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"Who is on-call for PCRS?"

"Who is taking care of my patient?"

Did you know that the Pediatric Consultation and Referral Service (PCRS) has approximately 10 physicians in-house each day to cover call and on-service duties? While our on-call physician is the appropriate "point person" if you are ever in need of assistance, there are now other tools available should you wish to identify a specific on-call or on-service attending. The PCRS has a new website for viewing our schedule: utswa.spinfusion.com (DO NOT enter www.utswa.spinfusion.com)

This site provides links to our on-call calendar, our on-service attending calendar, as well as a report to help you with faculty names, service team names and corresponding room numbers.

Please use the following login information to gain access:

Group name: utswa
User name: utswa
Password: pcrs

Reliable patient-specific attending information may also be found in COMPASS under the 'Tracking List' tab at the top middle of any patient list page. As always, please contact Mark Shen, MD at mshen@seton.org if you are having difficulty locating the appropriate PCRS physician.

EDITOR'S WELCOME



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Welcome to another edition of our combined Link Letter and ConnectED newsletters. Although the content is lighter, we have a superb collection of articles. Maintaining our attempts to bring you the most interesting and up-to-date clinical information, two residents, Nick Wagner, MD and Corey Fish, MD have partnered with senior attendings to bring you a puzzling case and thoughts on radiation exposure. Joel Blumberg, MD has crafted a concise and useful review on Apparent Life Threatening Events (ALTE). But perhaps most importantly, embodying the spirit of partnership and a community of learning, Dan Terwelp, MD shares his experiences from a day with us on PCRS rounds! Enjoy, and please continue to send in ideas for upcoming newsletters.

Thoughtful Radiation: Reducing unnecessary exposure to children

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For the past several years, more attention is being paid to the increasing amounts of medical ionizing radiation that patients are being exposed to and the risk of that radiation for development of malignancy. This attention is due in part to the explosive growth of CT scans since the 1990's. CT is now so fast, and so widely available that it has, in some ways, become a physical exam by proxy. The danger is that CT represents the single, most significant source of medical radiation for patients.

This concern around medical radiation, and CT specifically, has led to attempted quantification of the incidence of radiation-induced malignancy,

in addition to several recommendations and tools for risk reduction. In this discussion, we hope to shed light on this important topic.

From a molecular standpoint, ionizing radiation is capable of causing damage to DNA through the generation of free radicals. This damage becomes a problem when DNA repair mechanisms are affected, specifically when mutations are incurred by tumor suppressor genes and by proto-oncogenes. With tumor suppressors deactivated and proto-oncogenes transformed into oncogenes, cell growth becomes uninhibited and malignant transformation may occur.

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Thoughtful Radiation (Continued)

Further complicating matters is when this cellular damage happens to the germ line through exposure of the gonadal cells to ionizing radiation. This scenario can lead to hereditary forms of radiation-induced malignancy and disease.

Most of the concern regarding medical ionizing radiation and cancer risk is drawn on a plausible biological mechanism for radiation induced cellular damage in addition to studies of radiation exposure and rates of cancer in survivors of the 1945 nuclear bombings of Hiroshima and Nagasaki, as well as the tragedy in Chernobyl.¹

However, despite the increasing recognition and the documentation of risks of radiation exposure, published data from the adult world suggests that we are woefully misinformed. One survey of resident and attending radiologists and ED physicians showed that upwards of 53% of the radiology group and 91% of the ED group did not believe radiation exposure increased lifetime risk of cancer.^{1,3}

As a result of ongoing debate and an expanding body of data, the FDA has published an "Initiative to Reduce Unnecessary Radiation Exposure from Medical Imaging."⁴ This document is centered around a two-pronged approach. The first half of the approach is optimization of radiation doses and education regarding using only the necessary radiation to produce a study of sufficient quality to be interpreted. We would argue that further discussion of this half of the FDA statement should be reserved for accreditation committees and radiology departments.

