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Stay tuned for more improvements and additions, including features such as CME activities by 2013. Please share with us the gift of your feedback. Let us know your thoughts, your questions, your concerns or any other input you believe will enable the NJ Pediatrician to provide you with greater service and assistance.

If interested in submitting a new idea or article, please contact Michael Weinstein, Newsletter Editor at 609-588-9988, ext 116 or at mweinstein@aapnj.org

Executive Director’s Column

We are hoping you, your families, and your practices are well in the wake of Hurricane Sandy.

In the spirit of “Jersey Strong”, we have joined with many partners to work together in efforts to rebuild, link pediatricians and the families they serve to resources, and yes diligently work to develop future disaster preparedness plans.

AAP/NJ is participating with the NJ Department of Children and Families Hurricane Sandy Disaster State Led Child Task Force that is attempting to look at how the State, FEMA, ACF, etc... are responding specifically to the needs of children following the hurricane; resources are cited throughout this issue and on our website (www.aapnj.org).

In addition to post Sandy efforts, healthcare changes on the horizon continue providing us with challenges that are both exciting and ambitious. Together, we will work to ensure all the children in New Jersey have the ABCs of health care: Access to health care services, age-appropriate Benefits, and health care Coverage - an enormous opportunity and challenge at the same time. The Government Affairs Committee, our advocates, and many of you have been working with legislators and our State partners to focus on pediatric health and these efforts are beginning to pay dividends. There are many Practice Management challenges and with each there is also opportunity. Read about an opportunity to join the AAP/NJ Practice Management/Pediatric Council on page five.

The AAP/NJ FaceBook (www.facebook.com/AAPnj) page is now up and running and I’d like to invite you to check it out and use it to interact with your Chapter and your colleagues. This powerful social media tool can help us share and benefit from our collective experiences and ideas. While you are there, please remember to “Like Us”.

We welcome hearing from you and will do our best to help.

Like you, we are constantly striving to improve in every aspect of our work and we encourage your feedback. Our new magazine will feature a number of new sections including Letters to the Editor, which will highlight your thoughts, your assessments and your recommendations.

NJ Pediatrician: The Quarterly Newsletter of the American Academy of Pediatrics, New Jersey Chapter

Editors:
Jeanne Craft, MD, FAAP
Michael Weinstein

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If interested in submitting a new idea or article, please contact Michael Weinstein, Newsletter Editor at 609-588-9988, ext 116 or at mweinstein@aapnj.org
MESSAGE FROM THE PRESIDENT

Margaret (Meg) Fisher, MD, FAAP
American Academy of Pediatrics, NJ Chapter President

The fall has certainly handed us a plate full of challenges. Hurricane Sandy decimated much of the coastal areas of New Jersey. It will be years before many of these areas will rebuild but I found that the overwhelming sentiment in my town, Sea Bright, was that we will rebuild because we are Jersey Strong! My heart goes out to all of you who were affected directly or indirectly by Sandy and the subsequent nor’ easter (I am writing this on November 7 so the storm is still forming but evacuation orders for parts of Monmouth County have already been issued).

The American Academy of Pediatrics’ Fund for Children offers help to chapters who have been affected by disasters. Fran Gallagher is already working on an application for funds for New Jersey; we have been in contact with the AAP staff per the Disaster Preparedness Advisory Council. Even before the storm, Dr. Rubin was establishing contacts with the state disaster people and our FEMA area people. We will continue with these efforts and likely include disaster planning as part of future continuing medical education meetings.

We have many resources within the Academy to help us during disasters. Please go to the Academy website: http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Children-and-Disasters/Pages/default.aspx. From this site you can search Sandy or any other disaster and get specific guidance. There is a wealth of information about talking to children affected by disasters.

Outside of the Academy, remember that the government has readily available resources. Having used them personally, I can attest to the speed and ease of registering with FEMA if you have a disaster claim. Take advantage of the many things they have to offer, from transportation, housing, food and small business loans.

By now you are all aware of the election results. Hopefully this means that access to care for children will be preserved and the Affordable Care Act will continue to protect our children and their families. Medicaid reimbursement changes are scheduled to go into affect shortly. See http://www.aap.org/en-us/about-the-aap/aap-press-room/Pages/MedicaidPaymentFinalRule.aspx for the Academy’s statement regarding the Final Rule.

Finally our Chapter and our District are in the midst of a membership drive; we hope to increase our membership and to ensure that our Chapter is relevant to all of our pediatricians. Bert Mulder, our Director of Membership and Events is working hard on expanding benefits and responding to members needs.

Sincerely,

Margaret (Meg) Fisher, MD, FAAP

(Editor’s Note: In order to meet the publication deadline, this column was written in advance of Dr. Fisher’s extended overseas business trip.)

See page 31 for details on a December 17th presentation by nationally renowned disaster recovery authority, David Schonfeld, MD,FAAP. The free event, SUPPORTING CHILDREN IN THE AFTERMATH OF A DISASTER, is being jointly presented by AAP/NJ, Monmouth Medical Center and Jersey Shore University Medical Center in the Pollak Theatre at Monmouth University.
Natural disasters like Hurricane Sandy leave in their wake enormous emotional and health consequences.

In the aftermath of such devastation, people often experience fear and shock. They can have difficulty making decisions, become overwhelmed searching for help for themselves and their families, and are often confronted with a driving desire to help others.

However, a large number of people develop delayed effects that can occur months later. These delayed responses include change in appetite, headaches, inability to sleep, anger, suspicion, depression, withdrawal, disillusion, and guilt about not protecting their families. This pain is exaggerated in people who are isolated from family and their social network and in people who have lost their home and/or their possessions.

An underlying etiology is an increased sense of vulnerability. The normal assumptions about life and cause and effect are lost and this leads to enormous stress. Some of the categories of destructive responses include:

- Emotional reactions- helplessness, depression, anxiety
- Cognitive reactions- confusion, worry, negativity, unwanted memories
- Physical reactions- fatigue, restlessness, somatic pains, rapid heart rates, sleepless
- Interpersonal- distrust, irritable, conflict in relationships, withdrawal, feeling rejected, being overly judgmental

These responses can last for a long time.

Steven Kairys, MD, FAAP

Those at increased risk include in addition to the loss of home and social supports people with a history of previous trauma, history of chronic health issues, close proximity to the actual disaster, experiencing chronic poverty, unemployment, homelessness.

Children also experience these same responses. Some regress, some children act out while others withdraw. Parents and family should anticipate these responses and help reduce the toll by increasing the time spent with the children, reassuring with hugs and physical contact and restore some semblance of normalcy by reestablishing regular schedules and routines.

The old theories of providing the usual counseling support when these symptoms arise have proven to be not very helpful. What appears to be helpful is psychological first aid (PFA) to monitor the person’s mental state, attend to practical needs and encourage social supports.

Skills for Psychological Recovery (SPR) have proven very effective for many. SPR aims to accelerate recovery and prevent maladaptive behaviors. SPR encourages problem solving, planning more positive and meaningful activities, managing stress, engaging in helpful thinking and building healthy social connections. These are short term interventions. So for such concerns as having a difficult problem that needs solving, or having upsetting reactions, or not having enough people that care about me, or not doing enough positive activities, or having upsetting thoughts, or having a serious health and mental health condition there are concrete responses that can be provided.

The first step is to recognize how prevalent these issues are, be sensitive to them and seek or offer help early before the responses turn into long term consequences.

Steven Kairys, MD, FAAP

EXECUTIVE DIRECTOR’S COLUMN CONTINUED FROM PAGE 2

Please submit all letters-to-the-editor for the Spring issue to mweinstein@aapnj.org. by February 4, 2013.

We welcome your gift of feedback on both what you like and where you think we can improve.

I thank our new editorial board featured on the inside front cover and co-editors Jeanne Craft, M.D., FAAP, Chapter Secretary, and Michael Weinstein AAP/NJ Communications Director for dedicating their time, expertise and commitment to ensuring meaningful communications.

Our team thinks you will like what you see in this issue and in those yet to come. Watch for the arrival of a new AAP/NJ Chapter quarterly news magazine, which premieres in March of 2013.

Happy Hanukkah, Happy Kwanzaa, Merry Christmas and a Healthy and Prosperous New Year to ALL!

Warm Regards,

Fran Gallagher, MEd
Understand the Needs of Sexual Minority Youths

Preliminary Findings From “A Medical Home For Gay, Lesbian, Bisexual and Transgender Youth”

By Barbara K. Snyder, MD, FAAP, Department of Pediatrics (Division of Adolescent Medicine), UMDNJ-Robert Wood Johnson Medical School, New Brunswick, NJ

and

Gail Burack, PhD, Department of Pediatrics (Division of Allergy, Immunology and Infectious Diseases) UMDNJ-Robert Wood Johnson Medical School, New Brunswick, NJ

It is very difficult to obtain accurate data about the numbers of sexual minority youth— that is, teens who self-identify as gay, lesbian, bisexual, or transgender (GLBT). However, general estimates are that 2-4.5% of high school students self-identify as gay, lesbian or bisexual, with many more youth having had at least one same-sex sexual experience. (We usually include a “Q” for “questioning” in the sexual identity spectrum, because many teens are unsure about their own feelings and identity.) There is growing evidence that sexual orientation has a biological basis; thus, it is not a choice on the part of a child, teen or adolescent to be GLBT. Recognizing one’s sexual orientation and developing a sexual identity is a process that typically begins in late childhood and evolves during adolescence. This process may or may not include same-sex sexual experiences and “coming out” to family, friends, and/or others.

