Pediatricians Tackle a Pandemic

By the time you read this, I imagine most of you will know someone who has been afflicted by the SARS-CoV-2 virus. During this devastating and protracted pandemic, pediatricians are tasked with watching over the smallest amongst us, the nation’s children. They have been affected in multiple ways. We pediatricians care for the 7-year-old boy with a fever and a rash who has a case of coronavirus associated MIS-C. We listen to the 13-year-old with autism who is feeling increasingly anxious when he watches the news. We notice the 4th grader who stopped all virtual schooling because of poor internet access and the twelve-year-old girl who, due to the pandemic, waited for three additional days before coming to the office with appendicitis. We explain to families the importance of wearing masks and keeping social distance to help stop the spread of the virus. As President of the AAP Dr. Sally Goza has said, what we are doing now “may be the most important work of our lives.”

As the Covid-19 crisis began to unfold in March, the Georgia Chapter of the AAP became a flurry of activity. Under the leadership of immediate past president Dr. Terri McFadden, the Executive Committee began to meet weekly. A Georgia Covid-19 Task Force was created comprising pediatric infectious disease specialists, CDC physicians, public health officials, and community pediatricians from throughout the state. This distinguished committee advises Chapter leaders of the medical situation on the ground. The Chapter increased email communications to members (currently weekly) and shared messages through social media. Topics have included everything from proper infection control procedures in the pediatric office to breastfeeding guidance for the Covid-19 positive mother to educational opportunities for pediatricians.

Our amazing Chapter staff works with urgency every day to distribute these communications, coordinate a multitude of committee meetings, and to respond to physician members’ questions and concerns.

Simultaneously, the health crisis rapidly became an urgent financial crisis for many practices around the state (including my own) due to a steep drop in patient volume. We developed a communications strategy that included press releases and media interviews encouraging families to continue their child’s routine health care. We partnered with the Georgia Department of Public Health to create a social media campaign that encouraged childhood wellness exams and worked with the school system to keep immunization and sports physical requirements in place. We disseminated to pediatricians all the details of the new federal small business loans and the provider relief fund. We also urged government officials to allocate scarce PPE for pediatricians and children’s hospitals. Chapter leaders have been engaged with all levels of state government, meeting with the commissioner of Public Health Dr. Kathleen Toomey, the Chief of Medicaid Services Blake Fulenwider, the State School Superintendent Richard Woods, and with Governor Brian Kemp as we continuously advocate for children’s health issues.

Many of our Chapter’s committees have become more active during this crisis. The Legislative Committee, led by Dr. Melinda Willingham, navigated a challenging legislative session interrupted by the coronavirus and facing budget shortfalls due to a steep drop in state revenues. Remarkably, they were able to secure important wins for children that included a small increase in the Medicaid rate, an expansion of Medicaid
Seemingly overnight, we deep cleaned our offices, gowned up in personal protective equipment, and radically altered our workflows. We stayed open, treated the sick, and counseled families through this stressful event.

on telehealth and advocated for adequate payment from insurers for this service. The Emergency Preparedness Committee, the Infectious Diseases Committee, the Inigrant Child and Family Committee, the Medical Home Task Force, the Communications Committee, the Bioethics Committee, the Committee on Child Abuse and Neglect, the Breastfeeding Committee, and others have all been engaged in important work during the pandemic.

Looking back over the past few months, I am proud to say that Georgia’s pediatricians have risen to an incredible challenge: seemingly overnight, we deep cleaned our offices, gowned up in personal protective equipment, and radically altered our workflows. We stayed open, treated the sick, and counseled families through this stressful event. We have kept calm, stayed sane, and supported each other. I would like to thank our state’s children’s hospitals for stepping up during this crisis with their leadership, resources, and expertise. And, of course, I would like to thank all of you, our state’s pediatricians, for your service to your young patients and for frequently putting their needs in front of your own. Although this is a difficult time, I have never been more proud to be part of the physician community, to be a practicing pediatrician, and to be a loyal member of our organization, the Georgia Chapter of the American Academy of Pediatrics.

