



The GEORGIA Pediatrician

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

President's Letter

Helping our Patients Build Resilience



Terri McFadden, MD

He seemed like a typical teenager. He was smart, respectful, and funny. I always looked forward to his visits, as I could count on a witty response to my questions about school or friends or romantic interests. He was finishing his junior year and starting to think about colleges. He enjoyed music, hanging out with his friends, and family gatherings. When I learned of

his suicide attempt, I was stunned. Although, his attempt had been thwarted, I still wondered what I had missed. He bore no obvious signs of the hopelessness, anxiety or depression that we often associate with teens on the brink of suicide. Did he lead a secret life that he hadn't wanted to share with me?

Had he been bullied at school by classmates or perhaps online? Was he struggling with an addiction? Had he been exposed to adverse childhood experiences (ACEs) or other trauma? Was he suffering from the psychological stress that comes from worrying about mass school shootings? Rather than a mass shooting, was he a victim of the steady drip of daily gun violence which has become ubiquitous in many communities? Was he experiencing the sense of sadness that can come from incessant social media exposure—where everyone is living their best life and no one ever has a bad day? Whatever the cause, he felt driven to end his life.

Of the many conditions that we manage as pediatricians,

behavioral health issues are among the most difficult and overwhelming. While a suicide attempt gets our attention, it is important to remember that suicide is only the deadly tip of this very troubling iceberg. Every day, thousands of children and adolescents deal with mental and behavioral health disorders. The question for us as pediatricians is "How can we be a part of the solution?"

Problems with mental health often start early in life, with half beginning by age 14. Nearly one in seven children aged 2 to 8 years has a mental, behavioral, or developmental disorder; and among those aged 9 to 17 years, as many as one in five may have a diagnosable psychiatric disorder.

It is not surprising that so many of us struggle to find appropriate behavioral health services of any kind for our patients...

Effective treatments exist, but unfortunately, less than half of adolescents with psychiatric disorders receive any kind of treatment. When left untreated, mental health disorders can lead to serious consequences including suicide. Regrettably, suicide has become the second

leading cause of death for 15- to 24-year-olds, and in 2013 and 2014, children ages 10 to 14 were more likely to die from suicide than in a motor vehicle crash. Despite the high prevalence of behavioral and mental health disorders among our children, according to DHHS data, not a single state in the US has an adequate supply of child psychiatrists, and 43 states have a severe shortage. It is not surprising that so many of us struggle to find appropriate behavioral health services of any kind for our patients and their families. The pediatrician may be the only health professional available to families as they search for answers, yet only 1 in 3 of us report that we have had enough training to manage these conditions effectively. We also struggle to find resources in

Continued on next page.

Helping our Patients Build Resilience

Continued from previous page.

our communities. Further, for many children, behavioral health problems may result from psychological trauma or other adversity and are difficult to diagnose and treat, especially for young children. Treating these children frequently requires treating the parents as well, and most of us have even fewer resources to obtain care for parents. What is a busy pediatrician to do?

The AAP mental health toolkit provides valuable resources and a structure for caring for our patients within the medical home.

Partnerships are an essential strategy according to the Milbank Memorial Fund. Options for effective partnerships include the gold standard of behavioral health integration, allowing for behavioral health specialists to practice in primary care sites and remove barriers of stigma and access. While this practice option may feel out of reach for many of us, additional options include telemedicine and other forms of consultation with child psychiatrists. Some have used school-based services to access health care, especially in rural or isolated areas. As pediatricians, we can also consider receiving additional behavioral health training through CME and other offerings. The AAP mental health toolkit provides valuable resources and a structure for caring for our patients within the medical home. Although only a part of the answer, these activities may provide a starting point for learning more about screening, treatment and linkages for patients with the most common diagnoses.

Regardless of our ability to manage behavioral health disorders, we all have an important role in promoting mental health in our patients, just as we promote physical health. One approach is to promote resilience--being able to recover from difficulties, change, or challenging life situations. Resilient children tend to be interested in school, dedicated to learning, and hopeful about the future. Mental health professionals speak about risk and protective factors as the key to understanding resilience. Risk and protective factors are characteristics of individuals, their families and their communities or environments that either increase (protective factors) or decrease (risk factors) the likelihood that a young person will be resilient. The protective forces that allow us to recover after difficult times are the same ones that prepare us to thrive in the best of times. As we partner with parents, consider a framework describing the

characteristics that foster resilience in our children. It was first published by the American Academy of Pediatrics in 2006 and refers to the Seven C's.

Confidence

believing in themselves that they will ultimately succeed.

Competence

possessing real skill sets to be able to navigate the world, including communication, self-advocacy, and academic skills.

Connection

having human connection allows celebration during joyous times and recovery during challenging times.

Character

having strong core values leads to the best sense of self and the most secure and healthy relationships.

Contribution

having a sense of meaning and purpose in their lives and learn firsthand of the joy of giving.

Coping

learning to deal with the uncomfortable reality of stress as a part of life in a way that is positive rather than negative

Control

knowing that actions matter; without a sense of control, there is no hope.

Helping our patients and families to both build resilience and attain optimal mental health may feel like a daunting task. Yet, if we approach this undertaking as we have the other significant pediatric issues of our time, we can watch our patients flourish. We will need to be both skilled clinicians and tireless advocates as we go forward. Join us as we advocate for a behavioral health system of care that prioritizes behavioral health workforce, strengthens the medical home, reimburses behavioral health services appropriately, supports families in their efforts to create nurturing environments, and creates a culture of wellness and resilience in our state. Often our biggest challenges lead to our greatest sense of accomplishment. Stay engaged!



Terri McFadden, MD



Nutrition Update Spring-Summer 2019



Jay Hochman, MD

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

1. Low sugar diet effective for fatty liver disease

–**JB Schwimmer et al. (JAMA. 2019;321(3):256-265)** examined the beneficial effects of a low free sugar diet for Nonalcoholic Fatty Liver Disease (NAFLD) in adolescent boys. Key findings: In 40 adolescents, followed up for 8 weeks in a randomized controlled study, provision of a diet low in free sugars compared with a usual diet resulted in a greater reduction in hepatic steatosis [based on MRI] from 25% to 17% in the low free sugar diet group and from 21% to 20% in the usual diet group.

2. Deamidated gliadin rarely helps with Celiac diagnosis

–**MJ Gould et al. (JPGN 2019; 68: 20-5)** showed, in a retrospective study, that deamidated gliadin peptide (DGP) is rarely useful in screening for celiac disease when Tissue Transglutaminase IgA is negative. Key findings: Of the 40 patients with DGP (IgG) positivity, only 1 patient (2.5%) had biopsy-proven celiac disease; this patient was IgA deficient. The cohort included 6 patients with DGP levels >250 U/mL (reference <12). Only 5 of 40 patients were younger than 2 years; none had celiac disease. The number in this age group (< 2 years), however, is too small to draw a definitive conclusion.

3. Overdiagnosis of cow's milk protein allergy in infants

–**C Van Tulleken. (BMJ 2018;363:k5056) Commentary Title: "Overdiagnosis and Industry Influence: How Cow's Milk Protein Allergy is Extending the Reach of Infant Formula Manufacturers"** Key points: Because the diagnosis of non-IgE mediated cow's milk protein allergy is based mainly on a formula trial/reintroduction, it is susceptible to overdiagnosis. Expert guidelines have been authored mainly by those with conflicts of interest. "Industry funded online information promotes non-specific symptoms potentially indicating cow's milk allergy as a diagnosis in exclusively breastfed infants. Although there is evidence that cow's milk and other food proteins can be transferred from mother to infant in breastmilk, the quantities transferred are likely to be too small to cause symptoms in most infants."

