

OPERATIVE NOTES

American Academy of Pediatrics - Section on Surgery Newsletter

AAP Section on Surgery begins its 75th Anniversary



AAP Section on Surgery
Together, We Heal Children

The AAP Section on Surgery began its storied history in November 1948. Since that time, the SOSu has continued to champion the health of children in innumerable ways. We do so in collaboration with members within our section, with other AAP sections, committees, and councils, and with colleagues outside the AAP.

To mark the 75th Anniversary, we roll out a special logo that will celebrate this important year. We plan to continue marking this anniversary throughout 2023, culminating in the fall annual meeting. More details to follow as events crystalize.



Important Announcement for the 2023 Abstracts

We look forward to your Spring abstract submissions to the 2023 AAP Section on Surgery Meeting, to be held in Washington, DC, October 20-22, 2023.

New for the 2023 meeting, residents applying for the Jens Rosenkrantz Research Resident Awards will **not require an accompanying manuscript submission to the Journal of Pediatric Surgery**. Scoring of awards will be determined by the quality of the abstract and presentation.

Winners of the awards will be *strongly encouraged* to submit an accompanying manuscript to the Journal of Pediatric Surgery.

With this requirement change and in close collaboration with the Journal's editor-in chief, we will closely monitor the number and type of abstract submissions, and the number papers submitted for the annual meeting.

With this change, we hope to open opportunities for an even higher level basic science and clinical submissions.

The AAP Continues to Offer Strong Support for the Use of Metabolic and Bariatric Surgery in the Pediatric Population

Marc P Michalsky, MD, FAAP & Kirk W Reichard, MD, FAAP

According to the newly published *Clinical Practice Guideline for Evaluation and Treatment of Children and Adolescents with Obesity* from the American Academy of Pediatrics (AAP), approximately 14 million US children and teens are affected by obesity. Furthermore, the most severe forms of childhood obesity, categorized as \geq Class 2 Obesity, \geq BMI 120% of 95th percentile or \geq BMI 35kg/m², have been recently described as an “epidemic within an epidemic” and are often cited as a harbinger of impaired quality of life, and shortened life expectancy for today’s youth compared to similar measures from previous generations.¹ Within the context of an expanding body of literature that has linked severe obesity with numerous related comorbid and cumulative conditions in the pediatric population (i.e., hypertension, obstructive sleep apnea, type 2 diabetes, renal disease, etc.) as well as recent evidence highlighting the acceleration of weight gain among US children during the COVID-19 pandemic,² it is not surprising that interest in the application of metabolic and bariatric surgery continues to rise.^{1,3}

Despite encouraging results from several large and ongoing prospective studies evaluating the safety and clinical efficacy of weight loss surgery in the pediatric population, related access to bariatric surgical care remains challenging for a number of complex reasons.⁴⁻⁶ In a recent review of factors affecting insurance authorization among a group of teens seeking metabolic and bariatric surgery by Inge *et al*, investigators showed that initial payor authorization for such surgical intervention among clinically eligible pediatric patients was significantly lower when compared to the corresponding experience in the adult population.⁶ In addition however, the authors went on to highlight the observation that initial authorization denials (47%) were likely to be overturned (88%) as a consequence of the often arduous and repetitive insurance appeals process. Ultimately, the authors noted that 11% of the study cohort failed to obtain the required authorization for surgical intervention, with age less than 18 years being cited as the most common cause for insurance denial.

To address the increasingly complex issues associated with multi-tiered strategies related to the treatment of childhood obesity, the AAP released its first comprehensive guidance on the topic in more than 15 years. Published online on January 9, 2023, and featured in the upcoming February 2023 edition of *Pediatrics*, the CPG is the culmination of an extensive review of current literature and associated development of up-to-date consensus recommendations across the continuum of obesity-related care. In addition to addressing the full spectrum of treatment approaches designed to offer clear guidance for the primary care setting, including concise recommendations pertaining to motivational interviewing, intensive health behavior and lifestyle treatment, and pharmacotherapy, the new CPG offers a clear rationale and framework with regards to clinical eligibility for metabolic and bariatric surgery. Echoing the previously published eligibility criteria put forth in the 2019 AAP policy statement¹ as well as the 2018

