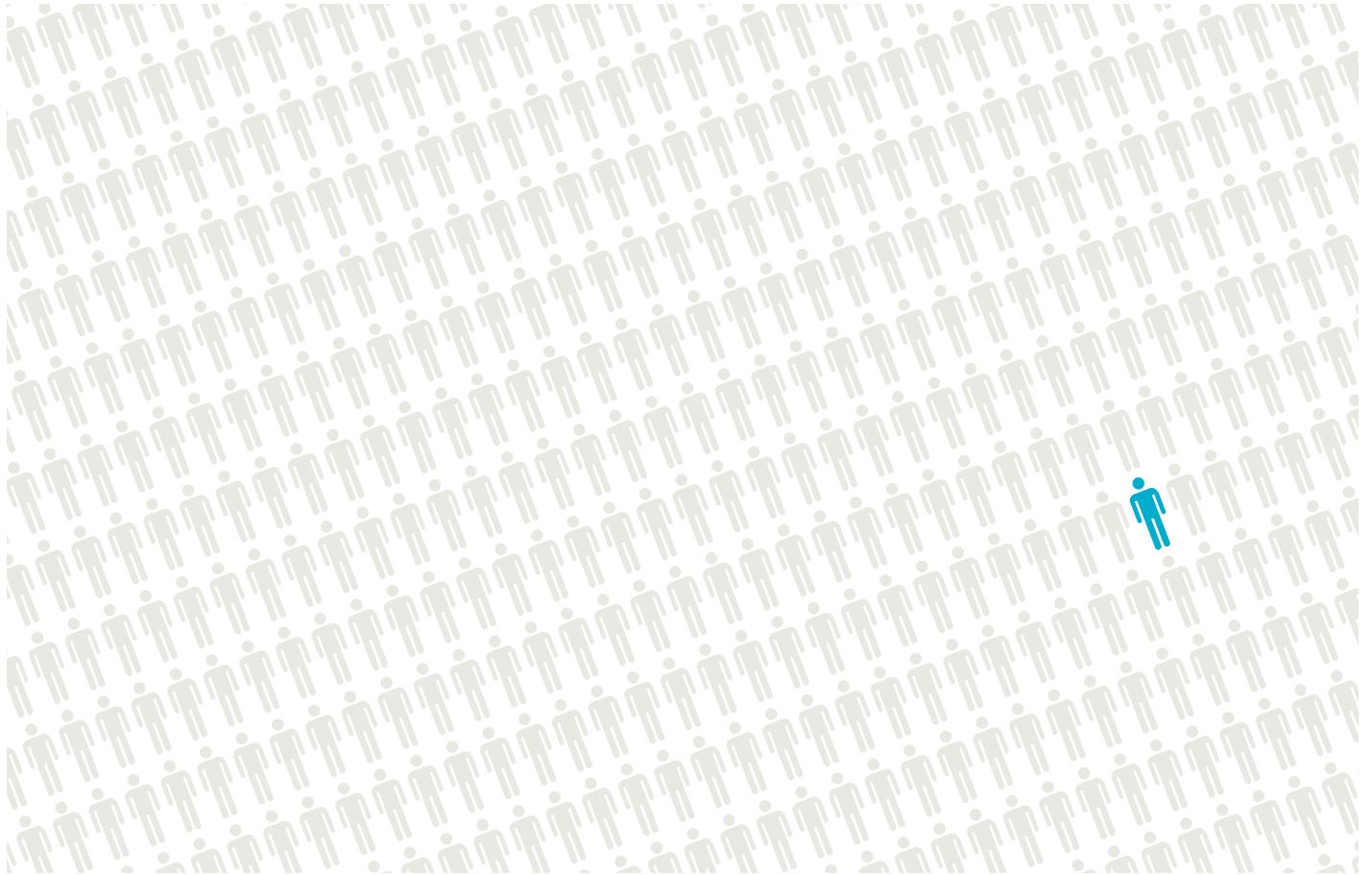


Epidemiology 2015



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letter from the chair



Colleagues,

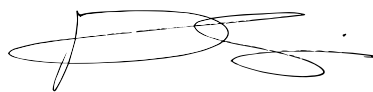
It is my great pleasure and distinct honor to present the 2015 Annual Report of the Department of Epidemiology. This past year was the most productive year in the history of our Department, with over 800 peer-reviewed articles published by our faculty in the first ten months alone. While we cannot do justice to this extraordinary volume of research in these pages, we hope to provide, through a few examples, a snapshot of the scientific advances and their impact on public health made by our stellar faculty.

In 2015, we explored how gentrification affects population health in communities, elucidated how famine exposure can change gene regulation, and delved deeper into the etiology of autism spectrum disorders. We looked under the hood at how publication bias in clinical trials limits the availability of critical data. We examined the broad health consequences of marijuana's growing ubiquity, and the deadly opioid epidemic that touches every walk of life and every community in the United States.

Our faculty engaged in research around the globe and garnered numerous notable awards. And the value of our master's and doctoral degree programs was once again borne out by our graduates' robust employment statistics.

The arrival of the New Year brings a new journey. Among the many exciting academic programs we have planned for 2016 is a year-long seminar series on the future of epidemiology. This special seminar series will engage our faculty and students in a vigorous discussion about the challenges and opportunities facing our field and help us to forge a shared vision and roadmap for ensuring our Department's successful transformation and continuing growth in the years to come.

Sincerely yours,



Guohua Li, MD, DrPH
Finster Professor and Interim Chair



New clues into cognitive dysfunction in chronic fatigue syndrome

related media coverage

Yahoo Health
yhoo.it/1MxQ8aI

Researchers in epidemiology have identified a unique pattern of immune molecules in the cerebrospinal fluid of people with myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS) that provides insights into the basis for cognitive dysfunction—frequently described by patients as “brain fog”—as well as new hope for improvements in diagnosis and treatment.

In the study published in *Molecular Psychiatry*, Dr. Mady Hornig, and colleagues used immunoassay testing methods to measure levels of 51 immune biomarkers called cytokines in the cerebrospinal fluid of 32 people with ME/CFS for an average of seven years, 40 with multiple sclerosis, and 19 non-diseased controls. The researchers found that levels of most cytokines, including the inflammatory immune molecule interleukin 1, were depressed in individuals with ME/CFS compared with the other two groups, matching what was seen in a blood study in patients who had the disease for more than three years. One cytokine—eotaxin—was elevated in the ME/CFS and MS groups, but not in the control group.

“We now know that the same changes to the immune system that we recently reported in the blood of people with ME/CFS with long-standing disease are also present in the central nervous system,” says Dr. Hornig, professor of epidemiology and director of translational research at the Center for Infection and Immunity at the Mailman School. “These immune differences may contribute to symptoms in both the peripheral parts of the body and the brain, from muscle weakness to brain fog.”

Implications for diagnosis and treatment

“Diagnosis of ME/CFS is now based on clinical criteria. Our findings offer the hope of objective diagnostic tests for disease as well as the potential for therapies that correct the imbalance in cytokine levels seen in people with ME/CFS at different stages of their disease,” says Dr. W. Ian Lipkin, John Snow Professor of Epidemiology and director of the Center for Infection and Immunity.

There is precedent for use of human monoclonal antibodies that regulate the immune response in a wide range of disorders from rheumatoid arthritis to multiple sclerosis. However, the researchers note, additional work will be needed to assess the safety and efficacy of this approach.

Hornig M, Gottschalk G, Peterson DL, Knox KK, Schultz AF, Eddy ML, Che X, Lipkin WI. Cytokine network analysis of cerebrospinal fluid in myalgic encephalomyelitis/chronic fatigue syndrome. *Mol Psychiatry*. 2015 Mar 31. doi: 10.1038/mp.2015.29. [Epub ahead of print] PubMed PMID: 25824300.



People conceived during Dutch famine have altered regulation of growth genes

Individuals conceived in the severe Dutch Famine, also called the Hunger Winter, may have adjusted to this horrendous period of World War II by making adaptations to how active their DNA is. Genes involved in growth and development were differentially regulated, according to researchers at the Leiden University Medical Center, Harvard University, and Columbia University's Mailman School of Public Health. Findings are published in the journal *Nature Communications*.

During the winter of 1944–1945 the Western part of The Netherlands was struck by a severe 6-month famine, the result of a German blockade. During this Hunger Winter the available rations provided as low as a quarter of the daily energy requirements. Children conceived—but not born—during the famine were delivered with a normal birth weight. Extensive research on the DNA of these Hunger Winter children shows that the regulatory systems of their growth genes were altered, which may also explain why they appear to be at higher risk for metabolic disease in later life.

Decades later growth genes seemed different

“The different setting of the growth genes may have helped the Hunger Winter children to withstand the Famine conditions as compared with their unexposed siblings, but these changes may likewise be unfavorable for their metabolism as adults,” says Leiden University principal investigator Dr. Bas Heijmans. For example, the altered settings were associated with LDL cholesterol at age 60, according to the authors.

The research team in Leiden compared the DNA of the Hunger Winter children, now aged 60, at 1.2 million CpG methylation sites comparing them with same-sex siblings not exposed to famine. They were able to see how the genes were differentially regulated in the Hunger Winter children, as compared with their siblings with a similar genetic and familial background. Groups of genes involved in growth and

development showed a different gene activity setting. The Hunger Winter children were all approximately 60 years of age when they gave blood for DNA research.

“The potential for a gene to become active is mainly determined in the crucial weeks after fertilization. This master regulatory system that determines which genes are on and which are off is called epigenetics and can be compared to a sound technician making adjustments during a recording to get that perfect sound. Environmental factors during development can make a lasting imprint on this system,” says Dr. Heijmans.

The authors point out that a wealth of past epidemiological studies suggests that early development is important for later health. “Thanks to the willingness of the Hunger Winter children and their families to contribute to our studies, we can pinpoint which phases of development are especially sensitive to the environment. We are currently extending our inquiries not only to those conceived during the famine, but also to those exposed during other gestation periods,” says co-author Dr. Elmar W. Tobi.

“These findings are exciting and provide tremendous opportunities for epidemiologists,” says Dr. L.H. Lumey, associate professor of epidemiology at Columbia University's Mailman School of Public Health and senior author who collected the analyzed blood samples. “Looking at the human genome we see systematic changes in gene regulation during early human development in response to the environment. The epigenetic revolution has given us the tools to investigate these changes and look at the impact for later life.”

Tobi EW, Goeman JJ, Monajemi R, Gu H, Putter H, Zhang Y, Slieker RC, Stok AP, Thijsen PE, Müller F, van Zwet EW, Bock C, Meissner A, Lumey LH, Slagboom PE, Heijmans BT. DNA methylation signatures link prenatal famine exposure to growth and metabolism. *Nat Commun*. 2014 Nov 26. doi: 10.1038/ncomms6592. [Epub ahead of print]



Seals harbor hepatitis A-like virus

related media coverage

NBC News
nbcnews.to/1LvCHXY

Infection Control Today
bit.ly/1Nh9tOb

Drug Development & Discovery
bit.ly/1VBG8NN

Scientists in the Center for Infection and Immunity at Columbia University's Mailman School of Public Health have discovered a new virus in seals that is the closest known relative of the human hepatitis A virus. The finding provides new clues on the emergence of hepatitis A. The research appears in the July/August issue of *mBio*, the online open-access journal of the American Society for Microbiology.

"Until now, we didn't know that hepatitis A had any close relatives, and we thought that only humans and other primates could be infected by such viruses," says lead author Dr. Simon Anthony, assistant professor of epidemiology at Columbia.

Hepatitis A viral infection, which impacts 1.4 million people worldwide annually, can cause mild to severe illness. It is a highly contagious disease that is usually transmitted by the fecal-oral route, either through person-to-person contact or through consumption of food or water. "Our data suggest that hepatitis A and this new virus share a common ancestor, which means that a spillover event must have occurred at some point in the past," says Dr. Anthony. "It raises the question of whether hepatitis A originated in animals, like many other viruses that are now adapted to humans."

The researchers discovered the new virus while investigating a deadly strain of avian influenza that killed over 150 harbor seals off the coast of New England in 2011. In an effort to determine what viruses might co-occur with influenza, researchers performed deep sequencing of all the viruses present in three of the marine mammals. They discovered a new virus that was genetically similar to hepatitis A and named it phopivirus. An analysis of additional animals living off the coast of New England (29 harbor seals, 6 harp seals and 2 grey seals) identified phopivirus in 7 more animals. The researchers say the virus appears to be fairly common in seals based on the juvenile animals examined for their study, and so far

there is no evidence that it causes them any harm. However, they caution that further research is needed in mature seals, because if it acts anything like hepatitis A it might only cause disease in adults.

In the natural history of phopivirus and hepatitis A, it is unclear whether a common ancestor (virus) spilled over from humans to seals, vice versa, or from a third unrelated host that has not yet been identified. The researchers next plan to look at species that have close interactions with seals to see if they can find other wildlife reservoirs of hepatitis A-like viruses. "Coyotes regularly scavenge dead seals along the coast, so it would be very interesting to examine coyotes to see if they have any similar viruses," says Katie Pugliares, a senior biologist at the New England Aquarium in Boston who was also involved in the study. Another project might study humans who eat seal meat to see if the seal virus has ever spilled over.

The vast majority of emerging infectious diseases in humans have origins in wildlife. In recent years, scientists in the Center for Infection and Immunity led by Dr. Simon Anthony have been working with partners at the EcoHealth Alliance, University of California Davis, and others under the auspices of the United States Agency for International Development's PREDICT program to identify potential zoonotic viral threats to human health. "Our goal", says Dr. W. Ian Lipkin, director of the Center and John Snow Professor of Epidemiology, is "to try to understand drivers of infectious disease emergence thereby enhancing pandemic preparedness."

Anthony SJ, St Leger JA, Liang E, Hicks AL, Sanchez-Leon MD, Jain K, Lefkowitz JH, Navarrete-Macias I, Knowles N, Goldstein T, Pugliares K, Ip HS, Rowles T, **Lipkin WI**. Discovery of a Novel Hepatovirus (Phopivirus of Seals) Related to Human Hepatitis A Virus. *MBio*. 2015 Aug 25;6(4). pii: e01180-15. doi: 10.1128/mBio.01180-15. PubMed PMID: 26307166.