Hugo Scornick, MD, FAAP

I am amazed at the parents, grandparents, and children I see in my practice. I’ve taught virtual New Mommy Classes and found these new Mamas are fierce! They have been to Obstetrics appointments alone, given birth with one partner present, and attended pediatrician office visits with masks for themselves and their children (over age 2 years). They breastfed and they bottle-fed. They work on the frontline or at home with various childcare issues. Many have been dealing with the decision to send children to school in-person or virtual this school year.

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Just like them, my life has been filled with worry and angst about the COVID-19 pandemic. The first time I donned PPE and swabbed a pediatric patient for COVID-19, both the mother and I cried due to the uncertain future. In another case, I hospitalized a pediatric patient with COVID-19, both the mother and I cried due to the uncertain future. In another case, I hospitalized a pediatric patient for COVID-19, both the mother and I cried due to the uncertain future.

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Join us in welcoming some of our new pediatric specialties.

**Orthopaedics and Sports Medicine**

**Dell McLaughlin, MD**, will join Children’s as a pediatric orthopaedic surgeon in October. Dr. McLaughlin completed a pediatric orthopaedic fellowship at The Hospital for Sick Children in Toronto, Ontario, Canada, as well as a fellowship in musculoskeletal oncology at Memorial Sloan Kettering Cancer Center in New York. Prior to her fellowship training, she completed her residency at the University of California San Francisco and received her medical degree at Emory University School of Medicine. Her interests include musculoskeletal tumors, complex limb reconstruction and general pediatric orthopaedic conditions. She will see patients at the Center for Advanced Pediatrics, Children’s at Fayette and Children’s at Old Milton Parkway in Alpharetta.

**Saj Azeri, MD, MPH**, will join Children’s as a pediatric orthopaedist in October. Dr. Azeri recently completed his nonoperative pediatric fellowship training at the University of Wisconsin School of Medicine and Public Health. He attended the Helen DeVos Children’s Hospital for his residency training after receiving his medical degree at the University of Alabama School of Medicine. His areas of focus include club foot care and pain management, musculoskeletal trauma, and sports medicine. Dr. Azeri will care for patients at Children’s at Forthyn and Athens.

**Otolaryngology (ENT)**

**Clarice Brown, MD**, joined Children’s in September as a pediatric otolaryngologist. Dr. Brown attended the University of Texas Southwestern Medical Center for her pediatric otolaryngology fellowship training. Prior to her fellowship, she completed her residency training at the University of Buffalo and received her medical degree from Morehouse School of Medicine. Her clinical areas of interest include general pediatric otolaryngology, head and neck masses, pediatric sinonasal disease, pediatric obstructive sleep apnea, and dysphagia. Dr. Brown sees patients at Children’s at Satellite Boulevard in Duluth.

**Sean Evans, MD**, joined Children’s as a pediatric otolaryngologist following the completion of his complex pediatric otolaryngology fellowship training at Seattle Children’s Hospital. Prior to his fellowship, he completed his residency training at the University of Alabama at Birmingham and received his medical degree at Tulane University School of Medicine. His clinical areas of interest include general pediatric otolaryngology, head and neck masses including tumors and vascular malformations, congenital deformities, diseases of the sinuses and nose, airway abnormalities, sleep difficulties, and ear infections and disease. Dr. Evans sees patients at Children’s at Fayette.

**Pediatric General Surgery**

**Allison Linden, MD, MPH**, will join Children’s as a pediatric general surgeon in October. Dr. Linden recently completed her pediatric surgery fellowship training at the Sid Girlim Medical College at Thomas Jefferson University/AI duPont Hospital for Children. Prior to her pediatric surgery fellowship, Dr. Linden completed a pediatric surgery critical care fellowship at Children’s Hospital Los Angeles and an ECMO fellowship at the University of Chicago Comer Children’s Hospital. She finished her general surgery residency at Georgetown University Hospital and received her medical degree from Georgetown University School of Medicine. Dr. Linden’s areas of interest include neurosurgical, minimally invasive surgery, surgical critical care, ECMO and global surgery. She will hold clinics at the Center for Advanced Pediatrics and Children’s at Satellite Boulevard.

