

## SMOKING CESSATION TREATMENTS: MEASURING RESPONSES AMONG ETHNIC GROUPS

Few studies have been completed on whether programs or devices are successful in encouraging African American and Hispanic smokers to quit smoking. Most of the research has been based on White smokers. This study compared responses to several smoking cessation treatments among a sample of 559 adult African American, Hispanic, and White smokers.

Of the sample, 53% were considered abstainers, that is, they did not smoke during the last four weeks of the eight-week treatment program. However, this percentage was different according to race/ethnicity: only 33% of the 126 African Americans were abstainers, as were 41% of the 73 Hispanics, and 60% of the 360 Whites.

When we looked more closely at the data, we found that African Americans

who were thinner or living with another smoker were less likely to quit smoking than other African Americans. For these smokers, programs that change attitudes about weight and weight gain and household policies against smoking could help them to quit smoking.

For Hispanics, older participants were less likely to quit smoking; this may be linked to generational norms or place of birth, either in or outside the United States. Among Whites, those who were confident that they could quit smoking were more likely to quit. For this subgroup, interventions that encourage self-confidence could increase the number of those who stop smoking.

In previous studies on the use of bupropion and the nicotine patch for African American smokers, those who

received the patch were twice as likely to stop smoking compared to those who did not receive bupropion or the patch. However, our findings suggested that White smokers may receive more benefit from these types of treatments than do African Americans or Hispanics. Researchers should conduct more studies to gain better knowledge of the effectiveness of nicotine dependence treatments by race/ethnicity.

*Source: Smokers' Response to Combination Bupropion, Nicotine Patch, and Counseling Treatment by Race/Ethnicity*  
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## USE OF COMPLEMENTARY AND ALTERNATIVE MEDICINE AMONG MINORITY WOMEN

Socioeconomic factors, such as education, income, access to resources, and availability of health care, play an important role in how people use health care. These factors are often the reasons for racial/ethnic disparities in health care. Yet, little is known about how these factors account for differences between ethnic groups and their use of complementary and alternative medicine. We examined whether the relationship between these factors and complementary and alternative medicine use among women differs by racial/ethnic groups.

Using national survey data, we reviewed data on four groups of women: Whites, Blacks, Mexican American, and Chinese American. Complementary and alternative medicine use was defined as using at least one of the following during

the year before the survey: vitamins and nutritional supplements; special diets; medicinal herbs; remedies or practices associated with a particular culture; homeopathy; yoga, meditation, or tai ji; chiropractic; manual therapies (eg, massage or acupressure); energy therapies; acupuncture; or any other remedy or treatment not typically prescribed by a medical doctor.

For Mexican American and non-Hispanic White women, those with higher levels of education were more likely to use complementary and alternative medicine techniques than those with lower levels of education. Also for this group, those with a household income of \$60,000 or more used complementary and alternative medicine more often than those with lower incomes.

Although both non-Hispanic White and Mexican American women with higher education levels were more likely to use complementary and alternative medicine, this was more true for non-Hispanic White women.

For Chinese American women, socioeconomic factors did not appear to make a difference in complementary and alternative medicine use. For African American women, income levels were not linked to complementary and alternative medicine use. However, college graduates were three times more likely to use complementary and alternative medicine than those with less than a high school education.

Other factors, such as immigration, insurance and health status, social networks, culture and worldview may in-

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fluence complementary and alternative medicine use in minority populations. Complementary and alternative medicine includes many different therapies, all of which may not be available in minority communities. Costs and in-

surance reimbursements for complementary and alternative medicine treatments also vary widely. These factors may also influence the use of complementary and alternative medicine by minority women and should be studied further.

*Source: Socioeconomic Factors and Women's Use of Complementary and Alternative Medicine in Four Racial/Ethnic Groups*

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## A LIFESAVING EDUCATION

High blood pressure, or hypertension, is a major risk factor for heart, brain and kidney disease leading to heart attacks, strokes and kidney failure. Hypertension affects all people, but Mexican Americans with hypertension are much less likely to be aware of their condition, less likely to be on medication, or less likely to have their hypertension under control. Although hypertension is mostly found in adults, it is now found in children and young adults in increasing numbers. A recent study of persons aged 10–19 years in Houston found that 4.5% had hypertension and most of those were Hispanic.

