

# The Nevada Pediatrician

Summer 2008 • Volume 1, Issue 1

## FROM THE EDITOR

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This is the first issue in a quarterly newsletter designed for Nevada pediatricians to exchange ideas on local healthcare issues affecting children.

Our fall issue will include topics on vaccines for children and problems faced by local pediatricians; autism and immunization; antibiotic use in skin infections; choosing an electronic medical records and legislative priorities affecting children. Our immunization focus will be on combination vaccines.

Pediatricians who are interested in contributing to the newsletter are welcome to submit their proposal to me at [eezeanolue@medicine.nevada.edu](mailto:eezeanolue@medicine.nevada.edu).

The following are the next events for the American Academy of Pediatrics:

### AAP First Annual Meeting

August 22 and 23, Friday and Saturday

### The Young Physicians Workshop

Morning of August 23

For more information regarding these events, visit [www.nevadaaap.org](http://www.nevadaaap.org) or email at [nevadaaap@gmail.com](mailto:nevadaaap@gmail.com).

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*Nevada Pediatrician* is generously supported by unrestricted grants from Sanofi Pasteur Inc., Med Immune Inc. and the Mapuije Ezeanolue Foundation.

## Addressing the Health Needs of Nevada Children

### A 'revitalization' at the Nevada Chapter of the American Academy of Pediatrics

*Beverly Neyland, M.D.*

The Nevada chapter of the American Academy of Pediatrics has been revitalized by members who are dedicated to the task of continuously improving the overall health care of our children. Specifically, we are focusing on improving the low immunization rate for the State of Nevada, the poor access to health care for underserved populations, and the inadequate coverage for developmental delays and mental illness. These issues, as well as concerns about increased obesity of the pediatric population, adolescent immunizations, and injury and violence prevention are also serious health conditions which must be addressed. The concerns listed above have all been instrumental in galvanizing pediatricians to work to improve these disturbing pediatric problems and, at the same time, insure that pediatricians are appropriately compensated for services rendered so that they will continue to be the effective medical specialty to care for our children.

Since this re-vitalization process was initiated, we have had two workshops on immunization and code/billing. As a chapter, we have received a Resident CATCH grant, and we have submitted several other promising grant proposals. We most recently held a workshop on immunization as well as an intensive review of coding and billing on April 19 at the Red Rock Casino. Dr. Richard Tuck, a nationally known expert on coding and billing, was our keynote speaker and consultant. We received commendations from District VIII for the progress that our chapter has made over



**Dr. Neyland introduces keynote speaker Lance Rodewald, M.D. at the American Academy of Pediatrics Nevada Chapter Physician Workshop III on April 19. The workshop was held at Red Rock Casino Resort and Spa in Las Vegas.**

the last 22 months—increasing our membership to 199. Also, our membership shows a good mix of young physicians, residents and medical students, as well as pediatricians who want to have a voice in the pediatric concerns of the State of Nevada.

We have a Nevada chapter Website, a community needs assessment survey, and we are actively planning an annual meeting for our chapter. Our community needs assessment survey was done

by Dr. Shuruti Kant, a pediatric resident. Dr. Nandine Mandlik has submitted a young physician's grant for consideration.

We have also had several dinners with pharmaceutical and business groups which featured informative speakers and were well attended. With the increasing support of concerned pediatricians, the Nevada chapter of AAP could become one of the most influential chapters in the nation.

## Immunization Recommendations: 2008 Updates

*Echezona E. Ezeanolue, M.D., MPH*

During the last century, infectious disease prevention through vaccination has remained one of the top ten public health achievements in the U.S. We witnessed the eradication of smallpox, elimination of polio from the Western hemisphere and tremendous reduction in cases of measles, diphtheria, pertussis (whooping cough), rubella (German measles), mumps, tetanus, and Haemophilus influenzae type B (Hib).

Vaccination prevents disease in individuals who receive them as well as protects those who may be too young or have contraindications to receiving the vaccines through development of herd immunity. The success of disease prevention through immunization lies with technologies that led to development of new vaccines, such that we saw an increase in vaccine preventable diseases from seven diseases in 1985 to 16 diseases in 2008.

While the U.S. currently has a record low number of cases of vaccine preventable diseases, the viruses and bacteria that cause them still exist in most parts of the world. Even diseases that have been eliminated in this country, such as polio, are only a plane ride away. As the number of physicians and parents who have seen the devastating effect of some vaccine preventable diseases continue to decline, we have witnessed an increasing complacency towards vaccination. Outbreaks of vaccine preventable diseases continue to occur in various communities with the most recent outbreaks of measles in several U.S. communi-

ties, heralding what can occur as more and more people decide not to vaccinate their children and herd immunity drops.

Every year, the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians put together recommendations for childhood and adult immunization.

