

Fall/Winter 2010: Global Health

In this issue of Children's Doctor:

Articles: *Tetanus, Pediatric Global Health: The Impact Back Home, Full Disclosure, Overcoming Cultural Taboos, Education Around the Globe* News at The Children's Hospital of Philadelphia, Pediatric Reflections, Alumni Notes, Make the Diagnosis

We welcome your comments; please direct them to 267-426-6050 or childrensdoctor@email.chop.edu.

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Make the DIAGNOSIS

A 4-year-old boy presents to his pediatrician for a routine well-child check. On examination, the physician hears a murmur that he had not previously heard.

- The murmur is medium-pitched and is heard at the apex, left lower sternal border, left middle sternal border, and right upper sternal border while the patient is supine.
- When the patient sits up, it becomes somewhat quieter and localizes to the left lower sternal border.
- The murmur sounds vibratory, almost buzzing, and is about as loud as the breath sounds.
- The second heart sound splits normally, there is no abdominal organomegaly, and pulses are 2+ without lag between the right radial and right femoral arteries.

What is this murmur, and is it pathologic?

Please respond with your comments to "Make the Diagnosis" by e-mail to childrensdoctor@email.chop.edu or online at www.chop.edu/childrensdoctor.

Congratulations to Diana M. Schlesinger, MD, of West Reading, Pa., for sending the first correct answer to last issue's challenge. The correct answer was tetanus, the topic of the first article in this issue.

Coffee Winners

Thank you to everyone who responded to the online survey seeking your input on Children's Doctor. Readers from as far as Tulsa, Okla., and as close as CHOP took the survey. We appreciate your feedback as we strive to make the newsletter as relevant and helpful to you as possible.

Winners of a \$10 gift card to Starbucks were: Jennifer Walton, MD; Samir S. Shah, MD; Joel Fein, MD; Ted Tapper, MD; Robert W. Block, MD, FAAP; Cindy Christian, MD; Richard M. Freedman, MD; Todd M. Sterner, MD, FAAP; William F. Bonner, MD; David Webner, MD; Risa Altman, DO; and Theresa D'Amato, MD.

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DOCTOR

Fall/Winter 2010

Global Health

Tetanus

Neil Uspal, MD, David Chao, MD,
Rakesh Mistry, MD, Fred Henretig, MD

TG is a 10-year-old girl who presents to a Haitian hospital 1 week after surviving a severe earthquake. She had been trapped under rubble and suffered a deep, open wound to her right foot, extending to her ankle. Her father attempted to manage her injuries in their temporary tent shelter; however, she developed persistent swelling and pain. TG was admitted to a pediatric inpatient tent "ward," staffed by a team from The Children's Hospital of Philadelphia, for treatment of a wound infection and stable foot fracture.

While on call, the team was called to the bedside because the patient's father felt that TG was in significant pain. Upon assessment, she was in obvious distress, exhibiting paroxysmal rhythmic spasms of her torso and extremities. She was tachycardic and tachypneic; however, the lack of a blood pressure cuff or thermometer made it impossible to obtain other vital signs. She was conscious and oriented during the event. The neurologic exam was notable for trismus and the absence of a gag reflex; the remainder of her cranial nerve and overall neurologic exams were normal.

Discussion: Tetanus is a disease that causes significant morbidity and mortality in the developing world. Tetanus is rare in the United States, with an incidence of 0.16 cases/million population, with adults older than 60 years being at greatest risk for infection. Tetanus carries

a high mortality rate worldwide, especially among the pediatric population: children's deaths from tetanus in 2004 were estimated to be 163,000, with 128,000 in the neonatal period.

Clinical disease from tetanus is due primarily to a toxin known as tetanospasmin, elaborated by *Clostridium tetani*, a gram-positive, spore-forming, obligate anaerobic bacillus. Tetanospasmin's primary activity is inhibition of neurotransmitter release at spinal cord inhibitory synapses. The toxin causes spasms and increased sympathetic activity, but has no effect on cognition or mental status.