The second half of the FDA bulletin, however, centers around the idea of justification for a given radiologic study. Justification, in contrast to the idea of optimization, falls squarely on the shoulders of the pediatric clinician. Several tools to aid in the justification of radiologic studies have emerged in recent years, the Pediatric Emergency Care Applied Research Network mild traumatic brain injury head CT scan guidelines being a notable recent example.⁵ Using this guideline, CT of the head could routinely be avoided in 25% of children under two years of age and 20% of children over two years of age. In practical terms, in a group of one hundred children undergoing head CT, using this rule would save the same amount of radiation as 5000 chest x-rays in children under two years of age and 4000 chest x-rays in children over two years of age (Table 1).²

In an age marked by ever-accelerating medical advances and increasing amounts of exposure of patients to diagnostic radiology, it is important to acknowledge the risk of radiation induced cancer. This risk is thrown into stark relief by the estimate, in one study, that for every 600,000 children who receive a CT scan under 15 years of age, there will be 500 new cancers.⁶ This estimate,

while very real, also leaves room for minimization strategies. Many strategies, such as reduction of head CT utilization in mild traumatic brain injury as well as state-of-the-art bismuth CT shields used at Dell Children's Medical Center in Austin, TX are already in place.

More importantly, though, pediatric practitioners should spend as much time carefully considering whether a CT scan is necessary as

TABLE 1 Estimated Medical Radiation Doses for a 5-Year-Old Child

Imaging Area	Effective Dose, mSv	Equivalent No. of CXRs
3-view ankle	0.0015	1/14th
2-view chest	0.02	1
Anteroposterior and lateral abdomen	0.05	2½
Tc-99m ² radionuclide cystogram	0.18	9
Tc-99m radionuclide bone scan	6.2	310
FDG PET ³ scan	15.3	765
Fluoroscopic cystogram	0.33	16
Head CT	4	200
Chest CT	3	150
Abdomen CT	5	250

CXR indicates chest radiograph; Tc-99m, technetium 99m; FDG PET, fluorodeoxyglucose positron emission tomography.

Data were provided by R. Reiman, MD (Duke Office of Radiation Safety [www.safety.duke.edu/RadSafety], written communication, 2006).

they do considering the radiation dose of a simple chest x-ray, as the radiation dose of the latter pales in comparison to the former. It is this thoughtful decision making in concert with our pediatric radiology colleagues that will end up most protecting our patients while providing the best care possible.

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The PCRS Experience

Longtime Austin Area Pediatrician Daniel R. Terwelp, MD joins PCRS for Morning Rounds

Dinosaurs once roamed the hospital...and then came the era of PCRS! ... Somewhere between these epochs, pediatricians in private practice volunteered as ward attendings making rounds at Brackenridge Hospital along with the residents while juggling office schedules, taking care of their own hospitalized patients, and attending deliveries at three different hospitals. So...this "dinosaur" (yours truly) went back to see just how things have changed. Thanks to Dr. Mark Shen, I had the opportunity to participate as a private attending at Dell Children's and follow along with Dr. Lynn Thoreson's PCRS team. Admittedly, while some things have changed, THE most important remains the same, and that is, our families are happy to have a good "team" taking care of their medical needs. So for all primary care pediatric physicians, I am happy to report the following on my PCRS experience:

Impressive!

The PCRS team and the residents at Dell Children's present an extraordinary array of diagnostic and clinical skills, knowledge, scope, and proficiency. Our patients are in fine hands under their care.

Interesting!

No shortage of complex or motivating cases to test your diagnostic and clinical skills here! Absolutely a great way to re-fire those neurons from residency days!

Innovative!

Technology abounds. State of the art equipment! Instant data at your finger tips! No memorizing every lab value to report to your attending or sifting through charts.

Inspiring!

The PCRS team and residents care about our patients and are dedicated to providing the best care possible.

How can we, as private pediatricians, contribute as part of this team?