Anxious? depressed? Blame it on your middle- management position

related media coverage

The Atlantic
theatlantic.com/story/1JsDkyJ

Washington Post
[wapo.st/1MDjzXC](https://www.washingtonpost.com/archive/local/2015/08/03/wapo.st/1MDjzXC)

ScienceDaily
[bit.ly/1NDIyJX](https://www.sciencedaily.com/news/1NDIyJX)

Individuals near the middle of the social hierarchy suffer higher rates of depression and anxiety than those at the top or bottom, according to researchers at Columbia University's Mailman School of Public Health. Nearly twice the number of supervisors and managers reported they suffered from anxiety compared to workers. Symptoms of depression were reported by 18 percent of supervisors and managers compared to 12 percent for workers. Findings are online in the journal *Sociology of Health & Illness*.

While social disadvantage related to income and educational attainment is associated with a higher risk of most adverse mental health outcomes, these latest findings show that people towards the middle of social hierarchies suffered higher rates of depression and anxiety based on their social class and position of power in the labor market.

"Contradictory class locations are those that embody aspects of both ownership and labor, and using this construct we found patterns of depression and anxiety that are not easily detected or explained with standard approaches," says first author Seth J. Prins, MPH, a doctoral student in epidemiology at the Mailman School of Public Health and fellow in the Psychiatry Epidemiology Training Program. "We explored how social class might influence depression and anxiety in ways that may be masked or incompletely explained by standard socioeconomic status measures."

The researchers based their findings on the largest representative population data set ever used to test these hypotheses directly: the 2001–2002 National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), a nationally representative survey of the U.S. population age 18 and older, interviewed in person. This study used data on the 21,859 participants who were full-time workers. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) Alcohol Use

Disorder and Associated Disabilities Interview Schedule was used to assess DSM-IV psychiatric disorders.

The researchers estimated the prevalence and odds of any lifetime and previous 12-month depression and anxiety by occupational class categories, income, and education. Class designations were made by sorting respondents into three categories: owners, who identified as self-employed and earned greater than \$71,500; managers and supervisors, who occupied executive, administrative or managerial positions; and workers, who were defined by various occupation categories in the NESARC including farmers and laborers.

"We chose to focus on depression and anxiety because the average age of onset is older than age 18, and these disorders are likely to arise after entry in the workforce," says Dr. Katherine Keyes, assistant professor of epidemiology.

Prior research has shown that work stress and job strain are important risk factors in developing depression. Workers with little opportunity for decision-making and greater job demands show higher rates of depressive symptoms.

"Our findings highlight the need for population health research to both conceptualize and measure social class in ways that go beyond the standard measures of socioeconomic status," says Dr. Lisa M. Bates, assistant professor of epidemiology, "Standard measures are most readily available, but can mask important complexity in the relationship between social class and population health."

Prins SJ, Bates LM, Keyes KM, Muntaner C. Anxious? Depressed? You might be suffering from capitalism: contradictory class locations and the prevalence of depression and anxiety in the USA. *Sociol Health Illn*. 2015 Aug 3. doi: 10.1111/1467-9566.12315. [Epub ahead of print] PubMed PMID: 26385581.



The law of epidemics: Heroin, prescription painkillers, and the addiction dilemma

Drug abuse spreads within a community, sometimes quickly. It devastates. And it kills.

But unlike diseases such as HIV or Ebola, drug abuse is not, technically, infectious.

So, is talking about an epidemic of drug abuse—the surge in opioid and heroin abuse reported this summer by the Centers for Disease Control and Prevention, for example—just a sloppy metaphor? Or can we actually use epidemiological tools to predict its course and figure out ways to stop it?

Epidemiologist Dr. Guohua Li thinks we can. According to Farr’s law, infectious outbreaks follow a predictable and symmetrical path—a steady rise in cases to a peak, followed by a decline. The 19th-century model has been applied to cattle plague, smallpox, even the aids epidemic. In a January article in the journal *Injury Epidemiology*, Dr. Li, the Finster Professor of Epidemiology, and his research team applied it to drug use in the United States. If Dr. Li’s resulting predictions are correct, the number of drug overdoses will keep rising until 2017, then begin to fall. “One of the contentious points,” he says, “is to apply Farr’s law to a noninfectious epidemic like opioid abuse.” As with infectious diseases, he says, environmental factors play a part in drug abuse trends. Addiction—like other “social contagions” such as behavioral disorders and obesity—spreads through social networks, much like a pathogenic outbreak. If his projections are borne out, says Dr. Li, they “may help to gauge whether interventions are working and guide long-term planning and management of public health resources and prevention efforts.”

In the last two years, the increase in overdoses of opioid painkillers—Demerol, Dilaudid, Vicodin, and the like—has begun to slow, likely because multiple ongoing interventions are starting to work. Prescription monitoring programs, as the name suggests, are statewide databases that track the dates and details of all prescriptions

for controlled substances. They’re designed to make it more difficult for patients to shop around, getting multiple doctors to prescribe opioid painkillers or using multiple pharmacies to fill a single prescription. (Some states even make the information available in neighboring states, to prevent a New Yorker, for example, from scoring a duplicate prescription in New Jersey or Connecticut.)

Meanwhile, drug companies have been reformulating opioid painkillers to make them harder to abuse. And increasing access to overdose treatment—by having police carry the antidote naloxone, for example—has helped.

But, as the fairy tales caution, beware what you wish for. The current heroin epidemic is a result, at least in some measure, of the success states have already had in limiting access to opioid painkillers. As pharmaceuticals become less accessible, people turn to heroin. “We call this the substitution effect,” Dr. Li says. “It’s going to make control of this drug overdose epidemic more challenging.”

Between 2002 and 2013, the number of people in the U.S. dying from heroin overdose quadrupled. And in 2013, more than half a million Americans said they had used heroin in the past year, an increase of almost 150 percent from 2008.

It’s gotten so bad that, in the last three years, drug overdose has been overtaking motor vehicle crashes as the leading cause of accidental death in the U.S.; in 34 states, it already has. For Dr. Li, much of whose earlier work focused on traffic injuries, turning his attention to drug abuse and prevention was a logical shift. And, he points out, there is even overlap between the two, since driving under the influence is (obviously) dangerous.

Beyond vehicular risks—public health scholars know them as “unintentional injury mortality”—opioid injection poses additional hazards. Heroin use has been implicated in the spread of HIV, hepatitis C, and other

blood-borne diseases. Earlier this year, the governor of Indiana declared a public health emergency in rural Scott County after health officials there noticed a surge in the number of new HIV infections tied to intravenous use of opioid painkillers. The county had already recorded an increase in hepatitis C and endocarditis, an infection of the lining of the heart that can be spread through the use of dirty needles. The governor, who had previously been opposed to harm reduction programs, quickly stepped in to implement a temporary needle exchange program.

Given the geographic concentration of the painkiller abuse, the intervention focused narrowly on Scott County. That approach exemplifies one of the first steps in figuring out how to stop an epidemic: Understand who's involved. Dr. Silvia Martins, associate professor of epidemiology, uses data from the federal government's National Survey on Drug Use and Health to analyze who is using opioid painkillers and heroin and how those patterns have changed over the last few years.

In a report this year for Drug and Alcohol Dependence, Dr. Martins documented critical differences in drug abuse across racial and other lines. Between 2002 and 2011, for example, heroin use rose 75 percent among non-Hispanic whites. Among blacks, on the other hand, use increased only among those who had taken opioid painkillers within the prior year, particularly those who had used them frequently—at least once daily for between 100 and 365 days. “We need to better delineate who is at higher risk,” Dr. Martins says, and target prevention programs to those populations.

That means updating old-fashioned “Just Say No”—style drug abuse prevention programs to promote harm reduction, the drug use equivalent of teaching safe sex rather than abstinence only.

In an age of Google and the increased information—and misinformation—the internet affords, we need comprehensive public education, Dr. Martins says. With prescription drugs, that means explaining not only the benefits of the medication but also its side effects, not stigmatizing prescription opioid use, and reminding people that it's important to get professional help

for psychological problems, rather than trying to self-medicate. (In another study, published in Psychological Medicine, Dr. Martins documented a higher incidence of opioid drug use among people with mental illnesses like bipolar disorder and anxiety and mood disorders.)

Equally important, Dr. Martins says, is targeting the right audience with those drug abuse prevention programs. Many universities emphasize the dangers of opioid abuse in their drug prevention programs. Dr. Martins' study published last year in Social Psychiatry and Psychiatric Epidemiology showed that people who don't have a college education are more likely than those with a degree to abuse opioid painkillers. It would probably be more effective, she says, to find ways to engage a non-college educated audience to talk about opioid drug abuse and perhaps refocus college programs to address stimulants, which her studies show are a bigger problem among people with a college education.


The U.S., Dr. Martins says, has the highest rate of opioid painkiller use in the world; medical professionals here use the drugs not just to manage the extreme pain caused by, say, cancer but also to manage much less serious complaints, like the discomfort following a tooth extraction.

So healthcare providers and policymakers will have to do their part. This summer, the U.S. Senate debated the Safe Prescribing of Controlled Substances Act, which would impose new continuing education requirements on prescribers (already required in New York and nine other states), while the White House boosted training for federal healthcare providers.

At the state level, prescription monitoring programs vary widely. While 49 states have laws in place, Missouri legislators have wrangled for years over competing bills. Nationwide, Dr. Martins sees room for improvement. Physicians could inquire about prior drug use and mental health history, for example, to identify patients for whom opioids might become a problem, then monitor those individuals more closely or offer them alternatives such as physical therapy or non-narcotic painkillers.

Then there's the question of how people end an addiction. Only a small number of those with a drug problem seek treatment, says Dr. Martins. Others just quit using on their own. Certainly, we need monitoring programs and other interventions to avert overuse and addiction. But that won't be enough. “It's complicated,” she says. “We need policies to regulate this, but we also need to make sure that people who need medications can get them.”

Regardless how difficult the work may be, says Dr. Li, public health has a duty to help turn the tide. “A decline in overdose deaths shouldn't be used as justification to pull back,” he says. “That would be wrong. If there is no intervention, then the epidemic will last much longer.”



Certainly,
we need
monitoring
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IMAGE: DIANA GAZZIA

As America inhales, scientists raise health concerns

Marijuana is going mainstream. So far, 23 states have legalized medical use of the drug or effectively decriminalized it. Ohio recently voted against legalization, but another 17 states will consider the issue next year. As laws and societal mores around marijuana are rewritten, public health scientists at the Mailman School are taking a close look at a range of issues, from who is using it and how widely to its long-term consequences.

Epidemiology professor Dr. Deborah Hasin has written more than 350 papers on the epidemiology of drug and alcohol use disorders. In October, she published a study in *JAMA Psychiatry* finding marijuana use among adults more than doubled between 2001 and 2012. The numbers of people diagnosed as abusing the drug or dependent on it also climbed, reaching nearly 7 million, or nearly three in ten users. Was legalization of marijuana for medical purposes a factor? Among one group, at least, it wasn't. A study

of teenagers, published by Dr. Hasin in *Lancet Psychiatry*, found teen use of pot was elevated in states with medical marijuana laws, but because the rates of use were higher in these states before they even passed the laws, some other factor seems to be responsible for both the higher rates of use and the laws.

As director of the Substance Dependence Research Group at the New York State Psychiatric Institute, Dr. Hasin sees considerable evidence that using marijuana involves some risk. "Our studies show there are dangers from using marijuana," she says. "Others have shown lasting impairments in brain functioning among adolescents who are heavy, regular users, while adults with marijuana use disorders show impairments across various areas of functioning."

Dr. Silvia Martins, associate professor of epidemiology, points to a wealth of data on the health risks of regular marijuana use. Using it this way over the long-term is associated with

Regular and heavy marijuana use during the adolescent years can affect brain development and may reduce thinking, memory, and learning.

reduced IQ, and with hallucinations, schizophrenia, and major depression, particularly if adults started using it heavily as teenagers. "Research shows that about one in eleven users can become addicted," she says. "Regular and heavy marijuana use during the adolescent years can affect brain development and may reduce thinking, memory, and learning."

Some of us are more attune to the risks than others. A study by Dr. Martins published in Drug and Alcohol Dependence earlier this year found women were twice as likely to see regular use of cannabis as potentially harmful, although that number had dropped from 59 percent in 2002 to 27 percent in 2012.

What Is the evidence for medical marijuana?

Three-quarters of Americans favor using marijuana for medicinal purposes. Many in the medical community too favor its use for pain, as muscle relaxer, appetite enhancer, and for other reasons. Yet there has been very little careful research to back up this and other potential upsides. "We see segments on the news about children with epilepsy showing tremendous improvement from taking the drug," says Dr. Hasin. "Yet while it does help some, it could harm others, and we still need rigorous studies and data to guide our decisions about medical marijuana."

One significant hurdle to research: marijuana is still classified as a Schedule I drug. This could change. Recently presidential hopeful Hillary Clinton echoed the sentiment of the American Medical Association by saying she would like to see marijuana reclassified so it can be more easily studied. "I want to move from Schedule 1 to Schedule 2 so researchers can research what's the best way to use it, dosage, and how it works with other medications," she says.

Driving high

It's well known that alcohol and automobiles are a deadly combination. According to the Centers for Disease Control, almost 30 people in the United States die in motor vehicle crashes that involve an alcohol-impaired driver every day. What about pot? While driving under the influence of marijuana is illegal no matter what state you live in, growing numbers of marijuana users are getting behind the wheel.

In an analysis of toxicology reports from fatal car accidents published in the American Journal of Epidemiology, Dr. Guohua Li, Finster Professor of Epidemiology and Anesthesiology, found that one in eight drivers tested positive for the drug—up three-fold from a decade ago. A study published in the journal Accident Analysis & Prevention, found that relative to drivers who tested positive for neither alcohol nor drugs, the odds of a fatal crash climbed 13-fold for drivers testing for alcohol alone, but 24 times for those positive for both alcohol and marijuana. Whether or not the driver was high was unknown—marijuana lingers in the system for days—but it does point to the fact that the driver uses marijuana. In the future Dr. Li says, a breathalyzer-type device might provide more accurate information on intoxication.

