding, plus the knowledge that prophylactics need to be distributed to affected populations within 48 hours, and the assessment that distributing stockpiled treatments to urban populations quickly is a weakness in the preparedness system, led to the development of the CRI. Briefers said grant guidance would be distributed to all 62 current grantees, plus the 21 CRI cities, over the next week. The deadline for response is August 1st and funds will be distributed August 21st.

FIRST JOINT SURVEY OF HEALTH IN CANADA AND THE UNITED STATES SHOWS BOTH COUNTRIES REPORT HIGH LEVEL OF HEALTH -- The overwhelming majority of Americans and Canadians rate their health as good, very good or excellent, but there are differences in key risk factors and patterns of health care in the two countries, according to the first joint U.S.-Canadian health survey released today by the Centers for Disease Control and Prevention (CDC) within the U.S. Department of Health and Human Services. Overall, Americans were more likely than Canadians to report that they were very satisfied with health care (53 percent compared to 44 percent), but findings for uninsured Americans accounted for significant differences between the countries in a number of categories.

The Joint Canada/U.S. Survey of Health, conducted by Statistics Canada and CDC's National Center for Health Statistics, covered measures of health status, risk factors, health disparities, access to health care, and quality of and satisfaction with health care services. Because the survey contacted a representative sample of adults in each country and asked for exactly the same information in the same manner in a one-time telephone interview, this survey achieves a degree of comparability never before attained.
In the survey, people were asked to rate their health from poor to excellent, and 85 percent of Americans and 88 percent of Canadians reported that they were in good, very good or excellent health. Americans were slightly more likely than Canadians to rate their health as excellent (26 percent compared to 24 percent). This was particularly true for senior citizens; almost twice as many Americans 65 and over (15 percent compared to 8 percent) reported they were in excellent health. Americans were also slightly more likely to indicate that their health was only poor or fair (15 percent compared to 12 percent).
Among low-income respondents, 31 percent of Americans said they were in fair or poor health, compared with 23 percent of low income Canadians.

The survey looked at measures of physical and mental health. Overall, 25 percent of Americans and 24 percent of Canadians reported some level of mobility limitation (problems with walking, standing or climbing). More Americans, particularly American women (7 percent compared to 4 percent), report highly severe mobility limitations. Approximately 8 percent of adults and 10 percent of women in both countries had experienced a major depressive episode in the past year.

Two key risk factors – smoking and obesity – were examined. Canadians were more likely than Americans to be current daily smokers (19 percent compared to 17 percent) and this difference was more pronounced among older women. However, a significantly higher proportion of Americans than Canadians are obese, primarily because among U.S. women the rate of obesity is nearly twice that of Canadian women. In both countries, those with the lowest incomes report poorer health and higher rates of severe mobility limitations as well as higher levels of smoking and obesity.

Since the health systems and the role of public and private insurance differ in each country, another important aspect of the report compares access to health care and people's satisfaction with the health care they receive. Americans were more likely to

report that the quality of their health care services in general was excellent compared with Canadians (42 percent compared to 39 percent.) Among uninsured American respondents, 28 percent said the quality of the health care services they received was "excellent," 44 percent "good," and 28 percent "fair" or "poor." When asked about their satisfaction with health care services in general, 53 percent of Americans and 44 percent of Canadians said they were "very satisfied," while 37 percent of Americans and 43 percent of Canadians said they were "somewhat satisfied." Among uninsured Americans, 39 percent were "very satisfied" with the services they received, and 40 percent were "somewhat satisfied."

Unmet medical needs during the past 12 months were reported by 13 percent of Americans and 11 percent of Canadians. Among those with an unmet need, Americans were more likely to identify cost as the primary barrier to health care (53 percent of unmet needs cases), while Canadians cited waiting for care as the primary barrier (32 percent of cases). Among the 11 percent of American respondents who were uninsured, four out of every ten reported an unmet medical need. Likewise, only 43 percent of the uninsured respondents said they had a regular medical doctor, compared with 80 percent of total American respondents and 85 percent of Canadian respondents.
The overall pattern of the use of prescription medicine was similar in the two countries, with use higher among those 65 years of age and older and among women. However, there was higher prescription drug use among Americans aged 45-64 than Canadians in this same age group.