C. tetani is ubiquitous in nature, often found as hardy spores that are highly resistant to moisture, disinfectants, or changes in temperature. The spores find optimum conditions for growth in contaminated wounds possessing low oxygen tension, where they become activated and begin to produce toxins. The incubation period for tetanus is generally 1-2 weeks.

There are several clinical manifestations of tetanus, the most common being generalized tetanus. Onset of clinical disease is usually insidious, often with trismus being the presenting symptom. Gradually, stiffness in the back, neck, and abdominal muscles develops, followed by development of *risus sardonius* (sarcastic smile), which is characteristic of tetanus. As symptoms worsen, paroxysmal spasms develop, causing the opisthotonus observed in our patient. These events may be confused with seizures, however, the patient remains entirely conscious. Untreated patients may develop potentially fatal respiratory failure from laryngeal obstruction or decreased chest wall compliance. Autonomic instability may cause blood pressure lability, diaphoresis, fevers, and cardiac dysrhythmias.

Other manifestations of tetanus include localized tetanus, which presents as muscle rigidity of the area close to the inoculation site; and neonatal tetanus. This form develops in infants born to inadequately immunized mothers. The disease is first manifest by weakness, developing into spasms and rigidity, and mortality is greater than 90%.

Diagnosis of tetanus is usually made based on the clinical picture. Blood counts and CSF studies are typically normal. Wound cultures are positive for *C. tetani* in only 30% of cases, and even if positive do not confirm if the bacteria are toxin-producing.

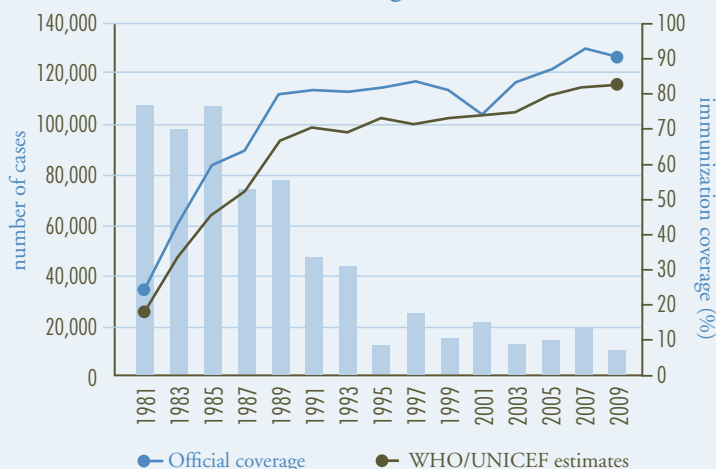
Treatment of tetanus involves supportive care and eradication of the causative pathogen. Patients with suspected tetanus should be transferred to an intensive care unit. Stimuli should be minimized, as slight triggers may result in paroxysms of spasms and autonomic



ON ROUNDS

Medical Editor:
Richard Rutstein, MD

Total tetanus global annual reported cases and DTP3 coverage, 1981–2009



Note: Reported tetanus cases represent approximately 10% of actual cases.

continued >

lability. Wounds infected with tetanus should be thoroughly cleaned and debrided. Specific therapy consists of human tetanus immune globulin (TIG). The dosing is 3000 to 6000 units intramuscularly, with at least part given at the site of infection. In countries where TIG is not available, equine tetanus antitoxin is a potential alternative. Metronidazole should be given for 10-14 days. Supportive care includes sedation and muscle relaxation for spasms, typically using diazepam. Treatment of hypertension and tachyarrhythmias is often accomplished with propranolol.