But the notion that alcohol is more dangerous than marijuana should be subjected to rigorous scrutiny and requires important qualification, argues Dr. Li. "Although alcohol is more addictive and more impairing to cognitive functions than marijuana, moderate alcohol consumption may confer significant health benefits," he says. Whether marijuana has a similar upside remains to be seen. And there is always potential for its misuse. Says Dr. Li, "There is no such thing as safe substance abuse, regardless of the drugs involved."

Children of older parents and May–December couples at increased risk for autism

related media coverage

Medical News Today
bit.ly/1F6zeXn

There is a substantial body of research associating parental age with autism spectrum disorders, although not all studies agree with each other and it has been a challenge to pinpoint the shape of the relationship. A recent study co-authored by epidemiology faculty members sheds new light on the nature of the risk relationship by examining the ages of both parents to determine if paternal age and maternal age contribute independently or jointly to the likelihood of autism spectrum disorders in offspring.

Drs. Ezra Susser, professor of epidemiology and psychiatry; Michaele Bresnahan, assistant professor of epidemiology; and Mady Hornig, associate professor of epidemiology and Director of Translational Research of the Center for Infection and Immunity at Columbia's Mailman School of Public Health, analyzed data from more than 5.7 million children born in Israel, Western Australia, Denmark, Norway, and Sweden between 1985 and 2004.

Children born to older parents or to couples who differ in age by ten years or more appear to be at an increased risk for autism spectrum disorders (ASD), according to a largest-of-its-kind, multinational study in *Molecular Psychology*.

"This is the first major result from a historic collaboration among epidemiologists that combines registry data from many countries to study autism spectrum disorders," says Dr. Susser.

Obtaining and analyzing data from millions of children allowed the researchers to ask important questions about parental age and children's relative risk for autism that were, until now, impossible to examine.

"Since maternal and paternal age tend to be highly correlated, very large numbers are required to clearly differentiate their effects," says Dr. Susser.

Using this extremely large data set, the researchers separated out the influence of mother's age versus father's age, while adjusting for the potential influence of the other parent's age.

Results show that "older maternal age and paternal age at conception are each independently related to the risk of ASD," says Dr. Susser.

Kids born to older moms, older dads, or parents who differ in age by a decade or more had an elevated risk for autism.

While it's important to note that most children developed normally—even those in high-risk groups—the chances of autism were lowest when

mothers were 25-35 years old, fathers were 29-39 years old, and the parents were closely matched in age.

"Comparing fathers and mothers over the same age range, the RRs [relative risks] with advancing age were of similar magnitude," the authors say in the article. This "... suggests that advancing paternal age may contribute more to the risk than advancing maternal age overall, due to the longer male child-bearing potential."

In other words, advancing maternal age and paternal age both increase children's risk for autism, but because men are fertile longer than women, older dads may actually contribute more to overall autism risk than older moms.

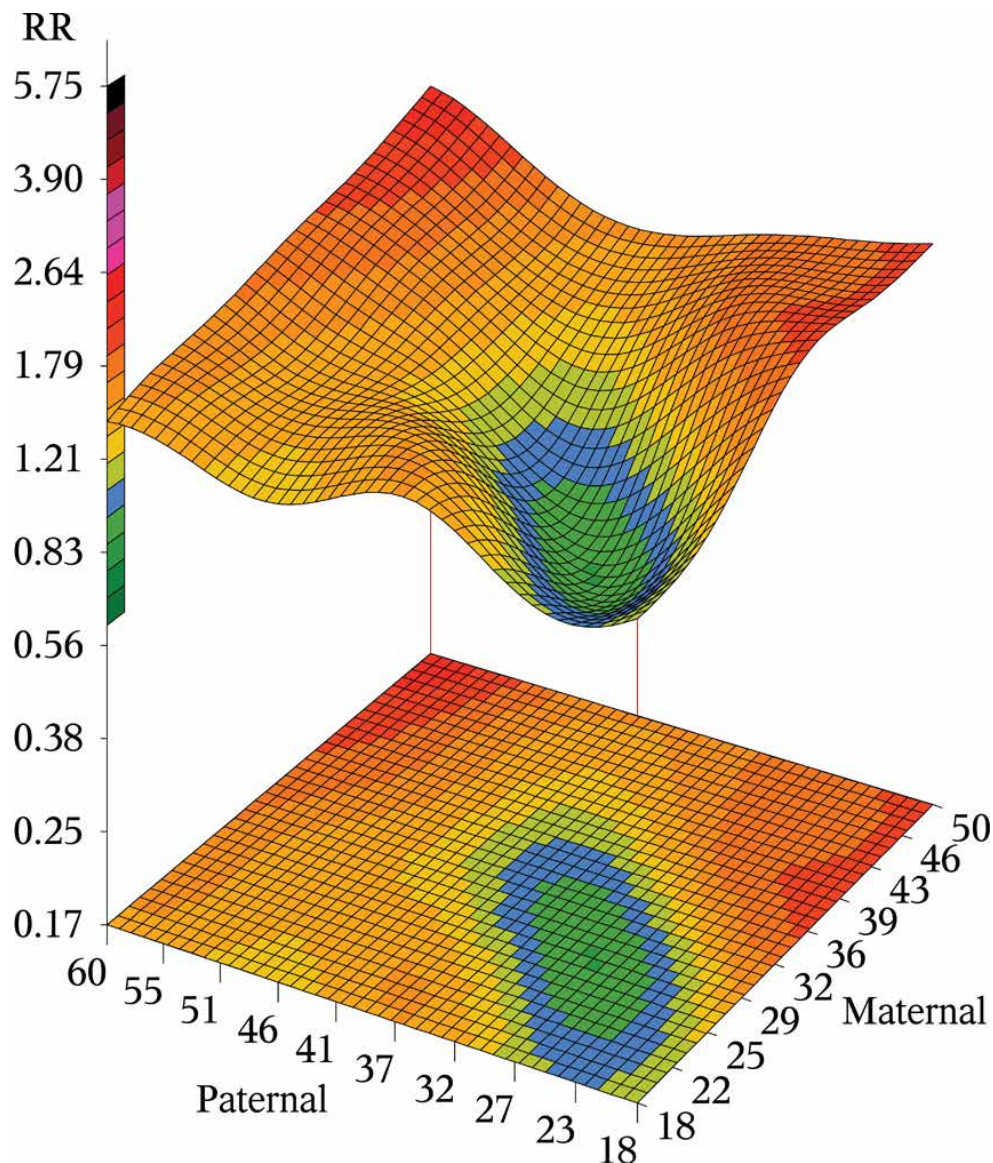
In Denmark, Norway, and Sweden (but not in Israel or Western Australia), the association between mother's age and child's autism risk was U-shaped: Teen moms were, much like older moms, more likely to give birth to children with autism. The "safest" age for giving birth among women in these Scandinavian countries was just over 30 years old.

The study "... raises a number of new puzzles for future research," says Dr. Susser.

No previous research has been able to examine autism trends in such great detail. This article provides new directions for scholarly inquiry on the subject of parental age and children's autism risk.

Sandin S, Schendel D, Magnusson P, Hulman C, Surén P, Susser E, Grønberg T, Gissler M, Gunnes N, Gross R, Henning M, Bresnahan M, Sourander A, Hornig M, Carter K, Francis R, Parner E, Leonard H, Rosanoff M, Stoltenberg C, Reichenberg A. Autism risk associated with parental age and with increasing difference in age between the parents. *Mol Psychiatry*. 2015; Figure 3, Retrieved June 23, 2015 from Nature. doi: 10.1038/mp.2015.70 Used with permission from Nature Publishing Group.

Relative risk for autism spectrum disorder by joint paternal and maternal age



Relative risk (RR) for autism spectrum disorder by joint paternal and maternal age (referent parental ages 25 years). RR's adjusted for offspring sex, birth year, and country of birth. Color Code: dark greens indicate $RR < 1$; blue indicates $RR \approx 1$; lime green, yellow, oranges and reds indicate increasing RR's > 1 .

SANDIN S, SCHENDEL D, MAGNUSSON P, HULTMAN C, SURÉN P, SUSSER E, GRØNBORG T, GISSLER M, GUNNES N, GROSS R, HENNING M, BRESNAHAN M, SOURANDER A, HORNIG M, CARTER K, FRANCIS R, PARNER E, LEONARD H, ROSANOFF M, STOLTENBERG C, REICHENBERG A. AUTISM RISK ASSOCIATED WITH PARENTAL AGE AND WITH INCREASING DIFFERENCE IN AGE BETWEEN THE PARENTS. MOL PSYCHIATRY. 2015; FIGURE 3, RETRIEVED JUNE 23, 2015 FROM NATURE. DOI: 10.1038/MP.2015.70 USED WITH PERMISSION FROM NATURE PUBLISHING GROUP.

Spotty on measles?

Everything you need to know about the virus and its vaccine

In 2000, the Centers for Disease Control and Prevention (CDC) announced that measles was eliminated from the United States. The highly contagious infection was no longer ever-present on home soil, thanks to an effective Measles, Mumps, and Rubella (MMR) vaccine, licensed in 1971, and a vaccination program refined to emphasize two doses over one. Between 2001 and 2011, the CDC reported 63 outbreaks, with a median number of six cases per outbreak. The majority of these outbreaks were concentrated in communities with low MMR vaccination rates, primarily affecting those who were not vaccinated or had unknown vaccination status.

Measles cases reached a 20-year high in May 2014 and came to the fore of national news with an outbreak at California's Disneyland theme park in December 2014. By February 13, 2015, 141 cases had been reported across 17 states, 80 percent of which stemmed from the Disneyland outbreak.

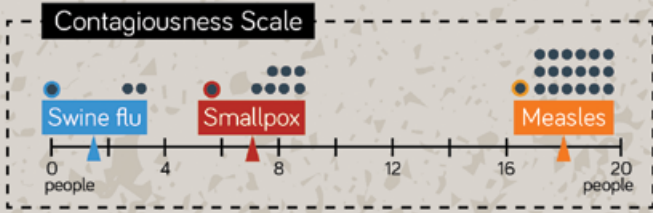
Whither measles? What does it look like, and how does the MMR vaccine work? From basic reproductive rates to herd immunity, this infographic has got you covered.

Originally published at the2x2project.org

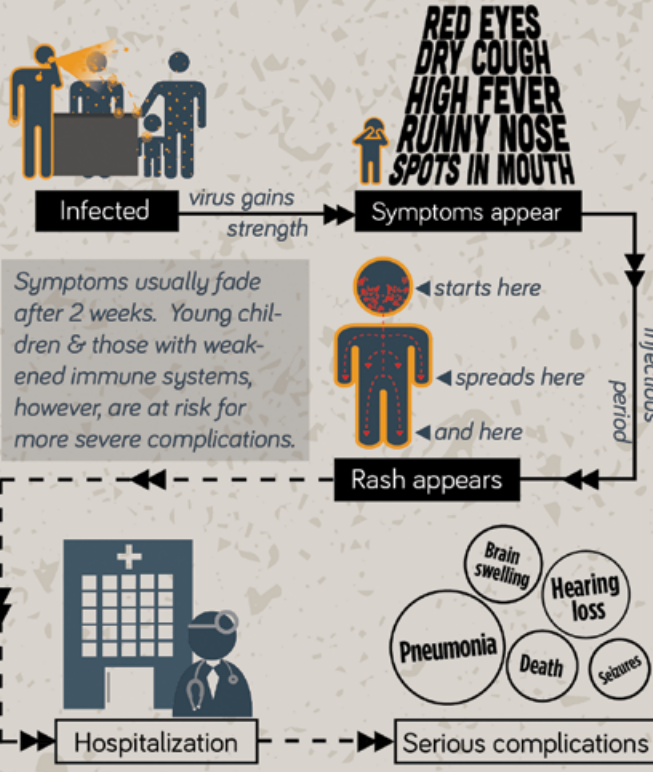
VIRUS PROFILE

Measles virus

- **Where it lives:** Nose, throat, lungs
- **How it's spread:** Coughing, sneezing, contact contaminated surfaces/air
- **Contagiousness:** Very. Someone with measles can infect up to 18 people.



• **What an infection looks like:**



X A NOTE ABOUT MEASLES ELIMINATION
 In 2000, the Centers for Disease Control and Prevention (CDC) announced that measles was "eliminated" from the U.S. Even so, outbreaks have continued to surface as people travel to locations where the virus persists and return to largely unvaccinated communities.

VACCINE PROFILE

MMR Measles Mumps Rubella Vaccine

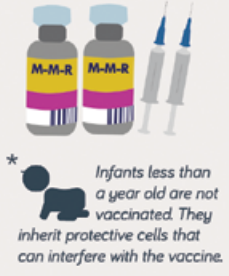
- **Ingredients:** Weakened viruses to help the body produce a faster response to future infection
- **Administration:** Two shots

1st shot
12-15*
 months old

2nd shot
4-6
 years old

With 1 MMR shot, only 5 people out of every 100 would be infected w/measles.

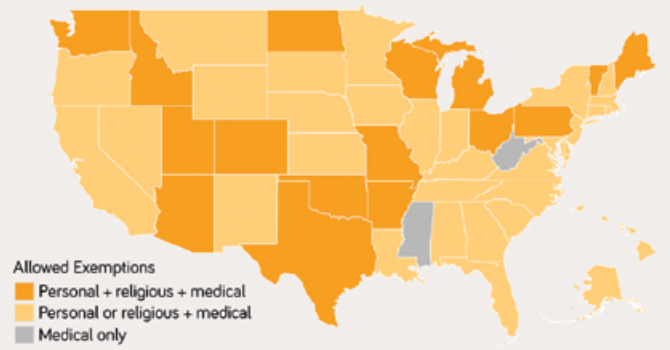
With 2 MMR shots, only 1 person out of every 100 would be infected w/measles.



