The Forum
American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™
Massachusetts Chapter
Newsletter of the Massachusetts Chapter of the American Academy of Pediatrics

PRESIDENT'S MESSAGE

Recently, I've come to appreciate one thing about the inner workings of state government: It really does seem true that virtually all meaningful business takes place during the compressed timeframe of budget season. Throw in payment reform for good measure, and things really start to get interesting.

As a result, the chapter has been very engaged on Beacon Hill during May and June. Chapter representatives have met with members of the Patrick administration and testified before various legislative committees to advocate for programs that are critical to the needs of children and to drive home the point that payment reform deliberations have to take into account the unique needs of children, as well as preserve and support the systems and providers that are essential to meeting those needs.

Difficult budgetary times have led to retrenchment in many areas that could have real negative impact on the pediatric population. While there seems to be a nearly endless number of programs that are of interest to pediatricians, children, and families, our primary focus has been on a few areas that seem most critical: payment reform and maintaining adequate funding for the WIC program, early intervention, MCPAP, and childhood immunizations.

On a different note, I had the privilege of representing the chapter at a conference in May that put a spotlight on the considerable number of children who are connected to the military. More than 13,000 children in the Commonwealth have a parent currently serving in the active military, reserves, or Massachusetts National Guard. Even more children have a parent or sibling who's

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Pediatric Neurosurgery in Mbale, Uganda

This spring, in April and May 2011, the MCAAP generously provided an international grant, which enabled me to volunteer for four weeks at a pediatric neurosurgical hospital in Uganda.

CURE Children's Hospital of Uganda (CCHU) is a regional teaching hospital for pediatric neurosurgery. Since its inception in 2000 in the town of Mbale, the hospital has provided life-saving operations to over 8,000 children from Uganda and neighboring countries in East Africa. CCHU employs a staff of nearly 100, including Dr. John Mugamba, a pediatric neurosurgeon. The facility hosts 40 beds — including an 8-bed intensive care unit, 2 operating rooms, and one of the few CT scanners in the region. CCHU also sends out monthly mobile clinics to distant sites throughout Uganda.

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CURE Children's Hospital of Uganda (CCHU)

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EDITOR'S NOTE

The Case for Self Care

At this year's MCAAP meeting, speakers such as Charles Homer and Susan Linn emphasized strategies to promote diet and exercise and highlighted the crucial role that pediatricians play in improving the health of their patients and communities. Together, pediatricians from across the state reviewed dozens of ways to promote behavior change in our practices, communities and across the country.

But despite all the fabulous ideas and opportunities, I think we left one item out. While we all know the current recommendations for diet and exercise, how many of us practice what we preach? The most recent study of Massachusetts physicians, performed in 2005, found that only 3 percent eat the recommended number of fruits and vegetables, 42 percent exercise once a week or less, and 45 percent are outside the healthy BMI range.

With long work hours, busy practices, and social taboos on eating, stretching, or taking a break in front of others, it can be difficult to follow our own advice. Yet it is critical for several reasons.

First of all, diet and exercise can help prevent and mitigate the burnout and depression that will affect almost 50 percent of physicians at some point in their career. More importantly, taking care of ourselves actually helps us to take care of others. In a recent study in *Preventative Cardiology*, the more physicians exercised, the better they were at counseling their patients on exercise, and the better they felt that these interventions had worked.

Additionally, modeling healthy behaviors is the most effective way to lead our patients and communities to make healthy changes. In business academia, "modeling the way" is not only considered to be the most effective form of leadership, but also the groundwork from which all others follow. Similarly, social science experts such as Albert Bandura believe that social modeling is second only to direct mastery experiences in promoting behavior change.

According to these models, the most effective way to encourage healthy behavior changes in our patients is to model them publicly. I realize that such changes are not always easy to put into practice. For years I was shy about refilling my water bottle at the waiting room fountain, and I never biked to work because I worried about what I'd look like upon arrival. In my mind, doctors were supposed to look like they took care of themselves — but only perform self-care in private. For me, the metaphorical tipping point came at the same time as the physical one; when I had started moving the weights on our office scale farther and farther to the right.

In many ways, committing to a healthy lifestyle at the office has been harder than I expected. From wedging an almond deep in the fax machine (sorry, tech support!) to arriving at the office looking like Dr. Swamp Thing after an unexpected thundershower, I haven't always been graceful. But surprisingly, my embarrassment has never lasted long. In fact, my patients have loved it.

Since I've become visibly healthy at work, I have been stopped by hundreds of families who want to know more about my routine. At the water fountain, they ask me how much water I drink each day and if the local tap water is safe. When they see my hiking boots stashed in the corner, they ask me about local trails. Children who see my bike helmet, complete with a few silly stickers, always want to talk about helmet decorations. Suddenly, something that always felt like a lecture (wear your helmet or else!) has become an effortless conversation between enthusiasts. Even my gaffes have sparked discussions with patients on how hard it can be to stay active, and what neighborhood resources we can use to do so.