The American Heart Association (AHA) and District Nursing Services at the Los Angeles Unified School District (LAUSD) got together to educate and prepare high school students to test high blood pressure (BP).

Between November 2005 and May 2005, 960 students from 17 high schools in mostly Hispanic communities in the Los Angeles Unified School District, were given a seminar on the causes of heart attacks and strokes, and the proper way to take BP readings with a digital BP monitor. These students came from health education, biology, and economics classes.

Students participating in the program tested and gave out educational materials to more than 5,000 persons in their communities. Six percent of those screened were found to have high blood pressure, of which only 26% were taking blood pressure medication. 46% of those with high blood pressure at screening said they had a history of high blood pressure. Three percent of all those screened were identified as having high blood pressure for the very first time.

Those with high blood pressure were more likely to be older, male, heavy alcohol users, and had a history of hypertension.

Training high school students to identify persons with high blood pressure is possible, and may help reach large numbers of ethnic minorities not aware that they have the silent killer: hypertension.

*Source: Educating and Mobilizing Youths to Detect Undiagnosed Elevated Blood Pressure: Searching for the Silent Killer*

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## A BETTER UNDERSTANDING OF ARTERIES AND VALVES WOULD HELP PREVENT HEART DISEASE

The Multiethnic Study of Atherosclerosis (MESA) is a large research project supported by the National Heart, Lung and Blood Institute, a major federal government health agency. An important goal of MESA is to compare the frequency and progression of early forms of atherosclerosis (a condition in which a mass, calcium, or fat builds up on the walls of large- or medium-sized arteries) in different ethnic groups. By

doing so, we hoped to have a better understanding on how to prevent diseases of the heart and arteries.

One of the discoveries emerging from MESA is that African Americans and Hispanics have less coronary artery calcifications than Whites of equal age and risk. The mitral annulus is a ring of tissue that surrounds and supports the mitral valve, one of the four heart valves. Like the coronary arteries, the mitral

annulus is susceptible to developing deposits of calcium called mitral annulus calcification (MAC). Several experts believe that MAC is caused by, and is a marker for, the same atherosclerosis that affects the coronary arteries.

MAC is easily diagnosed with cardiac ultrasound or echocardiography, which is more readily available than computed tomography and does not expose the patient to radiation. We performed

a study comparing the frequency of MAC diagnosed by echocardiography in African Americans, Hispanics and Whites in order to test whether ethnic patterns of calcification observed in the coronary arteries also occur at the mitral annulus.

We reviewed the echocardiograms of 857 patients who were between the ages of 40–75 years. Our study sample included 217 African Americans, 349 Hispanics and 291 Whites. MAC was detected in 35 (16.1%) African Amer-

icans, 80 (22.9%) Hispanics, and 66 (22.7%) Whites. For the entire group, advanced age and smoking were associated with having MAC. After adjusting for other differences among the participants, the frequency of MAC did not differ between the three ethnic groups.

We conclude that the frequency of MAC is not related to ethnic origin. We suspect that the difference in the ethnic patterns of calcification in the coronary arteries and mitral annulus are caused by differences in blood flow at the two sites.

More studies should be conducted to find out whether MAC predicts heart disease and how it could guide preventive therapy equally in different ethnic groups.

*Source: Prevalence of Mitral Annulus Calcification in African Americans: Comparison with non-Hispanic Whites and Hispanics*

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## DO BLACK AND WHITE PATIENTS ACCEPT AND REJECT DOCTOR RECOMMENDATIONS FOR HEART TREATMENTS AT THE SAME RATE?

Studies have found that Blacks undergo fewer heart procedures than Whites when both have heart disease. To find out why this happens, our study looked at whether or not a patient would accept a heart procedure when offered by a physician and compared patient preferences, accepting or rejecting the treatment, to the patient's ethnicity.

To perform the study, we reviewed medical records at a public health hospital located in southeastern Louisiana. In order to be selected, patients had to be in need and suitable for a heart (cardiac) procedure and the patient's

medical chart had to show that the patient was referred by a physician.

We found that patient preferences were similar for both Blacks and Whites. That is, both groups accepted or rejected treatment at the same rate. The study confirms that patient preferences do not differ according to race.