A NOTE ABOUT THE 2014 DISNEYLAND OUTBREAK
 Last December, 42 measles cases were linked to an initial exposure at Disneyland. Of the 42 cases, 5 had previously received 2 or more MMR shots. As the third-most visited theme park in the world, Disneyland is an ideal incubator for contagious diseases.

- **"Herd immunity":** If 94% of the population is vaccinated, those who are too young or too sick for vaccination will be protected. Even if enough people are vaccinated state-wide, low vaccination rates locally (e.g. at school) can result in outbreaks.

- **Vaccine exemption policies differ across the country:** Non-medical exemptions are now under scrutiny.



WHAT EXACTLY IS GOING ON WITH MEASLES?

Ending publication bias

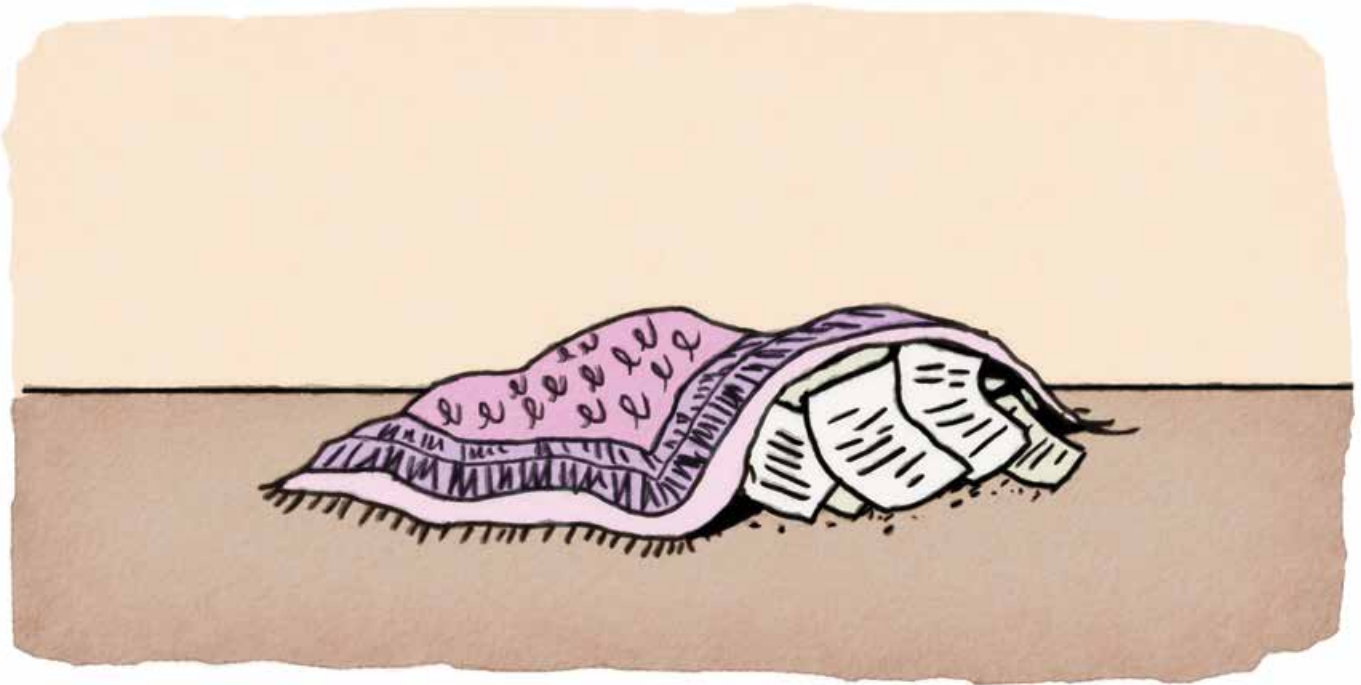
How much do we actually know about
our medical treatments?

BY ELAINE MEYER

the2x2project.org

2x2.ph/publication-bias





Most of us who take a medication expect our doctor has prescribed it based on evidence. But it turns out that basic assumption is often incorrect.

In fact, many clinical trials of medical treatments—particularly negative ones—never make it to publication in academic journals, which doctors consult to make medical decisions and the media publicize in their health reporting. According to a 2014 systematic review in PLoS, more than half of trial results are not published, and those that are published are three times more likely to come out with positive rather than negative results.

“I think your average consumer thinks that their treatment is based on data or research—that it’s odd that it is not,” says Dr. Kay Dickersin, the director of the Center for Clinical Trials at Johns Hopkins Bloomberg School of Public Health.

Even studies that are published may over-emphasize positive results—a kind of spin that we are conditioned to expect from politicians but not from clinical researchers. These are just some of the many misleading practices known as publication bias, and they can seriously skew the evidence doctors and patients use to make health decisions.

“People are rewarded for publishing in well known, high impact journals, not for producing well designed, well reported, well conducted papers,” Dr. Simera acknowledges.

Yet in addition to misleading the public and doctors, publication bias has a whole other cascade of negative effects. It betrays the trust of the patients who participate in clinical trials. And it skews the findings of systematic reviews, analyses of all available research on medical treatments. Indeed, systematic reviews are conducted precisely to do what publication bias prevents: provide the most accurate information about how effective and safe a treatment is based on all of the available evidence.

“We cannot know the true effects of the medicines we prescribe if we do not have access to all the information,” Dr. Ben Goldacre, a physician and science writer said in a 2012 TedMed Talk, which became an opening salvo for a science transparency group he founded called AllTrials that goes after this problem.

In recent years, a variety of governmental and nongovernmental groups are forming or stepping up efforts to bring transparency to medical research. What remains to be seen is whether these efforts can attack a problem that has persisted for decades.

Tamiflu and antidepressants

The story of Tamiflu is perhaps one of the most headline grabbing cases of publication bias. This anti-influenza drug, also known as oseltamivir—along with a similar drug called zanamivir, marketed as Relenza—came under scrutiny by the Cochrane Collaboration, an independent NGO that works to acquire data to conduct accurate systematic reviews.

After engaging in a drawn out battle for the regulatory documents that formed the basis for approval of the two drugs, Cochrane “came to the conclusion that there were substantial problems with the design, conduct, reporting and availability of information from many of the trials,” according to a statement published last year. Cochrane concluded from its analysis of the trials that the drugs did little to prevent flu symptoms beyond reducing the duration of the virus by half a day. The report called into question the billions of dollars governments including the U.S. have spent stockpiling Tamiflu to prevent a flu outbreak and the lack of easy access to important regulatory data.

In another widely covered story, a 2008 New England Journal of Medicine study of 74 FDA-registered studies of a dozen popular antidepressant drugs, like Prozac, Zoloft, and Paxil, found 94 percent in the medical literature were positive. But when the researchers filed freedom of information requests for FDA review documents, they found a good chunk of those trials were not published. Of 33 trials the FDA had perceived as having negative or questionable results, 22 were not published, and 11 were published but communicated

positive results. (One unpublished trial was positive). The study was led by Dr. Erick Turner, a former FDA medical officer who had begun to question the veracity of the medical literature while working on the drug approval process at the agency.

In 2012, GlaxoSmithKline, the maker of Paxil, even pled guilty and paid a \$3 billion fraud settlement in part for concealing negative information about the effects of the drug on children and teens.

“If you start to dig down...you sort of wonder what this is like for every drug. Is this really a problem across all classes of all drugs? What can we really believe? And very quickly you’re sort of down a rabbit hole,” says Dr. Joseph Ross, an associate professor of internal medicine at Yale University.

Trial registries

As the problem has become more evident, the U.S. government has tried to catch up by passing regulations requiring more transparency. In 1997, Congress passed a law requiring all trials file public information at their outset. In 2000, the National Institutes of Health launched a web site called ClinicalTrials.gov where this information would be made available. “Before clinical trial registration, no editor could

have known what data was being collected as part of a trial,” says Dr. Ross.

In theory, academic journals could now use the registry to double check the veracity of an article they were planning to publish—to make sure a trial reported on what it originally set out to measure.

In 2007, Congress went even farther, passing the FDA Amendments Act, which mandated reporting final study results of a drug, biological product, or device to ClinicalTrials.gov within a year after the trial concluded. The rules apply to drugs that are being studied, manufactured or seeking new drug status in the U.S.

Today, over 178,000 clinical trials are registered in ClinicalTrials.gov—the largest registry in the world—and 15,000 report results, according to the National Institutes of Health. To the 2007 law’s credit, trials registered increased significantly from three years before that year to three years after, according to a 2012 study in JAMA, and the number of missing data elements declined overall.

Dr. Dickersin, an early advocate for trial registries, believes ClinicalTrials.gov has provided a good picture of where the problems are. “It’s clear that there is failure to report,” she says. For instance,



‘We cannot know the true effects of the medicines we prescribe if we do not have access to all the information.’

‘People are rewarded for publishing in well known, high impact journals, not for producing well designed, well reported, well conducted papers.’

fewer than half of registered studies made it to a journal publication, according to a study published in 2012 by Dr. Ross and colleagues in the BMJ. Another BMJ study from 2013 found that nearly 30 percent of trials of at least 500 participants registered in ClinicalTrials.gov remained unpublished three years after they were completed.

ClinicalTrials.gov also may be providing a check on spin. A study published last year in JAMA found cardiovascular trials that had registered were less likely to report positive findings than those not registered. According to a 2013 study in PLoS, “serious adverse events,” were reported only 63 percent of the time in journal articles compared to 99 percent on the registry.

And studies published last year in *Annals of Internal Medicine* and JAMA found more accurate information in ClinicalTrials.gov than published papers. “This is a problem,” says Dr. Philippe Ravaud, director of the Centre of Epidemiology at the Hotel-Dieu in Paris, adjunct professor of epidemiology at Columbia University’s Mailman School of Public Health, and the senior author of the PLoS study.

Several sources interviewed for this article say they are not aware of the FDA ever fining an organization for failing to report trial results, even though the agency is authorized to collect civil penalties for violation of the regulations.

One deterrent to posting on ClinicalTrials.gov may be that it is a challenging website to use. A 2011 study found it takes about 38 hours to submit basic results on the site, and an additional 22 hours to collect the data and information required to register. Still, one wonders whether studies

that are not being reported are more negative studies.

Even a little bit of enforcement—such as an email reminder—could improve reporting. Dr. Ravaud and his team put this to the test when they sent emails to investigators in 190 studies that had not posted results on ClinicalTrials.gov. The researchers disguised the reminders as surveys notifying recipients of their lateness and querying them about why they had not posted their results. They compared them to a control group that did not receive emails. After three months of receiving the email, there was little difference in number of studies posted by the control versus intervention group, but after six months, there had been an increase in those who posted their study results among the intervention group. The authors noted that the message might be more powerful if it came from regulators and threatened some kind of fine or sanction.

Targeting the journals

Because journals are the gateway through which medical research is publicized, some experts believe they are the best hope for cracking down on publication bias. “The best enforcement is really going to be the journals refusing to publish,” says Dr. Dickersin.

The goal of the international EQUATOR network, short for “Enhancing quality and transparency of health research,” is to improve the standards of what is published in medical journals. EQUATOR helps journals and medical researchers use what are called reporting guidelines in the writing and editorial process. The guidelines, created for many different kinds of studies, are

written by experts in study design.

“We try to improve the quality of reporting after the submission of the papers. We ask editors to check if the papers follow the reporting guidelines,” says Dr. Ravaud.

While most journals endorse the guidelines, only a few require authors to submit a checklist ensuring they have met them. “If a journal is going to be really tough, they’ve actually got to pay a technical editor to do that. Some people say, can peer reviewers do that? But peer reviewers are not paid,” says Dr. Elizabeth Wager, who consults editors, scientists, and writers on medical publishing and is a visiting professor at the University of Split School of Medicine in Croatia.

Dr. Wager suggests journals require articles to follow a very structured template, similar to trial registry requirements, but she acknowledges it would not be popular with academics. “I think [journals] know authors don’t like that. [Authors have] got a funny idea that academic writing should be like creative writing,” she says.

Targeting the investigators

Dr. Simera, who heads program development for EQUATOR based at the Centre for Statistics in Medicine at Oxford University, believes the push for accuracy and transparency should take place at research institutions. “At the end it’s researchers, scientists who are ultimately responsible for what they produce. You can say: editors, peer reviewers, they should spot the mistake. But it’s the manuscript that should be already good enough that things are not missing,” she says.



Bias, bias everywhere

A biased interpretation, aka “spin,” was evident in 84 percent of journal articles’ abstracts and 88 percent of the stories found on Google Health News in recent studies by adjunct epidemiology professor Dr. Philippe Ravaud.

More research is needed to determine if the spin found in health-related news stories originates from the scientific articles themselves or if journalists misinterpret the information they read in press releases and academic journal articles.

More on publication bias

- › *Classification and prevalence of spin in abstracts of non-randomized studies evaluating an intervention*
[1.usa.gov/1QMgoNq](https://www.usa.gov/1QMgoNq)
- › *Interpretation of results of studies evaluating an intervention highlighted in Google Health News: A cross-sectional study of news*
[1.usa.gov/1PCgrgo](https://www.usa.gov/1PCgrgo)

Dr. Ravaud, who directs the French EQUATOR Center says that to ensure better publications “we have to move to be able to intervene during the process of writing the first draft of the manuscript.”

There realities of the current incentive structure to publish positive results in top journals that make spending time improving manuscripts a tall order. Academics may be at work on multiple studies as well as trying to write new grants. It may not make sense for them to spend their time trying to publish a negative study when positive studies are more likely to get published in journals. Dr. Simera acknowledges as much: “Competitiveness in research is rising. People are rushing a lot more.”

Sometimes, Dr. Wager points out, medical researchers are also ignorant, especially those who may not have been trained in a discipline like epidemiology that emphasizes study design. “I do a lot of training with doctors and it surprises me how unaware they are of reporting guidelines,” she says.

Universities lack a single compliance office that can guide medical academics—some of whom may not be trained in study design, says Dr. Ross. “No one has the resources to do it, but academics are worse off.”

