



The GEORGIA Pediatrician

A Publication of the Georgia Chapter of the American Academy of Pediatrics

President's Letter

Greetings from the *NEW* Georgia Chapter AAP President!



Terri McFadden, MD

"May you live in interesting times!" It is said that in a moment of displeasure, an ancient wise man spewed this curse towards a worthy opponent. When we think of "interesting" times, the connotation is usually not positive! At best, the term is a euphemism for a sense of uncertainty in a time of rapid

changes; at worst, it represents a sense of discomfort and lack of control that we feel when the world seems to be swirling around us. During these times, we often feel anxious as the norms that we live and practice by seem to be in flux. Sometimes it is helpful to reframe the discussion and think of the uncertainty as an opportunity for rethinking our enterprise. Even in the midst of tumult, if we keep our eyes on the prize and maintain our focus on protecting our children, we will not go wrong. So it is against this backdrop that I thank you for welcoming me as your president! I am so honored that you have allowed me to represent you during these interesting times! Although there are opinions that sometimes divide us, our dedication to children and their families will always unite us.

I am so proud to be a member of this remarkable organization. As I prepared to assume my role as Vice President two years ago and reviewed our mission and vision, I was reminded of what makes our professional organization different from so many other medical associations. Although we work hard to represent pediatricians and the profession of pediatrics, at our core we advocate for our children. Our mission states it clearly: To attain optimal physical, mental, and social health and well-being for all infants, children, adolescents, and young adults. To accomplish this mission, the Academy shall support the professional needs of its

members. Further, the vision of the Georgia AAP is to be the leading authority, advocate and voice for the health of Georgia's children and for the profession of pediatrics.

Indeed there are many challenges that we will need to address going forward. We live in a time when one of the most significant healthcare interventions developed over the last century, vaccines, are increasingly under attack. In a time when science itself has become suspect to some, we find ourselves struggling to convince families of both the life-saving merits and safety of modern immunizations. For those of us old enough to have childhood memories of waiting in long lines for the chance of receiving a polo vaccine on a sugar cube, it is amazing to think that we must now convince parents of the importance. Many of us can also remember the diseases that we saw in our training that led to death or significant illness in children under our care. Now these are vaccine-preventable diseases.

We live in a time when school shootings and gun violence have become frequent occurrences, but as I heard recently at the District meeting, although these events are frequent, we can never allow them to be considered normal. We see physician burnout becoming an ever present part of our discussions. It is important that we work

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President's Letter

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with our members to understand how our organization can help to improve the quality of life for those in our profession and help maintain the joy in the practice of pediatrics.

Even as we face challenges, we also live in a time of great opportunities. Research emerging over the last few decades has revealed the incredible opportunities that pediatricians have to affect the life course of our patients. I am excited about our focus on early brain development and early literacy. When we begin with the end in mind, our children are ready for school, lifelong learning and success. Meanwhile, work on ACEs has shown us the boundless potential that the early years have for shaping life-long physical and mental health.

I am very excited to help steer our organization for the next two years. I look forward to representing the voices of all of Georgia's children and pediatricians in a way that is inclusive and inviting. We must continue to focus on access to quality healthcare for all of Georgia's children whether in urban or rural areas. Our rural areas are facing a major healthcare crisis with birthing hospitals closing at an alarming rate, and over a third of Georgia's counties lacking a pediatrician. The answers may not come easily, but we will work together with our collaborative partners in the healthcare system, state government and private sector to create innovative mechanisms for insuring access to healthcare for all children.

We will also need to continue to address the mental health of our children and their families. At a time when more children are being diagnosed with behavioral and mental health issues, it is important that our health care system has the ability to provide these services. We again, must work with our natural partners to insure that we are providing the care that our children need and deserve. It is critical that we continue the chapter's outstanding work in educating pediatricians so that we are prepared to handle appropriate issues in our offices, but also to continue to advocate for adequate referral services for children who fall outside of our scope of practice.

I know that I am stepping into big shoes. The Georgia Chapter has a national reputation for excellence. Under the leadership of immediate past president, Ben Spitalnick, the chapter recently won the award for outstanding Extremely Large Chapter of the year. I will work to continue the wonderful legacy left by Ben and Evelyn Johnson before him. At the end of the day our focus is simple. We are in the business of transforming the trajectory of children's lives. I look forward to working with you to make this happen. ■



Terri McFadden, MD



Chapter News & Updates

AAP Adolescent Vaccinations and Wellness Grant Program Recipients Announced

In August 2018, the Georgia Chapter was one of six recipients of the AAP Adolescent Vaccinations and Wellness Grant Program: Georgia, Louisiana, Maryland, North Carolina, Ohio, and Virginia. The overall goal of the program is for pediatricians to establish strategies to remind adolescents about receiving immunizations, to track patient immunization data, and to educate adolescents about the safety and importance of adolescent vaccines. This will be achieved through chapter level projects and programs designed to accomplish these goals and ultimately to improve adolescent immunization rates in their communities. ■

Breastfeeding News

Georgia has thirteen Baby Friendly Hospitals and 37 birthing hospitals that are working with the Department of Public Health 5 STAR Breastfeeding Initiative. In the past year we have provided 34 EPIC Breastfeeding programs to Georgia's hospitals. Hospitals have always encouraged mothers to breastfeed but now they are providing education, support and assistance with breastfeeding. The hospitals start with a policy and make sure that the staff is trained in the management of the breastfeeding dyad. Once a mother is to be discharged she is armed with a list of breastfeeding resources in her community. She has access to everything from a supportive physician or lactation consultant to a local breastfeeding support group. Research shows that most mothers do not end up breastfeeding for as long as they had intended, and the main reason is lack of support once she is discharged from the hospital.

If your local hospital has not had an EPIC Breastfeeding class for their staff please let them know about EPIC. Our programs are free and we also provide continuing education for the physicians, nurses and lactation consultants that attend. Please contact Arlene Toole, atoole@gaaap.org to request a program or go to our website www.gaepic.org to download an EPIC program request form. ■

Georgia Chapter partners with American Cancer Society - Southeast Region (ACS), and Georgia Cancer Control Consortium, for The Georgia HPV Health Systems Leadership Forum

On July 17th, Georgia Chapter members Terri McFadden, MD (Chapter President), Harry Keyserling, MD (Infectious Disease Chair), Noreen Dahill (Immunization Coordinator) and Cordia Starling EdD, MS, BSN, RN (EPIC® Immunization Program Director) participated in a half day fast-paced and action-oriented forum. The topics discussed were the current state of the HPV vaccination, the pivotal role that health systems can play, and practical strategies to increase your system's vaccination rates. The forum was also aligned with the new ACS mission of HPV Cancer Free. The goal is to have 80 percent of 13-year-old boys and girls in the U.S. fully vaccinated with HPV vaccine by 2026—20 years after introduction of the first HPV vaccine. The discussions have started, and the connections made at the forum are creating new and expanded ideas on how to increase HPV immunization rates. Event organizer Kelly Durden (Health Systems Manager, State-Based, ACS), after a long productive day summed it up best, "As I put my 2.5-year-old son to bed last night, it dawned on me the true impact that our new ACS campaign can have, in tandem with our amazing partners at the CDC, DPH, and AAP. In 2026, my son will be 10.5-years old. I can imagine the world that he and his generation could live in, if we deliver on our campaign goals." Let's keep the momentum moving forward!