Starting as a volunteer question writer with the American Board of Pediatrics (ABP) in 2000, I am about to complete a seven-year term on the Board of Directors, having served as Chair in 2019 and as Immediate Past Chair in 2020. Under the leadership of Dr. David Nichols, President and CEO, and with the vision of “inspiring a lifetime pursuit of learning to improve child health,” the ABP has launched major innovations in pediatric education and certification, including the new assessment platform MOCA-Peds and the popular learning tool Question of the Week. This year, the American Board of Pediatrics administered its first certifying exam in Pediatric Hospital Medicine (PHM), the fifteenth subspecialty in the field of pediatrics. The ABP is also committed to addressing the epidemic of behavioral and mental issues by working with training programs to ensure residents and fellows are better equipped to manage common issues in these areas, and by providing diplomates self-assessment (Part 2) and quality improvement (Part 4) opportunities as well.

Understanding that the coronavirus pandemic was significantly affecting diplomates and trainees, the ABP acted quickly to make adjustments in requirements. This summer, diplomates automatically received Part 2 and Part 4 points in their portfolios, acknowledging the tremendous learning and practice improvements pediatricians were making in response to the crisis. The ABP also granted the ability to defer the second MOC part payment for those enrolled in MOCA Peds, recognizing that keeping up with the assessment program may be difficult for some diplomates. A COVID-19 Improvement Project application was also developed to credit the innovative care delivery efforts that practices put into place in response to the pandemic. The ABP is actively working on ways to accommodate pediatricians who continue to face significant financial hardship through the end of the year. As a reminder, the annual payment option for MOC is $280, and will not be increased in 2021. For more details on these changes, I invite diplomates to log onto their portfolios at abp.org.

The ABP is also regularly communicating with residency and fellowship directors, reviewing and adjusting training requirements that might be difficult to meet during the pandemic. Four subspecialty exams that were originally scheduled in the spring were quickly rescheduled for August. Because some hot spots continued to exist in different parts of the country, the ABP also offered diplomates the option to defer their eligibility for two years, and to take those exams when they are next scheduled to occur.

I am very grateful for the opportunity to work with the ABP and want to especially thank the American Academy of Pediatrics and our very own Dr. Sally Goza for the Academy’s continued collaborative efforts. I also want to thank the many Georgia pediatricians who have donated their time to work on an ABP committee, and enthusiastically encourage office-based pediatricians to consider volunteering with the Board – it has been a true highlight of my career!

Anna R. Kuo, MD
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Imagine this scenario: Kayla is on her computer doing her classwork online since COVID has shut down her school. She is really hating life right now. Ugh! She hates virtual learning, she misses her friends, and she is at home alone with her mom’s creepy boyfriend since her mother has to work to help support them. She snacks on Ramen noodles, which is the only thing they have in the house because her mom had to sell their EBT card to help pay bills since work hours have been cut. While doing her homework, a cute picture of a boy pops up in her DMs. Who is this? He’s a “meat” (meaning cute in slang). Little does Kayla know that the cute boy is really Chester, a middle-aged man who lives in California who preys on young girls to “hook up” with and solicits illicit photographs. Unfortunately, Kayla trusts him and the relationship continues.

Kayla’s story reflects the effects of our current environment and should raise concerns for all of us. On April 3, 2020, Governor Brian Kemp declared a Shelter-In Place Order for the state of Georgia. Everything was shut down and life as we knew it changed. COVID-19 and its effects on society took over and we in the medical field kicked into high gear trying to manage the steady flow of patients ravaged by this novel virus. This pandemic has magnified risk factors similar to those we see that propagate child abuse. Although we are seeing an overall suppression in child abuse reports and fewer children are being taken into care, simultaneously there is an increase in admissions for severe physical abuse and domestic violence.

