

Balance and Vestibular Testing

Public Health Objectives:

Balance disorders, disequilibrium and dizziness from vestibular disturbance constitute a major public health problem. Primary disorders of balance and dizziness are often hidden by their acute and serious consequences, such as falls; motor vehicle accidents; and on the job injuries. Subtle dysfunction of the vestibular system may underlie difficulties in learning, writing, and reading, and affects an individual's ability to perform the most routine activities. These problems may not only interfere with most activities of everyday life but may prevent employment and limit personal independence. Tremendous health care resources are committed to the medical, surgical, and physical rehabilitative therapy of patients with balance disorders.

Disequilibrium may be responsible and is certainly related to many of the fractures caused by falling, including 200,000 hip fractures, that occur annually in Americans over the age of 65. Data from the National Institute on Aging indicate that combined medical and surgical costs for care of individuals with hip fractures exceed \$8 billion per year. Accurate prevalence data on vestibular function is critical to improve the diagnosis and treatment of balance disorders.

The specific objectives of this component are: 1) to obtain accurate prevalence data on disorders of balance and vestibular function; 2) to examine the relationship between balance disorders and other covariates, such as certain medical conditions and health status; and 3) to characterize normal and disordered balance and spatial orientation.

Staff:

Health technician trained in modified Romberg test

Protocol:

Methods:

The balance function component of NHANES will be performed on a half-sample of adults ages 40-69 using the standard Romberg test as a measure of postural sway. This test is performed on normal and compliant support surfaces in a corner of a room in the MEC with a chair placed behind the participant. The subject is instructed to maintain standing balance without shoes for 15 seconds under each of four conditions that reduce or eliminate input from the sensory avenues of vision and/or proprioception: normal support surface with eyes open; normal support surface with eyes closed; compliant support surface with eyes open; and, compliant support surface with eyes closed. This test is a pass/fail examination, with failure defined as having occurred if the subject begins to fall within 15 seconds. Increased sway without indication of falling is not considered abnormal. The medical technician stands immediately to the side of the participant prepared to stabilize the participant by use of the safety belt.

Time Allotment:

6 to 7 minutes

Health Measures:

Identification of balance disordered individuals

Eligibility:

Participants aged 40-69 who do not meet exclusion criteria

Exclusion Criteria:

Participants who are unable to stand

Justification for using vulnerable populations:

There is no reason to exclude mentally impaired or handicapped individuals because there is no contraindication if they can understand exam instructions.

Risks:

Minimal risk of falling

Report of findings:

None

Body Composition - Bioelectrical Impedance Analysis (BIA)

Public Health Objectives:

Evaluation of body composition will: 1) provide nationally representative data on body composition (lean and fat tissue), overall and for age, gender, and racial/ethnic groups; 2) provide estimates of the prevalence of obesity, as distinct from overweight; 3) provide data to study the association between body composition and other health conditions and risk factors, such as cardiovascular disease, diabetes, hypertension, and activity and dietary patterns; and 4) provide nationally representative data from a simple measurement (BIA) to develop equations to estimate body composition as measured by a more expensive and complicated measurement (dual-energy x-ray absorptiometry). BIA was successfully introduced into NHANES III (1988-94).

Staff:

Health technician (MEC).

Protocol:

Methods:

The sample person lies on his/her back and electrodes are placed on the wrists and ankles. A low-level alternating current (< 1 mA) is delivered and impedance through the body fluids is measured using the BIA equipment.

Time Allotment:

3 minutes.

Health Measures:

Resistance, reactance, impedance (all in ohms), and phase angle (degrees) are determined at 50 distinct frequencies between 5KHz and 1MHz. Prediction equations can use these values to estimate extra- and intra-cellular water content, and by further estimation, lean tissue and adipose tissue. However, these outcomes will not be calculated because of lack of consensus on the appropriate equations.

Eligibility:

Sample persons aged 8- 49 years who do not meet any of the exclusion criteria.

Exclusion Criteria:

- Any amputations other than fingers or toes
- Artificial joint or any orthopedic hardware
- Pacemaker or automatic defibrillator
- History of radiographic contrast material (barium) use in past 72 hours
- Coronary stents or metal suture material.

Justification for using vulnerable populations:

- Minors are included in the body composition assessment to develop simple measures of body composition for this age group.
- Mentally impaired individuals will not be excluded from body composition because there is no contraindication.

Risks:

- Minimal risk.
- There is no shock and the current is not perceptible. The BIA procedure is safe because of the following three factors: 1) no adverse event has been reported in the course of thousands of individuals undergoing measurement, 2) the test frequencies (5KHz - 1MHz) are unlikely to stimulate electrically excitable tissues, such as nerves or cardiac muscle, and 3) the relatively small test current is less than the threshold of perception.
- Although there has been no risk or contraindication reported, experts in the field recommend that measurements *not* be performed on people with implanted defibrillators, pacemakers, stents, metal suture material in the heart or great vessels, metal pins, or artificial joints.