Please contact the Immunization Coordinator, Noreen Dahill at ndahill@gaaap.org or 404-880-5094, if you have any immunization questions. ■





Chapter News & Updates

Have you requested an EPIC® Immunization Program for your office?

EPIC® is a physician and/or healthcare professional-led, peer-to-peer immunization education program designed for presentation to staff (provider, nurse, medical assistant, office manager, etc.) in a healthcare setting at your convenience. The program is free, offers CME and CNE contact hours for physicians and nurses, and provides a valuable resource box filled with useful immunization tools for your practice. The information provided is based on the evidenced-based recommendations of the CDC's Advisory Committee on Immunization Practices and contains the most recent data, guidelines, and standards regarding immunization.

Seven curriculums from 1-2 hours in length are available to meet your particular staff education needs. The topics include: Childhood, Adult, Adolescent, Combination, Women's Health; School, and Coding for Childhood Immunization focus. A new presentation specific to HPV will also be available this fall. Please schedule your presentation today!

For more information or to request an EPIC Immunization program, contact EPIC® staff: Cordia Starling, EdD, RN, Program Director at 404-881-5081 or Shanrita McClain, Program Coordinator at 404-881-5054 or visit the EPIC® website at: www.gaaap.org or www.gaepic.org. ■

Project LAUNCH Enters its Fifth Year in Muscogee County

Project LAUNCH, a five-year federal initiative from the Substance Abuse and Mental Health Administration (SAMHSA), seeks to promote the wellness of young children ages birth to age 8 by addressing the physical, social, emotional, cognitive, and behavioral aspects of their development. Referring to Project LAUNCH provides families with support, social emotional and developmental screenings, links to community and mental health resources as well as parent and professional training. Since Year 1 of Project LAUNCH, there have been

2,009 screenings completed on children in Muscogee County. These screenings included the ASQ-3, ASQ-SE, and CDQ. Also, through our efforts in physician outreach, 150+ children have been referred for mental health and community support services.

As Project LAUNCH heads into its 5th and last year in Muscogee County, the focus will shift to evaluation and developing a sustainability plan. We will be conducting in-person evaluations with the physicians who received Project LAUNCH Lunch & Learns in Year 3 and Year 4 to help determine the impact our in-office visits had on their screening and assessment practices. We will also collaborate with the local and state Project LAUNCH teams to assist in developing a sustainability plan for the Project LAUNCH efforts in Muscogee County after the grant period ends.

If you have any questions regarding Project LAUNCH, please contact Kathryn Autry, the Project LAUNCH Physician Outreach Coordinator, at kautry@gaaap.org or by phone (404)-881-5089. ■

Georgia Newborn Screening Updates

SMA Pilot - The Georgia Department of Public Health's Newborn Screening Spinal Muscular Atrophy (SMA) pilot is targeted to start on September 1st. While SMA results will not appear on lab reports mailed to physicians, the Emory Department of Human Genetics will be notified of positive screens. All abnormal screens will be reported to the physician listed on the dried blood spot screening card via phone and fax by the follow up program at Emory.

Additions to the Newborn Screening Panel – The Georgia Department of Public Health will be seeking approval from the Georgia Legislature to add screening for Pompeii, X-ALD, and MPS1 to the newborn screening panel. Screening for these conditions was previously piloted by the newborn screening program. ■

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Chapter News & Updates

Georgia Medicaid EPSDT Reminders & Updates

Georgia's Early Periodic Screening Diagnosis & Treatment has expanded the services reportable when providing preventative visits and non-preventative visits to children enrolled in Medicaid. A summary of those updates is included below, for full reporting information including appropriate diagnosis codes, place of service, and the modifier for catch-up visit screenings please refer to the EPSDT manual on GAMMIS:

- Autism Screening – The 96110 with the EP, UA modifier to report the use of the M-CHAT/R-F. As a reminder the 96110 without the UA modifier, is reportable for developmental screening using a standardized developmental screening tool at the 9, 18, and 30-month preventative visits.
- Brief Emotional/Behavioral Assessments - The 96127 with the EP modifier to report the use of the PHQ2 or

PHQ9, for depression screenings; and emotional/behavioral assessments conducted for other conditions, such as ADHD, suicidal risk, anxiety, eating disorders, etc.

- Health Risk Assessments – The 96160 with the EP modifier for annual tobacco, alcohol, or drug use assessment to report the use of CRAFFT.
- Maternal Depression Screening – The 96161 with the EP modifier can be reported at the by 1 month, 2-month, 4-month and 6-month as a caregiver-focused health risk assessment such as the PHQ2, PHQ9, and Edinburg.

If you have questions about these items for general public health or EPSDT, please contact Fozia Khan Eskew at the Chapter office at either feskew@gaaap.org or 404-881-5074. ■

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Nutrition Update Fall 2018



Jay Hochman, MD

Several important nutrition articles have been published recently which may be of interest to Georgia pediatricians.

1. VJ Flaherman et al. *J Pediatr* 2018; 196: 84-90. Background: using formulas for newborns during the birth hospitalization has been discouraged due to concerns that this will diminish the frequency/success of breastfeeding and undermine benefits of breastmilk on the intestinal microbiome. In addition, some have worried that if mothers perceived formula-feeding to be easier, that this could lower satisfaction with breastfeeding.

Yet, on the other side of the ledger, there are “about 80,000 newborns who require readmission after discharge” with the majority related to dehydration and hyperbilirubinemia.

Methods: 163 mother-infant pairs were randomly assigned to either early limited formula (ELF) along with breastfeeding or breastfeeding exclusively. ELF involved giving infants 10 mL of a hydrolysate formula with a feeding syringe after each breastfeeding until the onset of copious breast milk.