The war against obesity is a huge one, and it will be fought on dozens of fronts. But as you plan your battles, I urge you to work for yourself as well as for your patients. Take your own advice — not only because you deserve the same care and attention that you teach them, but also as the best way to lead others towards a healthier tomorrow. ***— Anne Light, MD***

Left: Brain CT scan demonstrating severe post-infectious hydrocephalus in a Ugandan infant. Right: CCHU has offered life-saving neurosurgery to thousands of children across East Africa.

Pediatric Neurosurgery in Mbale, Uganda

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CCHU specializes in the surgical treatment of hydrocephalus and myelomeningocele, as well as other childhood neurosurgical disorders such as encephalocele and pediatric brain tumors. The hospital provides comprehensive care with an interdisciplinary team comprised of surgeons, anesthesiologists, medical house officers, physical therapists, social workers, and counselors. Treatment is offered at a reduced cost to those who cannot meet their fees, and hospital costs are subsidized by CURE International and other organizations.

Despite these efforts, hydrocephalus remains a devastating problem in Uganda. Left untreated, affected infants often die, while those who survive face severe disability and social isolation. Many who seek treatment do so very late, when accompanying neurological insults may be irreversible.

Recently, CCHU has emerged as a leader for managing hydrocephalus in Africa. Cerebrospinal fluid (CSF) shunting, the mainstay of hydrocephalus treatment in North America and Europe, is a challenge for developing countries. Shunts are expensive and susceptible to malfunction or infection, the latter of which can be deadly when there are obstacles to timely emergency care. Aiming to avoid shunt dependency, neurosurgeons at CCHU have pioneered an alternative therapy for children with hydrocephalus: combined endoscopic third ventriculostomy and choroid plexus cauterization (ETV-CPC). This procedure reduces the production of CSF and also creates an alternate pathway to its absorption site, obviating the need for a shunt in many patients. Studies from CCHU have demonstrated excellent outcomes for children treated with ETV-CPC and led to a scoring system and protocol for its application elsewhere.

During the time I spent at CCHU, my clinical involvement spanned a range of activities, including rounding on perioperative patients in both ward and ICU settings, evaluating and admitting new patients, assisting in the OR, performing ventricular taps and other procedures, following up on previously operated patients, and traveling with the hospital's mobile clinic for patient follow-ups in distant regions.

My experience at CCHU was invaluable on a number of levels. In a practical sense, I gained a familiarity with manifestations and management of a variety of pediatric neurosurgical disorders in the developing world, notably hydrocephalus and myelomeningocele. While these disorders are by no means unique to Uganda, the incidence, etiology, and severity at presentation of these clinical entities are distinct from their counterparts in the United States.

More broadly, I was exposed to the delivery of neurosurgical care in a unique, resource-limited setting. Without an MRI or other sophisticated diagnostic or interventional techniques, we relied heavily on a basic set of tools that included our neurologic exam and clinical intuition. Despite the thrill of this challenge, I was often left humbled. Once, even our team's best efforts to revive a young patient fell short when faced with a CT scanner that had been shut down for the evening, an ICU without ventilators, and an OR closed for a long holiday weekend. I wont' soon forget the night I spent in the muggy ICU, swatting mosquitos with one hand and bag ventilating a deteriorating 9-month-old girl with the other.

Yet, through all this adversity, the CCHU staff never ceased to amaze me with their optimism and resourcefulness. The dedication of their remarkable team is the primary reason that CCHU continues to transform the lives of thousands of children throughout East Africa.

I had a memorable experience in Uganda, and would recommend a clerkship at CCHU to other students and residents — particularly those with an interest in pediatric neurology, neurosurgery, infectious disease, or medical humanitarian aid. Visitors dropped by CCHU frequently; the campus features a convenient guesthouse and hospital business is conducted in English. Students and residents interested in learning more about CCHU can visit www.cure.org or email info@cureuganda.org. ***— Matthew Mian, fourth-year medical student, Harvard Medical School***

President's Message

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been deployed as part of the conflicts in Iraq and Afghanistan over the past decade. These children are dispersed throughout our communities and often unrecognized as having military connections. Not surprisingly, these children also experience stressors that are frequently unidentified. This idea isn't necessarily news to many Massachusetts pediatricians, and it's likely that there are docs more enlightened than me out there who are already striving to meet the needs of these children and families. But for my part, I realized that there is a quick and easy way to help them. Just as we ask any new patient about tobacco exposure, housing, domestic violence, and other social or environmental determinants of health, I suggest that we add a question about family members in the military to our history. I've found that my militarily connected patients are eager and delighted to have their sacrifices acknowledged, even if they're coping admirably well.

And as a brief, final note I'd like to give interested members a heads-up about an event that the chapter will be sponsoring in November, in partnership with the Children's Museum and Strategies for Children. In an effort to rally the troops of all the groups that serve children in the Commonwealth, our chapter will convene a "Summit on Early Childhood Development." Our goals are to present an evidence-informed examination of programs and services that can foster optimal early childhood development, as well as lay the groundwork for a sustainable coalition that can support this important work in the future.