pediatric metabolic and bariatric surgery best practice guidelines published by the American Society of Metabolic and Bariatric Surgery⁷, the current publication has devoted a key action statement to address the matter of bariatric surgery to help guide primary care providers and improve access to this much needed and generally underutilized treatment paradigm; *Pediatricians and other primary healthcare providers should offer referral for adolescents 13 years and older with severe obesity (BMI ≥ 120% of the 95th percentile for age and sex) for evaluation for metabolic and bariatric surgery to local or regional comprehensive multidisciplinary pediatric metabolic and bariatric surgery centers.* Although no lower age limit exists to define the safety or effectiveness of metabolic and bariatric surgery among children, the CPG acknowledges the relative paucity of data related to children younger than age 13 years which serves as a distinguishing parameter compared to the intentional vagueness used regarding guidance on lower age limit reported in the earlier policy statement and current clinical eligibility consensus recommendations (see Table).¹ It is hoped that this important publication, which also offers a number of organizational resources designed to improve professional education and practice-level strategies will serve to enhance patient related access and associated health outcomes for years to come.

Weight Criteria	Co-morbid Conditions
Class 2 obesity, BMI ≥ 35, or 120% of the 95th percentile for age and sex, whichever is lower	Clinically significant disease, including obstructive sleep apnea (≥ AHI .5), T2DM, IIH, NASH, Blount disease, SCFE, GERD, and hypertension
Class 3 obesity, BMI ≥ 40, or 140% of the 95th percentile for age and sex, whichever is lower	

AHI, Apnea-Hypopnea Index; GERD, gastroesophageal reflux disease; IIH, idiopathic intracranial hypertension; NASH, non- alcoholic steatohepatitis; SCFE, slipped capital femoral epiphysis; T2DM, type 2 diabetes mellitus.

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Pediatric and Adolescent Gynecologists Regional Location

Jennifer E Dietrich, MD, FAAP, Sari Kives, MD, and The North American Society for Pediatric and Adolescent Gynecology

Girls and adolescents make up approximately 30% of the world's female population. Obstetricians and Gynecologists, in addition to Pediatric and Adolescent Gynecology (PAG) specialists, typically provide medical and surgical care for this special patient population. As care continues to become more subspecialized, and the need for PAG specialists rises, potential patient access to a PAG surgeon location within North America remains a significant concern. Many patients' reproductive healthcare needs, both medically and surgically, may fall within an access to clinical care gap.¹

A 7-question survey sent by the North American Society for Pediatric and Adolescent Gynecology (NASPAG) was conducted among all PAG Surgeons in North America about their current location of PAG practice in February 2022.² Among 306 eligible members, 120 completed the survey for a response rate of 39.2%. Most PAG Surgeons (89.2%) were located within the United States and 9.2% in Canada. The majority reported being in an academic practice setting (68.3%) and >50% of practices were devoted to the PAG population (60.4%). Providers provided surgery in children \geq 12 years (>95%), ambulatory care (>95%), multidisciplinary care (>85%), global health services (~15%) and surgery in children <12 years (<85%). The US state reporting the most PAG providers was Texas (9), followed by California (8) and New York (7). The Canadian territories and provinces reporting the most PAG providers were Quebec (5), Ontario (3) and Alberta (3). Fourteen US states and 10 Canadian territories and provinces reported no PAG Surgery provider. The number of PAG surgeons increased with higher state and territory and province population numbers, as expected. Most PAG surgeons in the US were noted to be centralized in states with a population of at least 6 million or more, while in Canada, most PAG surgeons were in areas with a population size of at least 2.5 million.²⁻⁴

There has been renewed interest in highlighting care access gaps based on pediatric specialty provider location from the American Academy of Pediatrics (AAP).⁵ PAG has not previously been included in this analysis, but the AAP is interested in understanding potential care access gaps by highlighting PAG care locations. This survey is a first step toward improved understanding gaps in PAG care. The need for specialized care is important when considering management of emergent conditions, such as ovarian or adnexal torsion⁶, and complex surgical reproductive care needs among those with congenital reproductive tract anomalies. Patients needing PAG services may therefore have a delay in care related to location of a PAG provider.⁶ Thus far the AAP, in collaboration with the Surgical Section of the AAP, has helped to create fact sheets and recommendations to assist general pediatricians for pediatric surgical care especially in complex areas.^{5,7} Specifically, recommendations stressed that major congenital anomalies, malignancies, major trauma and chronic illness should be managed by a pediatric medical or surgical specialist and should be referred to a major referral center.⁷ Furthermore, research has shown improved

