New Jersey Pediatrics

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The advent of vaccines was the single most important public health advancement in the 20th century, following the 19th century improvements in sanitation and hygiene. Life expectancy dramatically increased from 50 years in 1900 to about 80 in 2010 due in large part to the reduction in mortality from infectious diseases.

The measles vaccine is a striking example of a vaccine success story. In 1912, 6000 measles related deaths per year were reported. In the 1950’s 3-4 million people per year in the US contracted measles, with 400-500 annual deaths, 48000 hospitalizations and 4000 who developed encephalitis (brain inflammation) from measles. In the 60’s, measles vaccines were developed and perfected and since then the incidence had declined dramatically to actually being declared eliminated in the US by the year 2000. In 1989 the protocol for measles vaccination was refined to the current two doses.

Since 2008, there has been a resurgence of measles in the US and several outbreaks, not as a result of vaccine failure, but instead related to people travelling to the US or returning to the US with measles and spreading the disease to pockets of unvaccinated communities. In 2014 there were over 600 cases and so far this year there are over 120 cases predominantly related to the Disneyland, California outbreak that has spread to mostly unvaccinated people in 17 states, including New Jersey, with the most recent Jersey City case.

Measles is now in our local communities. A person with measles is contagious 4 days prior to their symptoms, by droplets expelled from just breathing, that can persist in the air for up to 2 hours after the person has left the area. If you are exposed and susceptible there is a 90% chance you will develop measles. Children under one year of age who are too young for the MMR vaccine and others who are immunocompromised and cannot receive the vaccine are vulnerable and at risk for developing measles and its potential complications of pneumonia, deafness, brain damage from encephalitis and death. In addition the concept of herd immunity, whereby the background vaccination rate needs to be at least 94% of the population, comes into play and is necessary to protect those in the population who are the most defenseless- those not vaccinated or are too young or immunocompromised.

Evidence-based scientific studies have shown that vaccines work, are effective, and are safe. With respect to the MMR vaccine in particular, numerous, reproducible studies have debunked any association with autism, after an initial assertion of a link that was based on a fraudulent study.

It is imperative from a public health perspective that vaccine rates must be kept above the herd immunity threshold. Failure to do so will result in more frequent and extensive disease outbreaks with the potential for devastating outcomes affecting the children and other susceptible populations in NJ and elsewhere. NJ has close to 9000 or 1.7% of reported schoolchildren that claim a religious exemption to one or more vaccines and thus are potentially susceptible to vaccine preventable diseases like measles. In the pre-kindergarten age alone there are over 5000 children or 2.5% with religious exemptions with the highest percentages in Hunterdon, Monmouth, Sussex and Warren counties. That number is almost identical to the personal belief exemption percentage in California, where the current outbreak originated.

When it comes to public health and personal choice, it is best to keep in mind the oft quoted adage, “Your liberty to swing your fist ends just where my nose begins”. Personal decisions that affect only you personally (or those in your charge) may be open to debate but they cross into another realm entirely when they affect your neighbor and her children.

We need to work together to find strategies to increase vaccination rates of our under vaccinated populations in order to keep NJ from becoming the next outbreak hub. It is our duty and responsibility as medical professionals and community leaders to assure the health and safety of our most vulnerable populations and to keep them out of harm’s way.

Keep encouraging your caregivers to vaccinate their children!

Sincerely,

Elliot Rubin, MD, FAAP
Welcome to the Spring edition of NJ Pediatrics! I hope delivery of this issue is accompanied by some highly anticipated warm spring breezes.

The NJAAP mission is the attainment of optimal health, safety and well-being of New Jersey’s children (infants, children, adolescents, young adults) and promotion of pediatricians (primary care, pediatric medical subspecialists, pediatric surgical specialists) as the best qualified of all health care professionals to provide child healthcare.

This is such an important mission. We seek to provide a strong voice on behalf of children and pediatricians. In order to advocate and educate the various stakeholders: parents, health care providers, legislators and other partners, we turn to you, our membership, for information about the successes and challenges of real children / patients and their families in your practices. We ask for your insights and case scenarios both positive and problematic that can help to guide our efforts and resources. Below is one scenario received that epitomizes access issues.

“I have a patient who is an 11 y.o. young girl who was diagnosed at birth with a severe cyanotic heart defect. She was followed closely by pediatric cardiology after her repair. As she got older, she was not followed as closely – as she was growing well and thriving, the cardiology team spaced out her checkups. Two years ago at the age 9, she had a seizure at school. When she was brought to the ER, she was found to be in a very dangerous cardiac arrhythmia, that had caused her to seize and needed to be fixed—the arrhythmia was caused by scar tissue from when she had her initial heart surgery and needed immediate medical care/treatment. As she has an NJ Medicare plan, when we tried to get her transferred to a hospital that could do her surgery AND that accepted her insurance- there were none! She continued to stay in her arrhythmia and “coded” 4 times- nearly dying each time- while awaiting transfer.

Finally, St. Christopher’s Hospital in Pennsylvania agreed to accept her as a transfer and we life flighted her to that hospital. She now has a pacemaker and is doing well, but does show some signs of neurologic damage from the incident. 4 codes! All because no one takes her insurance!” (Christian Canzoniero, MD, FAAP, Community Pediatrician)

Please send us your real stories with similar de-identified case scenarios. Share with us when pediatric health care promotes optimal health and why, and when optimal health is not accessible for a child. Your voice helps us to support you in caring for your patients and supporting their families. These stories will be shared with insurance providers, State partners, and other partners in our efforts to educate decision makers about pediatric health care needs. NJAAP Government Affairs and Practice Management Committees are aligned and hard at work.

Stay tuned for updates on new initiatives: development of an MOC Part 4 Quality Improvement Collaborative Program; Linking Mental Health and Primary care; a new Health Literacy program designed for pediatric residents, and more. Valuable new developments in Allstate Office Interior (is it time to update your practice look?) and Art in Motion designed to help you create your own personal messages on camera to be used on your website. The NJAAP Members Only tab on our website is a great resource to be sure you’re making the most of your membership – saving money on malpractice insurance through MD Advantage; getting valuable discounts on services and products. Please make plans to attend our Annual Meeting on May,13. See page 33 for more details.

NJAAP has again been nominated for AAP Outstanding Large Chapter Award based on our 2014 Annual Report highlighting our accomplishments (see www.aapnj.org, members only site). Award decisions will be announced at the AAP Academy Leadership Forum Meeting in March.

Kind Regards and Happy Spring.

Fran Gallagher, MEd
Medical Director's Column

Steven Kairys, MD, MPH, FAAP
Medical Director, NJAAP/PCORE

The PCORE Executive Advisory Council met for the first time since the merger of PCORE and NJAAP on Feb 18, 2015. The Council will continue to meet four times a year with its major purpose being to brainstorm new projects and directions for NJAAP/PCORE. That brainstorming will result in more complete details about NJAAP initiatives and allow the time to drill down into the data and issues. Summation of these meetings will be presented to the Executive Council.

There were a number of important highlights that emerged from the meeting:

• The Medical Director praised the growth of PCORE and the number of new projects getting underway. There are also many more pediatricians willing to be champions for these new initiatives. To get involved, see the info box on the right below.

• Plans are underway to transform New Jersey Pediatrics into a PubMed-approved publication. While achieving this very important designation will take at least a year, it is well worth the effort. It will provide New Jersey pediatricians, PCORE and the Chapter, with an accredited venue to reach a national audience by way of the PubMed database.

• The timing is also right to expand chapter MOC efforts to other areas. There is no question that the MOC process brings the improvement table more than the usual early adopters that turn up for many of our interventions. We are hoping to be designated a portfolio institution, which requires a minimum of three ABP-approved projects. Given the time commitment required for pediatricians and their practice teams to participate in collaborative MOC projects, we are looking at opportunities to schedule initial training sessions during the Chapter’s Annual Meeting starting in 2016.

• The group spent over 40 minutes reviewing and discussing various content and educational delivery options for the new pilot pediatric residency program in Health Literacy, funded through a grant from the Horizon Foundation.

• The chapter has been awarded a 250K subcontract to develop and implement an MOC for behavioral and mental health screening and care in pediatric primary care. The project is funded by DCF for one year. The principle institution is Jersey Shore University Medical Center.

• The group received an overview of the major current active projects including; Child Abuse and Neglect, Healthy Homes, Health Literacy, NJ Immunization Network, Medical Home, NJIN-adolescent vaccination, Oral Health, Pulse Oximetry, Pediatric Partnership Initiative and Project Launch.

Each meeting of the Executive Advisory Council will highlight one or more programs with input from Council members, content experts, NJAAP team members and other specially invited attendees. The goal for the Executive Advisory Council is to increase the depth of each project, its reach throughout the state, its sustainability and the measures needed to demonstrate true value.

Sincerely,

Steven Kairys, MD, MPH, FAAP

Interested in Becoming a Physician Champion?
Contact the Chapter at (609) 842-0014
To Learn More

Breaking Alerts

TAKE 10
10 Minutes to complete an important survey on the impact of ending Medicaid Parity payments on December 31, 2015

Please look for the link to this survey in upcoming emails, ENews, and NJAAP FaceBook & Twitter posts

Please participate, your voice is needed

Student-Athlete Cardiac Assessment Professional Development Module

Keep alert to all NJAAP communications for information on the imminent release of the Student-Athlete Cardiac Assessment training module.

Contact NJAAP at (609) 842-0014 with any questions.
INTRODUCTION

Daytime urinary voiding problems in children occur in approximately 7% of 7 year-olds, making it a relatively common pediatric condition. The etiology for this condition is usually maturational delay of the nervous system with resulting urinary frequency, urgency, and urge incontinence. The most compelling evidence that daytime voiding problems in children are associated with maturational delay is the observation that the vast majority of children with this condition improve over time, even without treatment. Other common etiologies of daytime voiding problems in children include constipation, psychological causes, neurological abnormalities, and anatomical anomalies. This paper will mainly focus on daytime voiding problems in otherwise normal children.

Common daytime voiding problems in children include urinary incontinence, frequency, urgency, hesitancy, and delayed voiding. Compared to bedwetting, daytime urinary symptoms occur less frequently, but can be a greater source of psychosocial distress for the child and family. For example, it has been reported that children with daytime voiding problems have an increased risk for peer teasing and classroom conflict. For example, we recently reported that children with daytime incontinence are more likely to be bullied compared to their normal peers.

From a medical perspective, daytime voiding problems may need attention when it results in skin rash and breakdown from chronic wetness, urinary tract infection from improper voiding dynamics, hydrenephrosis from inadequate bladder emptying or evidence of renal scarring. Therefore, is important for pediatricians to be able to diagnose and manage children with voiding problems in order to avoid the morbidity that is associated with this condition.

It is recommended that the International Children’s Continence Society (ICCS) standard terminology be used when managing a child with daytime urinary complaints. This classification was developed to improve patient care and reduce semantic confusion associated with daytime urinary symptoms. This classification is helpful clinically since there is considerable overlap between conditions and the classification provides a framework for managing patients with daytime urinary complaints. Table 1 lists the various presenting symptoms, and Table 2 lists syndromes, or conditions, as classified by the ICCS.

Storage Symptoms
- Frequency
- Incontinence
- Urgency

Voiding Symptoms
- Straining
- Hesitancy
- Weak stream
- Intermittency

Other Symptoms
- Holding maneuvers
- Feeling of incomplete emptying
- Genital/lower urinary tract pain
- Post-void dribble

Table 1: Common Pediatric Voiding Symptoms

<table>
<thead>
<tr>
<th>CONDITIONS</th>
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<tbody>
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<td>Overactive Bladder</td>
</tr>
<tr>
<td>Underactive Bladder/Voiding Postponement</td>
</tr>
<tr>
<td>Dysfunctional Voiding</td>
</tr>
<tr>
<td>Stress Incontinence</td>
</tr>
<tr>
<td>Vaginal Reflux</td>
</tr>
<tr>
<td>Giggle Incontinence</td>
</tr>
<tr>
<td>Obstruction</td>
</tr>
<tr>
<td>Extraordinary Daytime Urinary Frequency</td>
</tr>
</tbody>
</table>

Table 2: Pediatric Voiding Conditions

The condition is thought to be due to over activity of the bladder muscle due to maturational delay of the nervous system. This results in sudden and random episodes of urinary incontinence that are unrelated to activity, cough, or laughter. Children can present with damp underwear or major episodes of incontinence.

The ICCS definition of this condition allows for the diagnosis to be made by the pediatrician based on history and physical examination alone, although urodynamic testing can confirm the presence of bladder over activity if indicated. The majority of otherwise normal children who present to the pediatrician with urinary frequency, urgency and incontinence will have OAB.