Report of findings:

Because there is no consensus on appropriate prediction equations for all populations, no outcomes that are meaningful to participants will be obtained. Therefore, no findings will be reported to the participant.

Body Composition - Dual-energy X-ray Absorptiometry (DXA)

Public Health Objectives:

Evaluation of body composition will: 1) provide nationally representative data on body composition (bone, lean, and fat tissue), overall and for age, gender, and racial/ethnic groups; 2) provide estimates of the prevalence of obesity, as distinct from overweight; 3) provide estimates of low bone density/osteoporosis; 4) provide data to study the association between body composition and other health conditions and risk factors, such as cardiovascular disease, diabetes, hypertension, and activity and dietary patterns; and 5) provide nationally representative data from a sophisticated instrument (DXA) to allow development of equations to estimate lean and fat composition from a simple measurement (BIA).

Information on bone, lean, and fat content is obtained by DXA. The importance of lean and fat tissue in relation to obesity and chronic disease has been addressed in the section on BIA. Therefore, this section focuses on the bone measure aspect of DXA.

It has been estimated that the annual cost of osteoporosis is about \$10 billion. The magnitude of this problem is likely to increase dramatically over the next few decades as the population ages. The risk of hip fractures (the most costly fractures in terms of morbidity, mortality and health care costs) begins to increase exponentially after age 65. Important pieces of data are not currently available about the changes in bone mass in the population, especially in minority populations. There are no data on total body bone measures from a nationally representative sample. Measures of total body bone mineral content or density will allow researchers to gain insights into age, sex, and racial/ethnic differences in the skeleton relative to other measures of body composition such as total muscle and fat mass, as well as behavioral factors such as diet and activity.

NHANES is the only nationally representative survey that can shed light on when peak bone mass is attained and the degree of total body bone loss with age. Childhood and adolescence are the periods to target for intervention strategies in osteoporosis. Measurement in younger individuals will provide insight into early racial/ethnic differences in the rate of bone accretion. This information is vital to all aspects of treatment and prevention of this disease and is particularly critical to government funding of related research, medical screening, treatment, and reimbursement programs.

Staff:

Health Technician (MEC)

Protocol:

Methods:

Dual-energy X-ray absorptiometry delivers a small amount of radiation through a scanning arm while the participant lies in the supine position.

Time Allotment:

Scan time is 3 minutes; 10 minutes are allowed for the procedure.

Health Measures:

Values are obtained for the total body and for each arm, each leg, the trunk and head. Bone measures may also be obtained for pelvis, left and right ribs, thoracic and lumbar spine.

- Total body tissue (gm)
- Bone mineral content (gm)
- Bone area (cm²)
- Bone mineral density (gm/cm²)
- Fat content (gm)
- Lean mass (gm)
- Lean mass plus bone mineral content (gm)
- Percent fat (%)

Eligibility:

Sample persons aged 8 years and older who do not meet any of the exclusion criteria.

Exclusion Criteria:

- Any amputations other than fingers or toes
- Pregnancy

Risks:

- Artificial joint or any orthopedic hardware
- Pacemaker or automatic defibrillator
- History of radiographic contrast material (barium) use in past 72 hours
- Coronary stents or metal suture material.

Minimal risk. The total radiation dose is extremely low, 0.01 to 0.04 mrem, which is within the range of background radiation and considerably less than conventional X-rays. A chest X-ray, for example, delivers a radiation dose of 40 mrem.

Justification for using vulnerable populations:

- Males under 18 are included in the DXA assessment to obtain information on critical periods for bone accretion.
- Pregnant women will be excluded from DXA because of the radiation exposure, however minimal.
- Mentally impaired individuals will not be excluded from body composition because there is no contraindication.

Report of findings:

- MEC None
- NCHS

Level 1: None

Level 2: DXA grader will fax any abnormal pathology to DHES physician (e.g., abnormal densities, fracture). Physician will call participant and send report when appropriate.

Level 3: Total bone mineral density (BMD) and interpretation using the T-score from analyzed whole body scan, and % total body fat. Males will be analyzed as if they were females because the reference group includes only females.

Text as it appears in final report:

The whole body DXA scan provides two pieces of health information; the first is your percent body fat and the second is your bone density.

The body composition analysis showed that your total body fat is ____%

The percentage of body fat varies considerably among normal people. <If age < 17 print statement A; else print statement B>

Statement A. For boys between the ages of 6 and 16, percent body fat normally ranges from about 5% to 26%. (note: norms for girls tbd)

Statement B. For adults, the percentages reach up to 30% for men and 35% for women in middle age.

IF SP is \$ 20 years of age:

The bone density measurement can help identify persons who may be at greater risk for fracture because they have weaker bones. In general, a lower bone density means that the bone is weaker. However, not all men or women with low bone density will have fractures.