- Take a morning off from your office and join PCRS on morning rounds. Walk a mile in their shoes. It's only a ½ day of production off your schedule! It's really a lot of fun! It will help you stay connected to the hospital experience. You'll understand when your patients relate their Dell Children's Medical Center experience. You'll know how to interface if there's been a problem or applaud those who have provided a quality experience.
- Get to know the PCRS staff, residents, and subspecialists by coming down to see your hospitalized patients even though PCRS is providing their hospitalized care. PCRS staff and residents are real people, too! They'd like to put a face to your name as much as you would like to put a face to theirs! And besides, the continuity of care and transition in follow-up in your office will benefit your patients.
- Attend Grand Rounds on selected Friday mornings at 730am...great speakers and great topics. You can be back in the office by 9 am! CME credits are available as well!
- Join us at the quarterly Pediatric Section meeting...yes, it's becoming more relevant! Let your voice be heard!

In Dell Children's Hospital, we have a great, state of the art facility. The community based pediatric sector worked painstakingly over many years to get where we are today with a Children's Hospital. Those dinosaur days of providing care are gone...even though some of us dinos are still roaming the halls! We now have a dedicated group of physicians and pediatric subspecialists working with those of us in the community to provide the best medical care for children of Central Texas. Let's all stay connected! Let's continue to support the PCRS staff, residents, and subspecialists at Dell Children's Medical Center. Let's all stay involved!

Daniel R. Terwelp, MD

ED-PCRS Puzzler: Systemic Lupus Erythematosus (SLE)

A Case Study in Diagnosing an Uncommon Condition

Nick Wagner, M.D.

A 17-year-old African American female presented to the Dell Children's Medical Center Emergency Department with profound bilateral periorbital swelling that had been getting progressively worse over the previous two days. She stated that she "had not felt very good" all week. For the prior 5 days, she had fevers up to 104°F and felt very fatigued. She wasn't eating very much because she found it difficult and painful to swallow. She also developed a red rash over her forehead, eyelids, nose and cheeks over the preceding few days, but attributed it to a reaction to the sun, as she had been outside more than usual lately.

In reviewing further history with the patient, it seemed as if things hadn't really been "normal" for her for the past several months. She had an episode of tingling in her hands and a concurrent red, bumpy, itchy and painful rash on her right upper chest and shoulder 7 months prior to presentation at DCMC. She was evaluated at that time and diagnosed with Varicella Zoster, which was treated with oral Acyclovir. As follow up to the tingling sensation in her hands, an EMG was done which found abnormal function of the median nerve in one hand. These symptoms eventually went away, and left residual hyperpigmented spots in the area where the original rash had been. Five months prior to presentation, she began having pain in her joints that seemed to move around and stiffness in her lower extremities that was treated symptomatically with various pain relieving and anti-inflammatory medications with mixed success. These symptoms persisted through the time of presentation to DCMC. Two months prior to presentation, a seemingly different rash appeared on her palms. This rash was dark and flat, with some lesions appearing ring-like. This too had faded over a couple of weeks, but this past week's symptoms of facial swelling and "not feeling well" seemed to coincide with the return of her "dark spots" as well as their extension up her arms.

On a review of systems, she reported almost 30 pounds of unintentional weight loss. She also stated that it felt like her hair was getting a lot thinner than it used to be. She denied any symptoms such as chronic cough, night sweats, vomiting/diarrhea, or frequent infections. She had not traveled recently, and had no known exposure to insects or animals outside of her family dog.

On physical exam, the patient had marked periorbital swelling (so much so that she had difficulty opening her right eye at all), which was boggy, non-erythematous, and non-indurated. Swelling was not noted anywhere else on the body. The patient had a maculopapular rash around her eyes, the bridge of her nose, and her upper cheeks. She had a more darkly pigmented macular rash on her forearms and palms. Some lesions were between one and two centimeters across and were roughly annular in shape. Her palms had areas of desquamation where old lesions had been. The rash on her right upper chest was hyperpigmented, papular, and patchy with indistinct borders. The patient had a few discrete whitish ulcers on her lips and palate. Her cardiac exam was significant for a 2/6 systolic murmur. There was no arrhythmia or pericardial rub. Her lung exam was unremarkable. Her extremity exam was significant for subtle proximal interphalangeal joint enlargement across all digits and stiffness in her right lower extremity.