4. Low FODMAPs diet for IBS

–**AC Ford et al. (Am J Gastro 2018;113:1–18)** provide a systemic review on recommendations for irritable bowel syndrome (IBS) including dietary and medication management. With regard to diet, "three fairly firm conclusions were made ... (1) the low-fermentable oligosaccharide, disaccharide, monosaccharide, and polyol (FODMAP) diet seems to be effective for overall IBS symptom improvement; (2) a gluten-free diet is

not effective for symptom improvement; and (3) conducting tests to detect various types of allergies or intolerances in order to base a diet on those results does not appear to be effective... the most impressive data that came out of the research was the evidence for the low-FODMAP diet... the results were fairly consistent and favorable, at least for the short-term management of IBS." It should be noted, however, that another systematic review and meta-analysis in the same journal (**J Dionne et al. Am J Gastroenterol 2018; 113: 1290-1300**) concludes that the data for a low FODMAPs diet is "very low" according to the GRADE criteria; therefore, after a 2-6 week trial, those who "fail to improve should not continue the diet."

5. How important are adequate calories in the ICU?

–**The "TARGET" investigators (NEJM 2018; 379: 1823-34)** examined the outcomes of 3957 adult patients undergoing mechanical ventilation who received either a 1.5 kcal formula or 1.0 kcal formula for provision of enteral nutrition. This was a double-blind randomized trial. Key finding: "Increasing energy intake with the administration of energy-dense enteral nutrition did not affect survival among critically ill adults." Only 2% of their cohort, however, had a BMI less than 18.5; thus, these findings may be less applicable to those with less nutritional reserve.

6. Gastrostomy tube placement in Cystic Fibrosis

–**RT Khalaf et al (NCP 2018; doi.org/10.1002/ncp.10219)** showed that PEG placement was associated with a trend (not statistically significant) towards improved weight gain and better lung function. Key findings: BMI percentile increased for those with PEG (0.51, 95% confidence interval (CI) = –0.05–1.08, P = .08), but decreased for those without PEG (–0.03, 95% CI = –0.33–0.28, P = .86). There was a FEV1 decrease for those without PEG which was higher than those with PEG; however, the difference between the groups was not statistically significant (0.18; 95% CI = –0.17–0.52, P = .32).

Please contact me at jhochman@gicareforkids.com with questions and suggestions.

Jay Hochman, MD

Chair, Committee of Nutrition for Georgia Chapter of AAP
Blog site: gutsandgrowth.com



2019 State Legislative Session Concludes: Sudden Cardiac Arrest, Dyslexia, Required School Recess, & “Healthy” Housing Addressed; But Anti-Vaxx Bills Appear



Melinda Willingham MD, FAAP

The Georgia General Assembly adjourned on April 2 ending its annual 40-day session. It was a year that did not see many major issues impacting pediatrics but did have several bills of significance. One troubling exception to that was the introduction of two anti-vaxx measures: one was a bill (HB 416) to create an “Office of consumer protection for vaccines body” and a resolution (HR 648) to urge Congress and UGA to study “vaccine injuries.” While their bills did not even get committee hearings, it marked that first time in memory that such anti-immunization measures were even introduced in the Georgia General Assembly; and they will be eligible for consideration next year. Here are some of the key bills we followed this year.

THE FOLLOWING BILLS PASSED:

CARDIAC ARREST — SB 60 would require the Georgia DOE to develop and post on its website guidelines and other materials to inform students, parents, guardians and coaches about the nature and warning signs of sudden cardiac arrest.

DYSLEXIA — SB 48 requires schools to develop more resources for these children, and a pilot program for pre-kindergarten students to be screened for dyslexia, moving eventually to statewide screening.

FETAL HEARTBEAT — HB 481 makes it illegal for a physician to perform an abortion once fetal heartbeat is detected. This would conflict with *Roe v. Wade* so will likely be challenged in courts.

HEALTHY HOUSING — HB 346 would prohibit retaliation against tenants who complain of unsafe and unhealthy housing conditions for Code Enforcement. This measure will help children with asthma in such unhealthy homes.

PRECEPTOR TAX CREDIT — HB 287 creates the Preceptor Tax Incentive Program, a new income tax credit for taxpayers who are licensed physicians, advanced practice registered nurses, or physician assistants and who provide uncompensated preceptorship training to the same.

REQUIRE RECESS — HB 83 would require schools to provide 30 minutes of daily recess.

TELEMEDICINE—SB 115/118. SB 115 provides for telemedicine licenses for physicians licensed in other states to practice in Ga. SB 118 requires that all health insurance policies cover “appropriately provided telehealth services.”

LOW THC OIL PRODUCTION — HB 324 would allow for the production (in 6 sites), manufacturing, and dispensing of low THC oil.

THE FOLLOWING FAILED TO PASS BUT CAN BE CONSIDERED IN 2020 SESSION:

ANTI-VAXX BILL — HB 416 by Rep. Rick Williams (R-Milledgeville) would create a State Vaccine Consumer Protection Office, a committee of anti-vaccine consumers, and provide information on Dx, and treatment of “vaccine injuries”. Assigned to House HHS committee and received no hearing this session. **OPPOSE**

VACCINATIONS: MINORS SELF-CONSENT — HB 615 by Rep. Teri Anulewicz (D-Smyrna) would allow minors who are 16 or 17 years of age to receive vaccinations without parental consent. Assigned to the Health and Human Services Committee. **SUPPORT**

ANTI-VAXX RESOLUTION: VACCINE INJURY — HR 648 by Rep. Ed Setzler (R-Acworth) introduced an urging resolution in the House recognizing “vaccine injuries, their required reporting and compensation and do hereby urge the U.S. Department of Health and Human Services and the University System of Georgia to fund additional vaccine-

Continued on next page

2019 State Legislative Session Concludes...

Continued from previous page.

injury related research. The resolution was assigned to the House Health and Human Services Committee, which did not take up the measure. **OPPOSE**

STUDY COMMITTEES: The following study committees were authorized:

PANS/PANDAS — HR 590 to study the conditions, needs, issues and problems associated with Pediatric Acute-Onset Neuropsychiatric Syndrome (PANS) and Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal infection (PANDAS).

INFANTS & TODDLERS — HR 421 by Rep. Katie Dempsey (R-Rome) on Infant and Toddler Social and Emotional Health to focus on early intervention and prevention of mental health problems in children and adolescents.

MID-LEVEL PROVIDERS — HR 261 creates the House Study Committee on Evaluating and Simplifying Physician Oversight of Physician Assistants and Advanced Practice Registered Nurses; a similar Committee was created in the Senate; and the two committees are expected to work jointly.

HEAT-RELATED INJURIES — HR 259 on Heat-Related Injuries, Cardiac Injuries, and Other Sports-Related Injuries

MATERNAL MORTALITY — HR 589 creates the House Study Committee on Maternal Mortality. The Study Committee is charged with studying the issues related to maternal mortality.

For a complete list of bills visit the Chapter website at www.GAaap.org. I would like to thank the members of the Legislative Committee for their faithful participation and work in our weekly conference calls during the session. And thanks also to those who attended our Legislative Day at the Capitol in February. We had 225 PCP there and 75 of them were from the Chapter, including residents from all five training programs in Georgia! The committee will meet again in-person at Pediatrics by the Sea on June 14th at Amelia Island, Florida.

