

DEAR COLLEAGUES,

Fall is underway and the school based programs starting into full activities. The sexual health program is one of the busiest. The overview of that program is:

The Sexual Health Program provides services related to birth control, unplanned pregnancies, and sexually transmitted diseases (including AIDS and HIV and cervical cancer). Services include clinics, education programs and community support.

There is a full description of the services and scope of the program on the web site www.publichealthgreybruce.on.ca (click on sexual health program).

There have been increases in both the types of sexually transmitted infections and the numbers of these in the past year. It is a challenge to try to contain this type of communicable disease and we need a consistent and persistent approach if we are to limit the spread. I am including with this issue a user friendly outline of STI and their management. Thank you for your continued good care of these folks and together we hope to decrease the incidence this season!

Thank you also for your great surveillance during the West Nile virus season. Your awareness and consistent testing of patients with compatible symptoms makes us confident that we are not missing cases. The two human cases diagnosed in Grey Bruce have both made good recoveries. The two birds are of course deceased. No positive mosquitoes were detected in spite of highly increased trapping activities around the human and bird cases.

Coming in the next issues will be the results of the meconium survey, and the real time outbreak detection surveillance system and what it can do for you in practice.

Yours truly,

Hazel Lynn, MD, FCFP, MHSc
Medical Officer of Health

What's Inside:

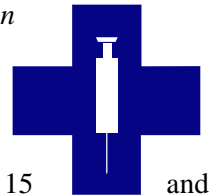
- Vacs Facts
- Cold Chain
- Importance of Up-to-date Immunization Information
- New Vaginal Ring Contraception
- Exclusive Breastfeeding Duration Increased to 6 Months
- Sodium Concentrations

Inserts:

- Confirmed Episodes – Infectious Disease
- Emerging and Re-emerging Sexually Transmitted Infections: An Update
- STI Guide
- New Guidelines To Accompany Recommendations About SIDS (Handout)

VACS FACTS

My patient missed the school immunization clinic. Where can he/she receive the publicly funded meningococcal C conjugate vaccination?



All Grade 7 students and anyone between 15 and 19 years of age since January 2005 are still eligible for the publicly funded MenC-conjugate vaccine. Adolescents who were 12 years of age (in Grade 7) during the 2004/2005 school year, but were not immunized, do not need to wait until they are 15 years of age to receive the vaccine. Also all 1-year-old children born on or after September 1, 2003 are eligible. It is now recommended that the MenC-conjugate vaccine be given with the 12 month MMR.

Publicly funded MenC-conjugate vaccine is available free of charge, to eligible patients, through the usual vaccine ordering process at the Public Health Unit. Public Health will continue to offer immunizations by appointment at weekly clinics. The MenC-conjugate vaccine clinics will be held at all Grey and Bruce high schools and Grade 7 classes again, during the 2005/2006 school year. Please remind parents to contact Public Health after their child receives any immunization.

COLD CHAIN

*LeAnn White, Public Health Nurse
Vaccine Preventable Diseases Program*

Vaccine wastage due to cold chain failure is an ongoing issue. Varivax[®]III is very unstable and has reduced potency when exposed to temperatures above 8°C for over 30 minutes. Waterloo region recently experienced a power outage which resulted in cold chain failure. Patients who had received the exposed Varivax[®] III vaccination were offered re-vaccinations or serological titre testing (requires specialized testing at the national lab).

Please remember to:

- Maintain vaccine cold chain by monitoring your vaccine fridge twice a day when your office is open. Check the fridge temperature at time of office closure and when re-opening. Remember to “clear” the thermometer.
- Inform Public Health immediately if your vaccine fridge goes outside the 2° to 8°C range for any length of time.
- Reduce the amount of vaccines kept in your vaccine fridge prior to any holidays. Better yet, store your vaccines at Public Health or your local hospital while you are away.

Limit vaccine orders to a maximum 3-month supply. If you do not need a full box of 10 Varivax[®]III vials, at a government pharmacy cost of \$275, the Public Health Unit can supply individual doses.

IMPORTANCE OF UP-TO-DATE IMMUNIZATION INFORMATION

*LeAnn White, Public Health Nurse
Vaccine Preventable Diseases Program*

Thank you very much for your patience and assistance as we complete yet another round of updating school immunization records. Unfortunately, we had to impose 118 school suspensions in order to get the students' immunization information from parents. Suspension from school is used as a last resort as

we attempt to keep all students' records up-to-date. Once again, we have found that the immunization most frequently not reported to Public Health is the 18-month Pentacel[™]. With the new Ontario Immunization Schedule (implemented as of Jan 2005), we predict the same inconsistencies with the 15-month immunization. Parents are still learning that it is their responsibility, not the physician's, to inform Public Health when their child is immunized.