Key findings:

1. Breastfeeding rates at one month of age: 86.5% of ELF group and 89.7% of controls; 54.6% of ELF and 65.8% of controls were breastfeeding exclusively at 1 month of age.
2. Readmission occurred in 4 (4.8%) of control infants and none of the infants in the ELF cohort ($P=.06$)
3. Using a subset of 15 (8 with ELF), the authors did not identify significant changes in microbiome of ELF group compared with the exclusively fed group when examined at 1 week and 1 month (as well as baseline). Thus, this study shows that ELF is safe and does not appear to significantly increase breastfeeding cessation.
2. M Abu-El-Haija et al. *JPGN* 2018; 67: 131-43. This position paper on pancreatitis made 27 recommendations and indicated the quality of evidence supporting each recommendation. For pediatricians:
 - a. Children with mild acute pancreatitis should be started on a regular diet within 24 hours of diagnosis.
 - b. Children with recurrent pancreatitis should be fed a regular diet (not low fat) in between bouts of pancreatitis. Antioxidants and pancreatic enzymes are NOT recommended (except the latter are used in pancreatic insufficiency).
 - c. Regular specialist follow-up is likely helpful (at least yearly)

in those with recurrent pancreatitis or chronic pancreatitis to assess exocrine pancreatic function.

3. P Kumar et al. *JPGN* 2018; 67: 75-9. This study showed that fatty liver disease is common even in non-obese 12 to 18-year-olds using data from NHANES. Suspected NAFLD was defined by abnormal ALT (>25.8 U/L for boys and >22.1 U/L for girls) who did not have another explanation. Suspected NAFLD was present in 8% of lean adolescents in the U.S.
4. M Barroso et al. *Gastroenterol* 2018; 154: 2087-96. Higher adherence to a “prudent” diet which had a higher intake of vegetables, vegetable oils, pasta, and grains and low consumption of refined cereals and sweet beverages at 1 year of age was associated with lower odds of celiac autoimmunity at 6 years of age with an odds ratio of 0.67. This study indicates that diet plays a role in the development of celiac along with other diseases, but this likely involves a complex mix of components rather than a single toxic agent.
5. P Singh et al. *Clin Gastroenterol Hepatol* 2018; 16: 823-36. After a systemic review which selected 96 articles from a pool of 3843 published between 1991 through 2016, the authors determined a pooled global celiac disease prevalence of 1.4% in 275,818 individuals based on seroprevalence (positive TTG or EMA). Biopsy-confirmed celiac disease was noted in 0.7% in 138,792 individuals.
6. A Rodriguez-Palacios et al. *Inflamm Bowel Dis* 2018; 24: 1005-20. Editorial 1055-6 by B Chassaing and AT Gewirtz. In case you hear about Splenda risk from your patients, this highly-technical study in mice was titled, “The Artificial Sweetener Splenda Promotes Gut Proteobacteria, Dysbiosis, and Myeloperoxidase Reactivity in Crohn’s Disease-Like Ileitis.” It indicated that Splenda may alter the microbiome and increase susceptibility (in some populations) to inflammatory bowel disease. Thus, while understanding the factors which affect the microbiome are complex, don’t assume that nonabsorbed agents are harmless. ■

Jay Hochman, MD
Chair, Nutrition Committee
Georgia Chapter of AAP

Blog site: gutsandgrowth.wordpress.com



There is No Try



Robert Wiskind, MD, FAAP

In *The Empire Strikes Back* (1980), the sequel to *Star Wars*, Luke Skywalker travels to Dagobah in search of Yoda, the Jedi Master who will teach him the ways of the Force. Yoda tells Luke to focus his thoughts and energy, but Luke struggles at first. Yoda instructs him to “unlearn what you have learned” and Luke responds “All right, I’ll give it a try.” Yoda’s rebuke is “Do. Or do not. There is no try.” Meaning that Luke needs to commit fully or he will never succeed. When it comes to embracing technology in their practices, Pediatricians need to stop trying and worrying and simply DO IT to succeed.

In 2012 nearly 80% of office-based Pediatricians utilized an Electronic Medical Record (EMR). By now, those still clinging to paper charts are a small and shrinking minority. Compared to paper, electronic records have the obvious advantages of legibility, organization and accessibility.

Here are some of the common complaints I hear about EMRs and my counter arguments:

- I can’t see as many patients on the EMR as I could on paper. It may be true that patient volumes go down after converting to EMR, but with time those numbers come back up close to the pre-EMR level. More importantly, the reason EMR documentation takes longer is because so much more information is captured. This information is essential to providing better care on the patient and population level. For my patients with ADHD, I can see on a single screen a summary of all my notes on their medication management; on paper that required flipping back through dozens of pages looking for relevant notes. Recently, a Pediatric Endocrinologist working on better communication with PCPs in caring for kids with Diabetes asked me how many Type 1 Diabetics are followed in my practice. A simple query to my EMR gave him the answer in minutes; on paper, I had no way to answer that question other than trying to remember patient names and diagnoses.
- It takes too long to document a patient visit in the EMR. Yes, we capture more information in the EMR so it takes more time, but we want and need this documentation to

follow AAP clinical guidelines, meet insurance (HEDIS) requirements, justify level of service and demonstrate the value of the care we provide. Value-based care is the future of medicine and the main way that our country will control our skyrocketing expenditures on healthcare and create a system that provides care to ALL Americans. An EMR is essential to provide and demonstrate valuable care at the individual, practice and population level.

- EMRs are too expensive. Yes, EMRs are expensive and the cost doesn’t always correlate to value or return on investment.

Studies consistently show, however, that more efficient and profitable practices spend more on infrastructure and staff. In most cases, the cost of an EMR is outweighed by the benefit of better documentation, better access, better reimbursement and better care.

- My EMR is difficult to use and doesn’t adapt to my practice. Moving a practice to an EMR or converting from one EMR to another can be difficult and requires a lot of time, effort and patience. Like many big tasks, the more you do on the front end results in more benefits down the line. Taking the time to customize your EMR to fit your workflow is invaluable; after all, practices didn’t use blank pieces of paper for written records but took the time to construct documents that maximized documentation and information retrieval.

When looking to purchase an EMR, the ability to customize easily at the practice and individual level should be one of the most important criteria.

Later in *Empire*, Han Solo, chased by Imperial ships, intends to lose them in an asteroid field, but C-3PO informs him of the low probability of successfully navigating through the asteroids. Han interrupts, saying “Never tell me the odds!” I see a future of Pediatrics where all practices have fully implemented their EMRs and seamlessly share data with other practices and hospitals so that children get comprehensive care and we achieve true population health management. The odds that we achieve that goal may be long, but we won’t achieve it if we merely try. We must DO IT to continue serving our patients and families in the best way possible. ■

Robert Wiskind, MD, FAAP
Past President, Georgia AAP
Peachtree Park Pediatrics, Atlanta



Georgia Immunization Program Receives Two National Awards for Adolescent Immunization Coverage



The Centers for Disease Control and Prevention (CDC) honored the Georgia Immunization Program at the 48th annual National Immunization Conference, held this past spring in Atlanta, with the following two awards for outstanding performance:

- Healthy People 2020 Immunization Coverage Award Adolescents Aged 13-17 Years (for four vaccinations), 2016
- Most Improved Coverage among Adolescents 13 – 17 years Award (for four vaccinations), 2016

**Healthy People 2020 (HP2020)
provides science-based, 10-year
national goals and objectives for
improving the health of all Americans.**

Healthy People 2020 (HP2020) provides science-based, 10-year national goals and objectives for improving the health of all Americans. Both awards were granted based on results from the National Immunization Survey, which is a random telephone survey conducted by the CDC every year.