Our patient was diagnosed with generalized tetanus and received antibiotics, TIG, and diazepam. During the medical team’s stay in Haiti, the patient improved significantly; at the time of the CHOP team’s departure her rigidity had significantly decreased and she was not experiencing paroxysmal spasms. Unfortunately, as a consequence of Haiti’s low pre-earthquake immunization rate of 50%, her illness was not unique among earthquake survivors, with widespread reports of tetanus and other preventable diseases. Since the earthquake, more than 1 million internally displaced persons have been immunized against tetanus and other diseases.

References and Suggested Readings

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**Pediatric Global Health:
The Impact Back Home**

Rodney R. Finalle, MD

Dr. Finalle is director of CHOP’s Global Health Department and International Patient Services.

What does the Global Health Department at The Children’s Hospital of Philadelphia have to do with helping patients and families who are treated in Philadelphia and throughout the CHOP Care Network?

I believe that broadening CHOP’s mission to include caring for some of the poorest and most vulnerable children in the world has created a heightened sensitivity to the cultural differences of our domestic patients, and made us better care providers as a result.

Global Health gives CHOP clinicians, trainees, and staff the opportunity to spend time caring for patients in our partner communities of Consuelo, Dominican Republic, and in Botswana.

Our Global Health programs encourage active participation by CHOP attending physicians, nurses, and other trainees in Consuelo, where they collaborate with clinical partners and provide hands-on care to children and their families who have limited access to healthcare. Often, our clinicians must practice without labs and high-tech equipment, and sometimes even without electricity or running water. By necessity, they sharpen their diagnostic skills relying on what they see and hear, and they learn from local experts in partner communities.

Visiting CHOP professionals also assist in building local capacity by providing training sessions for community health workers, local men and women who live in the communities where our programs are active, to teach families about the importance of nutrition, clean water, sanitation, breast-feeding, and much more. In the give-and-take of the ensuing relationships, CHOP practitioners learn of the overwhelming challenges families struggle with daily, and help partners on the ground develop strategies to mitigate them. Well-trained community

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Global Health Research

David N. Pincus, a Philadelphia philanthropist, has generously endowed a 2-year global health fellowship program for CHOP physicians working in the Dominican Republic and southern Africa. Henry Welch, MD, and Lara Antkowiak, MD, are the inaugural David N. Pincus Global Health Fellows. Here, they describe some of their research and daily work.

Full Disclosure

Henry Welch, MD

“This person is strong because he’s taking his medicines and the bad guy goes to sleep.”

This is the response of a 7-year-old girl sitting at a table in rural South Africa, looking at a cartoon drawing of 2 figures fighting. “This person is sick because she doesn’t take her medicines and the bad guy attacks the soldier cells.”

She could be describing a battle between police officers and criminals in her home village. But in fact, she is describing a fight of a different nature—this child has HIV and is sitting in a clinic, where her doctor is showing her a cartoon that depicts the human body fighting off the virus that causes AIDS.

I work at Sparrow Village near Johannesburg. It is an HIV orphanage and hospice, an inspirational place that cares for more than 250 children living with or orphaned by HIV. Explaining a chronic illness, such as HIV, to a child is challenging in any setting, particularly when the patient is an orphan. Communicating an HIV diagnosis means discussing a stigmatized, potentially life-threatening illness. Many caregivers are reluctant to disclose the diagnosis to young patients for fear of causing significant distress for the child.

The child examining the cartoon drawings is an example of my research exploring how best to ensure children



Photo: Ryan Ulmer-Quinn

Estimated HIV Prevalence (%), 2008

South Africa		
age	male	female
2 – 14	3.0	2.0
15 – 19	2.5	6.7
20 – 24	5.1	21.1

Source: South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey, 2008.

Botswana		
age	male	female
1.5 – 4	2.3	2.1
5 – 9	4.6	4.8
10 – 14	3.5	3.5
15 – 19	2.4	5.0
20 – 24	7.4	16.0

Source: Botswana AIDS Impact Survey (BAIS) III, 2008.

are informed, in an age-appropriate manner, about their HIV status. Most children are told by a physician or nurse. When first learning of their illness, many children think they are going to die. Many are scared, uncertain, and angry. Some are relieved finally to know why they constantly must take medicines and get blood drawn. The majority had known nothing about HIV before being told of their diagnosis, and almost all wished they had known more before.