GLBTQ are resilient, and the majority “do fine” as adults; however, being part of a sexual minority can make the challenges of adolescence significantly more difficult. GLBTQ youth often encounter stigma and rejection. As a result, they are at increased risk for a variety of psychosocial and health problems, including violence (usually as a victim), depression, anxiety, suicidal ideation/suicide, substance abuse, and the consequences of high risk sexual activity (STIs and HIV, pregnancy).

Thus, GLBTQ youth especially need confidential, sensitive, and comprehensive health care and of understanding and support from their medical providers.

With these issues in mind, we sought to better understand the health care needs and experiences of sexual minority youth as well as their ideas about what they want from their medical providers. A CATCH grant from the AAP supported this research. In addition to identifying gaps in services for local GLBTQ youth, we wanted to explore the desirability of having a specialized, multi-disciplinary service—a “medical home”—for GLBTQ youth in our area of central New Jersey. We also wanted to identify usual practices of NJ pediatricians when they see teens for well care visits—particularly how they structure such visits and the history and anticipatory guidance topics usually covered. Lastly, we asked the pediatricians how they assess their skills in providing care for GLBTQ youth and whether they perceived a need for more education and training in providing such care.

Youth Surveys/Focus Groups

We identified five community-based sites in central and northern NJ which included groups of GLBTQ youth: a residential home for GLBT youth (Triad House, Trenton area), two community-based organizations (Hudson Pride Connections Center, Jersey City and HiTOPS, Princeton) and two gay-straight alliance clubs (North Brunswick High School and Rutgers Preparatory School, Somerset). A convenience sample of youth attending each of the five sites completed the Youth Survey and participated in a focus group discussion based on the survey questions. All surveys and groups were conducted by the co-investigators, Drs. Snyder and Burack. Participation was voluntary, and no identifying information was obtained. The survey consisted of 20 questions about the youth’s experiences with their primary care physicians. For those under 18 years, letters for parents about the project were given to site personnel for distribution prior to survey/focus group date. Youth were given gift cards for participating.

A total of sixty youth (ages 14-22 years) participated. The racial and ethnic mix of participants was believed representative of the state demographics. Twenty-five of the participants identified themselves as male, 26 as female, 6 as transgender, and 3 as “other.” As expected, there was a spectrum of sexual identities among the youth: heterosexual/straight (12), bisexual (10), gay or lesbian (24), transgender (2), and questioning (7). Five youth did not answer the question.

Some of the key survey results are as follows:

- 30% reported they are not seen alone during a well visit (although, during the group discussions, the majority said they are not routinely seen alone).
- 83% reported physicians did not discuss sexual orientation with them during a well visit.
- 64% reported physicians did not discuss safe sex and/or birth control.
- 53% reported physicians did not discuss emotional health.
- 54% youth reported they do not feel comfortable discussing personal matters with their physicians.
The focus group discussions provided more details about the youth’s experiences with their primary care physicians (almost all of whom were pediatricians). Though the populations varied greatly between the different sites (including ages represented, having health insurance, and having access to a primary care provider), there was consensus about several key points:

1. The doctors’ offices and practices tend to be oriented toward young children, not adolescents. Pediatric offices seldom contain brochures/materials relevant to adolescents and young adults.

2. Comments and questions during visits are often directed to the parent, not the young person.

3. The majority of youth said they were not given the opportunity to meet with their physician in private and that they would not request being seen alone because of fears of how their parents would interpret this (e.g., “what is he hiding from me that he needs to be seen alone?”)

4. Few of the participants recommended having special health care sites for GLBTQ youth. Rather, they felt strongly that all health care providers (doctors and the staff in their offices) should be knowledgeable about and comfortable caring for all teens, regardless of their sexual orientation.

**Provider Surveys**

Most youth reported that physicians are not discussing sexual orientation or identity, safe sexual practices, emotional health or high risk behaviors during their medical visits.

Using Kwiksurvey, we posted a link to the survey on the NJ AAP’s e-newsletter for several months. A total of 157 pediatricians completed the 20-question survey (with most questions similar to those asked of the youth). Respondents practiced in 17 different NJ counties as well as some practicing outside the state. The majority of the pediatricians reported that they routinely speak to teens about the following topics: safe sex (87%); pregnancy and STI prevention (87%); drug and alcohol use (92%). About 2/3 of the physicians said they discuss mood and emotional functioning with all teens.

However, only 38% of providers reported that they routinely speak with patients about their sexual identity/orientation, even though 74% reported feeling comfortable discussing these issues.

Of note, 92% of the pediatricians indicated that they needed more training in the health needs and concerns of GLBT youth, and most of these said they were interested in obtaining further training. Sixty-nine percent of the pediatricians were not aware of community-based resources for GLBTQ youth.

**These youths expressed a strong desire to have a health care provider who was accepting of and knowledgeable about GLBTQ issues...**

**Conclusions and Recommendations**

Despite the increased risk for psychosocial and medical problems faced by sexual minority youth, many GLBTQ youth do not have access to comprehensive and confidential health care. In our study, the youth felt that many pediatric practices lacked sensitivity to their needs. Most youth reported that physicians are not discussing sexual orientation or identity, safe sexual practices, emotional health or high risk behaviors during their medical visits. In sharp contrast, the majority of surveyed pediatricians reported that they do discuss these topics during well visits. Very few youth are comfortable bringing up these (or other very personal) topics themselves because of how that would be interpreted either by the provider or their parents.

Youth expressed a strong desire to have a health care provider who was accepting of and knowledgeable about GLBTQ issues, although they perceived their providers as being obviously uncomfortable discussing most sensitive topics (such as sexual orientation or sexual behavior). They suggested one simple way to show that the provider/practice was “GLBTQ-friendly”: put a rainbow or “Safe Zone” sticker or sign at the front desk or entrance to the office. In contrast to the youth’s impressions, most of the pediatricians indicated discussing personal and their adolescent patients. pediatricians recognized about the needs and appropriate community resources and expressed an interest in obtaining additional training.

We thank the youth and pediatricians for helping us with this work.
Whooping cough was a common childhood infection in the 1940s; it caused tremendous morbidity and significant mortality. Vaccination, introduced in the 1940s, led to a dramatic decrease in infection rates. The initial vaccine antigens were diphtheria toxoid, tetanus toxoid and whole cell pertussis; aluminum hydroxide was used as an adjuvant. The efficacy of the various whole cell pertussis preparations varied not only by the product but by the lot. Despite this, the incidence of pertussis dropped dramatically as is illustrated in the graph shown below:

Unfortunately the whole cell pertussis vaccines caused significant although generally mild side effects including fever, drowsiness, fretfulness and swelling at the injection site. Far less common but more serious side effects included prolonged crying, unusual cry, seizures, collapse with shock-like state and anaphylaxis. During the 1980s and 1990s, several pharmaceutical companies developed vaccines using specific pertussis antigens rather than a suspension of inactivated cells of Bordetella pertussis (whole cell). These acellular vaccines were proven to be both efficacious and far less reactogenic; they were licensed for use for the 4 and 5th doses in 1991 and 1992 and for the entire series in 1996 and 1997. By 2000, the use of whole cell vaccines in the United States had ceased. From 1970 to 1990, the rates of reported pertussis were quite low; thus people were much less likely to be exposed to the pathogen and less likely to boost their immunity.

Since 2000, the reported cases of pertussis have increased with peaks in 2004 and 2011. The rates of reported cases were highest in children under a year and next highest in those age 11 to 19 years. (See graphs)

Prior to widespread immunization there were 3 to 5 year outbreaks of pertussis. The increase in cases since 2000 is likely related to several factors: lack of boosting by background disease and limited duration of protection following immunization leading to an increase in susceptible people, better diagnostic tests and more awareness of the illness among physicians leading to more recognition of mild cases and better reporting. Further, vaccine hesitancy has limited the number of teens and adults who have received the Tdap booster. A recent article published in the New England Journal of Medicine confirmed that immunity following immunization decreases over time the protection following the 5th dose of DTaP wanes during the 5 years after immunization. The basis of the recommendation for Tdap at age 11 to 12 years was the known drop in antibody levels following the last dose of DTaP. The question that is now raised is whether the timing of that booster should be earlier and are subsequent doses of Tdap needed to ensure ongoing protection. To date there is no recommendation for more than a single dose of Tdap; I suspect that this will change in the near future.

Pertussis outbreaks have occurred throughout New Jersey over the past few years - even among our highly immunized populations.
The symptoms of pertussis are paroxysms of cough often followed by vomiting. Fever is generally absent unless there is a superinfection.