These awards indicate the State is doing an excellent job of immunizing its children and adolescents. According to Sheila Lovett, Immunization Program Director at the Georgia Department of Public Health, “Such success can be attributed to Georgia’s healthcare providers who are committed to making sure their patients receive the appropriate immunizations.”

Advisory Committee on Immunization Practices (ACIP) recommendations and state-mandated vaccination requirements for school entry have contributed as well. Georgia should be acknowledged and congratulated on the improvements made in the adolescent coverage rates in 2016.

(Chart provided below). Georgia is above national averages for HPV, Tdap and MCV4; however, the state is still below Healthy People 2020 goals for some vaccines.

National Immunization Survey–Teen (13 to 17 years), United States, 2016

Names	% Coverage
≥1 HPV Vaccination, both males and females – Age 13-17 years	
Georgia	67.3
United States	60.4
HPV Vaccination Up-To-Date, Males and Females – Age 13 to 17 years	
Georgia	45.6
United States	43.4
≥1 dose Tdap Vaccination - Age 13 to 17 years	
Georgia	92.8
United States	88.0
≥1 dose MenACWY Vaccination – Age 13 to 17 years	
Georgia	91.4
United States	82.2

In Georgia, two studies are conducted annually to further assess infant and adolescent coverage rates. The first is the Georgia Immunization Study (2016) which employs a retrospective cohort research design to determine the up-to-date (UTD) immunization rate for 2-year old children born in the State of Georgia.

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The study looks at immunization rates based on ACIP recommendations of 4 DtaP, 3 Polio, 1 MMR, 3 Hib, 3 Hepatitis B, 1 Varicella, and 4 PCV (4:3:1:3:3:1:4). The 2016 statewide UTD immunization rate by 24 months was 82.1 percent, down from 82.7 in 2015.

Vaccine or Series	Coverage or Goal	Georgia Coverage
4 DTaP	90%	84%
3 Hib	90%	91%
1 MMR	90%	91%
3 Hep B	90%	95%
3 Polio	90%	95%
1 Varicella	90%	93%
4 PCV4	90%	91%
4313314 Series	80%	82%

Although Georgia is above goal for total series completion, DTaP coverage is lagging below the goal by 6%, which perhaps explains the slight drop in total series completion from 2015 to 2016. Thus, ensuring the DTaP series has been covered should be an area of focus for improvement in infants and toddlers.

The second study is the Georgia Adolescent Immunization Study (GAIS2017) which ascertains vaccine coverage rates for 7th grade children. The percentage of 7th graders UTD, which included having at least 3 doses of Hepatitis B, 2 doses of MMR, 2 doses of Varicella, 1 dose of Tdap, and 1 dose of MCV4 vaccines was 94%.

Vaccine or Series	Coverage Goal (13 to 18 Years)	Georgia Coverage*
1 Tdap	80%	97%
1 MCV4	80%	96%
3 HPV (female only)	80%	23%**
2 Varicella	90%	97%

* This is not a direct comparison. HP2020 Goals are based on females aged 13 to 18, while the GIAS17 looks at 7th grader males and females.

**HPV coverage was assessed using the 2016 ACIP recommendations of a 2 or 3-dose schedule based on the age of the recipient.

As shown by the table above, though mandated immunization rates for adolescents are in the mid- to high-nineties, the recommended HPV vaccine series completion rate is a dismal 23%. Therefore, provision of the first dose and completion of the HPV series should be another area of focus for improvement.

The State as well as the American Cancer Society have responded to these findings by initiating campaigns to assist healthcare providers with strategies to increase HPV immunization rates. The strategies include bundling HPV with the mandated immunizations required

of 7th graders and using a strong healthcare provider recommendation followed by practice reminder/recalls.

According to Harry Keyserling, MD, Infectious Disease Chair for the Georgia Chapter, American Academy of Pediatrics, “We

are doing an excellent job of immunizing our patients. All practices should review office protocols to optimize identification and recall of children that are behind in their schedules. We must remain vigilant in maintaining high immunization coverage rates.” Immunization has proven to be the most efficient and effective means of maintaining overall health, reducing disease-associated healthcare expenses, and protecting children and communities against vaccine preventable diseases. For these reasons, immunization should remain at the forefront of our efforts to meet the mission of the Chapter to improve the health and welfare of all the infants, children, and adolescents in the state. ■

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- Noreen Dahill, BS
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Acute Flaccid Myelitis (AFM) is Reportable in Georgia

Acute Flaccid Myelitis (AFM) was recently added to the notifiable disease/condition reporting list in Georgia, and is reportable to the Georgia Department of Public Health (DPH) within seven days.

AFM, a form of acute flaccid paralysis (AFP), is characterized by the acute onset of weakness absent signs of spasticity or other signs indicating a central nervous system disorder¹. Other types of AFP include Guillain-Barre syndrome, toxic neuropathy, and muscle disorders [1]. Additional symptoms of AFM can include: facial droop/weakness, difficulty moving the eyes, drooping eyelids, or difficulty with swallowing or slurred speech.² There is no known single cause of AFM, and causes can include viral infections, environmental toxins, and genetic disorders.² Viruses associated with AFM include: polio and non-polio enteroviruses, West Nile virus, Japanese encephalitis virus, Saint Louis encephalitis virus, herpesviruses, and adenoviruses.² Sometimes, despite extensive laboratory testing, the cause of a patient's AFM cannot be identified.²

The Centers for Disease Control and Prevention (CDC) has requested states provide information on suspect AFM cases since the fall of 2014, when clusters of pediatric cases with AFM were identified in Colorado and Kansas.³ At the same time, there was an ongoing nationwide outbreak of Enterovirus D68 (EV-D68), though not enough evidence exists to determine any causal relationship between the EV-D68 outbreak and AFM cases occurring at that time period.^{3,4} In fall 2014, a CDC health advisory was issued requesting that cases consistent with AFP in children younger than 21 years old be reported and specimens submitted for testing.³

From August 2014 to December 2014, CDC verified reports of 120 children in 34 states who developed AFM [4]. In 2015 there were 22 confirmed AFM cases reported from 17 states.⁴ In 2016 there were 149 confirmed AFM cases reported from 39 states.⁴ In 2017,

33 confirmed AFM cases were reported to CDC, and eight (8) confirmed cases have been reported from January 2018 -June 2018.⁴ There is no known single etiology or epidemiologic cause for the AFM cases reported in the US since 2014.⁴ Reported AFM cases typically required extensive medical care and diagnostic testing.^{2,5-6} In one review of published clinical articles on AFM from January 1, 2012- July 1, 2016, the authors found that nearly all reported cases were hospitalized, and recovery outcomes were not consistent among cases.⁷ A clinical study conducted by the Children's Hospital of Colorado following a cohort of 12 AFM cases with onset in 2014 reported that at one year post-illness onset, most cases (60%) did not display full neurologic recovery.⁸