Melinda Willingham MD, FAAP
Chair, Legislative Committee
Georgia AAP



SAVE on VACCINES

Physicians' Alliance of America (PAA) is a nonprofit Group Purchasing Organization that uses the purchasing power of more than 10,000 member practices nationwide to negotiate discounts and preferred terms for the products and services practices use every day.

- ◊ Free Membership
- ◊ Best Prices on Vaccines
- ◊ Vaccine Rebate Program
- ◊ 20+ Discount Pricing Agreements
- ◊ Superior Customer Service

Join Today!

PhysiciansAlliance.com/join
866-348-9780



Photo Review

The Chapter held multiple events across the state this winter and spring. Here are a few photos from these events.



Columbus, March 28: the Chapter held a “Meet & Greet” beside the beautiful Chattahoochee River. Pictured above are some of the attendees: (l to r) Susan McWhirter, MD; D. Ross MacLeod, MD; Fozia Eskew; Kathryn Cheek, MD; Devica Allapan, MD; Mrs. Christine Zanga; chapter president Terri McFadden, MD; Kathryn Autry; Joseph Zanga, MD; and Noelle Tran, a medical student headed for pediatrics!



Savannah, Winter Symposium, Feb. 23: Our first “WinSym” outside of Atlanta was a big success with 80 attendees and a stellar faculty. Photo 1 (Left): Ben Spitalnick, MD (left) served as program chair and at the luncheon we presented Doris Greenberg, MD (front) with the 2018 Leila Denmark Lifetime Achievement Award for her outstanding work in behavioral-developmental pediatrics. She is joined here by her husband, Martin Greenberg, MD and Terri McFadden, MD. Photo 2 (Right): The Symposium also brought together (from left) Nelson Elam, MD; William Webb, MD of Southcoast Pediatrics and Stephen Thacker, MD, Director, Pediatric Infectious Disease at Dwaine & Cynthia Willett Children’s Hospital.

Continued on next page



Macon, February 25: Do they look like “proud parents”?! Drs. Mitch Rodriguez, NICU director & Edward Clark, Mercer department chair (both at center) and the pediatric physician team gather for a shining moment after community and Navicent Health leaders officially cut the ribbon to open Beverly Knight Olson Children’s Hospital, in Macon.



Photo 1 (Left): Atlanta, Feb. 28: Our Patient-Centered Physician’s Coalition of Georgia had 230 physicians at our Legislative Day at the Capitol, highlighted by an address by Governor Brian Kemp, pictured here with Drs. Terri McFadden and Hugo Scornik. Photo 2 (Right): Morehouse residents spend a morning at the Capitol during the legislative session to observe the ...ahem... process. From right, Drs. Nicole Mathis, Rebecca Greenbaum, & Hillary Cornell and faculty advisor Megan Douglas, JD are joined by Dr. Bob Wiskind at the bust of Georgia native Dr. Crawford Long, discoverer of anesthesia.



Lake Oconee, Children’s Orthopedics of Atlanta took home the Sub-Specialists Challenge trophy at the Pediatric Foundation golf tourney in April. Drs. Mike Busch, Tim Schrader, & Dave Marshall celebrate with the hardware!



The amazing Double Eagles continued their reign as Women’s Team champions at the tournament. From left, Dr. Jennifer Smart, Becky Smith, Dr. Sharon Steele, & Hank Smart (one token male permitted!)



Falling with Style



Robert Wiskind, MD, FAAP

Toy Story (1995), the first of many animated classics from Pixar studios, introduced the world to Woody, Buzz Lightyear, and a cast of toys come to life. Woody, the favorite toy, is the undisputed leader until Andy receives Buzz as a birthday present. Woody is immediately threatened by Buzz who doesn't know he is a toy. Buzz insists that he can fly like a real space explorer, and proves it by jumping headfirst off the bedpost, bouncing off a ball, down a Hot Wheels track and around the fan before landing gracefully back on the bed. When the other toys congratulate Buzz on his flight, Woody insists, "That wasn't flying! That was falling with style!" Over the years, I have come to appreciate how important style is in connecting and communicating with patients and families.

During my career in pediatrics, there has been a concerted effort to move towards "patient-centered" care. This term can be interpreted in many ways, but, in general, it means involving the patient (and in our case, the parent) in decisions about evaluation and treatment. Based on parent feedback, I have worked hard to be more inclusive, and have changed my language from "you should" to "I recommend" or even, "I suggest." In the end, however, my style remains more paternalistic than that of many other people. In my view, the patient visit is NOT a discussion between equals; the parent may know their child best, but my knowledge and experience in the care of a wide variety of children is the biggest asset I bring to the table. The parent has "hired" me as the expert and I shouldn't feel guilty about acting that way. Fortunately, there are enough parents who value my no-nonsense, straightforward approach to keep me busy and professionally satisfied.

Style also plays a big role in discussions with vaccine-hesitant parents. Years ago, my practice allowed parents to delay or skip some immunizations. I would spend a lot of time trying to convince parents to "get their child up-to-date." Eventually, due to concerns about errors and creating stress and anxiety, we made a policy that all patients had to be immunized

consistent with the CDC/AAP schedules. For me, the conversation often begins in the prenatal visit. If asked about vaccines, I will discuss the science that documents vaccine safety and effectiveness and share resources from the Vaccine Education Center that review many of the concerns parents have. At the end of our conversation, I will close with "I am happy to talk further with you about vaccines, but, if you want your child to be a patient here, they will have to be immunized by the standard schedule." Now, vaccine conversations can be a highlight of my day. In response to a parent's concern, I will review the science behind the

standard schedule and explain that what we do has good data to document safety and effectiveness while any non-standard schedule lacks that data. I get to use my scientific knowledge, experience, compassion, and powers of persuasion in the noble cause of protecting a child.

As a general pediatrician, my day is full of discussions about diet, sleep, behavior,

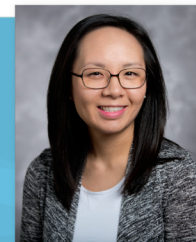
and development. Millennial parents often seek very specific answers to questions about these issues, but my style is to speak about the broad range of normal. If I tell the mom of a 6 month-old that her baby should be drinking 24 ounces of formula per day, there is a good chance Mom will worry if she only gets her to take 22 ounces. Instead, I will say that there is considerable variability between children, and from day-to-day for an individual child. There are many ways to get the nutrition that will promote good growth. I encourage parents to look at my advice as guidelines and adapt them as required to meet the needs of their child and family.

Over the past 10-12 years, during the middle third of my career, I have become more introspective and have realized that I am not too old to change my habits and there may be better ways to practice pediatrics. I have worked on refining my style to improve communication with patients and their families. I hope that I will continue to evolve my style and, as Buzz Lightyear would say, strive to provide care that goes "to infinity and beyond."

As a general pediatrician, my day is full of discussions about diet, sleep, behavior, and development. Millennial parents often seek very specific answers to questions about these issues, but my style is to speak about the broad range of normal.



Preventable Harm: Nephrotoxic Medication-Associated Acute Kidney Injury



H. Stella Shin, MD

Acute kidney injury (AKI) is defined as the abrupt loss of kidney function, resulting in a decline in glomerular filtration rate, which manifests as a rise in serum creatinine, retention of nitrogenous waste products, as well as dysregulation of extracellular volume and electrolytes. AKI in hospitalized children (hospital-acquired AKI, HA-AKI) has been associated with negative outcomes in the short-term, as well as increased risk for long-term complications.