The duration of cough is weeks to months. Symptoms are generally mild in immunized children. Children at highest risk are those under a year of age, especially those under 6 months of age. If you suspect pertussis, you can confirm the diagnosis with PCR testing of a nasal swab specimen.

The swab must sample the nasopharynx; generally obtaining the specimen will trigger the classic cough of pertussis.

Protect yourself and your staff by wearing a mask to obtain the specimen. Culture can be done of the same sample; this requires special transport media to ensure growth of B. pertussis. Testing is most likely to be positive just before and during the first week after the onset of cough. Many patients come to you weeks later; in these cases, a clinical diagnosis should be made based on the history. Pertussis tests can be done in your office. If you do not offer testing in your office, you will have to find out where the test can be performed in your area. Some hospitals have testing sites whereas many do not offer this testing. If you send your patients to an emergency department, you will expose multiple others while the patient is waiting to be evaluated and/or tested. I have been told that it is very difficult to find a hospital that will do the test. I suggest you speak to the Chair of the Department of Pediatrics at your hospital to find out how testing can be obtained. Pertussis serology is difficult to interpret; generally I do not recommend it.

Macrolides are the treatment of choice. Antibiotics alter the course of the illness if given during the incubation or in the catarrhal stage (the week or two of runny nose which precedes the coughing spasms). Although antibiotic therapy after the cough begins is unlikely to alter the course, it will make the patient non-contagious. Antimicrobial prophylaxis of family members and close contacts will limit the spread of the agent. Prophylaxis therapy is the same as treatment: the preferred drug is azithromycin, 10 mg/kg as a single dose on day 1 followed by 5 mg/kg as a single dose on days 2 through 5.

As in all of pediatrics, prevention is far better than treatment. Current recommendations for DTaP have not changed: doses are given at 2, 4, 6, 12 to 18 months and 4 to 7 years. Tdap is recommended as a single dose at age 11-12. Tdap is recommended for all adults. The newest recommendation is for Tdap immunization of pregnant women; this strategy protects not only the mother but also the newborn for the first several months of life. This is the time when the infant is at greatest risk. The first dose of DTaP does not provide protection but primes the child for the next dose; protection reaches about 80% following the third dose. It is important to ensure that all contacts of young children are immunized as well.

References:
1. CDC site for pertussis information: http://www.cdc.gov/pertussis/index.html
4. Tdap updated recommendation: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6001a4.htm

**REQUEST FROM THE NEW JERSEY DEPARTMENT OF HEALTH**

**Perinatal Hepatitis B Prevention Survey – New Jersey 2012**

The New Jersey Department of Health is conducting a survey to evaluate perinatal hepatitis B prevention practices in New Jersey delivery hospitals. In order to better understand these practices, we are seeking your assistance. Completing the survey will take less than 20 minutes.

All pediatricians, family health practitioners, obstetrician/gynecologists, nurses and midwives who work in a New Jersey delivery hospital in a maternal/child health unit are invited to participate.

Please use the following link to access the electronic survey:

https://www.surveymonkey.com/s/NJ_Perinatal_HepatitisB_Prevention_Survey

If you have any questions about the survey, please contact Dr. Andria Apostolou, at the New Jersey Department of Health (135 E State Street, Trenton NJ 08625). Her number is 1-609-826-5964 and email address is andria.apostolou@doh.state.nj.us
The Case of the Disappearing/Reappearing Limp

By: Yukiko Kimura, MD
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Ginger Janow, MD MPH
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Joseph M. Sanzari Children’s Hospital
Hackensack University Medical Center

A two year old Caucasian girl presents with a limp that began almost 6 weeks ago after falling on the playground. She seems otherwise well and has not had any fevers or rashes. The limp is always present in the morning but by early afternoon she is walking normally. On physical exam, there is some left knee swelling and although range of motion seems normal, she cries when you examine her knee. You do some tests, which are all normal: CBC, ESR, CRP, ANA, RF, Lyme titer and knee X-rays. What is the most likely diagnosis?

1. Traumatic ligamentous injury of the knee
2. Undiagnosed developmental dysplasia of the hip
3. Sub-acute bone or joint infection
4. Chronic arthritis of the knee
5. Transient synovitis

The answer is 4: Chronic arthritis of the knee, most likely oligoarticular Juvenile Idiopathic Arthritis (JIA). Some may be surprised that this is true in the setting of a completely negative work-up. However, a large percentage of children with JIA have normal blood tests and X-rays, including acute phase reactants, ANA and RF, so normal blood work does not rule out this condition. The RF in particular is a poor screening test for arthritis in children (as opposed to adults) because it is only positive in 5% or fewer patients with JIA. Traumatic ligamentous injury in this age is unusual and would have to be associated with a severe traumatic event which is not the case. Although hip pathology can present with knee pain in children, and developmental dysplasia of the hip can cause unexplained limping, it does not generally present with pain and would not explain the knee swelling. A bacterial infection, even when sub-acute, would likely be associated with fever and elevated inflammatory markers as well as an elevated white blood cell count. Transient (or toxic) synovitis usually affects the hip, not the knee, and it generally resolves in 1-2 weeks.

The key to making the diagnosis of juvenile idiopathic arthritis (JIA) or any type of chronic arthritis is to know what clues to look for in the history and physical examination. Here they are in a nutshell:

- A morning preponderance to the symptoms, including irritability, stiffness and/or limping or inability to walk that improves with activity (in some children, especially very young non-verbal children, this may be the only clue that there is a problem)
- Swelling with or without pain in the joint that is insidious in onset and not associated with high fevers (except for systemic JIA)
- Rashes, fevers, or serositis (only associated with systemic JIA)
- Heel pain or jaw (TMJ) pain with chewing
- Micrognathia or asymmetrical jaw size and opening of mouth suggests TMJ arthritis (even if asymptomatic)
- Muscle atrophy or limb length discrepancy (this is suggestive of long-standing disease)
- Uveitis which is often asymptomatic

Bacterial bone and joint infections, Lyme arthritis, post-Streptococcal reactive arthritis and Parvovirus infection should be excluded through history and/or blood tests. Also, malignancies can present with musculoskeletal complaints, but these children usually appear ill, will often refuse to weight bear at all, and may have abnormal blood work including thrombocytopenia or elevated LDH. Ultimately, if your evaluation is suspicious for arthritis, the patient should be referred to a pediatric rheumatologist for further work-up and management. There are many new and effective therapies for arthritis, and with early detection and treatment, outcomes are excellent.

NOTE: If you are interested in learning more, there is an AAP Pe-dialink course entitled “Pediatric Musculoskeletal Medicine” which resulted from collaboration matologists and pediatric or-modular, multi-media web-gram that teaches how to limp, assess gait, do a screening and also to examine specificidents and other trainees, and

There are many new and effective therapies for arthritis, and with early detection and treatment, outcomes are excellent.

http://pedialink.aap.org/visitor/cme/course-series/pediatric-musculoskeletal-medicine-course-series
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The Comprehensive Medicaid Waiver included recommendations that would: streamline the program by consolidating multiple waivers across state government; maximize federal reimbursement for programs currently funded by state-only dollars; and advance New Jersey’s efforts to redirect care for seniors and individuals with disabilities to the community, rather than to institutions. The Centers for Medicare and Medicaid Services (CMS) also approved the state’s request to deliver behavioral health services through an Administrative Services Organization.

The Department of Health and Human Services issued guidance in 2011 that gave states the latitude to choose from one of several existing health plans to serve as the benchmark plan for the state exchange. However, public insurance options were not included.

The American Academy of Pediatrics states that the Affordable Care Act must fulfill its promise of giving children the ABCs of health care: Access to health care services, age-appropriate Benefits, and health care Coverage.

The Comprehensive Medicaid Waiver application, which was submitted in September of 2011, demonstrates New Jersey’s efforts to redirect care for seniors and individuals with disabilities to the community, rather than to institutions. The Centers for Medicare and Medicaid Services (CMS) also approved the state’s request to deliver behavioral health services through an Administrative Services Organization.

A critical emphasis in the waiver involved increasing community-based services for children who are dually diagnosed with developmental disabilities and mental illness by providing case management, individual supports and respite for caregivers.

CMS did deny certain reform proposals outlined in the application, including New Jersey’s request to no longer provide retroactive Medicaid eligibility for applicants; consolidation of all nine state waivers into one, and the state’s appeal for an estimated $107 million in Medicare Part B retro payment for Medicare services erroneously billed to Medicaid. The federal government also determined that approval of future programmatic changes and that the Community Care Waiver will remain outside the comprehensive waiver.

With the approval of the waiver the appropriate State agencies are now working toward implementation. Representative of AAP will be meeting in the coming weeks with appropriate state officials to work toward the most effective implementation of the waiver components impacting children.

Health Insurance Exchange Legislation Passed by Legislature

Both houses of the Legislature passed S2335, the NJ Health Benefit Exchange Act. The bill was passed along a strict party line vote in both houses. It is similar, although not identical, to legislation passed and vetoed by Governor Christie in June. The bill passed this month expands the membership of the HIE board to include insurance and health professionals and it does not provide salaries for the board members, two of the aspects of the previous legislation that the Governor mentioned in his veto. Having delayed making any final announcements regarding the state’s essential health benefits package, the Governor continues to work with State and Federal representatives to finalize plans on this legislation.

