

Winter 2008-2009

Issue 1 Volume 2

Bronchiolitis Update: Winter 2008-2009

By Mark Shen, MD

Our wards are once again filled with respiratory disease and this might be a useful opportunity to highlight our thoughts, in line with the AAP guidelines for the diagnosis and management of bronchiolitis.¹ Instead of reprinting the document, or addressing issues not covered in the guideline (see *Winter 2007 LinkLetter*), a recap of some salient recommendations might be useful. In part to explain some of the management that your patients may experience and in part to illustrate some of the common controversies involved in the diagnosis and management of this disease, I will discuss these recommendations in the framework of a teaching institution:

RECOMMENDATION 1a

Clinicians should diagnose bronchiolitis and assess disease severity on the basis of history and physical examination. Clinicians should not routinely order laboratory and radiologic studies for diagnosis (recommendation: evidence level B; diagnostic studies with minor limitations and observational studies with consistent findings; preponderance of benefits over harms and cost).

A common question I often ask our residents and students is, "How would you diagnose bronchiolitis [and exclude other diagnoses] if you didn't have radiography or viral testing?" In our hospital environment, learners often do not have the same luxury (of thought) that an office-based pediatrician has because most infants admitted with bronchiolitis have already had a viral swab and a chest x-ray performed. From an educational perspective, the danger is that a quick association is formed in the mind of the novice; s/he learns that these tests must play a large role in determining the eventual diagnosis. Varying degrees of clinical uncertainty must be embraced and made clear prior to the interpretation of any test. With

chest radiographs, there are many instances where radiologists cannot distinguish between infiltrates and atelectasis and here the test becomes much less useful. Even when there is an unquestioned pneumonia, dense infiltrates and severe disease have occurred in the presence of RSV infection alone.² A chest x-ray cannot determine the need for antibiotics and a positive swab for RSV does not guarantee a diagnosis of bronchiolitis. As with most respiratory viruses, RSV may cause rhinitis, croup, bronchiolitis and/or pneumonia.

Students and residents often acknowledge that their limited experience and knowledge lead to subsequent clinical uncertainty and that testing then offers a hope of clarity. But should this overreliance on testing be a part of the natural learning curve of becoming a doctor? In an era where cost and efficiency are direct measures of quality of care, I would emphatically answer, "No." Instead, I would suggest that educators from all disciplines and points of contact with the patient share both their experience and uncertainty with learners (and parents!) to broaden their understanding of the complex clinical decisions that are a daily occurrence in the winter.

RECOMMENDATION 2a

Bronchodilators should not be used routinely in the management of bronchiolitis (recommendation: evidence level B; RCTs with limitations; preponderance of harm of use over benefit).

RECOMMENDATION 3

Corticosteroid medications should not be used routinely in the management of bronchiolitis (recommendation: evidence level B; based on RCTs with limitations and a preponderance of risk over benefit).

Most students and residents are well aware of the lack of evidence for these interventions

WELCOME to our largest issue yet! We hope that everyone had a restful and happy holiday season and that the steady burden of seasonal pediatric care has been manageable. To help with the monotony of febrile respiratory infections, we've included two very interesting case reports from some of our residents, as well as a timely update on bronchiolitis. Toni Wakefield, MD, also discusses the current level of uncertainty surrounding the utility of imaging studies in the infant or child with a first urinary tract infection. Finally, change and improvement are continuing themes here at Dell Children's Medical Center and Patty Bardole has provided us with useful contact updates and information. Please do not hesitate to call, (512) 324-0165, or email me, mshen@seton.org, with any PCRS-related concerns or suggestions.

Enjoy,
Mark Shen

in bronchiolitis, but they might be surprised to find out that the vast majority of patients receive at least one bronchodilator treatment (and often multiple treatments) during their illness. Steroid use is less common, but certainly not rare. The commonly accepted reasoning for ordering interventions that have a low likelihood of positive effect is, "Let's just try it and see if it works." Typically, as the ordering physician is less comfortable with the disease, more interventions are tried. Although this is not surprising given the standard paradigms of illness and treatment that are learned in medical school, the management of self-limited diseases is fraught with false reassurance, particularly when the treatment is short-acting (hours) and the disease has a naturally variable course (days to weeks). Parents are particularly vulnerable to these misconceptions and this focus on intervention then diminishes the importance of careful support and monitoring.

