

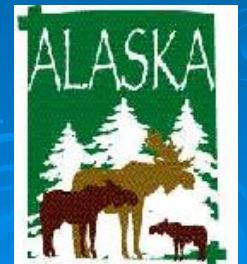
Diagnosis and Treatment of FAS in the Alaska Native
Community

FASD Surveillance in Alaska

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<http://www.epi.hss.state.ak.us/mchepi/programs.stm>



Birth Defects Registry

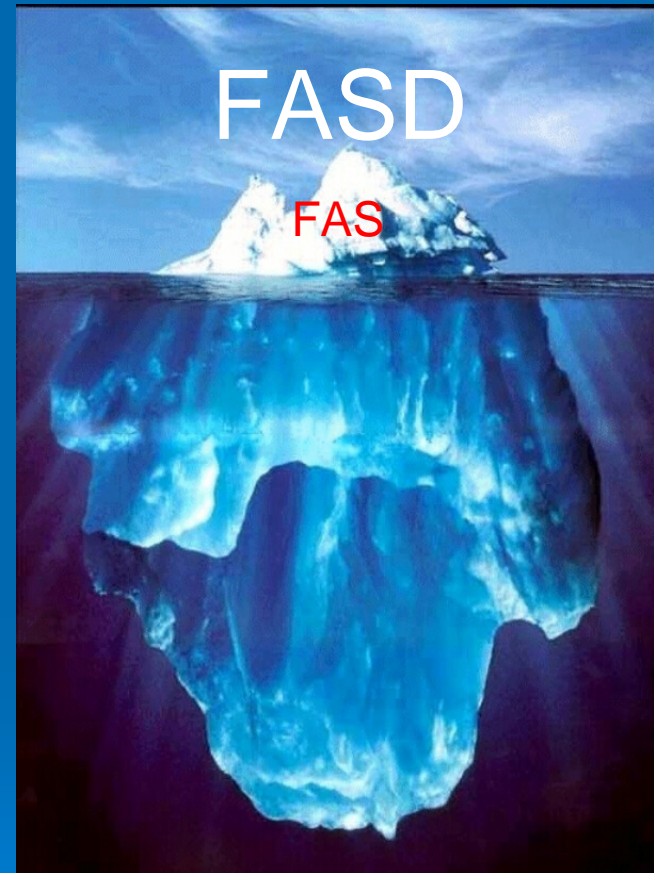
ABDR Surveillance for FASD

- Population-based, passive surveillance through multiple source reporting
- Reportable conditions include ICD-9
 - 760.71 – infant affected by prenatal alcohol exposure
 - 742.1 - microcephalus



FASD prevalence estimate

- All children with a report of 760.71 to ABDR
- Prevalence of children with FAS is a subset of FASD
 - small proportion
 - the tip of the iceberg



Source: <http://londoncoder.files.wordpress.com/2007/12/iceberg.jpg>

FAS Prevalence Estimate

Surveillance and Case Definition

- FAS prevalence estimates based on reports submitted by health entities and verified through medical record review
- Use FASSNET methodology (CDC)
- Differs from University of Washington four digit approach used by diagnostic teams in Alaska