Many studies support a positive correlation between disasters and elevated risk for trauma. In the midst of our current evolving chaos, I worry about our children. Our eyes are not on them as before. Schools are closed and they are at home alone, or disclosure of abuse. How can we keep our children safe?

We must remember that not all homes are safe. The majority of school districts have gone to virtual platforms. While revolutionary in many ways, these platforms mean more time is spent at home and, with many parents still working, children are being left with unsafe or distracted caregivers. School may have been the only safe place for a child to have reprieve from the abuse that is occurring at home. With confinement to the home, abusers have more access to them. Additionally, online predators are becoming more aggressive during the pandemic. More than 500,000 predators are online every day. One in seven youth are contacted by an internet predator with girls making up 78% of child victims. This situation is why education regarding online predators should be discussed with families.

We should also not forget about food poverty as one in four Georgia children live in food insecure homes. School may provide their only meals for the day and, although many schools have made it possible for families to obtain food, there are associated risks for infection exposure with these programs as well. All of these factors are concerning for the physical and mental health of our children.

Child abuse is a major concern during this pandemic. We as pediatricians must be exquisitely vigilant about checking on our families and offering support and resources. We are not alone in our stewardship over our patients. Even though life as we knew it has changed, our resources are the same. If a pediatrician has concerns for abuse, the Division of Family and Children’s Services (DFCS) has the 1-855-GA-CHILD (1-855-422-4453) hotline and are continuing to perform investigations and offer services. Prevent Child Abuse Georgia has a hotline (1-800-CHILDREN) that offers support to families and has multiple resources. There are 52 Children’s Advocacy Centers throughout Georgia that have local resources to help families provide direction. Local law enforcement continues to provide welfare checks for families if there are concerns. Child Abuse Pediatricians located in Macon, Atlanta, Savannah and Augusta are available to support and information. The National AAP and Georgia AAP also have resources to help families and pediatricians. In short, we can and should raise concerns for all of us. On April 3, 2020, Governor Brian Kemp declared a Shelter-In Place Order for the state of Georgia.

In our resident clinics we collectively see hundreds of thousands of children. They come smiling and playful or apprehensive and screaming. We talk about sports, school, friends, and joke about what we find in their ears or hear in their bellies. As we transition to teen years our questions become more serious and conversations can become more embarrassing. These discussions, however, are essential to their evolving care.

There is danger in letting these conversations become routine because they, like the patient, change. Questions about school performance can quickly lead to talks about bullying, problems at home, or disclosure of abuse. I recall a conversation with a patient of mine who admitted that her father often choked and slammed her against the wall. Afterwards, she begged me not to tell anyone because she feared repercussions and asserted it was her fault for provoking him. On exam, there was evidence supporting her accusation and I was left with the dilemma of how to ensure my patient’s safety with the accused abuser, who was unemployed, literally waiting on the other side of the door.

In the midst of the stressors of the current global pandemic, probing questions and frank conversations with our patients are more important than ever. The CDC estimates at baseline that at least 1 in 7 children is a victim of abuse or neglect and that those from lower socioeconomic populations are 5 times more likely to suffer abuse than their more financially secure peers. The pandemic environment expands this at-risk population by compounding financial stressors of underemployment and employment-related infection risks with preexisting relationship discord. Infection control measures, while necessary, disrupt access to social support institutions (family, school, child care, community and religious organizations), leaving at-risk families or individuals with limited access to resources. Confinement augments the concern for limited disclosure opportunities and more online time with distracted or absent parental supervision gives sexual predators broader access to potential victims.

The AAP recently published a call to action on childhood sexual abuse, which begins with the line, “Every one of my doctors failed me.” This is a powerful and somber statement regarding our stewardship. Asking appropriate open-ended questioning, building rapport, and using the physical exam as an opportunity to identify abuse and educate about body safety are all resources we have in this fight.