Specifically, HA-AKI has been independently associated with increased duration of mechanical ventilation, increased overall hospital length of stay as well as ICU length of stay, and increased risk for death. Furthermore, while these poor short-term outcomes after HA-AKI are well-established, there is a misconception that AKI is a self-limited condition with no long-term effects. Studies in both adults and children, however, have demonstrated that AKI can lead to chronic kidney disease (CKD)¹⁻⁴. Development of CKD is especially consequential in children because of its impact on cardiovascular health, bone disease, growth, and neurodevelopment.

It is consequently very concerning that recent literature suggests that the incidence of AKI in hospitalized children is increasing.⁵ Among causes of HA-AKI, nephrotoxic medication exposure accounts for 16% of cases of AKI, second only to dehydration. It is the only modifiable cause of AKI in hospitalized children.⁶ Exposure to nephrotoxic medications, however, is highly prevalent among non-critically ill children, who are hospitalized at tertiary care pediatric hospitals, with up to 86% of children being exposed to at least one nephrotoxin during their admission.⁷ Nephrotoxin-associated AKI (N-AKI) can be diagnosed with serum creatinine measurement, which is an inexpensive and widely available test, but it is underutilized in children exposed to high levels of nephrotoxic medications.⁸

In 2017, Solutions for Patient Safety (SPS) recognized N-AKI as a serious adverse event and adopted it as the newest hospital-acquired condition (HAC), joining other well-known HACs such as central-line associated bloodstream infections (CLABSI) and catheter-associated UTI (CAUTI). Children's Healthcare of Atlanta (CHOA) is among the first children's hospitals in the country to join the SPS mission to reduce inpatient N-AKI by implementing a novel surveillance program known as Nephrotoxic Injury Negated by Just-in-time Action (NINJA). NINJA, led by Dr. Stella Shin, a pediatric

nephrologist at CHOA, utilizes the electronic medical record to identify patients exposed to high levels of nephrotoxic medications, provide real-time feedback to clinicians, suggest daily serum creatinine monitoring for early identification of AKI, and recommend strategies for mitigating N-AKI risk.

Preventing kidney injury is critically important given the potential for the development of CKD secondary to AKI. NINJA aims to increase awareness of AKI in hospitalized children and collaborates with bedside clinicians to decrease rates of N-AKI at CHOA. For children who do develop AKI, our team of pediatric nephrologists at CHOA are available for consultation or referral. For urgent inpatient consultation, please call 404-785-7778. For outpatient consultation or referrals for AKI follow-up, please call 404-785-DOCS. For more information on our NINJA program, please email Dr. Shin at stella.shin@emory.edu.

References

1. Askenazi DJ, Feig DI, Graham NM, Hui-Stickle S, Goldstein SL. 3-5 year longitudinal follow-up of pediatric patients after acute renal failure. *Kidney Int* 2006; 69(1): 184-9.
2. Mehta RL, Pascual MT, Soroko S, Chertow GM, Group PS. Diuretics, mortality, and nonrecovery of renal function in acute renal failure. *JAMA* 2002; 288(20): 2547-53.
3. Menon S, Kirkendall ES, Nguyen H, Goldstein SL. Acute kidney injury associated with high nephrotoxic medication exposure leads to chronic kidney disease after 6 months. *J Pediatr* 2014; 165(3): 522-7 e2.
4. Metnitz PG, Krenn CG, Steltzer H, et al. Effect of acute renal failure requiring renal replacement therapy on outcome in critically ill patients. *Crit Care Med* 2002; 30(9): 2051-8.
5. Andreoli SP. Acute renal failure. *Curr Opin Pediatr* 2002; 14(2): 183-8.
6. Hui-Stickle S, Brewer ED, Goldstein SL. Pediatric ARF epidemiology at a tertiary care center from 1999 to 2001. *Am J Kidney Dis* 2005; 45(1): 96-101.
7. Moffett BS, Goldstein SL. Acute kidney injury and increasing nephrotoxic medication exposure in noncritically-ill children. *Clin J Am Soc Nephrol* 2011; 6(4): 856-63.
8. Zappitelli M, Moffett BS, Hyder A, Goldstein SL. Acute kidney injury in non-critically ill children treated with aminoglycoside antibiotics in a tertiary healthcare centre: a retrospective cohort study. *Nephrol Dial Transplant* 2011; 26(1): 144-50.

H. Stella Shin, MD
Assistant Professor
Medical Director, General Nephrology
Director, STOP-AKI Program
Division of Pediatric Nephrology
Emory University School of Medicine
Children's Healthcare of Atlanta

Roshan George, MD
Assistant Professor
Fellowship Associate Program Director
Director, Renal Transplant Transition Program
Director, Transplant Quality
Emory University School of Medicine
Children's Healthcare of Atlanta



Making a Difference in Georgia Through Home Visiting



Jeannine Galloway, MPH

Program Overview

The Georgia Home Visiting Program (GHVP) is a statewide effort, managed by the Georgia Department of Public Health (DPH) in partnership with local communities, to provide voluntary evidence-based home visiting to at-risk pregnant women and families. GHVP is designed to foster a community culture of care, encouragement, and support for all families before and after the birth of a child. In select Georgia communities, services are available to ensure these important early years are rich with opportunities to bolster a child's education, safety and health. GHVP helps inform expectant parents and families with young children about all the available services and resources in their community they can turn to if and when the need arises: everything from how to find a doctor or quality child care, to learning about a child's growth and development. There is also help for parents with more serious concerns like depression, safe housing, and other baby care needs.

Evidenced-based home visiting is a service provided by qualified professionals inside the homes of pregnant women and families with children from birth up to kindergarten entry at five years of age. Home visiting provides parents with support to enhance the crucial child-parent relationship. Evidence-based programs are implemented with fidelity, and use a clear, consistent model based on a rigorous research design, grounded in relevant empirical knowledge.

County Locations

- | | | |
|------------------------|--------------|------------|
| • Bartow* | • Houston* | • Bibb |
| • Chatham/
Liberty* | • Muscogee* | • Chatham |
| • Clarke* | • Richmond* | • Valdosta |
| • Crisp* | • Rockdale* | • Clayton |
| • DeKalb* | • Whitfield* | • Fulton |
| • Glynn* | • Gordon | • McDuffie |
| | • Lowndes | |

*Counties funded by MIECHV

Evidence

Funding from the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, which is administered by the Health Resources and Services Administration (HRSA) in close partnership with the Administration for Children and Families (ACF), supports the Georgia Home Visiting Program.

MIECHV requires grantees demonstrate measurable improvement in at least four of the following six benchmark domains:

- Improvement in maternal and newborn health
- Reduction in child injuries, abuse, and neglect
- Improvement in school readiness and achievement
- Reduction in crime or domestic violence
- Improvement in family economic self-sufficiency
- Improvement in coordination and referral for other community resources and supports

Examples of Outcomes of Evidence-based Home Visiting:

• Healthy Moms and Babies.

During and after pregnancy, home visiting programs support maternal health by assisting moms schedule regular doctor's visits, improve diets, reduce stress levels, and quit smoking or substance abuse. In 2018, 76% of new moms in GHVPs completed a postpartum visit and 80% of the moms completed a depression screen.

• Better Prepared Children for School.

Home visiting programs promote positive parenting practices that help parents better prepare their children for school. In 2018, 95% of children in GHVPs reported having a caregiver read, tell stories or sing songs to them daily.

• Safer Children.

Home visiting programs are associated with reduced rates of child maltreatment and injuries. In 2018, 99% of children in GHVPs had no reports of maltreatment.

Evidenced-based home visiting is a service provided by qualified professionals inside the homes of pregnant women and families with children from birth up to kindergarten entry at five years of age.

Home Visiting...

Continued from previous page.