Please continue to update the yellow cards and remind parents to update Public Health every time their child receives any immunization. We will continue our campaign to remind parents to take their yellow immunization cards to their physician to be updated, and to then contact Public Health with the information needed to update their child's electronic record.

If you need a new poster (every time your child is immunized, bring in the yellow card....) for your waiting rooms, or a new supply of the yellow cards, contact the Vaccine Preventable Diseases Program.

NEW VAGINAL RING CONTRACEPTION

*Kristi Waram, Public Health Nurse
Youth Program*

NuvaRing is a non-biodegradable, flexible, transparent ring that is inserted into the vagina once a month. This low dose contraceptive slowly releases a combination of progestin (etonogestrel) and estrogen (ethinyl estradiol). NuvaRing remains in the vagina for 21 days and is then removed for 7 days when the women gets a period. It is not necessary to remove the NuvaRing before or after intercourse, however it is important to use condoms to prevent sexually transmitted infections. In clinical testing with thousands of women, NuvaRing, when used as directed, proved 99% effective, similar to that of combination birth control pills. The NuvaRing is available at Sexual Health Clinics for \$18.00 per month. For more information about the product, see www.nuvaring.com.

EXCLUSIVE BREASTFEEDING DURATION INCREASED TO 6 MONTHS

Dana Aitken-Howes, Public Health Nurse.
Family Health Team

In late 2004, Health Canada amended its recommendations regarding exclusive breastfeeding duration from 4 months to 6 months for healthy term infants. The new recommendation states:

“Exclusive breastfeeding is recommended for the first 6 months of life for healthy term infants as breast milk is the best food for optimal growth. Infants should be introduced to nutrient-rich solid foods, with particular attention to iron at six months, with continued breastfeeding for up to two years and beyond”



Health professionals are encouraged to promote and implement this new recommendation into their practice when working with breastfeeding women and their families.

This change mirrors the World Health Organization's (WHO) stance regarding exclusive breastfeeding. Since 2001, WHO has recommended that exclusivity be increased to 6 months. Before aligning with the WHO's position, Health Canada reviewed the evidence that was presented by WHO and took careful consideration to view its value in the context of Canadian society. Research revealed that exclusive breastfeeding until 6 months of age reduces the incidence of gastrointestinal infections. In addition, growth rates and iron levels in exclusively breastfed healthy term infants were similar to infants who were breastfed exclusively until 3 or 4 months, then partially breastfed until 6 months.

In response to Health Canada's new recommendations, the Canadian Paediatric Society

also made changes to their position on exclusive breastfeeding. This past March, the society released a new position statement on exclusive breastfeeding duration that concurs with Health Canada and the World Health Organization's recommendations.

SODIUM CONCENTRATIONS

Lou D'Alessandro, Manager – Health Protection
Water Program

The Medical Officer of Health was notified in September that the drinking water supply known as Winburk located in the Town of South Bruce Peninsula had sodium levels > 20 mg/l. Reported sodium test results ranged from 20.5 to 22.3 mg/l.

Ontario Regulation 170 under the Safe Drinking Act, 2002 requires the Medical Officer of Health to be notified of the sodium concentrations exceeding 20 mg/l in any regulated system. The information is then released to community physicians as they consult with residents who might be affected, i.e., infants < 6 months, patients on sodium reduced or restricted diets and pregnant women.

This newsletter is being reproduced with permission from Vinita Dubey MD MPH CCFP, Community Medicine Resident, U. of Toronto Acting-Manager, Sexual Health Promotion Team, Middlesex-London Health Unit and Bryna Warshawsky MDCM CCFP FRCPC, Associate Medical Officer of Health, Middlesex-London Health Unit

Emerging and Re-emerging Sexually Transmitted Infections: An Update

August 2005

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1. Lymphogranuloma venereum (LGV): An Emerging Disease in Canada

LGV is an infection caused by a strain of *Chlamydia trachomatis* (serovars L1, L2 or L3). It is endemic in many developing countries. However cases are occurring in Western European and North American cities among men who have sex with men (MSM). **Multiple cases have been identified in Ontario, including Southwestern Ontario.**

Symptoms: LGV occurs in 3 stages.