This is where the “bad guy/good guy” cartoons come in. While the 7-year-old may not truly comprehend what a soldier cell—or CD4 cell—does, or understand that the “bad guy” is HIV, the drawings and discussion give her a better grasp of her illness. This is important as she gets older: Clinical reports have indicated positive outcomes with disclosure to chronically ill children, including trust, improved adherence, open family communication, and better long-term health and emotional well-being.



Overcoming Cultural Taboos

Lara Antkowiak, MD, M Ed

The mother came to our clinic for help, an alert 4-month-old on her lap. “I can’t afford formula for my baby,” she told me in a lilting Haitian Kreyol accent. I explained that our program, Niños Primeros en Salud, in Consuelo, Dominican

Republic, was a clinic where her child could receive all pediatric care, medicines and lab tests free. But we did not give out formula.

“Why aren’t you breast-feeding?” I asked.

“Breast-feeding!” she laughed. She looked at her friend, another mother in our program who laughed back. “I lost too much weight breast-feeding!” she said. “You want me to look like a stick?”

I looked at her slim figure, thinking how much I would love to be her size. But beauty is relative, and most Haitian women I know prefer curves.

I told the mother that breast milk is the best food for her baby, and that letting the baby suck is the way to increase milk production. The second mother looked at me unhappily. Her child was 2 months old, and she was not breast-feeding either. Like many Dominican women, she began feeding her baby solid foods at 6 weeks of age. She fed her formula, tea, pasta, and mashed-up foods.

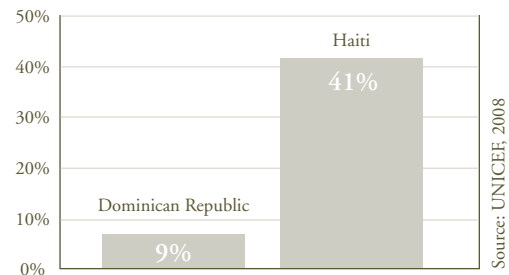
“I wanted to breast-feed,” she told me. “But I didn’t have enough milk.”

“Why do you think you didn’t have enough milk?” I asked her.

“The baby was always crying,” she told me. “I didn’t have enough to satisfy him. And I couldn’t afford to buy oatmeal or chocolate.”

I explained again that the best way to make more milk is to let a baby suck, that sucking leads to the production of milk. Many Dominicans believe that certain foods—oatmeal, chocolate, codfish—increase the production of breast milk, so if

Rate of 6-month Exclusive Breast-Feeding



you can’t afford them you are in trouble. I told both women that they were capable of breast-feeding and that we could help them.

“You can breast-feed the next baby,” I reassured them. They looked at me skeptically. This is going to take some work, I thought.

Since I brought my breast-feeding daughter home to the Dominican Republic 9 months ago, I have confronted myths every day. Dominicans’ cultural beliefs about breast-feeding are strong.

People have come up to me in restaurants and asked me to stop breast-feeding while eating, as it could harm the child. Much of it seemed harmless until I began to encounter babies in my pediatric practice with severe malnutrition who were not breast-feeding. Their mothers mixed extra water with formula to make it last longer, and often the water carried infection. These children returned to clinic repeatedly with diarrhea and malnutrition.

I spoke to our colleagues here at the Divine Providence Health Center in Consuelo, and we decided to spearhead a new project. Research shows that breast-feeding lowers childhood mortality rates, diarrhea, ear infections, respiratory infections, and malnutrition. The prevalence of exclusive breast-feeding through the first 6 months of age in the Dominican Republic is abysmally low, at 9%. In contrast, the 6-month exclusive breast-feeding rate in neighboring Haiti is 41%, according to UNICEF data. We hope to find out the reason for the disparity, and work to remedy it.