Bladder and bowel dysfunction

Bladder and bowel dysfunction (BBD) is a less common condition that should be considered when symptoms affect the bladder and bowel in children who are otherwise neurologically normal. Symptoms of OAB are present, but there is also significant constipation or fecal
Daytime Voiding Problems in Children

Incomplete evacuation of bladder or bowel are common secondary to withholding and could result in urinary tract infection, abdominal pain and renal damage if left untreated for a prolonged period of time. A history of delayed toilet training, stubbornness and withholding behavior is common in children with BBD.

BBD should be viewed as a condition that could result in urinary tract infection, vesicoureteral reflux, hydronephrosis, and renal damage due to long-term inadequate bladder emptying with subsequent urinary retention. Historically, BBD was termed “Hinmann syndrome” but this term is no longer appropriate. The key to the diagnosis is the presence of bowel issues that are often of equal severity to the child’s urinary symptoms.

Underactive Bladder and Voiding Postponement

Some children can willfully delay voiding for more than 10 hours without discomfort. The prolonged intervals between voiding, generally without any symptoms between voiding periods, is the key to making this diagnosis. Regardless of the etiology, children usually present with a large post void residual urine and a large bladder capacity, which typically results in a palpable lower abdominal mass and urinary tract infection. As the bladder muscle weakens, the child will use abdominal straining to void which helps make the diagnosis.

Voiding postponement may be associated with psychological comorbidity or behavioral problems and may require a psychological treatment approach that differs from the other lower urinary tract conditions described above. This condition can be documented by urodynamics which demonstrate low amplitude bladder contractions, but history and physical examination should be sufficient to arrive at the diagnosis.

Dysfunctional Voiding

Dysfunctional voiding is a syndrome that can only be diagnosed using urodynamic testing, so this diagnosis should not be made without urological testing. The syndrome is characterized by incomplete relaxation of the pelvic floor muscles during micturition. As such, urodynamic testing is needed to determine if the pelvic floor fails to relax during voiding in order for this syndrome to be diagnosed. Children typically present with symptoms of OAB plus slow urinary stream or feelings of incomplete bladder emptying. The term “dysfunctional voiding” is unfortunately a common term that is applied incorrectly to describe all forms of daytime urinary symptoms in children. This condition should be considered in children with OAB symptoms who do not respond to therapy.

Stress Incontinence

Stress incontinence is exceedingly rare in otherwise normal children. Stress incontinence refers to leakage of urine with increased intra-abdominal pressure such as running, laughing or sneezing. Stress urinary incontinence in children is almost exclusively seen in children with neurological or anatomical problems such as spina bifida, sacral agenesis or anal rectal malformation. Since this condition is not seen in normal children, it mandates a pediatric urological consultation when it is suspected.

Vaginal Reflux

Vaginal reflux is a common condition that tends to occur in toilet-trained girls between the ages of 4 and 8 years with high body mass index. The girls experience mild to moderate amounts of post void leakage that is due to reflux of urine into the vagina during voiding. When the child stands after voiding, the urine is released from the vagina and leakage occurs generally within a few seconds to minutes of normal voiding. In contrast to OAB, the leaking associated with vaginal reflux only occurs after voiding. This condition is not associated with any urodynamic abnormalities and is cured by spreading the legs widely apart during voiding or voiding backwards facing the toilet.

Giggle Incontinence

Giggle incontinence is a less common but bothersome condition that is characterized by incontinence that occurs during or immediately after laughing. This condition should not be confused with stress incontinence, since leaking occurs only after laughing with giggle incontinence. With stress incontinence, leaking occurs after any increase in intra-abdominal pressure such as with cough, sneeze or exercise.

The mechanism of giggle incontinence is unknown, but is believed to result from a bladder contraction that is induced by laughing. In contrast to OAB, vaginal reflux, or stress incontinence, children with giggle incontinence only experience incontinence with laughter which is helpful in making the diagnosis.

Obstruction

An anatomical obstruction is a relatively uncommon cause of daytime urinary symptoms in children. Most cases occur in boys. The most common causes of obstruction include meatal stenosis, posterior urethral valves, and urethral stricture. Obstruction caused by meatal stenosis generally produces a deflected urinary stream. Children with obstruction complain of having to strain to urinate and there may be evidence of bladder distention on physical exam. Imaging of the urethra or cystoscopy are often required to diagnose this condition.

continued on page 8
Extraordinary Daytime Only Urinary Frequency

Childhood extraordinary daytime urinary frequency (EDUF) is a common condition characterized by frequent daytime voiding without incontinence. The key to making the diagnosis of EUD is to recognize that it is not associated with urinary incontinence, altered urinary stream, urinary tract infection, or any nighttime symptoms. The causes of EUD are unknown, but several studies have suggested a recent infection as a possible etiology. This is a benign, self-limited syndrome that can last a few weeks to 18 months.

Medical History

The evaluation of children with voiding complaints should begin with a medical history. It is important to consider the child's developmental history since it can be associated with maturational delay. Toilet training history is important since late toilet training could suggest BBD. The severity and duration of symptoms should be established along with the pattern and type of symptoms to arrive at a preliminary diagnosis. Leaking that occurs only after voiding suggests vaginal reflux, while leakage only after laugh suggests giggle incontinence. A random pattern of incontinence is most consistent with OAB. Extreme daytime frequency without incontinence suggests EUD. Significant associated bowel problems suggests BBD as a diagnosis.

Physical Exam

The physical exam should look for bladder distention and fecal impaction which might indicate BBD, obstruction or underactive bladder. The genitalia should be examined with special attention to meatus in boys for meatal stenosis. A basic neurological examination with care spent examining the back for any sacral dimpling, skin discoloration, or hair tufts is essential as these can all be signs of potential spinal malformations with resulting neurogenic bladder. In most children, the examination will be normal with no specific findings.

Further Testing

In addition to the standard history and physical examinations, further evaluation should include urine analysis to provide information about a possible urinary tract infection or medical renal disease. Urine culture should be performed if symptoms are consistent with infection and if the urine analysis is positive. Most patients do not require any further testing initially, however, a renal/bladder ultrasound is a good screening test for patients who do not respond to initial therapy. Uroflow, urodynamic testing and cystoscopy can be performed by a pediatric urologist for refractory cases or cases that are difficult to classify. Voiding cystourethrogram should be performed as part of urodynamic testing when necessary.

Initial Treatment

Urotherapy

Urotherapy should be instituted by the pediatrician and is considered the cornerstone treatment for children with daytime voiding problems. It includes management of diet, treatment of any underlying constipation, proper hygiene and timed voiding. Urotherapy should be attempted initially for all children with voiding problems since it has been shown to be effective in up to 45% of cases. If the child does not respond to standard urotherapy, ultrasound or referral to a specialist can be considered.

If BBD is suspected, management includes an aggressive bowel clean-out regimen with laxatives and/or enemas, followed by recommendations to increase fiber and fluid intake in the diet. Many children lack adequate fluid and fiber in the diet. It is also reasonable to remove any potential bladder irritants (such as caffeine and artificial sweeteners) for children with irritative bladder symptoms including urinary frequency or urgency.

Children should be encouraged to develop and maintain proper toilet and voiding hygiene. The use of scented soaps and harsh laundry detergents should be minimized as they can irritate the external genitalia and cause urinary frequency and urgency, especially in girls. It is important to protect the perineal area in children who are constantly wet from incontinence. The use of protective zinc oxide barrier creams and twice weekly oatmeal baths should be encouraged.

Use of timed voiding is essential for children with voiding problems. Children should be instructed to spend sufficient time in the bathroom to eliminate completely. A 2-4 hour timed voiding schedule will ensure regular voiding and is especially important for children with voiding postponement and BBD. The use of a vibrating watch is often helpful to establish a timed voiding routine since it provides the child with an element of privacy that loud alarm watches do not. Finally, girls with suspected vaginal reflux should be encouraged to void facing towards the toilet. This position will force the child to spread her legs wide apart during voiding and reduce the chance of vaginal reflux.

Almost half of children who present to the pediatrician with voiding problems will respond to urotherapy as described above. Since all children should undergo this treatment, arriving at an exact classification is not essential at this point in the child’s management. If the child does not respond after 2 months of urotherapy, additional treatment or consultation with a specialist can be considered.

continued on next page
Pharmacotherapy

When patients do not respond to standard urotherapy the next step is generally pharmacologic treatment. Although these medications are fairly safe, starting a medication should be viewed as a long-term commitment and may be best instituted following specialist evaluation. Once started, these medications are often required for at least 6 months and sometimes are needed for several years.

The recommended drugs vary with the diagnosis, but the principles generally revolve around the use of medications for the maintenance of consistent bladder tone. The two most common medications are anticholinergics and alpha blockers. Care should be taken when prescribing anticholinergics since they can cause incomplete bladder emptying with possible hydronephrosis, especially in children with BBD. Therefore, any child placed on medication for voiding symptoms requires regular three to six month follow ups to ensure proper bladder emptying.

Anticholinergics

Anticholinergics are the first line pharmacotherapy for voiding symptoms that are resistant to standard urotherapy, but their use is often limited by low efficacy rates and adverse side effect profiles, including dry mouth, facial flushing, and constipation. Oxybutynin is the standard for anticholinergic therapy, but has recently been replaced by tolterodine, an anticholinergic designed specifically for OAB.

Alpha Blockers

While anticholinergics are effective on the bladder muscle, alpha blockers are effective for relaxation of α-adrenergic nerve fibers located within the bladder neck. Several authors have therefore demonstrated alpha blockers to be effective for the treatment of dysfunctional voiding. Since these medications can cause dizziness, they should be taken at bedtime.

Less Commonly Used Drugs

Besides the above commonly used drug classes, methylphenidate has proven efficacious for giggle incontinence. The mechanism by which it works is not well understood, but some authors suggest that it is the result of increasing urethral resistance or a central nervous system effect. Underactive bladder, which can be considered to be the opposite of OAB, has occasionally responded to muscarinics, but this medication is not routinely used in clinical practice.

Conclusions

While they share common symptoms, pediatric voiding problems differ in etiology, presentation, and management. It is important to use accepted ICCS terminology when diagnosing these problems to ensure appropriate management. Nearly one half of children can be treated successfully by the pediatrician using standard urotherapy. Patients who do not respond to urotherapy may be referred to a specialist for further evaluation and treatment.

References

1. A 7-year-old child presents to your office with daytime wetting. History and physical examination are normal. His parents are concerned that daytime wetting is rare in a 7 year old. You inform his parents that daytime wetting is present in approximately what percentage of 7 year olds:
   a. 1%
   b. 7%
   c. 15%
   d. parents are correct, daytime wetting is rare in 7 year olds

2. The most common etiology for daytime wetting in otherwise normal children is:
   a. spina bifida occulta
   b. behavior issue
   c. maturational delay in the development of the central nervous system
   d. severe constipation

3. A 5-year-old boy presents with the isolated symptom of a deflected urinary stream that points upward. His parents state that he “makes a mess in the bathroom” each time he urinates. The most important element of the physical examination for this child is:
   a. examination of the back for sacral dimple
   b. palpation of the bladder for retention of urine
   c. palpation of the abdomen for constipation
   d. examination of the penis

4. A 16-year-old girl presents to your office with the chief complaint of urinary incontinence only when she laughs. The remainder of her history and physical examination is normal. Which treatment option below would not be indicated?
   a. observation
   b. methyphenedate
   c. anticholinergics
   d. antibiotics

5. Which of the following conditions are most likely associated with sudden urinary incontinence that occurs at random times during the daytime:
   a. syndrome of extraordinary frequency and urgency
   b. overactive bladder
   c. vaginal voiding
   d. urinary tract infection

6. Which treatment option is not indicated for children with daytime voiding problems?
   a. anticholinergics
   b. timed voiding
   c. DDAVP
   d. alpha-blockers

7. Untreated, severe daytime voiding dysfunction could result in:
   a. UTI
   b. dermatitis
   c. hydronephrosis
   d. all of the above

8. A 4-year-old girl with a BMI of 27 complains of urinary incontinence that only occurs immediately after voiding. Her history and physical examination are normal and urine analysis is negative. Next step should be:
   a. anticholinergics
   b. observation
   c. urine culture
   d. instruct her to urinate facing the toilet

9. An 8-year-old boy presents to your office with the sudden onset of daytime urinary incontinence. History does not reveal any findings after careful questioning of the patient and parent. Physical examination demonstrates a non-tender but distended abdomen with normal bowel sounds. External hemorrhoids are noted on physical examination. The most likely underlying problem that is causing the incontinence is:
   a. constipation
   b. Wilms’ tumor
   c. UTI
   d. developmental delay

10. A 4-year-old girl presents with the sudden onset of daytime urinary frequency and urgency, without incontinence. She has no symptoms at night. History and physical examination are normal and urine analysis is normal. The next step in management is:
   a. urine culture
   b. observation
   c. renal and bladder ultrasound
   d. anticholinergics

CME Instructions

Read the CME-designated article and answer the Spring issue, quiz questions above. Print your name and phone number and mail or fax this form within six months from the date of issue to: NJAAP CME Quiz, 3836 Quakerbridge Road, Suite 106, Hamilton, NJ 08619 • Fax: 609.842.0015

NAME ____________________________
EMAIL ___________________________________________ PHONE ______________________

Submitter must answer 8 of the 10 questions correctly to qualify for CME credit

CME Activity is Free to all NJAAP Members in Good Standing --- Non Members’ Fee $15.00

Accreditation Statement:

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Medical Society of New Jersey through the joint providership of Atlantic Health System and the New Jersey Chapter, American Academy of Pediatrics. Atlantic Health System is accredited by the Medical Society of New Jersey to provide continuing medical education for physicians.