In the emergency department, the differential diagnosis for a patient with localized edema included localized facial infections such as cellulitis, dental infections, sinusitis with complications (Pott's Puffy Tumor), angioedema, nephrotic disease, cavernous venous thrombosis, and rheumatologic diseases -- with her history of rash, joint pain and unexplained fever. Infectious diseases were thought to be less likely with no warmth or tenderness to the area of swelling, but a CT scan was done to look for sinusitis and possible extension to the extra-sinus space. This was negative. A CMP was performed, which was grossly within normal limits. Specifically, electrolytes, renal and hepatic function tests were all normal. Urinalysis revealed absence of protein or blood in the urine. Nephrotic syndrome was not considered due to the lack of generalized swelling on exam and the lack of proteinuria. CBC showed WBC: 4.4, H/H: 9.7/28.7, Plts: 295. Given her symptoms, rheumatologic disease was considered high on the differential and an ANA, ESR, and C3/C4 were sent.

The patient was admitted to the floor after initial workup in the ED. Given her cytopenias, migratory rashes, weight loss, and constellation of other symptoms, several consultants including Hematology/Oncology, Allergy/Immunology, Dermatology, Ophthalmology, and Rheumatology were involved her workup. As data began to unfold, Systemic Lupus Erythematosus (SLE)

ED-PCRS Puzzler (Continued)

became the primary consideration of her diagnosis. After a few days time, our patient's ANA came back positive with a high titer of 1:1280. An anti-nuclear antibody screen was also positive (a more specific indicator), and her complement levels (C3, C4) were low, further raising the likelihood of SLE.

SLE is a chronic autoimmune inflammatory disease affecting several organ systems. Diagnostic criteria, as described by the American College of Rheumatology, are presence of four of the following eleven items:

- Malar, or "butterfly" rash to the face**
- Discoid lesions on the skin**
- Photosensitivity**
- Oral Ulcers**
- Arthritis**
- Serositis**
(inflammation of the covering over the heart or lungs)
- Neurologic disturbance such as seizures or psychosis**
- Kidney disease**
- Hematologic disturbance**
(low counts in any cell line)
- Positive immunologic laboratory testing**
(including anti-ds DNA)
- Positive ANA**

We came to the eventual consensus that SLE was the most likely diagnosis, given that our patient met 8 of the mentioned criteria (checked above). She was treated with 3 pulse doses of Solumedrol before beginning 1mg/kg Prednisone daily, and responded well symptomatically within the first few days.

The prominent, isolated periorbital swelling, as well as her varying rash phenotypes initially clouded the path to diagnosis of SLE in this patient.

However, a review of the literature shows that isolated periorbital swelling is a rare but reported manifestation of both primary SLE presentation and disease flares.¹ Our patient had rashes that were just atypical enough (e.g. the "malar" rash extended periorbitally and onto the forehead, her "discoid" lesions had

faded somewhat by the time of presentation). Typical A) malar and B) discoid lesions are pictured below.

A



B



SLE can affect male and female patients at any age, but it is overwhelmingly more prevalent in females compared to males, with a ratio of 4:1 before puberty and 8:1 after puberty. Prevalence rates are disproportionately higher in African American, Native American, Asian American, and Latin American people compared to those in other ethnic groups. While some patients with SLE may present in the childhood years, most (especially females) will begin to show increased symptoms in adolescence, in concert with the physiologic increase in female sex hormones.

Although the dermatologic features of SLE are perhaps the most widely recognized, the most common presenting symptoms of patients found to have Lupus are fever and malaise, and only after a review of other organ system involvement is the diagnosis reached. This case highlights the often complicated and confusing diagnosis of SLE, and how the diagnosis may not come to light until a constellation of criteria present over a series of weeks to months.

1: Letter to the Editor. Gómez-Puerta et al. *Lupus*.2003; 12: 866-869

An ALTErnative to SIDS:

Evaluation of the Infant with an Apparent Life-Threatening Event

Joel S. Blumberg, M.D.