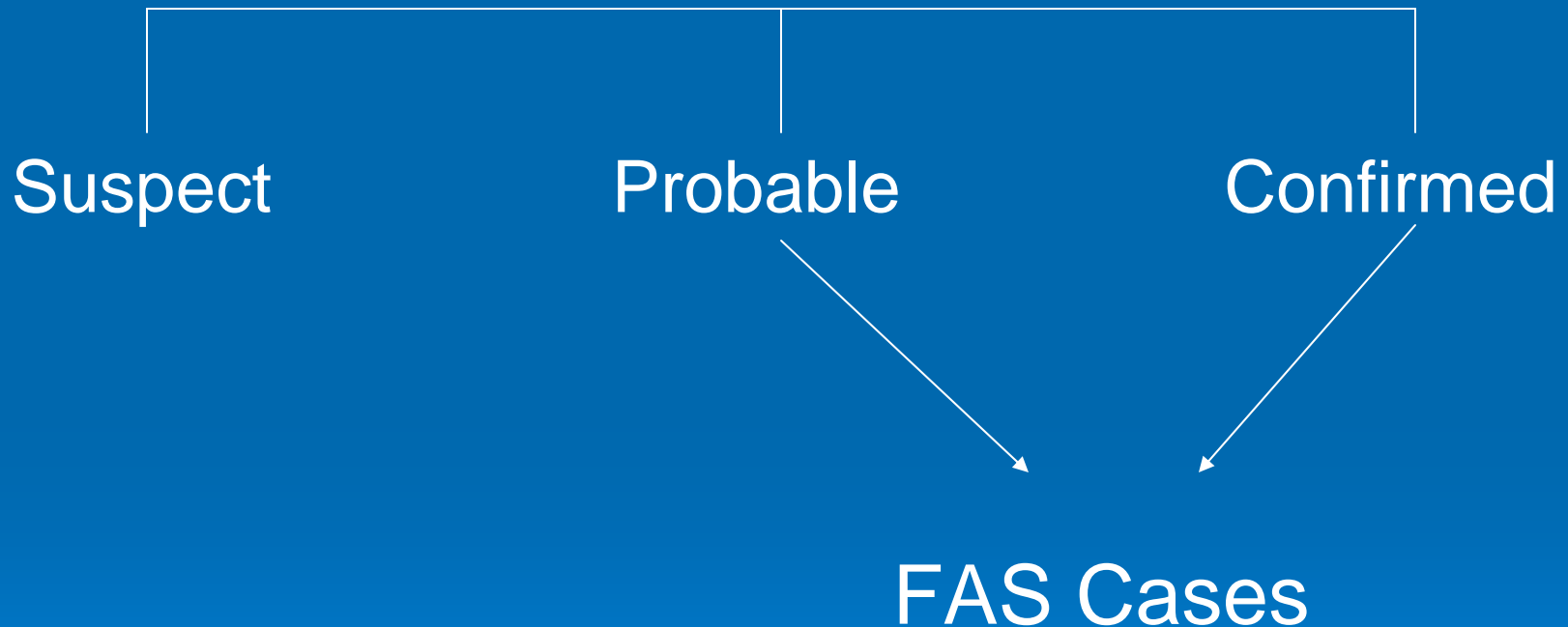
FAS Standardized Case Definition (CDC/FASSNet)

- Requires presence of all three findings in medical record:
 1. All three facial abnormalities:
 - a. Smooth philtrum
 - b. Thin vermilion
 - c. Small palpebral fissures
 2. Growth deficits
 3. CNS abnormalities (structural, neurological or functional, or a combination)



CDC Criteria for FAS Diagnosis

➤ Algorithm outcomes:

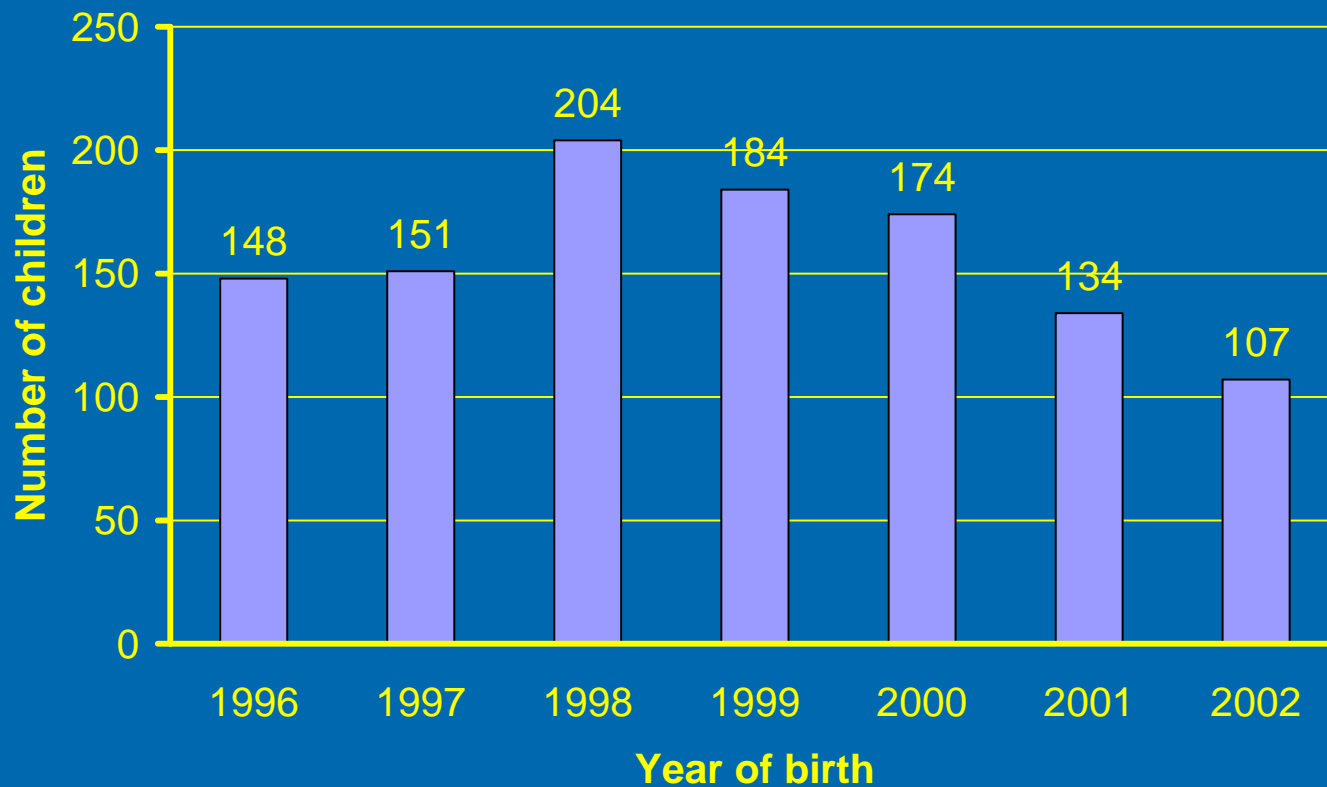


University of Washington 4-digit diagnostic codes

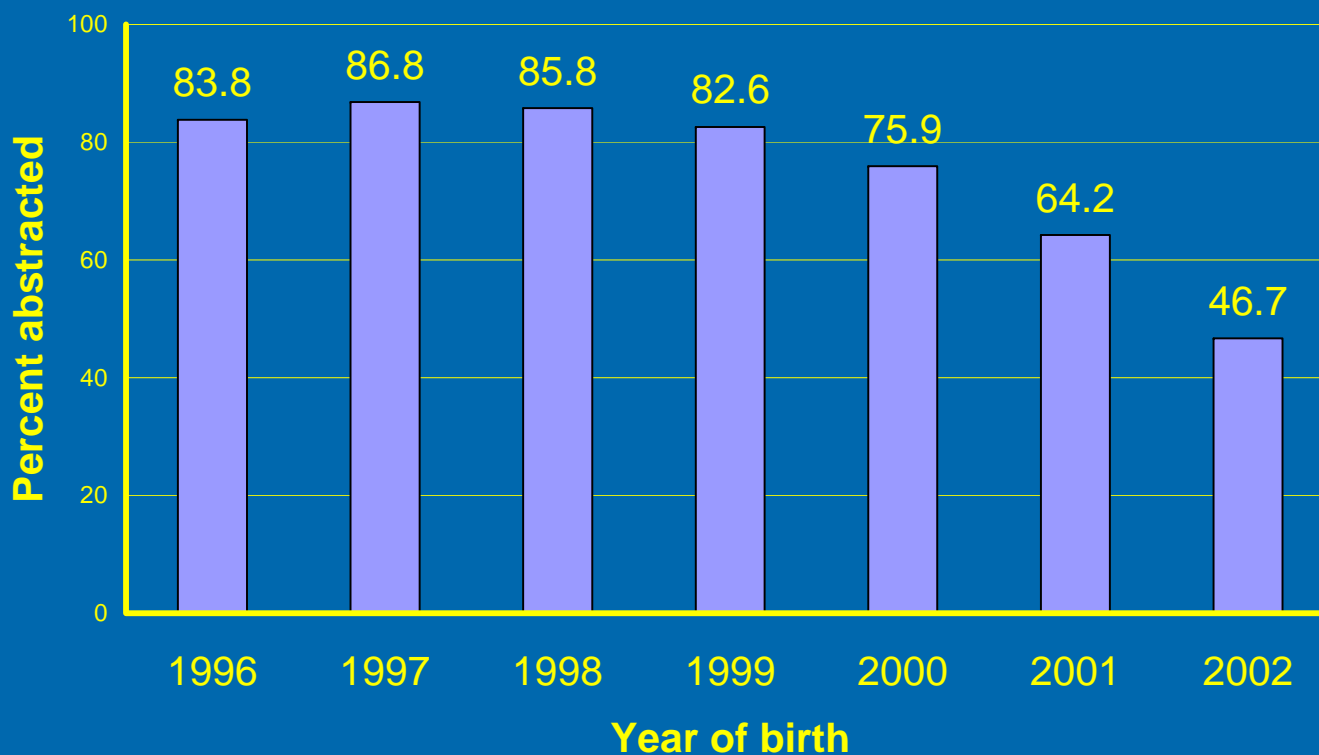
- Four key diagnostic features
 - Growth deficiency
 - FAS facial features
 - CNS damage
 - Prenatal alcohol use
- Each area ranked on Likert scale 1 – 4
- 256 possible combinations yield 22 possible diagnoses, FAS being one of those diagnoses



Number of children with reports of 760.71 (FASD) to the Alaska Birth Defects Registry, birth years 1996-2002



Percent of children reported under 760.71 with at least one abstracted record, birth years 1996-2002, Alaska Birth Defects Registry, *preliminary results*