Many cultural beliefs and practices undermine breast-feeding in our community. Yet mothers are receptive to education, especially when it comes from their peers. In each of the barrios that we serve there is a community health worker (CHW), whose role is to act as a liaison between the poor, urban neighborhood and the clinic.

Using materials from experts like La Leche League, we plan to train the CHWs to act as breast-feeding educators for the community. They will make regular home visits to all pregnant mothers, before and after their children are born, to offer ongoing breast-feeding education. They will visit them in the hospital immediately after their child’s birth to offer first-hand guidance. And together with the breast-feeding mothers, they will lead support groups in the barrios, offering help woman-to-woman.

It’s not going to be easy, but I am hopeful. My daughter’s nanny was once the most skeptical critic of my exclusive breast-feeding. Now she is pregnant and tells me that she wants to breast-feed, too. It is possible to make a change, one mother at a time.

health workers multiply the effort’s impact while collaborating in the development of educational materials to help CHOP staff improve their presentation and teaching skills.

The focus of our efforts in Botswana tends to be more on partnership at the new University of Botswana School of Medicine and its Department of Paediatrics. Specialists from infection control, adolescent medicine, and nutrition, for example, have worked with professional colleagues in Africa to share their expertise and develop relationships with their Botswana counterparts. This important work is done in conjunction with the Botswana-UPenn Partnership at the University of Pennsylvania School of Medicine. Our clinicians stay in touch with colleagues from Botswana through e-mail and Skype, continuing to provide support, guidance, and resources.

Through the David N. Pincus Global Health Fellowship, Children’s Hospital has 2 physicians living in our partner communities full-time, working alongside local care providers and undertaking research and scholarly activities. (*See previous pages for their stories.*) They also serve as resources for Global Health initiatives and guides for CHOP residents who complete Global Health electives at one of our collaborative sites.

The clinical professional who has traveled to one of our partner communities returns with a changed perspective and with a renewed sense of appreciation for the facilities, equipment, and expertise we have access to within CHOP. I often hear stories of how these CHOP clinicians are now able to interact in a more meaningful way with patients and families, especially those from a culture different from their own. Participants in the Global Health programs work intensively in challenging scenarios, including the use of interpreters, appreciating the unique needs of immigrants, and crossing through cultural barriers that affect children’s health. As the clinicians develop skills in these areas, they also build their confidence as they care for children in their Philadelphia-based practices. Philadelphia has an increasingly diverse population of immigrants and non-English speaking families, and our Global Health efforts can be put directly to use in our local efforts as well.

Global Health is increasingly local health. And a vibrant, engaging Global Health program—partnered with motivated and passionate

teachers and learners—benefits not only the professional participants, but also the global and local pediatric population CHOP serves.

References and Suggested Readings

To learn more about our Global Health programs, visit us on the Web at: www.chop.edu/globalhealth.

Education Around the Globe

Stephen Ludwig, MD

As I was preparing to write about the international education program we share with the American Austrian Foundation (AAF), I received an e-mail from Zsolt Matrai, MD. As it turns out, telling Dr Matrai’s story tells it all.

Dr Matrai is a pediatrician from a small, rural town in Hungary. He was selected by the AAF to attend a 1995 seminar in Salzburg, Austria, where I was leading a group from The Children’s Hospital of Philadelphia to teach a Pediatric Emergencies course. The AAF, through funding in part from the Austrian government and the Soros Foundation, had established a program for adult medical education subjects, and we were selected to initiate a program for pediatric education topics. The students came from all over Eastern Europe, some from traditional European countries and some from the emerging new countries that gained independence after the Soviet Union’s dissolution. Five instructors and 30 students spent a week living together, having family-style meals, and most importantly, learning about how to improve medical care for children in the students’ home communities. Dr Matrai was a physician “student” in this class.