Primary LGV: Develops after 3-30 days of contact as a small, painless papule on the genitalia or rectum that can ulcerate. It is self-limited and the ulcer may disappear before the patient notices it or seeks care.

Secondary LGV: Begins within 2-6 weeks of the primary lesion. It is associated with systemic symptoms such as fever, chills, malaise, painful inguinal lymphadenopathy, and acute hemorrhagic proctitis. *Proctitis (85%) and inguinal lymphadenopathy (52%) were the most common presentation for LGV in Ontario.*

Tertiary LGV: Results from chronic untreated LGV and can cause chronic inflammatory lesions leading to scarring such as lymphatic obstruction causing genital elephantiasis or rectal strictures/fistulas.

Method of Transmission: LGV spreads through sexual contact of mucous membranes or breaks in the skin. The bacteria travel to the lymphatic system and multiply in regional lymph nodes. It is occurring most commonly among men who have sex with men. Condoms are effective at preventing LGV.

Continued on page 2...

2. Free Meds for Sexually Transmitted Infections!!

The Grey Bruce Health Unit can provide a free stock of cefixime and azithromycin for your office to treat patients for chlamydia and gonorrhea. Contact the Sexual Health Clinic, Owen Sound - 376-9420 or 1-800-263-3456, Walkerton - 881-1920 or 1-800-821-7714 for more information.

Did you know?

A **Bubo** is an enlarged lymph node that is tender and painful, particularly in the groin and axillae. It is a feature of a number of infectious diseases including gonorrhoea, syphilis, lymphogranuloma venereum, tuberculosis, and the plague. (Hence, the bubonic plague).

Summary of LGV:

- **LGV should be considered in the differential diagnosis of STI symptoms, rectal bleeding or inguinal lymphadenopathy, especially in an MSM client.**
- **Suspected cases of LGV should have both a swab and serology submitted for laboratory testing.**
- **Report all cases you suspect may be LGV to the Health Unit.**
- **Treatment is effective and available free of charge.**

Diagnosis: LGV is difficult to diagnose. The symptoms and signs of LGV may overlap with other STIs, other infections, drug reactions and malignancies. The diagnosis is often based on the history and clinical picture and is supported by laboratory testing. Swabs of the papule or ulcer if present, rectum, cervix or urethra; aspiration of buboes; urine; biopsy of lymph nodes; or serology may be helpful in laboratory detection. Serology may be particularly helpful if the genital sore has healed. *Physicians should specify LGV testing on the requisition.* Call the Health Unit for further assistance with laboratory testing.

Testing for HIV, syphilis, gonorrhoea, chlamydia, and hepatitis B and C should also be done due to high rates of co-infection.

Treatment: Doxycycline 100 mg orally twice a day for 21 days is the first line treatment. Erythromycin is another option. Treatment with azithromycin 1 g orally weekly for 3 weeks is a possible regimen but has not been proven in clinical trials. If untreated, long term problems can result including pain, scarring and drainage from the anus and rectum.

Treatment of sexual partners: Sexual partners of LGV cases in the 60 days preceding onset should be treated with azithromycin 1g po in a single dose or doxycycline 100 mg orally twice daily for 7 days.

For more information: <http://www.phac-aspc.gc.ca/publicat/lgv/>

3. Screening for STIs

At the Grey Bruce Health Unit, we screen all clients who are seen in The Clinic as follows:

- Chlamydia: endocervial/urethral swab or urine
- Gonorrhoea: endocervical/urethral swab or urine
- Syphilis: VDRL blood test
- HIV, hepatitis B and C blood tests
- Pap smear (done at least yearly)
- Offer free hepatitis B vaccination

Additional testing in sexually active MSM (men who have sex with men), or those practicing oral/anal sex include:

- Rectal swabs for chlamydia and gonorrhoea
- Throat swab for gonorrhoea
- Treponemal specific testing (TP-PA) for syphilis with the VDRL
- Offer free hepatitis A vaccine to MSM and injection drug users

In community practice, we suggest all clients with one or more risk factors for an STI be screened as outlined above.

Ensure any client who is diagnosed with one STI is screened for all other STIs.