There is no known single cause of AFM, and causes can include viral infections, environmental toxins, and genetic disorders.²

Since August 2014, nine⁹ confirmed or probable cases of AFM have been reported to DPH. Establishing routine surveillance for AFM in Georgia is necessary

to determine the burden of this syndrome and establish baseline incidence. Suspect cases of AFM reportable to DPH are classified according to the following criteria:

Clinical Criteria:

An illness with onset of acute flaccid limb weakness

Confirmed case:

- Clinically compatible case AND
- MRI showing spinal cord lesion largely restricted to gray matter and spanning one or more spinal segments

Probable case:

- Clinically compatible case AND
- CSF showing pleocytosis (white blood cell count >5 cells / mm³).

Continued on next page.

Acute Flaccid Myelitis (AFM) is Reportable in Georgia

If you suspect a case of AFM in one of your patients, notify DPH as soon as possible by calling 404-657-2588 and asking for Carolyn Adam, the Vaccine Preventable Disease Surveillance Coordinator. Specimens are recommended for collection as soon as possible after onset of limb weakness and include⁹:

- Cerebrospinal Fluid
- Blood serum
- Respiratory specimen
 - o A nasopharyngeal (NP) swab or nasal + oropharyngeal (OP) swab
- Stool
 - o Two stool specimens collected as soon after onset of limb weakness as possible and separated by 24 hours

For questions about AFM reporting in Georgia, please contact Carolyn Adam at 404-657-2588 or at carolyn.adam@dph.ga.gov. ■

Carolyn M. Adam, MPH

**Vaccine-Preventable Disease Surveillance Coordinator
Georgia Department of Public Health**

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Psychiatric Co-morbidities of Eating Disorders



Anna Tanner, MD, FAAP, FSAHM, CEDS

One of the most challenging clinical situations faced by a medical provider can be discerning when an eating disorder is present if accompanied by a co-morbid psychiatric disorder. At times, patients will struggle overtly with weight or eating issues in the face of known mental illnesses including anxiety, depression, obsessive compulsive disorder (OCD), and substance use. In fact, diagnostic criteria for depression include changes in appetite, eating, and weight. Individuals with OCD or anxiety may limit their food intake or binge eat in response to their emotional and physiologic states. Substance use can also alter appetite leading to changes in eating and weight. When first getting to know a patient, symptom overlap may make it difficult for a medical practitioner to ascertain if changes in weight or issues with eating are secondary to such psychiatric diagnoses, or if the patient has a primary eating disorder with comorbid diagnoses.

Individuals with OCD or anxiety may limit their food intake or binge eat in response to their emotional and physiologic states. Substance use can also alter appetite leading to changes in eating and weight.

The known comorbidity rates of eating disorders and other mental health concerns are very high. In a national study of adolescents aged 13-18, more than 50% of adolescents diagnosed with an eating disorder met criteria for another mental health diagnosis (Swanson, et al., 2011). Review of a large clinical database in Sweden showed that more than 70% of adults diagnosed with an eating disorder had comorbid mental health concerns (Ulfvebrand, et al., 2015). Similarly, the prevalence of substance and alcohol use disorders is greater in individuals diagnosed with eating disorders than in nonclinical populations (Hudson, et al., 2007; Kessler et al., 2013; Root et al., 2010). High rates of self-harm, borderline personality disorder, PTSD, and ADHD are also seen in patients with eating disorders.

It can be helpful for the non-psychiatric medical provider to remember that primary eating disorders are ego states. Patients with anorexia nervosa have an ego-syntonic illness. In very simple terms, for these patients, the

eating disorder is part of who they are, and they cannot comprehend the need to change their behavior. Patients with bulimia nervosa or binge eating disorder have an ego-dystonic disorder. These patients view their illness as problematic and they often have great shame about their behavior. In both instances, when presenting to a medical provider, the patient will not disclose their eating disorder thoughts but will seek help for medical concerns caused by the eating disorder behaviors.

Initially, it may be challenging for a medical provider to identify the treatment needs of a person struggling with issues around eating, weight, and mental health. A multi-disciplinary team evaluation can be helpful. Often, family members or mental health providers become concerned that an eating disorder is present when a patient is in appropriate care for their presenting mental health concerns, but not making progress in improving weight or medical complications. Many patients with eating disorders have predated mental health issues but the weight or eating concerns are new, often a sign of co-occurring illnesses.

In some instances, weight restoration may be necessary before co-morbid diagnoses can be clarified. In a hallmark study of the physical and psychological impact of starvation, Ancel Keys showed that starvation dramatically alters mood and personality (Keys, et al., 1950). Patients who are starving can be irritable and have obsessional thinking about food and weight. For some patients, thoughts and depression may improve with nutritional rehabilitation. For other patients, however, weight restoration may unmask severe accompanying depression and even suicidality. As some individuals recover from an eating disorder, the loss of behaviors once used to manage distress can lead to increases in other behaviors such as self-harming and substance use.

How do we help these complicated patients? First, assess for suicidality and self-harm at every visit. Never forget

Continued on next page.

Psychiatric Co-morbidities of Eating Disorders

Continued from previous page.

that suicide is still a major cause of death in patients with eating disorders. Second, monitor and treat all medical complications, especially those related to starvation. For the starving brain, it does not matter which diagnosis is primary. The starving patient must be refed and medically stabilized before medications can be expected to work and before the patient is well enough to actively engage in therapy. For patients with a history of substance use, ongoing supervision and frequent drug testing allow providers to monitor for use which might impair recovery during treatment. Comorbid mental health issues must be identified, addressed, and monitored in parallel to treatment for the eating disorder. ■

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Parents Can Now Access Autism Screening Directly



Ami Klin, PhD



Jennifer Stapel-Wax, PsyD

Screening and detection of developmental delays in social-communication skills in infants and toddlers is the primary way to trigger a referral to an autism center. The American Academy of Pediatrics (AAP) recommends screening of all children for Autism Spectrum Disorder (ASD) at 18 and 24 months of age; often the early signs can be seen prior to that on regularly administered broad developmental screenings. Pediatricians, therefore, are a critically important connection for infant/toddlers and their parents/caregivers.

The American Academy of Pediatrics (AAP) recommends screening of all children for Autism Spectrum Disorder (ASD) at 18 and 24 months of age;

The Marcus Autism Center has been conducting the NIH funded research study “Mobilizing Community Systems to Engage Families in Early ASD Detection and Intervention” for the past 3 ½ years. The goal of the study is early identification of ASD through the use of the web-based Early Screening for Autism and Social-Communication Disorders (Smart ESAC) tool. We have successfully engaged community members, including clinicians from primary care, and educators and clinicians from Early Head Start, Healthy Start and faith-based programs and organizations.