The results from your whole body scan show that your bone density is _____g/cm², and your T-score is _____. Compared with young adults, your bone density is <insert statement>.

Statement choices
 If examinees T-score is \$ -1.0 insert **normal**
 If examinees T-score is less than -1.0 but greater than -2.5 insert **low**
 If examinees T-score is # -2.5 **very low**

<If T-score is # -2.5 print the following:> Most people develop low bone density over many years and you should not be alarmed. We do recommend that you discuss these results with your doctor in the near future. Your doctor may wish to do another bone density test of your spine or hip, since fractures due to osteoporosis often occur at these sites.

<If T-score is > -2.5 print the following:> The whole body scan is used for research only. This type of scan gives information on the bone density of your skeleton. The fragility of your spine or hip are best evaluated by DXA scans of those specific areas.

Else if SP is < 20 years of age:

This is the first time that bone density in young people is being measured in a national survey. We are using this information to learn about bone formation in your age group. We will not be able to give you results about your bone density until we know what typical bone density is in your age group. Your participation is helping us determine this.

Body Measurements - Anthropometry

Public Health Objectives:

Evaluation of body measurements (anthropometry) will: 1) provide nationally representative data on selected body measures, overall and for age, gender, and racial/ethnic groups; 2) provide estimates of the prevalence of overweight; 3) provide data to study the association between body measures and body composition, other health conditions and risk factors, such as cardiovascular disease, diabetes, hypertension, and activity and dietary patterns; and 4) monitor growth and development in children.

Overweight and obesity are important nutrition-related public health problems. The recent increase in overweight prevalence among all sex, age, and racial-ethnic groups has been called an epidemic. NHANES is unique in collecting nationally representative measured data on body measures and composition. Body measures data from NHANES are used to provide representative reference data, set health objectives, and monitor trends. Anthropometry data have been collected with comparable methods since the first National Health Examination Survey (1960-62).

Staff:

Health technician (MEC): (second person needed for young children)

Protocol:

Methods:

- Weight: the participant will stand on a digital scale that is connected to the ISIS system.
- Stature and recumbent length: measured with an electronic stadiometer that is connected to the ISIS system.
- Other lengths and circumferences: measured with a metal tape.
- Skinfolds: measured with a skinfold caliper.

Time Allotment:

Range 4-5 minutes.

Health Measures:

	Birth+	2mo+	2yr+	4yr+	8yr+
Head Circumference	Y	Y (through 6 months)			
Weight	Y	Y	Y	Y	Y
Upper Leg Length					Y
Maximal calf circumference					Y
Recumbent Length	Y	Y	Y		
Standing Height			Y	Y	Y
Upper Arm Length		Y	Y	Y	Y
Arm Circumference		Y	Y	Y	Y
Waist Circumference			Y	Y	Y
Thigh Circumference					Y
Triceps Skinfold		Y	Y	Y	Y
Subscapular Skinfold		Y	Y	Y	Y

Eligibility:

All sample persons. See Health Measures table for age-eligibility.

Exclusion Criteria:

None

Justification for using vulnerable populations:

- Minors are included in this component because they are an important target population group. Body composition findings are linked to other household interview and health component data and are used to track changes that occur in health over time.
- There is no reason to exclude mentally impaired or handicapped individuals because there is no contraindication if they can understand exam instructions.

Cardiovascular Fitness

Public Health Objectives:

Low levels of physical activity and physical fitness are surely the most important public health problem on which we have such limited data. Reports on population attributable risk place inactivity in the same general category as tobacco use and unhealthful diet as problems, yet the amount of data from nationally representative samples on smoking and diet is several orders of magnitude greater than the data on physical activity, and there are no data on physical fitness on a nationally representative population of U.S. adults.

Evaluation of cardiovascular fitness will: 1) provide nationally representative data on cardiovascular fitness; 2) estimate the prevalence of persons at risk due to poor physical fitness; and 3) provide data to study the association between cardiovascular fitness and other health conditions and risk factors, such as obesity, cardiovascular disease, diabetes, hypertension, and activity and dietary patterns.

Staff:

Health technician (MEC) and physician

Protocol:

Methods:

The protocol is a submaximal exercise test. The exam consists of a 2 minute warm up, two 3 minute exercise periods, and a 3 minute recovery period. The grade and speed of the treadmill during exercise are determined by: 1) the participant's physical activity readiness determined by responses to the household interview, 2) age, and 3) BMI. During the first stage of the exercise period, the participant should attain approximately 55-65% of age-predicted maximal heart rate (APMHR). During the second stage, the participant should attain approximately 70-80% APMHR.

Time Allotment:

22 minutes

Health Measures:

Pre-test heart rate and blood pressures will be captured and stored by ISIS. Additionally, at the end of warm-up, each exercise stage, and each minute of recovery, the ISIS will capture:

- Heart rate (bpm)
- Systolic blood pressure (mm Hg)
- Diastolic blood pressure (mm Hg)
- Treadmill speed and grade (mph, %)

From the exercise heart rate and treadmill settings, maximal work capacity will be predicted. Predicted maximal work capacity is the measure of fitness obtained.