The teaching was eye-opening for many students. There were, of course, interesting new concepts, medical facts, and patient management protocols. But more than the information, most students marveled at teaching techniques that were informal, case-based, and interactive. Most had been trained in a system where the professor came to class and gave a lecture, often without soliciting questions or discussion. Our teaching techniques seemed to be unheard of in that part of the world,

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NEWS

at The Children's Hospital
of Philadelphia

New Therapy Boosts Neuroblastoma 2-Year Cure Rate

Using immunotherapy, Children's Hospital oncologists have achieved the first substantial increase in more than a decade in cure rates for neuroblastoma. A new study shows that the treatment improved 2-year survival rates by 20 percentage points compared with standard treatment for high-risk neuroblastoma. The study appeared in the Sept. 30 issue of the *New England Journal of Medicine*.



"We expect these findings will change clinical practice, setting a new gold standard of treatment," said John M. Maris, MD, (pictured top left), a co-author of the study and director of CHOP's Center for Childhood Cancer Research.

In the current study, researchers assigned 226 high-risk patients at multiple cancer centers to receive either standard therapy (isotretinoin) or immunotherapy (3 biological agents in combination with isotretinoin). The evidence of clear immunotherapy benefits allowed the trial to be halted early.



In separate research, Dr Maris and Yael Mossé, MD, (pictured bottom left), identified mutations in the anaplastic lymphoma kinase (*ALK*) gene as the main cause of familial neuroblastoma. The team also found that the same mutations can occur in the cancer cells in the sporadic form of the disease. The study was published in *Nature*, in 2008, and CHOP is now leading a clinical trial of an *ALK* inhibitor.

Large Gene Study Pinpoints Gene Areas That Raise IBD Risk

An international study led by researchers at CHOP has identified 5 new gene regions that raise the risk of early-onset inflammatory bowel disease.

The largest genetic analysis of the disease in the pediatric population included DNA from more than 3,400 children and adolescents with IBD and approximately 12,000 genetically matched control subjects from North America and Europe.

In subjects with IBD, gene variants were found more often on chromosomes 16, 22, 10, 2, and 19. The most significant finding was at chromosome locus 16p11, which contains the *IL27* gene that carries the code for the cytokine IL27.



Cardiac Center Introduces Single Ventricle Survivorship Program

The Cardiac Center is now enrolling patients in its new Single Ventricle Survivorship Program.

Because of significant advances in surgery and intensive care capabilities, most children with these defects survive, though 30 years ago, most died in infancy. The patients, now living into their 20s and 30s, are experiencing complications such as exercise intolerance, heart rhythm disturbances, abnormal clot formation with risk of stroke, and loss of protein in the stool. The program, directed by

Jack Rychik, MD, (pictured below left), and the first of its kind, brings together a multidisciplinary team to provide screening, evaluation, and coordinated care.

The program accepts single ventricle patients of any age. For more information, contact Katie Dodds, CRNP, program nurse manager, at 267-426-3057 or svsp@email.chop.edu.



Clinical Pathways Use Evidence to Improve Care

New "clinical pathways" at CHOP aim to create a standard of care based on existing evidence as well as expert consensus. Jane Lavelle, MD, (pictured top left), of Emergency Medicine, and Susan Coffin, MD, (pictured below left), of Infectious Diseases, have expanded the pathway work to develop a pathway for febrile infants. Lavelle and Coffin also created a scorecard to track the best practices the pathway promotes.



When an infant comes to the ED with fever above 100.4 degrees Fahrenheit, the bedside team can now go to the ED site on CHOP's Employee Intranet and review the pathway for febrile young infants (0 – 56 days old). The pathway includes triage criteria, expectations for RN bedside care, important history and physical examination components, and recommendations for laboratory and radiology evaluation, antibiotics, and admission.