Atlantic Health System designates this live activity for a maximum of 1.0 MA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
Dear Editor,

Lead poisoning is an important and a challenging issue that we face in New Jersey and in states across the nation. Across the country, 4 million households have children living in them who are being exposed to high levels of lead, according to the Centers for Disease Control and Prevention.

One of the most troubling aspects of lead poisoning is that there are no obvious symptoms, so it often goes undetected. Silently, it affects the organs of young children, causing permanent damage to the brain and nervous system and can lead to a lower IQ, inability to pay attention and decreased success in school.

Recent published reports showed that more than 5,000 children each year in New Jersey have elevated lead levels. While New Jersey is not alone in facing challenges when it comes to lead exposure, particularly since many older homes contain lead paint, the prevalence of children with lead poisoning in New Jersey is concerning. This is an issue that we have to address.

I recently signed on to sponsor legislation (S-1279) to provide $10 million in funding for the state’s Lead Hazard Control Assistance Fund, which provides funding to address lead-based paint in New Jersey in a comprehensive and focused manner. Programs that are funded include lead-based paint hazard control through lead abatement or interim controls, emergency relocation of households which include a child with an elevated blood lead level and education and outreach.

I will be working with the prime sponsor of the bill, Senator Ronald L. Rice, and Majority Leader Loretta Weinberg, a cosponsor, to get the legislation passed and sent to the governor’s desk. We have also committed to working together to secure funding in the upcoming budget for lead hazard prevention. We will continue to look for additional ways to protect children in the state from the hazards associated with ingesting and inhaling this hazardous substance.

As professionals who have dedicated their careers to caring for children, I know that Pediatricians also understand the vital importance of taking preventive steps to safeguard children against the harmful effects of lead poisoning, and I ask for your support in our effort.

Sincerely,

Jeff Van Drew
Senator

Senator Van Drew serves as Chair of the Senate Community and Urban Affairs Committee. He represents the 1st Legislative District in New Jersey, which includes Atlantic, Cape May and Cumberland counties.
Allergic Rhinitis

Allergic Rhinitis is an inflammation of the nasal mucosa caused by allergens leading to production of rhinorrhea, sneezing, itchiness, postnasal drip and rarely, bleeding.

Epidemiology

At least 10-20% of the US population suffers from seasonal allergic rhinitis. Physician diagnosed allergic rhinitis has been observed in 42% of 6 year old children. Another study shows allergic rhinitis occurs in 8-10% of US children. The morbidity of rhinitis and its complications like sinusitis lead to millions of lost school days. In total 20-40 million US individuals suffer from allergic rhinitis annually. In 1996, treatment of allergic rhinitis cost 3 billion dollars and an additional 4 billion in treatment of related complications.

Etiology

Dust, dust mites, pets, pollens of grass, trees, weeds and mold and other allergens.

Pathophysiology

Allergens presented to B-Cells (Plasma cells) cause them to produce IgE which attaches itself to both mast-cells and basophiles. This is a sensitization phase. When the sensitized mast cells are re-challenged with more allergens the allergens interact with the IgE attached to the mast cell. The IgE/allergen complex interacts with the mast cell membrane which leads to the release of preformed chemicals stored in the granules.

These chemicals/mediators are histamine, eosinophil chemotaxis factor, neutrophil chemotaxis factor Kinins, platelet activating factor and cytokines. Newly formed mediators are also released at the same time and these are leukotrienes B4, C4, prostacyclin, prostaglandins and thromboxanes. The IgE/allergen production is enhanced by cytokine interleukin 4 produced by the Th2 cell which also produces IL5 to increase clonal expansion of eosinophils and histamine releasing factor to stimulate mast cell release of histamine.

All these mediators released end up causing mucous secretions from mucous glands, vasodilation and edema as well as nasal nerve stimulation. The consequence of these sequences of events leads to immediate vascular swelling caused by vascular permeability and oozing of fluid engorgement causing nasal congestion, sneezing and pruritis caused by irritation of the nerves by the mediators. Other mediators like leukotrine B4, platelet activating factor and eosinophil chemotax to the site are responsible for late phase/delayed congestion, rhinorrhea and increasing nasal reactivity. In late phase allergic rhinitis patients exposed to allergens do not show symptoms until after 4 hours and beyond while early phase reactant allergy symptoms usually occur within an hour after exposure.

Patients who have perennial allergic rhinitis, most of the time due to dust and other allergens, continuously release the aforementioned nasal mediators that end up causing obstruction of the anterior aspect of the nasal passage. If left untreated stasis of secretions left in the sinuses and middle ear car will cause sinusitis and otitis media.

Clinical Presentation

History—Patient may complain of:

Nose
1. Rhinorrhea (usually clear, watery)
2. Nasal congestion and obstruction
3. Sneeze
4. Nasal and throat itchiness
5. Clogged ears
6. Cough (mediators stimulating cough receptors in the nose as well as post nasal drip stimulating pharyngeal cough receptors,

Eyes
1. Watery, itchy eyes
2. Hyperemic conjunctiva

Sinuses—Symptoms suggestive of acute and chronic sinusitis

Lungs—Chest tightness, wheezes, spastic, congestive cough

Skin—Eczema and pruritus as well as urticaria

Speech—Parents may complain of delayed speech and language development in infants and toddlers.

Seasonality—spring and fall tend to be associated with symptoms; trees, grass and mold (spring) and ragweed (fall).

Family History—Parents and other relatives may have history of allergies.

Environmental History— Carpets, stuffed toys and vents may accumulate dust and cause allergies. Pets, wood, cigarette smoke may do same. If cleaning, vacuuming and dusting increase or start symptoms then dust is the culprit. If raking grass and leaves trigger the symptoms suspect mold to be the etiology. If a child is away for an extended period from pets and symptoms return with return of pets then the trigger is the pet.

Physical Exam:

HEENT:

• Conjunctival erythema with cobblestones may be seen in allergic shiners (darkened area in and around lower eyelids). This is due to obstruction of lymphatics and venous systems.
Allergic Rhinitis continued

Dennie-Morgan lines, which are double skin folds under lower eyelids, may also be observed.

- The turbinates in the nose may be pale and swollen/boggy, likewise the nasal mucosa with clear rhinorrhea. The swollen, thickened mucosa may obstruct nasal airflow forcing patient to become obligate mouth breather causing lips to look dry persistently.

- Superinfection with bacteria may lead to presence of purulent, deep greenish, yellowish or brownish nasal discharge.

- Nasal crease which is a line across the bridge of the nose resulting from allergic salute which is the rubbing of the tip of the nose upwards with the palm of the hand to relieve nasal congestion and itchiness. If you are lucky the patient may do this several times while you take the history in the office.

- Occasionally nasal poly may be observed in the nose. As a pulmonologist I always suspect Cystic Fibrosis and Primary Ciliary Dyskinesia whenever I see one.

- Tickle cough may be heard while the patient is in the office and when the pharynx is examined pharyngeal cobblestones may be observed. Another name for it is pharyngeal follicular hypertrophy. Post-nasal drip, usually white or clear may be seen in allergic rhinitis. Infections/neutrophilic rhinitis or sinusitis often produce a purulent discharge.

EAR—Fluid may be seen behind the tympani which may look dull. Hyperemic, hypomobile tympanum may suggest otitis media.

SKIN—May show eczema, urticaria or patient scratching because of pruritus.

LUNGS—Wheezing, rales, and expiratory rhonchi may be heard in complicated allergic rhinitis. Most of the mediators described in the pathophysiology may cause broncho constriction in those who are predisposed to have asthma.

Differential Diagnosis:

1. Non-eosinophilic Rhinitis: Symptoms are usually perennial. Severe nasal obstruction with anosmia and polyp seen mainly in adults although I have seen a few teenagers with it. They have aspirin triad, aspirin sensitivity, nasal polyp and asthma. Cytology shows predominantly eosinophils.

2. Neutrophilic Rhinitis—Purulent discharge, sinus tenderness; nasal congestion seen more in winter and fall. Infections caused by cytology are mainly neutrophil predominance. Some may have intracellular bacteria. Smelly unilateral purulent nasal discharge is usually due to a foreign body in the nostril.

3. Vasomotor Rhinitis—Rare in children and triggered by odors (perfumes, cigarette smoke, paint fumes, alcohol, spicy foods, temperature, barometric pressures and bright lights.) Patients may be “runners” in which case they have rhinorrhea or they may be “dry” in which case they have nasal obstruction and air flow resistance with minimal rhinorrhea. The former is thought to be due to cholinergic glandular activity. The latter is due to nociceptive neuron activity and cytology is unremarkable.

LABS: IgE levels and peripheral eosinophils are neither sensitive nor specific for identifying patients with allergic rhinitis.

- Nasal Cytology: Nasal secretion may be stained with Wright or Hansel stain. Eosinophil presence of >10% is positive for Eosinophilic rhinitis although infectious rhinitis with neutrophils >90% does not necessarily rule out underlying allergic rhinitis.

- Skin Test: This is indicated in patients whose history and physical exams and tests prove they have allergic rhinitis. Scratch test may be done and if it is not conclusive intradermal tests may be performed to identify the allergens.

Immunol CAP Specific IgE Blood Test: This is a newer invitro IgE test as is the older Radioallergosorbent Test (RAST) but this method has superior sensitivity than the old RAST. This test is indicated in patients that:

1. Have widespread skin disease.
2. Take antihistamine, B-Blockers, ACE inhibitors and tricyclic antidepressants.
3. Are at risk for anaphylaxis.
4. Are uncooperative for skin testing.

Ancillary Test:

1. PFT—Pre and post bronchodilator may be done. 35-40% of patients with allergic rhinitis have silent asthma. It is indicated in patients with allergic rhinitis, chest tightness and/or wheezing and shortness of breath.

2. Tympanometry/Audiometry—indicated in patients with allergic rhinitis who also have effusion behind tympani and/or wheezing and shortness of breath.

Treatment

1. Avoidance:
   - If a patient has allergies to outdoor allergens he or she should reduce time spent outside. Windows and doors should be closed and air conditioners should be used liberally where they are indicated. Early hours between 5:00am and 10:00am are peak pollen hours so patients should avoid these peak hours.
   - Those with allergies to dust should have:
     a. Encasement of mattresses and box complementsed with weekly dusting with wet cloth.
     b. Linens washed with hot water weekly
     c. Electrostatic air filter which may be used with forced air systems. Air purifiers are said not

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to be very effective with dust mite allergies as they remain on surfaces of pillows, bedding and furniture.

d. Vacuuming once a week but not to be overdone as that aerosolizes dust unless HEPA filter is in use.

e. Benzylbenzoate and Tannic Acid may be applied to carpet and furniture surfaces every 2-3 months.

f. Indoor humidity <50% to reduce dust mite viability.

• Those allergic to mold must avoid dead and decaying leaves. Indoor humidity should be kept <50%.
  Also, especially in home basements, dehumidifiers are useful in decreasing humidity levels. Bleach is effective against mold growth.

• Those allergic to pets must remove the pets from the home. If not practical then keep it from child’s bedroom and wash pet frequently.

• Those irritated nasally by non-allergic factors like paints, cigarettes, cleaning solutions, should avoid them.