We are excited to let you know that the Smart ESAC screening is now available on the First Words Project website (www.first-wordsproject.com). This website provides information and resources to parents about how to promote their child’s social-communication development.

By accessing the website, parents now have the opportunity to take the Smart ESAC screening at a time and location that is convenient for them. THE PARENT SIMPLY CLICKS THE “SCREEN MY CHILD” BUTTON AND THE SCREENING WILL BE SENT TO THE PARENT’S EMAIL OR TEXT-ENABLED PHONE NUMBER. Once the screening is complete, personnel from Marcus will schedule a phone appointment to discuss screening results and make recommendations.

Children between the ages of 9 and 18 months who have an ASD-positive screening result and live within a 50 mile radius of Atlanta will be offered a no-cost

diagnostic evaluation at Marcus at 18, 24 and possibly 36 months. There is no waiting list for the evaluation. Parents will be paid \$50 to cover the cost of travel to Marcus for the assessment. Children with an ASD-positive screening

result living outside of the 50 mile radius will receive screening results through the First Words Project.

Screenings will be conducted until Dec. 31, 2018 and evaluations will be administered until the end of the study on June 30, 2019.

Screen My Child

If your child is between 9 and 18 months, we invite you to participate in our research and have your child screened with the Smart ESAC.

Find out how at

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CHECK OUT OUR GROWTH CHARTS

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Ami Klin, PhD

Director, Marcus Autism Center, Children’s Healthcare of Atlanta

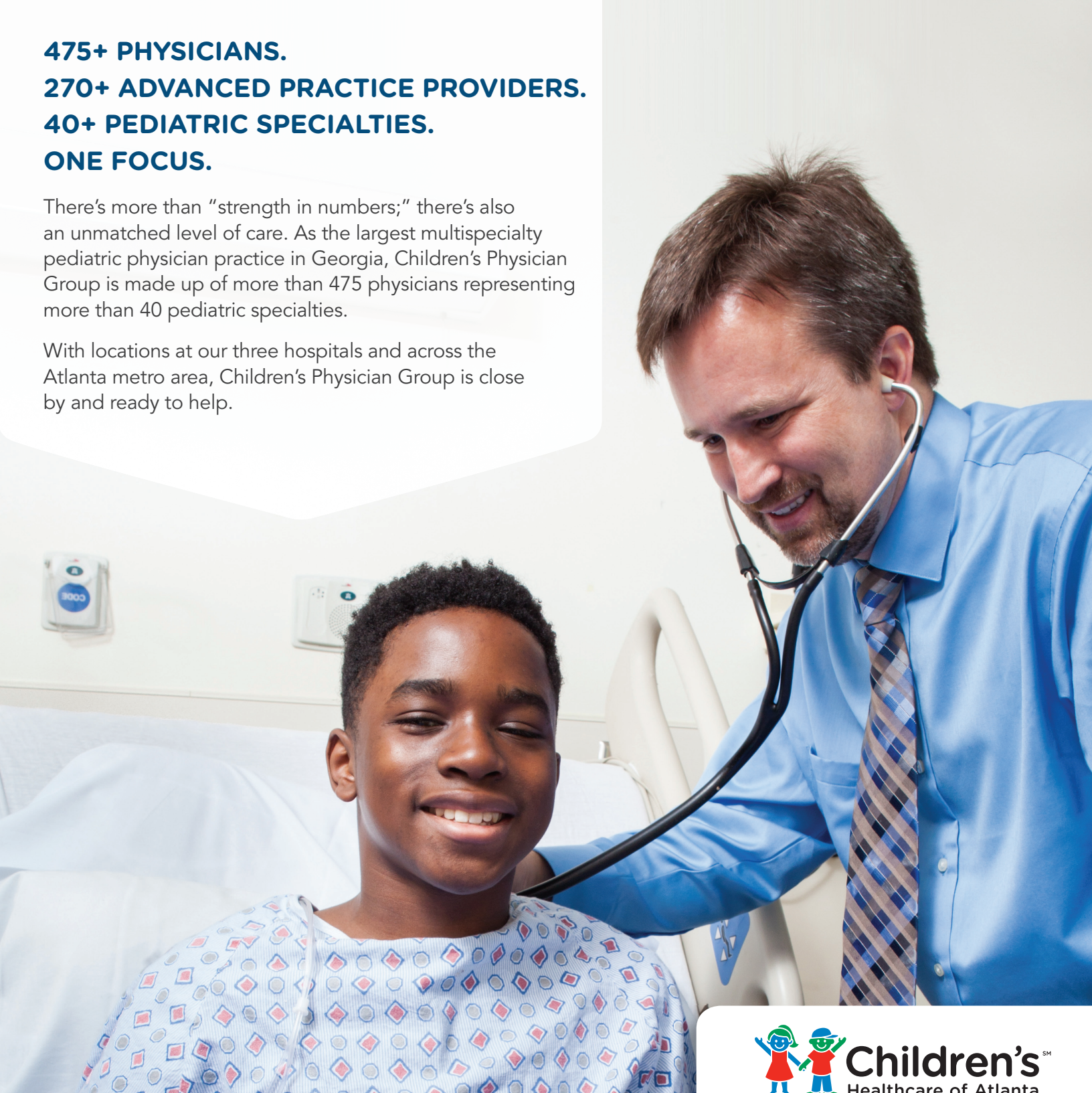
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Medical Nutrition Therapy for Prevention Program



Mary Lauren Salvatore
MPH, CHES



Rani H. Singh
PhD, RD, LD

The Medical Nutrition Therapy for Prevention (MNT4P) program is a Georgia initiative that supports long-term follow-up and comprehensive nutrition therapy for patients living with inherited metabolic disorders. MNT4P is funded by the Georgia Department of Public Health and housed within the Department of Human Genetics at Emory University School of Medicine. The program was established in 2016 and is led by Rani Singh, PhD, RD, LD, Director of the Genetic Metabolic Nutrition Program at Emory, the only location where metabolic patients are treated in Georgia. Inherited metabolic disorders are primarily diagnosed at birth through newborn screening and require lifelong treatment with nutrition therapy. The impetus for developing MNT4P stems from the widespread obstacle of inadequate insurance coverage for nutrition therapy and related medically necessary supplies and services. Georgia is one of several states that lack a mandate for coverage of medical foods (specialized formulas, low-protein modified foods), the primary treatment for these disorders.