There is probably nothing more frightening to the caretaker of an infant than the apparent cessation of breathing. The term ALTE refers to an event, rather than a specific diagnosis, and is defined as an acute, unexpected change in an infant's breathing behavior characterized by some combination of apnea, color change, change in muscle tone, and choking or gagging. The apnea component may be central or obstructive. The color change is usually cyanotic or pallid, but may also be plethoric. Muscle changes are usually characterized by decreased tone, but may rarely involve stiffening.

The incidence of ALTEs is estimated to be 0.05 to 1 percent in population-based studies, with the peak between one and three months of age. Evaluation with a careful history, physical examination, and appropriate laboratory and imaging are necessary, but elucidate a specific cause in only about one half of such cases. The physical exam is often normal once the episode has resolved, so great emphasis must be placed on a thorough history. An abbreviated Differential Diagnosis is listed in Figure 1.

at time of the event, abnormal physical exam findings, elevated lactate level, and recurrent ALTEs. It is important to remember that apnea can be a presenting symptom of serious infections such as sepsis, meningitis and RSV infection. A thorough history should include complete details of the event, including duration, preceding circumstances, location and position of the infant, and any intervention required. Specifically ask about the presence of respiratory effort, color change, choking gasping, emesis, limpness, stiffness, rhythmic movements, eye movements, URI symptoms, cough and fever.

The physical exam, while often normal, should focus on the respiratory, neurologic, and cardiac systems and include pulse oximetry and fundoscopy. One must always have a high index of suspicion for the possibility of abuse. Apparent life-threatening events alone are unlikely to cause retinal hemorrhages in children younger than 2 years; therefore, if retinal hemorrhages are detected, investigation into the possibility of non-accidental injury is essential.^{1,2}

Figure 1 - Differential Diagnosis of ALTE

Normal Physiologic Variation	Periodic pauses in breathing during sleep of 10-20 seconds Breath-holding spells
Pulmonary	Apnea of Prematurity (usually resolved by 43 weeks post-conception), Aspiration, Reactive Airway Disease
Gastroesophageal	Gastroesophageal Reflux Disease
Neurologic	Seizure
Hematologic	Anemia
Otolaryngologic	Laryngomalacia, Subglottic Stenosis, Obstructive Sleep Apnea
Infectious	Sepsis, Pertussis, Respiratory Syncytial Virus, Meningitis
Metabolic	Inborn Errors of Metabolism, Hypoglycemia, Hypocalcemia
Cardiovascular	Conduction Disorders (Long QT), Congenital Malformation, Cardiomyopathy
Child Abuse	Non-Accidental Head Trauma, Poisoning, Suffocation, Drug Effect, Munchausen's by Proxy

Since there is no standard work-up for an ALTE event, the evaluation is based on the history and physical findings. Risk factors for significant underlying disease include age > 2 months

lactate, CXR, U/A, and swabs for RSV or pertussis - as indicated by the history and physical. The typical low yield of laboratory tests has been clearly documented. Brand, et al reviewed

The initial lab evaluation might reasonably include a CBC, electrolytes, and glucose. Also consider lactate, urine drug screen, urinalysis, EKG, and nasal swabs for RSV and pertussis, as indicated. Based on the patient's age, presence of fever, and severity of the event, a full sepsis evaluation with cultures of blood, urine and CSF may be necessary. In general, diagnostic testing is of low yield in most cases. Statistically, the tests most likely to be helpful are the CBC, serum bicarbonate,

An ALTErnative to SIDS: (Continued)

3776 tests ordered on 243 patients with ALTEs and found that while 17.7% returned positive results, only 5.9% contributed to diagnosis, and even in a majority of these cases one could question their true utility.³

Imaging may include a chest x-ray for respiratory symptoms or clinical findings. If there is a concern for non-accidental trauma, long bones and head imaging may be needed. To evaluate for reflux, one can obtain an upper GI series or pH probe study. This may be conducted with a pneumocardiogram which can help distinguish between central and obstructive apnea. If the history is suggestive of seizure, consider an EEG.