Eligibility:

Sample persons aged 12-49 years who do not meet any of the exclusion criteria

Exclusion Criteria:

All persons not excluded by household questionnaire will be evaluated by the MEC physician for eligibility for the CV fitness component. Physician will follow the protocol for medical exclusion based on responses to safety exclusion questions, pulse and blood pressure.

Exclusions based on household interview and/or other components:

- Any amputations of legs and feet other than toes
- Self reported weight > 350 pounds, exclude
- Pacemaker or automatic defibrillator
- Pregnancy greater than 12 weeks

Exclusions based on household interview

- Medical Conditions and Health Status (COQ) (if 1, 7, or 9 exclude)
- COQ.160b Congestive heart failure
 - COQ.160c Coronary heart disease
 - COQ.160d Angina pectoris
 - COQ.160e Myocardial infarction
 - COQ.160f Stroke
 - COQ.160 Emphysema
- Physical Functioning - (PFQ) - (if 3, 4, 7, or 9, exclude)
- PFQ.060b Difficulty walking for a quarter mile (2-3 blocks)
 - PFQ.060c Difficulty walking up 10 steps without resting

- PFQ.060h Walking from one room to another on the same level
- PFQ060I Standing up from an armless straight chair
(if 1,7, or 9, exclude)
- PFQ.090 Use of a device such as a cane or wheelchair
(if 2,5,6,7,8,10,12,16, 97, 99 exclude)
- PFQ.067 2=Back or Neck Problem
5=Depression/Anxiety/Emotional Problem
6=Developmental Problems (Cerebral Palsy)
7=Diabetes
10=Heart Problem
12=Lung/Breathing Problem
16=Stroke Problem
Diabetes (DIQ) (if 1,7, or 9, exclude)
- DIQ.080 Retinopathy
Cardiovascular (CAQ)- (if 1, 7, or 9)
- CAQ.030 Stop when walking at own pace on the level
- CAQ.040 SOB after walking 100 yards or few minutes on the level
- CAQ.050 PND
- CAQ.060 PND relieved by sitting on side of bed
- CAQ.070 Orthopnea
Respiratory Health (RSQ) - (if 55 {code for 12 or more attacks}, 77, or 99 exclude)
- RSQ.080 Wheezing in past 12 months (if 1,7,or 9, exclude)
- RSQ.110 Wheezing that limits speech (last 12 months)
- Vision (VSQ) -
- VSQ.020 Blind (if 1,7, or 9, exclude)
- VSQ.030 Very poor eyesight (if 1,7, or 9, exclude)
- DSQ.240 medications will be available in SP History in Physician's Exam. Physician will check this list and exclude based on medication on the Exclusion list below. (See questions 9-14 below)

Cardiovascular Safety and Exclusion Questions (Asked in Physician's Exam):

(If Yes or Don't Know, exclude unless otherwise indicated)

1. Have you been hospitalized in the past 3 months? (See exclusion list below)
2. (12-19 years only) Has a doctor ever said you should not participate in sports or other activities because of a health condition?
3. Has a doctor ever said you have a heart condition and that you should only do physical activity recommended by a doctor?
4. (20-49 years only) Do you feel pain in your chest when you do physical activity?
5. (20-49 years only) In the past month, have you had chest pain when you were not doing physical activity? (Probe: Have you seen a medical doctor about your chest pain? Did the doctor tell you that the chest pain was related to your heart?)
6. Do you lose your balance because of dizziness? (Probe: Is this an isolated incident or does it occur on a regular basis?)
7. Do you ever lose consciousness? (Probes: Did this occur as a result of illness or was it unexplained? Is this an isolated incident or does it occur on a regular basis?)
8. Do you have a bone or joint problem that could be made worse by walking? (Probe: Do you think you can do the test without injuring yourself?)
9. Are you currently taking any prescription medications? (yes go to 10, no go to 15)
10. Are you currently taking any prescription medications for your blood pressure? (yes go to 11, no go to 14)
11. What is the name of this medication? _____.
(If medication is on list, exclude. If not on list, go to 12.)
12. Are you taking any other medication for your blood pressure? (Yes, go to 13/ No go to 14./Don't Know, exclude.)
13. What is the name of this medication? _____.
(If medication is on list, exclude. If not on list, go to 14.)

14. Are you currently taking prescription medications for the following conditions:
 - heart condition Yes/No/Don't Know (If Yes or Don't Know, exclude)
 - prescription eye drops for glaucoma (If Yes or Don't Know, exclude)
15. Do you know of any other reason why you should not do a treadmill test?

Question 1: List of reasons for exclusion based on hospitalization from ACSM Guidelines, 5th edition, page 42.