Pharmacotherapy

If avoidance cannot be accomplished pharmacotherapy should be tried. Pharmacotherapy consists of:

a. Oral Antihistamines which competitively inhibit histamine:
  Except for Zyrtec, Claritin (2nd generation) most of the over the counter oral antihistamines are first generation (Diphenhydramine, Hydroxyzine, Cyproheptadine) and can cause drowsiness and/or problems with thinking and driving. The newer medications like Zyrtec (Cetirizine), Allegra (Fexofenadine) and Clarinex (Desloratadine) have fewer such problems.

b. Oral Decongestants:
  Examples of these: pseudoephedrine and phenylephrine reduce stuffiness of the nose by vasoconstricting the vessels of the lining of the upper respiratory tract. Their main side effects are nervousness and sleeping problems as well as an increase in blood pressure.

c. Nasal Corticosteroid Inhalants:
  These are the most effective medications for allergic rhinitis as well as non-allergic rhinitis. It should be sprayed after nasal saline hygiene has been done to remove nasal crusts. The spray should be done away from the nasal septum as failure to follow this simple instruction can lead to nasal septal perforation. It causes nasal irritation in some patients and occasionally epistaxis. In pediatric patients, lowest effective dose is used and height of the patient closely followed.

d. Nasally Inhaled Antihistamines:
  These alleviate symptoms of both allergic and non-allergic rhinitis. To avoid having a bitter taste in the mouth the medicine should be sprayed as the head is tilted down towards the feet. Occasional sleepiness may be observed in some patients.

e. Decongestant Nasal Sprays:
  Oxymetazoline is an over the counter medication nasal decongestant and it does so by vasoconstricting the blood vessels in the nose. This medication can be given for only 3-5 days. Usage beyond this simple stipulated duration will result in rebound phenomenon in which the swelling in the nose becomes worse causing what is known as rhinitis medicamentosa.

f. Intranasal Ipratropium:
  This medication helps to reduce the rhinorrhea, but not the nasal congestion. It is beneficial in both allergic and non allergic rhinitis.

g. Intranasal Mast Cell Stabilizers:
  Cromolyn Sodium nasal spray may reduce allergic rhinitis symptoms in some patients. It is effective for preventing symptoms when used 20-30 minutes prior to exposure to allergens.

h. Oral Montelukast:
  This is a leukotriene antagonist that reduces nasal congestion, sneezing, itching and eye allergies. Some neuropsychiatric events such as agitation, aggression, nervousness, night terrors and hallucinations occur in a subgroup of patients. It also helps in controlling asthma (mild persistent). When used with antihistamine a synergistic effect may occur.

  Medications that can be used in infants and toddlers are Montelukast. Those that can be used >2 years old are Fexofenadine, Cetirizine, Desloratadine and Loratidine, Diphenhydramine and Hydroxyzine as well as intranasal steroids.

Allergen Immunotherapy

Those with difficult to control allergic rhinitis symptoms for quite a few months in the year, as well as those taking several medications to control their symptoms, may benefit from Immunotherapy (allergy shots as popularly known). The treatment involves desensitization injections for 3-5 years. If no relief is noted after 1-2 years then most likely it is not going to be beneficial for the patient and further investigations have to be done. Moderate/severe allergic rhinitis and its complications may require consultation with allergist and ENT specialist.

  Both antihistamine intranasal steroids and antileukotriens as well as immunotherapy have been found to control asthma and improve pulmonary function in asthma patients. This is not surprising because upper airway disease influences the lower airways. Studies dating back over 20 years and recently have
shown that adults, adolescents and children with allergic rhinitis, have increased bronchial hyper-responsiveness compared with those without allergic rhinitis 8,11,12.

Summary/Conclusion

Allergens stimulate nasal mast cells to produce mediators which cause the symptoms noted in allergic rhinitis. By avoiding the triggers or using pharmacotherapy and immunotherapy to treat it, quality of life improves significantly and asthma control becomes optimal and associated complications attenuated.

References


Suggested Reading

Legal: U.S. Supreme Court to Decide Whether Providers May Sue Over Medicaid Rates

By: Michael J. Schoppmann, Esq.
Managing Partner
Kern Augustine Conroy & Schoppmann, P.C.

Question: What is the status of the lawsuit over whether or not providers may sue in court over Medicaid rates?

Answer: On January 20, 2015, the United States Supreme Court heard oral argument in Armstrong v. Exceptional Child Center, Inc. The issue to be decided is whether or not healthcare providers have the right to bring suit in federal court over Medicaid rates which they feel are inadequately low.

A United States District Court in Idaho ruled that Idaho’s Medicaid rates did not comply with the requirement under federal law, that states must assure payments which “are consistent with efficiency, economy and quality of care and are sufficient to enlist enough providers” in the program to ensure adequate access to care. The District Court’s decision was upheld by the United States Court of Appeals for the Ninth Circuit.

Idaho Medicaid officials petitioned the United States Supreme Court for review. Their petition was granted with respect to the issue of whether or not providers have a private right of action to enforce the provision of federal law which the Idaho District Court had found the Medicaid program had failed to meet. The legal issue concerns the fact that Congress did not provide for a right to enforce the statute in question. The providers argued that the Supremacy Clause of the United States Constitution gives them the right to bring an enforcement action, as the federal law provision mandating sufficient payments takes precedence over the Idaho state statute setting the Medicaid rates.

The case is significant, as unless the Supreme Court finds a private right of action for providers to institute such suits, there is no effective enforcement mechanism to ensure that Medicaid rates established by a state are indeed sufficient to meet the standard established under federal law. Absent such a private enforcement right, the only other way to enforce this provision is for the Department of Health and Human Services to withhold federal matching funds from the state. We will continue to follow this case, and report when the Supreme Court issues its opinion.

If you have any questions, please contact our Managing Partner, Michael J. Schoppmann, Esq at 1-800-445-0954 or via email at MSchoppmann@DrLaw.com.


Mr. Schoppmann may be contacted at 1-800-445-0954 or via email - MSchoppmann@DrLaw.com

On April 1st RWJ, in partnership with Prevent Child Abuse -NJ, and NJAAP, we will host a community forum entitled, “Human Trafficking: Let’s Make this the End of the Road Part II”. We anticipate approximately 200 attendees who will participate in a discussion with a panel of statewide experts, develop action plans and create “Interest/Action Groups” that will carry out the “next steps” required to put a stop to Human Trafficking in NJ.
As we write this update, Governor Christie proposed a $33.8 billion fiscal year 2016 state budget to a joint session of the Legislature. In his remarks to the Legislature, remarks that focused heavily on the state’s pension system, the Governor said that the budget he proposed contains no new taxes and will keep aid to towns and public schools as well as property tax relief at current levels.

As a result of the Governor’s decision to expand NJ FamilyCare in 2014, 390,000 additional New Jerseyans are covered by the program. The budget includes $45 million in state and federal funds to increase reimbursement rates for certain primary and specialty care services offered through FamilyCare. The Governor’s budget reduces charity care payments to hospitals by $148 million to a total of $502 million and increases funding for Graduate Medical Education by $27 million for a total of $127.3 million.

The budget proposal also speaks to the Children’s System of Care (CSOC) which is designed to address the holistic needs and concerns of families with children with multiple needs, including behavioral health, substance abuse and intellectual and developmental disabilities. This program was established to help more youth remain at home, in school and in their own communities, while still receiving the full scope of services they require, and provides coordinated care for more than 8,000 children and adolescents. The Fiscal Year 2016 budget includes a total of $522.9 million in state and federal funds for the operations and services provided by the Division of Children and Families, an increase of $13.9 million over last year’s budget.

The Legislature will begin its review of the Governor’s proposed budget next month. The budget must be passed by the Legislature and signed by the Governor by July 1, 2015.

On the legislative front, the Assembly’s Women and Children’s Committee released A3834, sponsored by Assemblywoman Lampitt referred to as “The Child and Family Suicide Prevention Act.” This bill requires the State Board of Medical Examiners to include educational programs or topics related to suicide prevention in continuing medical education requirements for physicians who are pediatricians and physicians who regularly provide pediatric care services. Under the bill, pediatricians would be required to attend courses concerning suicide prevention in addition to completing any other continuing medical education requirements generally applicable to physicians. Several physician groups had concerns with the additional CME mandate and have been working on amendments with Assemblywoman Lampitt. The bill is likely to be amended on the floor to provide that physicians, advanced practice nurses and physician assistants who regularly provide pediatric care (defined as 30% of their practice) must complete training in suicide prevention but that the training need not be CME but could also be seminars or society-sponsored education. If physicians take CME on this topic as part of their normal CME requirement, the CME course would fulfill the requirements of this bill.

Finally, the Assembly passed A3435, Assemblyman Garcia’s bill to permit a minor to give consent for behavioral health care for the treatment of mental illness or emotional disorders. The bill provides that the minor’s consent to treatment under the supervision of a physician, an individual licensed to provide professional counseling, including, but not limited to, a psychiatrist, licensed practicing psychologist, certified social worker, licensed clinical social worker, licensed social worker, licensed marriage and family therapist, certified psychoanalyst, licensed psychologist or licensed clinical social worker, an advanced practice nurse, or in a health care facility would be valid and binding as if the minor had achieved majority. This treatment would be considered confidential information. The provisions of the bill are similar to those which already permit a minor to consent to treatment for venereal disease, human immunodeficiency virus, acquired immune deficiency syndrome, sexual assault, or drug or alcohol abuse.
Introduction:

The incidence of button battery ingestion has risen dramatically over the last 10 years, with a particularly dramatic rise in the rate of severe injuries related to button batteries. Button battery ingestion is a multifaceted problem that is complicated by the increased use of button batteries in the U.S., nonspecific presenting symptoms, and rapid onset of injury. Dangerous complications include mucosal burns, esophageal strictures, full-thickness injury and perforations, and fistula formation (trachea-esophageal or aorto-esophageal), many of which could lead to permanent disability or death. We present the case of a 3 year old male who developed a fatal complication from button battery ingestion.

Case Report:

A 3 year old male with no significant past medical history presented to our emergency department (ED) in cardiac arrest following a one hour history of massive upper gastrointestinal bleeding. One week prior to presentation, the patient was seen at an outside ED for vague abdominal pain and decreased appetite. There was no reported episode of foreign body ingestion at this time. He was discharged in stable condition with a working diagnosis of bacterial pharyngitis, for which he received oral antibiotics. Otherwise, the patient was in a good state of health and asymptomatic until the morning prior to presentation.

The morning prior to presentation, the patient was at home playing video games with his siblings when caretakers noticed sudden onset dyspnea and hematemesis. This prompted the caretakers to seek immediate medical attention. When emergency responders arrived 20 minutes afterwards, the patient was found unresponsive to painful stimuli, and cardiac monitoring revealed asystole. Advanced cardiovascular life support measures were initiated. He was unable to be intubated in the field due to copious airway blood and secretions. Upon arrival to our ED, the patient remained unresponsive and asystolic. Endotracheal intubation was performed by the ED team, and advanced cardiovascular life support continued. Despite aggressive resuscitative efforts, the patient expired. The total time from onset of event to pronouncement was estimated at 90 minutes.

Prior to autopsy, an antero-posterior view chest x-ray revealed a radio-opaque, flat, circular object lodged in the esophagus at the level of the arch of the aorta (Figure 1). Autopsy revealed a 20mm lithium-ion battery lodged in the middle-third of the esophagus with an aorto-esophageal fistula identified at the level of the battery (Figure 2). Eschar formation was also appreciated around the battery. The cause of death was determined to be exsanguination from the aorto-esophageal fistula secondary to soft tissue damage from button battery ingestion.

Discussion:

The National Battery Ingestion Hotline (NBIH), established in 1982 at the National Capital Poison Center, was designed to gather battery ingestion case data to help identify risks and guide policy changes. Data from the NBIH confirm an increase in the frequency and severity of ingestions in children under 6 years of age over the last decade: 13 major or fatal complications from 2,227 reported ingestions in 2013 compared to 1 major or fatal complication from 1,735 reported ingestions in 2003.1 This trend is attributed to the increased use of 20mm diameter lithium batteries, which are more likely to lodge in the esophagus than 7.9mm or 5.8mm sizes commonly found in hearing aids.2 According to the NBIH, the most frequently reported source of ingested 20mm lithium batteries is remote control devices, but these batteries are also found in small toys, watches, flameless candles, bathroom scales, key fobs, book lights, calculators, garage door openers, glucometers, and cameras, among other household items. The type of battery in the case we present is a 20mm lithium coin cell from an unknown source.

Given these alarming trends, a national Button Battery Task Force (BBTF) was established in 2012. The BBTF has outlined goals for prevention and diagnosis, including outreach and education, design changes, warning labels, packaging, and product design. In their most recent published update, the BBTF provided a diagnostic and therapeutic algorithm for suspected button battery injury.3 This algorithm is contingent upon a high index of suspicion, prompt radiographic evaluation, and aggressive endoscopic removal.

Figure 1. Antero-posterior view chest x-ray taken just prior to autopsy, which demonstrates a radio-opaque, round, flat object in the esophagus at the level of the arch of the aorta.

continued on page 19
The initial presenting symptoms of button battery ingestion are nonspecific, including cough, sore throat, dysphagia, fever, decrease oral intake, and vomiting, which mimic viral illnesses. Up to one third of patients are initially asymptomatic. Another difficulty in the diagnosis is that the initial event is rarely witnessed by a caretaker. Battery ingestions are not witnessed in 92% of fatal outcomes and 56% of major complications. Given the nonspecific presenting symptoms and high likelihood of unwitnessed ingestion, the diagnosis is often missed. A thorough history of exposure to button batteries is, therefore, critical in the diagnosis of ingestion and prevention of serious complications.

In cases of button battery ingestion, time is of the utmost importance as the injury process begins from the moment that the battery is swallowed. The main mechanism of injury results from esophageal mucosa "connecting the circuit" between the battery poles, which causes caustic alkaline mucosal injury from the generation of hydroxide ions at the battery’s negative pole. We demonstrate the time course of this injury in Figure 3, where gross soft tissue damage can be appreciated within 2 hours of button battery ingestion. Late stages of this injury can be appreciated in the gross pathology from our case depicting aorto-esophageal fistula formation (Figure 2B).

