

The health of “emerging adults” in Australia: freedom, risk and rites of passage

TO THE EDITOR: I wish to thank Kang for her editorial on the health of “emerging adults”, articulating experience familiar to those who care for young people.¹ The overview should be read in conjunction with Kang’s contributions as a senior co-editor of *Youth health and adolescent medicine*, which I reviewed in the Journal last year.²

The student health services developed in our universities during the past 50 years resemble facilities elsewhere; more than first-aid posts, they teach us to respect and cherish young people who seek help and spur us to find the best ways to work with them. Encounters with students may begin with consultations about everyday problems, but well managed sore throats and sprained ankles can be door openers for more serious questions.

An accepting environment encourages the exploration of personal concerns, many of them related to what Kang recognises as “The widening gap between biological and psychosocial maturation”. Student health workers become aware that young people often need simply to talk to accepting older people, which an appropriate attitude can facilitate.

Kang’s editorial waves a flag for the uniqueness of young people and challenges us to address a critical transitional period with thoughtful research and imagination.

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Competing interests: No relevant disclosures.

doi: 10.5694/mja15.00019 ■

- 1 Kang MS-L. The health of “emerging adults” in Australia: freedom, risk and rites of passage [editorial]. *Med J Aust* 2014; 201: 562-563.

- 2 Williams MG. Youth health comes of age [book review]. *Med J Aust* 2014; 200: 55. ■

Identified health concerns and changes in management resulting from the Healthy Kids Check in two Queensland practices

TO THE EDITOR: Thomas and colleagues, in their article on identification rates for health and developmental problems of preschoolers before and after Healthy Kids Check (HKC) services,¹ make a valuable contribution to the literature on the outcomes of health assessments.

Their research showed that HKCs were more likely than routine general practitioner visits (in the first 4 years of life) to detect oral health, vision and behavioural problems (prevalence rates among 557 children of 1.8% v 0, 3.8% v 1.4% and 2.3% v 1.8%, respectively), suggesting that HKCs presented an opportunity for families to deal with previously unmet health needs. However, the numbers of height and weight problems and oral health problems reported in this study were surprisingly small. National prevalence rates of more than 20% for childhood overweight² and 40% for untreated dental caries³ were not matched in this study, where the rates for height and weight problems and oral health problems were only 3.2% and 1.8%, respectively.

It is possible that the communities involved experienced exceptional health status (the socioeconomic status of clinic populations was not described) or that only healthy children attended HKCs — or it is perhaps more likely that these problems remained undetected. Such discrepancies in the rates are significant because HKCs were established, in part, to detect early lifestyle risk factors; an aim that cannot be realised if there



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is incomplete recording of these developmental indicators.

The findings of Thomas and colleagues suggest that HKCs are partially improving the early detection of lifestyle risk factors. However, a more comprehensive evaluation of HKC outcomes — incorporating the views of clinicians and parents with long-term follow-up of children across various health settings — is needed to determine the true impact.

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Competing interests: No relevant disclosures.

doi: 10.5694/mja14.01557 ■

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- 3 Chrisopoulos S, Harford J. Oral health and dental care in Australia: key facts and figures 2012. Canberra: Australian Institute of Health and Welfare, 2013. (AIHW Cat. No. DEN 224.) ■

IN REPLY: We thank Alexander and colleagues for their interest in our article. They query the low rate of detection of oral health problems and overweight and obesity. We are surprised that they question our failure to detect oral health problems, given that their analysis found this screening to be ineffective.¹ Perhaps the general practitioners in our study did not embark on ineffective screening.

Our data show that the overall detection was 5% for problems related to height and weight. This might correspond to the 6%–7% of children aged 5–9 years with obesity² (for whom action may be effective), rather than to the additional 15% with overweight.

More importantly, by viewing the prevalence of health problems in children as a general practitioner compliance and measurement concern, we lose sight of the bigger picture. Does the Healthy Kids Check detect problems that lead to better child outcomes? We do not know. This is a health policy that has been implemented without adherence to evidence-based practice principles. We agree — long-term follow-up is essential.

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Competing interests: No relevant disclosures.

doi: 10.5694/mja14.01606 ■

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The importance of molecular testing to confirm measles, mumps and rubella in vaccinated individuals

TO THE EDITOR: Despite high vaccination coverage, Australians remain at risk of measles, mumps and rubella, either while travelling to endemic countries or from domestic exposure to imported cases. Those most at risk include incompletely vaccinated adults and children whose parents choose not to have them vaccinated. Additionally, immunity generated by vaccination (rather than natural infection) may be less protective, especially if only one vaccine dose is received.^{1,2}

When measles, mumps and rubella were commonly encountered, their clinical features were well recognised, but far fewer cases are now seen, diminishing clinical acumen and the positive predictive value of a clinical diagnosis. Further, the relative proportion

of cases in previously vaccinated individuals has increased, making the clinical diagnosis more difficult as these cases may present atypically.^{1,3}

With this clinical uncertainty, laboratory confirmation assumes greater importance.⁴ However, the IgM response can take several days to appear and can be attenuated or completely absent in post-vaccination infection,^{1,2} necessitating molecular detection methods to confirm the diagnosis.²⁻⁴ Polymerase chain reaction (PCR) testing has been shown to contribute significantly to laboratory confirmation of measles^{2,5} and mumps^{3,4} in highly vaccinated populations.