The Joint Canada/US Survey of Health was conducted from November 2002 through March 2003 with a representative sample of civilian, non-institutionalized population of adults 18 and over; the sample size was approximately 3500 Canadians and 5200 Americans. For more information about the survey and a copy of the report check the CDC website at: www.cdc.gov/nchs.

NATIONAL STUDY SHOWS 82 PERCENT OF U.S. HOMES HAVE MOUSE ALLERGENS -- Scientists at the National Institute of Environmental Health Science (NIEHS), one of the National Institutes of Health (NIH), have found that detectable levels of mouse allergen exist in the majority of U.S. homes. NIEHS researchers analyzed dust samples, asked questions, and examined homes in the first National Survey of Lead and Allergens in Housing, a survey of 831 homes. Allergen levels were studied and related to demographic factors and household characteristics.

82 percent of U.S. homes were found to have mouse allergens. The findings by Cohn et al. appear in the June 2004 issue of the Journal of Allergy and Clinical Immunology. The survey was conducted using established sampling techniques to ensure that the surveyed homes were representative of U.S. homes. The homes were sampled from seventy-five randomly selected areas (generally counties or groups of counties) across the entire country. The 831 homes included all regions of the country (northeast, southeast, midwest, southwest, northwest), all housing types, and all settings (urban, suburban, rural).

The selection of homes was controlled to be a representative sample of U.S. homes. For statistics derived from the 831 homes, the contribution from each home was weighted as necessary to ensure that the statistics are representative of the U.S. population.
Dust samples used in the study were collected from kitchen and living room floors, upholstered furniture, beds, and bedroom floors. Kitchen floor concentrations exceed 1.6 micrograms of allergens per gram of dust in about one in five homes (22 percent). The amount of these allergy-triggering particles on the kitchen floor is high enough to be associated with allergies and asthma. Residents of high-rise apartments and mobile homes are at greatest risk, but the allergen is also present in all types of homes.

The NIEHS study, with collaborators at Constella Group, Inc. and the Harvard School of Public Health, characterized mouse allergen prevalence in a representative sample of U.S. homes and assessed risk factors for elevated concentrations. The odds of having elevated concentrations were increased when rodent or cockroach problems were reported.
Exposure to mouse allergen is a known cause of asthma in occupational settings. Until now, exposure to these allergens had not previously been studied in residential environments on a national scale. Clinicians should consider these risk factors when treating allergy and asthma patients.

NIEHS conducts and supports research to reduce the burden of human illness and dysfunction from environmental causes by understanding environmental factors, individual susceptibility and age and by discovering how these influences interrelate.

CDC COLLABORATION YIELDS NEW TEST FOR ANTHRAX -- A new test funded by the Centers for Disease Control and Prevention and developed in collaboration with a commercial partner has become the first test approved by the Food and Drug Administration for detecting antibodies to anthrax. The test, produced by Immunetics Inc. of Boston, provides an easy-to-use clinical laboratory tool for assessing whether patients have been infected with anthrax.

The Anthrax Quick ELISA test, which was recently approved by the Food and Drug Administration, detects antibodies produced during infection with *Bacillus anthracis* – the bacteria that causes anthrax. The approval shows how cooperative work between government agencies and industry can lead to the development of diagnostic tests for biothreat agents and emerging infectious diseases.

The new test helps confirm a diagnosis of anthrax because it demonstrates that a person's immune system has responded to a protein produced by the infecting bacteria. The test is quicker and easier to interpret than previous antibody testing methods. The new test can be completed in less than one hour, compared to about four hours for previous testing methods. Before FDA approval of the new test, very few laboratories other than the CDC and the U.S. Army had the ability to test blood for antibodies to anthrax. The new test will be available shortly for use in state and private laboratories.