Plain-film radiography is an essential tool in making the diagnosis of ingestion as well as confirming the location and positioning within the body. A chest x-ray with lateral and postero-anterior views is recommended as slimmer batteries may be indistinguishable from coins in the lateral view. A "double-ring sign" or "halo sign" may help differentiate between button batteries and coins on plain-film radiography. An example of the appearance of a button battery within the esophagus on a chest x-ray is provided in Figure 1.

Confirmed button battery ingestion may require emergent endoscopic or open surgical removal. For this reason, clinicians who suspect button battery ingestion should maintain patients nil per os during diagnostic work-up. To guide appropriate consultation, the NBHI, BBTF, and Brumbaugh et al. have provided guidelines for proper removal of button batteries depending on battery location and likelihood of complications.

The most common cause of death from button battery ingestion is aorto-esophageal fistula, as was seen in the case we have described. Fatal hemorrhage has been reported up to 18 days after endoscopic removal of button batteries. Children with vascular injury secondary to button battery ingestion frequently present with a “sentinel” bleed event: hematemesis or melena in the days to hours preceding fatal hemorrhage. It has been suggested that emergent computed tomographic angiography is critical in the identification of possible aorto-esophageal fistulae in patients with sentinel bleeds. Unfortunately, there have been no reported survivors of aorto-esophageal fistulae from button battery ingestion, thus no data exist for the efficacy of emergent angiography in such patients.

Beyond clinical management, there have been steps taken by industry and legislative powers to prevent button battery ingestion. Some of these steps include: strict product safety standards set by the American National Standards Institute; child-resistant packaging and design by Energizer and other major producers; and a legislative push in the Committee on Commerce, Science and Transportation to establish legal button battery product safety standards. Future endeavors include button battery design modifications for circuit activation only when in a device, radio-opaque markers to facilitate radiographic evaluation, and amylase-activated dye coatings to alert caregivers and clinicians for potential ingestion.

![Figure 1](image1.png)

**Figure 1.** Photographs from an in-house experiment to model button battery-associated soft tissue destruction. A 20mm lithium ion battery was placed within a slit in a beef frankfurter to simulate button battery impaction within the esophagus. Photographs show time 0 hours (A), 2 hours (B), and 6 hours (C) after simulated button battery impaction. At times 2 and 6 hours, marked charring can be seen around the area of button battery impaction.

![Figure 2](image2.png)

**Figure 2.** Autopsy photographs demonstrating a 20mm lithium ion button battery impacted in the middle third of the esophagus at the level of the transverse aorta (A). A fistula with surrounding eschar (B, white arrow) was identified between the aorta (B, black arrow) and esophagus at the level of the lodged battery. The esophagus was packed with bright red blood, clots, and gastric contents. Not shown are the post-mortem small and large bowels, which were filled with darkly colored stool.
Conclusion:

We have presented the case of a 3 year old boy who developed a fatal gastrointestinal bleed from an aorto-esophageal fistula following an unwitnessed button battery ingestion. Clinicians should have a high index of suspicion when a patient presents with a history and symptoms suggestive of button battery ingestion. Prompt radiographic diagnosis with postero-anterior and lateral view chest x-rays are critical in early diagnosis. Warning signs for more severe complications, such as sentinel bleed events, should prompt emergent diagnostic angiography and surgical consultation. Specific information regarding diagnostic and therapeutic work-up can be found at the NBHI Button Battery Ingestion Triage and Treatment Guideline: [http://www.poison.org/battery/guideline.asp](http://www.poison.org/battery/guideline.asp). All injuries must be reported to the NBHI at (202) 625-3333 to aid in the national understanding of the problem.

References

Question:
What is Medicaid’s policies regarding reimbursement of Medicaid Providers?

Answer
Medicaid providers are permitted to submit claims related to additional blood lead screenings for all Medicaid FFS Beneficiaries above the two mandated times of screening. Using procedure code 83655 (assay blood for lead for patients ages 0 months to 99 years), they can submit additional claims using this procedure code 83655 provided they have a Provider Specialty Code of 010, 080, 160, 220, 370, 420, 700 and 950.

In regards to the Medicaid HMO Blood Lead Claims, I would direct you to outreach to our Medicaid HMO Lead Liaison: Jeane Covington, MS, RN as she is the Environmental Health Services Consultant/Liaison within the Division of Medical Assistance and Health Services Office of Quality Assurance. Her e-mail address is Jeane.Covington.@dhs.state.nj.us and her direct line is 609-588-7991.

I hope this information was helpful to you. Please do not hesitate to contact me with any other questions or concerns.

Sincerely,
Margarite Nebbia RN
Quality Assurance Specialist
NJ Department of Human Services
Division Of Medical Assistance and Health Services
Phone 609-588-4650 Fax 609-588-4614

Healthy Homes Initiative
Identification & Management:
Lead Poisoning & Asthma Care

Many long-term health threats exist as a result of Superstorm Sandy, the most significant being lead poisoning and the growth of mold in the home, which often triggers asthma. With generous funding from the NJDOH, the NJAAP is conducting trainings in nine counties in the state to help providers and practices identify, treat and manage lead poisoning and asthma in children. The nine counties include: Bergen, Essex, Hudson, Union, Middlesex, Monmouth, Ocean, Atlantic and Cape May.

Participation in this program will enable you to:

✓ Serve as a reliable source of recovery information in order to help prevent exposure to lead and other housing-based hazards
✓ Understand the importance of conducting lead exposure surveillance and screening children for lead poisoning
✓ Promote the maintenance of a healthy home
✓ Identify the link between a change in housing status as a result of a natural disaster, and the health manifestations you will see in the clinical setting
✓ Utilize training resources so you know what to do, and who to contact, should you identify a patient with elevated lead levels or other health hazard

CME Credits & CNE Contact Hours Available

To schedule a training at your site, please contact:
Lindsay Caporrino
609-842-0014
lcaporrino@aapnj.org

Medicaid Reimbursement Policies for Blood Lead Screening

Services Consultant/Liaison within the Division of Medical Assistance and Health Services Office of Quality Assurance. Her e-mail address is Jeane.Covington.@dhs.state.nj.us and her direct line is 609-588-7991.

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Sincerely,
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Identification & Management:
Lead Poisoning & Asthma Care

Many long-term health threats exist as a result of Superstorm Sandy, the most significant being lead poisoning and the growth of mold in the home, which often triggers asthma. With generous funding from the NJDOH, the NJAAP is conducting trainings in nine counties in the state to help providers and practices identify, treat and manage lead poisoning and asthma in children. The nine counties include: Bergen, Essex, Hudson, Union, Middlesex, Monmouth, Ocean, Atlantic and Cape May.

Participation in this program will enable you to:

✓ Serve as a reliable source of recovery information in order to help prevent exposure to lead and other housing-based hazards
✓ Understand the importance of conducting lead exposure surveillance and screening children for lead poisoning
✓ Promote the maintenance of a healthy home
✓ Identify the link between a change in housing status as a result of a natural disaster, and the health manifestations you will see in the clinical setting
✓ Utilize training resources so you know what to do, and who to contact, should you identify a patient with elevated lead levels or other health hazard

CME Credits & CNE Contact Hours Available

To schedule a training at your site, please contact:
Lindsay Caporrino
609-842-0014
lcaporrino@aapnj.org

Medicaid Reimbursement Policies for Blood Lead Screening

Question:
What is Medicaid’s policies regarding reimbursement of Medicaid Providers?

Answer
Medicaid providers are permitted to submit claims related to additional blood lead screenings for all Medicaid FFS Beneficiaries above the two mandated times of screening. Using procedure code 83655 (assay blood for lead for patients ages 0 months to 99 years), they can submit additional claims using this procedure code 83655 provided they have a Provider Specialty Code of 010, 080, 160, 220, 370, 420, 700 and 950.

In regards to the Medicaid HMO Blood Lead Claims, I would direct you to outreach to our Medicaid HMO Lead Liaison: Jeane Covington, MS, RN as she is the Environmental Health Services Consultant/Liaison within the Division of Medical Assistance and Health Services Office of Quality Assurance. Her e-mail address is Jeane.Covington.@dhs.state.nj.us and her direct line is 609-588-7991.

I hope this information was helpful to you. Please do not hesitate to contact me with any other questions or concerns.

Sincerely,
Margarite Nebbia RN
Quality Assurance Specialist
NJ Department of Human Services
Division Of Medical Assistance and Health Services
Phone 609-588-4650 Fax 609-588-4614
Resident Voice

Katie Parisio DO, PGY-1
Goryeb Children’s Hospital
Atlantic Health System

HOPE

The stories themselves were parallel, as if two separate entities that ran alongside each other, with merely the characters in common. On one side was a boy full of life, who if he wasn’t playing video games, was playing with his baby brother who never left his side. He couldn’t wait to get out of the hospital and return to everything that was typical of a 7-year old boy. His parents were full of hope. The steroids were decreasing the inflammation in his brain, so other than the scar on the right side of his scalp, their child appeared unchanged. They hoped that it was nothing and so did I.

On the other side, I sat among a group of specialists with the parents at the head of the table. “We want him to be home for Christmas” were words that so lovingly came out of the attending’s mouth, yet sat so heavily on the shoulders of the two people who imagined spending at least 50 more Christmases with their son. The mom put her head down. She couldn’t speak. The father put his arm around his wife and his eyes filled up with tears. There was silence. When the silence broke, there were questions. They searched for answers and hoped that this wasn’t their reality, and so did I.

When his parents walked back upstairs, the two stories collided. There was the boy full of life, playing video games, and patiently waiting for his parents to come back. They no longer hoped for nothing. They knew what it was. There was an 85% chance that their child had terminal brain cancer. They hung on to the 15% chance that it wasn’t. They hoped for everything and so did I.

Editor’s note

Goryeb Children’s Hospital has a narrative writing program run by a member of the medical humanities faculty. This program allows residents to reflect on their clinical experiences and express their emotions. This piece highlights the type of stories residents submit.

Additional Resource on Palliative Care for Children and Families:
http://epen.net/epen_pediatrics.php?curid=6
http://www.nhpco.org/pediatric
www.cancer.org/after-diagnosis-pdf
https://acco.org/.../Resources/B..

“T don’t want to give my daughter any vaccinations.”

This was not the first time I had come across this problem. It is something that unfortunately, I have heard all too often. I tried to explain to her father why we give the vaccines, but he already knew they were to prevent infections. I tried to explain to him how each bacteria and virus might harm his daughter if she were infected, but he wasn’t interested. When I asked why, he said he did his research and was sure that the vaccines were more likely to hurt his daughter than they were to save her life. Unfortunately, it is because of how well they work, and how many lives they have saved. that she would not be receiving her vaccines today. Her father hasn’t seen measles, or mumps, or epiglottis, and neither have I.

Over the past month or so, you haven’t been able to turn on the news without hearing about another measles infection. Chicago, New Jersey, Seattle, and the “Happiest Place on Earth” have all been affected. In 2014, there were over 600 confirmed cases, the majority of which occurred in unvaccinated children. This number will continue to grow unless children are vaccinated. We all know the value of having our children vaccinated, but that is what we went to school to understand, and it is our duty to protect children from these illnesses.

So how can we impress upon parents the importance of these vaccines?

First we must realize that there is no one universal method to gaining parents agreement to vaccinations, but certain strategies have been shown to be more helpful, while others can be detrimental. Perhaps most importantly is to avoid confrontation, by not demanding vaccinations, criticizing or discrediting their sources of information, or overstating vaccine safety and efficacy. Instead, we should ask their understanding of the issue, and attempt to guide them in the right direction. Ask if they are ready to have a discussion on the topic. Acknowledge their fears. Listen to their concerns, and then ask how you can help them, and their children. Finally, inform parents about why we vaccinate, not just in conversation, but also by posting information about the diseases in our offices and providing families with resources. Teach about the harm these viruses and bacteria can inflict upon the children.

Additional Resource on Immunization

http://www.cdc.gov/vaccines/hcp/vis/
http://www.vaccines.gov/
New Jersey Immunization Network
Even as a young girl, becoming a mom and having a career helping kids were my biggest aspirations. At 36-years old, I became pregnant with our son, Brady. He was born on August 21, 2008, and was perfectly healthy in every way. Similarly to other first-time parents, my husband Michael and I read all we could about how to raise a well-mannered child. We devoured information on everything from spreading out vaccinations to administering CPR for infants and everything in between. We were prepared for anything, or so we thought.