MNT4P is a multi-disciplinary team that provides holistic support and navigation of healthcare access to patients in Georgia who are experiencing coverage issues related to their treatment. The program has created a network of stakeholders from different areas of this community to identify sustainable solutions for patients and prevent interruptions in treatment. As mentioned above, inadequate insurance coverage is a significant contributing factor to inconsistent adherence to medical foods treatment. Without access to medical foods on the recommended and prescribed basis, patients can experience problems with executive function, day-to-day skills, and in some cases, death. Medical foods are typically dispensed on a monthly basis by durable medical equipment companies (DME), and lack of appropriate insurance coverage can leave patients empty-handed and with unmanageable bills.

In the past two years of the MNT4P program, we have seen that the majority of nearly 300 patients we have served were simply “underinsured.” Fifty-five percent of the patients who required some type of service related to nutrition therapy through MNT4P had commercial insurance, as opposed to 39% with Medicaid. Of the patients receiving insurance through Medicaid, those under age 21 were likely to have access to medical foods either through Georgia WIC (Age 0-5) or a DME. Patients experiencing denials with commercial insurance often had plan exclusions for medical foods, experienced a billing discrepancy, or had unmanageably high deductibles. MNT4P contracts with an insurance navigator who specializes in billing and reimbursement

for medical foods to assist in these cases. The contractor has provided services to approximately 30 of our patients in the past year to work towards overcoming these issues, as well as navigating the Marketplace. Patients age out of Medicaid coverage for medical foods at age 21, which is a Georgia Medicaid policy. These patients may have access to coverage through Marketplace insurance plans/managed care organizations, but they often require a monthly premium and small deductible. Regardless of how the issue arises, MNT4P is able to bridge the patient with the prescribed medical food until a solution is identified.

Connecting with patients through MNT4P has revealed multiple obstacles in addition to medical foods coverage. These include lack of access to low-protein modified foods, which are specially manufactured foods that have been modified to have minimal protein content. Low-protein modified foods are supplemental to the diet of patients whose disorders are characterized by inadequate protein metabolism, such as phenylketonuria (PKU) and maple syrup urine disease (MSUD). When necessary, MNT4P provides a monthly allowance of these foods to patients who may be struggling to meet their daily nutrition needs. The second notable obstacle is the lack of access to appropriate monitoring services for patients with PKU or MSUD, and who may be (or are interested in becoming) pregnant. Close monitoring during pregnancy is imperative for patients with PKU, as inability to

maintain levels within treatment range can result in Maternal PKU syndrome, with effects comparable to fetal alcohol syndrome. Most importantly, immediate intervention by counseling and access to necessary supplies for these patients contributes to optimal birth outcomes.

MNT4P is accessible to all patients living with inherited metabolic disorders in Georgia, regardless of age, insurance, or income status. We prefer that patients have been seen in the Emory Genetics Clinic within the past year, but if not, our team can assist the patient in returning to clinic and connecting them to resources as needed. To apply for services through MNT4P, patients may complete an application online at <https://mnt4p.org/how-to-apply/>. To refer a patient to MNT4P and/or request additional information, please contact the project manager, Mary Lauren Salvatore at mlsalva@emory.edu / 404-778-8527. ■

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MNT4P is a multi-disciplinary team that provides holistic support and navigation of healthcare access to patients in Georgia who are experiencing coverage issues related to their treatment.



Have you ever thought about medical missions, but just didn't know where to start?



David R. Sprayberry, M.D., F.A.A.P.

The desire to participate in medical missions is one of the reasons I became a pediatrician. As a young physician with a growing family and significant expenses, however, it was several years after residency before my first experience in medical missions became a reality. I had previous experience in developing nations, but not in medical missions. In medical school, I was fascinated by tropical diseases and envisioned myself traveling the world to treat them. When my first opportunity presented itself, the idea of helping at a hospital in east Africa was quite exciting. I knew I needed some preparation, but I wasn't sure what. I contacted the hospital to try to find out what my responsibilities would be. I received some general answers, but few specifics. I sought out a medical missions CME, which was terrific. I learned a lot, but unfortunately most of what I learned was not useful on my upcoming trip.

Upon arrival at the hospital complex, my family and I settled into the apartment provided. I prepared to meet my contact at the hospital the next morning. I still did not know how I would be serving, but I was excited, and quite a bit nervous, to get started. As I toured the hospital with the physician who would help me get my feet wet, I began to realize I was not prepared for what I was going to be doing and I might be in over my head. I learned I was to supervise the family medicine residents who were rotating on the pediatric ward.

Okay, I know inpatient pediatrics. I've got this. Wait, what is this medicine here? Never heard of it. I have no idea how to dose it. Is there no Rocephin here? What about D5 1/4 NS? No? What can I use for IV fluids? Hmm, I guess I have some learning to do.

Next we toured the "nursery". Why is nursery in quotes? Well, this nursery is really a NICU without ventilators. There are, however, 2 ventilators elsewhere in the hospital that can be used with babies if needed. At least I'm only helping in the nursery and I'm not in charge. I dutifully learn not just what settings might be used on these ventilators, but also how to connect all the cords

All over the world, our knowledge and skills are in demand, even if only for a few weeks at a time.

and tubes, "just in case" I am on call and need to intubate and ventilate someone or in case one ventilator breaks and I need to switch them out.



Hold on a second, I might have to be in charge of the nursery some? Gulp. All right, don't worry David, surely nothing like that will happen while you are on call.

Sure enough, one week later the physician in charge of the nursery had to suddenly leave the country for a while. Guess who is now in charge of both pediatrics and the nursery for the next 3 weeks. That's right, yours truly. Doh! Okay, I can do this. What are the chances I'll have to intubate or ventilate someone? By now, I'm sure you are predicting I did have to go to the hospital in the middle of the night to deal with ventilators. One ventilator stopped working so I had to get someone to bag the baby while I set up a new one.

Over the 3 1/2 weeks I was there, I faced some difficult and sometimes terrifying situations. I performed procedures I had not performed since my NICU rotations. I treated illnesses I had never treated before. I was challenged as much or more than I ever was in residency. So, what did I learn from all this?

First, there is a huge need for our services in resource-limited settings. All over the world, our knowledge and skills are in demand, even if only for a few weeks at a time. Second, we pediatricians are capable of doing so much more than we are allowed to do in our daily practices here in the U.S. Let's use those skills! Third, sharing information about our medical missions experiences is extremely valuable to those who will participate in future missions.

I am greatly pleased that the Georgia Chapter has created the Section on Medical Missions. My desire for the Section is to see pediatricians share their experiences abroad so we can prepare each other for upcoming opportunities and so we may encourage each other to use our talents and our time to serve those who need us most. Please join the Section on Medical Missions if you have medical missions experience or interest and wish to share your talents, skills, and experience with the world.