CHOP Begins Family-Centered Care Grand Rounds

Children's Hospital is one of the nation's first pediatric hospitals to institute Family-Centered Care Grand Rounds to educate CHOP clinicians on the value and best practices of family-centered care. Participants will hone skills to develop and promote partnerships between families and their child's healthcare team. FCC sessions will be held quarterly.

New Center Treats Patients with Thyroid Disease

Children's Hospital has opened the Pediatric Thyroid Center, a new multidisciplinary center focused on caring for children and adolescents with thyroid disease. The center, run by Andrew J. Bauer, MD, FAAP, medical director, and Sogol Mostoufi-Moab, MD, FAAP, of both the Endocrinology and Oncology divisions, sees patients with all forms of thyroid disease, including hypothyroidism and hyperthyroidism, with a specific focus on the evaluation and care of thyroid nodules and thyroid cancer.

The goal of the center is to provide coordinated, comprehensive care in a patient- and family-centered way. Endocrinology, Oncology, Surgery, Interventional Radiology, Pathology, Radiology, and Nuclear Medicine are all part of the center.

For information, contact Megan Lessig, MSN, CRNP, Endocrine nurse practitioner and Thyroid Center coordinator, at ThyroidCenter@email.chop.edu.



Pediatric Reflections

Catherine Bonita, MD

In this issue, we introduce a new column. Members of our physician editorial board, on a rotating basis, will contribute the articles for Pediatric Reflections. Catherine Bonita, MD, is a physician with the CHOP Care Network, Flourtown, Pa. Her interests include pediatric nutrition and allergies.

Allergy Anxiety

When my youngest daughter, Sonia, was 6 months old, she erupted into hives within minutes of eating yogurt. She also developed hives after eating grapes, bananas, wheat, and avocado. As her diet became more restricted, she gained little weight. We often approached mealtimes with anxiety. How could I keep my child well-nourished and safe?

With time, I have learned that much of the fear that comes from raising a child with food allergies can be mitigated by following a few simple guidelines. By adhering to these and using common sense, you can reassure parents that their children can have full lives with minimal restrictions.

- **Prevention is critical.** Read labels carefully, use separate utensils for cooking and eating, and educate others around your child about the allergy. When eating out, never assume that food is prepared without a specific allergen. Always ask. If you are unsure, go to plan B (bring home-prepared foods that you know are allergen-free).
- **Get tested.** Just because there is a temporal relationship between ingesting a food and a reaction doesn't necessarily mean there is a causative one, too. To avoid overly restricting a child's diet (or a mother's, if she's nursing) and running the risk of leaving her nutritionally deficient, avoid questionable foods, but have the child tested as soon as possible.
- **Always carry an Epi-Pen and teach others how to use it.** Encourage parents and other care providers to practice with a trainer and watch the instructional video, available online and in DVD format.
- **Have an action plan.** This is a written plan that details what the allergy is, symptoms to notice, and necessary medicines. A copy should be given to every caregiver, the school nurse, and daycare providers. It should be reviewed periodically and renewed at the start of every school year.

For more information and helpful tips, visit foodallergy.org.

"Education" continued

and they benefited the students and made a difference in the material they were able to master in the course.

Dr Matrai was an avid student, and we quickly struck up a collegial relationship. We remained in communication, and he has since visited CHOP on 4 occasions, attending our Annual Pediatric Emergency Medicine CME Course in Philadelphia, where he also had an opportunity to observe in the ED, hear lectures and participate in skill stations and workshops. In 1997, he edited and published a small pamphlet for his patients' parents entitled, *What to Do in Emergency Situations in Childhood*. In 2001, he published a handbook for pre-hospital pediatric emergency care. He has taught in several life-support courses in Hungary and published 3 articles in Hungarian medical journals. He also has become a strong advocate for children's emergency services. It is astounding and gratifying to see that Dr Matrai, and others like him, are taking the knowledge from these CHOP-led seminars and putting it directly to work to improve pediatric care in their own corners of the world.