- A recent significant change in the resting ECG suggesting infarction or other acute cardiac event.
- Recent complicated myocardial infarction
- Unstable angina
- Uncontrolled ventricular arrhythmia
- Uncontrolled atrial arrhythmia that compromises cardiac function
- Third degree AV heart block
- Acute congestive heart failure
- Severe aortic stenosis
- Suspected or known dissecting aneurysm
- Active or suspected myocarditis or pericarditis
- Thrombophlebitis or intracardiac thrombi
- Recent systemic or pulmonary embolus
- Acute infections
- Significant emotional distress (psychosis)
- Moderate valvular heart disease
- Known electrolyte abnormalities
- Fixed rate pacemaker
- Frequent or complex ventricular ectopy
- Ventricular aneurysm
- Uncontrolled metabolic disease (diabetes, thyrotoxicosis, myxedema, etc)
- Chronic infections disease (mononucleosis, hepatitis, AIDS)
- Neuromuscular, musculoskeletal, or rheumatoid disorders that are exacerbated by exercise
- Complicated pregnancy (N.B. this is an exception to the ASCM guidelines - the guidelines also include advanced pregnancy)

Questions 9-14: Exclusion Medication List

Antianginal Agents

Calcium Channel-Blockers
 Bepridil (Vascor) Diltiazem
 (Cardizem) Verapamil
 (Calan, Isoptin)

Anti Arrhythmics

Amiodarone (Cordarone)
 Bretylium (Bretylol)
 Disopyramide (Norpace)
 Encainide (Enkaid)
 Ethmozine (Moricizine)
 Flecainide (Tambocor)
 Lidocaine (Xylocaine, Xylocard)
 Mexiletine (Mexitil)
 Procainamide (Pronestyl, Procan SR)
 Propafenone
 Sotalol (Betapace)
 Tocainide (Tonocard)
 Quinidine (Quinidex, Quinaglute)

Beta Blockers

Acebutolol (Sectral)
Atenolol (Tenormin)
Betaxolol (Kerlone)
Bisoprolol (Zebeta)
Cartelol (Cartrol)
Labetalol (Normodyne)
Metoprolol tartrate (Lopressor)
Nadolol (Corgard)
Pindolol (Visken)
Propranolol (Inderal)
Timolol (Blocardren)

Eye Drops

Betoptic Eyedrops
Timoptic Eyedrops

Nitrates and Nitroglycerin

Isosorbide dinitrate (Isordil, Diltrate)
Nitroglycerin (Nitrostat, Nitrolingual spray)
Nitroglycerin ointment (Nitrol ointment)
Nitroglycerin patches (Transderm Nitro, Nitro-Dur II, Nitrodisc)
Isosorbide mononitrate (Ismo, Monoket)
Pentaerythritol tetranitrate (Cardilate)

Digitalis

Digoxin (Lanoxin)

Physician exam exclusions: If participants resting pulse rate is > 100 bpm or systolic blood pressure > 180 mm Hg.

Criteria for stopping during the fitness protocol:

- Onset of angina or angina-like symptoms
- Significant drop (20mmHg) in SBP or a failure of the SBP to rise with an increase in exercise intensity
- Excessive rise in BP: SBP >260 mmHg or DBP >115 mmHg
- Signs of poor perfusion: lightheadedness, confusion, ataxia, pallor, cyanosis, nausea, or cold and clammy skin
- Failure of heart rate to increase with increased exercise intensity
- Subject requests to stop
- Physical or verbal manifestations of severe fatigue
- Unusual or severe shortness of breath
- Leg pains or cramps
- Failure of the testing equipment
- Severe headache
- Visual disturbances
- %HR_{max} >90% and SP appears/feels exhausted
- Unable to complete test without holding on to the handrail

Justification for using vulnerable populations:

- Minors are included in the cardiovascular fitness assessment to obtain information on fitness among adolescents.
- Pregnant women will be excluded from fitness testing because physiologic changes with pregnancy affect heart rate, and therefore the interpretation of the data. The exclusion also considers safety.
- Mentally impaired individuals will be excluded from the treadmill test.

Risks:

- There is much experience across the country to suggest that submaximal testing in a healthy population

poses minimal health risk. Persons with any conditions that may increase risk of adverse outcome on the treadmill will be excluded. Risk associated with this test in a screened population include fatigue, muscle soreness, exercise-induced asthma, and chest tightness.

- The Cooper Institute for Aerobic Research and Stanford University have conducted tens of thousands of submaximal tests similar to what is proposed in NHANES. These tests were conducted in community survey centers and work-site health promotion programs. They were done after screening and determination of eligibility by a nurse or exercise technician with no physician supervision, other than supervising training and monitoring for quality control. There have been no complications from these tests. No one even missed 30 minutes of work due to delay caused by some incident related to the exercise test. This accumulated experience also points to the low risk associated with submaximal exercise testing in an apparently healthy population. There is also no problem associated with conducting the exercise test after venipuncture. That is the procedure followed in most exercise laboratories including the Cooper Clinic and Stanford surveys since exercise changes hemoconcentration and provides inaccurate readings for lipids etc.