Additionally, mentioned in this call to action is the use of a 17-item screener tool (currently undergoing randomized controlled trial) that we may potentially use to identify Adverse Childhood Events and thereby better advocate for our patients.

Despite current societal challenges, we cannot fail our patients. We must figuratively, through serious screening and patient education, and, when necessary, literally stand at the door between our patients and their abuser with the solemn responsibility to allow no harm.

Yameika Head, MD, FAAP
Child Abuse Pediatrician
Chair, Committee of Child Abuse and Neglect
Beverly Olson Children’s Hospital
Macon

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Ryan B. Davies, MD
PGY-III Chief Resident, Pediatrics
The Medical Center Navicent Health
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Nutrition Update – Fall 2020

Jay Hochman, MD

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

1. “Doughie Bag: Study for Celiac disease,” JA Silvester et al (Gastroenterology 2020; 158: 1497-1509) examined the gluten-free diet (GFD). 12 of 18 were exposed inadvertently to gluten within the 10-day study period due to food contamination. 25 of 515 (8%) of food samples from 9 participants had detectable gluten with a median of 11 parts per million. This study shows that a GFD may be more aspirational than achievable, even by highly committed and knowledgeable individuals.

2. Milk consumption and health, WC Willett et al (N Engl J Med 2020; 382: 644-54) provide a provocative review on why a healthy diet may not need milk, especially in adolescents and adults. All the nutrients in milk can be obtained from other sources (including calcium and vitamin D). If the diet quality is low, especially for children, dairy foods can improve nutrition. However, “if diet quality is high, increased [milk] intake is unlikely to provide substantial benefit, and harms are possible.”

3. Nutritional risks in adolescents after bariatric surgery, S Xanthakos et al (Clin Gastroenterol Hepatol 2020; 18: 1070-81) completed a multicenter prospective cohort study with 226 adolescents (mean age 16.5 years, mean BMI of 52.7) who had either Roux-en-Y bypass (RYGB, n=161) or vertical sleeve gastrectomy (VSG, n=65). Key findings:

- Overall, this study shows that adolescents undergoing VSG had fewer nutritional deficiencies than RYGB and provides data supporting nutritional monitoring after bariatric surgery.


- After 5 years, 99% of RYGB and 27% of VSG had no nutritional deficiencies.
- The most prevalent deficiency was hypovitaminosis A, which affected nearly twice as many RYGB recipients by Year 5 compared with VSG.
- Vitamin B12 status likewise worsened disproportionately after RYGB, despite similar trajectories of weight loss after VSG.
- Overall, this study shows that adolescents undergoing VSG had fewer nutritional deficiencies than RYGB and provides data supporting nutritional monitoring after bariatric surgery.


Key findings:

- About 40% of children with eczema have a mutation in a protein called filaggrin, which is important in reducing the gap between skin cells. If the skin barrier is disrupted then irritants and allergens are more likely to pass through and cause irritation, itching, and rash, but this is not the ‘cause’. In rare instances, specific foods may be a major contributor to a child’s eczema, but this is the exception and typically affects infants less than one year of age with truly unmanageable, severe eczema, despite good daily skin care.
- Breastfeeding mothers everywhere are incorrectly told to stop eating dairy or other foods to ‘treat’ their baby’s eczema. Not only is this unnecessary for most mothers but can lead to significant problems.


- Among adults, severe gluten atrophy of childhood diagnosis did not predict complications, persistent symptoms, quality of life, or adherence with gluten-free diet.
- Thus, severe villous atrophy due to celiac disease can respond fully to a gluten-free diet. (As an aside, children with IgA deficiency should not be offered a ‘no-biopsy diagnosis’ (JPGN 2020; 72: 59-63)).

