New guidelines detail use of ‘infant-safe’ peanut to prevent allergy

by Scott H. Sicherer, M.D., FAAP

With a potentially huge public health impact, new AAP-endorsed guidelines outline a new approach that promises to reduce the risk of peanut allergy.

Estimated to affect 1%-2% of children, peanut allergy often is severe and lifelong. The new guidelines recommend early introduction of peanut protein for infants who are at increased risk of developing the allergy. They caution, however, that peanuts and peanut butter are choking hazards, and advise on forms that are safe for infants such as peanut butter smoothed into pureed fruits or vegetables.

Addendum Guidelines for the Prevention of Peanut Allergy in the United States: Report of the National Institute of Allergy and Infectious Diseases-Sponsored Expert Panel is available at http://dx.doi.org/10.1016/j.jaci.2016.10.010 and is co-published in the Journal of Allergy and Clinical Immunology and other journals.

The guidelines are based primarily on the results of the landmark Learning Early About Peanut (LEAP) trial (Du Toit G, et al. N Engl J Med. 2015;372:803-813). The study randomized 640 infants from 4-11 months of age with severe eczema and/or egg allergy to ingest or avoid peanut until 60 months of age. The study excluded infants with large positive skin prick tests (SPTs) to peanut, assuming they already were allergic, and stratified the enrolled infants as having no peanut SPT wheal or having one that was 1-4 millimeters in diameter.

The results showed that in the negative SPT group, the prevalence of peanut allergy at age 5 was 13.7% in the avoidance group vs. 1.9% in the consumption group.

Updated guideline advises on treating children with impacted cerumen

by Jesse M. Hackell, M.D., FAAP

An AAP-endorsed clinical practice guideline on the diagnosis and treatment of cerumen impaction focuses on primary prevention, the decision to intervene, and referral and coordination of care.

The updated guideline was released by the American Academy of Otolaryngology – Head and Neck Surgery Foundation. It is published in Otolaryngology — Head and Neck Surgery and is available at http://bit.ly/2j0y9O9.

Clinical Practice Guideline (Update): Earwax (Cerumen Impaction) is a revision of a 2008 guideline and includes evaluation of new evidence reviews, newly formulated action statements with an algorithm for implementation and enhanced tools for patient education. The authoring group represented otolaryngology, audiology, pediatrics, internal medicine, nursing and consumer health care advocacy, and the updated guideline has been endorsed by multiple professional societies.

Research Update

Study: Only 23% of youths with hypertension receive diagnosis

from the AAP Department of Research

Only 6% of children diagnosed with hypertension were prescribed antihypertensive medication within 12 months of diagnosis, the study also found.

Among U.S. children meeting clinical criteria for hypertension, few are given a diagnosis of hypertension and even fewer are being treated with medication. These findings are detailed in a recently published study involving the AAP Pediatric Research in Office Settings (PROS) network (Kaelber DC, et al. Pediatrics. 2016;138:e20162195).

Prior research has shown that hypertension is underdiagnosed among children, and untreated hypertension can have negative effects on child development and health over time. The current study used a large national sample of electronic health records (EHRs) from more than 1.2 million children in 196 pediatric primary care practices to determine how frequently hypertension is diagnosed and treated.

Data came from analyses of EHRs from 398,079 children ages 3-18 years who had three or more primary care visits between 1999 and 2014 where both blood pressure and height were mea-

In this issue

Common legal questions answered

Committee on Medical Liability and Risk Management member answers questions about practicing across state lines, tail insurance. Page 18

Updated policy on confidential care

Pregnant adolescents have the right to confidential care when seeking abortion services, according to an updated AAP policy. Page 26
Many parents use time-outs incorrectly


More than three-quarters of parents reported using time-outs to manage their child’s misbehavior, but the vast majority made at least one implementation error, according to a survey of 401 parents of children ages 15 months to 10 years.

Time-out is based on removing positive reinforcement such as social attention and access to physical objects. Evidence shows it is effective in reducing behaviors such as aggression and noncompliance. It also is the most widely used disciplinary method among parents and is commonly recommended by primary care providers.

The authors of this study, however, noted that many parents report the procedure does not work. Therefore, they set out to determine how parents use time-outs.

Parents who visited a primary care clinic were recruited to complete a survey that asked about their discipline practices, how difficult it was to manage their child’s behavior, perception of time-out and how they implemented the procedure.

About 77% had used time-out, and 70% said it usually or always was effective. However, 85% reported using at least one technique that was counter to evidence-based practices, and 64% made multiple implementation errors. The most common mistakes were giving the child multiple warnings before putting him or her in time-out, talking to the child during time-out, and allowing the child access to toys, books, electronics or other people.

Parents who said time-out was effective were more likely to use the method correctly.

The authors said clinicians should advise parents to give one warning then a short reason for the time-out (e.g. “no hitting”). Parents should not talk to their child during the time-out, and they should reduce the child’s access to stimulation. If a child tries to escape, the parent should return him or her to the time-out area with minimal interaction.

“Ultimately, counseling on TO (time-out) may be misguided or ineffective for many families until more positive parenting practices are established,” the authors concluded.

Drug-resistant bacteria in children a growing problem


The prevalence of multidrug-resistant (MDR) and carbapenem-resistant (CR) *Pseudomonas aeruginosa* infections in children increased significantly from 1999 to 2012, according to data from a national surveillance network.

*P. aeruginosa* is responsible for about 51,000 health care-associated infections in adults and children each year, according to the Centers for Disease Control and Prevention. More than 6,000 of the infections (13%) are MDR and account for 400 deaths.

Most studies have focused on *P. aeruginosa* infections in patients with cystic fibrosis, and none have looked at MDR or CR *P. aeruginosa* infections in children. Therefore, the authors of this study assessed the epidemiology of *P. aeruginosa* isolates from children without cystic fibrosis and analyzed trends in antibiotic resistance.

Researchers used antibiotic-susceptibility data from about 300 inpatient, outpatient and long-term care facilities to identify MDR and CR *P. aeruginosa* isolates in 77,349 patients ages 1-17 years.

Results showed 20.2% were MDR, 11.3% were CR and 8.4% were MDR and CR.

From 1999 to 2012, MDR isolates increased from 15.4% to 26%, while CR isolates rose from 9.4% to 20%.

After adjusting for year, patient and isolate characteristics, the prevalence of MDR and CR *P. aeruginosa* was highest among children ages 13-17 years, in the West North Central region of the U.S. and in respiratory specimens.

The prevalence of CR *P. aeruginosa* was highest among patients in intensive care units, while MDR prevalence was highest among children in long-term care facilities.

The increase in MDR *P. aeruginosa* strains could be due to increases in prescriptions for third- and fourth-generation cephalosporins and other broad-spectrum agents in outpatient settings, according to the authors.

“The results of our study highlight the need for bacterial surveillance, strategies for implementing effective infection-prevention, and antimicrobial stewardship programs,” they concluded.

Pertussis among infants younger than 1 year of age remains high


The pertussis rate among infants younger than 12 months of age is high, and the incidence is highest among 3-month-olds, according to a nationwide study of 1.2 million infants.

Pertussis is the least-controlled bacterial disease for which a vaccine is universally recommended, according to the Centers for Disease Control and Prevention. However, limited data are available on the disease burden in U.S. infants.

Using databases of commercial health plans around the country, researchers estimated the incidence of pertussis in infants younger than 1 year of age who were born between July 2005 and September 2010. They also sought to identify factors associated with a pertussis diagnosis by comparing each infant diagnosed with pertussis with 10 matched infants without the disease.

Results showed 1,023 infants were diagnosed with pertussis during the study period. In the two weeks before their diagnosis, infants were 18 times more likely than their matches to have been treated for a cough, seven times more likely to have a wheezing-related illness and nearly six times more likely to have an acute upper respiratory infection.

The difference in health care costs between the two groups was highest among 1- and 2-month-olds at $18,781 and $15,446, respectively.

About half of both groups had received at least one dose of diphtheria, tetanus and acellular pertussis vaccine prior to the date of the pertussis diagnosis in the affected infant.

“This study supports the CDC decision to protect infants from exposure to the pertussis organism by recommending a dose of reduced-antigen Tdap vaccine to each pregnant woman between 27 and 36 weeks gestation during each pregnancy and to all people with close contact with the infants, including parents, grandparents, relatives, babysitters, nannies, daycare providers, and housekeepers,” the authors wrote.
AAP leads efforts to protect children’s access to health care

From the moment the 115th Congress took office in January and lawmakers began deliberating how to repeal the Affordable Care Act (ACA), the Academy has been leading the charge in Washington to protect children’s access to health care.

At press time, new federal legislators were being sworn into office, with speculation still surrounding the timeline and process for ACA repeal and replacement. The week new members of Congress were sworn in, the Academy sent a letter to Congress urging them to protect the needs of children while considering any changes to the ACA, reminding leaders that children are not little adults and have unique health care needs. The letter outlined essential elements in the ACA that the Academy believes any major changes to health reform must maintain or improve upon:

- **Access to pediatric care**, including access to pediatric providers and pediatric subspecialists.
- **Pediatric appropriate benefits**, including preventive care and essential health benefits.
- **Insurance coverage for children and families**, including insurance market reforms, dependent coverage to age 26, affordable coverage, Medicaid expansion and other innovations.

“We encourage Congress to build on its record of improving children’s coverage and provide long-term health care stability for children,” said AAP President Fernando Stein, M.D., FAAP, in the letter. “The Academy supports proposals that invest in child health and move towards achieving the goal of ensuring that all children have health care coverage that meets their unique needs.”

The Academy also joined the American Academy of Family Physicians, the American College of Physicians and the American Congress of Obstetricians and Gynecologists in sending a letter to Congress, urging federal leaders to protect patients’ access to care, as well as a broader coalition of children’s health groups whose message to lawmakers focused on the need for any health reforms to build on progress improving children’s access to health care.

No matter the outcome of the ACA repeal process, the Academy will be working with lawmakers, their staffs and various coalitions to protect children’s access to affordable, quality health coverage and to maintain the progress made to date.

In fact, AAP chapter leaders from every state will travel to Washington this month to urge their members of Congress to prioritize children in their policymaking, especially as they approach issues related to children’s access to health care. The momentum behind these efforts will be maintained when more than 100 pediatricians come to the nation’s capital for the AAP Legislative Conference in April. Visit www.aap.org/legcon for more information about the conference and to register.

To receive federal advocacy communications with the latest news from Washington, email kids1st@aap.org.

Unfinished business: What happens next?

Before adjourning, the 114th Congress was unable to pass legislation regarding two AAP advocacy priorities: child nutrition reauthorization and child welfare reform.

**Child nutrition**

Programs such as the Special Supplemental Nutrition Program for Women, Infants and Children, the school meals program, the Child and Adult Care Food Program, and the summer feeding program will continue to operate as Congress continues to fund them. Unfortunately, Congress is unlikely to take up child nutrition reauthorization this year as work will begin on the Farm Bill, which reauthorizes the Supplemental Nutrition Assistance Program (SNAP). As these conversations begin, the Academy will be advocating to maintain the current structure of the program, improve the program’s benefits, reduce barriers to enrollment and protect the scientific integrity of nutrition standards and guidance.

**Child welfare reform**

Funding for the child welfare system will continue to go to the states, with disproportionate emphasis on funding foster care over services that help keep families together.

Although the AAP-supported Family First Prevention Services Act did not pass in the 114th Congress, there may be opportunities to revisit its policies as discussions of other health and social issues arise on the legislative agenda. The Academy will continue advocating for policies that support families and prevent the need for foster care.

To be notified of advocacy opportunities regarding SNAP or on behalf of children in the welfare system, email kids1st@aap.org and indicate your interest in one or both of the issues.

From legislation to implementation: 21st Century Cures

While advocacy is most often thought of during the process of drafting and passing legislation, the Academy also works with the federal agencies that implement a bill after it becomes law to ensure it is working for children and families as intended.

The Academy will be working on implementation of the 21st Century Cures Act, which was signed into law in the 114th Congress.

Under the new law, the National Institutes of Health (NIH) is required to track and report on the number of children enrolled in clinical trials. Although the agency has had a formal policy since 1998 requiring the inclusion of children in trials, it has failed to track and publish data on the numbers of children actually enrolled.

The Academy long advocated for NIH to collect this information. The data are needed to ensure that children are benefiting from important scientific and medical advancements so that pediatricians can better understand chronic childhood diseases and how they persist into adulthood.

The NIH has six months from the law’s enactment to host a workshop on the issue. As the leading champion of this issue, the Academy will be working with the agency to ensure swift implementation so that children’s health can benefit from this provision of the law as soon as possible.

**Advocacy challenge: Get to know your legislators**

A new Congress means new leaders representing states and districts across the country, including new senators and representatives for you to get to know.

To find out who your elected officials are, log into http://federaladvocacy.aap.org and type your ZIP code into the box “Find your elected officials” on the right side of the screen. You also can search for your elected officials by visiting www.House.gov and www.Senate.gov.

Most federal legislators are on Twitter. Be sure to follow them for the latest news from their offices.

Dr. Dreyer, surgeon general warn of e-cigarette use

AAP Immediate Past President Benard P. Dreyer, M.D., FAAP, speaks at a press conference with U.S. Surgeon General Vivek H. Murthy, M.D., M.B.A., following the release of *E-Cigarette Use Among Youth and Young Adults: A Report of the Surgeon General*. 
Peanut allergy continued from front page

...Peanut skin prick test
≥0.35
≥8 mm
3-7 mm

Studies following up on the LEAP study had infants eat this amount of peanut protein is given over three or more feedings based on what was done in the LEAP study, 6-7 grams of peanut introduction according to the test results. The guideline discusses the manner of peanut introduction according to the test results, whether at home or under physician supervision. Additionally, the amount to feed weekly is discussed. Based on what was done in the LEAP study, 6-7 grams of peanut protein is given over three or more feedings per week. The LEAP study had infants eat this amount to age 5 years. In studies following up on the LEAP trial, this approach resulted in durable protection, was safe, did not affect duration or frequency of breastfeeding, and did not influence growth or nutrition.

**Guideline #2** suggests that infants with mild to moderate eczema, a group also at increased risk of peanut allergy, should be introduced to peanut around 6 months of age, in accordance with family preferences and cultural practices, to reduce the risk of peanut allergy. These infants may have peanut introduced at home following successful ingestion of other solid food(s) without an in-office evaluation, although an evaluation can be considered.

**Guideline #3** addresses infants without eczema or food allergy who are not at increased risk, suggesting that peanut be introduced “freely” into the diet together with other solid foods and in accordance with family preferences and cultural practices.