Home visiting is one of several service strategies critical in a comprehensive, high-quality early childhood system to promote maternal, infant and early childhood health, safety, development, strong parent-child relationships, and responsible parenting among mothers and fathers.

Success Story: Home visiting transforms lives. Here is a home visiting participant's testimony.

Sarah and Marcus voluntarily began the Parents as Teachers Program in Whitfield County in 2015. They met in drug court and shared similar dysfunctional childhood stories of growing up in families where they did not often receive nurturing or support. Once their son was born in 2014, Sarah and Marcus made a conscious choice to be the parents they never had and to give their child what they could. When their parent educator (home visitor) explained the program, the young couple came on board quickly and became active in the home visits from the beginning. Sarah and Marcus'

son was born with webbed fingers and the parent educator supported them during the surgeries their son underwent. The parent educator helped by sharing information and types of activities that would increase their son's fine motor skills, which in turn helped with his recovery. Sarah and Marcus learned about child development and appreciated the advice, information, and resources provided by their parent educator. Marcus recently completed his GED and Sarah obtained a CAN license. The young parents bought their first home and their son recently started a Pre-Kindergarten program. The parent educator will always be a resource for this family as Sarah and Marcus continue to surpass even their own expectations.

Note: In the Parents as Teachers program home visitors are referred to as parent educators.

To learn more about home visiting in Georgia visit dph.georgia.gov/homevisiting or call 404-657-2465.

Jeannine Galloway, MPH
Maternal and Child Health Director
Georgia Department of Public Health



Pediatrics by the Sea
& Pediatric Coding Conference

Pediatrics by the Sea

June 12-15, 2019

**The Ritz-Carlton
Amelia Island, Florida**

.....
Rated Top 10
Child-Friendly Resorts
in the U.S.A.
- Child Magazine
.....

**For more information, visit
www.gaaap.org/pbs**

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™
Georgia Chapter





Asking Saves Kids – Firearm Injury Prevention and the Pediatrician’s Role



Kiesha Fraser Doh, MD

My four-year-old patient was articulate and he knew his facts. “I was playing; I saw my Uncle’s gun; and I thought it was a toy; I picked it up and I shot myself in the hand,” he said. That’s one patient history I won’t easily forget.

I was reminded of this patient’s story, three years ago, when I saw the AAP daily briefing promoting **ASK** day on June 21st. **ASK** days stands for Asking Saves Kids. For 19 years, the AAP and the Brady Center to Prevent Gun Violence have used **ASK** day to remind doctors to encourage parents to ask about the presence of unlocked guns in homes where their children play.

ASK day occurs annually on the first day of summer, a season where children spend a lot of time in the homes of others. As a pediatric emergency medicine (PEM) physician, I am very cognizant of safety. I personally ensure that my children are always buckled into car seats with whoever drives them and I ask about swimming pools, pets, and medication storage when they visit other homes. I had never asked about the presence of unlocked guns in the homes my children visited. I knew that:

- 1 in 3 children live in homes with firearms and 45% of gun-owning households do not store their firearms safely.¹
- Georgia’s gun ownership rate is 31.6%.²
- 75% of children know where their parents store their guns.³
- In 2016, Georgia had the 4th highest death rate in the nation by firearm injury which makes Georgians two times as likely to die from a firearm injury compared to New Yorkers.⁴
- At Children’s Healthcare of Atlanta, the only pediatric level 1 trauma center in the state, we see on average one firearm injury every 2.5 weeks.

Confronted with the reality that I had neglected to ask this important safety question, with trepidation I broached the topic with our neighbor, parent of my son’s best friend. After

this uncomfortable conversation, I reflected on how difficult it was to initiate this conversation for me, a PEM physician who has seen multiple children harmed by firearms. Then, I imagined how difficult it is for other parents without a similar perspective to ask these questions.

In a survey conducted in our Children’s emergency departments, we found that, when caregivers were educated to ask about firearm storage in the homes of their children’s playmates, 76% indicated they would.⁵ As pediatricians, we don’t always have this conversation. One study of parents found that 75% felt pediatricians should ask about firearm

safety but only 12% of parents reported having this important conversation with their pediatrician.⁶

As pediatricians, the foundation of our care is prevention. Our ultimate goal is to care for children into healthy adulthood. As a PEM physician, I spend more time treating rather than preventing illness or injury. When a patient comes into the

ED with symptoms suggestive of leukemia, it is upsetting to inform the parents of the diagnosis. Unfortunately, there is no treatment to prevent childhood leukemia. There are, however, common sense and scientifically sound practices that can prevent firearm injury. The U.S. General Accounting Office estimates that 31% of accidental firearm deaths are preventable with the addition of two devices: a childproof safety lock and a loading indicator.⁷ I use the comparison to leukemia because, as of 2017, the # 1 and #2 killers of children ages 1-19 are motor vehicle crashes and firearms. Childhood leukemia has been surpassed by two **preventable** causes of death.⁸ Thus, it behooves us as pediatricians to **ASK**.

Last summer, a multi-disciplinary group from Children’s Healthcare of Atlanta, Grady Medical Center and Emory University developed a multi-faceted approach to educate families and medical personnel about **ASK** day. Our efforts led to **ASK** day educational stations at Children’s and Grady

The U.S. General Accounting Office estimates that 31% of accidental firearm deaths are preventable with the addition of two devices: a childproof safety lock and a loading indicator.

Asking Saves Kids

Continued from previous page.

Hospitals' along with flyers distributed at discharge to Children's and Grady ED patients. Providers were encouraged to wear stickers that denoted the words **ASK**. We encourage you to join us this year and make this a Georgia wide-initiative to decrease the numbers of unintentional firearm injuries.

To get involved:

1. On June 21st **ASK** parents about the presence of unlocked firearms
2. Educate your staff to **ASK**
3. When screening for mental health disorders, **always** inquire about the presence of firearms in the homes of your patients
4. **Inquire** of patients if they have access to firearms at well visits

Don't forget to **ASK** on Friday, June 21st because **ASKING SAVES KIDS**.

For more information go to askingsaveskids.org

Sources:

1. Crifasi C, Doucette ML, McGinty EE, Webster DW, Barry CL. Storage Practices of US Gun Owners in 2016. American Journal of Public Health 2018;108:532-7.
2. Kalesan BVM, Keyes K, Galea S. Gun Ownership and Social gun culture. Injury Prevention 2016;22:216-20.
3. Baxley F, Matthew M. Parental Misperceptions about Children and Firearms. Archives of Pediatric Adolescent Medicine 2006;160:542-47.
4. Judd A. You're twice as likely to be shot to death in Georgia than in New York (and other gun violence facts). Atlanta Journal Constitution 2017.
5. Fraser DK, Chaudhary S, Agarwal M, Holmes S, Middlebrooks L, Simon H. Parental Acceptance of a Firearm Educational Intervention by Emergency Medicine Physicians Pediatric Academic Society Abstracts 2017.
6. Garbutt J BN, Dodd S, Sterkel R, Strunk R. What are Parents Willing to Discuss with Their Pediatrician about Firearm Safety? A Parental Survey. Journal of Pediatrics 2016;179:166-71.
7. Accidental Shootings: Many Deaths and Injuries Caused by Firearms Could Be Prevented. In: Office USGA, ed. Chairman Subcommittee on Antitrust, Monopolies, and Business Rights, Committee on the Judiciary, 17. S. Senate 1991.
8. Cunningham RM, Walton MA, Carter PM. The Major Causes of Death in Children and Adolescents in the United States. N Engl J Med 2018;379:2468-75.