Anthrax is a serious infectious disease that most commonly occurs in wild and domestic cattle, sheep and other herbivores. Humans can contract anthrax by handling products from infected animals or by breathing in or coming in close contact with *Bacillus anthracis* spores from infected animal products such as unprocessed hides and bones. Anthrax can also be transmitted to humans when anthrax spores are used as a bioterrorist weapon. The anthrax attacks of 2001 sickened 22 people, leading to five deaths.

CDC REPORTS LATEST DATA ON SUICIDE BEHAVIORS, RISK FACTORS, AND PREVENTION -- Analysis of data on suicide methods by the Centers for Disease Control and Prevention (CDC) found that among youth aged 10-14 years, suffocation (mostly hangings) has replaced firearms as the most common method of suicide. In 2001, suffocation suicides in this age group occurred nearly twice as often as firearms suicides, the most frequently used method before 1997. The findings were released today in the Morbidity and Mortality Weekly Report along with data on the relationship between suicide attempts and physical fighting in high school students, school-associated suicides, suicide trends in Hispanic populations, and suicide trends in China.

"Suicide remains the third leading cause of death among young people in this country," said Dr. Ileana Arias, acting director of CDC's Injury Center. "We must focus on the underlying reasons for suicide and a comprehensive strategy to prevent them."
Other youth-related findings included these:

* One in 20 high school students reported both suicide attempts and involvement in physical fights in the past year. Students who reported attempting suicide in the past 12 months were nearly four times as likely to report involvement in physical fights.

* Of the lethal acts of school violence carried out by students between July 1, 1994, and June 30, 1999, more than 20 percent were suicides. One in four suicide victims injured or killed someone else before their suicide.

Suicide is a major public health problem for youth in the United States and abroad. Several of the studies identified a connection between interpersonal violence and suicide. CDC researchers believe a promising approach for future suicide prevention efforts is to determine if effective strategies for preventing youth violence, such as school-based curricula, are also effective for preventing youth suicide. In addition, the findings highlight the need for parents, teachers, and other youth influencers to be aware of potential signs of suicidal behavior, such as fighting and expressions of suicidal thoughts.
Other findings reported in the MMWR were these:

* Hispanic males were almost six times as likely to die by suicide as Hispanic females, representing 85 percent of the 8,744 Hispanic suicides between 1997 and 2001. Hispanic youth are the fastest growing segment of the U.S. population and account for one fourth of all Hispanic suicide deaths.

* Suicide is the fifth leading cause of death in China, where more than 287,000 people were victims of suicide annually between 1995 and 1999. In most countries

suicides are most common among males, but in China, suicides and suicide attempts were most common among young Chinese women between the ages of 15 and 34.

CDC's suicide prevention efforts include describing and tracking the problem of self-directed violence; using research to increase knowledge of the risk and protective factors related to suicidal behavior; evaluating and demonstrating ways to prevent suicidal behavior; effectively communicating scientific information about suicide prevention; and integrating proven suicide prevention efforts.

INDOOR MOLD, BUILDING DAMPNESS LINKED TO RESPIRATORY PROBLEMS AND REQUIRE BETTER PREVENTION; EVIDENCE DOES NOT SUPPORT LINKS TO WIDER ARRAY OF ILLNESSES -- Scientific evidence links mold and other factors related to damp conditions in homes and buildings to asthma symptoms in some people with the chronic disorder, as well as to coughing, wheezing, and upper respiratory tract symptoms in otherwise healthy people, says a new report from the Institute of Medicine of the National Academies. However, the available evidence does not support an association between either indoor dampness or mold and the wide range of other health complaints that have been ascribed to them, the report says. Given the frequent occurrence of moisture problems in buildings and their links to respiratory problems, excessive indoor dampness should be addressed through a broad range of public health initiatives and changes in how buildings are designed, constructed, and maintained, said the committee that wrote the report.