How do we allow our learners, in this case parents and residents, appropriate autonomy while balancing the potentially harmful effects and perceptions of unnecessary treatment? I would argue that there is no larger body of experts than those pediatricians who have battled parental expectations and pharmaceutical advertising campaigns for decades – all in a war over the common cold. Pediatricians are no strangers to expectations from sleep-deprived parents seeking miracle cures (drugs). Reassurance techniques and careful time-sequenced evaluations are powerful weapons that have come to the forefront of our armamentarium with the FDA's recent recommendations against over-the-counter cough and cold medicines for young children. I would encourage that educators share their battle stories with not just the sleep-deprived parents, but the sleep-deprived residents as well, lest the bronchodilators of today become the cough and cold medicines of tomorrow.

RECOMMENDATION 7a

Supplemental oxygen is indicated if oxyhemoglobin saturation (SpO₂) falls persistently below 90% in previously healthy infants. If the SpO₂ does persistently fall below 90%, adequate supplemental oxygen should be used to maintain SpO₂ at or above

90%. Oxygen may be discontinued if SpO₂ is at or above 90% and the infant is feeding well and has minimal respiratory distress (option: evidence level D; expert opinion and reasoning from first principles; some benefit over harm).

An interesting point here is that the commonly accepted cutoff of 92% is not present. Although a discussion of 92% vs. 90% might be enlightening, the useful learning point would not be the specific cutoff, but rather, a discussion of the (tenuous) relationship between the pulse oximeter reading and the more important PaO₂. Such a discussion would allow for a broadened understanding of how a single reading, at a single point in time and without clinical interpretation, cannot give us much meaningful information. Physicians, students, nurses and families often all have to be "weaned" off of the monitor once a child has been given supplemental oxygen. Although no one would doubt the physiologic need for oxygen when a child has work of breathing early in the course of disease, there have been implications that pulse oximeter numerology is responsible for longer lengths of stay once the infant has otherwise clinically improved.⁴ The pulse oximeter reading is one lone data point. It comes with enough limitations such that readings in the low 90s should rarely guide decision-making without careful appreciation of the clinical status and course of the infant. Those that have managed patients with bronchiolitis in the bygone era without pulse oximetry should share the tools they used when determining whether or not patients were safe to go home with parents.

References:

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As kids continue to flock to our bright shiny facility, you may have noticed that beds on the floor have become somewhat of a hot commodity. This is a significant and nationwide issue in many respects and we want to reassure you, our referral community, that we will always work with you to determine the best placement for your patient. PCRS is always available to take calls, night or day, and it is our hope that collaboratively we can come up with the best solutions depending on the clinical scenario and the up-to-date status of hospital operations.

There may be times when we are waiting for rooms to be turned over and bed space is limited, but it is our responsibility to assist you in the determination of the best option for your patient. In some scenarios, we may be able to prioritize a floor bed for your patient, depending on the clinical history that you give us; at other times, our emergency department will be a better location than your office (or ED) for that patient. Many factors go into this determination, to include diagnosis, acuity, projected timing of room availability and most importantly, the safety of the patient.

At the same time, we are likely utilizing each and every bed that we have, to include those in intensive care, and at times, even ones on our pre/post-surgical units. The hospital is also critically examining its post-surgical observation bed needs each and every day. Other processes have been addressed since shortly after we arrived at this facility – for over a year we have been working on optimizing our throughput by improving the overall efficiency of patient movement in and out of the hospital. Finally, on a long-term basis, strategic planning regarding a new bed tower will commence after the new calendar year.

Austin is growing and we are seeing the effects on our units. With your continued support and assistance, we hope to create the safest possible environment for your patients' needs.

Please contact me, Mark Shen, at mshen@seton.org for specific questions and/or concerns.

Case Report: An Infant with Fever, Irritability, and a Remote History of Bloody Diarrhea

By Daniel E. Howard, MD, MPH

A six-month old male presented to the emergency department with several days of fever, decreased appetite, and irritability. He had been treated several weeks previously with amoxicillin-clavulanate for otitis media, then with cefdinir for non-resolution for the 10 days prior to presentation. Over the previous six days prior to admission, he had become more irritable, with fevers to 103° F, and poor oral intake. He had one day of non-bloody loose stools and occasional emesis.