We investigated the vaccination status and mode of laboratory confirmation of notified cases of measles, mumps and rubella in Western Australia over almost 10 years, from January 2001 to September 2010. During this period, 82 cases of measles, 335 of mumps and 38 of rubella were notified to the Department of Health. Of these, eight patients (10%) with measles, 117 (35%) with mumps and four (11%) with rubella were fully vaccinated; 16 (20%), 39 (12%) and five (13%), respectively, were partially vaccinated; and 46 (56%), 53 (16%) and 22 (58%), respectively, were



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unvaccinated. Thirty-two per cent of measles, 49% of mumps and 89% of rubella cases were confirmed by IgM serological testing alone; 34%, 2% and 3%, respectively, were confirmed by serological testing and PCR; and 20%, 38% and 3%, respectively, were confirmed by PCR alone (IgM not detected or not requested). A further 15% of measles, 10% of mumps and 5% of rubella cases were diagnosed using clinical and epidemiological criteria, without testing. Overall, when laboratory-confirmed cases were stratified by vaccination status, the proportion confirmed by PCR alone increased from 18% in the unvaccinated to 71% in the fully vaccinated, including from 21% to 63% for measles, and 22% to 74% for mumps, respectively (Box).

These data confirm the increased number of measles and mumps cases diagnosed by PCR rather than serological testing among people who are fully vaccinated compared with the unvaccinated group. Diagnosis by PCR allows virus genotyping, which is important for epidemiological purposes² and can distinguish wild-type measles virus from the vaccine strain when vaccine is used for post-exposure prophylaxis.⁵ We recommend collection of respiratory specimens, whole blood and/or urine for PCR

Laboratory-confirmed cases of measles, mumps and rubella in Western Australia, January 2001 to September 2010

Vaccination status	Laboratory confirmation	Measles (n = 70)	Mumps (n = 300)	Rubella (n = 36)	Total (%)
Fully vaccinated	Serological	3	26	3	32 (28%)
	PCR	5	75	0	80 (71%)
	Both	0	1	0	1 (1%)
Partially vaccinated	Serological	5	17	4	26 (46%)
	PCR	3	15	0	18 (32%)
	Both	8	3	1	12 (21%)
Not vaccinated	Serological	13	39	20	72 (69%)
	PCR	7	11	1	19 (18%)
	Both	14	1	0	15 (14%)
Unknown	Serological	5	82	7	94 (90%)
	PCR	1	27	0	28 (24%)
	Both	6	3	0	9 (8%)

PCR = polymerase chain reaction. ◆

diagnosis, in addition to serological testing, for laboratory diagnosis in suspected cases of measles, mumps and rubella.

Acknowledgements: We thank the clinicians and laboratory and public health staff involved in the diagnosis, testing and follow-up of these cases.

Competing interests: No relevant disclosures.

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doi: 10.5694/mja14.01413 ■

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Pharmacological management of low milk supply with domperidone: separating fact from fiction

TO THE EDITOR: After publication of our peer-reviewed perspective article on the safe and effective use of domperidone in the management of low milk supply,¹ we are disappointed to have been informed that the *Australian*

medicines handbook (AMH) has removed lactation stimulation as a recognised off-label indication for domperidone (as well as metoclopramide). It appears that this change could be a kneejerk response to recent regulatory warnings, despite these being highlighted as not being of relevance to most breastfeeding women.^{1,2} These changes carry with them the significant potential to create confusion among prescribers and the public.

We would like to re-emphasise the points we have made previously that further restrictions regarding the use and availability of domperidone do not appear to be warranted; they risk subjecting women to additional emotional trauma and are not in the interests of the immediate and long-term health of breastfeeding women and their babies.^{1,2} There is absolutely no evidence that domperidone places breastfeeding mothers at increased risk of severe cardiac events, whereas, in contrast, there is evidence of the significant benefits to be gained from the use of domperidone in supporting breastfeeding. Domperidone has been used widely in clinical practice for women experiencing low milk supply,³ with no reports of significant adverse effects.

We also re-emphasise our previous practice points regarding the importance of adequately screening women for factors that may place them at increased risk of cardiac arrhythmia, should this be of concern.

It is clear that domperidone is not a magic bullet for adequate milk production in breastfeeding women. Non-pharmacological management options are the mainstay of treatment, with medications only to be considered as a last resort, and always in addition to these management strategies.⁴ There is no easy fix when it comes to supporting women who are struggling with low milk supply, but when used appropriately, domperidone can be

a very safe and effective treatment option.

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Acknowledgements: Luke Grzeskowiak acknowledges salary support from a National Health and Medical Research Council Australian Public Health Fellowship (ID1070421).

Competing interests: No relevant disclosures.

doi: 10.5694/mja14.01585 ■

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