Incentivizing data sharing

Clinical trial registries require publication of the results of studies, but a large portion of data from clinical trials is never published or made available. Concerns about publication bias, among other things, has driven a movement toward data sharing. “Almost all other professions share a lot more data under much more liberal circumstances than we do,” says Dr. Andrew Vickers, an attending research methodologist at Memorial Sloan Kettering Cancer Center, during a Columbia University Epidemiology Scientific Symposium about health research outcomes in February.

There are many barriers to sharing of clinical trial data, such as issues surrounding privacy of patient health information and the extensive technology infrastructure it may require. But as suggested by an Institute of Medicine report released in January, clinical trial data sharing is the future. The report outlines a framework for developing “a culture, infrastructure, and policies” to foster data sharing among the multiple stakeholders involved. “We think responsible sharing of clinical trial data will advance the science that underlies as the foundation of good clinical care,” says Dr. Bernard Lo, president of the Greenwall Foundation and the chair of the committee that published the report, at a press briefing.

“Fake fixes”

Dr. Goldacre of AllTrials to refer to journal guidelines and trial registries as “fake fixes,” a term he used in his 2012 TedTalk and still stands by today.

“There’s still no routine audit of whether registration and reporting are enforced, so there’s no accountability, and no way of knowing the levels of compliance,” Dr. Goldacre wrote in an email in January. He also points out that ClinicalTrials.gov only requires registration of trials that were ongoing during or after the 2007 FDA Amendments Act was passed.

He doesn’t have much faith that stepped up enforcement of registry requirements will happen anytime soon. Thus, his organization AllTrials has tried to “take the bull by the horns” and directly audit company’s public statements and their actions. They plan to publish the results.

“That way,” he writes “doctors, patients, researchers, journalists and policymakers can all see for themselves who are the worst offenders, but also, crucially, who is showing leadership.”

Tuberculosis through the looking glass

A prismatic view of novel research
to combat an ages-old disease

BY EMILY AUGUSTINI, MPH '16
PRATIVA BARAL, MPH '16
EDITED BY DANA MARCH, PHD



White plague. Phthisis. Consumption. Depicted in early Egyptian art and referenced in the Bible, tuberculosis (TB) has been called many different names since it began infecting humans long before recorded history. For centuries, its cause was elusive. Ever since the 1882 discovery of *Mycobacterium tuberculosis*, the infecting agent, we have been searching for new ways to track the bacterium and minimize its effects. In the mid-20th century, antibiotics seemed to promise an end to the disease, but the microbe has become stubbornly drug resistant in the 21st century.

One third of the world's population is infected with TB. In 2014 alone, 9.6 million people fell ill with the disease. Across the globe, TB kills over 1.5 million people each year. Cases of multi-drug resistant (MDR) and extreme drug resistant (XDR) TB are rising at an alarming rate. Moreover, TB and HIV have developed into a co-epidemic, with 1.2 million people infected by both the TB bacterium and HIV virus worldwide. Of those living with both diseases, one in three people are never notified that they have TB and do not receive treatment for it.

Now, the scientific community is more focused than ever on finding innovative methods to combat this chronic infectious disease.

Together, a passionate, dedicated core of faculty in Columbia's Department of Epidemiology are imagining new approaches to TB that span the spectrum of the challenges it presents. Their innovative research ranges from tracking the molecular messages that TB sends to better detect the disease, and telling the tale of transmission dynamics through the tubercule itself, to a more humane way of delivering what historically has been one of the more punitive population-level treatment protocols.

TRACKING TRANSMISSION

The majority of people who are infected with TB do not have the disease—the bacterium remains dormant in 90–95 percent of people, kept in check by their immune systems.

Latent TB can turn into active disease years after a person is infected, which obscures transmission. From a clinical perspective, the “when,” “where” and “how” don't necessarily matter: regardless of the means by which an individual becomes infected, treatment is much the same. Those seeking to control the spread of this infectious disease, however, must concern themselves with such details.

“People lie but bugs don't”

From an epidemiological perspective, an epidemic demands a systemic—and systematic—approach: households, individuals and their respective contacts all need to be investigated, which requires tracing and verification. But memories are unreliable at times—especially given that infection may have occurred years ago and doesn't even require direct physical contact (the bacterium that causes TB is airborne).

Understanding the pathogen through molecular genetics and mechanisms of characterization is essential to painting a bigger picture of TB transmission and consequentially, global epidemics.

What's more, individuals may not want to share information because of stigma or social constraints. All of these factors hinder TB control because they make it difficult to paint a clear picture of how the bacterium is being spread using traditional epidemiological methods.

A pathogen-centric approach can lead to a much deeper understanding of TB transmission because while, with respect to their exposure, people might forget, or may even be compelled to lie, bugs simply don't.

From microorganism to macro movements

Historically, the pathogen responsible for TB, the *Mycobacterium tuberculosis* bacterium, has been observed superficially: we started out by recognizing its shape, texture, and growth characteristics. In other words, basic microbiology relied on the phenotype of the organism for classification purposes. Modern methods are more granular, relying on genotyping, a laboratory-based method that analyzes and recognizes the genetic configuration of the organism, to detect outbreaks earlier and recognize unsuspected relationships.

Dr. Barun Mathema is an assistant professor of epidemiology at Columbia University's Mailman School of Public Health. He uses a combination of molecular genotyping and epidemiological methods, such as surveillance, spatial analysis, and network analysis in order to understand the spread of TB epidemics. He says TB is fascinating because it has endured years of insults by the host's immune system and constant attacks by a slew of antibiotics.

"The bug innately wants to survive—it's a very well-adapted human pathogen, a product of hundreds of thousands of years of evolution, and fine-tuning. And in that process, it adapts, spreads and mutates," says Dr. Mathema.

Dr. Mathema uses data to understand this evolution and to observe the natural changes that occur over time. "Over the years, the organism has gone through a Darwinian process of selection and adaptation such that the pathogen has learned to co-adapt and survive with us as a host," he says.

Tracking the evolution of the bug is one way to control the epidemic because the specific changes and mutations that occurred during evolution can indicate possible targets that can be used to develop more effective drugs. Furthermore, analysis of the strains can demonstrate similarities and differences, and allow for early detection of mutations that may result in multi-drug-resistance.

All of this is vital to public health's ongoing efforts to control the epidemic: the pathogen-centric lens leads to a more nuanced understanding of transmission. The pathogen doesn't just tell us who gave TB to whom. It provides insight into specific mutations that affect the ease of transmissibility from one person to the next and drug resistance. Such examination is the key to identifying chinks on the microbe's armor, which helps clinicians select appropriate treatment protocols and researchers to avoid wasting time on pharmaceutical dead-ends.

It should be noted that simply recognizing the pathogen is alone inadequate

because transmission is complex and at times, perplexing. Distinctive strains may be observed within the same household, which suggests a non-linear method of transmission. A father, for example, may contract TB from someone at work, while his children pick up a different variant of the bacterium at school.

Tracking this non-linear transmission requires spatial and social network analysis. Understanding the pathogen through molecular genetics and mechanisms of characterization is essential to painting a bigger picture of TB transmission and consequentially, global epidemics.

Social medium

Indeed, poverty and TB are closely associated, where the poorest and most vulnerable communities are most at risk of developing the disease. In an ideal world, eradicating poverty and the discrepancies in the wider societal structures would eliminate TB. But until then, Dr. Mathema says, hotspot mapping, a visualization of high-density occurrences, is a valuable public health tool that can advance our understanding of the disproportionate prevalence and the population dynamics of TB.

South African gold miners, for instance, have an extremely high TB prevalence. We now know that this is a consequence of their exposure to silica dust in the mines. But it was through spatial analysis and genotype analysis of the strains prevalent in that population that led public health scientists to conclude that TB emerged from the gold mines. Recognizing the strain-specific catalysts of TB transmission, mapping the

highly prevalent locations and finally, prioritizing interventions tailored towards these highly dense areas is key for TB control.

Merging the fields of public health and biomedicine can lead to a better understanding of the complexities of TB transmission for the prevention and control of the disease. This way, a more targeted implementation of public health strategies can occur, kick-started by a thorough understanding of the pathogen and its transmission.

According to Dr. Mathema, “Transmission is a real Achilles heel of TB—we really need to knock down the incidence. And the best way for us to do that is to understand the pathogen and then concentrate on hotspots.”

THE BIOCHEMICAL ILLUMINATI

For a disease as ancient as TB, we have shockingly few tools with which to fight it. Most people who have attended college have had the tuberculin skin test, which

measures a patient’s antibody levels to determine if they’ve been exposed to TB bacteria. While relatively cheap and easy, the skin test has a high false positive rate. The Interferon-Gamma Release Assay, or IGRA, is more reliable but far too expensive for resource-poor settings. These are the two most common diagnostic tests for TB.

The tests available for assessing treatment outcomes are even more inadequate. The “gold standard” for drug trials is merely determining whether subjects are still infected with TB after two years.

The emphasis now is on a worldwide hunt for biomarkers of TB that can be used to precisely determine disease status, and therefore improve the diagnosis and prognosis of TB patients. Dr. Max O’Donnell, an assistant professor in the Division of Pulmonary, Allergy, and Critical Care Medicine and the Department of Epidemiology at Columbia, described his search for new methods of assessing and optimizing treatment outcomes through the use of biomarkers.

Disease signals

The term “biomarker” is reminiscent of other buzzwords like “synergy” and “empowerment”—trendy, catchall terms with many meanings. This is because “biomarkers” aren’t just one thing; they comprise a vast array of molecular signals. When a person is infected with TB, these molecular messages sound off.

According to Dr. O’Donnell, “A biomarker is a surrogate that’s close to the disease process and reflects disease activity.” These surrogates are biochemical signals that are given off by either the bacterium itself or the human host, and can be quantified in order to determine disease status and progression.

Host-derived biomarkers are often antibodies that the immune system creates to fight the infection. These antibodies are an attractive target because of our knowledge of the human immune system, but may provide an imperfect measure of disease activity. Instead of monitoring the bacteria,

Transmission electron microscopy image of *mycobacterium tuberculosis*



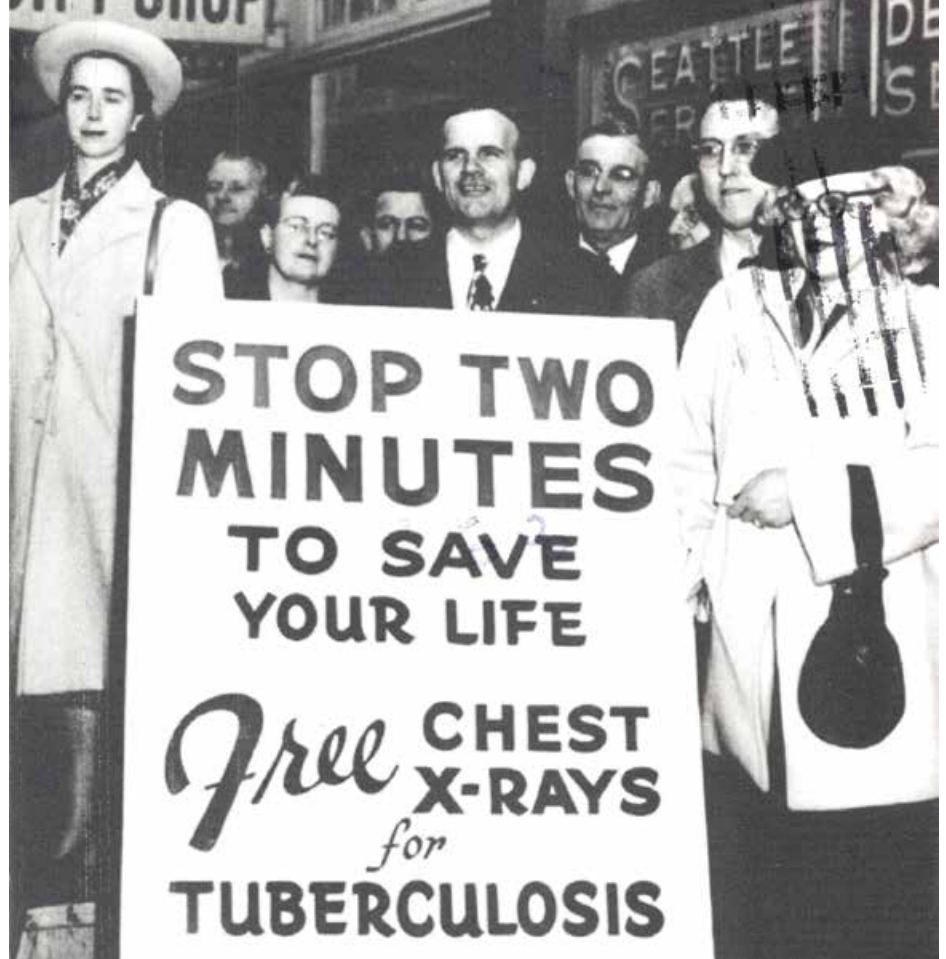


IMAGE: U.S. NATIONAL LIBRARY OF MEDICINE

the results are filtered through the immune response of the host.

Dr. O'Donnell's research focuses on biomarkers derived from the TB bacterium itself. His lab has created a virus that feeds on TB. It releases a fluorescent green protein when it finds a snack.

Researchers collect a sputum sample from the patient and add the modified virus. If the sample glows green under a fluorescent microscope, TB bacteria are present. If the sample glows in a well when antibiotics are added, the TB is drug resistant.

The virus created by Dr. O'Donnell's team only infects TB bacteria, making it more accurate than the traditional tests, and it can detect extremely small concentrations of bacteria. When the procedure was tested in a clinic in South Africa, it was found to be more sensitive but less specific for detection of TB—meaning it was better at detecting true cases of TB than it was weeding out the non-cases—than an expensive, sophisticated PCR machine. It did not make a difference if the patient also had HIV, which is critical in the developing world, where co-infection is extremely common.

Predicting resistance

The uses for this modified virus are virtually limitless. One of Dr. O'Donnell's priorities is examining whether treatments are likely to generate drug-resistant strains of TB.