His past medical history was remarkable for an episode of fever and hemocult-positive but culture-negative diarrhea at age four months; he had been treated with trimethoprim-sulfamethoxazole for five days. Immunizations were up-to-date. Physical examination revealed a febrile, irritable infant with a bulging anterior fontanel. He had neck stiffness, pronounced hip and knee flexion, and preferentially held his head to the left.

Initial lumbar puncture revealed 8700 WBCs (89% segmented neutrophils), protein of 473, glucose of 3, and gram stain showed gram-negative rods. He was empirically started on IV vancomycin and meropenem for bacterial meningitis. CSF and blood cultures both grew pan-susceptible Group D *Salmonella*, and his antibiotic therapy was changed to IV ceftriaxone and ciprofloxacin.

His hospital course was complicated by secondarily generalized seizure activity on day three, and an MRI of the brain revealed small bilateral subdural empyemas. He subsequently developed a partially occlusive subclavian thrombus associated with his PICC line. A workup for primary immunologic disorders was negative.

He was discharged home on IV antibiotics, low molecular weight heparin, and phenobarbital after 18 days in the hospital, and continued to receive IV antibiotics for a total of six weeks. Long-term neurologic sequelae of this infection are unclear for this infant.

Salmonella enteritis is a relatively common infection in the United States, and strongly peaks in incidence during infancy, with approximately one infection per 1000 infants.¹ In general, *Salmonella* is a pathogen of the GI tract that causes self-limited disease, but infection is sometimes complicated by invasive disease such as bacteremia, osteomyelitis, and meningitis. Certain serotypes of *Salmonella*, such as typhi, paratyphi, choleraesuis, and dublin are much more prone to cause invasive disease,² and invasive disease from *Salmonella* infection is estimated to be five to 10 times more common in infancy than in the general population.¹

While treatment of invasive *Salmonella* infections is always warranted, current AAP RedBook guidelines suggest treatment for uncomplicated *Salmonella* gastroenteritis only for severely ill patients or for those at increased risk of invasive disease, including infants less than three months of age, people with chronic GI disease, cancer, hemoglobinopathies, HIV, or immunosuppression due to other illness or therapy.³ In otherwise healthy individuals with nontyphoidal gastroenteritis, antibiotic therapy results in no improvement in duration of illness, fever, or diarrhea.⁴

When antibiotic treatment is initiated for severe or complicated gastroenteritis, ampicillin, amoxicillin, or trimethoprim-sulfamethoxazole are recommended initial therapies, although ceftriaxone, cefotaxime or ciprofloxacin are recommended in areas of high resistance to the aforementioned antibiotics,³ and azithromycin may have an important future role as fluoroquinolone and cephalosporin resistance increases.⁵

Meningitis is a rare but serious complication of *Salmonella* infection and is associated with high rates of complications and mortality.⁶ Due to widespread resistance to ampicillin (and chloramphenicol), many experts recommend treatment of *Salmonella* meningitis with third generation cephalosporins, such as ceftriaxone, with or without ciprofloxacin, due to the excellent CSF penetration of these two drugs. Duration of parenteral therapy should be at least four weeks, but often longer if infection is complicated by cerebral abscess or subdural empyema.^{3,7}

For this infant, the exact source for invasive *Salmonella* infection remains somewhat unclear. *Salmonella* bacteria are able to survive intracellularly within macrophages⁸ and this patient's meningitis may be a result of bacteremia due to release of sequestered intracellular *Salmonella* bacteria after an initial GI infection, despite seemingly adequate therapy for enteritis. However, his previous bout of enteritis was never culture-proven to be *Salmonella*, so the two illnesses may be unrelated.

This case demonstrates one of the most serious complications of a relatively common infection in infancy. The spectrum of *Salmonella* infection is wide, and treatment with antibiotics should be based largely on severity of illness and host factors, such as age, which may predispose to invasive disease.