Data Limitations

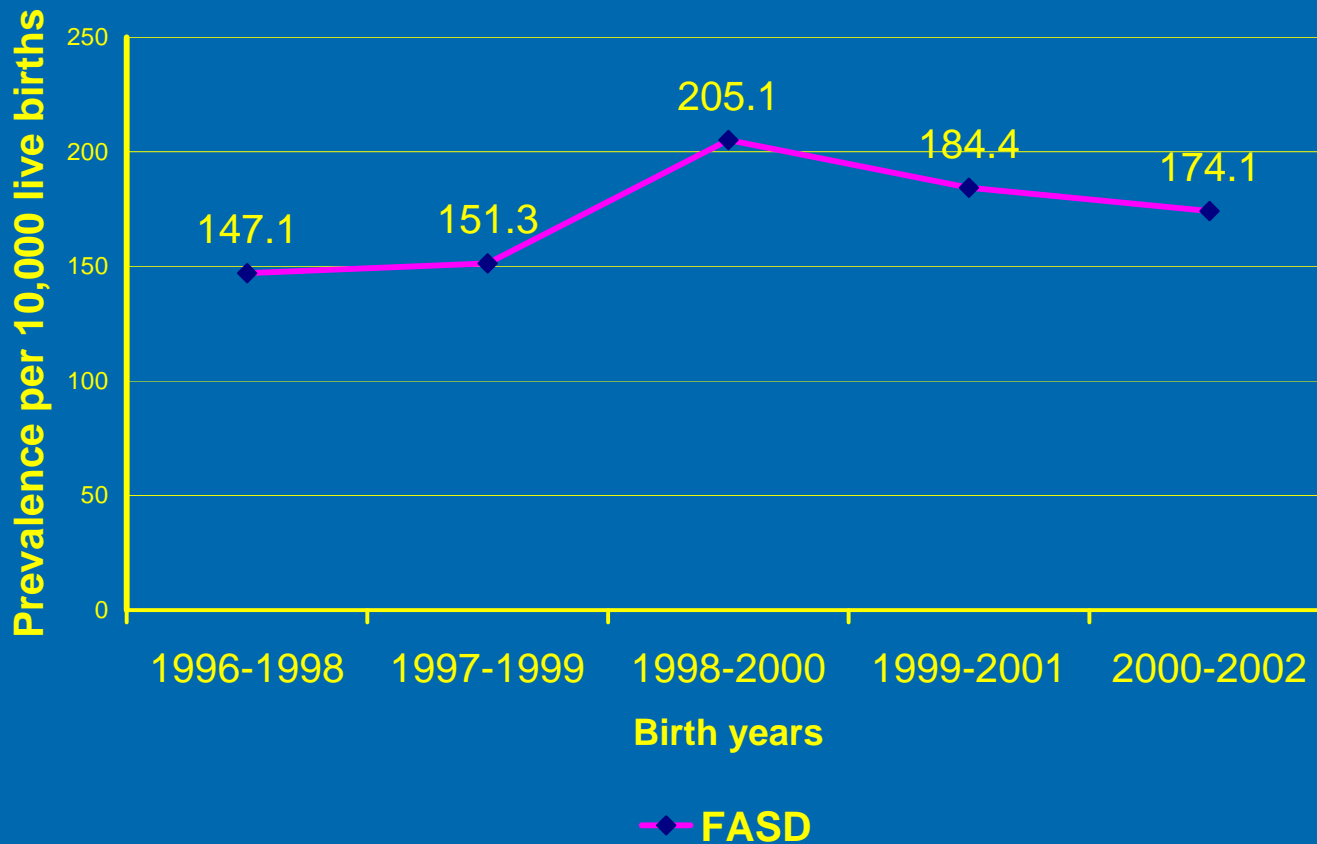
- **Preliminary, unpublished data** – it will change!
- Use of passive surveillance methodology
 - Only children reported to the ABDR are counted and included in prevalence estimates