Report of findings:

MEC:

Level 1: MEC Physician notified if participant has acute chest pain, acute respiratory distress or signs of hemodynamic instability. If the participant is deemed medically unstable, emergency medical procedures will be instituted.

Level 2: If the MEC Physician determines that a condition discovered during fitness testing requires follow-up by a community physician, a referral will be made.

Level 3: Grade, speed, test duration, and general fitness classification relative to same sex and age group based on estimated maximum work capacity (V02 max).

Text in MEC report is as follows:

Your fitness test was done on a treadmill. The test consisted of a warm-up, two exercise periods (stage 1 and stage 2), and a recovery period. The table below shows your test results.

Stage	Required Time	Your Time	Your Heart Rate
Warmup	2 min		
Stage 1	3 min		
Stage 2	3 min		
Recovery	2 – 3 min(s)		

During this exercise your maximum incline on the treadmill was __%, and your maximum speed was __mph. Compared with other people of your age and sex, your cardiovascular fitness level is _____. (Superior, excellent, good, fair, poor, very poor).

Dermatology Examination

Public Health Objective:

One in three Americans has a skin condition serious enough to require medical attention. However, there are major gaps in knowledge about the frequency, impact, etiology, and prevention of most skin diseases.

A review of current literature shows that psoriasis affects health-related quality of life (HRQOL) in ways similar to other major medical conditions. The impact on HRQOL can be seen in physical, emotional, and social measures. Studies of disability caused by psoriasis indicate that the levels of disability for those with the condition are greater than for those of healthy controls. There is also an association between psoriasis, stress, and depression.

Hand dermatitis is the most common occupational skin disease, as well as a common cause of occupational disability. Acute eczematous dermatitis is one of the few skin diseases that, according to the Americans with Disabilities Act of 1990, may still be used as a reason for exclusion from employment. The estimated cost associated with this condition is greater than \$300 million dollars a year.

Fitzpatrick skin type is a method of classifying individuals based on their response to sun exposure in terms of tanning or burning (photosensitivity). Individuals' susceptibility to different skin diseases is known to vary by skin type. In addition, skin type has been used to help determine starting doses for phototherapy and to assess the possibility of cutaneous side-effects of certain dermatologic treatments. Under the Americans with Disabilities Act of 1990, photosensitivity is an allowable exclusion criterion for outdoor workers. Currently, the distribution of skin type across the U.S. population is unknown. Knowing more about the U.S. distribution of skin type will be helpful in developing more accurate measures of risk factors for various skin diseases. It may also be important to the development of better national health education campaigns regarding sun protective behavior.

Staff:

Health technician

Equipment:

Kodak DCS760 digital camera with 50mm lens.

Protocol:

The exam consists of four digital images taken by a health technician (with a Kodak DCS760 digital camera with 50mm lens) as follows:

Picture A: "BACK with ELBOWS"



- a. Subject is positioned facing the mirror in the body measure room.
- b. Back of gown is opened and clipped to expose Subject's back.
- c. Sticky rule is placed on Subject's back.
- d. Camera is in horizontal position.
- e. Arms are rotated out to square up the elbows.
- f. Hands are not critical in this shot.
- g. *Top of shot at Subject's neck (no head).*
- h. *Camera focus indicator is on Subject's spine.*

Picture B: "INNER ARM"



- a. Subject's gown is closed and they are instructed to turn around and face the camera.
- b. Subject extends the left arm to the left side, with palm up.
- c. *Top of shot is Subject's neck (no head).*

Picture C: "FRONT OF LEGS with HANDS"



- a. Subject is instructed to face the camera.
- b. Subject places hands on lower abdomen, with fingers extended, for tops of hands
- c. *Bottom of shot is Subject's booties.*
- d. *Camera focus indicator is on front of Subject's gown.*

Picture D. "BACK OF LEGS with PALMS"



- a. Subject is instructed to turn and face the door.
- b. Subject places hands behind back on lower hips, with palms flattened and fingers spread.
- c. *Bottom of shot is Subject's booties.*
- d. *Camera focus indicator is on back of Subject's gown.*

Eligibility:

Sample persons aged 20–59 years who do not meet any of the exclusion criteria.

Exclusion Criteria:

A person who is unable to stand unassisted would not receive this examination.

There are no other safety exclusions for this component.

Justification for using vulnerable populations:

Mentally impaired individuals will not be excluded from the dermatology exam because there are no contraindications. However, guardians will receive the report of findings and facilitate any referral if necessary.

Risks:

None.

Special precautions:

A chaperone will be made available should the SP request one.