"Almost all of our data on rates of mutation come from a petri dish. How frequently the bug mutates is based on in vitro data, and it may be that some of the second-line drugs we're giving have mutagenic potential. Because they interfere with...enzymes that are involved in DNA replication, it's totally plausible that the rates of mutation are quite different. We're trying to use deep sequencing and this phage, this modified virus, to detect subpopulations that are drug resistant as they emerge," says Dr. O'Donnell.

PRIORITIZING PATIENTS

For individuals, a diagnosis of TB is unlike any other. Quarantine is common. Treatment is laced with mistrust, precisely because of concerns regarding transmission and treatment resistance. Often,

health care workers must witness patients taking their medications, because treatment non-adherence is expected. And patients not completing their six-month regimens are labeled defaulters. Never mind the toxic side effects.

The treatment for TB is arduous, lengthy, and unaided by its impersonal, rather punitive nature.

A perfect storm for paternalism

TB is something of a perfect storm for paternalistic public health interventions. The disease is airborne, so it is spread simply by breathing; there's no deliberate action required on the part of the exposed. There aren't any corporate stakeholders to push back against TB control, like tobacco companies do with smoking. Those infected are usually of lower socioeconomic status and, in the United States, are often foreign-born, limiting their ability to access services and complete treatment.

The standards for TB treatments were developed originally with sound reasoning and no intent to demean patients. Directly observed therapy, or DOT, for TB treatment is not an inherently bad idea, just an outdated



Swaziland National TB Center

IMAGE: ICAP AT COLUMBIA UNIVERSITY

one. As medicine and public health become more technologically advanced and the biology of disease is better understood, the importance of humanity—human factors, humane engagement—is starting to emerge.

From punitive to patient-centered

Dr. Yael Hirsch-Moverman, an assistant professor of epidemiology at Columbia, focuses on a holistic, empowering approach to TB treatment known as patient-centered care, which is gaining traction worldwide.

According to Dr. Hirsch-Moverman, patient-centered care is “Basically the way it sounds, which is putting the patient at the center of the treatment.” In patient-centered care, providers consider the barriers that prevent patients from seeking and completing treatment, including social, educational, psychological, and structural factors.

This approach isn’t new, though. It has long roots in patient advocacy—activists for diseases like HIV/AIDS have been championing patients’ rights for years. However, patient-centered care only recently made its way into TB treatment. The WHO just adopted patient-centered care as one of

the three pillars of the End TB strategy for 2015–2030.

This shifting mentality is due in part to the relative failure of current TB control methods. Though TB deaths have decreased markedly since 1990, there were still 1.5 million TB deaths worldwide in 2014. Dr. Hirsch-Moverman says, “That’s unacceptable. It’s a preventable, curable disease. We’re not doing well, and we need to fix it.”

There are myriad reasons for these gaps in TB management, including absence of funding, lack of visibility, and the latent nature of the disease. Dr. Hirsch-Moverman and many others hope that patient-centered care for TB will not only empower patients but also improve their ultimate outcomes, all while being cost effective.

Packaged for patients

In a trial that Dr. Hirsch-Moverman is working on in Lesotho with the Columbia University organization ICAP, a patient-centered approach means combining multiple interventions that have been shown to be effective into a comprehensive package. This package includes reimbursement for

transportation to the clinic, educational programs to improve patients’ understanding of their treatment, job aides for nurses, and an SMS reminder system for appointments.

Each of the interventions is extremely inexpensive, and together they stand to improve treatment completion and survival rates. The team is doing a similar study in Ethiopia, but with the goal of enabling HIV positive patients to complete preventive treatment regimens for TB. The packages are tailored to the region in which they’re used. For example, in Ethiopia literacy rates are lower than in Lesotho, so the SMS text reminders are replaced by automated voice reminders.

Scaling up these culturally and locally specific interventions presents a grand challenge. However, Dr. Hirsch-Moverman is confident that it can be done in a cost effective manner. “We designed these interventions to be sustainable. Not too expensive, nothing super fancy, because at the end of the day we’re going to have to depend on the local ministries of health to deliver these things,” she says.

The high level of acceptance and buy-in achieved in the communities will usher

the process along. Although the research team won't know the final results for a few months, the trials have already had a significant effect on the patients that participated.

"What's been really interesting is to see them feeling like somebody cares about them," Dr. Hirsch-Moverman says. "Through the messages, they feel cared for. They feel that someone in the clinic is thinking about them. It's automated, but to them it's not necessarily." Emphasizing the humanity of this approach, Dr. Hirsch-Moverman adds, "It's beautiful."

Precision medicine

Indeed, the human touch is a focal point for patient-centered care. However, with his work on biomarkers, Dr. O'Donnell is interested in yet another dimension of individualized treatment for TB. He's striving to foster a shift towards the use of precision medicine for the disease. The current drug regimens for TB are highly standardized, and often don't detect when patients have drug-resistant strains until several treatment programs have failed. Dr. O'Donnell's work with the TB-detecting virus his lab developed, as well as biomarker research in general, has the potential to change those outcomes.

"It's a way of detecting way early if [the patient] has two populations of bacteria, one's antibiotic resistant and one's susceptible. As you get antibiotics that kill down the drug-susceptible, the drug resistant will emerge. As it's emerging, we want to detect it at say, one part in 100,000 rather than waiting until it's 50-50."

COMING FULL CIRCLE

If we have half a chance of fighting this disease that causes so much morbidity and mortality globally, it's going to take the complimentary, coordinated efforts of researchers represented by this Columbia thought collective. This group's unique set of perspectives, which encompasses the micro and the macro, the local and the global, offers fresh hope for one day adequately addressing this ages-old killer.

Scaling up these culturally and locally specific interventions presents a grand challenge.



Tuberculosis now world's deadliest infectious disease

About 1.5 million people died from TB in 2014, which means that tuberculosis is now causing more deaths than any other infectious disease. HIV/AIDS, no longer the world's deadliest infection, killed 1.2 million globally during the same time period, according new data released by the World Health Organization (WHO) in late October, 2015.

The WHO and the White House have both created new plans for addressing tuberculosis. Beginning in 2016, WHO will shift its focus from just controlling TB to eliminating the disease altogether with the launch of The End TB Strategy.

The WHO's goal is "to reduce TB deaths by 95% and to cut new cases by 90% between 2015 and 2035, and to ensure that no family is burdened with catastrophic expenses due to TB."

> bit.ly/VMb6tX

More on tuberculosis

- > *Tuberculosis surpasses HIV/AIDS as leading cause of global death: WHO*
bit.ly/1ZNVv9H
- > *TB surpasses HIV/AIDS as top killer: Drug quality control needs to change*
fxn.ws/1jX7m66
- > *White House releases plan to fight multidrug-resistant tuberculosis*
huff.to/1NM4LDM
- > *New plan to fight tuberculosis*
nyti.ms/1TgKaep

Gentrification and public health: Opportunities and challenges in change

BY AMY SCHELLENBAUM AND DANA MARCH, PHD



IMAGE: TIMOTHY KRAUSE



IMAGE: ANDREAS KAMBANIS



IMAGE: MATTHEW RUTLEDGE



IMAGE: RACHEL KRAMER BUSSEL

Longtime residents consider East Austin, Texas a victim of its own success. It's a narrative locals in transforming neighborhoods across America would recognize: As recently as the 1990s, East Austin's population was around 90 percent Latino; the area's families having carved homes here in the decades following a 1928 law that segregated Texas' capital.

Officials neglected the area for decades—unless, of course, something undesirable, like a power plant, needed a home.

Fast-forward to the mid-2000s. The neighborhood boasts the farmers' markets, coffee shops, and food trucks required of a blooming hipster haven. Land value has skyrocketed, and so have rents and down payments. Much of the old community can't afford to live here.

For decades the community came together to protect its neighborhood, many times to great success. For example, in the 1990s, community leaders combated what activist and longtime resident Susana Almanza called "environmental racism," demanding the closure of the Holly Street Power Plant. Eventually, in 2009, the government ceased the plant's operations.

This is where the victim-of-its-own-success moniker comes into play. As blights and polluting structures were demolished,

residents from greater Austin started moving in. The effect snowballed until, by 2014, housing prices were 70 to 80 times what they were even in the 1990s.

"We cleaned it all up," Ms. Almanza says, "just so the new [residents] can come in and take over the barrio."

Grappling with gentrification

Indeed, when people or institutions with more money decide land is valuable, the onrush of wealth drives up housing prices, squeezing out the neighborhood's original dwellers.

The effects of such a shift can be severe: researchers have long established the health woes of people whose lives have been uprooted. People leave their jobs and move into lesser-quality housing, life events are often paid for by working more hours or avoiding medical care. The psychological effects are long-lasting and dire.



IMAGE: STUART MCALPINE



IMAGE: SEE-MING LEE



IMAGE: TONY FISCHER



IMAGE: JOE NICKOL

The term gentrification dates back more than five decades—and its socio-political causes back much further—but the task of understanding this process has taken on a new urgency. Researchers endeavor to parse its context, causes, and consequences.

Researchers have focused on the extent of gentrification in U.S. cities. A 2013 analysis by economist Daniel Hartley, for example, shows the most pronounced effects of this complex social process in the nation’s largest urban areas—New York, Boston, Washington, DC, Seattle, and San Francisco. In Hartley’s investigation, the percent of gentrified urban neighborhoods ranged substantially, from 61 percent in Boston to less than five percent in other major metro areas, such as San Diego.

Meanwhile, advocates strive to keep neighborhoods from disintegrating or, barring that, mitigate the potentially negative effects of community dissolution.

What causes gentrification? How detrimental are its effects? How do we facilitate development that isn’t harmful for residents? The department of epidemiology recently convened a symposium to ask these questions, investigating themes that resonate here-and-now, despite having been gnarled by decades. Scholars and activists discussed the origins and implications of gentrification, calling upon a spate of tools from the academic’s arsenal.

The task at hand was not to pin down a solution to the displacement of poor communities—though many were discussed—but rather to inform researchers and organizers, inspire new collaborations, and reiterate the importance of studying the topic.

To introduce the symposium, its hosts Dr. Mindy Fullilove, professor of clinical psychiatry and clinical sociomedical sciences, Dr. Robert E. Fullilove, professor of sociomedical sciences and associate dean

from minority affairs, and Dr. Gina Lovasi, assistant professor of epidemiology, first outlined the problem. Policies dating back before The New Deal set the stage for urban renewal, gentrification, and other forms of forced displacement.

In all, some one million Americans in 993 cities have been forced out of their communities. Some 75 percent of those displaced were people of color.

The narrative begins with Jim Crow laws, which allowed banks and real estate companies to limit where blacks could live and open businesses, and continues into the aftermath of the Great Depression, when the government decided where to invest New Deal money based on the number of foreign-born residents and people of color. Neighborhoods that were already neglected were given the lowest scores, furthering disinvestment.

Fast-forward a few decades, and the city labels some of these neighborhoods

Because new residents are also more likely to make noise complaints, gentrification too threatens place-based culture, one defined in Tremé by parades, bars, and live jazz.

“slums,” using eminent domain to demolish housing and community buildings in favor of university infrastructure or shiny cultural centers.

Gentrification is often viewed as a natural process, although its history indicates otherwise.

The eve of mass displacement

Dr. Richard Marciano from the University of Maryland and his co-authors examined data from the Home Owners' Loan Corporation, a New Deal program FDR created to refinance mortgages and prevent mass foreclosures post-Depression. (Over the next three decades, the U.S. government financed over \$120 billion in new housing, though less than two percent of that real estate was available to non-white families.)

The HOLC put in place appraisal methods that kick-started a practice known as redlining, or the institutionalized denial of services.

The appraisals are painful to read, describing neighborhoods in terms of racial makeup and the immigration status of their inhabitants. Documents discouraged realtors from “introducing any individuals whose presence will clearly be detrimental to property,” according to Dr. Marciano, with the capacity for detriment based largely on “race or nationality.”

Using these appraisals, HOLC categorized neighborhoods into colors, with “red” neighborhoods being the most “detrimental.” Redlining is how the government noted where it wasn't going to send money—again, based on race and ethnicity.

Perhaps unsurprisingly, the red areas of these maps “fit like a glove” with maps of urban renewal projects decades later. It's not hard to see why. Systematic neglect translates to less federal mortgage aid,

fewer parks, and poorer public schools. A dearth of housing code enforcement and tenants' rights contributed to the slum-like conditions the federal government tried to eradicate in the '50s and '60s.

Vulnerability to gentrification today, says Dr. Lovasi, is “the legacy of segregation.”

But gentrification is both dynamic and complex—and contextually dependent. It doesn't always rupture communities of color. Research using Census data from the 1990s led by University of Colorado economist Terra McKinnish indicates that gentrification of low-income black neighborhoods, in fact, renders them more attractive to middle-class black families.

A vulgar, criminal intrusion

To showcase the detrimental effects of gentrification, Dr. Trushna Parekh from Texas Southern University presented vignettes from the New Orleans Tremé neighborhood. One interviewee, George, described the changes in terms of police activity, and how he “couldn't move about the neighborhood freely without being stalked by the police,” Dr. Parekh says. “He was routinely harassed without any reason.”

Because new residents are also more likely to make noise complaints, gentrification also threatens place-based culture, one defined in Tremé by parades, bars, and live jazz.

'The last clean up is us leaving.'

Andrew J. Padilla, a filmmaker, documents changing neighborhoods like his own, East Harlem. At the symposium, he spoke about how communities fight to determine their own fate.

That quest for self-determination had duplicitous effects for East Austin, Texas, whose zip code is considered the

“second-most gentrified” in the country. Mr. Padilla interviewed community leaders last year, uncovering a troublesome narrative: the more success community members had expelling unsightly structures the government imposed, the more the community became endangered.

Twenty years ago a house “would cost you maybe about \$18,000,” an interviewee noted. In 2015, a new house goes for \$1.3 million.

For decades, a local environmental group worked to rid the neighborhood of power plants and other undesirable structures. By the 2000s, they had found a lot of success, but success meant people from “Anglo” Austin wanted to live on the other side.