**Guidance evolves**

Purposeful early feeding of peanut is a reversal from the 2000 AAP recommendations that suggested high-risk infants avoid peanut to age 3 years. The avoidance advice was rescinded in the 2008 AAP clinical report Effects of Early Nutritional Interventions on the Development of Atopic Disease in Infants and Children: The Role of Maternal Dietary Restriction, Breastfeeding, Timing of Introduction of Complementary Foods, and Hydrolyzed Formulas (Pediatrics. 2008;121:183-191; http://bit.ly/2ShDw1f), which concluded: “Although solid foods should not be introduced before 4 to 6 months of age, there is no current convincing evidence that delaying their introduction beyond this period has a significant protective effect ...

The new guidelines go further by promoting early ingestion for the highest risk infants. Evaluation and peanut introduction for this highest risk group at 4-6 months is conveniently timed with routine pediatric health care office visits, allowing for identification of infants at risk and discussion of the approach. Additionally, it is less likely for younger infants to have positive allergy tests to peanut. However, the guideline emphasizes that if the 4- to 6-month time period is missed for any reason, peanut should be introduced to infants older than 6 months as they also are anticipated to benefit (the LEAP study included infants 4 up to 11 months of age).

The addendum guidelines represent an update to the 2010 comprehensive food allergy guidelines published by a National Institute of Allergy and Infectious Diseases (NIAID)-sponsored expert panel (http://bit.ly/2gTLoSF). They reflect the work of a coordinating committee and expert panel representing 26 professional organizations, including the Academy, advocacy groups and federal agencies, which evaluated a literature review prepared by the NIAID.

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**Definitions in the addendum guidelines**

Severe eczema is defined as persistent or frequently recurring eczema with typical morphology and distribution, assessed as severe by a health care provider and requiring frequent need for prescription-strength topical corticosteroids, calcineurin inhibitors or other anti-inflammatory agents despite appropriate use of emollients.

Egg allergy is defined as a history of an allergic reaction to egg and a skin prick test wheal diameter of ≥3 millimeters with egg white extract or a positive oral egg food challenge.

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Dr. Sicherer represented the Academy on the guideline coordinating committee and was a member of the expert panel. He is past chair of the AAP Section on Allergy and Immunology Executive Committee.

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**Recommended approaches for evaluation of children with severe eczema and/or egg allergy before peanut introduction**

<table>
<thead>
<tr>
<th>Severe eczema or Egg allergy or Both</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peanut sIgE*</td>
</tr>
<tr>
<td>&lt;0.35</td>
</tr>
<tr>
<td>Risk of reaction low</td>
</tr>
<tr>
<td>Over 90% will have (-) SPT** to peanut</td>
</tr>
<tr>
<td>Options:</td>
</tr>
<tr>
<td>a) Introduce peanut at home</td>
</tr>
<tr>
<td>b) Supervised feeding in the office (based on provider/parental preference)</td>
</tr>
<tr>
<td>Refer to specialist for consultation/SPT protocol</td>
</tr>
<tr>
<td>≥0.35</td>
</tr>
<tr>
<td>Risk of reaction low</td>
</tr>
<tr>
<td>(95% will not have peanut allergy)</td>
</tr>
<tr>
<td>Options:</td>
</tr>
<tr>
<td>a) Introduce peanut at home</td>
</tr>
<tr>
<td>b) Supervised feeding in the office (based on provider/parental preference)</td>
</tr>
<tr>
<td>Peanut skin prick test</td>
</tr>
<tr>
<td>0-2 mm</td>
</tr>
<tr>
<td>Risk of reaction varies from moderate to high</td>
</tr>
<tr>
<td>Options:</td>
</tr>
<tr>
<td>a) Supervised feeding in the office</td>
</tr>
<tr>
<td>b) Graded OFC*** in a specialized facility</td>
</tr>
<tr>
<td>≥3 mm</td>
</tr>
<tr>
<td>Infant probably allergic to peanut</td>
</tr>
<tr>
<td>Continue evaluation and management by a specialist</td>
</tr>
<tr>
<td>≥8 mm</td>
</tr>
</tbody>
</table>

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* To minimize a delay in peanut introduction for children who may test negative, testing for peanut-specific IgE may be the preferred initial approach in certain health care settings. Food allergen panel testing or the addition of sIgE testing for foods other than peanut is not recommended due to poor positive predictive value.

** skin prick test
*** oral food challenge

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Pediatricians must partner with others on disease prevention

From 2008-10, I participated in the Vision of Pediatrics 2020 project. Eight transformational drivers of pediatrics were identified, No. 1 being the changing socio- and clinical demographics of the child population. The Vision of Pediatrics 2020 report postulated increasing rises of health problems related to social determinants of health and chronic illness.

I believe the changing demographics and epidemiology of morbidity and mortality in childhood and adolescence are both challenging and transforming the practice of pediatrics. During the early 1900s, pediatricians concentrated on educating parents about child-rearing, treating infectious diseases (for which neither antibiotics nor vaccines were available), respiratory and diarrheal illnesses, and the care of minor trauma. With the advent of antibiotics, vaccines and infection control and the explosion of scientific knowledge regarding health and disease toward the middle of the 20th century, pediatricians were able to diagnose and treat diseases in a consistent, predictable way.

Mortality in children under 5 has decreased by more than 75% in the last 50 years. Mortality in the pediatric intensive care unit dropped from nearly 30% in the early 1970s to 3% last year. The absolute number of children living with congenital and genetic disorders, the decrease in morbidity and mortality from infectious diseases, and the increase in survival rates in neonatal and pediatric intensive care units have contributed to a shift in the nature of diseases encountered in everyday pediatrics. This shift has been in the direction of greater complexity, with increasingly frequent visits from children with neurodevelopmental disorders and sequela correlated to social determinants of health.

After age 5, the majority of the burden of disease in children now is from noncommunicable diseases (NCDs). Traumatic injuries, malignant neoplasms, diabetes related to obesity, suicide and homicide lead the list.

Life expectancy at birth has been increasing every year in the U.S. for the last 50 years — until 2015 when it decreased. The World Health Organization makes a compelling case for the difference between life expectancy at birth and healthy life expectancy. The U.S. is seeing an increase in the number of years lost due to disability, and we saw with concern the absolute decrease in life expectancy in 2015. In 2016, our country ranked 42nd in the world for life expectancy at birth. The U.S. is seeing an increase in the number of years lost due to disability. We as pediatricians are witnesses to the consequences of the changing demographics and epidemiology of morbidity and mortality in childhood and adolescence.

The challenge for the pediatrician is the tension between the care of patients grow up and leave us. One thing we can do is engage our adult medicine colleagues in disease prevention efforts that continue for a lifetime.

While the pediatrician clearly plays a pivotal role, along with all physicians, we know these challenges cannot be solved in the doctor’s office alone. To win the battle against NCDs, there has to be a convergence of physicians, medical scientists, educators, legislators, government, business and industry. The pediatrician’s office already is a cross-section of the social, economic and political problems manifesting themselves in a variety of forms. The social determinants of health are raising their claws more and more every day. Is the pediatrician capable of solving this in the 15 minutes per patient expected by the health plan? Hardly.

We as pediatricians are witnesses to the consequences of policies being decided elsewhere. Now more than ever before, we have to raise our voices in defense of children and families. We must play a leadership role and articulate the important difference between life expectancy at birth and years lost due to disability.

The challenge for the pediatrician is the tension between wanting to do what is right for the patient and family and the sense that the problems are too big, too complex or both. This is a known factor contributing to pediatrician burnout. I believe it is too heavy a lift for pediatrics alone. To me, the answer is clear. We must follow the call of past AAP leaders and double our efforts to engage new partners to work with us in innovative ways.

Fernando Stein, M.D., FAAP
President, American Academy of Pediatrics
Phoenix Children’s Hospital has one of the nation’s largest and highest-rated pediatric cardiology and congenital heart surgery programs. The Phoenix Children’s Heart Center performs more than 500 cardiac surgeries each year, using advanced technology such as integrated 3D multimodality imaging and modeling, and offers outstanding post-op care in a dedicated cardiovascular ICU.

With more than 25 board-certified pediatric cardiologists, four congenital heart surgeons, and nine advanced cardiac nurse practitioners, Phoenix Children’s delivers family-centered, multidisciplinary care for a wide range of congenital heart conditions, from simple to complex.

With a long history of exceptional surgical outcomes, Phoenix Children’s Hospital has earned the highest independent ratings for surgical excellence, as well as a Best Children’s Hospital ranking in Cardiology and Heart Surgery from U.S. News and World Report. Outcomes data is published online at heart.phoenixchildrens.org.

For breakthrough discoveries and lifesaving care, think Phoenix Children’s Hospital.
Is EV-D68 infection a cause of acute flaccid myelitis in children?

by H. Cody Meissner, M.D., FAAP

Enterovirus D68 (EV-D68) was first identified in California in 1962. Initially, it was classified as a rhinovirus but now is classified as one of more than 100 non-polio enteroviruses. For several decades after the initial description, EV-D68 was rarely recovered from patients. Between 2008 and 2014, the virus was isolated occasionally from clusters of children younger than 5 years of age with severe respiratory illness.

Which of the following statements are false?

a) Most enterovirus infections are asymptomatic.
b) Infants and children are at increased risk for infection by EV-D68 relative to adults because they are less likely to have developed immunity from a previous infection.
c) Enterovirus infections are most common in the summer and fall in the U.S.
d) EV-D68 is reliably inactivated with alcohol-based hand rub.
e) EV-D68 is a documented cause of acute flaccid myelitis (AFM).

In the summer and fall of 2014, a nationwide outbreak of EV-D68 occurred and was associated with severe respiratory tract disease. In September 2014, the Centers for Disease Control and Prevention (CDC) began to receive reports of AFM, and a possible association with EV-D68 was considered. During this enterovirus season, the CDC confirmed more than 1,100 infections, largely among children, many of whom had a history of asthma. Many more people likely experienced a mild EV-D68 infection for which medical treatment was not sought or from whom cultures were not obtained.

During the 2015 enterovirus season, the CDC received about 700 specimens for enterovirus testing, and none were positive for EV-D68. During most of 2016, sporadic EV-D68 detections occurred in the U.S., but evidence of unusual activity was not apparent. (See AAP News article “CDC: 108 cases of acute flaccid myelitis this year,” http://bit.ly/2hYZ9k7.)

EV-D68 should be considered especially during the summer and fall as a cause of unexplained, severe acute respiratory illness in children especially during clusters of disease. Nasopharyngeal or oropharyngeal specimens that test positive for enterovirus or rhinovirus should be considered for molecular testing using real-time polymerase chain reaction (PCR) or nested PCR. Virus may be detected in stool or rectal swabs for a longer period than from respiratory specimens.

Infection-control precautions for suspected cases should include standard, contact and droplet precautions. Non-enveloped viruses such as EV-D68 may be less susceptible to alcohol inactivation than enveloped viruses. Hand hygiene with soap and water upon removal and prior to donning of gloves may be preferred to alcohol-based hand rub.

Between 2012 and 2015, an increasing number of reports of a distinct syndrome of acute flaccid paralysis with anterior myelitis were noted. Symptoms were similar to those caused by polio viruses and to avoid confusion, the term acute flaccid myelitis (AFM) was proposed. AFM is defined as a case of acute flaccid weakness with either spinal cord gray matter lesions detected on imaging or evidence of spinal cord motor neuron injury on electrodiagnostic testing.

A typical case of AFM is preceded by a median of five days with rhinorrhea, cough or pharyngitis. Gastrointestinal symptoms (vomiting, diarrhea) are reported in about two-thirds of patients. Most patients report improvement of symptoms prior to return of fever and onset of muscle stiffness or pain around the time of neurologic deficit onset. Over a period of a few hours to a few days, there is progression from full strength to neurologic deficit. Weakness is flaccid with decreased or absent reflexes in one to four extremities and generally is asymmetric. Limb weakness may be accompanied by cranial nerve dysfunction resulting in hypophonia (soft speech), dysarthria, dysphagia, facial weakness and diplopia.

Optimal management of a patient with AFM is not clear. Immunomodulatory agents, antiviral agents, intravenous immune globulin, high-dose corticosteroids and plasmapheresis have not been evaluated in a controlled fashion, and no significant improvement or deterioration has been described with these interventions.
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- The AAP Red Book and the CDC recommend TREATING THE ENTIRE HOUSEHOLD since family members are frequently infected.
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AAP: American Academy of Pediatrics; CDC, Centers for Disease Control and Prevention; FDA, US Food and Drug Administration.

INDICATION
EMVERM (mebendazole) 100 mg chewable tablet is indicated in adults and children over 2 years of age for the treatment of Enterobius vermicularis (pinworm), Trichuris trichiura (whipworm), Ascaris lumbricoides (common roundworm), Ancylostoma duodenale (common hookworm), and Necator americanus (American hookworm) in single or mixed infections.

IMPORTANT SAFETY INFORMATION
Mebendazole is contraindicated in persons who have shown hypersensitivity to the drug.

Warnings: There is no evidence that mebendazole, even at high doses, is effective for hydatid disease. There have been rare reports of neutropenia and agranulocytosis when mebendazole was taken for prolonged periods and at dosages substantially above those recommended.

Precautions: Periodic assessment of organ system functions, including hematopoietic and hepatic, is advisable during prolonged therapy.

Adverse reactions include:
- Transient symptoms of abdominal pain and diarrhea with expulsion of worms in cases of massive infection; liver function test elevations [AST (SGOT), ALT (SGPT), and GGT]; and on rare occasions hypersensitivity (rash, urticaria and angioedema); rare reports of neutropenia, agranulocytosis (see Warnings) and hepatitis when mebendazole was taken for prolonged periods and at dosages substantially above those recommended; and very rare cases of convulsions.

Drug Interactions: Preliminary evidence suggests that cimetidine inhibits mebendazole metabolism and may result in an increase in plasma concentrations of mebendazole.

Evaluating impaction

The guideline emphasizes that cerumen is a normally occurring secretion of the external ear and serves to trap external dirt and other substances, thus preventing these materials from getting deeper into the ear canal. The normal ear is self-cleaning such that cerumen and trapped debris are slowly but steadily pushed outward from the ear canal. Cerumen impaction, defined as an accumulation of cerumen in the ear canal that causes symptoms, prevents needed examination of the ear or both, is diagnosed by direct otoscopic visualization.