Data Limitations

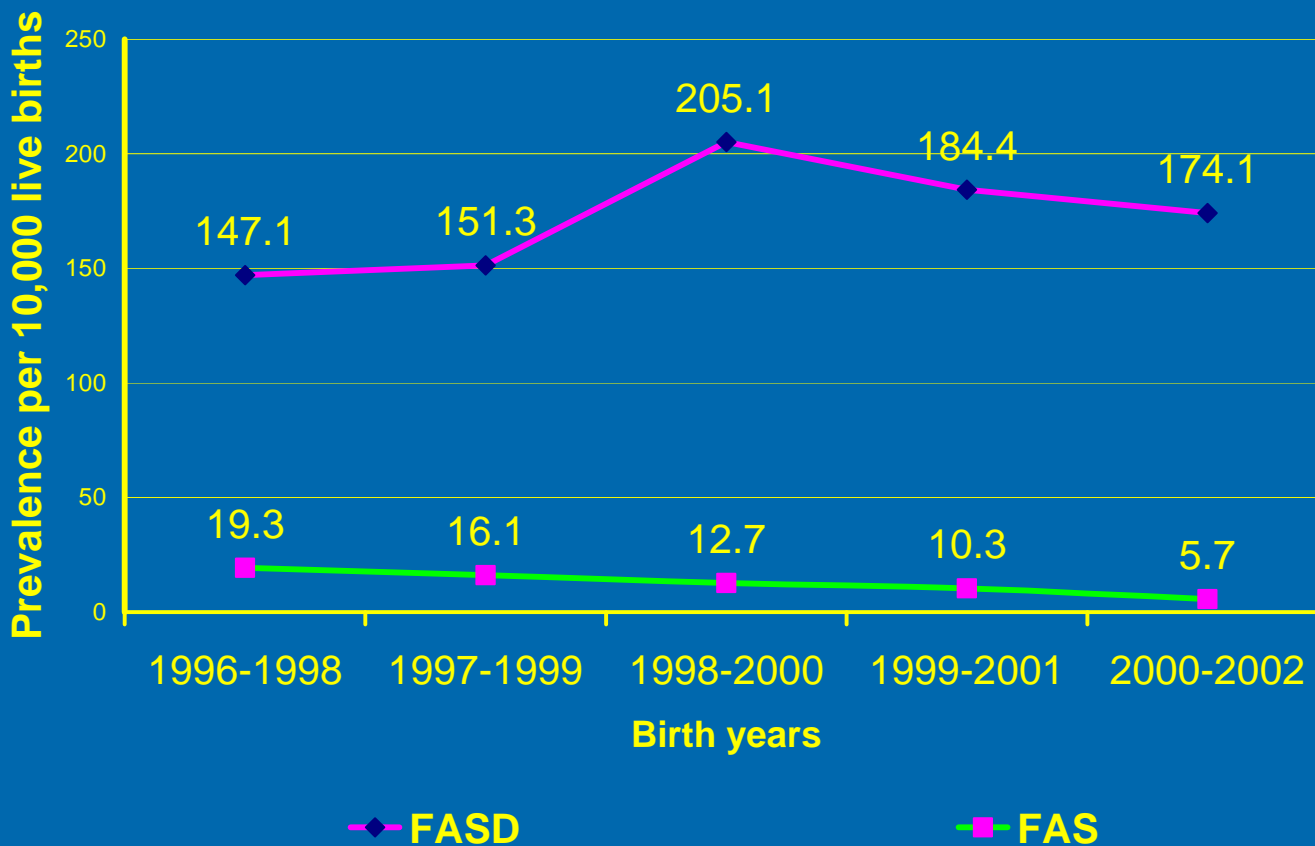
- FAS/D case prevalence determined only for children reported to the ABDR and whose records have been reviewed by a medical abstractor
 - Results are used in the CDC algorithm to determine # of children with FAS/D



Birth prevalence of FASD per 10,000 live births, Alaska Birth Defects Registry, 1996-1998 to 2000-2002 *preliminary results*