These recommendations are based on principles influenced by the age specific risks for disease and complications, potential interference with passive immunity and intervals that provide optimal protection or best evidence for efficacy. These recommendations are updated throughout the year as new evidence of vaccine effectiveness or associated adverse effects become known. Major changes in 2008 are related to the meningococcal, influenza, Diphtheria, Tetanus, Pertussis (DTaP) and Pneumococcal vaccines. Major changes in 2008 compared to 2007 immunization recommendations:

1. For meningococcal vaccines, the meningococcal conjugate vaccine (MCV4) became the preferred vaccine to the meningococcal polysaccharide vaccine (MPSV4) for individuals 11 to 55 years at increased risk for meningococcal disease. This includes children who are traveling to or residents of countries in which the disease is hyper-endemic or epidemic, children who have terminal complement component deficiencies, and children who have anatomic or functional asplenia. The conjugate vaccine also was approved and recommended for children aged two to ten years with the same risk factors above.

2. Recommendations for use of the live attenuated influenza vaccine (LAIV) now include healthy children as young as two years. LAIV should not be administered to children younger than five years with recurrent wheezing. Children aged less than nine years receiving an influenza vaccine for the first time or who were vaccinated for the first time last season, but only received one dose, should have two doses of vaccine, at least four weeks apart.

3. The tetanus and diphtheria toxoids/tetanus and diphtheria toxoids and acellular pertussis vaccine (Td/Tdap) catch-up schedule for persons aged seven to 18 years who received their first dose before age 12 months now indicates that these youths should receive four doses, with at least four weeks (not eight weeks) between doses two and three.

4. One dose of the pneumococcal conjugate vaccine (PCV) can now be administered to incompletely vaccinated children aged 24 to 59 months, as well as those with underlying medical conditions.

5. Although MMRV will not likely be available until 2009, the ACIP no longer prefers the combination to separate administration of MMR and Varicella separately. This change is due to the fact that fever-related seizures were seen more often in children who receive MMRV instead of the two separate shots.

**References:** 1. "How Vaccines Prevent Disease?" National Center for Immunization and Respiratory Diseases. Center for Disease Control and Prevention. April 18, 2007. 2. "Recommended Immunization Schedules for Persons Aged 0-18 Years - United States, 2008." Morbidity and Mortality Weekly Report. Center for Disease Control and Prevention. January 11, 2008.

## On Training Tomorrow's Pediatricians

David A. Gremse, M.D.

The specialty of pediatrics is entering into an exciting era where the opportunities to improve the health outcomes in children are greater than those that existed. However, the challenges facing the next generation of pediatricians are increasing as well. The technological advances in pediatrics increase the ability of pediatricians and pediatric subspecialists to diagnose and treat conditions that were poorly responsive to treatment a generation ago. Similarly, advances in preventative medicine and immunizations have decreased the morbidity and mortality of a number of infectious diseases that were previously common. The challenge to delivering the available medical treatments to all children includes the increasing costs of medical care, financial pressures from health insurance, and government providers limiting funds to pay for the cost of providing optimal pediatric healthcare.

Training for a future career in pediatrics involves not only learning about the genetic and environmental risk factors and pathophysiologic mechanisms of diseases in children, but also about delivering pediatric care. Optimal care consists of the patient-doctor relationship, as well as engaging and collaborating with allied health professionals, and child healthcare advocates in the community. Providing health care through a team approach will take on added importance in the future. The Nevada Care Program is one example of a team created to provide excellence in health care for a targeted pediatric population. Training pediatric residents of the future will include how accessing centers of excellence as part of a system based practice will improve health outcomes in the children for whom these programs are intended.

The needs of the pediatric workforce in the future will be as varied as the challenges facing pediatricians. There will be a need for more general pediatricians in ambulatory pediatrics or pediatric inpatient medicine, pediatric subspecialists, and academic pediatricians. The public's demand for high quality, evidence-based medicine will increase the need for pediatric clinician-scientists in basic research, translational research, clinical research, and health outcomes research. A broad fund of knowledge in pediatrics will be preferred in pediatric trainees in order to understand the significance and applications of new discoveries in pediatrics. Whether or not physicians enter into a career in research through academic medicine or incorporate research into their private practice through programs such as the American Academy of Pediatrics spon-

sored Pediatric Research in the Office Setting, including research training in medical school and residency, will better prepare pediatricians to provide the highest quality of medical care to children through their understanding of the science of medicine.

## A Brief History of Pediatric Surgery

John R. Gosche, M.D., Ph.D.

Pediatric surgery as a specialty is a relative newcomer in the history of medicine.

The first surgeon in the U.S. to exclusively limit his practice to the care of children was probably Dr. Herbert Coe, who received training at the Children's Hospital in Boston. Most pediatric surgeons, however, can trace their heritage back to Dr. William E. Ladd, a general surgeon, who as a result of his experiences during World War I, and in particular following an ammunition explosion in Halifax Harbor on December 6, 1917, during which many children sustained serious burns and other injuries, developed a special interest in caring for the surgical diseases of children. Dr. Ladd recognized that most surgeons of his day knew little about the management of sick children and even less about caring for infants. He therefore, set out to improve the care of infants and children by providing specialty training for surgeons with an interest in caring for the surgical diseases of infants and children.