Report of findings:

MEC: None

NCHS Level 1: Moles or lesions suspicious of melanoma or other malignancies. Report faxed directly from NIH dermatologist to DHES medical officer. Officer will call SP with findings in addition to sending report.

Level 2: Presence of eczematous dermatitis or other clinically relevant skin condition will be reported by letter to sample person.

Level 3: None

Lower Extremity Disease

Public Health Objective:

Lower extremity disease is disabling and costly among the elderly and persons with diabetes. The major manifestations of lower extremity disease are peripheral vascular disease and peripheral neuropathy. Late-stage complications are chronic ulcers, gangrene, and amputation. Lower extremity disease is associated with increased susceptibility to falls. Few population-based studies have been conducted and no national examination data exist on lower extremity disease and its risk factors. The Health Resources and Services Administration has launched a major initiative called the Lower Extremity Amputation Prevention Program, and would benefit from population-based data to help monitor this effort.

Information on the prevalence of lower extremity disease, especially in its early stages, and associated risk factors will be used to help develop early intervention and prevention programs for the disabling consequences of this condition. Specifically, the lower extremity disease examination will provide population data to: 1) determine a national estimate of lower extremity disease prevalence (diagnosed and undiagnosed), including those at high risk for the late complications of the disease (i.e., ulceration and amputation); 2) identify the risk factors of lower extremity disease; 3) permit a national cohort to be established for follow-up studies of this condition; and 4) provide critical information to clinicians and public health officials for the development of preventive care and community-based interventions.

Staff:

Health technician (MEC)

Protocol:

Methods:

- Peripheral vascular disease is assessed by the ratio between systolic blood pressure in the lower legs to that in the arm. Systolic pressure will be measured in one arm (brachial vessel, right arm if accessible) and both ankles (posterior tibial vessels). Each pressure will be measured twice in SP's age 40-59, while each will be measured only once for SP's 60 and above to reduce the time for this component in that age group.
- The feet will be examined for the presence of amputations, lesions, and bunions.
- Peripheral neuropathy is assessed by ability to feel slight pressure applied with a standard monofilament to the bottom of the foot at 3 sites. If an incorrect answer is given at any site, the test will be repeated at that site up to a total of three times.

Time Allotment:

15-18 minutes depending on age of examinee

Health Measures:

Peripheral vascular disease - systolic blood pressures (mm Hg):

- Brachial
- Right Posterior Tibial
- Left Posterior Tibial

Calculated means and ratios

Foot abnormalities - presence or absence of:

- Amputations (entire foot, partial foot, great toe, other toes)
- Lesions or bandages
- Bunions

Peripheral neuropathy - correct response, incorrect response, or inability to detect monofilament pressure on each foot at:

- Metatarsal Head 1
- Metatarsal Head 5
- Halux

Eligibility:

Sample persons aged 40 years and older who do not meet any of the exclusion criteria.

Exclusion Criteria:

- Bilateral above the knee or below the knee amputations
- Rash or open wound on both arms that would interfere with accurate measurement or would cause discomfort to the participant, exclude from the peripheral vascular disease measures.

Justification for using vulnerable populations:

- Minors are included in this component because they are an important target population group. Oral health findings are linked to other household interview and health component data and are used to track changes that occur in health over time.
- There is no reason to exclude mentally impaired or handicapped individuals because there is no contraindication.

Risks:

Minimal risks. These include possible discomfort, bleeding, and potential dislodging of already loose restorative material. There will be no exposure to radiation (no x-rays), hazardous material (no use of mercury) and no use of anesthetic agents.

Special precautions:

If the respondent reports a latex allergy, the dentist will wear vinyl gloves.

Report of Findings:

MEC:

- Level 1: Oral lesions requiring emergent attention -(e.g., abscess, oral cancer). Dentist will generate a referral letter for participant to take to oral health care provider.
- Level 2: Oral pathology requiring follow-up (e.g., severe periodontal disease or caries).Dentist will generate a referral letter for participant to take to oral health care provider.
- Level 3: Dentist will indicate participant should see dentist at his/her earliest convenience.
- Level 4: Dentist will refer participant to continue with routine dental visits.

Text as it appears in MEC report:

The dental examination of the National Health and Nutrition Examination Survey is not, and is not intended to be, a substitute for the examination usually given to persons seeking care from their own dentists.

Neither a dental history nor x-rays are taken, and therefore the findings are solely the result of what can be seen at the time of the examination.