THE AFFORDABLE CARE ACT AND ESSENTIAL HEALTH BENEFITS

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AAP/NJ Oral Health Roundup

Work to Increase Children’s Access to Preventive Oral Health Services Gains Support from the DentaQuest Foundation

Collaboration Focuses on Improving Oral Health Services to Underserved Communities in New Jersey

The American Academy of Pediatrics, New Jersey Chapter (AAP/NJ) proudly announced its selection as one of only 18 recipients from across the U.S. to receive funds from the DentaQuest Foundation for participation in its Oral Health 2014 Initiative.

Launched by the DentaQuest Foundation in 2011, the Oral Health Initiative aims to eliminate barriers that limit an individual’s access to oral health care.

The award supports efforts by AAP/NJ and its quality improvement arm, the Pediatric Council on Research and Education (PCORE) to improve access to essential preventative oral health services for children birth to three in underserved communities throughout New Jersey.

“Pediatricians see children early and often in the first two years of life and are therefore poised to provide effective, low-cost preventive oral health services,” say Fran Gallagher, AAP/NJ Executive Director. “Additionally, pediatricians can play an integral role in bridging young children to those services with timely referrals to dental professionals and every child should have a dental home by age 1.”

In concert with key community organizations and leaders, AAP/NJ seeks to increase access to care by addressing each of the six priority areas identified by the U.S. National Oral Health Alliance, including:

- Prevention and public health infrastructure
- Oral health literacy
- Medical/dental collaboration
- Developing metrics for improving oral health
- Financing models, and
- Strengthening the dental care delivery system

“The American Academy of Pediatrics, New Jersey Chapter and PCORE is a strong and passionate community leader. It has worked hard to build community support for oral health,” says Ralph Fuccillo, President of the DentaQuest Foundation. “We are excited to see what develops as they embrace the challenge and opportunity ofremediat-ing oral health disparities in their communities.”

For more information, please contact Fran Gallagher, MEd, Executive Director, AAP/NJ at fgallagher@aapnj.org or Juliana David, Program Director, j david@aapnj.org.

About the DentaQuest Foundation

The DentaQuest Foundation invests in national and community-based efforts to improve oral health for all Americans through its support of prevention and access to oral health care, and through its partnership with funders, policy makers and community leaders. For more information, please visit www.dentaquestfoundation.org. The DentaQuest Foundation of supported by DentaQuest. DentaQuest is a leading oral health company, administering prevention-focused dental benefits to nearly 15 million individuals across the United States.

Delta Dental Grant Links Preventative Oral Health and Primary Care at Somerset Family Medicine

Preventive Oral Health Training Program for Family Practice Residency Program

AAP NJ/PCORE in partnership with Delta Dental and Somerset Family Medicine is a preventive oral health training program for the family practice residency program at Somerset Family Medicine.

This 10-month long training program includes the following components:

1. 2 Grand Round CME events at Somerset Medical Center for:
   - Family practice residents
   - Pediatric and Family practice physicians
   - Community dental providers and support organizations

2. Family Resident Trainings:
   - Training #1: hands on workshop, “Integrating Oral Health into Routine Well Care” at AAP/NJ Annual meeting: June 12th from 4:00 PM – 6:25 PM
   - 3 trainings at Somerset Family Medicine for family practice residents
     1. Risk assessment - conducted by Cathy Ballance, MD, FAAP and Yasmi Crystal, DMD, FAAPD - pilot of curriculum for DentaQuest Implementation
     2. Fluoride Varnishing - hands on training
     3. Dental Care for Children with Special Healthcare Needs
   - Community resources

   • Evaluation: pre/post surveys to assess change in knowledge
Breakfast in the Classroom: An investment today for our kids’ future.

We support the benefits of the school breakfast program, especially Breakfast in the Classroom, because:

1. BETTER PARTICIPATION
   Significant increases in the levels of participation

2. BETTER NUTRITION
   Optimal nutrition provided via the breakfast meal that might otherwise have been skipped\(^1\)

3. BETTER BMI
   Works as an effective tool to fight childhood obesity\(^2\)

4. BETTER ATTENDANCE
   Reduces incidence of tardiness,\(^3\) nurse visits\(^3\) and absenteeism\(^3\)

5. BETTER BEHAVIOR
   Increased student attentiveness and improvements in student behavior\(^3\)

6. BUILDING SOCIAL SKILLS
   Students enjoy the experience of eating breakfast at their desks with their peers

7. PARENTS’ PEACE OF MIND
   Breakfast in the Classroom offers an inexpensive nutritious breakfast to all students, resulting in a decreased demand financially and time-wise on parents

8. EASY EXECUTION
   For teachers and school administrators alike

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Stephen Rice, MD, PhD, MPH, FACSM, FAAP describes the pathophysiology of concussion and the importance of immediate brain rest. Dr. Rice provided steps for returning athletes to full participation following a graduated return after resolution of symptoms, offered recommendations on referring patients to their medical home, and shared effective follow-up protocols. Attendees learn to distinguish real ongoing symptoms from possible psychological mimics.

Michael Rich, MD, the Mediatrician, describes how public and personal media permeates the lives and affects both negatively and positively - the health of school-aged children and their families. Dr. Rich offers guidance and resources for assisting school nurses and pediatricians in identifying negative behaviors and determining when to intervene.

Alan Weller, MD, FAAP, Diana Autin, and Peg Lueze present Resources for Children with Special Needs. The panel explored the top 5 special needs diagnoses in elementary, middle and high school and the role of the certified school nurse in each of these cases. Attendees learn strategies to help school nurses and doctors coordinate care of the special needs child with private physician and with parents.

Chapter President, Margaret (Meg) Fisher, MD, FAAP shares the latest developments in pediatric immunizations, insights into the goals of the NJIIS and describes the appropriate steps for handling a school-based outbreak of norovirus or other food borne illness.

Erica Lander provides guidance on how to recognize bullying - both the bully and the victim - and described strategies for addressing school-based bullying including assisting young children to develop resilience before it happens.

Chapter President, Margaret (Meg) Fisher, MD, FAAP shares the latest developments in pediatric immunizations, insights into the goals of the NJIIS and describes the appropriate steps for handling a school-based outbreak of norovirus or other food borne illness.

School Health Conference Co-Chair, Pauline Thomas, addresses attendees at the event's opening session.

AAP/NJ Executive Director, Fran Gallagher, introduces and thanks AAP/NJ staff members for their work on such a dynamic conference.
Gary Zuckerman, MD, describes the etiology, prevalence, recognition, and treatment of food allergy and anaphylaxis. He also provides the audience with a more comprehensive understanding of the impact of food allergy on school protocols for the lunchroom, and other events. Dr. Zuckerman offers guidance on when to use an Epi Pen and concluded with a discussion on the roles of the school doctor, the nurse, and the pediatrician.

Pat Barnett (E.D of NJ State Nurses Association) reviews the major legal issues facing school nurses and doctors throughout 2012 and provides valuable recommendations for locating contact information and web sites to use for future questions on school-based legal issues.

Monte Mills, MD, details the leading causes for screening failure and provided guidance on how to refer to the medical home. His session explored eye pathology including strabismus, amblyopia, the red eye, eye trauma and foreign bodies. Dr. Mills also offers details surrounding the controversy over vision therapy for non-ophthalmic diagnoses.

The 2012 Conference featured over 42 exhibitors and resource providers for attendees to explore and access free information and other valuable resources.

School Health Conference Co-Chair, Elliot Rubin, MD, FAAP, welcomes the over 450 attendees to the 2012 conference.
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Dear Colleague,

The North American Society of Pediatric and Adolescent Gynecology (NASPAG) has established the Young Scholars Grant to provide a venue for young physicians to voice their interest in the field of pediatric and adolescent gynecology.

We would like to invite residents and fellows from your districts, chapters, and sections to apply for the grant by submitting an essay on the topic: "Discuss how a case seen in your training shifted your career interests toward Pediatric and Adolescent Gynecology?" Information for how the essay should be constructed and submitted is available at www.naspag.org.

All application forms and essays must be submitted to rupadesilva@gmail.com by January 18, 2013.

Award recipients will be notified by February 15, 2013 so that they can arrange all travel and coverage to attend the NASPAG Annual Clinical and Research Meeting (ACRM) on April 18-20, 2013 in San Diego, CA. All award essays will be publicized at the ACRM. After the conference, all award recipients will be required to write a short summary of their experience at the NASPAG ACRM to share with other members of their department and possibly be included in future NASPAG publications such as the NASPAG member newsletter.

Please distribute this announcement to all applicable residents and fellows. NASPAG's ACRM promises to be an excellent forum for discussion of pediatric and adolescent gynecology issues and is sure to be enriched by representation from your physicians in training!

For more information, please contact Rupa DeSilva, MD at rupadesilva73@gmail.com.