- **Free hepatitis B vaccine is available to anyone who is at risk for an STI.**
 - **Free hepatitis A vaccine is available for MSM and injection drug users.**
- Call to order:**

Owen Sound 376-9420 / 1-800-263-3456

Walkerton 881-1920 / 1-800-821-7714

Factors for Sexually Transmitted Infections include:

- Under the age of 25, including sexually active adolescents
- History of previous STI
- Sexual contact of a person with an STI
- Any unprotected vaginal/oral/anal intercourse
- New sexual partner
- Multiple sexual partners
- Sex trade worker
- Injection drug use or shared drug equipment
- Men who have sex with men (MSM)

4. SYPHILIS: An Old Disease that's Making a Comeback

Background: Syphilis was rarely seen prior to 1997. However since that time, cases are increasing among men who have sex with men (MSM) in several cities in Canada and the United States, including Owen Sound. Syphilis is caused by the bacteria *Treponema pallidum* and has three clinical stages.

Primary syphilis: Infection with syphilis initially results in a painless sore (called a chancre) usually in the genital area, but also occurring on the rectum, lips or mouth. The chancre usually resolves within 3-6 weeks, however, if untreated, later stages of syphilis may develop.

Secondary syphilis: Occurs 4 to 10 weeks after primary infection when the bacteria spreads systemically. It is characterized by a non-pruritic maculopapular rash that can affect the whole body. Other symptoms include fever, weight loss, lymphadenopathy and hair loss.

Tertiary syphilis: Occurs 10 to 30 years after untreated secondary syphilis. It can cause long term, severe sequelae. Gumma, which are granulomatous soft-tissue tumours can form on the brain, testes, heart, skin and bones. Cardiac, ophthalmic and central nervous system involvement can also occur.

Latent syphilis: Latent syphilis refers to infections that are detected by serologic testing and lack clinical manifestations. Latent infection can relapse to secondary syphilis. **Early latent syphilis** is acquired in the preceding year and **late latent syphilis** refers to latent syphilis infection that was

Summary of Syphilis:

- Syphilis is re-emerging in Ontario
- Routine syphilis testing should be performed in men with a penile rash, all HIV positive patients, in men who have sex with men or those with other risk factors.
- When left untreated, syphilis can be a severe disease.
- Treatment with Penicillin G is effective and available free of charge from the Health Unit.

Did you know?

Safer sex fatigue is a term used to describe people's fatigue of hearing and complying with safer sex messages.

The increased life expectancy and treatment for HIV is associated with a misperception that the risk and seriousness of HIV is low. Safer sex is also perceived to be an impossible goal. It has led to a shift in messaging from only promoting safer sex to encouraging testing and screening. Safer sex fatigue is also called condom fatigue and prevention fatigue.

acquired more than a year ago. It is often difficult to determine when latent syphilis occurred. History and a change in risk factors can often help determine when the probable acquisition occurred.

Method of transmission: Syphilis is acquired through unprotected vaginal, anal and oral intercourse. People with syphilis can spread it during the first year of infection, including when the chancre or rash is present, although infectivity decreases with passing time. Unprotected oral sex is an important method of transmission.

Chancres make it easier to transmit and acquire HIV infection through sexual contact. Chancres can bleed easily. When they come into contact with vaginal, oral and rectal mucosa during sex, there is an increase in the infectiousness of and susceptibility to HIV.

Diagnosis: Syphilis is diagnosed by serum testing; a positive screening VDRL blood test and confirmatory treponemal specific test (eg. TP-PA, FTA-ABS). Most patients who have reactive treponemal tests will have reactive tests for the remainder of their lives, regardless of treatment or disease activity. **All patients who test positive for syphilis should also be tested for HIV and all other sexually transmitted infections.**

Treatment: Benzathine Penicillin G, administered intramuscularly is the preferred drug for treatment of all stages of syphilis. See *Sexually Transmitted Infections: A Quick Reference* for more details.

For more information:

<http://www.cdc.gov/std/STDFact-SM%26Syphilis.htm>

5. Laboratory Testing for Chlamydia and Gonorrhea: What's New

The rates of chlamydia and gonorrhea are rapidly increasing. The diagnosis is important so clients and sexual partners can be appropriately treated. There are two methods used by the laboratory for the testing of chlamydia and gonorrhea:

- 1) Non-culture molecular techniques such as an amplified DNA assay or polymerase chain reaction, and
- 2) Culture

Urine specimens can only be processed using non-culture molecular techniques. Cervical and urethral testing can be performed using both techniques depending on which swab is used.

The following describes when it is best to use:

- 1) Molecular techniques like amplified DNA compared to culture, and
- 2) Whether to use cervical/urethral swabs or a urine specimen to diagnose chlamydia and gonorrhea.