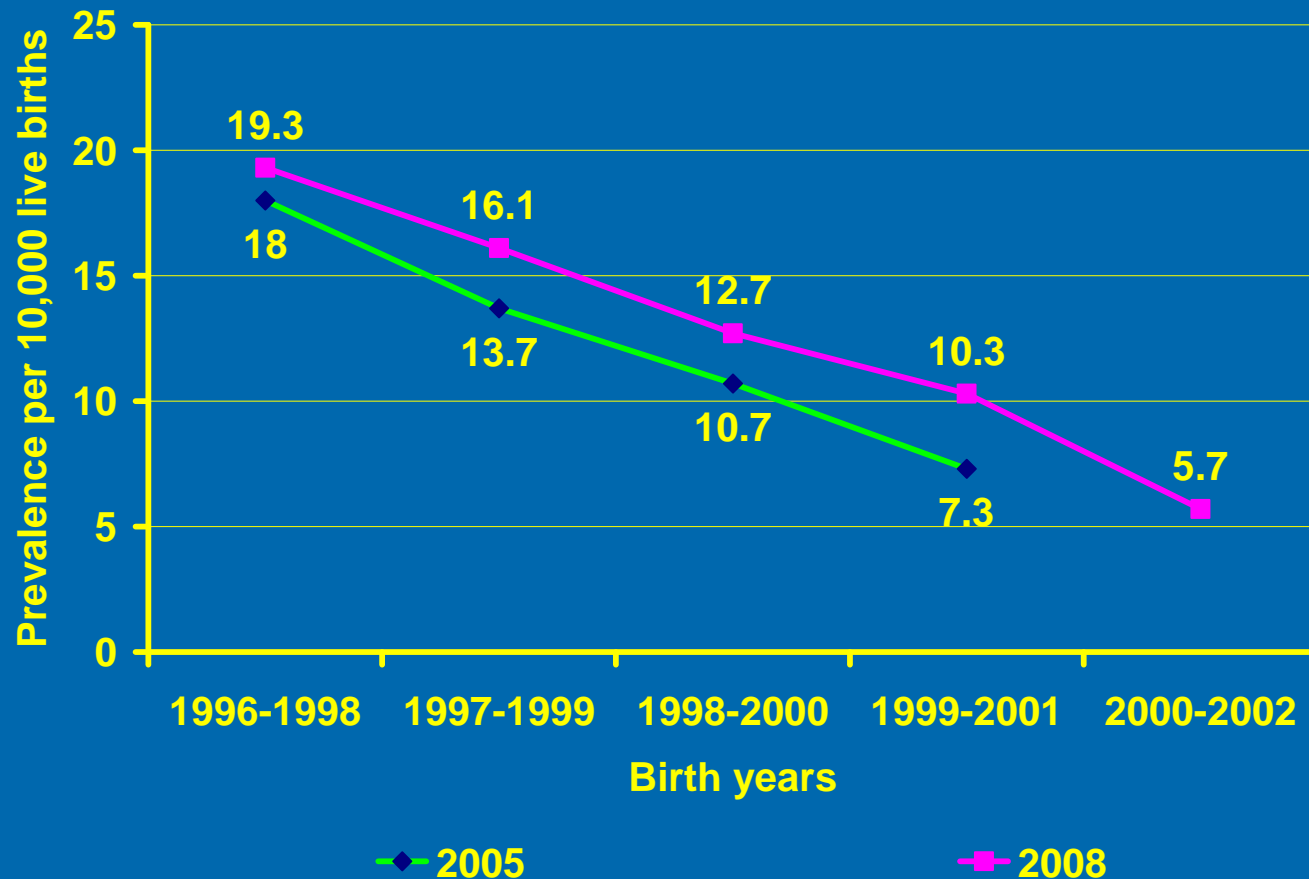
Birth prevalence of FASD and FAS per 10,000 live births, Alaska Birth Defects Registry, 1996-1998 to 2000-2002 *preliminary results*