References:

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Dan Howard is currently the third-year chief resident physician in the UTMB-Austin Pediatrics program. He is a graduate of Stanford University, where he earned a BS in Biological Sciences. He graduated from medical school at Mayo Clinic College of Medicine, and earned a MPH from the University of Minnesota. He has a particular interest in pediatric infectious diseases and public health. He plans on practicing general pediatrics in the Austin area.

Rethinking the Child with a First Time UTI

By Toni Wakefield, MD

Case example: *AK is a three-month old admitted for an acute febrile illness and poor oral intake and dehydration. An initial cath UA done on admit reveals significant pyuria as well as leukocyte esterase, and she is started on ceftriaxone empirically. The next morning she is significantly improved after IV fluids and antibiotics. Her urine culture demonstrates >100,000 of gram negative rods. What imaging studies are appropriate?*

Urinary tract infections are common in pediatric practice, both in the outpatient setting and here at Dell Children's Medical Center. A relevant question that arises with a UTI is whether the patient has an underlying urologic abnormality such as vesicoureteral reflux (VUR) that could predispose them to future infections. Studies estimate that 30 - 40% of children with UTIs have VUR¹. The concern is that repeated infections of the urinary tract could lead to renal scarring, hypertension, and increased risk for ESRD at a later age. The AAP practice guidelines in 1999 recommended that boys of all ages, all girls < 36 months, and girls three to seven years with fever > 38.5 get renal ultrasonography (RUS) and a voiding cystourethrogram (VCUG) soon after diagnosis to evaluate for this risk.² A renal ultrasound evaluates for anatomic abnormalities such as hydronephrosis and dilation of the distal ureters as would be seen with severe VUR (i.e., grades 4 or 5). A VCUG is then recommended to evaluate for and grade VUR. The drawbacks to this approach are two-fold. The first is the cost involved, and the second is patient discomfort and parental anxiety surrounding VCUGs, which involve urinary catheterization. These drawbacks could provide some explanation for the 52% compliance seen when VCUGs are done in an outpatient setting.³

There are new data that call into question the utility of requisite renal imaging after a first time UTI. Conway et al described a cohort study of 74,000 children that identified 611 children with first time UTI, 83 of which had recurrent UTIs.⁴ The study found that sex and grade 1-3 VUR were not associated with risk of recurrent UTI. Antibiotic use did not decrease risk of UTI recurrence but was a risk factor for antimicrobial resistance in children with recurrent UTI. Limitations of the study included a low rate of VCUGs performed, low numbers of children with higher grades of reflux, as well as no analysis of renal scarring and ESRD. Others point to the British National Institute for Health and Clinical Excellence (NICE) UTI guidelines as support for a move-away from routine renal imaging.⁵ Their guidelines recommend: RUS in all children with atypical UTI (seriously ill appearing, poor urine flow, abdominal or bladder mass, raised creatinine, failure to respond to appropriate antibiotic treatment within 48 hrs, infection with non-E. coli organisms), RUS within six weeks of UTI in infants younger than six months, and a DMSA scan four to six months after UTI in children younger than three years after an atypical or recurrent UTI. The guidelines specifically did not recommend routine imaging to identify VUR.

Ultimately, a randomized controlled trial (RCT) with long-term follow-up would be useful to settle the issue. The National Institute

of Diabetes and Digestive and Kidneys Diseases is sponsoring such a study of antimicrobial prophylaxis in the prevention of recurrent UTIs and renal scarring (called the Randomized Intervention for Children With Vesicoureteral Reflux or RIVUR). One of the enjoyable facets of continuous professional development is keeping up with researchers as they review existing standards and refine current thought. PCRS, as a group, has had lively discussions about the above topic, and there was even a timely Grand Rounds by Dr. Stephen Canon with Pediatric Urology last year that touched on the conflicting studies mentioned above. Community practitioners may observe increased variation in our practice, as some of our clinicians perceive the cost and risks of renal imaging to outweigh the potential benefits, and others counsel caution in extrapolating from limited preliminary studies. One item the group agrees upon is the importance of involving our community physicians who will care for these patients longitudinally. We will do our best to discuss our individual approaches with you when we call, and incorporate your long-term treatment plans into our hospital activities.