This is the nature of the AAF Project. Now CHOP sends teams 6 times a year to teach a variety of pediatric topics. Our courses are multidisciplinary and involve all the departments of the medical staff. The students are always appreciative, and we give them electronic copies of our lectures so they can share the information with their colleagues at their home institutions. I always complete these seminars with new contacts, new learning that I glean from the students, and a real sense that this is a kind of foreign diplomacy in which CHOP can take pride.

The AAF has also sponsored physicians coming to CHOP for periods of study, and it is now branching into other parts of the world. It has been a productive and important partnership for CHOP—though the true beneficiaries are countless children throughout the world. Dr Matrai's e-mails continue, and we plan to meet again somewhere, sometime soon.

CME

Continuing Medical Education

CHOP's Continuing Medical Education (CME) department offers more than 25 conferences each year on a variety of topics, including pediatric cardiology, emergency medicine, nutrition, and trisomy 21.

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NOTES Alumni



In July, Cindy Christian, president of our Alumni Association, was named the first medical director of the Philadelphia Department of Human Services by Mayor Michael Nutter. In this role, she will work to develop health policies and systems of care for abused, neglected, and otherwise dependent children in the Child Welfare system. Cindy will remain director of Safe Place: The Center for Child Protection and Health at CHOP. She joins Deputy Mayor for Health and Opportunity and Health Commissioner Donald Schwarz, another distinguished CHOP faculty member.

The CHOP Board of Trustees passed a resolution to complete funding of the Stephen Ludwig Endowed Chair in Medical Education. We are grateful to all the alumni who contributed.

We welcome CHOP's new chief medical officer, Michael Apkon. He brings considerable experience in quality of care and safety improvement, and he joins us from the Children's Hospital division of Yale-New Haven Hospital.

The Alumni Association provided travel stipends to 3 pediatric residents who made presentations at the Pediatric Academic Societies (PAS) meeting in Vancouver. We expect to continue this on an ongoing basis.

Are you connected? The CHOP Alumni Connection (www.chopalumni.org) now has 413 members. See old friends, relive memories, and tell us what you're doing. It's always nice to hear from you and about your accomplishments.

If you have news about yourself or other CHOP alumni, please send it to the alumni editor (Pasquariello@email.chop.edu) or Bill Gross (alumni@email.chop.edu).

Patrick S. Pasquariello Jr, MD
Alumni Editor

Awards, Honors



CHOP has named its 2010 Master Clinicians. They are **Brian Hanna, MD**; **Jane Lavelle, MD**; **Terri Brown-Whitehorn, MD**; **Tammy Kang, MD**; and *Children's Doctor's* own medical editor, **Richard Rutstein, MD**. The Department of Pediatrics and CHOP established this award to honor outstanding clinicians' commitment to patient care and clinical skills.

Jean Belasco, MD, (*pictured above left*) received the Pitcher of Hope Award from CHOP for dedicating her career to helping children with cancer.

Gil Binenbaum, MD, who won the 2010 Young Investigator Faculty Award at the Eastern Society for Pediatric Research annual meeting, was recognized for his research in infant blindness prevention.

Bimal Desai, MD, (*pictured below left*) was named CHOP's new chief medical information officer. His responsibilities will include supporting the development of clinical information systems and leading the continued implementation of the electronic medical record.



Katherine High, MD, (*pictured left*) received the Outstanding Achievement Award from the American Society of Gene & Cell Therapy in recognition of her extensive work in gene therapy.

Tom Kennedy, MD, was honored by the Bridgeport Hospital as former chief of the Department of Pediatrics and for his "Dr. Tom Kennedy Toy Closet."

On the international front, **Stephen Ludwig, MD**, has accepted the position of International Medical Education Director and **Cynthia Haines** is now senior vice president, International Medicine.