ENT consultation may also be helpful. McMurray et al, in a small retrospective review of 30 ALTE patients, reported 63% with laryngeal, tracheal or pharyngeal disorders.⁴ A smaller size of the mandible has also been associated with ALTE, which may suggest airway obstruction as a potential underlying cause.⁵

A meta-analysis of 8 studies including 634 children found that an underlying diagnosis could be made only 50% of the time, with the most common diagnoses being gastroesophageal reflux disease (GERD) (31%), seizures (11%), and lower respiratory tract infections (8%).⁶ One study has demonstrated that 71% of infants with ALTE who later developed epilepsy will have a second episode of ALTE within a month of the initial episode.⁷

There is a high frequency with which a diagnosis of gastroesophageal reflux disease (GERD) is made in the evaluation of ALTE. A full 53% of patients who presented with an ALTE in one study were ultimately diagnosed with GERD.⁴ Although it is true that GERD is a fairly common finding among infants, it has not been clearly demonstrated as an important cause of ALTEs, or even apnea. In a study regarding the effects of gastroesophageal acid reflux on the duration of apnea in premature infants, there was no specific temporal relationship found between the two of them. It was demonstrated that of 119 infants studied with concurrent oxygen saturation, esophageal pH probe, and cardiorespiratory

monitoring, with 6255 recorded episodes of gastroesophageal reflux, only 1% of these episodes were associated with apnea that lasted >15 seconds and there was no difference in apnea rate before, during, or after GER.⁸ Another study looking at the relationship between apnea and GERD among infants with ALTE showed that in 81% of the apneic episodes, no relationship to GER was noted. Apnea actually *preceded* reflux in 93.6% of the episodes, and in only 6.4% of the cases did apnea follow reflux. Thus, even apnea of very short duration precipitated by GER was extremely uncommon in infants with a definite history of ALTE.⁹ These data imply concurrency, rather than causality between ALTEs and GER.

There also does not seem to be a causal relationship between Sudden Infant Death Syndrome (SIDS) and ALTE's, and this term has replaced the prior "near-miss SIDS" terminology. There are striking epidemiologic and clinical differences between ALTE and SIDS. Up to 52% of ALTEs occur during wakefulness, whereas most infants with SIDS die during sleep.¹⁰ Also, the incidence of SIDS peaks at 3 to 5 months of life, whereas ALTE peaks 1 to 3 months earlier (Figure 2).¹¹ (reprinted from Reference 11)

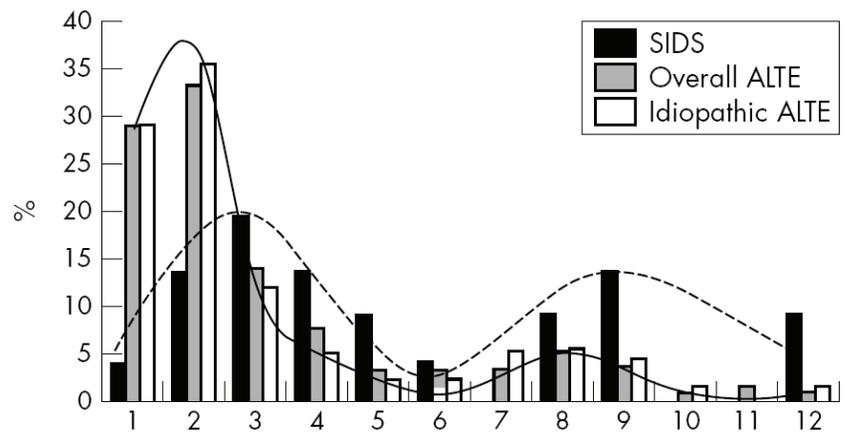


Figure 2 Age distribution of infants admitted to hospital with ALTE and those who died from SIDS, 1993–2001.