Indications for intervention

Excessive or impacted cerumen may be present in as many as 10% of children on routine examination and may block a child’s smaller ear canals, making removal necessary to allow full evaluation of the tympanic membrane in cases of fever and irritability. Intervention and treatment of cerumen impaction also are indicated when the patient has symptoms, including ear pain or pressure, fullness in the ear and hearing loss. However, therapy ordinarily is not warranted for excessive cerumen without symptoms or when the ability to examine the ear is not impaired. Special consideration is required for patients who are unable to communicate symptomatology, including infants and cognitively impaired patients, as well as those with structural abnormalities of the ear canal, immunosuppression, anticoagulant therapy, diabetes and non-intact tympanic membranes. Patients, including children, who wear hearing aids are at greater risk for cerumen impaction and should receive regular examination and treatment if necessary to optimize hearing efficiency.

Treating impaction

Appropriate methods to treat cerumen impaction include irrigation, manual removal of cerumen and the use of various types of cerumenolytic agents, including water and saline. All of these methods are of equal efficacy when used by trained practitioners. Failure of first-line treatments to resolve the impaction should prompt referral of the patient to a practitioner with specialized equipment and training in this procedure. The guideline advises against the use of ear candling or coning, as these popular folk remedies have no demonstrated efficacy and are associated with the potential for complications.

Patient education

The guideline also includes a list of questions often asked by patients, along with a discussion of suggested responses, reflecting the presence of a consumer representative on the panel. As there are many misconceptions about earwax among the public, health care providers should not neglect patient education opportunities. Patients should be instructed about normal earwax and the self-cleaning nature of the external ear. They also should be advised that attempts to clean one’s own ears or those of one’s children by using cotton swabs or other objects inserted into the ear may lead to further impaction of cerumen, damage to the skin of the ear canal or perforation of the tympanic membrane. Some patients with excessive cerumen buildup may benefit from regular removal, but this is unnecessary in the vast majority of patients.

Dr. Hackell represented the Academy on the panel that developed the guideline and is a co-author.

RESOURCE

MMWR in Review

Mother-to-child HIV transmission persists in most of the world

by Deborah Bloch, M.D., FAAP, and Larry K. Pickering, M.D., PIDS, FPIDS, FAAP

Introduction

The U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) was created in 2003 to establish an AIDS-free generation, committing $5.2 billion in 2016 to programs that provide access to HIV/AIDS prevention, diagnostic and treatment services and research (http://bit.ly/2j49Sef).

Despite global efforts, only four countries have eliminated mother-to-child HIV transmission: Armenia, Belarus, Cuba and Thailand, according to the World Health Organization (WHO) (http://bit.ly/2hNmBS6). Furthermore, in 2015, 1.4 million children under 15 years of age were living with HIV (including 170,000 infants born in 2015), mostly in sub-Saharan Africa. In 2014, 150,000 children worldwide died from HIV-related illness.

Since 2011, the estimated annual number of HIV-infected children has been reduced by 50%, yet only half of children living with HIV have access to antiretroviral therapy (ART). Early infant diagnosis significantly reduces overall morbidity and mortality of HIV when coupled with early treatment.

WHO recommends HIV DNA polymerase chain reaction (PCR) testing at 4-6 weeks of life for HIV-exposed infants (http://bit.ly/2IE4cHc).

The MMWR article reported on the progress of the seven countries supported by PEPFAR for HIV testing services, barriers to testing and HIV medical care for infants from 2011–2015: Cote d’Ivoire, Democratic Republic of the Congo, Haiti, Malawi, South Africa, Uganda and Zambia. Data on the number of infant HIV tests, percent HIV positive, age of infants at time of testing, turnaround time from specimen collection to return of results and mode of specimen transport were collected.

**Results**

During the study period, the total number of infant HIV DNA PCR tests performed increased in all countries. In 2015, however, testing within the first 6 weeks of life was greater than 50% of total infant tests only in South Africa and Zambia.

In 2015, most of the countries demonstrated an overall decrease in the number of HIV-positive test results. However, the number of positive results decreased by more than 50% since 2011 in only Cote d’Ivoire, the Democratic Republic of the Congo and Uganda.

Barriers to testing included difficulties in specimen transport, long turnaround times between collection and receipt of results, and limitations in supply chain management. Modes of specimen transportation included bicycle, motorcycle or car. Methods of transmitting results included phone, text message (unclear if sent to facility or directly to patient), email, hard copies transported by vehicle and web-based laboratory information system searches.

Barriers to early care included mother and child lost to follow-up, weak linkage between antenatal and postnatal care, and inability to reach infants outside the health care system.

Three countries reported that integration of HIV diagnostic services with routine care, infant immunizations and health outreach were crucial for success.

Public health and clinical applications

Progress has been made through 2015 in the field of perinatal HIV medicine in several developing countries. However, many obstacles, mostly logistic, to timely infant testing remain. Additionally, the lack of eradication of mother-to-child HIV transmission persists in most of the world, including in the U.S.

As the world becomes increasingly globalized, U.S. pediatricians should be aware of global HIV epidemiology and ensure adequate testing and treatment of all immigrant patients. Clinicians also should remain aware of local and global legislation regarding pediatric HIV.

If the goal of an AIDS-free generation is to be reached, we all must advocate for continued support of PEPFAR’s funding for mother and infant HIV testing and treatment, in addition to better diagnostics and timelier services in developing countries.

The first cases of AIDS were reported in the U.S. in 1981. Now, fewer than 200 infants in the United States are infected with HIV per year. Pediatricians should be aware of their patients’ maternal HIV status and knowledgeable about timing and methods of testing for HIV-exposed infants and treatment. Though the WHO recommends testing at 4-6 weeks of life, the U.S. Department of Health and Human Services (HHS) recommends using either HIV DNA or HIV RNA PCR tests at 14-21 days of life and repeating the same test at 1-2 months of life (preferably two to four weeks after cessation of infant ART prophylaxis) and again at 4-6 months of life.

HHS also recommends starting low-risk HIV-exposed infants (infants whose mothers were on ART during pregnancy and with undetectable viral loads prenatally) on a four-week course of prophylactic zidovudine. Infants of high-risk mothers (mothers not on ART during pregnancy or on ART only at delivery or with detectable viral loads around time of delivery) should begin a six-week course of combination therapy with zidovudine and nevirapine (http://bit.ly/2hLzdnZ).

**Pediatric HIV**

- In 2015, 1.4 million children worldwide under 15 years of age, including 170,000 infants born in 2015, were estimated to be living with HIV infection.
- In 2014, 150,000 children worldwide died from HIV-related causes.
- HIV-related mortality in infants under 2 years of age is 50% without appropriate treatment.
- In 2015, only 51% of the world’s HIV-infected children had received antiretroviral therapy.
- Fewer than 200 U.S. infants are infected with HIV per year.

**Questions**

1. The first cases of AIDS were reported in the U.S. in what year?
   a) 1961
   b) 1971
   c) 1981
   d) 1991

2. In the U.S., what is the recommended age an HIV-exposed infant should first be tested for HIV?
   a) Birth
   b) 14-21 days of life
   c) 4-6 weeks
   d) 18 months

3. Which of the following should be used to test for HIV in an HIV-exposed infant?
   a) HIV DNA PCR
   b) HIV RNA PCR
   c) HIV IgM and IgG
   d) a or b, but the same test should be used each time

**Resources**

- For guidance on providing prophylactic therapy to infants at risk for HIV infection or for infants of mothers whose HIV status is unknown, consult an HIV specialist or call the National Perinatal HIV Hotline at 888-448-8765 for a free consultation.
- The most up-to-date guidelines for testing and treatment of HIV-exposed infants in the U.S. can be found at https://aidsinfo.nih.gov/guidelines.
Focus On Subspecialties

Procalcitonin a promising biomarker to identify invasive bacterial infections in febrile infants

by Sri S. Chinta, M.B.B.S., M.S.C.I., and Elizabeth R. Alpern, M.D., M.S.C.E., FAAP

Infants younger than 90 days of age with fever often are evaluated in the emergency department due to their risk of serious bacterial infections (SBI) such as urinary tract infections (UTI) and invasive bacterial infections (IBI), including bacteremia and bacterial meningitis.

IBI are reported to affect 0.5% to 2% of febrile young infants. Because of poor discrimination of the clinical exam to identify SBI coupled with the risk of dire outcome if missed, physicians rely on intensive and invasive evaluations that often include urine, blood and cerebral spinal fluid studies. In addition, many of these infants are expectantly admitted to the hospital and receive intravenous antibiotics until cultures are negative.

Although UTIs may be identified early with urinalysis results, there has long been a quest for a test that could provide adequate early discrimination between febrile young infants with and without IBI.

Two recent European studies have evaluated procalcitonin (PCT) as a diagnostic test to identify IBI in young febrile infants and potentially decrease the need for invasive testing and hospitalization.

In a prospective study done in France, PCT was found to have diagnostic accuracy superior to that of C-reactive protein (CRP) in identifying IBI (Milcent K, et al. JAMA Pediatr. 2016;170:62-69).

The study enrolled febrile infants ages 7 to 91 days. Although 100% of patients had a PCT measurement and 99.5% had a CRP, a limitation of the study was that only 61.5% of patients had a blood culture and 65% underwent lumbar puncture.

Among the 2,047 infants enrolled, 6.8% were diagnosed with SBI and 1% with IBI. Compared to CRP, PCT had better diagnostic accuracy to identify febrile infants with IBI despite similar accuracy for SBI.

In an associated editorial, Kuppermann and Mahajan concurred that although PCT alone was shown to be superior to other biomarkers in identifying IBI, clinical prediction rules that incorporate PCT are likely to be even more discriminating in identification of low-risk infants. In addition, future development of genomic methods to identify the infection itself will be imperative for full resolution of this diagnostic quandary, they said (JAMA Pediatr. 2016;170:17-18).

In another recent study, Gomez and colleagues validated a step-by-step approach, including PCT, to identify febrile infants 90 days of age or younger who are at low risk of IBI and could be managed as outpatients without lumbar puncture or empirical antibiotic therapy (Pediatrics. 2016;138:e20154381). The components of the step-by-step approach, applied sequentially to identify risk assessment, included ill appearance, age (≥21 days), leukocyturia, PCT (>0.5 ng/mL), and CRP (>20 mg/L) or absolute neutrophil count (>10,000/mm³).

In this multicenter study that included 11 emergency departments in Europe, the step-by-step approach was validated and compared with the Rochester criteria and the lab score. Results showed the prevalence of IBI in the 2,185 enrolled patients was 4%. General appearance, age and urine dipstick identified 80% of the IBI patients. A fully implemented step-by-step approach had a sensitivity of 92%, specificity of 46.9% and negative predictive value of 99.3% for identifying IBI.

The step-by-step approach misclassified seven (0.7%) infants with IBI as low risk, whereas the Rochester criteria and the lab score missed 16 and 35, respectively. Four of the seven patients misclassified by the step-by-step approach were between 21-28 days and six of the seven missed patients had fever duration of less than two hours. This short fever duration group may indicate a biological limitation of the biomarker itself.

Aronson and Neuman commented in their editorial response that the risk of missing IBI with step-by-step is one in 143. They pointed out that as the study was a retrospective application of the data instead of a prospective testing of the full process, five of the seven patients who would have been “missed” by the step-by-step process were actually admitted to the hospital and treated with parenteral antibiotics (Pediatrics. 2016;138:e20161579). A further assessment of the threshold of “how low is low enough” from the provider, parent and patient perspective is necessary prior to full implementation.

These articles highlight procalcitonin as a potentially important biomarker in the evaluation of young febrile infants to identify IBI. More studies are needed to understand the true impact of procalcitonin in improving the outcome of this patient population.

This month in Pediatrics

The following are published in the February issue of Pediatrics:

Consent by Proxy for Nonurgent Pediatric Care
http://dx.doi.org/10.1542/peds.2016-3911
— An AAP clinical report from the Committee on Medical Liability and Risk Management (See article on page 25.)

The Adolescent’s Right to Confidential Care When Considering Abortion
http://dx.doi.org/10.1542/peds.2016-3861
— An AAP policy statement from the Committee on Adolescence (See article on page 26.)

Diagnosis, Treatment and Prevention of Congenital Toxoplasmosis in the United States
http://dx.doi.org/10.1542/peds.2016-3860
— An AAP technical report from the Committee on Infectious Diseases

Earwax (Cerumen Impaction)
http://dx.doi.org/10.1542/peds.2016-3912
— An AAP endorsed statement (See article on page 1.)

Improving Nasal Form and Function After Rhinoplasty
http://dx.doi.org/10.1542/peds.2016-3863
— An AAP endorsed statement

Coming in March
Policy statements
• Recommended Childhood and Adolescent Immunization Schedule, United States, 2017
• Financing of Pediatric Home Health Care
• A Public Health Response to Opioid Use in Pregnancy
• The Child Witness in the Courtroom
• Expert Witness Participation in Civil and Criminal Proceedings

Clinical reports
• Care of the Adolescent After an Acute Sexual Assault
• Epinephrine for First-Aid Management of Anaphylaxis
• Guidance on Completing a Written Allergy and Anaphylaxis Emergency Plan
• Counseling Parents and Teens About Marijuana Use in the Era of Legalization of Marijuana
• The Need to Optimize Adolescent Immunization
• Practical Approaches to Optimize Adolescent Immunization

Technical report
• Expert Witness Participation in Civil and Criminal Proceedings
Introducing NEW...

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* These statements have not been evaluated by the Food and Drug Administration. This product is not intended to diagnose, treat, cure, or prevent any disease.
FDA releases guidance on extrapolating data to enhance pediatric device development

Coordinated efforts during the past few decades that have led to improved and increased pediatric drug labeling have not resulted in the increased availability of medical devices labeled for children. Off-label use of devices remains a prevalent and necessary practice in pediatrics. For example, nearly 90% of devices used for cardiac catheterization in children are not approved for use in pediatric patients.

The Food and Drug Administration (FDA) recognizes the unique and unmet needs of children. It also appreciates the numerous factors associated with relatively few medical devices having pediatric indications and labeling, including challenges in pediatric evidence generation and market economics. As part of continuing efforts to promote timely access to safe and effective medical care for children, the FDA Center for Devices and Radiological Health (CDRH) recently finalized its Pediatric Extrapolation Guidance, http://bit.ly/2gZgqW2.

The guidance clarifies the FDA’s perspective on leveraging existing data to support pediatric indications and labeling for medical devices. The guidance outlines the approach used to determine the appropriateness and extent of extrapolation and a description of relevant statistical methods. Extrapolation has the potential to enhance pediatric device development but should be used judiciously.