Kiesha Fraser Doh, MD
Pediatric Assistant Professor of Emergency Medicine
Emory University



MagMutual means more

We reward policyholders at every stage of their career with over \$215 million returned in the form of dividends and over \$15 million paid out to retired policyholders with our Owners Circle® program. Make sure you're getting more from your insurance company and if you're not, get more with MagMutual, a leading provider of medical professional liability insurance.

MagMutual.com | 800-282-4882

*Dividends and Owners Circle allocations are declared at the discretion of the MagMutual Board of Directors.



Cancer is complex.

That's why your patients deserve
access to the most powerful treatments.

Partner with Emory Proton Therapy Center.

The only proton therapy center in Georgia.

Where your patients can receive an advanced form of radiation,
to better protect nearby healthy tissue and reduce side effects.

So patients can get back to their lives beyond cancer treatment.

Winship at Emory has multidisciplinary teams who will work with you to create a personalized
treatment plan. Give your patients the peace of mind they have every option possible.

For cancer patients, the right partner
can make all the difference.

To refer a patient, visit emoryhealthcare.org/protonreferral.

EMORY
PROTON THERAPY
CENTER
WINSHIP CANCER INSTITUTE



First Scan to Rapidly Diagnose Life Threatening Complications in Neonates Developed at MCG – A Technical Innovation

Physicians at the Medical College of Georgia at Augusta University have developed the first bedside sonography scanning regimen to evaluate rapidly deteriorating newborns in the neonatal intensive care unit.

The RANS scan or “Rapid Assessment of the Neonate with Sonography” Scan is a focused ultrasound exam that is easy to learn, rapidly performed, and relatively inexpensive.

The goal of the project was to create an impactful scanning regimen that can be used in any neonatal intensive care unit. As advanced as neonatology has become and as much traction ultrasound has gained in other areas like pediatric intensive care and the pediatric emergency rooms, it is still not a tool that is widely utilized in the Neonatal Intensive Care Unit (NICU).

The three-minute or less exam is utilized when a neonate begins showing signs of rapid deterioration and abnormal vital signs. It begins with a focused clinical exam, followed by a handheld ultrasound, which looks for – in this order – pericardial effusion, or fluid around the heart; poor positioning of a central venous line; a collapsed lung; fluid around the lungs; or bleeding inside or around the ventricles of the brain.

The group looked at the most important problems, which need to be identified quickly and are the most common causes of rapid deterioration in neonates. This exam is a tool to help quickly rule in or out major processes that need to be addressed.

The guidelines for the exam were developed with help from experts at AU’s Center for Ultrasound Education and from the Department of Emergency Medicine, where ultrasound has been in use and taught to medical students and residents for decades.

The working group consisted of two groups of people who don’t normally associate with one another (from emergency medicine and from neonatology), who got together to figure out how this tool can be useful. It was a true sharing of knowledge, with each group sharing their expertise with one another. AU is fortunate to have the center here and experts who are willing to collaborate and teach.

The scan is loosely modeled after the Focused Assessment with Sonography in Trauma or FAST scan, which emergency

physicians and EMTs use to look for blood around the heart and/or abdominal organs after trauma and is already widely used in emergency rooms across the country.

The RANS Scan is more of a protocol, a conceptual framework for evaluating an infant, who is critically ill, in a systematic fashion, which can be easily taught to someone without ultrasound experience. Not all neonatal intensive care units exist at academic medical centers like the one at MCG and AU Health. NICUs sometimes pop up in remote areas. The ultimate goal is to be able to provide a standard for some baseline training, which can be widely distributed.



(L to R) Drs. Ted Kuhn and Azif Safarulla; Becky Etheridge, director of ultrasound education; and Dr. Matt Lyon.

The RANS Scan is not a replacement for a clinical exam, but an adjunct tool. For all these conditions, X-rays and echocardiograms are the gold standard, but emergencies don’t often look at the time of day. Often there is a lag period between when an X-ray is ordered and when the X-ray technician arrives. This tool is right by the bedside. It takes only a few seconds to find out what’s wrong.

Safarulla and his colleagues are currently training MCG’s neonatologists and neonatology fellows. Eventually, they hope to expand the training to NICU nurse practitioners as well.

Azif Safarulla, MD, FAAP
Assistant Professor
Director, Children’s Summer Scholars Program
Division of Neonatology
Department of Pediatrics

Augusta University is Georgia’s innovation center for education and health care, training the next generation of innovators, leaders and health care providers in classrooms and clinics on three campuses in Augusta and satellite locations across the state. Groundbreaking research at Augusta is dedicated to improving and enriching the human experience as we seek to create a healthier, more prosperous Georgia. Nearly 9,000 students choose Augusta for experiential learning that blends arts and application, humanity and the health sciences. Augusta is home to the state’s only public academic health center, where world-class clinicians are bringing the medicine of tomorrow to patient care today.

augusta.edu | augustahealth.org



How Occupational Therapy Can Treat Children with Sleep Problems

Are your patients getting enough sleep? For children, regularly sleeping the number of recommended hours by the American Academy of Pediatrics is associated with better health, including improved attention, behavior, learning, working memory, emotional regulation, quality of life, and mental and physical health.¹

Typical Sleep Development^{2,3}

• **Newborns:**

Sleep during the first few months of life occurs at any time depending on the newborn's need to be fed, changed, and nurtured. Newborns may sleep anywhere from 10.5 to 18 hours each day with intermixed periods of one to three hours of awake time.

• **Infants 4-12 months:**

Older infants need nine to 12 hours of sleep at night with two to three 30 minute to two-hour naps during the day is recommended for infants. By nine months, 70-80 percent of infants will be sleeping through the night.

• **Children 1-2 years:**

Toddlers need 11-14 hours of sleep each day with naps decreasing to once per day and lasting one to three hours.

• **Children 3-5 years:**

Preschoolers should sleep 10-13 hours each night with most children foregoing naps at the end of this age period.

• **Children 6-12 years:**

Children ages 6-12 should get 9-12 hours of sleep each night.

Sleep is a primary occupation of children until the age of five. It is crucial for homeostatic balance, and, if left untreated, sleep deprivation can lead to more serious health issues.⁴ Sleep deprivation can impair safety and performance in daily tasks. Poor sleep also increases the risk of accidents, injuries, hypertension, obesity, diabetes, and depression.¹ Most studies have demonstrated a negative association between sleep duration and obesity. Shorter sleep periods align with an increased risk for children becoming overweight. Two analyses found that, for each increased hour of sleep, the risk of obesity or becoming overweight decreased.¹

Children, who regularly sleep less than the recommended amount of hours, may exhibit attention, behavior, and

learning problems. Decreasing a child's sleep by only one hour can have a negative effect on emotions, behavior, and cognitive skills, all of which play an integral part in a child's ability to perform in school.⁴ Insufficient sleep can lead to many academic problems by limiting planning and organizational skills needed for problem solving, by worsening mood and behavior, by reducing focus and attention, and by hampering both long-term and working memory. People who regularly get poor sleep are more socially rejected than those who appear and feel well rested. At UC Berkeley, researchers discovered that sleep-deprived people feel lonelier, disengage, and avoid eye contact with others. These behaviors also make them appear socially unattractive to others.⁵

Children sleeping at least 10 hours each night report fewer health complaints, while children with less than 8 hours of sleep report increased ADHD behaviors.¹ It is harder for sleep-deprived children to retain new information, and children with ADHD are specifically at higher risk.⁶