Editor's note: Dr. Wakefield lists just a few of the many articles and guidelines that pertain to this issue. It seems that not a month goes by without the publication of yet another report that challenges our traditional dogma. The AAP is currently working on a new set of UTI guidelines, but given that a tipping point of evidence may still be years away, there will almost certainly be the usual balance of caution and pragmatism in the upcoming sequel to the 1999 recommendations. In the meantime, shared decision-making in the setting of this uncertainty may offer the best hope for a collective solution. MWS

References

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An Eight Year-Old Male with Fever and Abdominal Pain

By Jaclyn Marroquin, MD and Monica McArthur, MD, PhD

An eight year-old male presented to the emergency department with a five-day history of fever and abdominal pain. The maximum temperature was 104° F. The abdominal pain was diffuse and not associated with vomiting or diarrhea. He also complained of a non-productive cough that started about the same time as the fever and headache. The patient had a brother and sister at home with similar symptoms for the past three to four days. Two weeks prior to admission, he and his family had returned from Nigeria where they had been living for the past two years.

On physical exam the patient was febrile (102.7° F) and somewhat ill appearing. He had scleral icterus. He was tachycardic with a regular rhythm and no murmurs. His lungs were clear to auscultation. His abdomen was diffusely tender to palpation (greater in the upper quadrants) with significant hepatosplenomegaly. Multiple scarred insect bites were also noted on bilateral lower extremities.

Laboratory studies revealed anemia and thrombocytopenia, with a normal peripheral white blood cell count. He also had elevated liver enzymes and hyperbilirubinemia. Peripheral smear showed many malarial trophozoites (*Plasmodium falciparum*) with an estimated parasitemia of 4-5%.

Due to the high parasite load, the patient remained in the intermediate care unit for several days and received malarone (atovaquone/proguanil) for five days with reduction in parasitemia. During this time he also showed clinical improvement with decreased hepatosplenomegaly, normalization of heart rate and respiratory rate, and decreased jaundice. Follow-up smear after discharge revealed no parasitized red blood cells.

There are approximately 1500 cases of malaria in the United States per year. Only 10% of these cases are in recent immigrants and refugees with the remaining cases associated with travel to endemic areas.

Malaria is a parasitic infection caused by *Plasmodium vivax*, *Plasmodium ovale*, *Plasmodium malariae*, and *Plasmodium falciparum*, with *P. falciparum* causing the most severe infections. It is transmitted by anopheles mosquitoes.

Prevention is an important component to the control of malaria in endemic countries as well as for travelers to these areas. When considering international travel, countries at risk for malaria can be found at <http://wwwn.cdc.gov/travel>. Travelers should visit their physician or local travel clinic four to six weeks prior to departure to discuss obtaining antimalarial medication for prophylactic therapy. While these medications do not prevent against the initial infection from the mosquito bite, they do prevent against parasite production in the bloodstream.

Travelers must also be cautioned to avoid mosquito bites. While mosquitoes are more frequent during the evening and night times, travelers should wear long sleeves, pants and sleep in screened areas or under bed nets. Also, DEET insect repellent should be used for adults, children and infants over the age of two.

Even with all of these measures, it is still possible to acquire malaria while traveling to high risk areas. Travelers, as well as physicians, should be aware of potential symptoms after travel. These symptoms include fever, chills, headache, muscle aches, flu-like symptoms, fatigue, anemia and jaundice. This case demonstrates how a patient presenting with several non-specific symptoms such as these can have a serious illness easily identified with a thorough history.

Monica McArthur, MD, PhD

is a third-year pediatric resident who joined DCMC for a few months after being displaced from her UTMB Pediatrics residency in Galveston by Hurricane Ike. She completed her graduate studies on the topic of yellow fever and will move on to an infectious disease fellowship next year. She has returned safely to Galveston to complete her pediatric training and we wish her the best.

Jaclyn Marroquin, MD

is a third-year pediatric resident at UTMB Austin. She received her medical degree from Loyola University Chicago Stritch School of Medicine and her undergraduate degree from the University of Notre Dame. After residency she plans to go into general pediatrics and is hoping to stay in the Austin area.

IMPORTANT DATES AND UPDATES

DCMC is World Class!

It's official! Dell Children's Medical Center of Central Texas has become the first hospital in the world to receive the LEED (Leadership in Environmental Energy & Design) Platinum designation from the U.S. Green Building Council.