CDRH also is developing the Pediatric Extrapolation for Devices (PEDs) Team, a group of pediatric experts available for consultation. The PEDs Team will enhance consistency and standardization regarding extrapolation decisions.

The guidance and development of the PEDs Team reflect the FDA’s commitment to the needs of pediatric patients. The FDA will continue to work with all stakeholders to address unmet medical device needs for children.

Clarification on infant sleep Parent Plus

A statement in the Parent Plus “Steer clear of crib bumpers, other unsafe sleep products” (January issue, page 29) requires a clarification. The statement should read: Parents should use caution when buying products that claim to reduce the risk of SIDS. The Food and Drug Administration (FDA) has never cleared or approved a baby product to prevent or reduce the risk of SIDS. The FDA is not aware of any scientific studies showing that a medical device prevents or reduces the risk of SIDS.

Examples of common over-the-counter baby products with unproven claims to prevent or reduce the risk of SIDS include: baby monitors, mattresses, crib tents, pillows, bumpers and blankets, and infant positioners, according to the FDA.

For more information, go to http://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/SIDSPreventionClaims/default.htm.
The new American Board of Pediatrics (ABP) pilot program that could replace the traditional proctored General Pediatrics Maintenance of Certification (MOC) Part 3 examination began last month for those due to sit for the exam in 2017. The pilot Maintenance of Certification Assessment for Pediatrics (MOCA-Peds) program is an online, non-proctored assessment platform that serves as an alternative to the proctored examination required every 10 years to maintain certification. (See related AAP News article, http://bit.ly/1UcARix.)

If successful, the pilot will replace the Part 3 examination that is administered at a testing center. The ABP contacted eligible diplomates last fall. Those participating in the pilot will be required to answer 20 questions each quarter. Questions can be answered in small batches over the course of each quarter, but each question must be answered within five minutes or they are marked incorrect.

All 80 questions given in 2017 will be scored, and diplomates will receive a scaled score between 1 and 300. A scaled score of at least 160 in 2017 (the equivalent of a score of about 60% on the current MOC exam) is necessary to continue with MOCA-Peds in 2018.

If the ABP determines the pilot program is successful, all diplomates will be enrolled in the MOCA-Peds at the beginning of the next five-year cycle in which their MOC Part 3 examination is due, according to the ABP. FAQs about the pilot program are available at https://www.abp.org/mocapeds/faqs.

Correction
In the January article on IEPs vs. 504 plans on page 4, under the listing of qualifying conditions for an IEP, the correct term for the first condition listed is intellectual disabilities.
RotaTeq®
(Rotavirus Vaccine, Live, Oral, Pentavalent)

BRIEF SUMMARY OF PRESCRIBING INFORMATION

DOSE AND ADMINISTRATION

FOR ORAL USE ONLY; NOT FOR INJECTION.

The vaccination series consists of 3 orally-dose of Rotavirus Vaccine (RotaTeq) given at 3, 4, and 6 months of age, with the subsequent doses administered at 4- to 6-week intervals. The third dose should not be given after 12 weeks of age.

CONTRAINDICATIONS

A history of hypersensitivity to the vaccine or any component of the vaccine. Infants who develop symptoms suggestive of hypersensitivity after receiving a dose of RotaTeq should not receive further doses of RotaTeq.

Infants with Severe Combined Immunodeficiency Disease (SCID) should not receive RotaTeq. Post-marketing reports of panhypogammaglobulinemic infants who are potentially immunodeficient include infants with agammaglobulinemia, Wiskott-Aldrich syndrome, hypogammaglobulinemia, and X-linked agammaglobulinemia. Such infants should not receive RotaTeq. Infants with a history of intussusception should not receive RotaTeq.

WARNINGS AND PRECAUTIONS

Managing post-vaccination intussusception: Appropriate medical treatment and supervision must be available to manage possible anaphylactic reactions following administration of the vaccine.

Immunocompromised Populations: No safety or efficacy data are available from clinical trials regarding the safety of RotaTeq in immune-compromised patients who are potentially immunodeficient including infants with congenital immune deficiencies, infants with concomitant conditions that may affect vaccine immunogenicity such as malnutrition, infants with the history of chronic or acute infections or conditions that lower the resistance of the infants to infection, infants with a history of significant drug-reactive or allergic reaction or complications to previous vaccines, infants with HIV/AIDS or other immune-suppressing conditions, or infants with a history of bone marrow transplant.

Intussusception: Following administration of a previously licensed live virus rotavirus-based vaccine, an increased risk of intussusception has been reported. A post-marketing observational study in the US cases of intussusception were observed in temporal association within 21 days following the first dose of RotaTeq, with a consistent trend of increased risk with each subsequent dose.

In the worldwide post-marketing surveillance, cases of intussusception have been reported in temporal association with the administration of RotaTeq.

Gastroenteritis Illness: No safety or efficacy data are available for administration of RotaTeq to infants with a history of gastrointestinal disorders including infants with active aseptic gastrointestinal illness, infants with a history of diarrhea and/or illness, and infants with a history of chronic or acute infection conditions that may affect vaccine immunogenicity. Such infants should not receive RotaTeq.

Intussusception: Intussusception is a rare complication of vaccination with oral rotavirus vaccine strains from vaccines to non-vaccinated contacts has been observed post-marketing. The potential risk of transmission of vaccine virus should be weighted against the risk of acquiring and transmitting rotavirus.

Intussusception: Infants with a history of intussusception should not receive RotaTeq. In a post-marketing observational study in the US cases of intussusception were observed in temporal association within 21 days following the first dose of RotaTeq, with a consistent trend of increased risk with each subsequent dose.

In the worldwide post-marketing surveillance, cases of intussusception have been reported in temporal association with the administration of RotaTeq.

Intestinal obstruction: Intestinal obstruction is a rare complication of vaccination with oral rotavirus vaccine strains from vaccines to non-vaccinated contacts has been observed post-marketing. The potential risk of transmission of vaccine virus should be weighted against the risk of acquiring and transmitting rotavirus.

Safety in Pre-Term Infants: RotaTeq was administered in a 2,878 pre-term infants (15 to 26 weeks postmenstrual age, median 36 weeks) according to their age in weeks since birth at REST. All 36 week infants were followed for serious adverse events; a subset of 368 infants using monitoring for all adverse events. There were 4 deaths throughout the study; 3 among vaccine recipients (5 SIDS and 1 neonatal death) and 1 among placebo recipients (1 SIDS and 1 unknown cause). No cases of intussusception were reported. Serious adverse events occurred in 5.5% of vaccine and 5.9% of placebo recipients. The most common serious adverse events were bronchitis, which occurred in 1.4% of vaccine and 1.2% of placebo recipients. Parent/guardians were advised to record the child's temperature and any episodes of vomiting and diarrhea daily for a week following vaccination. The frequency of adverse events was recorded. Parent/guardians were advised to record the child's temperature and any episodes of vomiting and diarrhea daily for a week following vaccination.

Salmonella: RotaTeq does not contain any live Salmonella-like organisms. The potential for transmission of vaccine virus should be weighted against the risk of acquiring and transmitting rotavirus.

Salmonella: RotaTeq does not contain any live Salmonella-like organisms. The potential for transmission of vaccine virus should be weighted against the risk of acquiring and transmitting rotavirus.

Reporting Adverse Events: Parents or guardians should be instructed to report any adverse events that their child experiences following RotaTeq vaccination to their healthcare provider or the National Childhood Vaccine Injury Act of 1986. For information or a copy of the vaccine's fact sheet, call the VAX Hot-Line toll-free number at 1-800-222-7267 or go to the website online to www.vaes.hhs.gov.

Immunosuppressive therapies including immunosuppression, immunostimulants, and antagonists, cytokines and drugs or cellular and molecular biology, both in vivo and in vitro, may reduce the immune response to vaccines.

Concomitant Vaccination Administration: In clinical trials, RotaTeq was administered concomitantly with diphtheria and tetanus toxoids and acellular pertussis (DTaP), inactivated poliovirus vaccine (IPV), Haemophilus influenza type b conjugate (Hib) vaccine, and oral polio vaccine (OPV). The data available from the ADVERSE REACTIONS section was to reduce for reduced antibody responses to the vaccines that are to be concomitantly administered with RotaTeq.

USE IN SPECIFIC POPULATIONS

Post-Marketing Experience: Safety and efficacy have not been established in infants less than 6 weeks of age or older than 26 weeks of age. Data are available from clinical trials to support the use of RotaTeq in pre-term infants according to their age in weeks since birth. Data are available from clinical trials to support the use of RotaTeq in low-birth weight newborns with gestational age less than 32 weeks.

NONCLINICAL TOXICOLOGY

Carcinogenicity, Mutagenicity, Impairment of Fertility: RotaTeq has not been evaluated for its carcinogenic or mutagenic potential or its potential to impair fertility.

PATIENT COUNSELING INFORMATION

Informed about Risk of Intussusception: Parents or guardians should be given a copy of the report of the vaccine's FDA-licensed live viral vaccines (EUA). Mention the importance of discussing the risks and benefits of vaccination with the healthcare provider.

For additional information, please refer to the Prescribing Information. USP<80-85> DS: 4311§201

Reviewed: 11/04

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VAC-114-0544-0802 05/15
sured. Over 12,000 (3%) of these children met criteria for hypertension as defined by the National Heart, Lung, and Blood Institute (NHLBI). Fifty-three percent of those with hypertension were female, 43% were white, 33% black, 9% other and 15% had no race noted in the EHR. Forty-five percent were normal weight, 17% were overweight and 38% were obese.

Analyses were designed to identify children who had repeated measures of high blood pressure that qualified for diagnosis of hypertension based on NHLBI criteria. Among children who met criteria for hypertension, researchers then looked at whether any diagnosis of hypertension or prescription for antihypertensive medication was found during the study period.

Results showed that of 12,138 children who met NHLBI criteria for hypertension with measures of blood pressure higher than the 95th percentile at three or more separate clinic visits, only 23% (2,813) had a diagnosis of hypertension. Among the 2,813 children who did have a diagnosis of hypertension, less than 6% (158) were prescribed antihypertensive medication within 12 months of diagnosis. (See figure.) Those who did receive medications were prescribed angiotensin-converting enzyme inhibitors or blockers (35%), diuretics (22%), calcium channel blockers (17%) and β-blockers (10%).

The study also measured the percentage of children who met NHLBI criteria for pre-hypertension and whether those children had a diagnosis of pre-hypertension. Results showed that of the 398,079 children who had at least three blood pressure measurements, 9.8% met the criteria for pre-hypertension but only 10% of those with pre-hypertension received a diagnosis.

This study highlights the power of large datasets to examine questions about uncommon conditions or conditions with infrequent treatment. The large cohort allowed researchers to detect the small percentage of children who were diagnosed with and received medication treatment for hypertension.

This study involved collaboration among pediatric practices from the AAP PROS Network; the AAP Comparative Effectiveness Research through Collaborative Electronic Reporting Consortium Research Team; and researchers from the MetroHealth System and Case Western Reserve in Cleveland, the Children’s Hospital of Philadelphia (CHOP), The University of Pennsylvania, University of Vermont and the Academy.

The project was supported in part by the Health Resources and Services Administration of the U.S. Department of Health and Human Services (HHS) with the National Institutes of Child Health and Human Development under grants R40MC24943, UB5MC20286 and UA6MC15585; CHOP; and the Academy. This content and conclusions are those of the authors and should not be construed as the official position or policy of, nor should any endorsements be inferred by HHS or the U.S. government.

**Prevalence of hypertension (HTN) symptoms, clinical diagnosis (Dx) and medication treatment among U.S. children in primary care**

<table>
<thead>
<tr>
<th>12,138 (3%) HTN</th>
<th>38,874 (9.8%) Pre-HTN</th>
</tr>
</thead>
<tbody>
<tr>
<td>2,813 (23%) Clinical Dx</td>
<td>3,990 (10%) Clinical Dx</td>
</tr>
<tr>
<td>158 (5.6%) Medication</td>
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**RESOURCES**

- For more information about PROS, visit http://www2.aap.org/pros or contact Laura Shone, in the AAP Division of Primary Care Research, at 847-434-7910 or LShone@aap.org.
- Information for parents on high blood pressure in children (available in English and Spanish), http://bit.ly/2j9QkFm

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AAP Fellows often send questions to the Committee on Medical Liability and Risk Management. While the committee is unable to give specific legal advice, following is general information in response to some of those questions that may be helpful.

It is important to recognize that laws vary state-to-state, and legal decisions depend on the facts at hand. It also is important to consult a qualified attorney for legal issues affecting your practice.

**If an established patient is located in another state (e.g., while on vacation or at college) in which the pediatrician is not licensed, can the pediatrician treat the patient (e.g., write prescriptions, treat via telephone or email, look at smartphone photos of rashes/dog bites)?**

The practice of medicine is regulated primarily by the state. Thus, the answer depends on the laws of the states in which the pediatrician and the patient are located.

The Louisiana State Board of Medical Examiners, for example, would not allow treatment from an out-of-state pediatrician, stating: “An individual who issues a prescription or orders medication for an individual who is … located in Louisiana, who does not possess a Louisiana medical license or other authorization to practice medicine in this state, is necessarily engaged in the unauthorized practice of medicine in contravention of the Medical Practice Act. Participants and entities engaged in such misconduct are subject to investigation, civil injunction, monetary fines and penalties. Such individuals may also be referred by the Board to the Louisiana Attorney General or an appropriate district attorney for criminal prosecution and incarceration for up to five (5) months for each such offense” (http://bit.ly/2iN7V5L).

Other states such as Alabama would allow practice across state lines as long as they occur less than 10 times per calendar year [Ala. Code §34-24-505(b)].

Some states have enacted the Interstate Medical Licensure Compact (www.licenseportability.org/) to simplify the process of obtaining licenses to practice in multiple states.

Due to the potential for civil, criminal or licensure penalties, it is critical to understand the relevant state laws where you and the patient are located prior to providing treatment. Additionally, electronic communications with patients should be technically secure (e.g., encrypted) to comply with the Health Insurance Portability and Accountability Act of 1996.
I am an employed pediatrician and recently accepted a position with a new practice. Who is responsible for paying my tail insurance — my former employer, my new employer or me?

The most common type of malpractice insurance policy, known as claims-made, covers claims that occur and are reported while the policy is active. Once the policy has terminated, claims for care that occurred while the policy was active are no longer covered unless additional coverage is purchased to extend the length of time a claim may be filed. This is known as tail coverage. It is important for pediatricians to obtain tail coverage when terminating a policy, given that many pediatric malpractice cases are filed years (sometimes more than a decade) after care was provided.