Sincerely,
Rupa K. DeSilva, MD
NASPAG Young Scholars Liaison
Joseph S. Sanfilippo, M D, MBA
NASPAG Executive Director

Hospital Ditch Formula Samples to Promote Breast-Feeding

By PAM BELLUCK
Published: October 15, 2012

Read It Here: http://nyti.ms/RwBpg5
What is Chronic Fatigue Syndrome?

Chronic Fatigue Syndrome is a debilitating and complex illness, characterized by incapacitating fatigue (loss of energy and stamina) and multiple symptoms in all body systems. The symptoms are made worse by physical and mental activity and are not relieved by rest. Patients' ability to function is substantially less than before the illness.

Chronic Fatigue Syndrome (CFS) is an unfortunate name for this illness, because fatigue occurs in many other chronic illnesses and the name does not differentiate the pathological exhaustion of CFS from the normal fatigue felt by healthy people after exertion. The name CFS also ignores the multi-system abnormalities found in this illness and trivializes its severity. Although the illness is called CFS in the USA, it is a global illness and in other parts of the world it is known as Myalgic Encephalomyelitis (ME). Current medical definitions of the illness now use the acronym ME/CFS (1,2). ME/CFS is also known as Chronic Fatigue Immune Dysfunction Syndrome (CFIDS) and was previously known as Chronic Epstein Barr Virus Syndrome (CEBV).

CFS in Children and Adolescents

Nearly one million Americans have ME/CFS, but only 15% have been diagnosed. A substantial but unknown number of patients are under the age of 18 years. Adolescents 12 to 17 years old are more likely than younger children to develop ME/CFS, but children as young as four years old have developed the illness. In adults, three to four times as many women as men have ME/CFS, but the gender ratio is almost equal in affected children. ME/CFS usually occurs as sporadic (isolated) cases of the illness, but in 20% of patients it affects more than one family member. Clusters of cases or outbreaks of the illness have been found worldwide and in many of these outbreaks the illness has been prominent in schoolchildren.

Causes

The cause of ME/CFS is unknown, but several factors may be involved. In some families, where two or more blood relatives have ME/CFS, genetics may produce a susceptibility to the illness. Frequently the illness follows an acute infection, and immune system changes found in ME/CFS are similar to changes found in some viral infections. In spite of much research, no known infectious agent has been shown to be the cause. Occasionally, ME/CFS is triggered by: toxins, immunization, or major trauma. ME/CFS is not a psychological illness. Depression and anxiety may occur secondary to ME/CFS, but Major Depression and ME/CFS can be distinguished by behavioral, immunological and hormonal testing.

The first sign of the illness may be the child's marked limitation of activity, noticed by a parent or teacher.

Symptoms, Diagnosis and Case Definition

There is no diagnostic test for ME/CFS. The diagnosis is made from the characteristic fatigue, the pattern of other symptoms and the exclusion of other fatiguing illnesses. The main diagnostic features of the illness have been incorporated into a number of different case definitions for adults (2) and more recently a case definition for children (3). An adult case definition (3) has often been used to diagnose children, but it excludes some children with genuine ME/CFS, who do not exactly fit the adult criteria.

Key symptoms of the pediatric case definition (1) are as follows:

Clinically evaluated, unexplained, persistent, or relapsing fatigue for at least three months, which is not the result of exertion, is not relieved by rest, and results in a substantial reduction in previous activities.

The concurrent presence of the following symptoms:

1. Malaise, fatigue, or worsening of other symptoms after exertion, with loss of mental and/or physical stamina, and delayed recovery of more than 24 hours

2. Un-refreshing sleep, day/night reversal, nighttime insomnia and/or daytime hypersomnia (excessive sleep), disturbance of sleep quantity or rhythm

3. Widespread or migratory pain. The pain can be located in the muscles and/or joints (without signs of inflammation), in the abdomen, in the chest, or it can be a new type, or an increase in severity of headaches

4. Two or more neuro-cognitive manifestations, including impaired short term memory, difficulty in concentration or focusing, difficulty finding words or numbers, absent mindedness, slowness of thought, difficulty understanding information and expressing thoughts, educational difficulties

5. At least one symptom from two of the following three subcategories:
   a. Autonomic manifestations, including neurally mediated hypotension, postural hypotension, postural orthostatic tachycardia, shortness of breath, disturbed balance
   b. Neuro-endocrine manifestations, including feeling of feverishness, cold extremities, low body temperature, sweating, intolerance to heat or cold, change of appetite or weight
   c. Immune manifestations, including recurrent flu-like symptoms, sore throats, fevers and sweats, tender lymph nodes, new sensitivities to food, medicines, odors, or chemicals

Other fatiguing illnesses must be excluded by clinical examination and medical tests. Routine tests are frequently normal, but specialized testing may show various abnormalities in some patients' immune systems, nervous systems, cardiovascular systems and/or in cellular energy production.

The pattern and severity of the symptoms experienced by a child may change markedly from day to day or during the day. Children with ME/CFS often do not look ill, so it is important to listen to what the child has to say about the severity of his/her symptoms. Mood changes, reactive depression or anxiety may result from the illness. Many children also have the symptoms of Juvenile Fibromyalgia (pain and tender points, or areas, in muscles when they are touched). It may also be difficult to distinguish ME/CFS from Infectious Mononucleosis, Rheumatoid Arthritis, Lyme disease, psychiatric disorders or other illnesses. ME/CFS has often been misdiagnosed as School Avoidance Behavior, or as Munchausen's syndrome by proxy (a condition in which, a parent fabricates their child's illness).

Progress and Recovery

ME/CFS in adolescents usually starts suddenly with a fever and flu-like symptoms. Sometimes the onset is gradual. In younger children, a gradual onset over months or years is more likely.
It can be especially difficult to diagnose ME/CFS in younger children, because they may not recognize that their fatigue and their other symptoms are abnormal.

The diagnosis is often made retrospectively when the child is older. The first sign of the illness may be the child’s marked limitation of activity, noticed by a parent or teacher.

Children with ME/CFS may be very ill at the onset of the illness and the diagnosis is often uncertain, because routine blood tests are frequently normal. By definition, the diagnosis of ME/CFS cannot be made for three months, even if no other illness is found. Sometimes a provisional diagnosis of ME/CFS can be made sooner. Early diagnosis may lessen the impact of the illness by ensuring the child gets adequate rest. The severity of ME/CFS varies. Some children are severely disabled and bedridden, while others can go to school and a few even do sports. Most are between these extremes. Remissions and relapses are common. Relapses may be caused by over-exertion or by other infectious illnesses. Over time, slow improvement is likely. Recovery rates are uncertain but rates of up to 40% have been reported. Dramatic improvement is more likely to occur in the first four years.

Children whose health improves to near pre-illness levels are likely to find that they need more rest than their contemporaries.

Management

Establishing the diagnosis of ME/CFS and confirming that the child has a recognized illness will relieve uncertainty in the minds of the patient and the parents. There is no medication, which will cure the illness, but medication can be helpful in the relief of individual symptoms. ME/CFS patients commonly respond to lower than expected dosages of many medications. Adequate rest is the mainstay of treatment. Patients should be advised to adapt their lifestyle to live within their capabilities. Advice on nutrition can be helpful. Children with ME/CFS who are unable to attend school will be isolated at home, miss their friends and often need to give up their favorite activities. They should be encouraged to see their friends when possible and take up hobbies, which are within their capabilities.

Education

Most students with ME/CFS fall behind in their education due to cognitive problems and fatigue. Many are too ill to attend school. A British study found that ME/CFS was the most common cause of long-term absence from school. Students with ME/CFS may qualify for Special Services under the Individuals with Disabilities Education Act (IDEA) and/or Section 504 of the Rehabilitation Act, 1973. Eligible students receive an Individual Educational Plan (IEP) and the school should provide reasonable accommodations and/or home tutoring.

References


VALUABLE WEBSITES

NJCFSA, Inc, Youth Corner, Scholarship
http://www.njcfsa.org

CFIDS Association of America, Youth
http://www.cfids.org/youth.asp

Dysautonomia Youth Network of America, Inc
http://www.dynakids.org

IACFS/ME, Pediatric Case Definition, 2007
http://www.iacfsme.org

Resources for Parents
http://www.yellowpagesforkids.com/help/nj.htm

Educational related resources for Parents
http://www.wrightslaw.com

Fatigue

Fatigue may be confused with other conditions, including:

- fibromyalgia syndrome
- myalgic encephalomyelitis
- neurasthenia
- multiple chemical sensitivities
- chronic mononucleosis
- Lyme disease
- HIV-related diseases
- depression
- hypothyroidism
- malignancies and parasitic diseases

For additional resources and information phone, visit or email us at:

E-mail: njcfsa@njcfsa.org.
Phone: (888) 835 3677 (Help Line).
Abdominal pain is a common pediatric chief complaint addressed on a daily basis in the office. Once acute illnesses associated with abdominal pain, such as streptococcal pharyngitis, urinary tract infections and viral gastroenteritis have been eliminated and you are faced with the third office visit or fourth phone call from a frustrated parent, common causes of recurrent abdominal pain (RAP) need to be considered. A community based survey found 15% of high school students had symptoms suggestive of irritable bowel syndrome (IBS) and 5-10% of adolescents experienced dyspepsia or discomfort in the upper abdomen. As we are trained to seek pathology, it becomes a time consuming challenge to identify and treat the functional gastrointestinal disorders (FGID) in which there are no known structural, infectious or metabolic causes but rather, strong socio-cultural and psychological associations are present. As a result, it is not unusual for physicians and patients to seek a “real” diagnosis through exhaustive diagnostic testing which may not only increase healthcare costs but significantly add to patient and family anxiety.