Molecular Testing: The BD Probe Tec™ swab (or the equivalent) tests for *Chlamydia trachomatis* and *Neisseria gonorrhoeae* using an amplified DNA assay on endocervical and urethral specimens. A single swab can test concomitantly for chlamydia and gonorrhea. Your lab will provide your office with a BD Probe Tec™ swab without media or a BD Probe Tec™ swab with media. Both types of BD Probe Tec™ swabs can test for chlamydia and gonorrhea in a single swab of the urethra (in males) or cervix (in females). A single urine specimen can test for chlamydia and gonorrhea as well. See the adjacent articles on proper specimen collection information.

Culture Testing: A swab in charcoal media can be collected from a male urethra or female cervix for a gonorrhea culture. A vaginal swab in charcoal media for culture can rule out bacterial vaginosis and yeast. A vaginal smear should be submitted to rule out *Trichomonas*. Alternatively, a second vaginal swab can be submitted so the laboratory can prepare the smear. For chlamydia and herpes culture, a special swab with viral media and refrigeration is required.

Tests for Chlamydia: For chlamydia, molecular testing such as amplified DNA is more accurate than culture. Cervical (female)/urethral (male) swabs and urine tests for chlamydia are all conducted using an amplified DNA technique. Urine testing is as good as a urethral swab in males, whereas in females an endocervical swab is preferable to a urine specimen. When a test of cure is required, a chlamydia culture is performed.

Tests for Gonorrhea: Culture using a cervical (female)/urethral (male) swab is still considered the gold standard to test for gonorrhea. However amplified DNA techniques are being used by the Public Health Lab to test cervical, urethral and urine specimens because they provide accurate results as well. A gonorrhea culture must be done for a test of cure or if anti-microbial resistance is a concern such as:

- a previous treatment failure
- documented resistance in the partner
- the patient is from or has traveled to Asia, the Pacific Islands, California, England or Wales, where gonorrhea resistance is prevalent.

Swabs sent for gonorrhea testing in charcoal media will be cultured. All other specimens (urine, Probe Tec™ swabs) will be sent for molecular testing. As with chlamydia, urine testing is as good as a urethral swab in males, whereas in females an endocervical swab is preferable to a urine specimen.

In a client who has been sexually assaulted, the collection of specimens follows specific guidelines some of which are time sensitive. These clients should be referred to the Grey Bruce Health Services – Sexual Assault Care Centre (376-2121 Ext. 2458).

STIs may also be the cause of urinary symptoms. If a pelvic examination cannot be performed to obtain cervical swabs, a urine sample provides a reasonable alternative to diagnosing the STI.

How good is urine testing for chlamydia and gonorrhea?

Urine testing in males has equivalent sensitivity as swabs for both chlamydia and gonorrhea (95%) and comparable specificity for both (>90%). In females, however, the sensitivity of urine testing is 83%, which is not as good as an endocervical swab (95%). This means that in males, a urine specimen is an appropriate test, but in females, an endocervical swab is preferable for both chlamydia and gonorrhea, if it can be obtained.

Urine testing has improved the acceptability of STI testing, especially among males. Proper technique and storage of urine specimens is included in the adjacent article.

Collection and testing of urine specimens is not intended to replace a proper physical examination and evaluation.

6. Specimen Collection Techniques

Female Endocervical Swab Collection:

- Remove excess mucus from the cervical os with the large-tipped cleaning swab and discard.
- Insert endocervical specimen collection into cervical canal and rotate for 15-30 seconds.
- Withdraw the swab carefully to avoid contact with vaginal mucosa.
- Place swab in transport media and seal.
- Make sure cap is tight and is labeled with the patient information and date/time collected.

Male Urethral Swab Collection:

- Insert the swab 2-4 cm into the urethra and rotate for 3-5 seconds.
- Withdraw swab and insert into media.
- Make sure cap is tight and label tube with patient information and date/time collected.

Urine Specimen Collection:

- Patient should not have urinated for at least 1 hour prior to specimen collection.
- Collect specimen in a sterile, plastic, preservative-free specimen collection cup.
- Patient should collect the first 15-20 ml of voided urine (the first part of the stream—NOT midstream). Ensure not more than 60 ml are collected by the patient (most urine bottles contain 90 ml).
- Make sure cap is tight and label container with patient information and date/time collected.
- Note:** Store and transport urine specimens to the laboratory at 2 to 8°C within 4-6 days of collection. Urine specimens must be shipped in an insulated container with ice.