Seremetis is New Chief of Staff

At the 2008 Dell Children's Annual Medical Staff Meeting, Dr. George Seremetis, pediatric urologist, was voted in as Chief of Staff and Dr. Karen Wright, pediatric cardiologist, was voted in as Vice Chief of Staff. Congratulations! And, a special thanks to Dr. Phillip Berry, pediatric nephrologist and outgoing Chief of Staff, for his two years of service and leadership.

New Pediatric Specialists from 2008 to 01/2009

Victoria Gregg, MD – EMERGENCY MEDICINE
Ann Dimick, DDS – DENTISTRY
Suzanne Yandow, MD – ORTHOPEDIC SURGERY
Susan Nunez, MD – ENDOCRINOLOGY
Rajani Prabhakaran, MD – ENDOCRINOLOGY
Jennifer Kiening, DDS – DENTISTRY
Carla Scott, MD – ENDOCRINOLOGY
James Gibson, MD – MEDICAL GENETICS
Rachel Trueblood, DDS – DENTISTRY
Matthew Wilkinson, MD – EMERGENCY MEDICINE
Winnie Whitaker, MD – EMERGENCY MEDICINE
Matthew Bayer, MD – EMERGENCY MEDICINE
Stephen Pont, MD – PEDIATRICS/UTMB
Kymberly Colman, MD – EMERGENCY MEDICINE
Adam Weinfeld, MD – PLASTIC SURGERY
Jill Jaimes, MD – EMERGENCY MEDICINE
Lisa Clewner, MD – HOSPITALIST
Jennifer Lai, MD – HOSPITALIST
Shaida Ziari, MD – HOSPITALIST
William Corbett, MD – ANESTHESIOLOGY
Molly Pont, MD – NEONATOLOGY
Moise Levy, MD – DERMATOLOGY
Arnold Fenrich, MD – CARDIAC ELECTROPHYSIOLOGY
Lisa Petiniot, MD – RHEUMATOLOGY
Mark Lee, MD – NEUROSURGERY

New Texas Child Study Center Provides Pediatric Mental Health Care

The Texas Child Study Center (TCSC) at Dell Children's Medical Center of Central Texas was created to provide enhanced mental health services for children ages 18 and under. The program is a joint effort between the University of Texas at Austin's Department of Educational Psychology and Dell Children's Medical Center. The TCSC opened last fall in the Jefferson Building, 1600 W. 38th St., Ste 212, in Austin. Future plans include a relocation to the DCMC campus. Dr. William Streusand serves as the Center's medical director and Dr. Kevin Stark serves as the clinical director of psychology. For more information, please call 512-324-3315.

New Program Addresses Childhood Obesity

Stephen Pont, MD, MPH, who practices at Dell Children's and at the East Austin Community Health Center, is leading "Healthy Living, Happy Living / Vida Sana, Vida Feliz", a grant-funded, multi-disciplinary after-school obesity intervention sponsored by Dell Children's and Austin Community Foundations. The program began this month and consists of nine dynamic, interactive sessions, each two and one-half hours long. The program is designed for children ages six to 11 and parent attendance and participation in each session is required. Dr. Pont's team includes experts in medicine, psychology, nutrition and physical activity from Dell Children's, UT-Austin and the Texas Child Study Center. Recruitment for future 9-week programs is currently underway. This pilot program primarily targets East Austin elementary school students and is presented in both English and Spanish. Dr. Pont and his team of collaborators hope to identify partners who may help them to continue and expand the program, making it available to more children. The team is also working to establish a permanent home for its obesity efforts through creating the Texas Center for the Prevention and Treatment of Childhood Obesity.

For more information, contact Dr. Pont at sjpont@seton.org or 364-0125.

Dr. Pont is a faculty member for the University of Texas Medical Branch-Austin Programs and the UT-Austin Department of Kinesiology and Health Education and serves as the medical director for AISD Student Health Services.

ED Expansion

On Oct. 7, 2008, 10 new beds were opened in the DCMC ED to accommodate the heavy patient demand, bringing the total number of beds to 44.

Along with the new beds, the Dell Children's ED is also staffing additional physicians and nurses, which will improve patient wait times and crowding issues.