The examining dentist recommends that you **Statement A** <part B> because of the following conditions:

Statement B

Statement A

1. see a dentist immediately
2. see your dentist within the next 2 weeks
3. see your dentist at the earliest convenience
4. continue your regular routine care

Statement B

1. decayed teeth
2. gum problems/disease
3. oral hygiene
4. clinical impression of a soft tissue condition
5. some other findings (See referral letter) **Attachment 33**
6. no significant findings

Physical Activity Monitor (PAM) Component

Public Health Objectives:

The primary objective of the component is to assess intensity and duration of physical activity levels of U.S. children and adults. *The U.S. Surgeon General's Report on Physical Activity and Health* reported that more than 60 percent of Americans do not engage in regular physical activity and that 25 percent do not engage in any activity. The report reaffirmed the importance of regular moderate or vigorous-intensity activity. Until now, it has been difficult to assess actual physical activity levels in freelifing populations because the cost and complexity of performing the monitoring tasks required to obtain this information were prohibitive. Physical activity data on children, particularly children in the 6-11 year age group are lacking. Proxy information on physical activity levels among youth are not useful because children spend large amounts of time away from home and they also engage in sporadic periods of activity that are difficult to document, let alone quantify. Activity monitors provide a reliable, objective, and accurate method to assess the intensity and duration of physical activity levels in children and adults.

Staff:

A trained health or medical technician initializes the activity monitors in the mobile examination center (MEC).

Protocol:

Examined persons are asked to wear the monitor for 7 days during normal waking hours. The monitors are not waterproof and must be removed prior to swimming or bathing. The monitor is worn on a flexible waist belt and can be removed easily. After 7 days of wear, participants return the monitor by mail in a postage-paid envelope. Respondents receive \$40 remuneration for returning their monitors.

Eligibility:

Ambulatory subjects 6 years of age and over are asked to wear activity monitors.

Time Requirement:

It takes approximately three (3) minutes to explain the component, initialize the monitor to record information, and fit the monitor belt on each subject.

Device:

The ActiGraph (formerly MTI/CSA) Model 7164 accelerometer manufactured by ActiGraph, Ft. Walton Beach, FL is used. Devices are calibrated prior to use in the study. The device is worn on an elastic waist belt over the right hip (underneath clothing).

Report of findings:

There is no report of findings for this component.

Vision

Public Health Objectives:

Eye diseases cause suffering, disability and loss of productivity for millions of people in the United States. In economic terms, eye disease and blindness are estimated to cost the U.S. in excess of \$22 billion each year. No high-quality, up-to-date information exists on the prevalence of visual impairment and the major causes of visual impairment in the general population. These data are needed in planning health services, in monitoring changes in disease prevalence, in research program planning, in developing and testing hypotheses about eye disease etiology.

Data collected over 20 years ago in the NHANES I (self-reported history questions and full vision examination with dilation) continue to be the only source of national prevalence data on eye disease and visual acuity impairment and there are no data on visual field impairment. Changes in disease definitions, population demographics, diagnostic capabilities, and treatments for eye diseases make it important to obtain new national data about eye disease. The absence of such data has forced researchers to use blindness registry data that are almost 25 years old. These studies select mostly white populations or non-nationally representative populations.

The ophthalmic data from NHANES will be used to: 1) measure the prevalence of visual acuity impairment in the U.S. population (visual acuity worse than 20/40), by cause; 2) measure the distribution of refractive error in the U.S. population; 3) evaluate screening strategies for visual impairment and eye disease; and 4) evaluate functional impairment related to vision.

Staff:

Health technician (MEC)

Protocol:

Methods:

Best corrective vision

Visual acuity is measured with an autorefractor. The examinee puts his/her chin on the chin rest and focuses on a chart with numbers and letters in the autorefractor screen. Examinee is then asked to sequentially read the largest to smallest possible line on a built-in chart in the autorefractor. The technician isolates the smallest line read by the examinee with 1 error. With the examinee's eye focused on the line, the autorefractor quickly takes three repeated measurements, which is also known as objective refraction. These three auto-retinoscopy measurements, their average, and other measurements from the objective refraction are saved in a database. If required, these readings are further fine tuned to obtain best visual acuity based on objective refraction readings. Data from completed examinations are transferred to the ISIS and saved in a database.

Current Prescription

The Lensmeter reads the current prescription of the eyeglass. This data is transferred to the autorefractor and later saved in the ISIS database to compare the current correction with the best corrective vision obtained from the auto-refractor.

Near visual acuity

For the near visual acuity, older examinees are asked to read five lines of numbers and letters written on the near acuity card at the comfortable distance and this distance is measured and saved in the ISIS database.

Time Allotment:

Depends on age and vision of sample person. Range 7-8 minutes.

Health Measures:

The ophthalmic data from NHANES will be used to: 1) measure the prevalence of visual acuity impairment in the U.S. population (visual acuity worse than 20/40), by cause; 2) measure the distribution of refractive error in the U.S. population; 3) evaluate screening strategies for visual impairment and eye disease; and 4) evaluate functional impairment related to vision.

Eligibility:

All sample persons aged 12+ years will have the refraction exam for the best corrective vision. Visual acuity assessment using the near card will be performed only on persons 50 years and over.

Exclusion Criteria:

Any evidence of injury (eye patch or bandage) or severe infection (i.e., purulent discharge with redness in eye) in both eyes.