So mark your calendar for Tuesday, November 16, at the Massachusetts Medical Society in Waltham, with more details to come. ***— Greg Hagan, MD, FAAP***

Traveling through Liberia with HEARTT

In February 2011, I traveled throughout Liberia, on the western coast of Africa, for five weeks as part of the HEARTT (Health Education and Relief through Teaching) organization. The goal of HEARTT is to help rebuild the Liberian healthcare infrastructure, including the medical education system, which was disrupted during years of civil war in the country. Although great strides have been made since 2005, when a stable government was established, medical care still remains a work in progress. Currently there is a severe shortage of medical personnel in Liberia, with an estimated 120 physicians and only one trained pediatrician for a population of 3.5 million. Pediatric healthcare is in a dismal state, with the probability of a child dying under 5 years of age estimated to be 235 per 1,000 live births.

HEARTT's efforts are currently based at JFK Hospital in the capital city of Monrovia. Once the premiere medical facility in West Africa during the 1960s, JFK Hospital actually closed for a time in the 1990s, but is now starting to rebuild. During my rotation, I spent most of my time in the pediatric ward, but also worked in the nursery/NICU, the emergency department (adult and pediatric), and the outpatient pediatric department (OPD). Along with other visiting residents and attending physicians, I had the opportunity to teach Liberian medical students during rounds and our day-to-day work. We also took turns presenting pediatric topics to the house officers and physician assistants.

The disease states we encountered ran the gamut from familiar entities (diabetes, asthma, seizures, hypertension, strokes, etc.) to the dire (tuberculosis, HIV/AIDS, malaria, retinoblastoma, Burkitt's lymphoma, etc.), and birth defects including myelomeningocele, untreated congenital heart disease, measles, and severe malnutrition. It was a challenging but rewarding experience to learn how to diagnosis and treat many diseases that we rarely see in the United States, and how to manage more commonplace problems in a setting with such poor resources.

During my rotation, I worked on a project to establish a database of the pediatric tuberculosis (TB) patients treated at JFK Hospital. While there is a National Leprosy and Tuberculosis Control Program, which attempts to track all TB patients and provide free medications through designated clinics, there are still gaps in the system that allow patients to become lost to follow-up care. In an effort to reduce this loss among the pediatric population, Kate Dickman, another resident from Boston Children's Hospital, and I established a TB ledger in the OPD through which all pediatric TB patients are to be registered prior to discharge. Data to be collected includes demographics, the type of tuberculosis infection, treatment regimen, clinical outcomes, and — just as important — contact information (e.g., phone numbers, addresses). Creating standardized documentation of all TB patients, allows them be tracked more closely as outpatients, ensuring medication compliance for a full treatment course as well as appropriate clinical care. Additionally, the TB ledger can serve as a resource for research on TB outcomes in Liberia and a means for quality improvement in tuberculosis care.

I have to thank everyone at HEARTT and JFK Hospital for what was really an incredible experience. Special thanks go to Dr. Emmanuel Okoh, the staff pediatrician at JFK Hospital; Dr. Patricia McQuilkin, the HEARTT pediatrics director; and Jessica Malenfant, an epidemiologist at the Massachusetts Department of Public Health for all their advice and support in regards to my project. Also, much appreciation goes to the MCAAP for the travel grant that made this experience possible.

— Lena Heung, Medicine-Pediatrics PGY4, Baystate Medical Center/Tufts University School of Medicine

Fighting Obesity on All Fronts: Improving Dental Home Access

Dental care and access to dental homes can help us fight obesity. There are many common risk factors that lead to both poor oral health and obesity in children, and pediatricians and dentists can convey similar messages to decrease the development of dental caries and obesity. These messages may include:

- Discouraging nighttime eating by encouraging no food or drink after a nightly brushing and flossing routine
- Discouraging sugar-sweetened beverages including juices, sodas, and sports drinks
- Decreasing grazing/frequent snacking to decrease caloric intake and the amount of time sugar is exposed to tooth surface
- Discouraging snacks with a high sugar content, such as hard candy and high carbohydrate snacks
- Encouraging healthy snacks, such as fruits and vegetables

Early dental home establishment can help in our battle against obesity. The current recommendations are to:

- Establish a dental home at one year of age for children with low caries risk
- Establish a dental home at six months of age for children with high caries risk

The current policy can be reviewed at http://aappolicy.aappublications.org/cgi/reprint/pediatrics;122/6/1387.pdf.

The MCAAP is currently collaborating with other health care professionals within the state to improve access to dental homes for all children by one year of age. In addition, the MCAAP has established an Oral Health Committee that will begin meeting in September 2011. If you are interested on working on the initiative mentioned above or joining this committee, please contact Cathleen Haggerty or Michelle Dalal.