"We put two large television screens in the waiting rooms to provide information about the ED process," said Pat Crocker, DO, Medical Director of the Dell Children's ED. "Patients also now receive identification cards to help expedite the registration process the next time they visit the ED."

The ED expansion was put into action earlier than expected, but Dell Children's is prepared for the next five years and has more room for future expansions.

3rd Bed Tower at DCMC

Plans for construction of the third bed tower at DCMC are in development. The additional tower will add 24 more inpatient beds to the existing 170. The tower will be constructed on the south side of the hospital.

IMPORTANT DATES AND UPDATES

Black Tie Gala is January 24

The 22nd Annual Children's Council Gala, "Gala 2009, For the Children," will be held January 24 at the Austin Convention Center Grand Ballroom.

The evening begins at 6 p.m. and includes a cocktail reception, silent and live auctions, dinner, casino activities and live music and dancing. The event is being chaired by Evelyn and Wyeth Wiedeman.

For more information, contact Judah Crossland at 512-324-9999, ext. 86870 or jcrossland@seton.org.

Pediatric Conference May 16

The 2009 Annual Pediatric Conference, "Keeping Texas Children Well," will be held Saturday, May 16 at DCMC. This year's conference will build upon the successes and audience responses from the 2008 conference and will continue to focus on the health and well-being of Central Texas children. The morning plenary session will be anchored by a keynote address. Afternoon activities will consist of break-out sessions that promote dialogue among conference faculty and participants on a range of issues.

The Karen W. Teel, M.D. Lecture at the 2009 DCMC Annual Pediatric Conference will be presented by:



Carol J. Baker, MD
Professor of Pediatrics, Molecular Virology & Microbiology
Baylor College of Medicine
Presentation: "Group B Streptococcal Infections in the 21st Century"

For more information go to http://www.dellchildrens.net/for_healthcare_professionals/keeping_central_texas_children_well

Pediatric Grand Rounds at DCMC

All lectures listed are held from 7:30 to 8:30 a.m. in the Sig Auditorium (within the Pat Hayes Conference Center) at Dell Children's

Friday, Jan 23

"Osteomyelitis and Oral Antibiotics"

Dr. Theoklis Zaoutis
(Pediatric Infectious Disease, Fellowship Director, The Children's Hospital of Philadelphia)

Friday, Feb. 6

"Bookspring's Read Out and Read Program"

Dr. Robert Needlman
(Co-founder of the first pediatric-based literacy support program, Reach Out and Read, Cleveland, Ohio)

Friday, Feb. 13

"Ordering the Appropriate Radiological Test"

Dr. Gael Lonergan
(Pediatric Radiology, Austin Radiological Associates, Dell Children's Medical Center)

Friday, Feb. 27

"Children's Healthcare Challenges in the Texas Legislative Session"

Dr. Hanoch Patt
(Pediatric Cardiologist, Children's Cardiology Associates, Dell Children's Medical Center)

For more information go to: http://www.dellchildrens.net/for_healthcare_professionals/pediatric_grand_rounds

Pediatric Grand Rounds at SMCW

For our physician friends in northern Travis and Williamson counties, Pediatric Grand Rounds are also held at Seton Medical Center Williamson (SMCW) in Round Rock, the newest member of the Seton Family of Hospitals. Please mark your calendars with dates for 2009:

February 11, March 4, April 1, May 6,

June 3, July 1, August 5, September 2, October 7, November 4, December 2

Where: The Learning Center, Room 3 First Floor – SMCW

Time: 12:15 – 1:15 p.m.

Directions: From I-35, take exit #256 (University Boulevard). Go east on University Boulevard approximately 2.5 miles. An entrance to the facility is on the right. Park near the Women's Center entrance and enter through the associates' entrance (silver canopy). The Learning Center is located on the left hand side after you enter the building.

Lectures are free and open to physicians, nurses and other interested clinical staff. Lunch will be served. **For more information, contact Patricia Bardole @pbardole@seton.org or 512-289-2683.**

2009 Pediatric Section Meetings

April 8, July 8 and October 14. Location: DCMC, The Sig Auditorium. Time: 12:15 – 1:15 p.m. Lunch is provided.