This finding is important because, when certain procedures are needed, patients must listen and select treatment options recommended by physicians. This study showed that Black and White patients make similar choices when treatment options are presented to them.

However, this study's conclusion does not explain why Blacks undergo fewer procedures when compared to Whites. It only shows that differences do not occur as a result of decisions made by patients. Therefore, racial differences in cardiac procedures are likely the result of patient symptoms and physician decisions to refer or not to refer patients.

*Source: Patient Preferences: Do They Contribute to Healthcare Disparities?*

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## LANGUAGE MAY PREVENT SOME HISPANICS FROM RECEIVING GOOD HEALTH CARE

*Healthy People 2010* is a set of goals developed by the US government to measure progress in the health of its citizens. The overall goals of this program are to increase the length and quality of life of all people in the United States and to decrease health disparities.

To reach these goals, several disparities in health care must be stopped. An example of one of the disparities is having access to and being able to receive

healthcare services, such as having health insurance, and seeing a doctor regularly to receive preventive care. As the population of the United States continues to grow and becomes more diverse, it is expected that issues with health disparities will continue. Research has suggested that patients who speak English poorly have difficulty receiving proper care.

The US Census Bureau states that Hispanics are the fastest growing ethnic

group in the United States and that one in five Americans now speaks Spanish as their first language. As more people who speak Spanish enter the country, healthcare resources need to be tailored to meet the needs of our diverse and growing population.

In our research, we examined a health survey for a national sample of Hispanic persons in the United States. We found that those who were

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more comfortable answering the health survey in Spanish rather than in English were less likely to have health insurance coverage, to have a personal healthcare provider, and to have had a routine health check-up within the past five years, compared to those who took the survey in English.

The findings from this study suggest that many people may not be receiving the care that they need and this disparity could result from being unable to speak English well.

To work toward erasing the language barrier, all federal agencies are required to have plans in place that would make the services that they provide more accessible to those who speak little

English. Some federal agencies, such as the Agency for Healthcare Research and Quality (AHRQ) and the Centers for Disease Control and Prevention (CDC), provide health information on their websites in Spanish. These websites include information on how to find Spanish-speaking healthcare providers and how to access information on healthy behaviors and lifestyle choices that will promote good health. These two websites can be found at: <http://www.ahrq.gov/consumer/espanoix.htm> and <http://www.cdc.gov/spanish/>.

Even with federal regulations and programs to help provide services to those who speak little English, disparities are still present. Many people who

require health care may not be receiving the care that they need and millions more may not be receiving public health messages on the importance of receiving preventive care in order to stay healthy.

The findings and conclusions in this report are those of the authors and do not necessarily represent the views of the Centers for Disease Control and Prevention.

*Source: Language Preference as a Predictor of Access to and Use of Healthcare Services Among Hispanics in the United States*  
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## MINORITY CHILDREN IN A LOW SOCIOECONOMIC ENVIRONMENT FOUND TO HAVE INCREASED RATES OF BEING OVERWEIGHT

Being overweight and at risk for overweight is a problem in the United States. Body weight is linked with diabetes, asthma, hypertension, high cholesterol; high body weight increases the risk of having heart disease. Although many adults are obese and overweight, more and more children are now overweight or at risk of becoming overweight.

In children, ethnic minorities and those of low socioeconomic status are groups that are especially at risk of having increased body weight. In order to find out why children of these groups are more likely to have increased body weight, we need to find out more about what factors might cause children to become overweight. This information

can help us create effective, culturally appropriate programs for these high risk subgroups.

School-based health centers provide treatment and some prevention services to students. We designed our study to find out more about children enrolled in these centers. The study was conducted in school-based health centers in the East Harlem neighborhoods New York City. After getting permission, we examined the medical records of children and teenagers, aged 5 to 18 years, enrolled in four pediatric school-based health centers in East Harlem during September 2002 through August 2003.

Of the 491 records reviewed, 46% of the children were either overweight or at

risk for overweight, with the highest risk observed in Hispanic/Latino children. These findings highlight the need for more research to find out what might cause overweight in minority, low socioeconomic status children attending school-based health centers, and also to test the effectiveness of school-based prevention programs for this high-risk population.

*Source: The Prevalence and Characteristics of Childhood Overweight in a Multiethnic, School-based Health Setting*  
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