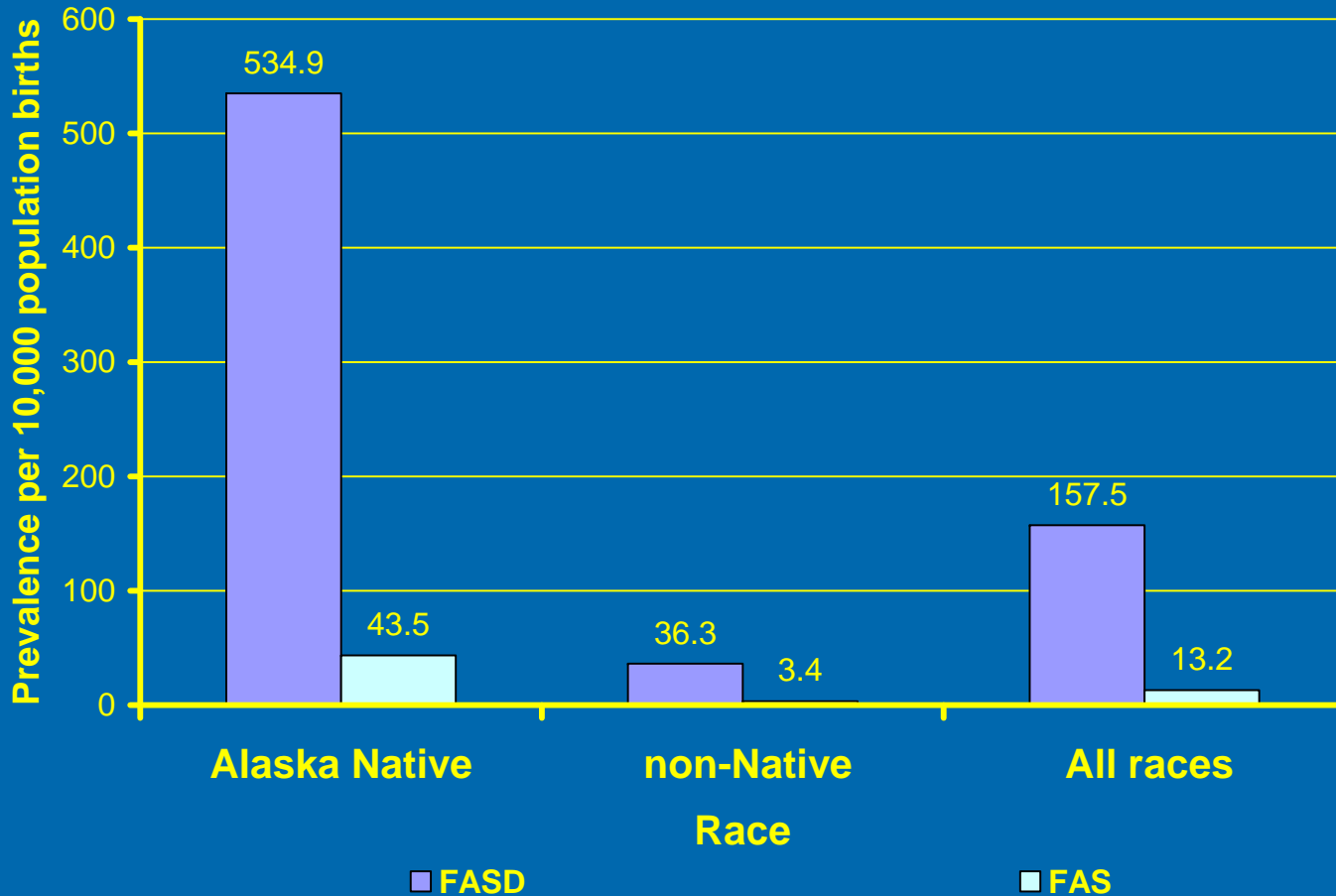
Data Limitations

- The older a child is, the more likely they are to meet the surveillance case definition for FAS (i.e. over time, the FAS prevalence estimate for the earliest birth cohorts is increasing)

Birth prevalence of FAS, confirmed cases as of January 2005 and July 2008, Alaska Birth Defects Registry, Alaska, 1996-1998 to 2000-2002



Birth prevalence of FASD and FAS, by race group, Alaska Birth Defects Registry, 1996-2002 *preliminary findings*



Disparity Issues

- Heightened awareness of maternal alcohol use among Alaska Natives and a well-established system for diagnosing FASD in the Alaska Native community
 - may result in more complete reporting and higher prevalence estimates of FASD among Alaska Natives as compared with non-Natives
- Potential underestimation of rates among non-Natives as a result of possible underreporting



Plans for the Future

- Continue with current analyses ⇒
 - Comprehensive MCH Databook dedicated to FASD – projected 2009
- Start abstractions for birth cohorts on annual basis; develop revised protocol
 - Birth year 2003 next cohort
- Advisory committee for ABDR
- EPI Bulletins; ABDR Newsletter
- Data presentations