Whether you or your former employer are responsible for paying for tail coverage is going to depend on the terms of your employment agreement. Some arrangements specify that the employer will pay unless the pediatrician is terminated with cause. Others split the cost, and some place the burden on the pediatrician regardless of the reason for separation.

In some cases, a new employer will agree to pay the cost of tail (or backwards looking “nose”) coverage. Tail coverage can be expensive, so it is advisable for the pediatrician to negotiate tail coverage as part of the employment agreement.

That brings up a second question. As I negotiate malpractice insurance for my new position, is an occurrence or claims-made medical liability insurance policy better?

Unlike claims-made policies described in the first question, occurrence policies cover any acts that occurred during the term of the policy, regardless of when the claim is filed. Which policy is better often depends on individual circumstances.

Additionally, it may be helpful for pediatricians to ask their liability insurance carrier whether claims-made or occurrence policies are purchased most often by a similar practicing provider in that community. Occurrence policies are “permanent,” while claims-made policies are more flexible (e.g., allowing increased limits).

While the rate and type of insurance are important, there are other considerations when obtaining professional liability insurance. These include, but are not limited to, the carrier’s financial stability, how it handles claims, physician involvement in resolving claims and who makes the decision to settle a claim.

Email your questions for future columns in AAP News to jake@aap.org.

Dr. Fanaroff is chair of the AAP Committee on Medical Liability and Risk Management.

RESOURCES

- For information on the difference between claims-made and occurrence policies, visit http://bit.ly/2ifOGRI.
#DeviceFreeDinner campaign

The Academy is a partner with Common Sense Media in the #DeviceFreeDinner campaign, which aims to help families set media and technology limits. The campaign highlights an important AAP recommendation that families designate screen-free times of day, such as during family meals.

The multiyear public awareness campaign encourages families to take a break from device use and enjoy in-person conversations. Children, along with their parents, spend an average of nine or more hours with media and technology every day. Research proves the benefits to kids of family meals, such as vocabulary acquisition, fewer behavior problems, lower rates of substance abuse and healthier eating patterns.

The campaign includes broadcast and digital public service announcements to raise awareness about the importance of device-free dinner. Pediatricians can direct families to www.CommonSense.org/device-free-dinner to take the challenge in their households. A Starrer Kit provides ideas to engage the entire family and start conversations. It also links to the AAP Family Media Use Plan tool on HealthyChildren.org. To review AAP media statements, visit http://bit.ly/2j4LB3C to create an account to place and track your order. The Academy is a partner in the educational campaign with the Measles & Rubella Initiative and others.

Measles educational materials

New educational materials, featuring children’s book characters Ivy and Bean, are available for pediatricians, schools, child care centers and other child health providers. Designed by children’s illustrator Sophie Blackall, the materials depict Ivy and Bean in various scenarios trying to stop the measles.

Each kit, available in English and Spanish, includes posters, coloring comic books, stickers and temporary tattoos. The resources are free of charge (including delivery) and are available for a limited time. There is a limit of two kits per order. Visit http://bit.ly/2j4LB3C to create an account to place and track your order. The Academy is a partner with Common Sense Media in the #DeviceFreeDinner campaign, which aims to help families set media and technology limits. The campaign highlights an important AAP recommendation that families designate screen-free times of day, such as during family meals.

Children’s Dental Health Month

Why should pediatricians participate in Children’s Dental Health Month? Dental caries is the No. 1 chronic disease affecting young children.

The Academy will focus on weekly themes in February. Week 1 focuses on the importance of oral health before and during pregnancy. Week 2 is Early Childhood Oral Health—Prevention is Key. Week 3 focuses on adolescent oral health. Week 4 is Oral Health During Childhood—What Can You Do in Primary Care? The AAP Voices blog (http://bit.ly/21JYnsu) and Campaign for Dental Health blog (http://ilikemyteeth.org/blog/) will feature stories from pediatricians about oral health focused on the four weekly themes.

The Campaign for Dental Health website, http://ilikemyteeth.org/health-professionals/, includes information on the benefits of community water fluoridation and other oral health topics in English and Spanish.

The American Dental Association’s campaign efforts focus on promoting fluoride as a way to prevent caries through its main message to “Choose Tap Water for a Sparkling Smile.” Download and print posters to hang in your office at http://bit.ly/2ifZiT.

Those interested in becoming more involved in children’s health initiatives can join the AAP Section on Oral Health and find more resources at http://www2.aap.org/commeps/dochsp/oralhealth/index.html.

AAP patient education brochures, booklets


Order with promo code REDESIGN17 to save 20% on all patient education brochures and booklets through April 30. Visit http://shop.aap.org/publications/patient-education/.

Reports on mental health, disasters

- Ready or Not, Protecting the Public from Diseases, Disasters and Bioterrorism from the Trust for America’s Health looks at key indicators of state readiness. Among the findings, just 10 states vaccinated at least half their population against influenza. Twenty-six states and Washington, D.C., scored a six or lower on 10 key indicators of public health preparedness. Access an interactive state map and the report at http://healthymariticans.org/reports/readyornot2016/.
- Mental Health Services for Latino Youth: Bridging Culture and Evidence from National Council of La Raza examines the importance of ensuring access to quality, culturally competent mental health care for Latino youths. The report notes that Latino youths, especially girls, have a high prevalence of depression. Latino youths also have higher prevalence of illicit drug and alcohol use. Read the report at http://publications.nclcr.org/handle/123456789/1673.
Medicare Physician Fee Schedule updated for 2017

from the AAP Division of Health Care Finance

Every year, the Centers for Medicare & Medicaid Services (CMS) publishes a new physician fee schedule that includes updated relative value units (RVUs) and payment statuses and a new conversion factor.

Many codes are revalued up or down based on different factors. The Academy publishes an RBRVS (Resource-Based Relative Value Scale) brochure annually (see resources) and makes updates throughout the year. The brochure lists many relevant primary care pediatric Current Procedural Terminology (CPT) codes and their current year RVUs. Also, new codes that impact pediatrics are added to the list.

For 2017, two new codes for health risk assessment were added: 96160 and 96161. Both are valued with 0.13 total non-facility RVUs. New codes for moderate sedation also were added and valued as follows:

### Moderate sedation provided by the same physician performing the diagnostic or therapeutic service

<table>
<thead>
<tr>
<th>CPT code</th>
<th>Work RVUs</th>
<th>NF PE RVUs</th>
<th>F PE RVUs</th>
<th>PLI RVUs</th>
<th>Total NF RVUs</th>
<th>Total F RVUs</th>
<th>100% NF Medicare</th>
<th>100% F Medicare</th>
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<td>$52.04</td>
<td>$12.56</td>
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<td>NA</td>
<td>$11.13</td>
<td>NA</td>
</tr>
</tbody>
</table>

### Moderate sedation provided by a physician other than the provider performing the diagnostic or therapeutic service

<table>
<thead>
<tr>
<th>CPT code</th>
<th>Work RVUs</th>
<th>NF PE RVUs</th>
<th>F PE RVUs</th>
<th>PLI RVUs</th>
<th>Total NF RVUs</th>
<th>Total F RVUs</th>
<th>100% NF Medicare</th>
<th>100% F Medicare</th>
</tr>
</thead>
<tbody>
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<tr>
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<td>0.11</td>
<td>1.63</td>
<td>NA</td>
<td>$58.50</td>
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</tr>
</tbody>
</table>

F – facility; NA – not applicable; NF – non-facility; PE – practice expense; PLI – professional liability insurance

### Non-direct prolonged services now payable

New for 2017, CMS will change the status indicator for CPT codes 99358-99359 (non-direct prolonged services) from “B” (bundled and not separately payable) to “A” (active status and payable). Per CMS in the Final Rule: “We agreed that these codes would provide a means to recognize the additional resource costs of physicians and other billing practitioners, when they spend an extraordinary amount of time outside of an E/M visit performing work that is related to that visit and does not involve direct patient contact (such as extensive medical record review, review of diagnostic test results or other ongoing care management work). We also believed that doing so in the context of the ongoing changes in health care practice to meet the current population’s health care needs would be beneficial for Medicare beneficiaries and consistent with our overarching goals related to patient-centered care.”

This is the type of work pediatricians and pediatric specialists perform but rarely have seen compensation for. With the status change and published RVUs, private payers and state Medicaid plans typically follow suit. AAP members are urged to code for these services when provided.

In addition to the non-direct prolonged services, CMS has followed suit with the same status change and published values for the complex chronic care management codes 99487 and 99489. While these are reported less often for pediatric patients, they are applicable.

It is important to remember that CMS now allows payment for many non-face-to-face services, including non-direct prolonged services (99358-99359), so pediatricians should report them.

### Prolonged service before/after direct patient care

<table>
<thead>
<tr>
<th>CPT code</th>
<th>Work RVUs</th>
<th>NF PE RVUs</th>
<th>F PE RVUs</th>
<th>PLI RVUs</th>
<th>Total NF RVUs</th>
<th>Total F RVUs</th>
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<td>0.07</td>
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<td>1.52</td>
<td>$54.55</td>
<td>$54.55</td>
</tr>
</tbody>
</table>

### Chronic care management

<table>
<thead>
<tr>
<th>CPT code</th>
<th>Work RVUs</th>
<th>NF PE RVUs</th>
<th>F PE RVUs</th>
<th>PLI RVUs</th>
<th>Total NF RVUs</th>
<th>Total F RVUs</th>
<th>100% NF Medicare</th>
<th>100% F Medicare</th>
</tr>
</thead>
<tbody>
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<td>1.47</td>
<td>$93.67</td>
<td>$52.76</td>
</tr>
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<td>99489</td>
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<td>0.03</td>
<td>1.31</td>
<td>0.74</td>
<td>$47.02</td>
<td>$26.56</td>
</tr>
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</table>

In addition to the RVU updates, the Medicare conversion factor (CF) has been updated. This is the dollar amount all RVUs are multiplied with to get to the payment. The 2016 CF was set at $35.80, while the 2017 CF is set at $35.89. Even though the increase seems small, there is always the concern that the CF will remain the same or decrease.

### RESOURCES


### AAP News Parent Plus INFORMATION FROM YOUR PEDIATRICIAN

Consider child’s age before trying tooth whitening products

After the tooth fairy has made a few visits to your home, you might notice that your child’s pearly smile doesn’t seem as white now that she has a few more adult teeth. This is because the top layer (enamel) of baby teeth is thinner and whiter than the enamel of adult teeth.

Over-the-counter tooth whitening products such as whitening strips, gels and trays have exploded in popularity in recent years. But should children use them?

Pediatric dentists usually do not suggest bleaching until all baby teeth have fallen out. If using at-home bleaching products, parents should read the product label for recommended ages and instructions.

Dark teeth can be caused by colas, dark juices, popsicles, coffee and other foods. A single dark tooth could be the result of an injury to the tooth, tooth decay or cavities.

Children should visit a dentist for a routine checkup and cleaning every six months, according to the American Academy of Pediatrics. There, they can talk about whitening treatments. “I tell parents to hold off decisions about bleaching (until) after age 14, because all the baby teeth are gone by then and the adult teeth are fully erupted,” said Martha Ann Keels, D.D.S., Ph.D. She suggests starting with an at-home kit with a low amount of bleach. “It is important to pay attention to the side effects and stop bleaching if the teeth start to be sensitive or the gums become irritated,” she said.

A dentist should examine an injured tooth that has turned dark. “I try to encourage accepting natural beauty over bleaching.”


— Trisha Korioth

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A new report from The National Academies of Sciences, Engineering and Medicine provides a roadmap to improve the care of those with food allergies. Titled Finding a Path to Safety in Food Allergy: Assessment of the Global Burden, Causes, Prevention, Management, and Public Policy (www.nationalacademies.org/FoodAllergies), the report includes recommendations on food allergy diagnostics, prevention, education of various stakeholders, emergency and daily management, allergen labeling and development of policy guidelines for a variety of settings to improve safety.

Supported by three federal and eight nonfederal sponsors, the guidance is the product of a study by a committee of 15 international experts considering a vast array of issues in the field.

Most of the recommendations directly or indirectly affect pediatrics in their management of food allergy. For example, current allergen food labeling practices can be confusing for families. Allergens such as sesame are not included in current laws, foods such as lychee are considered nuts (it is a fruit) and advisory labeling (i.e., “may contain”) is ambiguous and unregulated.

The report calls for action to improve labeling based on a scientific standard. It also identifies numerous areas that require further research, especially on prevalence, diagnostics, quality-of-life issues and treatments.

Of note, the committee recommended that various stakeholders, including the American Academy of Pediatrics, update guidelines on diagnosis, prevention and management of food allergy. Following is a summary of some of the areas in the report that are pertinent to pediatrics, along with how the AAP has been and will continue to be involved in these issues.

Diagnosis

The report recommends that physicians use evidence-based, standardized procedures as the basis for food allergy diagnosis and avoid unproven procedures (e.g., applied kinesiology, immunoglobulin G panels, electrodermal testing).

The AAP clinical report Allergy Testing in Childhood: Using Allergen-Specific IgE Tests (http://bit.ly/2hg3dVK) is related to this topic.

Prevention


Training

The report encourages training of various stakeholders such as medical students, residents and other health care providers on food allergy and anaphylaxis management, including through professional organizations.

Of note, the AAP National Conference & Exhibition, various online programming and other educational initiatives have included and will continue to include food allergy.

Anaphylaxis management

The committee recommended that health care providers and others use intramuscular epinephrine in all infants, children and adults as a first line of emergency management for episodes of food allergy-induced anaphylaxis. It also recommended that the Food and Drug Administration evaluate the need for, and, if indicated, industry should develop an auto-injector with 0.075 milligrams of epinephrine specifically designed for use in infants.

In a 2007 clinical report (http://bit.ly/2gROVhK) and two clinical reports coming in 2017, the Academy provides guidance to clinicians regarding the indications of using and prescribing self-injectable epinephrine and for dosing, including recognizing that fixed-dose auto-injectors are lacking for infants who weigh 7.5 kilograms or less.

Safety in various settings

The committee recommended that stakeholders, including advocates such as the Academy, participate in a task force to address emergency management and prevention strategies for venues such as schools, early care centers and transportation such as airplanes.

The Academy has been committed to these issues, and recently resolutions were submitted at the Annual Leadership Forum regarding availability of epinephrine on airplanes. In addition, the Academy produced a clinical report on food allergy management in schools (http://bit.ly/2gEI9qg) and provided input on the Centers for Disease Control and Prevention's Voluntary Guidelines for Managing Food Allergies in Schools and Early Care and Education Programs (http://bit.ly/2gEQy4z).