In 1958, two English pediatricians, Apply and Naish, started the discussion about RAP. Originally described as 3 episodes of abdominal pain over a period of 3 months that are severe enough to affect activities, RAP was later used to describe all children with abdominal pain that did not have an organic etiology. We understand the term RAP now to be more of a description rather than a diagnosis. There are many different causes of recurrent abdominal pain ranging from functional GI disorders to conditions commonly referred to as “organic” disease, including celiac disease and inflammatory bowel disease. In 1988 a group of gastroenterologists meet in Rome and attempted to more accurately define FGID. This developed into The Rome Foundation, which is now a group of adult and pediatric gastroenterologists dedicated to furthering the understanding and the science of functional bowel disease and to improve the lives of patients suffering with these disorders. The Rome criteria are symptom based definitions of the functional GI disorders (FGIDs) and include pediatric specific diagnosis.

Three commonly encountered pain-related FGIDs include IBS, Functional Dyspepsia (FD) and functional abdominal pain (FAP). IBS is defined by the Rome criteria as abdominal discomfort or pain that 25% of the time has two or more of the following features: improvement with defecation onset or associated with a change in frequency or form (appearance) of stool. Patients with FD have persistent or recurrent pain centered in the upper abdomen above the umbilicus and no evidence that the dyspepsia is exclusively relieved by defecation or associated with the onset of change in stool frequency or stool form. FAP is basically continuous or episodic abdominal pain in a child who does not meet the criteria for any other FGID. Some of these children may have loss of function of their daily activities and somatic symptoms like sleep difficulties and very commonly also have headaches or limb pain. With all these conditions, the criteria must be fulfilled at least once per week for at least two months prior to diagnosis and there should be no evidence of inflammatory, anatomic, metabolic, or neoplastic disease.

The best way to exclude other abnormalities is to look for “red flags” on history and physical exam and then if needed pursue directed testing. Family history of inflammatory bowel disease, other auto-inflammatory diseases, celiac disease or documented H. pylori infection might prompt screening tests. Nocturnal awakening, persistent vomiting, dysphagia, GI bleeding, systemic signs (fever, rash, arthritis), or affected growth should make you consider other differential diagnosis besides functional disorders but does not completely exclude them.

Once a FGID diagnosis is established, using a biopsychosocial approach to explain the etiology of the child's current pain will help guide treatment. It is essential for a family to understand that psychological and environmental factors play a role in their child's illness so that they can grasp the importance of coping strategies to manage his or her symptoms and improve their child’s quality of life. Reassurance that there is no life threatening condition and explaining the etiology of a FGID diagnosis may be sufficient treatment for many children and families; however, for others, psychological and pharmacologic treatment may also be needed. Strong evidence exists for cognitive-behavioral therapy and emerging data suggest that clinical hypnotherapy and biofeedback may be beneficial as well. Medications to target specific symptoms, such as anti-depressants for pain and/or anxiety, antisapmodics or laxatives, may be useful adjuncts to behavioral-based therapy for some patients. Above all, acknowledging that the patient's symptoms are genuine is most important in strengthening the doctor/patient/family bond, reassuring the patient that you believe them and opening the discussion about the “brain – gut” connection.

References and recommendations for further reading:

A Rome Foundation, which is now a group of adult and pediatric gastroenterologists.
In an attempt to assist our clients and business partners during these trying weather-related times, the firm thought it would be helpful to send along some information that might be of value to you.

If there is anything else that the firm can do to help you along, please do not hesitate to contact us at your earliest convenience.

Financial Assistance for Business Owners

The following is a brief summary of programs and relief provisions that are being implemented to assist businesses and individuals who are located in the counties designated as disaster areas by the respective jurisdiction:

Disaster Relief Programs

Federal: Through its Office of Disaster Assistance (ODA), the small business administration (SBA) provides low-interest, long-term loans for physical and economic damage caused by a declared disaster. SBA offers home and personal property loans, business physical disaster loans, and economic injury disaster loans.

Home and Personal Loans: Renters and Homeowners could qualify for $40,000 or $200,000, respectively, to repair or replace their primary residence and to replace clothing, furniture, cars, appliances, etc.

Business Physical Disaster Loans: Businesses, profit or nonprofit organizations located in declared disaster areas could qualify for disaster loans up to $2 million. The proceeds could be used to repair or replace real property, machinery, fixtures and equipment, and inventory. The terms can be up to 30 years depending on the business's ability to pay.

Economic Injury Disaster Loan: If your business is located in the declared disaster area, you may qualify for this program if your business cannot meet its obligations and pay its ordinary and necessary business expenses. Loan limits up to $2 million.

You can get more details on the above program by visiting the following SBA link: http://ow.ly/f6wg6.

IRS Disaster Relief

IRS Tax Relief postpones various tax filing and payment deadlines that occurred starting in late October. As a result, affected individuals and businesses will have until Feb. 1, 2013 to file these returns and pay any taxes due. This includes the fourth quarter individual estimated tax payment, normally due Jan. 15, 2013.

It also includes payroll and excise tax returns and accompanying payments for the third and fourth quarters, normally due on Oct. 31, 2012 and Jan. 31, 2013 respectively. It also applies to tax-exempt organizations required to file Form 990 series returns with an original or extended deadline falling during this period.

The IRS will abate any interest, late-payment or late-filing penalty that would otherwise apply. The IRS automatically provides this relief to any taxpayer located in the disaster area. Taxpayers need not contact the IRS to get this relief.
Appeals Court Provides New Interpretation of Physician’s Duty to Report Child Abuse

By Denise L. Sanders, Esq.
Kern Augustine Conroy & Schoppmann, P.C.

The New Jersey Superior Court, Appellate Division, in L.A. v. New Jersey Division of Youth & Family Services, et al., has provided a new interpretation of the statutory duty to report child abuse, which should result in increased reporting. The November 16, 2012 opinion is mandatory reading for all pediatric, family, and emergency room physicians, but understanding just how to meet the less than bright line standard may be difficult. The lawsuit alleged that the emergency room physician had committed medical malpractice by, among other things, failing to comply with the New Jersey statute, N.J.S.A. 9:6-8.10, requiring any person having reasonable cause to believe that a child has been subjected to child abuse to report the same immediately to the New Jersey Division of Child Protection & Permanency (previously DYFS).

In this case, although the physician conducted extensive tests when the 2-year old presented to the emergency room vomiting and unsteady, with a 0.035 percent blood alcohol level, he apparently did not inquire fully before concluding that the child’s condition resulted from ingesting cologne from a container later brought to the ER by the child’s father, and deciding to not report the incident. In the coming months, the child was the victim of numerous incidents of child abuse and was removed from the father’s home and later adopted. The adoptive parent later sued DYFS (which settled), the physician and the hospital. The Appellate panel reversed the lower court’s dismissal of the adoptive parent’s suit.

In addressing the standard of care, the Court focused on the statutory definitions of “abused or neglected child” and “child abuse,” with emphasis on injury caused “by other than accidental means” and the failure of the parent or guardian “to exercise a minimum degree of care,” including providing proper supervision of the child. From that analysis, the Court concluded that there is a statutory obligation to report not only injuries resulting from abuse, but from conduct that is reckless, or grossly or wantonly negligent, but not conduct that is “merely negligent.” Finally, the Court looked to the intent of the reporting statutes, stating: “The purpose of the reporting requirement is to bring potential cases of abuse to the attention of DYFS for further investigation and, if required, emergent action and eventual adjudication. The ‘safety of the children’ is of ‘paramount concern.’” (Citing N.J.S.A. 96-8.8(a)).

With that underpinning, the Court concluded that, in the context of a case in which the statutory language establishes a physician’s standard of care:

“A physician has ‘reasonable cause to believe’ that there has been abuse if a ‘probable inference’ from the medical and factual information available to the physician is that the child’s condition is the result of child abuse, including ‘reckless’ or ‘grossly or wantonly negligent’ conduct or inaction by a parent or caregiver. The inference need not be the ‘most probable,’ but must be more than speculation or suspicion.”

The Court noted that, in this case, there were no established facts as to how the 2-year old accessed and consumed enough cologne to cause her medical symptoms, nor was there any information as to who, if anyone, had been supervising her at the time. The Court held that a reasonable jury could find that the child’s condition resulted from reckless or grossly or wantonly negligent parental conduct or inaction and that the physician breached the standard of care by failing to report. Although the physician in this case ultimately could be exonerated, the new standard requires immediate attention by those who treat minors. In addition to the implications in a medical malpractice lawsuit, failure to report as required by N.J.S.A. 96-8.10 is a disorderly persons offense, punishable by incarceration for up to six months. The Appellate Division’s opinion is available at www.drlaw.com. For questions or assistance, contact Kern Augustine Conroy & Schoppmann, P.C., at 800-445-0954.