Finally, one timely additional reference: CV Almaroos et al (J Gastroenterol 2020) (pre-print posted online July 7, 2020) found an increased risk of acquiring COVID-19 infection among users of proton pump inhibitors: the risk with once a day was 2.2-fold and with twice a day it was 5.7-fold.

Please contact me at jochman@geaereofkids.com with questions and suggestions.

Jay Hochman, MD
Vice Chair, Committee on Nutrition, Georgia Chapter AAP
Blog site: gutsandgrowth.wordpress.com

AAP Names E-Cigarette Champions

In response to the growing epidemic of youth e-cigarette use among youth and young adults, the American Academy of Pediatrics has appointed an E-Cigarette Champion for each of the 59 chapters in the U.S. The purpose of this network of E-Cigarette Champions is to educate pediatricians on the extent of the vaping epidemic, advise them on screening for smoking and vaping in clinical settings, give them the means to educate patients and their parents of the harms of vaping and help those to quit who have become regular users. Half of these newly installed Champions underwent two days of virtual training in July. The other cohort will have their training in November. I am currently the Georgia E-Cigarette Champion and the editor of the AAP Section on Tobacco Control newsletter. Please contact me at alicielittle@gmail.com if you would like to work on this project.

The vaping epidemic has taken a back seat to the Coronavirus pandemic. Fortunately, the number of cases of E-cigarette or Vaping Associated Lung Injury (EVALI) has decreased, although they have not disappeared completely. There is no current data on e-cigarette use among youth and young adults during the pandemic; however, a recent article in the Journal of the Adolescent Health showed that young people (ages 13-24) who have ever used e-cigarettes have a 5 times greater chance of being diagnosed with SARS-CoV-2 and those who have ever been dual users of cigarettes and e-cigarettes have a 7 times greater chance.

(Gaeta et al. Association Between Youth Smoking, Electronic Cigarette Use, and Coronavirus Disease 2019)

To learn more about E-cigarettes & Vaping, plan to join me as I present, Webinar: Update on E-Cigarettes & Vaping, on Wednesday, October 14, 2020 from 12:30 - 1:30 pm.

Alice Little Caldwell, MD, MPH, IBCLC, FAAP
Associate Professor of Pediatrics, Medical College of Georgia
Contact: 1-877-266-3862 - free Georgia Tobacco Quit Line
Go to teen.smokefree.gov/
The Evolution of ECMO and Further Training in Advanced Technologies

Before the current coronavirus pandemic few people outside of the intensive care unit had heard of Extracorporeal Membrane Oxygenation (ECMO). In recent months, however, ECMO has been making the national spotlight on a routine basis with stories ranging from how care is rationed to ECMO to supporting a woman requiring a double lung transplant after COVID-19 severely damaged her lungs.

ECMO utilization has been increasing in adult patients since the early 2000s but initially made its foothold as a feasible life support technology in neonatal and pediatric patients. The pediatric intensive care unit at Children’s Healthcare of Atlanta at Egleston is one of two pediatric and neonatal ECMO centers providing care for critically ill children in the state of Georgia. (The other is the Medical College of Georgia in Augusta.) Children’s Healthcare of Atlanta is one of eleven Children’s Hospitals in the United States to be awarded the Platinum Center of Excellence by the Extracorporeal Life Support Organization, an award signifying commitment to high level performance, innovation and quality care.