In summary, this landmark report provides numerous avenues for pediatricians to bring the recommendations to bear to improve health and safety for their patients.

Disclaimer: The author is responsible for the content of this article, which does not necessarily represent the views of the National Academies of Sciences, Engineering, and Medicine, their committees, or convening bodies.

Dr. Sicherer is past chair of the AAP Section on Allergy and Immunology Executive Committee.
AAP News • www.aapnews.org • February 2017

AAP backs delayed umbilical cord cutting for term, preterm infants

by Trisha Korioth • Staff Writer

Umbilical cord clamping should be delayed in term and preterm infants due to several health benefits, according to AAP-endorsed guidance from the American College of Obstetricians and Gynecologists (ACOG).

Released Dec. 21, Delayed Umbilical Cord Clamping After Birth (http://bit.ly/2j8VkcP) is an update to a 2012 ACOG committee opinion.

The new guidance, which was published in Obstetrics and Gynecology in January, “recommends a delay in umbilical cord clamping in vigorous term and preterm infants for at least 30-60 seconds after birth.” It cites several benefits to term and preterm infants, and the position concurs with recommendations from several organizations.

The Academy previously supported the ACOG recommendation to delay clamping for preterm infants. In 2015, the Neonatal Resuscitation Program issued guidelines recommending delayed cord clamping for at least 30-60 seconds for most babies born at term or preterm (http://bit.ly/2h3Tji1). The World Health Organization recommends that the umbilical cord not be clamped earlier than one minute after birth for term and preterm infants.

“While there are various recommendations regarding optimal timing for delayed umbilical cord clamping, there has been increased evidence that shows that the practice in and of itself has clear health benefits for both preterm and term infants,” Maria A. Mascola, M.D., lead author of the committee opinion and ACOG liaison to the AAP Committee on Fetus and Newborn, said in a news release. “And, in most cases, this does not interfere with early care, including drying and stimulating for the first breath and immediate skin-to-skin contact.”

According to the new committee opinion:

• Delayed clamping in term infants increases hemoglobin levels at birth and improves iron stores for several months after birth, which may favorably affect infant development.

• For preterm infants, delayed clamping may improve transitional circulation and help increase red blood cell volume. It also reduces the need for blood transfusions and the incidence of necrotizing enterocolitis and intraventricular hemorrhage.

• Delayed cord clamping could lead to a slight increase in cases of jaundice that would require phototherapy in term infants. ACOG urges the adoption of mechanisms to monitor and treat neonatal jaundice.

Delayed clamping does not put mothers at greater risk of postpartum hemorrhage, the committee noted. However, immediate clamping is necessary in cases of maternal hemorrhage or hemodynamic instability, abnormal placentaion or if there is a need for immediate resuscitation of the infant or if infant placental circulation is not intact.

More research is needed on the benefits of umbilical cord milking, according to the committee opinion. This practice of rapidly transferring umbilical cord blood to the infant is used when a delay in umbilical cord clamping after birth is not possible.

Families considering cord blood banking will require counseling on the benefits of transfusion at birth vs. banking for future use, the committee wrote. Delayed cord clamping makes it less likely that donation and banking criteria are met.

“The ability to provide delayed umbilical cord clamping may vary among institutions and settings,” the committee wrote. “Decisions in those circumstances are best made by the team caring for the mother-infant dyad.”

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Over 2,000 years ago, Greek mathematicians postulated that the shortest distance between two points is a straight line. Although present-day scholars may quibble about that theory, there exists an applicable corollary for media-savvy doctors wishing to connect more effectively with interviewers: If you desire to implant your core message, known by communicators as a SOCO (single overriding communication objective), firmly in the listener’s memory, look no further than mastering the art of the sound bite.

Reporters love sound bites because they often make great headlines, as well as enhance their story. The public quotes them because they’re memorable. And you will benefit because they are a potent delivery system for your media messages.

Think of sound bites as the gift that keeps on giving — an opportunity to have your communication intent continue long after the initial interview. Their purpose is simple: leave viewers or readers with a verbal image that reinforces what you said and, more importantly, why you said it.

Here are some hints to create a tasty (and tasteful) sound bite:

- **Less is more:** Keep it to one or two sentences.
  - All screens teach, but are they teaching your family’s values?
  - Pediatricians first and foremost are child-health advocates.
  - The buck stops here. Trust but verify.
- **Express a consistent viewpoint** after you have detailed what and why.
  - Fever is a child’s friend. Respect it but do not fear it.
  - Children’s vaccines are safe and effective.
- **Avoid bombastic bites:** They guarantee airtime but will reflect poor judgment.
  - Any family who chooses not to vaccinate is not welcome in our practice.
  - Not vaccinating children is equivalent to child abuse.
  - Be specific and insightful: You can utilize contrast as well as paradox to paint a verbal picture for the audience.
  - We need to put a stop to seven children and teens dying every day from gun violence.
  - It is a tragedy that one out of every five American children lives in poverty.
- **Use metaphors and similes:** Make sure to discharge your message immediately after the bite.
  - Children are not small adults. They have unique health needs.
  - Teens need parents to have their backs, not constantly peering over their shoulders.
  - Treating obesity is like playing whack-a-mole…
  - Fighting the belief that vaccines cause autism is like killing zombies. No matter how much research has killed this concept, it keeps being resurrected to walk among us again.

**Annual survey finds youth substance use mostly declining**

Eighth-graders’ illicit drug use is at its lowest rate since 1991, and fewer teens are using substances such as marijuana, alcohol, tobacco and some prescription medications, according to an annual survey from the National Institute on Drug Abuse and University of Michigan.

The 2016 Monitoring the Future survey measured drug, alcohol and cigarette use and related attitudes of 45,473 students from 372 public and private schools.

Marijuana use in the past month dropped significantly among eighth-graders to 5.4%, but has remained relatively stable among 10th- and 12th-graders. In states with medical marijuana laws, however, 12th-graders had a higher rate of use. Marijuana edibles also were more popular among teens living in states where medical marijuana is legal, according to the survey. For example, about 40% of 12th-graders consumed marijuana in food in states with medical marijuana laws vs. 28% in other states.

Alcohol use has declined, and the rate of teens who reported having been drunk is the lowest in the survey’s history. Alcohol, which many teens report is easy to get, is the most used substance by teens, and more than half of 12th-graders reported having used it in the past year. But binge drinking (described as five or more drinks in a row in the last two weeks) is declining among all grades.

Use of e-cigarettes by high school seniors also dropped from 16.2% in 2015 to 12.4%. Marijuana and e-cigarettes have surpassed tobacco cigarettes in popularity among teens.

The survey has tracked substance use by 12th-graders every year since 1975, and added eighth- and 10th-graders in 1991. Read more at www.monitoringthefuture.org.
How to minimize liability when providing nonurgent care in parent’s absence

by Jonathan M. Fanaroff, M.D., J.D., FAAP

 Pediatricians often are asked to care for children when the parent is not present. In nonurgent situations, the pediatrician can take a number of practical steps to maximize their patients’ access to care while minimizing liability exposure.

These steps are discussed in the AAP clinical report Consent by Proxy for Nonurgent Pediatric Care from the AAP Committee on Medical Liability and Risk Management. The report, a revision of a 2010 clinical report, is available at http://dx.doi.org/10.1542/peds.2016-3911 and is published in the February issue of Pediatrics.

The report makes the following recommendations for pediatricians:

- Determine whether the practice will see minor patients without a parent or guardian present. It usually is best if all physicians within the practice adopt the same policy; otherwise, problems can occur during coverage situations.
- If the practice decides not to provide nonurgent care to patients without a parent or guardian present, then the office policy and an information sheet explaining it should be provided to patients and their parent or guardian.
- If the practice decides to provide nonurgent care to patients accompanied by someone other than their parent or guardian, it should establish a policy and procedural guide for the office as well as a patient information sheet that explains the policy.
- It is advisable to create a template consent form to be used in cases in which individuals other than the parent or guardian may be expected to accompany a child to the office. The report suggests a number of items to include.
- The proxy relationship should be verified and documented periodically. Additionally, when the office or pediatrician does not know the proxy personally, photo identification, such as a driver’s license, may be required.
- Establish an office procedure for providing and documenting informed consent for proxies with limited English proficiency (LEP), hearing impairment or limited health literacy. Similarly, information sheets related to office policies should be accessible for proxies with LEP and limited health literacy.
- Pediatricians need to be aware of state and federal laws that affect the ability to give consent by proxy (see www.plol.org). Additionally, it is advisable to have legal counsel review office policy and supporting documents to promote compliance with applicable laws.
- It is recommended that informed consent, including consent by proxy, be included in residency training and continuing medical education. Such educational efforts have been effective in improving knowledge and attitudes about informed consent.
- When in doubt about informed consent in a proxy situation, pediatricians should use discretion in deciding whether to treat and should base the decision on the child’s best interests.

Most important is for the pediatrician to recognize and distinguish between appropriate and inappropriate proxy consent. It is perfectly appropriate to perform a rapid test for Group A streptococcal infection in a patient with a sore throat with consent by proxy. It would be inappropriate, on the other hand, to perform genetic testing for Huntington disease.

AAP keeps children at forefront of dialogue on quality measures

from the AAP Division of Quality

The Academy is working to ensure that quality measures reflect the unique nature of care for children and demonstrate the value of care provided by pediatricians. To that end, the Academy has partnered with the National Quality Forum (NQF) to ensure the interests of children are at the forefront of the national dialogue about quality measurement.

The NQF is a nonprofit, nonpartisan membership organization focused on improving health care. It may be most well-known for its evidence-based standing committees’ final recommendations for endorsement health. The NQF Health and Well-Being Project, which reviews, evaluates and makes recommendations regarding endorsement of quality measures that address population health.

At the end of 2016, the Health and Well-Being Standing Committee completed its review and recommendations for 23 quality measures. The committee recommended 15 for endorsement, four of which included or directly impacted pediatric populations:

- childhood immunization status,
- preventive care and screening: influenza immunization,
- influenza vaccination coverage among health care personnel and
- preventive care and screening: influenza immunization (e-measure).

As a member of NQF, the Academy participates in public comment opportunities that include quality measures specific to, or that directly impact, pediatric populations. The Academy also votes on the standing committees’ final recommendations for endorsement. As of December 2016, over 30 AAPs had been appointed to standing committees for about 20 different NQF projects.

RESOURCES

AAP reaffirms adolescents’ rights to confidential care when seeking abortion

by Seema Menon, M.D.

Adolescents have the right to confidential care when seeking abortion services, according to a position reaffirmed by the Academy in an updated policy statement.

The stance is in line with other professional medical societies such as the American Medical Association, the Society for Adolescent Health and Medicine, the American Public Health Association and the American College of Obstetricians and Gynecologists.

The Adolescent’s Right to Confidential Care When Considering Abortion, from the Committee on Adolescence, is available at http://dx.doi.org/10.1542/peds.2016-3861 and is published in the February issue of Pediatrics.

Effects of state policies

Since 2011, states have been enacting more restrictive policies on abortion services than seen in previous decades. In 2015, 38 states required parental involvement in a minor’s decision to have an abortion. The Supreme Court has declared it to be constitutional for states to develop their own mandatory parental notification laws for minors seeking abortion services provided a judicial bypass process is in place.

The mandatory parental notification law is rooted in preservation of family communication and in the physical and emotional well-being of adolescents. However, research has shown that these laws have the opposite effect. Minors, particularly younger adolescents, are likely to involve a trusted adult when seeking abortion services regardless of whether a state law mandating parental notification is in place. Adolescents choosing not to involve parents do so because of their ability to accurately predict a family crisis stemming from severe anger and rejection.

It also has been found that the proportion of adolescents seeking abortion services in the second trimester has increased in several states where mandatory parental notification laws are in place. Rather than having a beneficial health impact, these laws may delay care, leading to a second trimester procedure that not only is more medically complex, but also associated more with psychological sequelae compared to abortion services in the first trimester. While the judicial bypass process may seem to be a reasonable compromise, adolescents find this process to be an obstacle in accessing health care. This process has been described as burdensome, humiliating and stressful. Important, it has been found that adolescents often are not made aware of this process in states requiring mandatory parental notification.

Concerns related to adolescent decision-making ability often are questioned when considering the need for mandatory parental involvement. Currently, laws allow adolescents to make independent medical decisions during pregnancy and for their children. The policy statement points out, therefore, that it is consistent to protect the right of adolescents to seek abortion services confidentially, without mandatory parental notification.

The Academy advocates a strong family relationship and holds the belief that parents generally act in the best interest of their children.

Recommendations

• Adolescents have the right to confidential care when considering abortion services.
• Health care professionals are in a position to facilitate family communication and should strongly encourage a pregnant adolescent to seek guidance from a trusted adult when considering all pregnancy options.
• Concern for incest or abuse should be raised when a younger adolescent resists parental involvement when seeking abortion services.
• It ultimately is the pregnant adolescent’s right to decide who should be involved in the decision-making process and what the outcome of the pregnancy will be.

Dr. Menon, lead author of the policy, is the liaison from the North American Society for Pediatric and Adolescent Gynecology to the AAP Committee on Adolescence.

Subspecialists benefit from AAP private payer advocacy

by Richard Lander, M.D., FAAP

One aspect of AAP private payer advocacy is to review insurance carrier policies to ensure they cover recommended pediatric services and provide payment to primary care and subspecialty pediatricians. Much review is not an endorsement of a carrier’s policy but an opportunity to advise the carrier on the policy’s impact on pediatrics and pediatricians.

The policy is shared with the appropriate AAP council, committee or section for review, and feedback then is forwarded to the carrier. When a carrier’s policy is not in alignment with AAP recommendations, the reviewing group recommends a response from the Academy.

The Academy has facilitated review of the nation’s largest private carriers’ clinical policies to incorporate pediatric perspective. Recent successes on subspecialty pediatric issues include the following:

• The AAP Committee on Fetus and Newborn and Section on Neonatal-Perinatal Medicine developed comments on the UnitedHealthcare (UHC) policy on inhaled nitric oxide (INO) and had a follow-up conference call with its authors. As a result of that discussion, UHC revised its policy regarding non-coverage for INO in neonates born at less than 34 weeks.
• Based on input from the AAP Section on Cardiology and Cardiac Surgery, Anthem revised its policy on implantable cardioverter defibrillators to expand the pediatric indications for implantation to include all adult indications considered medically necessary when criteria are met.
• Members of the AAP Section on Otolaryngology—Head and Neck Surgery provided clarification and peer-reviewed published reports supporting digital sound processing for certain types of hearing loss and urged Anthem and the Blue Cross Blue Shield Association to provide appropriate benefits coverage. In light of the information provided, clarifications on medical necessity for bone conducted hearing loss were included in policy templates.