"An exhaustive review of the scientific literature made it clear to us that it can be very hard to tease apart the health effects of exposure to mold from all the other factors that may be influencing health in the typical indoor environment," said committee chair Noreen Clark, dean, School of Public Health, University of Michigan, Ann Arbor. "That said, we were able to find sufficient evidence that certain respiratory problems, including symptoms in asthmatics who are sensitive to mold, are associated with exposure to mold and damp conditions. Even though the available evidence does not link mold or other factors associated with building moisture to all the serious health problems that some attribute to them, excessive indoor dampness is a widespread problem that warrants action at the local, state, and national levels."

Excessive dampness influences whether mold as well as bacteria, dust mites, and other such agents are present and thrive indoors. Moreover, wetness may cause chemicals and particles to be released from building materials. Many studies of health effects possibly related to indoor dampness do not distinguish the specific health effects of different biological or chemical agents.

Through its careful review of the available scientific studies, the committee found sufficient evidence to conclude that mold and damp conditions are associated with asthma symptoms in asthmatics who are sensitive to mold, and to coughing, wheezing, and upper respiratory tract symptoms in otherwise healthy people. However, the evidence did not meet the strict scientific standards needed to establish a clear, causal relationship. An uncommon ailment known as hypersensitivity pneumonitis also is associated with

indoor mold exposure in genetically susceptible people. Damp conditions and all they entail may be associated with the onset of asthma, as well as shortness of breath and lower respiratory illness in otherwise healthy children, although the evidence is less certain in these circumstances. Likewise, the presence of visible mold indoors may be linked to lower respiratory tract illness in children, but the evidence is not as strong in this case.

The committee found very few studies that have examined whether mold or other factors associated with indoor dampness are linked to fatigue, neuropsychiatric disorders, or other health problems that some people have attributed to fungal infestations of buildings. The little evidence that is available does not support an association, but because of the dearth of well-conducted studies and reliable data, the committee could not rule out the possibility.

Studies on animals and cell cultures in labs have found toxic effects from various microbial agents, raising concerns about whether these same agents growing in buildings can cause illness in people. Molds that are capable of producing toxins do grow indoors, and toxic and inflammatory effects also can be caused by bacteria that flourish in damp conditions, the report noted. Little information exists on the toxic potential of chemicals or particles that may be released when building materials, furniture, and other items degrade because of wetness. The committee recommended that current animal studies of short-term, high-level inhalation exposures to microbial toxins be supplemented with new research that evaluates the effects of long-term exposures at lower concentrations.

Moisture and mold problems stem from building designs, construction and maintenance practices, and building materials in which wetness lingers. Technical information describing how to control dampness already exists, but architects, engineers, building contractors, facility managers, and maintenance staff do not always apply this knowledge, the report says. Training curricula on why dampness problems occur and how to prevent them should be produced and disseminated. Guidelines for preventing indoor dampness also should be developed at the national level to promote widespread adoption and to avoid the potential for conflicting advice from different quarters. In addition, building codes and regulations should be reviewed and modified as necessary to reduce moisture problems.

Research on various means to prevent or eliminate excessive dampness -- including educational initiatives and building renovations or design changes -- should be undertaken to find out which are effective. While there is universal agreement that promptly fixing leaks and cleaning up spills or standing water substantially reduces the potential for mold growth, there is little evidence that shows which forms of moisture control or prevention work best at reducing health problems associated with dampness, the report notes. In addition, materials designed to educate the public about the actual health risks associated with indoor dampness should be developed and evaluated. The effectiveness of economic and other incentives to spur adherence to moisture prevention practices -- such as bonuses for facility managers who meet defined goals for preventing

or reducing problems, or fines for failure to correct problems by a specified deadline -- should be evaluated, and successful strategies should be implemented.

The committee had insufficient information to recommend either an appropriate level of dampness reduction, or a safe level of exposure to organisms and chemicals linked to dampness. Better standardized methods for assessing human exposure to these agents are greatly needed, the report says. It calls for studies that compare various ways to limit moisture or eliminate mold and to evaluate whether the interventions improve occupants' health.

The study was sponsored by the Centers for Disease Control and Prevention. The Institute of Medicine is a private, nonprofit institution that provides health policy advice under a congressional charter granted to the National Academy of Sciences.