Children’s Healthcare of Atlanta is one of eleven Children’s Hospitals in the United States to be awarded the Platinum Center of Excellence by the Extracorporeal Life Support Organization, an award signifying commitment to high level performance, innovation and quality care. Patients are considered for ECMO candidacy when their risk of mortality approaches 80% with conventional treatment and if the process leading to respiratory failure, cardiac failure or both is considered reversible. Early consideration of transfer to an ECMO center, however, is suggested in cases of severe illness or where a rapid escalation in supportive medical therapy is needed in order to facilitate safe transport and allow time for evaluation by the ECMO center. Egleston’s ECMO program can support patients needing cardiac support (venoarterial ECMO), bypass of the lungs (venovenous ECMO generally) or support of both the heart and lungs. Our cardiac ECMO program has approximately 50 ECMO cases per year with survival rates of close to 50%. Indications for cardiac ECMO include myocarditis or cardiomyopathy, uncontrolled arrhythmia, and failure to separate from cardiac bypass post-surgery for congenital heart disease, among others. Our pediatric respiratory failure patients generally require ECMO due to viral or bacterial pneumonia. Other less common indications include pulmonary hemorrhage, asthma non-responsive to conventional therapy, and pulmonary emboli. Survival rates are around 75% or higher depending on the underlying indication. We also care for neonates who most frequently require ECMO for congenital diaphragmatic hernia, meconium aspiration syndrome and persistent pulmonary hypertension of the newborn (or persistent fetal circulation). These patients also have varying survival rates depending on the underlying indication, ranging from 50-90%.

There have been many advances in the ECMO field that have improved the circuit technology, improved quality of life and family interactions while on ECMO, in addition to improving patient outcomes. Innovative cannula design allowing easier patient mobilization, more compact ECMO pumps and increased provider experience have promoted protocols affording decreased sedation and neuromuscular blockade utilization resulting in increased mobilization of patients. These advancements have allowed patients who would previously be lying in bed with minimal to no interaction with their family for potentially weeks at a time while on ECMO to be more alert and interactive. Additional benefits include improved physical strength and conditioning which ultimately lead to faster recovery and decreased rehabilitation needs after ECMO support is no longer required.

ECMO is a rapidly evolving and increasingly complex field with a human mechanical interface leading to nuances in management not generally accounted for in critically ill patients. For example, a child’s temperature is artificially regulated (the blood needs to be heated for the child to maintain a normal body temperature) due to the volume of blood outside of the patient in the ECMO circuit. There is also an inflammatory component with altered immunoregulatory effects due to contact of the patient’s blood with the plastic circuit. These two factors make accurately detecting infection while a patient is on ECMO more challenging. From a surgical standpoint, proper cannula placement and securement in tiny vessels is a technical procedure requiring finesse and precision. As the adoption of ECMO continues to increase and its utilization evolves, the Emory University School of Medicine saw a window to contribute to the knowledge and training of future critical care and surgical physicians by implementing a 1-year ECMO and advanced technologies fellowship starting this year in 2020. This fellowship will be offered to surgical, pediatric critical care, and neonatology fellows to include training on the intricacies of ECMO cannulation and patient management on ECMO in addition to other advanced technologies including continuous renal replacement therapy and plasma exchange.

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The Evolution of ECMO Continued from previous page
The Center for Disease Control and Prevention (CDC) defines sudden unexpected infant death (SUID) as “the sudden death of an infant under 1 year of age that cannot be explained after a thorough investigation.” SUID is routinely classified as one of these: 1) sudden infant death syndrome (SIDS), 2) accidental suffocation and strangulation in bed (ASSB), or 3) death from unknown causes. Each year, around 4,000 U.S. babies die from SUID, making it an important topic to understand and effect change. In Georgia, there are three deaths every week from SUID. Between 1990 and 1999, the SUID rate drastically declined following numerous safe sleep campaigns, the most notable being the ‘Back to Sleep’ campaign in 1994. In 2012, the AAP expanded their focus to include environmental recommendations (such as sleep location and environment) and renamed it the ‘Safe to Sleep’ campaign. Since 1997, SIDS deaths have become less common; however, rates of infant death due to unknown causes and ASSB are stagnant. With proper safe sleep education and adherence to the American Academy of Pediatrics (AAP) safe sleep recommendations, the risk of sleep-related infant death can be reduced.

To reduce sleep deaths, the AAP’s ABCs of sleep are paramount:

A) = place infants *Alone*; B) = on their *Back*; and C) = in a *clear* Crib with only a firm mattress and a tight-fitting sheet.