— Cathleen Haggerty, executive director, MCAAP, (781) 895-9852, chaggerty@mcaap.org, and Michelle Dalal, MD, FAAP, assistant professor, University of Massachusetts Memorial Medical Center, District 2 MCAAP representative, MCAAP oral health advocate, michdalal@gmail.com

Preventive Oral Health Intervention for Pediatricians
Pediatrics 2008;122:1387–1394

MCPAP Helps Thousands of Children

The Massachusetts Child Psychiatry Access Project (MCPAP) has impacted tens of thousands of children since it was launched in 2004. As most of you know, the MCPAP provides pediatricians, nurse practitioners, and family physicians in youth-serving practices unique access to a team of child psychiatrists, social workers, and care coordinators via telephone consultation for diagnosis and treatment of mental health disorders. The program is "insurance blind" and although the Commonwealth is currently the sole funder, 60 percent of the children served have commercial insurance.

While MCPAP is a vital resource for thousands of physicians, the state cannot fully fund the program. Legislation filed by Sen. Flanagan and Rep. Balser seeks to obtain proportional payments from commercial health insurance companies at a rate equal to the participation of their membership, a projected revenue source of $1.8 million. This would provide secure funding for the program into the future, bringing the program back to five days a week and allowing for pilot expansion into schools.

We need your support in seeing this bill signed into law and expanding MCPAP to serve the school system as well. Please contact your legislator today and ask him or her to support the MCPAP bills (H.R. 1416 and S. 984). To find your state representative please visit www.wheredoivotema.com.

For more information on the bill please visit www.childrensmentalhealthcampaign.org/legislation or call Erin Bradley, Children's Mental Health Campaign coordinator, at (617) 587-1513.

SOMSRFT Obesity Campaign

The AAP Section on Medical Students, Residents and Fellowship Trainees (SOMSFRT) recently launched a new campaign to help pediatricians become local advocates in preventing childhood obesity.

You can review this campaign and access its many resources at www.aap.org/ypn/r/advocacy/obesity.html.

Interested in getting involved but not sure where to start? Check out their Prevention of Obesity Policy Tool (POPOT) at www.aap.org/obesity/matrix_1.html to identify the best ways to engage and support your local community in healthy living.

Left: Carole E. Allen, MD. Right: Drs. Emily Kung and Carole Allen at the AAP Legislative Conference in Washington, DC, this past March.

Arlington's Dr. Carole Allen Honored by MMS with Special Award for Excellence in Medical Service

Arlington resident Carole Allen, MD, has been honored by the Massachusetts Medical Society (MMS) as the 2011 recipient of its Special Award for Excellence in Medical Service. The award is one of the most prestigious that is presented by the Society, honoring a physician who has provided exceptional care and dedication to the medical needs of his or her patients and the general public. She received the honor on May 20 at the Society's annual meeting in Boston.

Dr. Allen is specialty director for pediatrics at Harvard Vanguard Medical Associates, a non-profit multispecialty group practice serving 480,000 adult and pediatric patients in eastern Massachusetts and an affiliate of Atrius Health. Dr. Allen practices as a pediatrician at Harvard Vanguard's office in Somerville. She has special interest in issues related to the parenting of gay children and adolescents.

As a member of the MMS since 1991, she has served the society in a number of capacities and is currently a member of its Board of Trustees, House of Delegates, Task Force on Health Care Reform, and Committee on Legislation, as well as president of the Middlesex District Medical Society.

Dr. Allen has also been widely active in the state and national pediatric societies. She was president of the MCAAP from 2008 to 2010 and currently serves on the group's Pediatric Council and Legislative Committee. She's also the current district chair and a member of the AAP Board of Directors.

Among community activities, Dr. Allen has served as a member and chair of the Arlington Board of Health, school physician for the Belmont Public Schools, and chair of the Tobacco Free Mass Coalition.

Dr. Allen earned her BA from Cornell University and her MD from Tufts University School of Medicine. In addition to her clinical duties, she is a clinical instructor in pediatrics at Boston University School of Medicine and a clinical instructor in the Department of Population Medicine at Harvard Medical School.

She is the recipient of a number of honors, including the Special Achievement Award from the AAP, the Paul Revere Award from the Massachusetts Association of Health Boards, the Community Pediatricians Award from Children's Hospital Boston, and the Community Clinician of the Year Award from the Middlesex District Medical Society. She's a member of Alpha Omega Alpha, the national medical honor society, and has been a Fellow of the AAP since 1987.