The first official training program in pediatric surgery began in 1937 at the Children's Hospital of Boston under the direction of Dr. Ladd. Dr. Ladd, and his successor Dr. Robert E. Gross, along with their trainees, established the majority of the early training programs in pediatric surgery. By 1950, multiple training programs in children's surgery were established throughout the U.S. Initially, pediatric surgical training programs were 'self-declared' and were approved by the Conference Committee on Graduate Training in Surgery which was jointly sponsored by the American Medical Association (AMA) and the American Board of Surgery (ABS). In 1965, the Surgical Section of the American Academy of Pediatrics (AAP) assigned the task of establishing training standards to the Committee on Postgraduate Education and Residency Training. This committee's recommendations were published in 1967 as the "Special Requirements for Residency Training in General Pediatric Surgery". These recommendations were reviewed and revised by the American Board of Medical Specialties, and were subsequently adopted by the Liaison Committee for Specialty Boards of the AMA Council on Medical Education. Initially, pediatric surgical training programs were reviewed and

recommended for approval by members of the Committee on Postgraduate Education and Residency Training of the AAP. In 1972 this role was assumed by the Education Committee of the American Pediatric Surgical Association (APSA), and in 1977 control of the approval process was taken over by the Residency Review Committee (RRC) of the Accreditation Council for Graduate Medical Education. By the spring of 1970, 25 'self-designated' pediatric surgery training programs had been reviewed. Today there are 33 approved pediatric surgery training programs in the U.S. in more than 22 states and seven in Canada.

## Specialty Certification in Pediatric Surgery

The ABS recognizes the specialty of Pediatric Surgery by offering certification to individuals as have "Special Qualifications in Pediatric Surgery". Surgeons seeking Specialty Certification in Pediatric Surgery must be board certified in General Surgery, must have successfully completed training in an accredited Pediatric Surgical training program, must submit a list of pediatric surgical procedures in which they directly participated during their pediatric surgical training demonstrating an adequate depth and breadth of exposure, must successfully pass a written qualifying examination in Pediatric Surgery and finally must pass an oral certifying examination. All board certified Pediatric Surgeons are required to re-certify at least once every ten years in order maintain ABS certification.

Official recognition of Pediatric Surgery as a certified surgical subspecialty by the ABS required 18 years and multiple petitions by surgeons and pediatricians alike to obtain. Early requests for certification of 'special proficiency in pediatric surgery' were denied in part due to lack of organization of the pediatric surgical community as a specialty. Over the years however, pediatric surgeons have developed specialty organizations, first as members of the Surgical Section of the AAP beginning in 1948, and subsequently through establishment of its own specialty organization, the American Pediatric Surgical Association in 1970. Concurrent with the development of specialty organizations, prominent pediatric surgeons, following the lead of Dr. Stephen Gans, helped to establish a journal 'unique to the specialty', the Journal of Pediatric Surgery in 1966. These developments, along with the establishment of standards for the designation of official pediatric surgical training programs, ultimately contributed to approval a request for certification in pediatric surgery by the ABS in 1972, and by the American Board of Medical Specialties in 1973. The first examination for "special compe-

tence in pediatric surgery" occurred in 1975. No 'grandfathering in' was allowed.

## Why does it matter?

Over the years, pediatric surgeons have contributed to multiple advances in the care of surgical diseases of infants and children. For instance, pediatric surgeons introduced and espoused nonoperative management of isolated intraabdominal solid organ injuries, after recognizing that most children recover without the need for operative procedures that can be associated with significant morbidity. In addition, pediatric surgeons have participated in many of the cooperative pediatric oncology study groups that have contributed to significant improvements in the survival of children with solid tumors. Today and in the past, pediatric surgeons have been in the forefront of clinical and basic science research in the fields of fetal surgery, total parenteral nutrition, minimally invasive surgery, organ and tissue replacement, tumor biology, embryology, gut and lung physiology and much more.

Pediatric surgeons are general surgeons with special training in the preoperative, intraoperative and postoperative care of surgical diseases of infants and children. As mandated by the Program Requirements for Graduate Medical Education in Pediatric Surgery published by the ACGME, pediatric surgical trainees are exposed to a broad range and depth of pediatric surgical illnesses. However, probably more importantly, they are also educated to appreciate and manage the unique physiologic, metabolic and psychosocial needs of infants and children with surgical diseases. In addition, throughout their specialty training and daily practice, pediatric surgeons collaborate with neonatologists, pediatricians, family physicians and other pediatric medical and surgical subspecialists to provide care to infants and children with surgically treatable conditions. In its 'Guidelines for Referral to Pediatric Surgical Specialists' (Pediatrics 110(1), 187-191, 2002), the AAP recognized the potential benefits associated with involving a pediatric surgical subspecialist in the care of children with unique surgical diseases by stating that "the child who needs specialized surgical care is best served by the skills of the appropriate pediatric surgical specialist".

While the history of Pediatric Surgery as a specialty is relatively short, its contribution to the well-being of infants and children with surgical diseases has been immense. Pediatric surgeons today have continued to pursue the objectives of our predecessors, to improve the surgical care of infants and children now and in the future.

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