Shortly after Brady’s first birthday, he woke up one morning with a swollen right eye that was red like a bull frog. My husband Michael and I were concerned that he came in contact with a piece of insulation or something and rubbed his eye, irritating it to the point of being swollen. I immediately drove Brady to the pediatrician’s office. His doctor said that the eye looked fine, but just to be on the safe side, suggested I take him to the ER at RWJ-BMSCH. Upon arrival, Brady spiked a fever of nearly 104 degrees and as a result was admitted. On day six, with the fever still extraordinarily high, we were told to prepare for the worst. Michael and I were informed that Brady was unlikely to make it through the night and that we should say our good byes to him. On day seven, after surviving the night, the doctors performed a bone marrow biopsy. Later that same day, the oncologist delivered the news, our baby has cancer.

My husband and I went in polar opposite directions. He was devastated and couldn’t catch his breath. I on the other hand was relieved; we finally had a diagnosis so now we could start treating the problem. After all, in my naive world, only a handful of kids got cancer, and nearly all of them were cured. Optimism was my only hope in getting through this battle, and I don’t use the word battle lightly. One thing that Michael and I were very grateful for was the daily support, concern, and compassion - from Brady’s pediatrician.

I personally believe that my kids had and continue to have a GREAT pediatrician. So what makes a good pediatrician great in the eyes of a parent you ask? Here are some simple suggestions that might answer that question.

- Wash your hands in front of the patients. If they don’t see you wash your hands, it did not happen!
- Don’t dismiss “overly concerned parents.” Answer their questions until they are satisfied and fully understand. Remember, they don’t have the seven years of medical training that you do!
- Don’t be offended or dismissive if or when a parent questions your decisions. While parents mean well, few fully understand the dangers of searching the internet for answers.
- Be truthful to the parents. Try not to scare them, but don’t sugar coat it either. Let the parents know your full plans for treating their child.

What if you plan to have the child admitted to the hospital?

Consider these tips to help ease mom and dad’s concerns:

- If your patient has a serious illness, do the right thing; consider providing the parents with your personal cell phone number and email address. Let them know they can email or text you 24/7. While they probably won’t, it is comforting for us to know you care, you understand our concerns and that you are accessible, if the need arises.
- If a patient needs to be admitted to the hospital, I beg you to put the parent’s minds at ease by being in constant contact with the treating physician at the hospital. The parents know you and trust you, but are scared to death when a “new” doctor, no matter how qualified, enters the picture.
- Remind parents that they are their children’s best advocates. Encourage them to speak up when they don’t fully understand your answers to their questions. Let them know it is perfectly acceptable to ask for a second opinion if they are uncomfortable or their gut is just telling them something is wrong. A parent’s instinct should not be dismissed as being non-scientific or worthless.
- When a child needs to have blood drawn, please request a phlebotomist that is very experienced in drawing blood from children of a similar age.
- For any scary event, make sure that a child life specialist is present to ensure the “happiest” outcome by distracting the child with singing, blowing bubbles, or any other diversion technique. God forbid your child needs anesthesia, never allow an anesthesiologist to place a gas mask directly on the child without first reviewing exactly what is going to happen. And, if the child already has an IV line, insist that they first administer Propofol.

What’s common sense to the hospital staff is not common sense to an emotional parent during their child’s first hospital experience. We just assumed that we have to bring all of our own supplies (diapers, lotions, highchairs, movies to watch, etc). Provide parents with some guidance. Inform them that the hospital will supply nearly everything they will need.

And lastly, even if you are not actively treating the patient, you must always stay connected and involved. Through our eyes, this is how Dr. Bert Mandelbaum became and remains a great pediatrician.

Terrie Wells,
Founder, and more importantly, Brady’s Mom

Shortly after Brady passed away at the tender age of 23 months “young”, Michael and Terrie Wells founded the Hugs for Brady Foundation, believing no child deserves cancer and that every child should experience the joy of growing up healthy and happy. For more information on the foundation, opportunities to volunteer, or to donate, please visit www.hugsforbrady.org.
Update on Sudden Unexpected Infant Deaths in New Jersey

The incidence rate for sudden unexpected infant deaths (SUID) in New Jersey continues to be one of the lowest in the nation, thanks to the efforts by pediatricians and other health care providers to educate families about the safe infant sleep guidelines of the American Academy of Pediatrics. 1-2 This finding does not constitute an endpoint but rather a reminder that the intervention is working. The effort must continue as each year over 100,000 new infants will benefit from this advice. Moreover, recent data demonstrate that “booster shots” of education need to be provided over the course of the pediatric visits in the first year of life so that initial good intentions are sustained. The SIDS Center of New Jersey is therefore launching a “Keep It Up” campaign. (See Included Poster)

SUID is comprised of a group of sleep-related deaths coded as SIDS, accidental suffocation and strangulation in bed, or other ill-defined and unspecified causes. According to the most current data from the Centers for Disease Control, in 2012, with 31 such deaths, the SUID rate in New Jersey was 0.30 per thousand live births, in contrast to a rate of 0.87 nationally. 3 The number of 2012 New Jersey cases within that grouping that were defined as SIDS was too low for a reliable calculation of a rate specific to that diagnosis. Overall, rates will fluctuate somewhat each year, but the trend is downward. For example, in contrast to the 2012 data, in 2000, the New Jersey SUID rate was 0.81 per thousand live births and involved 94 deaths.

According to a 2013 New Jersey Pregnancy Risk Assessment Monitoring System (PRAMS) Survey, 85% of parents reported that a doctor, nurse, home visitor or other health care provider talked with them about putting their infants to sleep on their backs and in their own cribs. 4 The AAP guidelines on safe sleep for the first 12 months of life also address: 1) the importance of eliminating loose bedding such as pillows, bumpers, quilts, and stuffed animals from the crib; 2) the avoidance of smoke exposure; 3) the benefit of sharing the parent’s room but not their bed in sleep; 4) the dangers of using a sofa as a sleep setting; 5) the importance of protecting an infant from overheating; 6) the need to keep the infant’s face uncovered; 7) the benefit of offering a pacifier once breastfeeding is well established; 8) and certainly, the benefit of breastfeeding. Using tummy time when the infant is awake and supervised and avoiding excessive time in carriers, bouncers and similar devices are suggested to facilitate development and to protect the infant from the risk of plagiocephaly. For more details, both the guideline and the technical report can be accessed through the websites of the American Academy of Pediatrics (www.aap.org) or the SIDS Center of New Jersey (www.rwims.rutgers.edu/sids). An educational flyer in both English and Spanish can also be downloaded from the latter site and www.aapnj.org.

“Keep It Up” is intended to encourage recurring reviews of the safe sleep guidelines with families. The need is evident. According to data on New Jersey’s SIDS cases, the percentage of prone placement at the infant’s last sleep more than doubled in a comparison of deaths under two months of age with those between two and four months of age. 5 The recommendation calls for caregivers to initiate sleep in the supine position throughout the first year of life. 6 Once the infant is old enough to turn from the supine to prone and back, generally by six months of age, he or she may remain in the position (she subsequently assumes. 1, 6 The data also indicated that the percentage of SIDS cases in which there was maternal smoking rose with older infants. Pediatricians have an opportunity here too to encourage those mothers who have stopped smoking during pregnancy and the early postpartum period to continue that effort.

In addition to outreach to pediatricians, the SIDS Center of New Jersey works with birthing hospitals, presenting “Nurses LEAD the Way” an on-site education program that reviews safe sleep guidelines, the role of the nurse, and the importance of hospital discharge education policies. Other programs are directed at community health care facilities, high risk neighborhoods, grandparent groups, social service systems, child care providers, and home visitors. Still, despite the effort and the impact, unsafe sleep conditions continue to be evident in new cases. Therefore, it is vital for all who work with families of young infants to be sensitive to their needs and circumstances and to help them become more effective in providing a safe sleep environment.

The SIDS Center of New Jersey is funded in part by a grant from the New Jersey Department of Health to Rutgers Robert Wood Johnson Medical School and a grant from the CJ Foundation for SIDS to Hackensack University Medical Center.

References
4. NJ DOH, Steering Committee, NJ PRAMS Update, Oct 9, 2014
6. Safe sleep material can be accessed from the website of the SIDS Center of New Jersey and from the National Institute of Child Health and Human Development website.

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Jeffrey Linzer, MD, FAAP  
AAP Committee on Coding and Nomenclature

There is a lot of talk about how different ICD-10-CM is from ICD-9-CM and what seems to worry most coders and providers alike is the sheer number of codes that are found in ICD-10-CM versus ICD-9-CM. Much of this increase is found in the injury and poisoning chapters of the manual. Codes in this chapter have been expanded to a 7th character in order to 1) show the episode of care and 2) pre-coordinate conditions (make one code from 2 or 3 in ICD-9-CM). Additionally, increased specificity such as location (e.g., laterality) and details of conditions have also resulted in increased number of codes. It is important to note that some of this specificity already exists in ICD-9-CM but various medical societies have asked that the codes express more information. This article will go over some conditions in primary care pediatrics that were most impacted by the update.

Asthma

In ICD-9-CM, asthma was defined as being intrinsic or extrinsic. These are antiquated terms and are no longer useful in classifying asthma. ICD-10-CM will use the classifications defined by the National Heart, Lung and Blood Institute (definitions can be found at http://www.nhlbi.nih.gov/health-pro/guidelines/current/asthma-guidelines/quick-reference-html). This will provide a more common definition and make for better management. Patient documentation will help in choosing the most appropriate diagnosis code:

1. Mild intermittent
2. Mild persistent
3. Moderate persistent
4. Severe persistent

These in turn as then noted as uncomplicated, with (acute) exacerbation, or with status asthmaticus.

Injuries and Poisonings

With the exception of a few conditions, codes in the injuries and poisoning chapter require that a 7th character be added to define the encounter. Even injuries we may consider simple, such as laceration or contusions, will require this 7th character. Injuries other than fractures have 3 different characters to define the encounter, while fractures can have anywhere from 3 to 16 different characters to define the encounter. Fractures will vary based on whether they are closed (3 or 6 characters) or open (16 characters). It is unlikely that primary care pediatric offices would encounter fractures that are either open or have delayed healing.

The appropriate 7th character is to be added to all injuries and closed fractures:

- A - initial encounter for most injuries or closed fracture (including poisonings)*
- D - subsequent encounter (SE) for most injuries or closed fracture with routine healing (including poisonings)*
- G - SE for closed fractures with delayed healing
- K – SE for closed fracture with nonunion

P – SE for closed fracture with malunion
S – sequela*

* = most common in primary care

An initial encounter is when the patient is undergoing active treatment, including evaluation and continuing treatment, and not whether the provider is seeing the patient for the first time. A subsequent encounter indicates follow-up care where the patient has received active treatment of the condition and is receiving routine care for the condition during the healing or recovery phase. Sequela is used for complications or conditions that arise as a direct result of a condition, such as scar formation after a burn.

It is very important to remember that when you are coding for an injury or poisoning from Chapter 19 (Injury, poisoning and certain other consequences of external causes) you should always check for the appropriate 7th character. Most, but not all codes in this chapter will require a 7th character. Since all characters for a code must be reported, payers will deny claims missing a required 7th character. It is also important to note that some injury or poisoning codes may have less than 6 characters. In these cases the placeholder ‘X’ is used in order to show the required 7th character. For example,

S01.01 (laceration without foreign body of scalp)

You will need to use a placeholder character (X) to get the code to 6 characters in order to add the 7th – therefore the code you will submit for an initial encounter for a laceration to the scalp without a foreign body is S01.01XA (note that A defines the encounter as initial).

Unspecified, Laterality and Recurrent

With all the talk of the increased specificity in the ICD-10-CM code set, many are asking why unspecified codes are still part of the code set. Indeed unspecified codes are still part of the code set and they are for two reasons:

1. The ICD-10-CM Official Coding Guidelines require that they exist
2. Unspecified codes still have their place in identifying encounters

It is important to recognize that there may still be varying levels of specificity during an encounter, whereby the use of “unspecified” is the coder’s only option. Remember, unspecified codes are used “when the information in the medical record is insufficient to assign a more specific code.” Unspecified codes should not be used when the laterality and/or location have been clearly documented in the patient’s record, e.g., left ear, right forearm.

Example:

Patient presents to your office with classic pneumonia symptoms. You take a history and full exam and diagnose the patient with pneumonia. This is the highest degree of specificity that you have at the time of encounter, so your coder will submit J18.9 Pneumonia, unspecified organism

This is acceptable and appropriate because most outpatient physicians will not know the organism causing the pneumonia.

continued on next page
Recurrent is a term that is seen throughout the ICD-10-CM code set. ICD-10-CM official guidelines do not specifically define what is a “recurrent” condition, in terms of a timeframe, therefore it is up to the reporting provider to document if a condition is recurrent. The use of the recurrent code for a condition is based on the provider’s clinical judgment and documentation. The coder will not be able to make that decision unless the provider specifically documents. The use of the “recurrent” codes is not mandatory, however their use may help to fast track referrals and surgical procedure pre-certifications. An example of an entry where the provider can document and report a recurrence is:

**J03.01 Acute recurrent streptococcal tonsillitis**

It is important to remember that ICD-10-CM still has unspecified codes, and that their use may be appropriate, however providers should be diligent and document the details that are known at the time of the encounter to reduce the number of unspecified codes where appropriate. Laterality should always be documented by the provider as well as when a condition is recurrent as determined by the provider.