The MMS, with nearly 23,000 physicians and student members, is dedicated to educating and advocating for the patients and physicians of Massachusetts. The Society publishes the *New England Journal of Medicine*, a leading global medical journal and website, and Journal Watch alerts and newsletters covering 13 specialties. The Society is also a leader in continuing medical education for health care professionals throughout Massachusetts, conducting a variety of medical education programs for physicians and health care professionals. Founded in 1781, the MMS is the oldest continuously operating medical society in the country. For more information please visit www.massmed.org, NEJM.org, or JWatch.org. ***— Richard Gulla***

BOOK CORNER

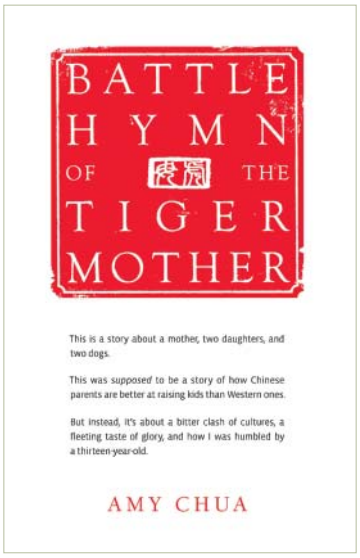
Summer 2011

Few books have captured the "pediatric popular media buzz" the way that Amy Chua's *Battle Hymn of the Tiger Mother* has. (Penguin Press, New York, 2011) Released January 11, with a sneak excerpt appearing January 8 in the *Wall Street Journal*, it has been talked about in coffee shops, around watercoolers, and in carpool lines. Reviews, criticism, and discussion appeared in various publications such as the *New York Times*, the *Washington Post*, *USA Today*, and more. I heard they're even mentioning it in next month's *Seventeen Magazine*! The controversy abounds — from writers who support Ms. Chua 100 percent as "the Mandarin Madonna leading American parents back to bedrock values" (*USA Today*), to others who have threatened to call child protective services. The passion and discussion have run deep and regardless of where you may stand (or if you've read the book yet), it behooves a pediatric clinician to at least understand the core messages of the book.

The popular coverage has focused on a list that appeared in the excerpt of Chapter 1, entitled "The Chinese Mother." In it Chua lists some things her daughters were never allowed to do:

- Attend a sleepover
- Have a play date
- Be in a school play
- Complain about not being in a school play
- Watch TV or play computer games
- Choose their own extracurricular activities
- Get any grade less than an A

The remainder of the book plays out a multitude of examples in which she enforces these rules, with a heavy dose on musical pursuits (e.g., piano for her oldest and violin for her younger daughter). Interestingly, there isn't much discussion about school performance — perhaps because her daughters had less difficulty with that than they did with maintaining "Carnegie Hall level" musical skills. Throughout all of the examples there's



a tongue-in-cheek tone, particularly as she hints on the cover page that in the end "she was humbled by a thirteen-year old."

What hasn't been mentioned in many of the critiques and blogs is, to me, the central message of the book: parents need to be involved in their child's development. Perhaps this book carried it to an extreme and a level of generalization about immigrant parents that goes beyond this one family. Nonetheless, Amy Chua loves her daughters. Perhaps she went too far, or perhaps she writes more about her dogs than her daughters, but at the end of the day, she loves them. Be it ever so humble, be it ever so different, her love and sacrifice stands out. The message I wish was being talked about by parents across the country is that *our children need us every day*. It's a message that pediatric clinicians make every time they hand a book to a child and talk to a parent about the importance of reading aloud to them. With that message, pediatric clinicians are giving parents the tools to take back control of their child. To help shape them and nurture them into the adult they're destined to become, with all the tools they need — a loving parent. ***— Marilyn Augustyn, MD, FAAP, medical director, Reach Out and Read Massachusetts***

For more information about Reach Out and Read and early literacy, you may contact her at augustyn@bu.edu.

ANNOUNCEMENT

Autism Insurance Resource Center

New England INDEX/UMass Medical School Shriver Center is pleased to announce the formation of the Autism Insurance Resource Center, Amy Weinstock, Director.

The center is a FREE resource for consumers, providers, employers, and educators on issues related to medical insurance for autism treatment.

Resources include:

- Information and referral by phone/email on issues related to insurance coverage for autism-related treatments and services
- Access to documents including legislation, FAQs, agency bulletins, etc.
- Support for employers and individuals covered by self-funded (ERISA) plans
- Webinars on insurance laws and related topics
- Focus groups and trainings

For more information, visit www.disabilityinfo.org, call (800) 642-0249, or email info@disabilityinfo.org.

MCAAP Annual Meeting

On May 17, 2011, the MCAAP had its annual meeting at the MMS headquarters. The focus was on chapter business and combating the recent epidemic of pediatric obesity. Participants heard talks from Charles Homer, president and CEO of the National Initiative for Children's Healthcare Quality; Susan Linn, director of the Campaign for a Commercial Free Childhood; and Cara Ebbeling of the Optimal Weight for Life Program at Children's Hospital Boston, who reviewed current data and learned strategies to intervene and assist their patients with appropriate weight goals. Perhaps most importantly, each speaker stressed ways in which pediatricians can work in their offices and on the local and national levels to improve the health and well being of all our patients. For more information on how you can get involved on the local and national levels, check out the SOMSRFT Obesity Campaign information on page 5.