Only 4% to 13% of SIDS cases have a history of apnea, a percentage only slightly higher than healthy controls. Moreover, there is no statistical difference between parental reports of apneic episodes in the 2 weeks preceding a SIDS episode and

An ALTErnative to SIDS: (Continued)

the frequency reported in healthy controls. Finally, the incidence of SIDS has declined since the institution of the Back-to-Sleep program, but there has been no similar decrease for the incidence of ALTE. One risk factor they do share in common is a history of maternal smoking during pregnancy.

Routine admission for most patients who appear to be well may not be necessary, but management should include hospital admission and observation for any clinically significant event. Admission should especially be considered for infants less than 30 days, those with a history of prematurity, episodes not related to feeding, and recurrent or severe episodes. A high level of parental anxiety may also warrant admission. While in-house, patients may be observed for event recurrence, and monitored with cardiorespiratory or apnea/bradycardia monitors.

Depending on age, empiric antibiotic therapy may be indicated if a sepsis evaluation is undertaken, while cultures are pending. Infants who suffer an apparent life-threatening event may be at higher risk for subsequent child abuse and adverse neurological outcomes,⁷ but for most, ALTEs seldom recur or develop into chronic conditions.

Finally, upon discharge, the decision will have to be made regarding the appropriateness for continued home monitoring. ALTE is only rarely an indication for home monitoring. Parents must be aware that apnea is generally not a precursor to SIDS, and that SIDS prevention is not an indication for home monitoring. It may be considered in cases of recurrent ALTE episodes, or ALTE of known etiology with high risk of recurrence. In most cases, home monitoring is not recommended.

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We Want to Hear From You!

Do you have questions about Dell Children's Medical Center? Ideas on content for future editions of the LinkLetter? Please contact Dell Children's Physician Relations & Recruitment Coordinator, Elizabeth Kane, at 512-276-0016 or ewkane@seton.org with questions or requests for more information. We want to hear from you!

Texas Center for the Prevention and Treatment of Childhood Obesity Updates

Our multidisciplinary pediatric weight management clinic, **ACES (Activating Children Empowering Success) Clinic**, has been seeing patients since April and we've very much enjoyed the opportunity to work with patients and their families at Dell Children's. Patients require a referral from their PCP, and the families must also complete a pre-visit information packet. The PCP referral form and the pre-packet can be downloaded from our website: www.dellchildrens.net/healthyliving, or we're also happy to fax or mail you copies. During the comprehensive clinic visits patients and their families see multiple providers, so please let your patients know that the first few visits will likely last longer than 2 hours. In order to manage comorbidities and to support, encourage and sustain healthy change we will see most patients back every 4-6 weeks for the first few visits and then at various times depending on the patient's needs.

Referral criteria are: aged 2-18 years, BMI >95th percentile with a co-morbidity or >99th percentile without a known co-morbidity, and most importantly having a family with an interest in making healthy changes. As this is a resource intense clinic we hope to target those children and families who are most motivated and ready for healthy behavior change. Patients will come for an initial consultation visit with Dr. Avila Edwards or Dr. Stephen Pont and will also see our counseling social worker. Patients will then be scheduled for a follow-up visit where they will again see a pediatrician and other members of the multidisciplinary team.

Any needed lab work will be obtained between the first and second visit. We see privately insured, Medicaid/CHIP, MAP and self-pay patients.

Our grant funded 10-week program **Healthy Living Happy Living**, for which Dr. Avila Edwards serves as the medical director, continues to have great success. This is a weekly afternoon/ evening program at Dell Children's for overweight or obese children aged 6-11 years and a parent/ guardian, who are able to attend all 10 sessions, and who are interested in making healthy changes. Additional information and the pre-participation form can also be found out our website. Both the ACES clinic and Healthy Living Happy Living staff offer services in both English and Spanish.

Additional exciting developments include Dr. Avila Edwards working with the American Academy of Pediatrics to develop resources for primary care pediatricians targeting overweight and obese children aged 0-5 years and Dr. Stephen Pont will be working with the AAP to establish a Section on Obesity.

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*Best regards,
Stephen Pont, MD, MPH, FAAP
Medical Director*