



The Blue Ridge Poison Center

Tox Talks

 October 2008 | A Bulletin for Health Care Professionals Who Manage Poisoned Patients | <http://hsc.virginia.edu/brpc/>

REFUGEES AND LEAD POISONING

DOES YOUR FACILITY HAVE TELE-

MEDICINE? The Blue Ridge Poison Control Center offers CME-accredited toxicology lectures through telemedicine. To request a topic, schedule a lecture for your staff, or more information contact Heather Collier: 434-924-5185 or HLC8E@virginia.edu.

THE UVA CENTER OF CLINICAL TOXICOLOGY associated with the Blue Ridge Poison Center manages over 500 patients each year on site in the University of Virginia Health System - from outpatient clinic visits to critically ill inpatients managed in our pediatric and adult intensive care units. In addition, over 2,000 requests are made each year for consultation with our Boarded Medical Toxicologists from other healthcare facilities by phone or telemedicine. Call 1-800-222-1222 24 hours a day, every day. [Cell users: 1-800-451-1428]

IN CHARLOTTESVILLE

Reminder: At University of Virginia Hospital, the first Wednesday of every month features toxicology Grand Rounds. For more information, contact Heather Collier: 434-924-5185 or HLC8E@virginia.edu

Register to receive this newsletter via email: Kristin Wenger: klw2s@virginia.edu

Federal standards currently stipulate that a refugee medical screening take place within 90 days after a refugee's arrival in the United States. The contents of the screening vary from state to state and many do not clearly define a blood lead level (BLL) screening protocol for refugee children. The CDC recommends blood lead testing of children within 90 days of arriving into the United States so treatment can be provided if necessary. The American Academy of Pediatrics also recommends testing children who have emigrated from other countries where lead poisoning is prevalent (American Academy of Pediatrics. Screening for elevated blood lead levels. Pediatrics 1998; 101 (6):1072 - 1078). Children with EBLLs should receive follow-up medical attention that adheres to CDC guidelines and state and local policies and laws, and their families should receive information on the prevention of lead poisoning.

Studies have shown that age is not a significant risk factor for elevated BLLs among refugee children. Although the risk for lead exposure among children older than 6 years may be the result of lead exposure in their country of origin, many of the prevailing health, social, and economic burdens accompany the children to the United States thus suggesting the value of screening all refugee children at time of arrival.

Within 3 to 6 months after refugee children are placed in permanent residences, it is recommended to repeat blood lead testing of refugee children aged 6 months to 6 years. The rationale to test refugee children again at 3 to 6 months is best described in the 2005 New Hampshire case study (CDC. Elevated blood lead levels in refugee children - New Hampshire, 2003-2004. MMWR 2005; 54(2); 42 - 46.) This study demonstrated that although some refugee children had elevated BLLs when they arrived in the United States, the majority of the children did not. The follow-up screening conducted on an average of 60 to 90 days after placement or after the children settled into their

permanent residences, revealed that these New Hampshire refugee children had elevated BLLs ranging from 11 to 72 µg/dL. Thus, the lead exposure had occurred in the United States. This repeat blood lead test should be considered a "medical necessity," regardless of the initial test result.

The refugee status for most of the children entitles them to Medicaid and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) services, and other social services for at least 8 months after their resettlement, regardless of family financial status. Upon United States arrival, all refugee children should have nutritional evaluations performed and should be provided with appropriate nutritional and vitamin supplements as indicated. Pre-existing health burdens such as chronic malnutrition, along with cultural, language, and economic barriers, compound refugee children's risk for lead poisoning.

Below is the *Guidelines for Childhood Lead Poisoning Testing*, developed by the Virginia Department of Health Lead Elimination Plan Medical Committee following CDC Guidelines and Virginia Regulations. The guidelines were amended recently to reflect the acknowledgment that recent refugee, immigrant, or international adopted children are at risk for lead poisoning. (To view the complete document, including guidelines for management of children with confirmed elevated blood lead levels, visit <http://www.vahealth.org/leadsafe/>)

VIRGINIA Guidelines for Childhood Lead Poisoning Testing

ALL MEDICAID ENROLLED CHILDREN ARE REQUIRED TO BE TESTED AT 1 AND 2 YEARS OF AGE

Blood lead levels shall be obtained in children at ages 1 and 2 if they meet ANY one of the criteria noted in the box below. In addition, children ages 3-5 years of age who have not previously been tested, and moved to a new address in a high-risk area, or meet ANY one of the criteria below shall also be tested.

- Eligible for or receiving WIC benefits? Medicaid eligible and not tested at both 1 and 2 years of age?
- Living in a ZIP Code determined to be high-risk based on age of housing and other factors? (See High – Risk ZIP Code list, available at <http://www.vahealth.org/leadsafe/>)
- Living in or regularly visiting a house or day care center built before 1950?
- Living in or regularly visiting a house built before 1978 with peeling or chipping paint or recent (within the last 6 months), ongoing or planned renovation?
- Living with or regularly visiting a sibling, housemate or playmate with lead poisoning?
- Living with an adult whose job or hobby involves exposure to lead?
- Living near an active lead smelter, battery recycling plant, or other industry likely to release lead?
- Recent refugee, immigrant, or child adopted from outside of the U.S.
 - Take careful history regarding possible lead exposure at each routine visit.
 - A child must be tested if the parent or guardian requests testing due to possible exposure (12 VAC 5-120).
 - Testing may be performed by venipuncture or capillary. Filter paper methods are also acceptable and often more convenient for the family if performed in the provider's office. The use of a CLIA-waived lead testing device must be approved through the Lead-Safe Virginia Program at 804-864-7694 to assure proper quality assurance and reporting of data.

More detailed information may be found at www.cdc.gov/nceh/lead. The CDC Web site gives specific information about medical, environmental, nutritional, developmental, and educational interventions.