When treating a child for sleep issues, many clinicians may not think to prescribe occupational therapy; however, sleep or rest is one of the eight areas of occupation treated by occupational therapists. Occupational therapists use their knowledge of sleep physiology, sleep disorders, and sleep promotion practices to evaluate and treat the complications of insufficient sleep or sleep disorders on daily activities. When occupational therapists evaluate clients, they assess issues including sleep preparation, participation, latency, duration, maintenance, and daytime sleepiness. They also look at the impact of sleep on work, school, and other life events, as well as the influence of pain and fatigue, psycho-emotional status, and troubles in other areas such as vision, balance, strength, skin, and sensory systems.⁷ Occupational therapists work together with the child's healthcare team to identify possible contributors to a child's sleep issues. These include, but are not limited to, daily routines, nap schedules, and the bedroom environment, as well as consideration of physical, cognitive, sensory, and emotional disturbances.⁸

Occupational therapists treat clients by first educating parents and caregivers on the misconceptions and expectations of sleep and addressing factors that may exacerbate poor sleep quality. Establishing a predictable and smooth routine is an important step in treating a child

Occupational Therapy and Sleep Problems

Continued from previous page.

with sleep problems. Setting regular wake and sleep times while modifying the bedroom environment, including noise, light, temperature, and bedding, helps the child wind down and prepare for sleep. Occupational therapists also focus on increasing coping skills and self-regulation to facilitate the child's capacity to relax for sleep onset.⁷

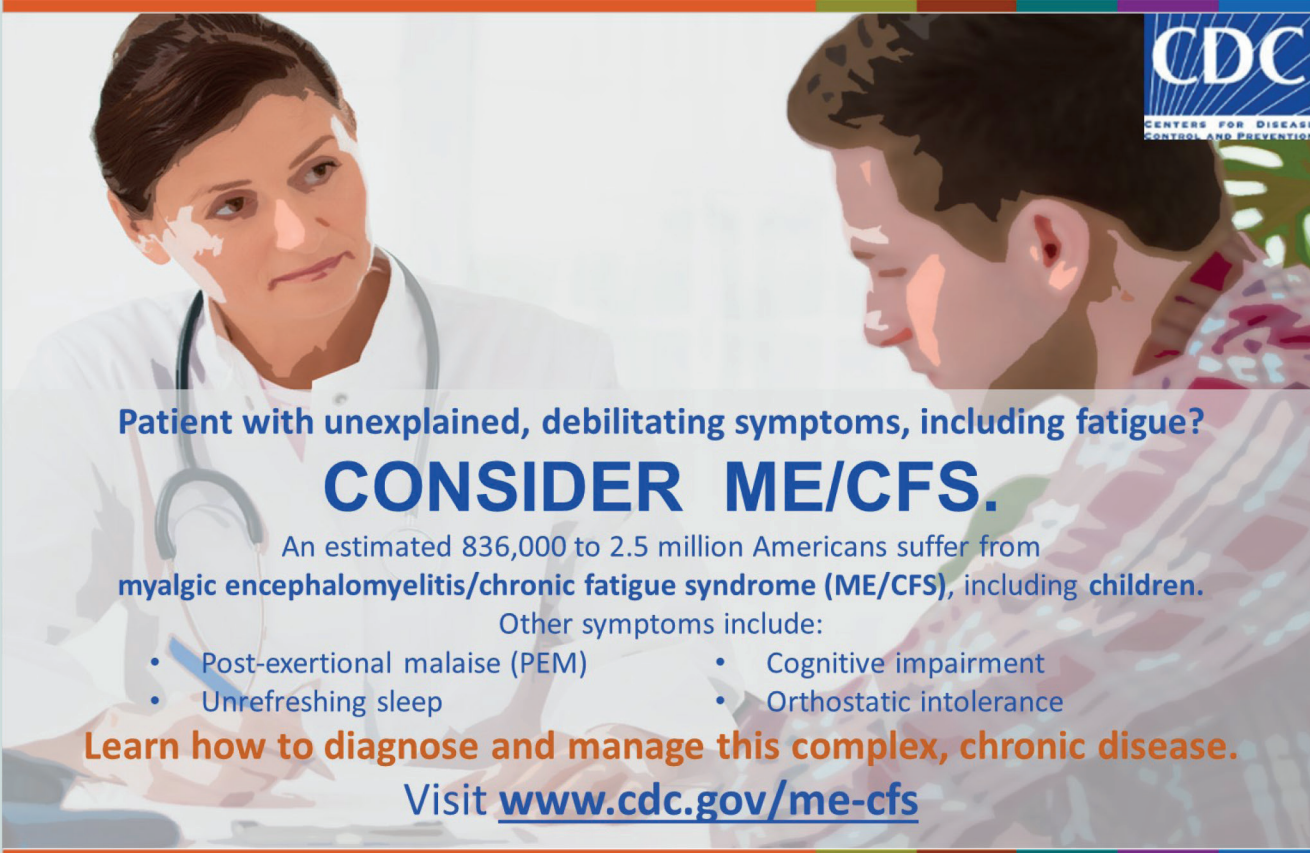
Sleep can be complex due to environmental, physiological, psychological, and sensory aspects. Because sleep is so important and can have a serious impact on daily activities, from self-care to academics to social skills, it is key that children receive appropriate care from professionals, like occupational therapists, who are well trained to consider all of these factors. Consider prescribing occupational therapy when you next treat a child with a sleep issue.

For more information about childhood development, please visit www.pathways.org or email friends@pathways.org. Chicago-based Pathways, founded in 1985, provides parents and health professionals with free educational resources on children's motor, sensory, and communication development to promote early detection and intervention.

Bobbie Vergo, OTD
Occupational Therapist

References:

1. Paruthi S, Brooks LJ, D'Ambrosio C, Hall WA, Kotagal S, Lloyd RM, Malow BA, Maski K, Nichols C, Quan SF, Rosen CL, Troester MM, Wise MS. Consensus statement of the American Academy of Sleep Medicine on the recommended amount of sleep for healthy children: methodology and discussion. *J Clin Sleep Med* 2016;12(11):1549-1561.
2. American Academy of Pediatrics Supports Childhood Sleep Guidelines. American Academy of Pediatrics. <https://www.aap.org/en-us/about-the-aap/aap-press-room/pages/American-Academy-of-Pediatrics-Supports-Childhood-Sleep-Guidelines.aspx>. Accessed November 15, 2018.
3. Children and Sleep. National Sleep Foundation. <https://www.sleepfoundation.org/sleep-topics/children-and-sleep/page/0/1>. Accessed November 1, 2018.
4. Quint N. Sleep in Pediatric Occupational Therapy Practice: A Family-Centered Approach. 2017. <https://www.occupationaltherapy.com/articles/sleep-in-pediatric-occupational-therapy-4018>. Accessed November 1, 2018.
5. Anwar Y. Poor sleep triggers viral loneliness and social rejection. *Berkeley News*. 2018. <https://news.berkeley.edu/2018/08/14/sleep-viral-loneliness>. Accessed November 7, 2018.
6. Rosen P. At a Glance: 4 ways sleep problems can affect how kids learn. *Understood.org*. <https://www.understood.org/en/learning-attention-issues/understanding-childrens-challenges/simple-changes-at-home/4-ways-sleep-problems-can-affect-how-kids-learn>. Accessed November 1, 2018.
6. Occupational Therapy's Role in Sleep. AOTA. <https://www.aota.org/About-Occupational-Therapy/Professionals/HW/Sleep.aspx>. Accessed November 1, 2018.
6. Porquez J, Porquez A. Occupational Therapy and Sleep Technology. *Sleep Review*. 2015. <http://www.sleepreviewmag.com/2015/10/occupational-therapy-sleep-technology>. Accessed on November 1, 2018.



Patient with unexplained, debilitating symptoms, including fatigue?