CHILD ABUSE AND NEGLECT (CAN) EDUCATION PROGRAMS

The mission of Educating Practices In Their Communities (EPIC) is to improve the health of children through practical, community-based, quality medical education to primary care providers, their practice staff, and emergency department professionals.

SCAN & PCAN Training

There are two presentations in the EPIC CAN program:

Part one: SCAN or Suspected Child Abuse and Neglect has the primary goal of increasing recognition of child abuse and neglect among patients in both primary care and emergency department settings as well as encouraging appropriate provider reports to the DCP&P hotline and referrals to the Regional Diagnostic and Treatment Centers (RDT). Part two: PCAN or Prevention of Child Abuse and Neglect emphasizes the prevention of child abuse or neglect by highlighting global issues of crying and parenting discussed within the context of a medical home and by connecting primary care providers with family support and family strengthening resources in their communities.

Strengthening Pediatric Partners, MOC Part IV Project

This ABP-approved program utilizes established collaborative quality improvement methods for enhancing patient care by providing practices with the necessary training, tools, and support to help parents and other caregivers circumvent critical child abuse and neglect triggers. If you need to complete a Maintenance of Certification (MOC) Part 4 activity in 2013, Strengthening Pediatric Partners will enable you to meet your certification requirements. For additional details, contact Program Director, Harriet Lazarus at (609) 588-9988, ext. 108 or can@aapnj.org.
Over 200 pediatricians, family physicians, school physicians, school and public health nurses and other healthcare professionals from across New Jersey attended the 8th annual Vaccine for Children (VFC) Conference at the National Conference Center this past November. The Conference, supported by an education grant from the New Jersey Department of Health - Vaccine Preventable Disease Program, was designed to enhance attendees’ knowledge of the New Jersey Vaccine for Children Program, promote best practices, help attendees identify opportunities for improvement and to share current evidence-based immunization updates affecting the children serviced by the VFC Program.

MANAGING VFC: BEST PRACTICES AND LESSONS LEARNED
Efforts by AAP/NJ Contribute to Improved State Immunization Rates.

Recently released information from the Centers for Disease Control (CDC) reporting on the status of immunization rates in New Jersey unequivocally validates the key role played by the American Academy of Pediatrics, New Jersey Chapter (AAP/NJ) in halting and reversing a multi-year trend of failing rates.

Over two years ago, in September of 2010 the Centers for Disease Control Morbidity and Mortality Weekly Report (MMWR) detailed just how far immunization rates had plummeted in New Jersey. In that report the State was ranked 38th in the nation for selected vaccines among children 19-35 months old – in the bottom 25% of all states and significantly below the national average. NJ ranked lower than the national average in 5 categories of recommended childhood vaccines, and 20% lower than the national average for Hepatitis B vaccination at birth.

Prior to the release of the 2010 report, AAP/NJ, already alert to the increased health risks to children from the falling vaccination rates, was engaged in addressing the issue head on, working with pediatricians and other healthcare providers at every corner of the State to reverse a trend that was needlessly exposing children – especially newborns – and other State residents to the perilous and needless risks of vaccine preventable diseases. The Organization, working collaboratively with others in the health care community including the New Jersey Department of Health, propelled a shift in the falling rates through consensus building and educational outreach with physicians, legislators and residents across the State.

In 2011, AAP/NJ ramped up efforts to spur immunization rates further by highlighting the issue as one of the Organization’s primary areas of attention. In addition to providing training and support to pediatric practices for help in identifying under-immunized patients and addressing caregivers concerns, the Chapter incorporated Immunization into its educational publication, the Agenda for Children.

The concise booklet outlined the Chapter’s eight principal spheres of concentration. This authoritative tool was created to heighten awareness and insight into the major physical, mental and social health challenges facing the State’s children and their families. The Agenda has been widely distributed to public and private leaders, locally and nationally, providing them with strategic action-steps for improving health care to children and demonstrates the Chapter’s commitment to support all efforts and legislation that provides for and protects the children of New Jersey.

The New Jersey Immunization Network, a project conceptualized and fostered by AAP/NJ in 2009, has grown into an influential statewide coalition committed to advancing immunization rates throughout the State by providing healthcare professionals, the public, and policy makers with the most current scientifically-sound information pertaining to the efficacy and safety of age-appropriate immunizations.

With support from New Jersey Department of Health and other private partners, this statewide alliance, comprised of a diverse membership including, public and private organizations, healthcare associations, parents and Public Health professionals, meets regularly to strategize on effective ways to advance immunization rates and encourage participation in the New Jersey Immunization Information System (NJIIS). The Network is co-chaired by nationally acclaimed pediatric infectious disease specialists Margaret (Meg) Fisher, MD, FAAP, Lawrence Frenkel, MD, FAAP, and vice co-chaired by John J. Moore, DO, FAAFP and Peter Wenger, MD.

Has NJIN made an Impact?

By stark comparison to the 2010 report, a recent MMWR report depicts an acutely different picture. The new report shows a dramatic improvement to selected vaccine rates among children 19-35 months old. The turnaround, which reports New Jersey leapfrogging 14 other states - now ranking twenty-third (23rd) – and also surpassing the national average.

The MMWR report described the improvement as a “Statistically significant increase.”

Despite these significant improvements, New Jersey’s toddler population remains largely under immunized with approximately one in four toddlers (26.1%) not meeting current vaccine recommendations.

Boosting the rates further will require a robust and collaborative effort. “The unnecessary risk of illness to children from vaccine preventable disease remains needlessly high,” says AAP/NJ Executive Director, Fran Gallagher. “Much more needs to be done to ensure the health of our communities. Collaborative efforts like those between AAP/NJ and NJIN will solidify the strong infrastructure needed to continue moving our agenda for children forward.”

The American Academy of Pediatrics, New Jersey Chapter is dedicated to ensuring the optimal physical, mental and social health and well-being for all the State’s infants, children, adolescents and young adults. The Chapter believes that the highest quality of care for these children is most capably provided by pediatricians, pediatric medical subspecialists, pediatric surgical specialists, and other highly trained and credentialed child health professionals.

For additional information on the New Jersey Immunization Network, contact Program Director, Suzanne Courtwright at scourtwright@aapnj.org or (609) 588-9988, ext. 104.
PM Pediatrics
By Michael Bachman, MD, MBA, FAAP

Dear Colleague,

I would like to introduce you to PM Pediatrics, a trusted provider of pediatric urgent care in New York, which has expanded into New Jersey with a new Livingston location. We offer a convenient and comfortable alternative to the Emergency Room for patients who need to be seen after hours. PM Pediatrics is staffed by Pediatric Emergency Specialists who treat newborn through college-age patients in urgent situations while minimizing pain and unnecessary tests. We are only open when most pediatric practices are closed, and feature on-site digital x-ray and a comprehensive laboratory. A breakdown of PM Pediatrics visits very closely approximates that of a Pediatric Emergency Department:

- Musculoskeletal trauma - 25%
- Laceration repairs - 10%
- Asthma care - 10%
- IV hydration - 5%
- Lab tests - 25%
- X-rays - 15%
- Extended care - 5%
- Critical care - 1%
- Other procedures - 5%

We view our relationship with primary care physicians as a partnership, working to provide the best care possible. Our NY locations have treated over 300,000 patients from over 1,000 pediatric practices, with direct referrals from over 450 physicians.

We DO NOT offer wellness visits, physicals, immunizations or scheduled appointments, and an electronic copy of each medical record and discharge instructions are sent to the primary care physician that same day.

PM Pediatrics of Livingston is open 365 days a year, on weeknights from 4pm to 11pm and on weekends and holidays from 11am to 11pm. We accept most insurance plans.

I welcome the opportunity to discuss how we can best serve your needs as a valuable resource for your staff and patients. I would also like to extend a personal invitation for you to come visit our new Livingston location.

Sincerely,

Michael Bachman, MD, MBA, FAAP
mbachman@pmpediatrics.com
973-992-4767

SAVE THE DATES

SAVE THE DATE
Saturday April 20, 2013
SECOND ANNUAL
New Jersey’s Children’s Ball
Spotlight on Children

SAVE THE DATE
2013 Annual Meeting
June 18-19, 2013
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Uncommon Course of a Common Skin Condition

By Bhargavi Kola, M.D., FAAP
Assistant Professor at Texas Tech University
Faculty Hackensack University Medical Center

HPI: 8-month old ex 32-weeker with CG

A (corrected gestational age) 6-month presented with increasing pink rash over the left side of her neck located specifically at the angle of the jaw. As per the parents, the patient was known to have been born with the rash.

Her initial presentation was a small strawberry colored rash (size 0.5 x 1 cm), which raised parental concern due to its appearance. The parent was reassured by the primary physician that it was a benign skin tumor called a hemangioma and was provided with further explanation of the usual course of initial increase and subsequent regression of the hemangioma.