The AAP Section on Urology worked with the AAP Private Payer Advocacy Advisory Committee (PPAAC) to develop appeal letter templates for its members to advocate for benefits coverage for biofeedback therapy for lower urinary tract dysfunction, testicular prostheses and treatment with Deflux for children with vesicoureteral reflux. The templates are available at http://www2.aap.org/sections/urology/.

Dr. Lander is chair of the AAP Private Payer Advocacy Advisory Committee.

RESOURCES

• PPAAC is available to work with chapters, councils, committees and sections on private payer coverage and payment issues. For more information, contact Lou Terranova, in the AAP Division of Health Care Finance, at 847-434-7633 or terranova@AAP.org.
• To assist in private payer advocacy, AAP members are urged to report any carrier concerns using the Hassle Factor Form at http://bit.ly/2f8nPT.
Chapters prioritize resident engagement, involvement opportunities

from the AAP Department of Community, Chapter and State Affairs

AAP chapters are engaging pediatric residents in advocacy and leadership opportunities, increasing the likelihood of retaining trainees as members throughout their careers.

Following are some of the strategies chapters are using to engage residents.

Advocacy in action

The Mississippi Chapter involved residents in its summer enrichment program, Ground Zero: Twenty Days in the Delta. The program addressed food insecurity, literacy, nutrition, physical activity, asthma education and management, and access to care in an impoverished community in the Mississippi Delta. Community involvement and sustainability were major components of the effort.

Through an AAP Healthy People 2020 grant, the program educated children on nutrition, healthy food choices and cooking strategies. It also increased awareness of summer school meal programs for children in need. Mississippi Chapter resident members volunteered during the event, where 855 meals were prepared and served to local children.

The Mississippi Chapter also holds a Capitol Day for residents to gain legislative advocacy experience, including a role-playing opportunity with retired pediatricians portraying immunization-resistant parents.

Preparing future leaders

For over a decade, the Nebraska Chapter has been providing practical resources and career support to residents. The chapter hosts a one-day retreat for second-year residents, offering sessions not typically covered in school curricula. Speakers lecture on medical malpractice, quality improvement, choosing a practice type, building a CV, interviewing tips, contract negotiation and financial planning.

In addition, the chapter designed programming to enhance residents’ experience at its annual and fall meetings in 2015. As a result, more than 25 residents and medical students (approximately 56% of resident membership) attended the meetings.

The chapter also encourages residents to assume leadership positions on the executive committee and other committees, and to attend events offering free continuing medical education (CME).

The chapter saw a 6% increase in resident membership from 2014 to 2015.

“Resident engagement has been one of the chapter’s top priorities,” said chapter President Arwa Nasir, M.D., FAAP. “In addition to the Resident’s Retreat, free CME and AAP Legislative Conference sponsorship we provide, our state’s chief residents are ex officio chapter board members and participate in meetings, phone conferences and emails related to the business and advocacy efforts of the chapter.”

Member benefits focused on residents

Some chapters create benefits uniquely designed for residents.

California Chapter 3 presents an annual Resident of the Year award and funds two $50 resident book awards on a monthly basis.

In West Virginia, the chapter holds a yearly Resident Research Competition, and the top four abstracts (two original research and two case reports) are presented orally at the chapter’s spring meeting.

The Kentucky Chapter provides toolkits to graduating residents that show the value of AAP membership and emphasize the importance of national and chapter membership.

Ongoing engagement of residents

Many chapters cite resident outreach as an ongoing recruitment priority as well as a retention challenge. Some chapters provide resident membership at little or no cost, pay all or a portion of national AAP resident dues, or offer free attendance at the AAP National Conference & Exhibition.

“Chapters that offer valuable benefits to trainees on an ongoing basis are building stronger relationships with them in the long term,” said Christian D. Pulcini, M.D., M.Ed., M.P.H., chair of the AAP Section on Pediatric Trainees. “These efforts are appreciated and will ensure that trainees stay involved and engaged with the AAP at every level.”

AAP responds to FDA warning on anesthesia use in children

by Raeford E. Brown Jr., M.D., FAAP, and Rita Agarwal, M.D., FAAP

The Academy has coordinated a response to a recent Food and Drug Administration (FDA) warning that cautions health care practitioners about the possibility of developmental problems associated with repeated or prolonged use of anesthetics in children younger than 3 years of age. The agency is requiring warning labels on all anesthetic agents and sedatives, including propofol, midazolam and all volatile anesthetic agents.

An FDA Drug Safety Communication highlights the abundant animal data from more than a decade concerning suspected toxicities when these agents are used during surgeries or procedures lasting longer than three hours or when administered multiple times to children younger than 3 and pregnant women in their third trimester. Laboratory studies of multiple species, including primates, demonstrate that prolonged use and multiple anesthetics or sedations have been associated with developmental anomalies of cognition and memory and cell death in the developing brain.

The findings cited in the warning are not new. They have been discussed by three FDA advisory committees since 2007. However, concerns have arisen recently that not all practitioners using these medications for sedation or surgical anesthesia in children are aware of these findings, reducing their ability to make informed decisions concerning the risks and benefits of procedures requiring sedation or anesthesia. In addition, lack of awareness reduces the clinician’s ability to educate families and get informed consent.

The Academy, led by the Section on Anesthesiology and Pain Medicine and the Committee on Drugs, coordinated a response that aimed to place this warning in the perspective of recent controlled trials in humans and multiple epidemiological studies of large homogeneous populations. These studies demonstrate no developmental problems in children exposed to a single, short anesthetic or sedation.

The response cautions parents and clinicians of the risks of delaying needed surgery and diagnostic procedures. Until additional information is available from the many ongoing studies in animals and humans, parents and providers should weigh the risks and benefits of each contemplated procedure prior to proceeding.

In addition to the Academy, numerous other professional organizations endorsed the response, including the American Society of Anesthesiologists, the International Anesthesia Research Society, Society for Obstetric Anesthesia and Perinatology, Society for Pediatric Anesthesia, Congenital Cardiac Anesthesia Society, Pediatric Anesthesia Leadership Council and the Society for Pediatric Pain Medicine.

RESOURCES

• For more information, contact Allison Buckley, in the AAP Division of Chapter and District Relations, at 847-434-7892 or abuckley@aap.org.


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Child Health Informatics Center stands up for pediatricians

by Christoph U. Lehmann, M.D., FAAP

Over the last seven years, the AAP Child Health Informatics Center (CHIC) has played a major role in improving the landscape for pediatricians and other health care providers who use health information technology (HIT) as they care for children and families.

The CHIC monitors legislation and regulations related to the meaningful use of electronic health records (EHRs) and HIT; works with government agencies; advocates for HIT that benefits children and pediatricians; and provides technical assistance.

The Academy launched the CHIC in 2009 to prepare pediatricians for anticipated changes regarding HIT and to support the following goals:

• build awareness of the importance of HIT as it relates to improved quality and efficiency of pediatric care;
• advocate for pediatricians’ HIT needs by coordinating and communicating issues at the national level, including with federal policymakers, the Office of the National Coordinator (ONC), the Centers for Medicare & Medicaid Services (CMS) and HIT vendors;
• provide resources and education to members about EHR adoption and implementation; and
• support the translation and spread of knowledge for integration into electronic formats.

Most recently, the CHIC facilitated a major win for a solo New Jersey pediatrician who had received meaningful use incentive monies and was being audited. In 2016, the practitioner received a notice from the New Jersey Medicaid office claiming the practice owed almost $6,000 from meaningful use incentives paid incorrectly. The Medicaid office threatened to forward the matter to a collection agency within 30 days and directed participating managed care organizations to forward any payments for the pediatrician to it instead.

The practice had testified that it met the measure requirements of patients or caregivers who requested an electronic copy. Unfortunately, the practice failed to maintain copies of the reports it sent to Medicaid. At audit, it turned the report which had been designed (based on ONC guidance) to report the measure over the whole life of the EHR and not for the reporting period. The auditor failed the practice, which triggered Medicaid’s recoupment attempt.

The pediatrician turned to her EHR vendor, which sought assistance from the CHIC. The CHIC reached out to ONC and CMS, which contacted New Jersey Medicaid officials and educated them that CMS guidance did not support the auditor’s view. The pediatrician subsequently was informed that she did not have to pay back the meaningful use incentive.

The CHIC has had several other major achievements, including:

• Development of survey questions and analysis of office-based pediatricians’ use and perceptions of EHRs in practice. In 2009, 2012 and 2016, CHIC developed questions for the AAP Periodic Survey of Fellows, and survey data have informed AAP advocacy, lobbying and educational efforts.
• Lobbying for reinstated payments for meaningful use of EHRs. In 2014, Florida stopped payments to providers participating in the Medicaid EHR Incentive Program (meaningful use). Florida Medicaid decided not to request additional spending authority for meaningful use after 2013, which meant eligible pediatricians and children’s hospitals were going to miss out on $70 million in reimbursements to support their use of EHRs to care for children. The CHIC, in collaboration with the Florida Chapter, worked with CMS on a plan to reinstate meaningful use payments through Florida Medicaid.
• Safer e-prescribing for children. In 2016, the National Council for Prescription Drug Programs approved a proposal from the Academy to include patient weight as a standard feature of electronic prescriptions for pediatric patients. The CHIC and AAP Council on Clinical Informatics worked with the Florida Chapter and CMS on a plan to reinstate meaningful use payments through Florida Medicaid.

From federal and state advocacy successes to supporting individual pediatricians, the CHIC has been a “boots on the ground” force for the application of technology to make pediatric care more efficient, effective and safer.

Dr. Lehmann is medical director of the AAP Child Health Informatics Center.

Tech Tip

CDC Opioid Guideline app helps with treatment decisions for patients 18 years and older

from the AAP Division of Quality

The Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain (https://www.cdc.gov/mmwr/volumes/65/wr/rr6501e1.htm) helps health care providers make informed clinical decisions about chronic pain treatment for patients 18 years of age and older in primary care settings. The guideline is not intended for patients in active cancer treatment, palliative care or end-of-life care.

The CDC Opioid Guideline app offers access to summaries of key guideline recommendations or the full guideline; a motivational interviewing (MI) portal to learn about the MI process and review examples of patient-provider dialogues; and a calculator that computes total daily opioid dose.

The app is free and available for both iOS (http://apple.co/2iJ33eR) and Android (http://bit.ly/2iNaZ1f) devices.

For more information about the app, guideline, and to access training, posters, videos or resources, visit the CDC website at https://www.cdc.gov/drugoverdose/prescribing/app.html.

If you would like to share a first-hand experience using technology, such as software, program, app, widget, etc., to improve patient care or practice management, email submissions of 250 words or less to Cathleen Guch at cguch@aap.org.

RESOURCE

Information about the Child Health Informatics Center, http://bit.ly/2i6vbHC
Fellows in the News

Wanda D. Barfield, M.D., M.P.H., FAAP, of Atlanta, was promoted to assistant surgeon general of the U.S. Public Health Service.

Dr. Barfield is director of the Division of Reproductive Health within the National Center for Chronic Disease Prevention and Health Promotion at the Centers for Disease Control and Prevention (CDC).

She is associate professor of pediatrics at the Uniformed Services University of the Health Sciences and adjunct assistant professor at Emory University School of Medicine. Dr. Barfield’s research has focused on perinatal morbidity and mortality; early child health services utilization; improving access to risk-appropriate perinatal services; and advancing the quality of women’s maternal and child health data for public health action.

She is the CDC liaison to the AAP Section on Neonatal-Perinatal Medicine and Committee on Fetus and Newborn.

Juan A. Dumois, M.D., FAAP, of St. Petersburg, Fla., received the Johns Hopkins Medicine Clinical Excellence Physician of the Year Award.

Dr. Dumois is clinical practice director for pediatric infectious disease and chair of the Division of Infectious Disease at Johns Hopkins All Children’s Hospital, where he is an attending physician.

He is a member of the AAP Council on Foster Care, Adoption and Kinship Care and Section on Infectious Diseases.

Berrin Ergun-Longmire, M.D., FAAP, of Toledo, Ohio, was named director of the Center for Diabetes and Endocrinology at Akron Children’s Hospital.

She most recently served as chief of pediatric endocrinology and diabetes in the pediatrics department at the University of Toledo College of Medicine. Her research has focused on type 1 and type 2 diabetes in children.

Matthew D. Garber, M.D., E.H.M., FAAP, of Jacksonville, Fla., was selected as the Paul V. Miles Fellow in Quality Improvement by the American Board of Pediatrics. The award is given to a mid-career pediatrician dedicated to improving quality of care for children. He was chosen for perspectives on quality improvement in community-based hospitals, as well as launching and sustaining new programs.

Professor of pediatrics at the University of Florida College of Medicine and a hospitalist at Wolfson Children’s Hospital, Dr. Garber is chair-elect of the AAP Section on Hospital Medicine Executive Committee.

He is one of the founders and chair of the Value in Inpatient Pediatrics (VIP) Network, which is part of the AAP Quality Improvement Innovation Networks. The VIP Network has grown to include projects on urinary tract infections, community-acquired pneumonia, bronchiolitis in the emergency department and hospital, and fever in infants.

Amy Groen, D.O., FAAP, of Ankeny, Iowa, was named medical director of the new Blank Children’s Hospital Pediatric Emergency Department.

She is adjunct assistant professor at Des Moines University and adjunct clinical assistant professor at University of Iowa.

Dr. Groen is a member of the AAP Section on Emergency Medicine. She serves as a disaster preparedness co-champion within the Iowa Chapter and is the chapter’s representative to the Iowa Trauma System Advisory Council and Iowa Department of Public Health Emergency Medicine Services Council.

Mona Hanna-Attisha, M.D., M.P.H., FAAP, of West Bloomfield, Mich., was among 11 nominees to be considered for Time magazine’s 2016 Person of the Year.

Dr. Hanna-Attisha became a public health advocate for children in Flint, Mich., who suffered health problems after drinking the city’s lead-contaminated water. A pediatrician at Hurley Children’s Hospital, she is director of the pediatric residency program at Hurley Medical Center and assistant professor of pediatrics and human development in the College of Human Medicine at Michigan State University.

Gilbert C. Liu, M.D., M.S., FAAP, of Louisville, Ky., was named medical director of the Kentucky Department for Medicaid Services in the Cabinet for Health and Family Services. He also was named endowed chair and distinguished scholar in Urban Health Policy Research at the University of Louisville, where he is associate professor of pediatrics.