MCAAP 2011 Election Results

The following members will be starting their terms as chapter officers on July 1, 2011:

District 3 Representative
Mark Vining, MD, FAAP *(re-election)*

District 4 Representative
Walter Rok, MD, FAAP *(re-election)*

District 5 Representative
Sheila Morehouse, MD, FAAP

District 6 Representative
Betsey Monaco, MD, FAAP

District 7 Representative
Brittanny Boulanger, MD, FAAP

District 9 Representative
Eric Fleegler, MD, FAAP *(re-election)*

District 10 Representative
Michael McManus, MD, FAAP *(re-election)*

PROS Update

Are you interested in participating in collaborative clinical research? Pediatric Research in Office Settings (PROS) is the Academy's practice-based research network. PROS is a network of over 1,700 practitioners from more than 700 practices across the United States, Canada, and Puerto Rico. Its mission is to improve the health of children and enhance primary care practice by conducting national collaborative practice-based research. Massachusetts has one of the largest PROS chapters, with 34 practices and nearly 150 practitioners. There's still room to grow!

What's new in PROS?

Studies under way:

- Brief Motivational Interviewing to Reduce BMI: a randomized controlled trial of motivational interviewing and dietitian visits to reduce BMI in overweight children
- Clinical Effort Against Secondhand Smoke Exposure (CEASE): a randomized controlled trial of a brief office-based intervention to help smoking parents quit. The principal investigator is MGH/Waltham-based pediatrician Jonathan Winickoff.

Massachusetts chapter members are participating in both studies.

Studies under development:

- ePROS, a PROS subnetwork using electronic health records for data collection. Already funded for a comparative effectiveness study of clinical decision support tools to improve pediatricians' use of stimulants for ADHD.
- Children's Oral Health: Motivation for Prevention (CHOMP), a randomized controlled trial to improve pediatric practitioners' anticipatory guidance on oral health. The principal investigator is Paul Geltman of Boston University and Cambridge Hospital.

You're invited! The next AAP National Conference and Exhibition will be held in Boston, and the next PROS Coordinators meeting will take place Friday, October 14, and Saturday, October 15. All PROS members are welcome to attend all or part of the meeting. If you are not a PROS member and would like to attend and learn more about PROS, just let us know! You'll meet PROS practitioners from around the country, hear preliminary study results, and see how PROS members collaborate on shaping new studies being developed for the network.

PROS can add a new dimension to your work with studies that are well designed and interesting. Practitioners are encouraged to be involved in data collection and to work on study design, analysis, and manuscript writing, if interested. Our academic colleagues welcome input from those of us in practice settings. Please contact one of the state PROS coordinators if you are interested or have questions about becoming a PROS practitioner.

— David Norton, MD, FAAP, and Ben Sheindlin, MD, FAAP, PROS chapter co-coordinators

For further information about these or other PROS studies, contact David Norton at nortond@holypeds.com or Ben Scheindlin at bscheindlin@yahoo.com.

ShotClock

Vaccine Safety Concern Update

Vaccines are said to be the greatest public health measure in the last 100 years. Immunizing children has prevented thousands of cases of deadly diseases, saved thousands of lives, and saved millions of dollars in health care costs. Families concerned about vaccine safety and anti-vaccine groups who oppose virtually all vaccines have raised many questions about the immunizations we give to our patients. Most of those questions have been thoroughly investigated and answered through various studies:

- There are not "bad lots" of vaccines.
- DTP vaccines do not cause SIDS or brain damage.
- The DTaP vaccines we use now have fewer minor reactions than the old, whole cell DTP vaccine used years ago.
- Thimerosal, which has now been removed from virtually all our pediatric vaccines, hasn't been found to cause any neurologic or developmental problems.
- Multiple studies from different countries haven't found any link between MMR and autism.

As these issues are put to rest through careful scientific research, other ones arise. There are concerns about aluminum in some vaccines and the harm it might cause. Aluminum is the third most common element in the earth's crust; it's in our food and water; there's more aluminum in six month's worth of breast milk than there is in all the recommended doses of childhood vaccines. There are concerns about giving "too many vaccines too early in life," but we must remember that the immunization schedule was developed to prevent the diseases when they're most likely to occur, or do the most damage. Diseases such as pertussis, tetanus, HIB, pneumococcal disease, and rotavirus are most devastating to young children. Babies infected with hepatitis B early in life have a 90 percent chance of developing a chronic hepatitis and later, liver cancer. To postpone immunizations until children are older or to "space out" the vaccines puts the smallest of babies at risk for these terrible diseases.

One of the concerns raised is that some vaccines are "made from aborted fetuses." Careful review of the vaccine-making process will show that the viruses for making varicella, rubella, hepatitis A, and rabies vaccines are grown in cell cultures that originate from 2 fetuses that were aborted more than 50 years ago. These fetuses were aborted by parental choice and were not aborted specifically to make vaccines. Cells donated from those fetuses have been perpetuated in labs for over 40 years and no additional fetuses have been aborted to make these cell lines. In the final preparation of these vaccines, the cultured cells are removed from the vaccine. There are no human cells in any of these vaccines (www.immunize.org/concerns/vaccine_components.pdf).