As Mr. Padilla put it, “We cleaned it up, but the last cleanup is us leaving.”

Housing instability as brain poison

Dr. Angela A. Aidala, associate research scientist in Sociomedical Sciences, points out that politicians and developers tend to focus on things like the increased sense of safety, property values, tax revenues, and even social mix, meaning poverty is less concentrated. “Yes, it facilitates mixing,” she says. “For a time.”

Impacts for the original residents, however, are hard to ignore: rent increases are often financed by cutting back on healthy food and medical care, or by working more hours. Residents may need to double-up in apartments or seek poorer-quality housing. They may also experience some unexpected boosts as well, like credit score increases of 1.5 to 8 points, depending on whether they are staying or going.

Rapid gentrification, in particular, may result in serious short- and long-term consequences that “undermine the resilience of communities,” according to Dr. Lovasi.



Higher rates of incarceration related to neighborhood depression and anxiety

There is “significant collateral damage for the mental health of people left behind in neighborhoods where incarceration rates are unusually high,” says a *New Republic* article that reports on a study by Dr. Katherine Keyes, Dr. Sandro Galea, Ms. Ava Hamilton, and colleagues.

Read more in *New Republic*.
> bit.ly/1KjVwdM

When gentrification breaks down social ties, says Dr. Lovasi, it “ultimately contributes to a sense of futility and cynicism.”

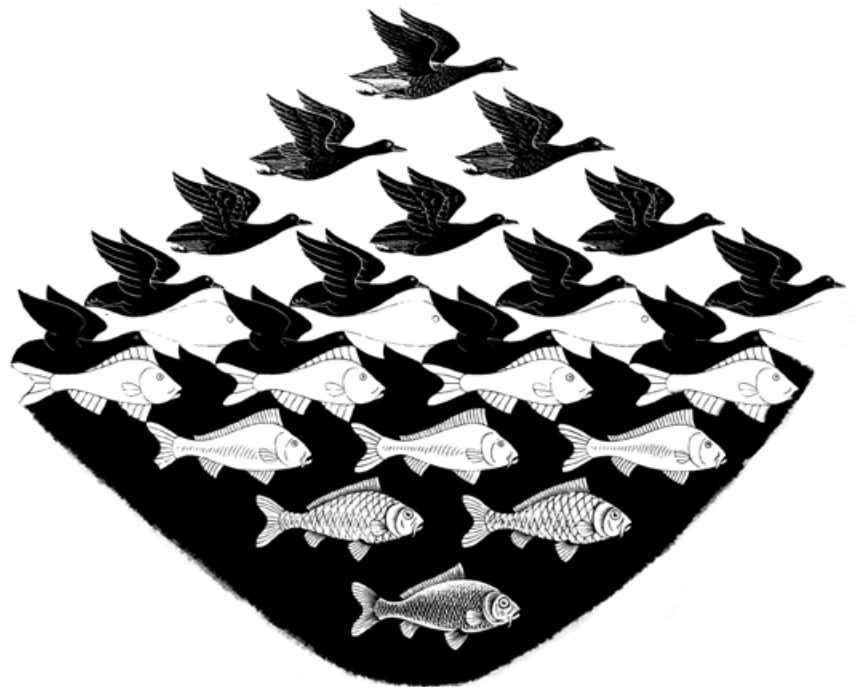
Another yoga studio is not the solution

“Things are really, really bad,” Dawn Phillips, a 20-year activist in California’s Bay Area, says. To live in Oakland on minimum wage, one must work 165 hours a week. Now is the time, she says, to figure out community-driven development.

So what exactly are the key components of establishing a community-driven model of development? Quite simply, a major paradigm shift. Development, she says, is very different when the government is not planning for wealthier residents. “We have never heard people say ‘we need another yoga studio.’”

The solution begins by stabilizing the community with tenant protections that keep rents affordable. As Ms. Phillips says, “Organizing for tenant protection is some of the least popular forms of organizing, but we’ve got to.”

What remains clear is that the changes inherent in gentrification can deeply affect communities that have forged meaningful lives despite a lack of financial resources. Families that are confined to lower socioeconomic positions are likely to retain that status across generations, living in disadvantaged neighborhoods regardless of their geographic mobility, as work by NYU sociologist Patrick Sharkey shows in his award-winning 2014 book, *Stuck In Place*. Residential neighborhoods are but one axis along which the staggering social inequality in the U.S. manifests itself. The complexities of gentrification demand sophisticated epidemiological, social, and economic research that can parse out its many causes and consequences. Such research should involve communities themselves, because there is no simple solution, especially when the challenges hit home.



The vaccine conundrum

Are immunization programs victims of their own successes?

When vaccines work, nothing happens. To some extent vaccines have become victims of their own successes, explained Paul Offit, a pediatrician and infectious disease expert, at a recent symposium on vaccines hosted by the Mailman School Department of Epidemiology.

Unlike 60 years ago when diseases like measles and polio were commonplace and the discovery of vaccines celebrated, Dr. Offit said, vaccines today are essentially a “matter of faith.”

This situation has led some parents to skip inoculations for their children, leading to outbreaks. Earlier this year, a case of measles at Disneyland spread across six states and infected 147 people. In the aftermath, Dr. Offit said, even some doctors who had been vocal about purported risks of vaccines were now giving more measles vaccines than ever before “because parents were scared of measles.”

Vaccines date back to the 1790s when English physician Edward Jenner successfully immunized people against smallpox by injecting them with pus from a cow infected with a similar disease. As Dr. Stephen Morse, professor of epidemiology, noted, the word “vaccine” derives from the Latin *vaccinus*, meaning “from cows.”

Smallpox was responsible for an estimated 300–500 million deaths in the 20th Century alone. But, after a vigorous inoculation campaign, the disease was finally eliminated in 1980. As Dr. Morse noted, smallpox remains the only infectious disease to be completely eliminated through human intervention. Inoculation programs have also brought rates of rubella, polio, and diphtheria infection down to negligible levels in most countries.

The fight against global infectious disease, however, is not over. Bird flu, Middle East Respiratory Syndrome Coronavirus (MERS) and, most notably, Ebola have emerged or flared up in the last decade or so. Combating these diseases relies on scientific ingenuity to develop vaccines and a society that embraces vaccination. “With microbes, it’s our wits versus their genes,” Dr. Morse said.

Fear of vaccines is nearly as old as vaccines themselves. A British political cartoon published in 1802, for example, shows recipients of smallpox inoculation morphing into cows. One hundred year later, the Anti-Vaccination Society of America published flyers and actively recruited followers. Some of the earliest anti-vaxxers were ministers who warned that God sends illness as a punishment for sin and any interference by humans borders on blasphemy: diseases, they maintained, should be allowed to run their course.

The latest iteration of anti-vaccine rhetoric isn’t rooted in fire-and-brimstone, but may be just as difficult to uproot. The 1998 vaccine-autism connection, based on one poorly designed (now retracted) study in *The Lancet*, is persistent.

“There aren’t two sides to this story,” Dr. Offit assured the audience. “Vaccines simply don’t cause autism.”

Media coverage of outspoken celebrities’ opinions on the matter, most notably, a focus on Jenny McCarthy’s misdirected outrage over her son’s health problems, has pushed the anti-vaccine movement into the popular consciousness in recent years, Dr. Offit said. Unfortunately, in the interest of balanced journalism, or perhaps higher ratings, the news media has highlighted anecdotes and given science rather short shrift, he said.

✕ The Columbia University Epidemiology Scientific Symposium (CUESS) series brings the best minds in epidemiology and other disciplines together for a day of discussion on the most pressing health questions of our time.



Anti-vaccine cartoon published in 1802

“Vaccine inventors were once celebrated with ticker-tape parades. Now they get hate mail.”

“Media’s job is to entertain,” Dr. Offit said. “As long as people enjoy ‘vaccines cause autism stories,’ we’ll have them.”

Whether and to what extent vaccines are compulsory is worthy of serious consideration. In the view of Dr. Ronald Bayer, “a very small number of people should be allowed to forgo vaccines,” including those with weakened immune systems.

Vaccinating children not only protects them, but the kids they interact with at school every day. “The unvaccinated are free-riders, which [also] violates justice,” Dr. Bayer said.

Dr. Offit, who co-invented the lifesaving RotaTeq vaccine that protects against rotavirus, maintains that vaccines are vastly underappreciated considering how many lives they’ve saved.

“Vaccine inventors were once celebrated with ticker-tape parades,” he lamented. “Now they get hate mail.”

Injury control through collaboration

Attendees at the third annual Innovations in Translating Injury Research into Effective Prevention Seminar are passionate about protecting community health in the United States and abroad.

“To just treat trauma and not try to prevent it is just absolutely immoral,” said Dr. Barbara A. Barlow, executive director of the Injury Free Coalition for Kids and professor emerita of surgery epidemiology at Columbia University.

The daylong symposium on May 22, sponsored by Columbia’s Center for Injury Epidemiology and Research, drew scholars and policy experts from across the country to examine and debate best practices for injury prevention.

More than 60 people attended the event, which covered a wide range of topics, including traffic fatalities, prescription drug overdoses, gun violence, falls from windows, sudden infant death syndrome, and techniques for geographic injury mapping.

The average person encounters numerous situations every day that involve a significant, preventable risk for injury, and, according to estimates by the Centers for Disease Control and Prevention (CDC), injuries are the number-one killer of Americans between the ages of one and 44. In the U.S. alone, injuries result in 2.8 million hospitalizations and 29 million emergency room visits annually.

Dr. Joyce C. Pressley, associate professor of epidemiology and health policy and management at Columbia, served as course director and was one of ten speakers to present new findings. Attendees also had the opportunity to participate in several roundtable discussions.

Dr. Pressley gave a talk on window falls, illustrating how the New York City initiative to prevent them via legislation alone and legislation combined with varying types of enforcement led to incremental improvements in window fall injury and mortality. More broadly, she also highlighted the roles that mandatory injury reporting systems for tracking the impact of health regulations/injury prevention legislation and various legal actions, such as complaints, citations, civil fines, criminal prosecution, and expanded liability, can play in safeguarding health.

In 1976, when New York’s window guard regulations were first enacted, 24 children died and 217 were injured in window falls. Since that time, falls from windows have significantly decreased: In 2013, only one child died and just six were injured in such incidents. Children Can’t Fly, the pioneering window guard campaign that inspired the formal health code requirement, was created by Democratic politician and civic leader Charlotte Spiegel who passed away on April 27 in Manhattan at age 92.

Kim Wiley-Schwartz, Assistant Commissioner for Education and Outreach at the NYC Department of Transportation, provided an update on Vision Zero, the City’s initiative to reduce traffic fatalities and injuries, especially among pedestrians. By 2024, the goal is to completely eliminate traffic fatalities in New York City.

In October 2014, Mayor Bill de Blasio signed local legislation reducing the default speed limit on New York City streets from 30 to 25 miles per hour. The Department of Transportation also recently installed more than 400 new speed bumps, five miles of protected bike paths, and 45 leading pedestrian interval signals (which show a walk sign for pedestrians before showing a green light to car traffic).



IMAGE: VICTORIA DINIELLI

Twenty-three percent fewer pedestrians lost their lives in 2014 compared to 2013 (138 deaths vs. 180 deaths), and pedestrian fatalities in NYC are at their lowest levels since 1910. The City's Vision Zero Task Force plans to concentrate on reducing truck- and bus-related pedestrian deaths in the coming year.

Dr. Hillary V. Kunins, Assistant Commissioner at the New York City Department of Health and Mental Hygiene and head of the Department's Bureau of Alcohol and Drug Use - Prevention, Care and Treatment, spoke about prescription drug initiatives in New York City. The City's multi-pronged approach includes: monitoring and surveillance; raising public awareness; promoting judicious opioid prescribing; distributing naloxone; and promoting access to effective treatment for opioid addiction.

Dr. Pina Violano, co-principal investigator of the Injury Free Coalition for Kids at New Haven, presented on a framework to mitigate gun violence, using the city of New Haven, New York as a test case. Informed by survey data collected from people in the area, she and her colleagues formed two Community Resilience Teams in the neighborhoods of West River and Newhallville, which will focus on building

social cohesion and making the local communities better places to live.

Dr. Steven C. Rogers, assistant professor at the University of Connecticut's School of Medicine, attending physician at Emergency Mental Health Services, and co-principal investigator for the Injury Free Coalition for Kids of Hartford, described the Pediatric E-Network, a pilot program for providing injury prevention education. He and his research team offered 101 patients a tablet pre-loaded with a mobile app that contains information about teen driving safety. The vast majority of patients, 81 percent, accepted the tablet when it was handed to them, suggesting that parents and children would be receptive to receiving injury prevention information at outpatient clinics when presented in this digital format.

Dr. Michael P. Hirsh, professor of surgery and pediatrics at University of Massachusetts Medical School and Surgeon-in-Chief at UMASS Memorial Children's Medical Center, made a compelling case for gun buyback programs using the Pittsburgh and Worcester gun buyback projects and their track records as successful examples. The U.S. is the most heavily armed country in the world with about 90 guns for every

100 Americans, according to the 2007 Small Arms Survey conducted by the Geneva-based Graduate Institute of International Studies. The United States Bureau of Justice Statistics found that firearm violence accounted for about 70 percent of all homicides in the U.S. between 1993 and 2011.

Garry Lapidus, Injury Prevention Center Director at Connecticut Children's Medical Center/Hartford Hospital and associate professor of pediatrics and public health at the University of Connecticut School of Medicine, reviewed the epidemiology and prevention of motor vehicle crashes among teen drivers, spotlighting risk factors for crashes and evidence that favors graduated driver licensing (GDL) systems, which place restrictions on underage drivers. Per mile driven, teen drivers are three times more likely to crash than drivers aged 20 years and older. Many studies in the U.S. and Canada have shown that GDL reduces motor vehicle crashes and fatalities by 20–40 percent. Since North Carolina implemented comprehensive graduated licensing laws, crashes involving 16-year-olds have decreased by 25 percent.