Factors influencing health status and contact with health services

Many changes and updates have occurred in Chapter 21 which are the “Z” codes in ICD-10-CM (formerly the “V” codes in ICD-9-CM). More specificity can be found in categories such as encounters for administrative exams; encounters for screening; and persons with potential health hazards related to socioeconomic and psychosocial circumstances and problems related to social environment and upbringing.

While ICD-10-CM does contain more specificity for many conditions, remember that most providers are already documenting the details needed for those codes with the increased specificity. Be sure to be preparing for the Transition to Ten as the implementation date is currently set for October 1, 2015.
CASE REPORT: Persistent Hypoglycemia in a 9 Month Old Patient Found to Have a Novel Mutation in the ABCC8 Gene

Kerri Bosfield, MD
Steven Ghanny, MD
Hackensack University Medical Center

Introduction

Congenital hyperinsulinism (HI) is a common cause of persistent hypoglycemia. HI is most commonly caused by genetic mutations of the ABCC8 and KCNJ11 which encode for SUR 1 and Kir6.2 respectively. These mutations lead to dysfunctions of the K+-ATP channels found on pancreatic beta-cells, responsible for depolarization and glucose mediated insulin secretion. Two histopathological lesions have been described: focal and diffuse. The disease can further be classified into two groups, those that respond to diazoxide (DZX-responsive) and those that don’t (DZX-unresponsive). The diffuse form may be caused by autosomal recessive or dominant inherited mutations, whereas the focal form is caused by paternally transmitted recessive mutations and a second somatic event [5]. However, there are many cases of HI in which an exact genetic mutation has not been identified. Persistent hypoglycemia can have dire consequences, especially on the young developing brain of the infant, leading to irreversible neurodevelopmental dysfunction. Therefore, early diagnosis and treatment is fundamental in the management of these patients, [5][6].

Case Report

The patient was a nine month old female who was born full term via normal spontaneous vaginal delivery, with a benign antenatal and postnatal period. Development had been normal and appropriate for age. Her past medical history revealed three prior episodes of staring, unresponsiveness and seizure like activity. On the day of presentation to the emergency department, the patient presented with similar symptoms. Glucose was checked as a part of the work-up and was found to be 29mg/dL.

On work-up, the patient was found to have an elevated insulin level of 7.9 UU/mL at a glucose level of 29 mg/dL and glucagon challenge test was also confirmatory for a diagnosis of hyperinsulinism. The patient was started on diazoxide at a dose of 15 mg/kg/day and eventually titrated up to 20mg/kg/day after failed attempts to lower glucose infusion rate. Mutational analysis of the ABCC8 gene was done, which showed a novel mutation (p.V715M), which was maternally inherited. Due to the fact that this mutation was uncharacterized and patient was not responding to diazoxide treatment, the patient was transferred to a congenital hyperinsulinism center. 18 F DOPA PET scan did not reveal any focal uptake. Diazoxide therapy was stopped and Octreotide was started (22.5 units /26 units) with D20 infusions at night with maintenance of blood sugars within the normal range.

Discussion

Our patient presented with typical symptoms of HI before age 12 months, which include seizures and increased drowsiness [4]. Her 3 prior episodes of staring and unresponsiveness may have been due to hypoglycemic episodes. Typical signs and symptoms usually manifest in nearly 50% of patients during the first hours or days of life [5].

The patient was found to have a novel mutation of the ABCC8 gene, which was maternally inherited. Mutations of this gene lead to a channelopathy caused by loss of function of the encoding subunit (SUR1) of the ATP sensitive K+ATP channel. Depending on the mutation, this may lead to the patient being unresponsive to diazoxide, as seen in our patient. The maternal inheritance implies that this was a dominant mutation that was inherited by the infant. It has been noted that some forms of congenital hyperinsulinism do not follow the classic recessive or dominant mode, which may suggest a genetically complex disease, which is influenced by other unknown factors.

The focal subtype of CHI, in which there is a focus of dysregulated beta-cells, which hypersecrete insulin is thought to be inherited by a paternally transmitted mutant allele of ABCC8 or KCNJ11, while the maternal allele is absent due to a second somatic mutation event. These focalities can be visualized by positron emission tomography/CT with increased [18F] fluoro-L-3,4-dihydroxyphenylalanine uptake. Focality was not established in our patient, therefore her disease is most likely due to a non-focal mutation. Patients with diffuse disease due to recessive mutations in ABCC8 and KCNJ11 have been found not to respond to diazoxide. [6].

Conclusion

Congenital hyperinsulinism caused by mutations in the ABCC8 gene have been found in the literature to be one of the most common identifiable causes of this disease [7]. Both autosomal dominant and recessive mutations have been implicated as the cause of HI [1]. This case identified the benefit of early diagnosis, which may have averted multiple hypoglycemic events and more importantly seizures in this patient. The most likely reason why this patient did not present earlier in life is due to the fact that the patient started to sleep for longer periods overnight without feedings. This case also showed the benefit of mutational analysis and parent-of-origin testing in a child who was not responsive to diazoxide. Pediatricians should be aware of the importance and early recognition of congenital HI in order to prevent the severe neurodevelopmental sequelae caused by persistent hypoglycemia.

continued on next page
Persistent Hypoglycemia in a 9 Month Old Patient found to Have a Novel Mutation in the ABCC8 Gene continued

References


Eighth Annual “Give Kids a Smile Oral Health Fair”
Delivers Preventative Oral Health Services to Children in Essex County

NJAAP support underscores Chapter’s commitment to build medical dental collaboration

The KinderSmile Foundation in Upper Montclair, NJ held its 8th annual “Give Kids a Smile Oral Health Fair.” Part of a larger national undertaking by the American Dental Association (ADA), the event provides Essex County dentists with an opportunity to join with others in their community to provide dental services to under served children. This year’s event, held at the Central Presbyterian Church on Friday, February 6, 2015, provided free preventative oral health services to young children throughout the County.

The KinderSmile Foundation, a non-profit organization under the leadership of President and CEO Nicole McGrath, DDS, provides free dental care to children who are underprivileged in New Jersey and abroad, while advocating for the increase in oral care access and education for low-income children. Tooth decay is a disease that often goes unnoticed and afflicts many economically disadvantaged children in communities across the nation. The ultimate goal of the foundation is to eradicate this silent epidemic by providing age-appropriate oral health education and increasing access to dental homes for children to receive quality preventative care.

Participation by the NJAAP Oral Health team accentuated the Chapter’s ongoing commitment to ensuring children in under served communities throughout New Jersey have access to preventive oral health services provided in a dental home by age one.

NJAAP is always searching for additional Physician Champions for our many programs. To become an Oral Health Champion contact Program Director, Juliana David via email at jdavid@aapnj.org or by calling (609) 842-0014.

In Montclair, children were bussed in or brought by parents and guardians from all over the county, with over 50 lay volunteers providing services and support.

As the day unfolded, children and families poured through the doors of the Central Presbyterian Church and moved upstairs to a large room filled with volunteers at different posts, including registration tables and individual hygiene stations where preventative services were performed by trained dental professionals. Across the hall in another large room, volunteers from community agencies populated tables around the perimeter of the room and provided information on health services to families. One local resident, Helen Garcia, brought her two children to receive free services to the event for the first time. “I brought my son and daughter from daycare to receive a check-up from a dentist, it’s just what they needed,” she said with a large smile. For parents like Helen, the event provided much needed services free of cost, and gets the children into the system of care early.

It’s a source of pride for Sara Kalambur, DDS, Program Director and Secretary of the Board. Dr. Sara, as she is known to her patients and colleagues, has been serving patients in Hoboken and Hudson County since 1975, so she is very familiar with the community she serves. She has served as Program Director since 2010, and volunteered for the foundation since 2007. “While this event is great, it represents only one aspect of our year-round efforts to provide screenings, treatments and education to children in under served communities.”

Zufall volunteers from left to right: Rebecca Weiner and Monica Falkin

The Child Abuse and Neglect Prevention and Healthy Homes programs are also looking for Physician Champions. Contact teams member for either program at (609) 842-0014.
Oral health is an integral part of the overall health of children. As health care professionals responsible for the overall health of children, pediatricians have an important role to play in their oral health. In a continuing effort to support pediatricians in that role, the AAP Section on Oral Health recently published, in the December 2014 issue of Pediatrics, an updated policy statement, “Maintaining and Improving the Oral Health of Young Children”. The policy focused on three key areas: the etiology and pathogenesis of dental caries (tooth decay), preventive strategies such as caries risk assessment and anticipatory guidance, and collaboration with dental providers. I am pleased to provide a summary of the policy statement in this issue of New Jersey Pediatrics.

The surface of the tooth is a dynamic location with constant demineralization and remineralization of the enamel. Multiple factors affect those processes and can be manipulated in ways that tip the balance toward disease (demineralization) or health (remineralization). Four key factors that pediatricians and families can control are bacteria, sugar, saliva, and fluoride.

The disease of dental caries (tooth decay) is an infectious disease with the key pathogens being acid-loving and producing bacteria that use dietary sugars (primarily sucrose) as a substrate for the production of acid. That acid decreases the pH at the surface of the tooth and tips the balance toward demineralization. Our saliva acts as a buffer that brings the pH back to a level where remineralization can occur. If fluoride is present during that remineralization process, the enamel can incorporate it and become more resistant to future decay.

At this point, we have enough information to understand where the opportunities are for preventing dental caries: decreasing acid-producing bacteria, decreasing frequency of sugar intake, increasing access to fluoride, and ensuring good saliva flow.

As pediatricians, we frequently assess a child’s risk for various health challenges, and dental caries should not be an exception. Assessing each child’s risk of caries and tailoring preventive strategies to specific risk factors are necessary for maintaining and improving oral health.

Pediatricians can conduct an excellent risk assessment for caries by focusing on the key risk factors for dental caries associated with diet, bacteria, saliva, and status of the teeth (both current status and previous caries experience).

Anticipatory guidance should be focused on topics that affect the risk of disease. These include dietary strategies like limiting the frequency of sugar-sweetened food and beverage intake, not putting children to bed with a bottle, weaning from a bottle by age one, encouraging fluoridated water intake, and promoting an overall healthy diet. Guidance to decrease presence of acidogenic bacteria includes encouraging parents to maintain their good oral health and hygiene as well as their children’s. It’s also good advice to discourage parents from sharing with children objects that have been in their own mouths, as bacteria are passed from caregiver to child. Many medications can decrease salivary flow, thus decreasing the caries-protective properties of saliva. This can be especially important for children with special health care needs. And, though it may be obvious, a child who has a history of, or current, caries is at risk for future disease.

Advice about fluoride includes encouraging intake of fluoridated water, if available, and brushing with a smear grain-of-rice–sized amount of fluoridated toothpaste as soon as the first tooth erupts. This can be increased to a pea-sized amount at 3 years of age and parents should observe brushing until age 8. Pediatricians can also apply fluoride varnish on children’s teeth starting as soon as they erupt.

Finally, all children deserve a strong connection to a dental home. All children should have a dental visit by 1 year of age. Pediatricians have an opportunity to establish collaborative relationships with dental colleagues, so their patients can benefit from the knowledge and skills of each professional.

Oral health is an integral part of the overall health and well-being of children. By becoming familiar with the science of dental caries, understanding risk factors of disease, implementing strategies to decrease risk and prevent disease, and collaborating with dental colleagues, we can contribute considerably to the health of our patients.
Questions & Answers with Patricia A. Costante, Chairman and CEO of MDAdvantage Insurance Company

Q: What are some of the top issues pediatricians need to pay attention to this year?

Costante: Pediatricians have quite a few things to pay attention to in the upcoming year. Certainly many changes are resulting from the implementation of the Affordable Care Act, including the development of ACOs and the continued movement toward outcomes and value-based delivery models. Additionally, pediatricians are preparing for ICD-10 and are focused on EMRs, technology, data sharing and transparency and regulatory compliance. At the same time, pediatricians are focused on the most effective ways to meet the needs of their patients, at a time when alternative sites of service such as urgent care centers and minute clinics continue to grow in popularity.

Q: What are the top medical malpractice risks facing pediatricians?