There are very different views about abortion in our society, but I think most of us would agree that whatever the reason for those two abortions, it's still sad that the fetuses died. However, we should recognize that the cell lines established from the two abortions decades ago have helped develop vaccines that in turn prevented incalculable pain, death, and waste of valuable health care resources. Even the Catholic Church has weighed in on this matter, stating "If it is a question of protecting the whole population and avoiding death and malformation in others, that is more important than abstaining from vaccines developed from abortions that might have occurred decades ago" (www.catholicnews.com/data/stories/cns/0504240.htm).

Concerns have also been raised about the possibility of DNA from these cultured cells being in the vaccines. The varicella vaccine package insert does indeed list DNA as one of the minor components of the vaccine. However, the amount of DNA is infinitesimal and hasn't been linked to any specific problems or medical conditions. Some of the anti-vaccine groups have suggested that this residual DNA might get into brain tissue and cause the chromosomal abnormalities that are being associated with autism. It's difficult to prove something can never happen, but there is scientific information to indicate that even the possibility of autism coming from residual DNA is minute. Patients receive large numbers of living cells in transplanted organs, skin grafts, and white blood cell transfusions. These cells all contain massive amounts of complete copies of a donor's DNA. There's never been any report of chromosomal breaks and autism developing after transplants, transfusions, or skin grafts.

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Vaccine Safety Concern Update

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There's been a lot of work on DNA vaccines and gene therapy recently. A good review article about DNA vaccines by M.A. Liu can be found in the *Journal of Internal Medicine* 2003;253:402–410. With DNA vaccines, small pieces of DNA with a specific gene are injected and taken up by local muscle cells, starting antigen production that stimulates immunity to a specific disease. This DNA does not enter the nuclei of host cells, incorporate into host DNA, and cause chromosome breaks. DNA vaccination has the potential to prevent diseases, such as meningococcus serogroup B and even HIV, and gene therapy as a whole has the potential to treat or cure many terrible genetic diseases.

As with everything we do in life, we have to weigh risks and benefits: Should you get out of bed in the morning? Should you drive your car? Should you eat the lettuce that might come from another country? Some risks are theoretical and non-measurable, while other risks are real and quantifiable. Before chickenpox vaccine was introduced, 100 children died every year and about 10,000 were hospitalized because of chickenpox. Those risks have been dramatically reduced with the vaccine. In the 1950s and '60s thousands of babies suffered terrible damage from rubella that infected their mothers during pregnancy. The rubella vaccine has lead to the virtual elimination of congenital rubella. Rabies is a fatal illness, yet there has never been a failure of rabies vaccine when it's used in the recommended schedule — another vaccine that has saved many lives. Unfortunately, measles is again rearing its ugly head in the United States, as is evident in the most recent report from the CDC (www.cdc.gov/mmwr/pdf/wk/mm60e0524.pdf?source=govdelivery). Of the 118 cases reported in the May 24, 2011, issue of *Morbidity and Mortality Weekly Report* (MMWR), 40 percent have had to be hospitalized! When looking at the known quantifiable risks of death or injury versus theoretical, unproven, and unquantifiable risks from DNA in a vaccine, the choice, in my opinion, is simple. To my thinking, the most pro-life step we can take for children is to protect them from these diseases.

— Richard Moriarty, MD, FAAP, Pediatric Infectious Disease, UMass Memorial Health Care, Worcester

Clinical Measles Update

Between 2001 and 2008, a median of 56 measles cases was reported in the United States to the CDC every year. However, in the first 19 weeks of 2011, 118 measles cases were reported — the highest number reported for this period since 1996. Of this year's cases, 105 (89 percent) were associated with importation from other countries, either U.S. residents traveling abroad or foreign visitors. Many of the cases came from the World Health Organization European and Southeast Asian regions. According to the CDC, those 105 cases occurred in people who hadn't been vaccinated, which emphasizes the importance of vaccination as a means to prevent this highly infectious disease and its related complications. According to statistics, 9 outbreaks accounted for almost half of the total cases, and 40 percent of the cases resulted in hospitalization, according to statistics.

Massachusetts has also been affected by the measles outbreak. As of May 26, 17 cases had been confirmed, and 12 were confirmed between May 1 and May 19 alone. The ages of the patients ranged from 10 months of age to 65 years of age. The Massachusetts DPH would again like to remind clinicians of the continued risk of measles, particularly among international travelers, and urge you to make sure all of your patients are appropriately vaccinated or have a documented positive titer.

For more information, visit www.mass.gov/dph/imm or www.cdc.gov/vaccines/vpd-vac/measles/default.htm.