If you would like to join the Section on Medical Missions, please contact Kathryn Autry at the Chapter office at kautry@gaaap.org or (404)-881-5089. ■

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Update on the Management of Acute Pancreatitis in Children



A. Jay Freeman, MD, MSc

In January 2018, the North American Society for Pediatric Gastroenterology, Hepatology and Nutrition (NASPGHAN) published the first pediatric-specific guidelines on the diagnosis and management of acute pancreatitis (AP). Entitled “Management of Acute Pancreatitis in the Pediatric Population: A Clinical Report From the North American Society for Pediatric Gastroenterology, Hepatology and Nutrition Pancreas Committee,” this manuscript provides 24 recommendations, some of which represent significant change from the previous “standard of care” concerning management of AP in children.¹

The management of pancreatic disorders in children has historically been based on adult guidelines due to low incidence rates and lack of standard definitions. Through the International Study group of Pediatric Pancreatitis:

In search for a cure (INSPPIRE) consortium, we have become aware of the increasing incidence of AP among children (~1/10,000) and now have pediatric-specific definitions in which to standardize both research and clinical care.^{2,3}

While recommendations set forth by the authors range from initial workup to indications for surgery and advanced endoscopy, those related to the management of AP within the initial 48-72 hours of admission are likely to be the most impactful. Common questions related to fluid, pain, and nutritional management are addressed, although they largely represent expert opinion, which highlights the lack of research in the field.

Fluid resuscitation remains an integral component of care for children with AP. Although Lactated Ringer’s (LR) solution has become a preferred fluid choice in many adult treatment algorithms, data in pediatrics is lacking and only aggressive fluid hydration at 1.5-2x maintenance with a crystalloid fluid (normal saline or LR) can be recommended at this time. Close monitoring of vitals, urine output and blood urea nitrogen (BUN) should be performed to monitor for theoretical side effects of aggressive hydration and inflammatory-mediated third-spacing, including pulmonary or cardiac effusions, as well as acute kidney injury.

The use of morphine and other narcotics is typically necessary during an episode of AP. Given the risk of addiction, however, there is concern for utilizing these medications as

the first-line pain agent. Narcotics should only be considered in those patients who have failed to respond to acetaminophen or NSAIDs, or if the provider anticipates a response to these medications is unlikely. Additionally, if available, a low threshold should be maintained to engage an acute pain specialist in order to optimize pain management and limit long-term risk of dependence.

In the guidelines, providers will find updated recommendations for the timing and type of nutrition to be provided during AP. Maintaining a patient on fluids without enteral nutrition is no longer recommended. Data suggests that early enteral nutrition may aid in dampening the inflammatory response in AP, regardless of disease severity. Resuming oral/enteral nutrition within 48-72 hours, therefore, should be considered the standard of care, particularly in

mild AP. Furthermore, there is no data to suggest that a low-fat diet is of benefit in pediatric AP unless an underlying etiology of hypertriglyceridemia is present, and may have a negative impact on growth and puberty.

Unless other factors such as hypertriglyceridemia or obesity is present, patients with AP should be provided a regular diet for age.

Other considerations addressed include antibiotics, antioxidants, probiotics, and surgery/advanced endoscopy. In short, antibiotics in the absence of a documented infection have not been found to be of benefit in children or adults. A lack of data limits the ability to make recommendations regarding antioxidants as standard therapy. High-quality data from adults suggests that probiotics may increase mortality rates and, therefore, are not recommended during AP. The role of surgery and advanced endoscopy in AP is limited and must be determined on a case-by-case basis, preferably at an experienced pediatric pancreas center.

The NASPGHAN Pancreas Committee guidelines represent a much needed update on the care for children with AP. Even mild cases of AP should be treated at a facility with pediatric specialists given the possible complications associated with the systemic inflammatory response, such as pleural effusions and acute kidney injury. For patients with more severe disease or in which surgery/advanced

Even mild cases of AP should be treated at a facility with pediatric specialists given the possible complications associated with the systemic inflammatory response, such as pleural effusions and acute kidney injury.

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Update on the Management of Acute Pancreatitis in Children

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endoscopy is considered, patients should be cared for at a center with advanced pancreatic expertise. The Advanced Pancreatic Care Program at Children's Healthcare of Atlanta is a multi-specialty program, the only National Pancreas Foundation recognized center in the state for children or adults. It is available for consultation or referral. For urgent inpatient referrals please contact 404-785-7778. For potential referrals please email us at pancreas@choa.org or visit our website at www.choa.org/pancreas. ■

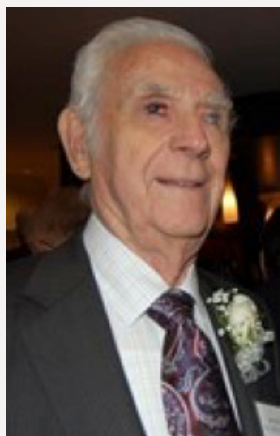
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References:

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In Memoriam



Jerome Berman, MD

Jerome Berman, MD, 93, of Atlanta, died May 31, 2018. He was born in Atlanta, Georgia and received his B.S. degree from Emory University and his M.D. degree from the Emory University School of Medicine. He completed his internship at Beth Israel Hospital in New York City and his pediatric residency at Grady Memorial Hospital in Atlanta. He began a solo pediatric practice in Sandy Springs, then an undeveloped area. His thriving pediatric practice grew as he added partners as he tended to the medical needs of many Atlanta children. He served on the Executive Committee of the Georgia AAP. He also served as chairman of the pediatrics section of Northside Hospital and conducted sick and well-baby clinics at Fulton County health centers. After 33 years, he ended his pediatric practice in 1982 when he

became blind. He faced the challenge of blindness with the assistance of the Center for the Visually Impaired in Atlanta that taught him how to adapt to his new circumstances. He took on this challenge and in 1989 received his Master of Public Health degree from the Emory University School of Public Health, the first blind student to achieve that degree. With the Center for the Visually Impaired and his friend Stanley Friedman he founded the Babies Early Growth Intervention Network (BEGIN) program in 1985 that brightens the future for the state's blind children and their families by providing an early intervention program for visually impaired pre-schoolers in the Southeastern United States. He served as a member of the Center for the Visually Impaired Board of Trustees from 1993-2002. He received a Special Award of Merit from the Chapter for his service to the children of Georgia. He is survived by his three daughters, and his two grandchildren and his sister. He is predeceased by his wife Betty Green Berman. ■



Georgia Chapter

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Looking Ahead:



- **October 18, 2018**
Georgia Pediatric Nurses & Practice Managers Association Fall Meeting
Georgia International Convention Center, College Park
- **November 4, 2018, 5-6pm**
Georgia AAP Reception at AAP NCE
Hyatt Regency Orlando, Orlando, FL

- **February 13, 2018**
Legislative Day at the Capitol
State Capitol, Atlanta
- **June 12-15, 2019**
Pediatrics by the Sea Summer CME Meeting
The Ritz Carlton, Amelia Island, FL

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Visit the Chapter Website for details on these Chapter events. www.GAaap.org
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