outcomes among surgeons based on their degree of specialization in pediatrics.⁸ While Pediatric and Adolescent Gynecology was not an included specialty listed in the referral or specialization papers, there are important themes learned that can be applied to help providers know when to refer to a PAG specialist.⁸ This includes referring to PAG specialists for congenital anomalies of the reproductive tract, fertility preservation concerns which may arise for a variety of reason, including for benign adnexal conditions and complex disorders involving the intersection of puberty and menses. Innovative strategies may be needed to overcome some access barriers based on PAG surgeon location currently. The AAP and the AMA have outlined strategies for providers concerned about care access and this may include incorporation of telehealth technology, which many PAG surgeons offer routinely as a result of the COVID-19 pandemic.^{10,11}

This NASPAG survey was an initial glimpse into the location of PAG surgery providers in North America and potentially highlights clinical access gaps based on the limited number of providers and location of PAG providers. Nonetheless, there were some limitations to the survey as not all PAG providers chose to participate, which resulted in some US states and Canadian territories and provinces not reporting a PAG surgery provider or under reporting the number in a given state, territory or province. Despite these limitations, it is important to note that PAG surgeons have subspecialized beyond general OBGYN training, specifically caring for children from birth-21 years of age with gynecologic concerns. A demand for this specialized care exists and continued specialty advocacy is needed in order to expand the number and location of PAG providers to fill potential clinical access to care gaps in North America.

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SOSu Famous Figure: Orvar Swenson (1909-2012)



 Orvar Swenson was born in Sweden in February 7, 1909. In 1917, his family immigrated to Independence, Missouri. In 1933, he graduated from William Jewell College in Liberty, Missouri and then entered Harvard University Medical School. He completed his surgical residency in Harvard. Swenson then spent a year as the Tracey Cabot Fellow performing research on Hirschsprung's Disease during which he developed a procedure that would be the first cure for the disease. In 1945, he became an Assistant Professor in Pediatric Surgery at Harvard and worked with Robert Gross. In 1949, he became the first pediatric surgeon at Tufts University, Boston Floating Hospital. In 1960, he moved to Chicago, Illinois and became the Surgeon-in-Chief at the Children's Memorial Hospital.

Swenson served as the **2nd AAP Section on Surgery Chair** from 1955 to 1957 and as **4th American Pediatric Surgery Association President** from 1973 to 1974.

The William E. Ladd Medal and Arnold M. Salzberg Mentorship Awards

William E. Ladd Medal

This award established in 1954 and is bestowed at “infrequent intervals” for accomplishments of outstanding merit in Pediatric Surgery. The award honors Dr. William E. Ladd, often termed the father of Pediatric Surgery. Nominations originate from the members of the Section on Surgery and are submitted to the Executive Committee of the Section for consideration. The Executive Committee then chooses the recipient. This is the highest award of the American Academy of Pediatrics Section on Surgery and recognizes a lifetime of achievement in the field. If you have suggestions for a worthy recipient this year, please send a note and reason to sosu@aap.org.

Arnold M. Salzberg Mentorship Award

This award was created in 1997 to recognize outstanding mentors in Pediatric Surgery. It is a tribute to the late Dr. Arnold M. Salzberg who was a mentor to many an aspiring pediatric surgeon. Attributes of the recipients are those who stimulate entrants into the matching process, train and educate surgical residents, encourage scientific research, and accumulate a track record as a mentor. The nominations are solicited from the members of the Section on Surgery, and the honoree is chosen from those nominated by the Section members. Often, a group of mentees of one particular mentor will decide to nominate their mentor in the same year, causing one particular individual to “rise to the top” based on the foundation of support they have received. Letters of support from the mentees are submitted to the Section Manager and reviewed by the Executive Committee, with the Executive Committee having the final determination in the award. The honor is bestowed at the Section on Surgery each year. Please fill out the [Nomination Form](#) with letter by **February 13, 2023**.