Source: *Morbidity and Mortality Weekly Report,* May 24, 2011, Vol. 60:p. 1; "MDPH Clinical Measles Alert" #2, MDPH, May 19, 2011

What Physicians Should Know

Measles should be considered in any child presenting with fever, rash, and cough, coryza, or conjunctivitis — especially if the child recently traveled internationally or was exposed to a person with a febrile rash or other clinically consistent history.

The CDC recommends that international travelers of all ages be up to date with their vaccinations.

The CDC and the Academy recommend 2 doses of MMR vaccine for children, the first dose at 12 to 15 months of age and the second dose at 4 to 6 years of age.

For children traveling internationally, the CDC and the Academy recommend an accelerated MMR vaccine schedule:

- Children 12 months of age or older should receive a first dose of MMR at 12 months of age and a second dose separated by at least 28 days.
- Children 6 to 11 months of age should receive one dose of vaccine. Since immune response to doses given before 12 months of age varies, this dose is not considered a valid dose, and a child receiving a dose at this age should get a normal 3-dose series of MMR vaccine starting at 12 months of age (total of 3 doses).
- Depending on the epidemiology of the outbreak, including the age group affected, state health departments may take the following actions: recommend MMR vaccine for infants 6 to 11 months of age or accelerate the second dose of MMR vaccine for children 12 months of age or older who have received only one dose or both.

Massachusetts Recipient of Multiple Awards at National Immunization Conference

In March, Massachusetts was recognized for its excellent immunization coverage at the 45th National Immunization Conference, sponsored by the Centers for Disease Control (CDC).

Two National Immunization Survey (NIS) awards were presented to the Massachusetts Immunization Program:

- An award for achieving 78.9 percent coverage of routinely administered vaccines for adolescents (based on 2009 NIS data)
- An award for achieving 58 percent interim cumulative influenza coverage during the 2010 to 2011 influenza season (based on NIS data from August to December 2010)

In addition, Susan Lett, MD, MPH, was the recipient of the Natalie J. Smith, MD, Award, presented by the Association of Immunization Program Managers. This award is the highest form of recognition for immunization program managers, recognizing high levels of initiative, creativity, and commitment in achieving vaccine-preventable disease goals. Dr. Lett was recognized as a "vigorous champion of children and adult immunization, who has worked through great fiscal and political challenge to preserve the universal vaccination program in Massachusetts."

Left to right: Regina Benjamin, MD, MBA, surgeon general, U.S. Public Health Service; Donna Lazorik, RN, MS, adult immunization coordinator; Susan Lett, MD, MPH, director, immunization program; Pejman Talebian, MA, MPH, deputy immunization program manager for policy and planning; Anne Schuchat, MD, director, Center for Immunization and Respiratory Diseases, CDC

From the Immunization Program, Division of Epidemiology and Immunization, Massachusetts DPH

MCAAP Immunization Initiative Program Manager Retires

Left to right: MCAAP Immunization Initiative Directors Richard Moriarty, MD, FAAP, and Sean Palfrey, MD, FAAP; Hadassa, Kubat, DSc, MPH, Immunization Initiative program manager; and Susan Lett, MD, MPH, medical director, Immunization Program, Massachusetts DPH

In March, Hadassa Kubat, DSc, MPH, retired from her position as program manager of the Immunization Initiative. Dr. Kubat served as program manager for 15 years. Among her achievements were the introduction of the ShotClock newsletter, the expansion of Grand Rounds seminars, a hepatitis B school initiative, and co-sponsorship of the annual Massachusetts Immunization Action Partnership Conference with the Massachusetts DPH. Dr. Kubat maintained a vast bibliography of literature as well as a library of slides for Grand Rounds seminars. Dr. Kubat was honored during her tenure by the AAP, the National Partnership for Immunization, the Massachusetts DPH, and the Massachusetts Immunization Action Partnership.

SAVE THE DATE

16th Annual MIAP Pediatric Immunization Skills Building Conference

Thursday, October 13, 2011
Best Western Royal Plaza Hotel
Marlborough, Massachusetts

The 16th Annual Massachusetts Immunization Action Partnership (MIAP) Pediatric Immunization Skills Building Conference will be held on October 13, 2011, at the Best Western Royal Plaza Hotel in Marlborough, Massachusetts. The all-day pediatric conference will provide the latest information on the fast-evolving field of immunization, delivered in plenary and interactive breakout sessions.

For more information, contact Cynthia McReynolds from the MCAAP Immunization Initiative at cmcreynolds@mms.org, (781) 895-9850, or visit www.mcaap.org/whats-new.

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Job listings are a free service provided by *The Forum* to MCAAP members and residents completing their training. Nonmembers may submit ads for a fee.*

To submit a listing, email alight@mcaap.org. Please include the following information:

- Contact information
- Practice name/residency program
- Position title
- Description (25-word limit)
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**Contact Cathleen Haggerty at chaggerty@mcaap.org for rate and payment information.*

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