CONSIDER ME/CFS.

An estimated 836,000 to 2.5 million Americans suffer from **myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS)**, including children.

Other symptoms include:

- Post-exertional malaise (PEM)
- Cognitive impairment
- Unrefreshing sleep
- Orthostatic intolerance

Learn how to diagnose and manage this complex, chronic disease.

Visit www.cdc.gov/me-cfs

growing our team and leading the way in pediatrics

At Children's Physician Group, we are dedicated to reaching more children with the pediatric care and expertise that is unique to us. To help achieve the best outcomes for children, we continue to recruit new talent. Today, Children's Physician Group is made up of more than 850 physicians and advanced practice providers representing more than 30 pediatric specialties.

Join us in welcoming four new and talented physicians committed to our goal of making the kids in Georgia better today and healthier tomorrow.

Learn more at choa.org/cpg or call 404-785-DOCS (3627).



Children's
Physician Group

©2019 Children's Healthcare of Atlanta, Inc. All rights reserved.



Paul Chai, MD
Chief, Cardiothoracic Surgery

We are excited to announce Paul Chai, MD will be joining Children's on May 13 as the new Chief of Cardiothoracic Surgery and Co-Chief of Cardiac Services. Dr. Chai comes to Georgia from New York-Presbyterian where he led their congenital heart surgery, pediatric heart transplant and mechanical assist device services. Dr. Chai completed his residency and fellowship training at Duke University Medical Center. His areas of expertise include pediatric congenital heart disease, cardiac surgery and cardiothoracic surgery.



Satyanarayana Gedela, MD
Chief, Neurology

Join us in welcoming Satyanarayana Gedela, MD as the new Division Chief of Pediatric Neurology and Practice Director of Children's Physician Group-Neurology. Dr. Gedela came to Children's by way of Nationwide Children's Hospital where he served as Medical Director of the Epilepsy Surgery Program as well as the Epilepsy Monitoring Unit. He completed his residency and fellowship training in child neurology at Children's Hospital of Pittsburgh of UPMC. His area of expertise includes epilepsy.



Sonal Patel, MD
Pediatric Gastroenterologist

Sonal Patel, MD joined Children's in April by way of the Ann and Robert H. Lurie Children's Hospital of Chicago. Dr. Patel received a Doctorate of Medicine at Northeastern Ohio Medical University. She completed her residency training in pediatrics at Riley Hospital for Children, followed by a fellowship in Gastroenterology, Hepatology and Nutrition at Ann and Robert H. Lurie Children's Hospital of Chicago. Dr. Patel has specific interests in general gastroenterology and inflammatory bowel disease.



Fawwaz Shaw, MD
Pediatric Cardiothoracic Surgeon

Fawwaz Shaw, MD joined Children's by way of West Virginia University where he served as Surgical Director of Extracorporeal Life Support at WVU Medicine Children's Hospital. Dr. Shaw graduated from the American International School of Medicine in Georgetown, Guyana and completed residencies in Family Medicine and General Surgery at the University of Tennessee Health Sciences Center in Memphis, TN. He completed his Cardiothoracic Surgery residency at the University of Washington and his Congenital Cardiac Surgery residency at Seattle Children's Hospital. His clinical interests include neonatal heart surgery, adult congenital cardiac surgery, extracorporeal life support and surgical education.



Camp Kudzu Seeks Champions to Help Children with Type 1 Diabetes



Robert G. Shaw

More than 6,000 children and teens in Georgia are living with Type 1 diabetes. Camp Kudzu, an Atlanta-based nonprofit that offers camps and educational events for children with diabetes, served more than 850 children and families last year. It is seeking additional volunteers and donors to help close the gap for those in need of support to attend camp.

Robert Shaw, Camp Kudzu Executive Director, is in search of champions, who will help make a difference in the lives of children throughout Georgia, particularly those living with Type 1 Diabetes who have inadequate or limited access to essential diabetes care.

"In 2018, we were able to help 121 new families from underserved areas of Georgia," Shaw said. "Celebrating our 20th anniversary this year, we are proud of the work and accomplishments we have collectively achieved and the impact we've made in the lives of campers and their families in Georgia that need us the most. Our ongoing focus now is to reach even more youth statewide with limited access to care."

Since 1999, Camp Kudzu has transformed the lives of more than 3,500 children and teens living with Type 1 diabetes, a life-long, insulin-dependent autoimmune form of diabetes. Camp Kudzu teaches campers how to manage Type 1 diabetes in an inclusive, fun-filled environment and creates life-long friendships for both campers and volunteers.

The Zezulka family, whose daughter Ivey received international attention recently, is an example of the impact of Camp Kudzu.

"I think one of the biggest benefits of Camp Kudzu is seeing our daughter in an environment where, for once, she's just like everyone else," said Paige Zezulka, whose daughter is looking forward to her fourth summer at camp.

Zezulka, whose video surprising Ivey with adoption papers spread virally worldwide and led to the family being featured on "The Today Show" and "The Ellen DeGeneres Show," understands the struggles inherent in fostering a child with a chronic disease.

"When you first sign up to foster, you have to check the boxes indicating what you are and aren't willing to take, and

'diabetes' is one of those options," she said. Thanks to the resources and community offered by Camp Kudzu, nobody should be afraid to check the 'diabetes' box."

Camp Kudzu awarded more than 340 scholarships last year and ensured that every applicant has the opportunity to attend camp. Awarding scholarships also underscored

its role as a second home and source of community for campers of all races, ethnicities, and socioeconomic backgrounds. Families with financial need are able to send their children to camp with scholarship support, thanks to Camp Kudzu's

generous donor network and corporate partners.

"I love Camp Kudzu because everyone can just be themselves," Ivey Zezulka said.

Camp Kudzu is dedicated to educating, empowering, and inspiring children and teens living with Type 1 diabetes. It promises, that until there's a cure, there's camp. Camp Kudzu was founded in 1999 with 93 campers. Today, Camp Kudzu hosts year-round programs through multiple summer sessions, family camps, and Sprouts Day Camp. Camp Kudzu,

accredited by the American Camp Association, enjoys a strong reputation as one of the top Type 1 diabetes camps in the country.

To learn more about Camp Kudzu and get involved, visit www.campkudzu.org or call (404) 420-5911 or toll-free (833) 99-KUDZU.



Website: www.campkudzu.org



YouTube: www.youtube.com/user/thecampkudzu



Facebook: www.facebook.com/CampKudzu

Robert G. Shaw
Executive Director, Camp Kudzu



Georgia Chapter

1350 Spring St, NW, Suite 700
Atlanta, Ga 30309



Looking Ahead:



May 17, 2019

**Georgia Pediatric Nurses & Practice
Managers Association Spring Meeting**
Cobb Energy Centre,
Atlanta

June 12-15, 2019

**Pediatrics by the Sea
Summer CME Meeting**
The Ritz Carlton,
Amelia Island, Florida

Oct 10-12, 2019

**Pediatrics "Just Off" Peachtree
CME Meeting**
Atlanta Buckhead Marriott,
Atlanta

Webinars

For schedule, visit www.GAaap.org

The Georgia Pediatrician is the newsletter of the Georgia Chapter/American Academy of Pediatrics

Editor: Alice Little Caldwell, MD | Email: acaldwel@augusta.edu



@ Georgia Chapter of the American Pediatrics



@ GAChapterAAP

1350 Spring St, NW, Suite 700, Atlanta, Ga 30309 | P: 404.881.5020 F: 404.249.9503

Visit the Chapter Website for details on Chapter events. www.GAaap.org
Call (404) 881-5020 for more information.