Beverly Miller, Associate Director of Research at Arkansas Children's Hospital Injury Prevention Center and Program

‘To just treat trauma and not try to prevent it is just absolutely immoral’

Coordinator at the Injury Free Coalition for Kids of Arkansas, enumerated the American Academy of Pediatrics’ recommendations for safe sleep environments to reduce infant mortality and described four specific interventions. Sudden Infant Death Syndrome (SIDS) is 133 percent higher in Arkansas than in the U.S. as a whole, according to Ms. Miller’s presentation. Forty-three babies would be saved in just one year if the incidence of SIDS in Arkansas could be brought down to the national level.

Arkansas experiences excess SIDS in part because caregivers are unaware of the risk factors. Fewer than half of teen mothers in Arkansas place their infants on appropriate sleep surfaces and 75 of these teen moms report occasional bed sharing.

Finally, Dr. Wendy J. Pomerantz, professor of pediatrics at the University of Cincinnati, showed how attractive data presentation is crucial to injury prevention efforts. A Geographic Information System (GIS) is a critical tool for visualizing spatial or geographical data, including public health data, such as incidence rates and factors contributing to local injuries. Researchers can use GIS to monitor

health events and detect trends, which helps inform decision making and priority setting. Injury maps are also useful for storytelling, as they enhance communication. The tool can play a key role in health-related program development, implementation, and evaluation. It can also inspire community members, motivate public leaders, and engage stakeholders.

Support and collaboration were among the seminar’s most prominent themes: Participants eagerly shared new-found knowledge while seeking to benefit from others’ wealth of experience.

“If you go into injury prevention and you feel like you are alone doing this, it gets overwhelming” said Dr. Kitty Gelberg, New York State Department of Health Bureau of Occupational Health and Injury Director, who attended the event. She added that seminars like this one provide a reminder that “you are not alone; you don’t have to recreate the wheel. The template is there and you can follow it.”



New study will look at elderly driving patterns

Researchers in injury epidemiology are now recruiting people between the ages of 65-79 to participate in an unprecedented 3,000-person study of elderly drivers, funded by AAA Foundation of Traffic Safety. They will fit cars with GPS to monitor driving patterns and accidents and do check-ups of participants’ cognition and physical health, Dr. Guohua Li, principal investigator of the study, told Reuters Health.

Read more on *Reuters*.

reut.rs/1yNQ5fG

As epidemiologists we believe that numbers can speak volumes. Here are just a few:

In 2015, our faculty published over 800 peer-reviewed papers in the first ten months alone. The bibliography at the end of this report demonstrates the scope and influence of their path-breaking research.

This past year, our faculty, along with our students, engaged in public health work around the globe—in 68 countries, at last count.

We are training a total of 406 students in our MPH, MS, Executive MS, PhD and DrPH programs.

Upon graduation, these students will be much in demand, locally and internationally. The graphic on the opposing page shows the jobs the class of 2014 entered into within six months of graduation.

selected faculty awards

Over the last calendar year, our faculty garnered numerous awards and honors. Here is a select (incomplete) list:

Dr. Quarraisha Abdool Karim received an A-Rating from the National Research Foundation (NRF) for her seminal scientific contributions in HIV prevention research; A-rated scientists are recognized by their peers as leading international scholars in their fields. > epi.is/1UFmJwg. She was also named a Laureate of the 2016 L'Oréal-UNESCO for Women in Science Award for her “remarkable contribution to the prevention and treatment of HIV and associated infections, greatly improving the quality of life of women in Africa.” > epi.is/1mq0H59

Dr. Salim Abdool Karim is the recipient of a new endowed Chair, the CAPRISA Professorship of Global Health in the Department of Epidemiology, which was announced by Mailman School Dean Linda P. Fried. > bit.ly/1hpekj1

Dr. Ryan Demmer earned a Junior Faculty Teaching Award from the Mailman School of Public Health; these awards recognize assistant professors who are making a remarkable impact on education. > epi.is/1T4gjFO

Dr. Wafaa El-Sadr was named the inaugural recipient of the Dr. Mathilde Krim-amfAR Chair of Global Health, a professorship endowed through the generosity of the Hess Foundation and of amfAR The Foundation for AIDS Research. > epi.is/1kD3ebA

Dr. Linda Fried was selected as the 2015 Lorraine and Ralph Lubin Distinguished Visiting Professor at Weill Cornell Medical Center; the Dean Fried of the Mailman School of Public Health, she was chosen because of her achievements in the field of epidemiology and because she is a role model for students > epi.is/1RrtHg. Dr. Fried was also named one of Next Avenue's 2015 Influencers in Aging. These 50 thought leaders, innovators, writers, advocates, experts and others are changing how we age and think about aging. > epi.is/1QvVFk6

Dr. Grace Hillyer was awarded a Calderone Junior Faculty Prize from the Mailman School of Public Health; these prizes provide financial support to further research with significant scientific merit. > epi.is/1ITLI3H

Dr. Katherine Keyes was awarded a Calderone Junior Faculty Prize from the Mailman School of Public Health; these prizes provide financial support to further research with significant scientific merit. > epi.is/1ITLI3H

Dr. Guohua Li received an Excellence in Science Award from the American Public Health Association (APHA) for his outstanding contribution to the science of injury epidemiology and prevention and for his leadership in advancing the academic field of injury control and prevention through his pioneering research and training programs. > epi.is/1P9kBuD

Dr. Jose Luchsinger became Editor-in-Chief of the journal Alzheimer's Disease and Associated Disorders. > epi.is/1IWNqv4

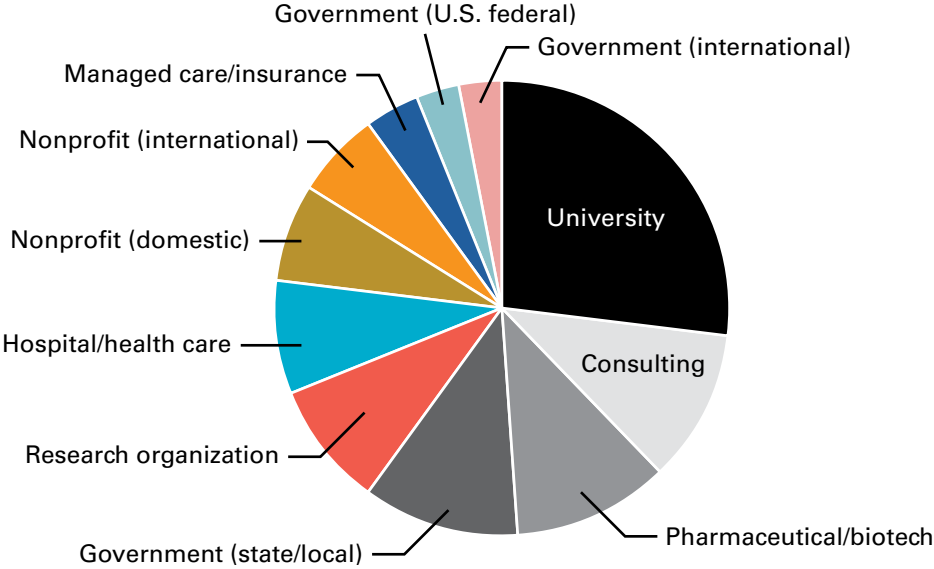
Dr. Alfredo Morabia became Editor of the American Journal of Public Health. > epi.is/1ZeJkh5

Dr. Andrew Rundle was presented with an Excellence in Leadership Award from the Mailman School of Public Health; these awards recognize efforts by the School's senior leaders that exceed the expectations of any individual role. > epi.is/1JeGjJh

recent alumni statistics

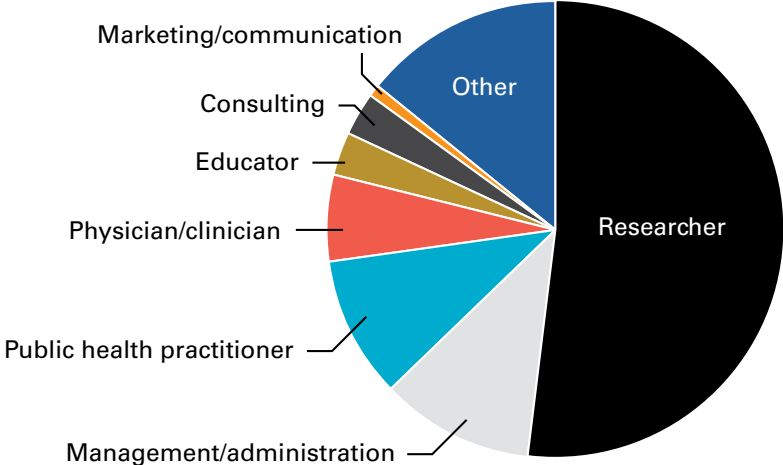
2014 graduates: Where do they work?

Our graduates from the class of 2014 have accepted a wide variety of jobs: 27 percent work at universities; 17 percent work for government entities; 13 percent work for nonprofits; 11 percent work for pharma/biotech—the remainder work for research organizations, hospitals/healthcare facilities, insurance companies, etc.



2014 graduates: What are their job functions?

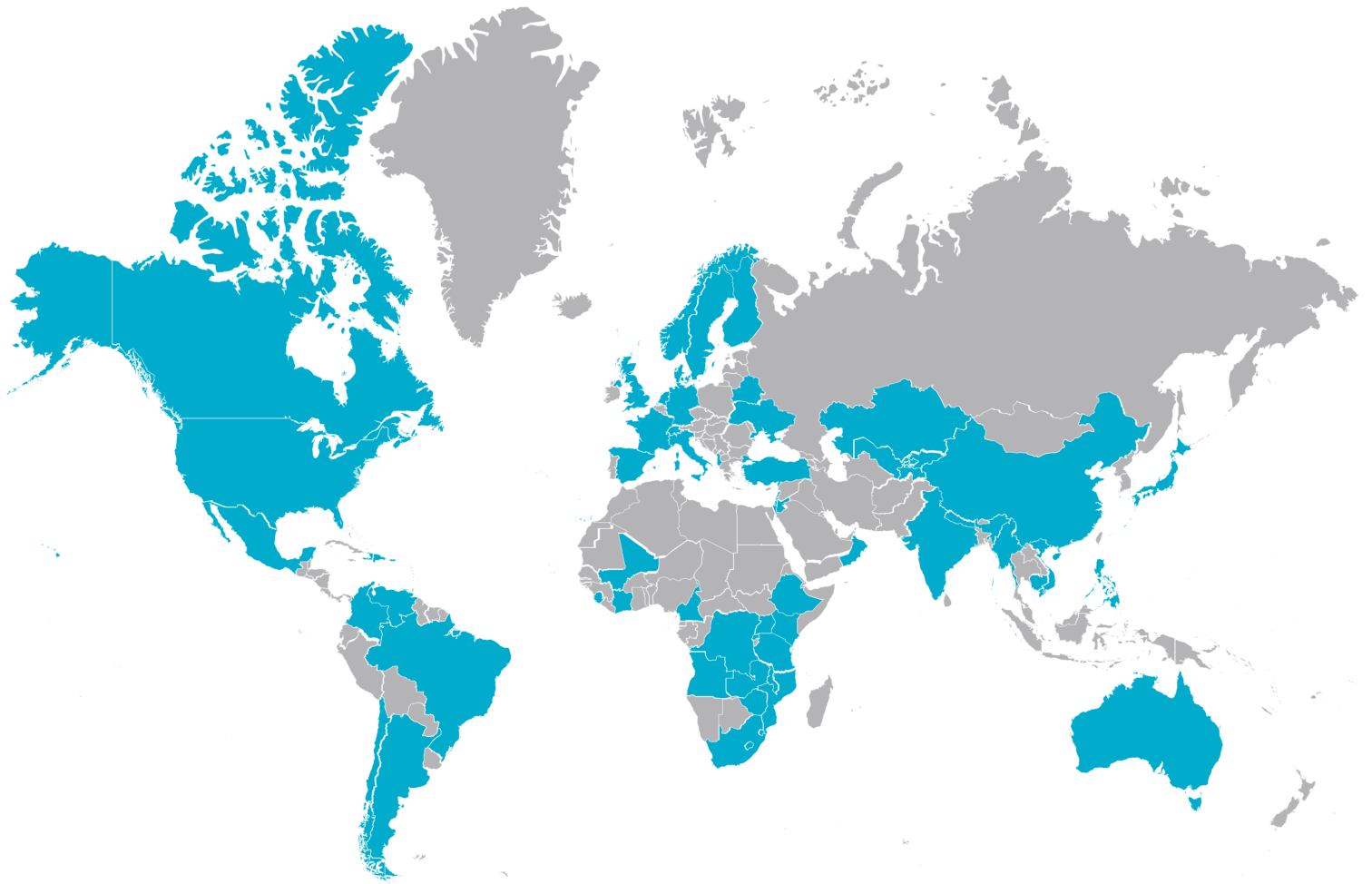
More than half (52 percent) of our alumni from the class of 2014 are employed as researchers, 11 percent are in management/administrative roles, and 10 percent are public health practitioners.



global reach

Our faculty members and students are doing public health work in more than 60 countries around the world.

Angola	Haiti	Rwanda
Argentina	Netherlands	Saudi Arabia
Australia	Hong Kong	Senegal
Bangladesh	India	Sierra Leone
Belarus	Israel	South Africa
Botswana	Italy	Spain
Brazil	Japan	Swaziland
Cambodia	Jordan	Sweden
Cameroon	Kazakhstan	Switzerland
Canada	Kenya	Tajikistan
Chile	Kyrgyz Republic	Tanzania
China	Lebanon	Thailand
Colombia	Lesotho	Turkey
Cote d'Ivoire	Malawi	Uganda
Democratic Republic of the Congo	Mali	Ukraine
Denmark	Mexico	United Kingdom
Dominican Republic	Mozambique	United States
Egypt	Myanmar (Burma)	Uzbekistan
Ethiopia	Nepal	Venezuela
Finland	Norway	Vietnam
France	Oman	Zambia
Gabon	Philippines	Zimbabwe
Germany	Puerto Rico	



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