Chair of the AAP Pediatric Leadership Alliance planning group, Dr. Liu serves on the National Institutes of Health Community Influences on Health Behavior scientific merit review panel. He also founded the Kentucky Pediatric Alliance for Transforming Children’s Healthcare, a learning collaborative to improve care quality for publicly insured children in the Louisville metro area.

Ellis J. Neufeld, M.D., Ph.D., FAAP, of Boston, was named clinical director, physician-in-chief and executive vice president of St. Jude Children’s Research Hospital effective in March.

He most recently was associate chief of the Division of Hematology/Oncology at Dana-Farber/Boston Children’s Cancer and Blood Disorders Center, medical director at Boston Hemophilia Center and Egan Family Foundation Chair in Transitional Medicine at Harvard.

Dr. Neufeld has researched non-malignant hematologic diseases and published on hemophilia, thalassemia and immune thrombocytopenia. He is a member of the AAP Section on Hematology/Oncology.

Frances L. Owen, M.D., FAAP, of St. Simons Island, Ga., received the Contributions to Quality Care of Children and Youth with Special Needs Award from the Georgia Department of Public Health.

Dr. Owen has a special interest in adolescent health, particularly attention-deficit/hyperactivity disorder. She is in practice with the Southeast Georgia Health System.

Sharon D. Rouse, D.O., FAAP, of Jackson, Mich., was named chief medical officer at the Center for Family Health, a federally qualified health center that operates seven sites across the Jackson area.

Most recently, Dr. Rouse served as medical supervisor of the pediatrics and family medicine departments at the Center for Family Health. She is a former high school science teacher and helped establish the medical residency program with Henry Ford Allegiance Health.

Submit news of Fellows’ awards, honors and appointments, including biographical sketch and photo, to Trisha Korioth at tkorioth@aap.org; phone 800-433-9016, ext. 4791. Please include any academic titles and memberships on AAP committees, sections or groups that should be listed in the item. Publication is at the discretion of AAP News.
In Memoriam

Dr. Lieberthal, past president of California Chapter 2

A pediatric pulmonologist who served as California Chapter 2 president from 2004-06, Allan S. Lieberthal, M.D., FAAP, of Agora Hills, Calif., died Dec. 25 at age 70.

Among AAP contributions, Dr. Lieberthal was co-chair of the Clinical Practice Guideline Subcommittee on Bronchiolitis Evidence Working Group and chair of the Clinical Practice Guideline Subcommittee on Acute Otitis Media. He served as lead author of the acute otitis media guideline and co-author of the bronchiolitis guideline. He also co-authored a policy and technical report on palivizumab prophylaxis for children at risk of hospitalization for respiratory syncytial virus infection.

He was a member of the AAP Steering Committee on Quality Improvement and Management, Council on Quality Improvement and Patient Safety, and Committee on Practice and Ambulatory Medicine.

Dr. Lieberthal focused on pediatric pulmonary disease, cystic fibrosis and asthma, serving as director of the Kaiser Permanente Southern California Cystic Fibrosis Center (1994-01) and chief of pediatrics from 1989-92. He also was a clinical professor of pediatrics at University of Southern California Keck School of Medicine.

He earned his medical degree from the University of Illinois College of Medicine in Chicago and completed his pediatric residency at Los Angeles County Hospital and University of Southern California Medical Center, where he was chief resident. He retired in 2010.

He is survived by his wife, four children and six grandchildren.

Retired AAP department director, Ed Zimmerman

Director of the AAP Department of Practice who retired in May 2016, Ed Zimmerman, M.S., of Wheaton, Ill., died Dec. 31. He was 60.

Those who knew him remember him as a well-dressed gentleman who also was well-read. A voracious bookworm, he often would gift books to others and urge them to “read it forward.”

“Ed was a kind man with a gentle heart who had a deep love for children and passion for the mission of the AAP,” said AAP CEO/Executive Vice President Karen Remley, M.D., M.B.A., M.P.H., FAAP. “His loss will be felt deeply, but his legacy at the AAP will remain.”

Zimmerman joined the AAP staff in 1990 as a senior health policy analyst in the Division of Pediatric Practice. Four years later, he became a division director overseeing health care finance, policy and quality issues. For more than 16 years, he was a department director, including over five years as a co-director of Practice and Research and 10 years leading the Department of Practice. His work included managing quality improvement and innovation efforts, patient safety, private payer advocacy, accountable care organizations, the periodicity schedule, more than 10 clinical practice guidelines, and policies on retail-based clinics, circumcision and Medicaid.

He is survived by his partner, Jim Provines, and three brothers.
Combine a spring break getaway with continuing medical education at PREP The Course, March 4-8, at the Hilton St. Petersburg Bayfront in Florida.

Attendees can expect a variety of educational formats to meet different learning styles: lectures, case sessions on diagnosis and management, faculty panels, visual diagnosis, pre/post-course self-assessment bonus, American Board of Pediatrics Maintenance of Certification (MOC) Part 2 eligible and Hot Topics.

Consider attending if you are interested in a diverse, intensive format to update knowledge and skills and would like to have questions answered by experts in group, case-based sessions.

Those seeking exam preparation for Part 3 of the MOC program or who need additional points for Part 2 also can benefit.

Highlights and faculty include:
• “Renal and Urologic Disorders/Fluid and Electrolyte Metabolism,” with Adam R. Weinstein, M.D., FAAP;
• “Sports Medicine,” with Andrew J. Gregory, M.D., FACSM, FAAP;
• “Cardiology,” with Angela M. Sharkey, M.D., FAAP;
• “Emergency Medicine/Critical Care/Injuries and Poisoning,” with Brett McAninch, M.D., FAAP;
• “Allergy and Immunology,” with David R. Stukus, M.D., FAAP;
• “Infectious Diseases,” with Dean A. Blumberg, M.D., FAAP;
• “Hematology and Oncology,” with Helge D. Hartung, M.D.;
• “Adolescent Health/Gynecology/Substance Abuse,” with Rebekah L. Williams, M.D., FAAP, and Oana Tomescu, M.D., Ph.D.;
• “Developmental/Behavioral Pediatrics,” with Jill J. Fussell, M.D., FAAP;
• “Respiratory Disorders,” with Thomas Lahiri, M.D., FAAP.

Earn up to 38.5 AMA PRA Category 1 credits. Register by Feb. 3 for early bird rates. Visit https://shop.aap.org/2017-prep-the-course-st-petersburg to register.

For information on AAP continuing medical education meeting registration, brochures and general meeting details, visit http://shop.aap.org/live-activities, call 866-843-2271 or email csc@aap.org. Outside the United States and Canada, call 847-434-4000, option 3.
Welcome New Fellows

Congratulations on passing the pediatric board exam! As a member and Fellow of the AAP (FAAP), you are part of an exceptional pediatric community. You have access to unmatched opportunities for leadership and quality improvement that will positively impact your care of children and take your career to the next level.

Attention Academy Fellows:
If you would like to comment on the qualifications of any of the below-listed individuals, please contact your district chairperson listed on page 33.

UNDISTRICTED
Nabil Atieh, M.D., FAAP
Riyadh, Saudi Arabia

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Timothy Fermin, M.D., FAAP
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Staten Island, NY

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Diana Maffel, D.O., FAAP
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Anjali Singh, M.D., FAAP
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Caterina Tizzo, M.D., FAAP
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John Yewpa, M.D., FAAP
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Fulton, MD

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Sarah Lo, M.D., FAAP
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Desiree Neville, M.D., FAAP
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Deanna Tocco, M.D., FAAP
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Brantney Martin, M.D., FAAP
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**Pediatrician BC/BE, FT/PT**

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Comprehensive Pediatrics with offices in Brooklyn and Staten Island. N.Y. have openings for BC/BE FT, PT and Hospitalists for experienced M.D.’s and new comers. We take patients for well and sick care in our three modern, well-equipped offices with ample ancillary staff to assist you. EMR up and running and our staff knows how to use it! We ‘round’ at 4 well respected hospitals. Flexible schedules for on call rotations and hospital coverage. Great salary and benefits. Write your own ‘ticket’ and join us. CV’s to creativehc@aol.com or by fax: 718-256-4912 ATT MIB.

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Private Practice looking for a pediatrician to join two other pediatricians in a rural community in Central New York. Our practice prides itself in being a community and family oriented health care provider. Candidate must be board certified or board eligible. The call schedule would be every three nights with no Emergency room coverage. Hospital duties would cover a Level 1 nursery with approximately 500 deliveries per year. Please send resume to kdandanian@oneidahealthcare.org or fax resume to 315-361-1827.

**Pediatrician**

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Seeking FT/PT BC/BE pediatrician to join well-established two doctor, family life-friendly, suburban practice, located one hour from New York/Philadelphia. Affiliated with community hospitals; no teaching responsibilities. Salary and benefits. Reply to practicepeds@gmail.com.

**Excellent Opportunity**

Bel Air, Maryland

Full-time or part-time opportunity for BC/BE pediatrician to join a growing and stable practice located in the heart of Bel Air, Maryland. Great opportunity to work in a positive, friendly and caring environment. Must have an active Maryland license. Competitive benefits, with no hospital rounds, only one night per week and one weekend per month call. Come join our group as we continue to grow and serve our families in the community, where we have been voted the “Best Pediatricians” year after year! We strive to provide the most current, comprehensive and compassionate care to our families. For more information send CV, salary requirements and contact information to: sue@brightoakspediatrics.com.

**Full-Time**

Pediatric Associates of Plymouth is a well-established and proud independent, multi-physician owned practice. We are looking for another full-time pediatrician to join our five doctor – one Nurse Practitioner team. Our patient population is filled with first, second and third generation families. Our clinical and office support staff are friendly, knowledgeable and ready to assist and welcome a new physician. Position: Our ideal candidate will be a graduate of an accredited Medical or Osteopathic School with both internship and residency already completed. Board eligibility is a minimum, with Board certification within two years of employment. Along with the above credentials, our ideal candidate should be positive, friendly and thrive in a collaborative environment. A four-day week schedule with some Saturday hours. No inpatient work. You will have over-night and weekend call, every sixth of each – strictly by phone. Competitive salary, health benefits, 401(k) retirement plan, and a malpractice package. Our offices are located in Plymouth Meeting and Collegeville, Pennsylvania. If you would like to join the PAP team, or if you would just like to know more about our practice, we would like to hear from you. Email a CV and cover letter to Linda Simon at lindagsplypeds@gmail.com. I can also be reached by calling 610.825.3500.

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**Pediatrician Needed for Outpatient Practice in Metro Atlanta**

Seeking a dynamic, enthusiastic pediatrician to join a growing, and busy pediatric practice in metro Atlanta. Office is located in a very desirable area of Atlanta, close to Downtown Decatur, midtown and Buckhead. Major highways also nearby. High and competitive salary offered. Comprehensive benefits package also included. Candidate must be proficient with excellent coding practices, ICD10 and chart (EHR) documentation. Must be comfortable working with an economically and culturally diverse population. Very light call schedule; phone only. No inpatient or new born nursery coverage. Outpatient only. Please contact Iyabo Okuwobi, M.D. Email iyabo.okuwobi@mileniumped.com or call 404-277-9709.

**Pediatrician Opportunity in Atlanta**

Primary Care Office

Briarcliff Pediatrics in Atlanta Georgia, is hiring BE/Board-certified, (Full-time/Part-time) experienced, energetic, pediatrician. Team player with a happy, positive attitude. EMR experience necessary. Excellent opportunity for growth after a proven track record. Great lifestyle, office closed weekends, evenings. No hospital/nursery responsibilities. Contact Dr. Deeb at 770-939-7676. www.Briarcliffpediatrics.com
Midwest Pediatrician
Pediatric & Adolescent Center is a well-established Primary Care Pediatric practice in the Detroit Metro area with four experienced Pediatricians & three Nurse Practitioners seeking to add another Pediatrician to our growing practice. Mostly outlaw patient, 1:4 to 5 calls. Competitive benefits package. Interested candidates please email administrator@thepediatricoffice.com.

Southwest BC/BE Pediatrician Scottsdale, Arizona
Small group practice has been providing high quality medical care for many years. We are seeking Pediatrician interested in a medical home-style practice. We offer the opportunity to become fully invested in the lives of our young patients while NICU, PICU and hospitalist support at local hospital ensure plenty of free time to enjoy our year-round outdoor lifestyle. Nurse triage service handles vast majority of phone calls. Competitive salary and benefit package. We are interested in potential partners or employed physicians. If interested, contact Scott Cannon, M.D., at 480-778-1732 or email sacannon@lapappedkids.com.

Pediatricians Needed in Pediatric Hematology-Oncology
The Baylor College of Medicine, Department of Pediatrics, Section of Hematology-Oncology is pleased to announce job openings for pediatric hospitalist physicians at the Texas Children’s Cancer and Hematology Centers at their Texas Medical Center. Applications are welcome from Pediatric Board-Eligible and/or Certified physicians. This is an opportunity to join the largest pediatric hematology-oncology program in the nation, working in close collaboration with renowned pediatric academic faculty, subspecialty fellows, and advanced practice providers. Candidates are expected to have excellent clinical, communication, and time management skills. Our Centers provide excellent care to a diverse population of patients with unusual presentations. These positions offer the distinct opportunity to interact and to collaborate with world-renowned subspecialists in an environment focused on evidence based medicine, quality improvement, international medicine, and teaching. Applications and inquiries should be directed to: Tim Porea, M.D., Hematology-Oncology Section, Department of Pediatrics, Baylor College of Medicine, 1102 Bates Avenue, Suite 1570, Houston, Texas 77030. (tjporea@txch.org). Applications should include the applicant’s CV, statement of career interests, and three letters of references (including names/contact information).

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Experienced General Pediatrician & Adolescent Medicine Specialist Available
Looking for a part-time job in VT, MA, NC, or SC. Excellent clinician, teacher, preceptor. Years of experience seeing babies, children, and adolescents and teaching medical students and residents. Board-certified in Gen Pediatrics and in Adolescent Medicine. References available. Contact 505-385-1891.

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The Children's Hospital at Montefiore (CHAM) is home to one of the few hospital-based urology divisions in the New York area with a comprehensive onsite team dedicated to treating pediatric patients and handling examinations, laboratory tests, radiology tests, surgery and pre-surgery consultations, all in one place. We specialize in all disorders of the urinary and genital systems. Discover more about the Division of Pediatric Urology at cham.org/urology.

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