Costante: Fortunately, pediatricians tend to see a fairly low frequency of medical malpractice claims compared to other specialties, however they certainly do occur. For the most part, the most common reasons for a medical malpractice claim remain the same as other specialties. Some of the top causes include failure to diagnose a patient’s medical condition, errors in performing procedures or surgeries, failure to monitor and track test results and incorrectly prescribing or administering medication. In many cases, ineffective communication between the patient and the physician compounds the issue. Pediatricians must be particularly aware of parents who perceive that he or she is distracted, trying to rush dialogue or is not valuing the parent’s input, which can lead to an adversarial relationship between parent and doctor. This tension can hinder the clinician’s efforts at diagnosis as well as foster a more litigious attitude should there be an adverse outcome. Pediatricians also must pay attention to ensuring effective communication among other physicians, such as referrals to subspecialists and hand-off of patients from one physician to another.

Q: What market changes are you paying attention to as a medical professional liability carrier?

Costante: We monitor any changes to the healthcare market that may impact the way physicians practice medicine and the risks that they face. At the moment, we are particularly focused on the trend toward increasing use of physician extenders in medical practices, such as nurse practitioners and physician assistants. We are also watching the trend toward telehealth and online healthcare, as well as the growth of outpatient medicine and the proliferation of multiple sites of service, including ambulatory surgery centers, retail clinics, urgent care centers and free-standing emergency departments.

We have also been quite focused on some of the other risks that impact physician practices, including the liability risks associated with employment practices, HIPAA violations, data breaches, billing errors and RAC audits.

Q: Can physicians still maintain an independent practice?

Costante: Physicians are continuing to strive for autonomy and decision-making authority at a time when independent medical practices are losing ground to consolidated structures with hospitals, large group networks and other entities. That being said, I know of many physicians who are committed to remaining independent practitioners. In order to remain autonomous and independent, physicians must look to new and innovative practice models that will allow them to adapt to shifting market dynamics, such as creating partnerships and networks that will allow them the economies of scale to be able to compete with larger entities.

Q: What advice do you have for pediatricians on how to work effectively with their medical professional liability insurance carrier?

Costante: My best advice is to develop and maintain a close and ongoing relationship with your professional liability team. At MDAdvantage, we encourage our physician insureds to call us for guidance at the time a problematic situation occurs, rather than waiting to see if a claim is going to arise. I often hear from my Claims Team that many lawsuits could have been avoided or at least minimized had the physician contacted us for guidance sooner.

Additionally, I would recommend that pediatricians take the time to understand fully the coverage that they have purchased. For example, MDAdvantage provides coverage beyond medical professional liability that also includes protection from billing errors, data breaches, RAC audits, HIPAA violations and employment practices liability. We have seen instances where physicians were not aware that they even had this type of coverage and therefore did not contact us regarding a claim or potential incident. Knowing when to call your carrier for advice is an important first step toward effective claim management, and reporting an incident early allows you to obtain advice on what to do next.

For more Q&A’s with Patricia Costante, please visit (http://bit.ly/1DZIu4N) or download New Jersey Pediatrics to your smart devise from your preferred app store.
NJAAP Annual Conference & Exhibition
Re-Stock Your Pediatric Toolbox
Wednesday, May 13, 2015 - The Palace at Somerset Park, Somerset, NJ

7:00 AM                              Registration / Breakfast / Exhibitor Showcase
7:30 - 8:15                           Senior Section Breakfast (55+)
8:30                                   Welcome
8:45 - 9:45                           Practice Management Track NEW for 2015
8:45 - 9:15                           Diagnostic Imaging in Appendicitis: What's the Use?  Yi-Horng Lee, MD
9:15 - 9:45                           Immunizations Up to Date: Convincing Your Vaccine Hesitant Parent! Joseph Domachowske, MD, FAAP
9:45 - 10:15                          Developmental Screening: How Do You Measure Up  Paul Dworkin, MD
10:15 - 10:45                         Ask the Experts Panel
10:45 - 11:00                         Break / Exhibitor Showcase
11:00 - 11:30                         Workshop Session 1
11:30 - 12:00                         Lunch / Exhibitor Showcase
12:00 - 12:30                         NJAAP Business Meeting
12:30 - 1:15                          Ask the Experts Panel
1:15 - 2:00                           Break / Exhibitor Showcase
2:00 - 2:45                           Workshop Session 2
2:45 - 3:00                           Hot Topics in Infectious Disease Margaret ‘Meg’ Fisher, MD, FAAP
3:00 - 3:45                           Visual Diagnosis 2015: First Impressions Binita Shah, MD, FAAP
3:45 - 4:30                           Workshop Session 3
4:30 - 5:15                           Ask the Experts Panel
5:15 - 5:30                           Break / Exhibitor Showcase
5:30 - 6:00                           Dinner Presentation - The Power Team: Combining Proteins and Exercise for Effective Results  Leslie Bonci, MOH, RD, CSSD, LDN
5:45 - 6:00                           The New 2015 CPT Codes That Keep on Giving Richard Lander, MD, FAAP
6:00 - 6:30                           Finance 101 for Pediatricians: What Everyone Should be Looking at Each Month  Paul Vanchiere, MBA
6:30 - 7:00                           HPV: You are the Key to Prevention Meg Fisher, MD, FAAP & Ruth Gubernick, MPH, PCMH, CCE
7:00 - 7:30                           Can't Get There from Here: Vascular Anomalies and Malformations Naiem Nassiri, MD, RPVI
7:30 - 8:00                           Getting to Eu: Understanding Pediatric Thyroid Disorders Ian Marshall, MD
8:00 - 8:30                           Juvenile Idiopathic Arthritis: Hot Joints, Cold Hands and More L. Nandini Moorthy, MD, MBBS, MS, FAAP

Workshops

Child Abuse & Neglect: Troubling Case Discussions  Martin A. Finkel, DO, FACP, FAAP
Can't Get There from Here: Vascular Anomalies and Malformations  Naiem Nassiri, MD, RPVI
Getting to Eu: Understanding Pediatric Thyroid Disorders  Ian Marshall, MD
Juvenile Idiopathic Arthritis: Hot Joints, Cold Hands and More  L. Nandini Moorthy, MD, MBBS, MS, FAAP
HPV: You are the Key to Prevention  Meg Fisher, MD, FAAP & Ruth Gubernick, MPH, PCMH, CCE
The New 2015 CPT Codes That Keep on Giving  Richard Lander, MD, FAAP
Finance 101 for Pediatricians: What Everyone Should be Looking at Each Month  Paul Vanchiere, MBA
Please welcome our new District III Resident CATCH Liaisons:
Christian Pulcini, MD, MPH, MEd
PGY-1
Children’s Hospital of Pittsburgh of UPMC
christian.pulcini@gmail.com
Alexandra Sims, MD
PGY-2
Children’s National Medical Center, DC
amsims@childrensnational.org

The role of the District Resident CATCH Liaison is to support and promote the CATCH program within their district. The resident liaisons work with the National Resident CATCH Liaisons and the District and Chapter CATCH Facilitators to empower pediatric residents to develop community-based programs. They will provide technical assistance to pediatric residents within their district, including CATCH grant applicants and recipients starting community based-programs in their communities. They will also review and score CATCH Resident grant applications.

Good luck to those who submitted applications in the last cycle. The next Call for Proposals opens May 1 and closes July 31.
If you have any questions, please contact your NJ Chapter CATCH facilitators:
Dr. Paul Schwartzberg - pschwartzberg@meridianhealth.org
Dr. Naveen Mehrota - nmehrota67@gmail.com

The C.O.A.C.H. Program
Community Outreach for Asthma Care and Healthy lifestyles

Approximately 10% of children in New Jersey have asthma. Low-income and minority children are at the greatest risk for increased morbidity from asthma. And asthma exacerbations account for more health care dollars spent and time lost from school/work, than almost any other pediatric chronic illness. Much of the morbidity associated with asthma is preventable. K.Hovnanian Children’s Hospital is addressing this problem head on with a new population health initiative to improve pediatric asthma care.

In July 2014, with a NJ Delivery System Reform Incentive Payment (DSRIP) Program grant, the C.O.A.C.H. Program began. The focus of the program is to reach the most at-risk children, in the hospital and community, to teach self-management skills and provide comprehensive case management.

This program focuses on all aspects of care. Interventions occur in the hospital and emergency department providing one-on-one asthma education to patients/families.

Follow-up phone calls and home visits help ensure compliance with therapy and facilitate identification of triggers and barriers to compliance. Prompt communication with primary care providers on patient’s hospital course and discharge recommendations allows for more effective outpatient follow-up.

The school initiative has education for both students and faculty. Sixth grade students with asthma attend a four-part lunch and learn program, on self-management skills. Younger students receive instruction on causes and symptoms of asthma. COACH team members provide asthma in-service education to teachers and school nurse. School nurses may refer their students/families to the program for one-on-one education and case management. The COACH program offers; assistance with establishment of asthma medical home for patients/families and education on implementation of the NHBLI 2007 EPR-3 Asthma Guidelines, to community based primary care providers.

A major obstacle to good self-management is the conflicting and provider specific information given to patient/families. Implementation of evidence-based guidelines results in consistent treatment and messages across settings. Providers in the hospital and in primary care offices must provide evidence-based care consistent with NHBLI 2007 EPR-3 Asthma Guidelines. Assessment of symptom/control, exposure to triggers and compliance with treatment are necessary to properly diagnosis/classify asthma. **The recommendation is to prescribe both a daily controller medication and short acting beta-agonist for all children with persistent asthma.**

In addition, receiving written asthma action plans developed with the patient/family and revised at asthma follow-up visits, further clarifies treatment parameter. A consistent message decreases confusion about when and how to take medications and increases the likelihood of compliance with controller medications.

By implementing evidence-based care across settings, educating patients with a consistent message and minimizing barriers to compliance, we are expecting a reduction in: hospitalizations, emergency room visits, emergency doctor visits and missed days from school and work.

Through Community Outreach for Asthma Care and Healthy lifestyles (C.O.A.C.H.), the program, like other population health programs, focuses on preventing morbidity by giving children and parents the tools to prevent and manage asthma symptoms reducing their need for more expensive medical interventions.
Pediatric Partnership Initiative (PPI)
Highlights from Learning Collaborative Session LC#2
Atlantic, Cape May, and Cumberland Counties (Tri-County)

PPI LC#2 for Tri-County occurred Wednesday, February 25, 2015 with great success. The practices clearly came prepared to get to work to get as much out of the session as possible.

Following opening remarks, Lisa Cox, PhD, LCSW, MSW discussed Motivational Interviewing techniques to improve Patient/Provider communication. The participants jumped into the role plays and report outs, joking that although it is much easier ask the “Yes”/”No” questions, the open-ended ones yield much more information. As far as what participants had been doing as a result of PPI LC #1, one pediatrician reported that he was now doing SWYC screenings at two, four, etc. month visits.

The informative segment on “Coding, Documentation, and Payment for Mental Health Screening/Services in the Pediatric Practice,” was led by Sherry Barron-Seabrook, MD, FAAP, FAACAP. Most participants stayed beyond the scheduled end time to get to know the Care Management Organizations (CMO) and other resource providers in attendance. CMO staff offered to visit the pediatric practices to meet with staff to discuss their services and how they can assist families treated by the practices.

The CMO staff also commented that since LC#1 the practices seem to understand the role or purpose of the CMO, and now are eager to reach out to them for assistance.

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NJAAP Announces Opening of the NCQA Patient-Centered Medical Home Recognition “Warm Line.”

Let NJAAP Help Your Practice Work Toward NCQA Recognition
Call the Warm Line anytime at (609) 842-0014 for technical assistance with:
• NCQA PCMH Recognition website navigation (http://www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHomePCMH.aspx), tools and resources
• Eligibility and readiness assessment
• PCMH 2011 and 2014 Standards and Guidelines questions
• Document review
• Available technical assistance, webinars/group trainings, and more.

For more info, please call Judie Grandjean, Program Director, at 609-842-0014 or email her at jgrandjean@aapnj.org
Join the New Jersey Chapter, American Academy of Pediatrics for an evening dedicated to all children in New Jersey at the

**FIFTH ANNUAL**

**New Jersey Children’s Ball**

**SPOTLIGHT ON CHILDREN**

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**PEDIATRICIAN OF THE YEAR**

* Nwando Anyaoku, MD, MPH, FAAP  
  previously at the Pediatric Health Center at Newark Beth Israel Medical Center

**CHAMPIONS FOR CHILDREN**

* Anthony R. Volpe, DDS, MS  
  Former Vice President, Scientific Affairs, Global Business Development at Colgate

* Cathleen Ballance, MD, MPH, FAAP  
  K. Hovnanian Children’s Hospital at Jersey Shore University Medical Center

* David Krol, MD, FAAP  
  Robert Wood Johnson Foundation  
  U.S. National Oral Health Alliance

**YOUTH ADVOCATE AWARD**

* Adeena Samoni  
  Sayerville War Memorial High School

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**WEDNESDAY, APRIL 22, 2015**

**SILENT AUCTION AND COCKTAILS: 6:15 PM**

**DINNER TIME: 7:15 PM**

**The Palace at Somerset Park**

333 Davidson Avenue  
Somerset, NJ 08873

For tickets visit www.aapnj.org  
or call 609-842-0014