In 2016, the AAP updated their sleep recommendations as follows:

1) Back to sleep for every sleep: Head of bed elevation has not been found to be protective against reflux, so it is no longer recommended!
2) Use a firm surface covered by a fitted sheet: no soft bedding, no bumpers, and crib must meet CPSC requirements. No sleeping in car seats, swings, or carriers.
3) Breastfeed: At least until 6 months if possible; 12 months is even better!
4) Room-sharing without bed-sharing: A child’s crib should be in the caregiver’s room, ideally until 12 months (but if you can make it to 6 months, that’s great!)
5) Keep everything out of the crib: no blankets or pillows, place in a sleep sack. Swaddling has not been found to be protective against SUID.
6) Consider offering a pacifier: they are protective against SUID. The mechanism is unclear, but even if they fall out, they are still protective.
7) Avoid smoking, drug use and alcohol during pregnancy and the newborn period (AND bed-sharing is strictly prohibited).
8) Avoid overheating and head-covering in newborns: once the newborn can regulate temperature, stop covering the head and avoid over-bundling (no more than one layer over what parents are wearing).
9) Pregnant women should get routine prenatal care.
10) Vaccinate per the CDC/AAP guidelines
11) Avoid use of devices that go against these regulations (bumpers/docks/socks).
12) Do not use cardio-respiratory monitors because they do not prevent SIDS (sneakers).
13) Avoid putting down baby when sleepy.
14) Always model safe sleep: NICU’s should model with every sleep.

Question: Which of the following has not been found to be protective against SUID?

A) Pacifiers
B) Breast-feeding
C) Hats
D) Routine vaccinations
E) Room-sharing without bed-sharing

Answer is C: All but hats have been found to be protective. We recommend not overheating babies, and although hats may be used in the immediate newborn state, once babies are regulating their temperatures well, head coverings are not necessary and may lead to overheating, or can tug over the nose, which can put at risk for suffocation.

Question: What type of reflux precautions are recommended?

A) Holding upright for 30 minutes after feeds
B) Putting books under infant mattress to keep the head of bed inclined
C) Putting infants to sleep in an inclined sleeper or car seat
D) Putting infants to sleep in an infant swing
E) Elevated head of bed to prevent reflux is no longer recommended due to higher risk of SUID

Answer is E.

Safety-approved® portable play yards can also provide a safe sleep environment for your baby. When using a portable play yard, always place baby to sleep on his or her back and keep toys, pillows, and blankets out of the play yard. These actions help reduce the risk of SIDS and other sleep-related causes of infant death.

*Visit the US. Consumer Product Safety Commission website for more information about safety approved baby sleep space: http://www.cpsc.gov/Safety-Education/Safety-Education-Centers/cribs/

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Pediatric Emergency Medicine Physician
Children’s Healthcare of Atlanta
Atlanta
We asked you all to send your pictures/selfies in PPE. Here are our members in their PPE taking care of Georgia’s children!

Rebecca Reamy, MD, Columbus
Don Helsky, MD, Atlanta
Fiona Blair, MD, Stone Mountain
Lisa Robertson, MD, Lawrenceville
Maria Coleman, MD, McDonough

Memorial residents:
L to R: Katie Ross MD, Lydia Davidson MD, Chris McConnell MD, Trish McLaughlin DO

Rebecca Reamy, MD, Columbus
Amanda Rose, AFPA, CNP-P, & Juliana Nahan, MD, Covington
Keryna Washington, MD, Decatur
Melinda Williams-Willingham, MD, Clarkston
Natalie Roosa, MD, Dunwoody

Pediatrics and Genetics, Alpharetta
Sylvia Washington, MD, Rome

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Join us for our upcoming virtual events!

Pediatrics on the Virtual Parkway: Halloween Edition, Virtual Fall CME Meeting
October 31 - November 1

To register for upcoming webinars, visit: www.gaaap.org/upcoming-webinars

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