8. When to Retest for an STI?

Clinical scenario: A client had an unprotected sexual encounter 3 days ago and visits you in your office today with concerns about sexually transmitted infections. You test for all STIs and all results come back negative. When do you consider retesting to ensure that your patient is free from infection?

STI	Length of time for positive result to be detected by laboratory test
Chlamydia	14 days
Gonorrhea	14 days
Hepatitis B	45 to 180 days
Hepatitis C	Up to 12 months
HIV	3 months
Syphilis (VDRL)	2 weeks to 2 months

7. Summary of Laboratory Specimen Collection for Sexually Transmitted Infections

Test Required	Specimen	Notes	Storage Requirement
Chlamydia/ Gonorrhea Molecular Testing	Swab cervix (females) or urethra (males)	Use BD Probe Tec™ swab (or equivalent) as supplied by lab. A single swab may be used to test for gonorrhea or chlamydia or both. Indicate clearly which tests are required and the specimen site. Swabs are preferable to urine when testing women.	Room temperature
	Urine	First 15-60 ml of voided urine (ie. not mid-stream). A single urine specimen can be used to test for gonorrhea or chlamydia or both. Indicate clearly which tests are required. Urine is as good as swabs in testing men.	Refrigerate immediately
Gonorrhea Culture	Swab cervix (females) or urethra (males)	Use charcoal media swab	Room temperature
Herpes/ Chlamydia Culture	Swab	Submit special swab in viral media (eg. Starswab™ Multitrans™ System) (media is orange)	Refrigerate immediately
Vagina	Swab	Include smear to rule out <i>Trichomonas</i> . Vaginal swab is cultured for yeast and bacterial vaginosis. Alternatively can submit two swabs , one for smear, one for culture. Indicate this is a vaginal swab.	Room temperature
HIV, Hepatitis B & C, Syphilis	Blood	Red top tubes. 1 separate vial for HIV, 1 vial for the rest (VDRL/TP-PA and Hepatitis serology)	Room temperature

NEW GUIDELINES TO ACCOMPANY RECOMMENDATIONS ABOUT SIDS

*Carrie Griffith, Public Health Nurse
Child Health*



Sudden Infant Death Syndrome (SIDS) refers to the sudden and unexpected death of a healthy infant less than one year of age, with cause of the death remaining unexplained even after a medical investigation.

According to the Public Health Agency of Canada's Canadian Perinatal Surveillance System (1999), SIDS is the leading cause of death for Canadian infants between 28 days and one year of age. Although the incidence of SIDS has been steadily declining since 1980, the SIDS rate remains at 0.5 per 1000 live births (Statistics Canada, 1996).

In 1993, a joint statement, "Reducing the Risk of Sudden Infant Death Syndrome in Canada", was released by the Canadian Foundation for the Study of Infant Deaths, the Canadian Institute of Child Health, the Canadian Paediatric Society and Health Canada. The statement has since been updated to add recommendations about positional plagiocephaly (flat head) and sleep positioning.

Furthermore, the Canadian Pediatric Society (CPS) has recently released recommendations for safe sleeping environments for infants and children (2004).

To reduce the risk of SIDS:

- Healthy infants should be placed on their backs to sleep. There is no evidence to suggest an increased risk of injury due to choking in infants that sleep on their backs.
- When an infant is able to roll over on its own, there is no need to force the infant into the back sleep position.
- Items such as pillows, comforters, bumper pads or loose bedding should not be used in a crib, as it decreases the circulation of air in the sleep environment.
- Cigarette smoke increases the risk of SIDS. If parents or caregivers cannot quit smoking, a smoke-free home should be strongly encouraged.
- There is some evidence that breastfeeding is protective against SIDS.

To reduce the risk of positional plagiocephaly (flat head):

- Change the infant's orientation in the crib. For example, one day put the infant's head at the head of the crib, the next day put the infant's head at the foot of the crib.
- Allow the infant plenty of tummy time when not sleeping. Many children do not tolerate this position for long periods of time. Parents can be encouraged to start with short periods of time and gradually work up to longer periods. Tummy time also encourages proper growth and development.

The Canadian Paediatric Society (CPS) has several handouts for parents relating to these recommendations, including: Sleeping position and SIDS, Preventing flat heads in babies who sleep on their backs and creating a safe sleep environment for your baby. These can be accessed via the Internet on the CPS's website for parents, Caring for Kids. (<http://www.caringforkids.cps.ca>)

For more information about these guidelines or copies of the CPS handouts for parents, contact Public Health.