The patient was born preterm at 32-weeks of age due to premature contractions and prolonged rupture of membranes. No maternal complications, no maternal fever or tachycardia, no ascending infection or chorioamnionitis. She was in the NICU for 6 weeks due to feeding issues and was transiently on nasal CPAP weaned to room air, which she tolerated very well after 3 days of life. She had an uneventful NICU period and was discharged at 38-weeks of gestation.

During her 2-months of age follow up visit at (CGA 40wks) the parents were more anxious about the rapid growth and the patient was referred to pediatric dermatology. She was thoroughly evaluated by the dermatology, who started her on propranolol 0.25mg once daily due to the rapidly increasing size and location of the hemangioma.

The patient continued follow up with the dermatology despite which she continued to have persistent growth of her hemangioma to 5x6 cm and her dose of propranolol was subsequently increased to 1mg (0.5mg bid). After the initial increase in her dosage she had reasonable stability in the growth and although there was no significant improvement in the size of the hemangioma.

During her 6th month, the child became more active and mobile. She started to play with her hemangioma by scratching and rubbing it against her toys, which was seemingly impossible for the parents to control and she was noted to have severe ulceration over hemangioma. She was then immediately referred to pediatric dermatology and it was decided that she should have it excised surgically in order to prevent the secondary complications—bleeding and secondary infections.

After surgery, the patient was completely asymptomatic, tolerated the procedure well and had no surgical complications.

A Hemangioma of Infancy is a benign self-involuting tumor (swelling or growth) of endothelial cells, the cells that line blood vessels. It usually appears during the first weeks of life and sometimes resolves.

Types of Hemangiomas:

1. Superficial: Tumorous lesions that develop near the surface of an infant’s skin are called superficial hemangiomas. Typically, superficial hemangiomas appear bright red in color and lie flat against the skin. Certain children can develop a superficial tumor called a strawberry hemangioma, which causes a raised, red lesion to appear across the skin.

2. Deep: A hemangiomatous tumor that develops deep within the muscles, internal organs or lower skin layers has a type of skin lesion called a deep hemangioma. Deep hemangiomas may appear smooth across the skin’s surface, but develop a blue or gray color. This type of hemangioma tumor may not be detectable until a child is several weeks or months old because it begins deep beneath the skin. Once detected, a deep hemangioma can feel firm or rubbery to the touch.

3. Combined or mixed: Children who develop hemangioma tumors within the upper skin layers as well as within their bodies, lower skin layers or muscles have combined or mixed hemangioma tumors, report Cincinnati Children’s Hospital Medical Center health professionals. The skin lesions exhibit characteristics of both superficial and deep hemangiomas and can appear red and blue in color. Combined or mixed hemangiomas can appear as flat or raised lesions across an infant’s skin.

Incidence: Hemangiomas are one of the most common birthmarks in newborns. Most hemangiomas are not present at birth but develop within the first few weeks to months of life. They are found in up to 10 percent of babies by the age of one. The cause of hemangiomas is unknown. In very rare instances they may run in families, but in general they are not inherited. For parents of children with this birthmark, there is no increased risk of having a subsequent child with a hemangioma. Hemangiomas are more common in baby girls than boys. They are also more commonly seen in premature infants.

Typical growth patterns of Hemangiomas

<table>
<thead>
<tr>
<th>Age of Child</th>
<th>Hemangiomas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth</td>
<td>often not present or noticeable</td>
</tr>
<tr>
<td>1-2 months</td>
<td>becomes noticeable</td>
</tr>
<tr>
<td>1-6 months</td>
<td>grows most rapidly</td>
</tr>
<tr>
<td>12-18 months</td>
<td>begins to shrink (involute)</td>
</tr>
</tbody>
</table>

Hemangiomas usually involute (shrink away) in time. 30% of hemangiomas will resolve by 3 years of age 50% by 5 years of age, and 80%-90% by 9 years of age. Over one-half of hemangiomas heal with an excellent cosmetic result without treatment.

Hemangiomas Requiring Treatment

Hemangiomas usually appear, grow and go away without problems. In most cases, we do not recommend treatment.

Some hemangiomas can cause significant problems. Scenarios that may be more complicated and require treatment include:
In involvement of a vital organ, like the eye or ear, or windpipe
Bleeding
Ulceration
Crusting or infection
Rapid growth and deformity of the surrounding tissues. Hemangiomas in certain areas may have a higher risk of complications. These areas include the face (especially nose and lips), body folds, and groin. Hemangiomas in certain locations, which affect function, or are complicated by infection or ulceration, may be treated with laser, medication, or injections. If any worrisome signs appear such as these listed above, please contact your physician.

TREATMENT - In many instances no treatment will be indicated. If treatment is needed, however, it may include:

Cortisone: Injected into the hemangioma or given orally by mouth. If given orally for prolonged periods has side effects including increased risk of systemic infection, high blood pressure, diabetes, increased appetite, stomach irritation, growth suppression, etc.

Pulsed Dye Laser Therapy: This therapy treats the superficial blood vessels best. If this treatment is recommended it is usually reserved for the superficial component of hemangioma, characterized by a flat, red lesion. It is usually administered in a series of laser treatments spaced 2-4 weeks apart.

Propranolol: Propranolol a beta blocker is now being tried as treatment of choice for most of the infantile capillary hemangiomas. It is known to affect during the growth phase and down regulates the vascular endothelial growth factor and basic fibroblast growth factor through a RAF-mitogen activated protein kinase pathway, thus resulting in activation of apoptosis of capillary endothelial cells and thus leading to vasoconstriction and palpable softening of the hemangioma. It can be started with a dose as low as 0.17mg/kg/dose to a maximum of 5.0mg/kg/dose and dosing interval of 6hrs. the dose is usually slowly escalated due to possible hypoglycemia.

Antibiotics: If the hemangioma is infected and open it may be treated with a short course of antibiotics and daily wound cleansing.

Alpha Interferon: This therapy is limited to the most severe and potentially life threatening hemangiomas. It involves administering systemic medication via daily shots, usually into the leg, for several months. It is usually given to the baby by the parents under physician direction and supervision. This therapy has serious potential side effects including neurologic effects, blood abnormalities and others.

Surgical removal: In rare instances, hemangiomas may be surgically removed especially if they are not likely to resolve spontaneously or lead to significant tissue distortion and deformation.

References


Graefes Archive for Clinical and Experimental Ophthalmology Volume 238, Number 3, 214-221, DOI: 10.1007/s004170050346

Photodynamic therapy of two choroidal hemangioma, case reports. I. Barbazetto and U. Schmidt-Erfurth


Spotlight: MD On-Line: a Leader in Healthcare Technology

In 1995, MD On-Line (MDOL) recognized the time and cost savings that could be realized from an electronic claims solution that eliminated paper and bridged the gap between insurance companies and doctors' offices. That vision allowed MDOL to grow dramatically, and today the Parsippany, New Jersey-based company has expanded its offerings to create a suite of easy-to-use, interoperable products that enable practices of every size to operate more efficiently while embracing the emerging technological changes accompanying healthcare reform. In addition to electronic claims processing, MDOL offers an intuitive, cloud-based PM/EMR system, revenue cycle management, patient reminders, medical transcription services, ERAs, real-time eligibility, and credit card processing.

A proven partner to pediatricians for over 17 years, MDOL recently partnered with the American Academy of Pediatrics of New Jersey (AAP/NJ) to both increase member education and improve office workflow. “MDOL has been working with pediatricians since the very beginning—they have since come to represent a significant portion of our customer base,” said Chris Kasmin, MDOL’s VP of Sales and Channel Partner Development. “As a result, our sales and support teams have become hypersensitive to the particular needs of a pediatrician’s office. We look forward to finding out how we can even better serve the pediatricians of the tri-state area through an exclusive partnership with AAP/NJ.”

In the fall of 2011, MDOL launched its Indistinct Data program, a free offering exclusive to MDOL customers that delivers a mixture of care, educational, and industry alerts to clinicians based on their specialty and patient population. The program aims to bring additional value to MDOL providers through increasing patient volume, coding and billing help, disease and product information, and paid survey opportunities, in addition to increasing awareness surrounding industry changes and updates. For more information on Indistinct Data or any one of MDOL’s product offerings, please visit www.mdol.com.
SAVE THE DATE

American Academy of Pediatrics, NJ Chapter along with Monmouth Medical Center & Jersey Shore University Medical Center Presents:

Supporting Children in the Aftermath of a Disaster

David Schonfeld, MD, FAAP

Dr. Schonfeld is a developmental-behavioral pediatrician, an expert in disaster recovery, and the Thelma and Jack Rubinstein Professor of Pediatrics and Director of the National Center for School Crisis and Bereavement at Cincinnati Children’s Hospital Medical Center.

Participants will be able to:

1. Describe common symptoms of adjustment reactions after disaster and risk factors for difficulty with adjustment
2. Discuss the elements of psychological first aid and importance of basic supportive services, and
3. Understand the timeline for recovery after a disaster

Monday, December 17, 2012

FREE! Pollak Theatre at Monmouth University - 7:00 PM
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