

Fall 2021

The Perspective

A quarterly newsletter published by the National Med-Peds Residents' Association in collaboration with the Med-Peds Program Directors Association & the AAP Section on Med-Peds

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2021-2022 Executive Board



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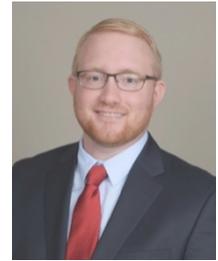
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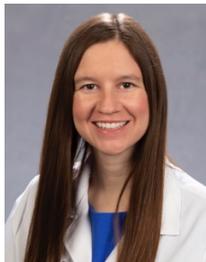
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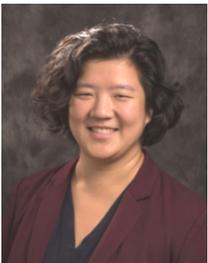
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President's Welcome

My dear Med-Peds family,

Gratitude always seems to me to be the main theme in our lives this time of year. I don't know if it's the holiday season, often full of memories that evoke a sense of comfort and peace, or the closing of a calendar year, which prompts reflection on the past and hope for a brighter future, or a combination of both. Whatever the cause for the sentiment of the season, I appreciate the opportunity to look back on past accomplishments and failures, memories joyful and heavy-hearted, in an effort to learn, grow, and evolve into a better daughter, a better friend, a better physician, and a better person each and every day.

In reflecting on this gratitude, I am often most thankful for this amazing community of individuals who inspired my career and who continues to inspire my daily life as a Med-Peds physician and NMPRA member. I am left awestruck by the seemingly endless support and encouragement, in moments both celebratory and sorrowful, from students, residents, and faculty across the country; the fierce commitment to equitable medicine in general and the unique, innovative nature of the Med-Peds specialty in particular; and the incredible dedication to our patients and our communities which is consistently focused on a desire to make the world a better place. My membership in this community evokes a sense of pride, joy, and, of course, gratitude – I don't have words enough to convey my thanks for your continued participation, innovation, and dedication to Med-Peds, but I hope you know what a vital part you are of this extraordinary family, one I will be forever grateful to call my own.

Any discussion of gratitude would be remiss without mention of our National Conference which took place virtually earlier this fall. Our theme of transition medicine was elevated to new heights by fantastic and inspiring presentations from all our speakers who gave selflessly of their time and their expertise to contribute to our growth in knowledge of this vitally important part of our mission as Med-Peds physicians. I especially want to thank all our 2020 and 2021 Grant & Award winners; our featured speakers including Sneha Dave, Dr. Eleanor Floyd, Dr. Samantha Robin, Dr. Dava Szalda, Dr. Thomas Davis, Dr. Mary Ciccarelli, Dr. Rachel Peterson, Dr. Ashley Jenkins, Dr. Francis Coyne, and Dr. Patience White; and our NMPRA Board of Directors for their dedication to making this event a great success. For those of you who were unable to join us live during the conference weekend, recordings of all presentations are now available on the homepage of our website (medpeds.org) with the passcode "Medpeds21."

Although we are fast approaching the end of 2021, we are only halfway through this academic year, and our Board of Directors has many new and exciting things planned for 2022. While our pre-recorded Educational Webinars are now live on our website (accessed at medpeds.org/educational-webinars), we have additional educational opportunities in the works, including live lectures from experts in fields relevant to Med-Peds, educational engagement on our social media platforms, and even development of a nationally-focused virtual Med-Peds Career Fair to learn more about the amazing job opportunities available through our specialty. We have been thrilled by the participation in and feedback from our

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Informational Webinars these past two years, and we are excited to continue this momentum throughout the year.

Finally, there is no better way to reflect gratitude for our specialty than by representing Med-Peds and NMPRA with official merchandise! We are happy to announce the opening of our NMPRA Online Shop where you can purchase t-shirts, facemasks, and more to show off your love for Med-Peds. Sponsored through the Bonfire platform, you can access the site from our website homepage or at this link: <https://www.bonfire.com/store/nmprpa-online-shop>. We plan to regularly expand and change the inventory offered, so check back to the site often and be on the lookout for updates on our social media platforms. A portion of each purchase will go back to NMPRA to fund educational and other opportunities to help us continue our mission to serve and support this community. We appreciate your patronage and welcome your feedback!

Yours in Med-Peds,

Sophia Urban
NMPRA President 2021-2022
president@medpeds.org
Internal Medicine/Pediatrics PGY-4
Medical University of South Carolina



A Message From MPPDA

Residency recruitment is an exciting time for programs and for medical students. As a program director, reading through files of and meeting truly inspirational humans gives me hope for the future. For medical students, recruitment is a time to meet members of your tribe, explore new opportunities and identify your priorities for the next four years. Wherever you match, you will receive excellent training and join a wonderful, tight-knit group, reflecting the Med-Peds community at large.

The MPPDA Spring Meeting (held along with Academic Internal Medicine Week) will take place April 10-13th, 2022 in Charlotte, North Carolina. Planned by MPPDA President Elect, J. T. Tolentino, the meeting will shine a light on our bright future. Undergraduate medical education (UME) and graduate medical education (GME) are in the process of formulating best practices to train a diverse group of resilient physicians who will improve patient outcomes. The residency match process is certain to evolve to align with these goals. How will the UME-GME transition change? Will medical students graduate asynchronously based on readiness? Will there be a longer, outcomes-focused on-boarding period for new residents rather than the typical 1-2 weeks of orientation? How will the residency match innovate? Will there be an early match process akin to the early action process for college admissions? Med-Peds training leads to thinking outside of the box. I look forward to robust discussions, learning from colleagues and future colleagues, and generating ideas that will shape the future of UME, GME and Med-Peds training. Most of all, I am excited to connect with members of my tribe.

Rita Rossi-Foulkes, MD, FAAP, MS, FACP
President, MPPDA
University of Chicago Internal Medicine-Pediatrics Residency

A Message From AAP-SOMP



The leaves are changing color, snow intermittently covers the grass, Med-Peds program director and associate program directors are interviewing medical students, and soon-to-be graduating 4th year Med-Peds residents are interviewing for fellowships or jobs. NMPRA, MPPDA, and SOMP completed another round of webinars as a tool to provide guidance and information to medical students interested in pursuing Med-Peds. Please congratulate our NMPRA authors, Max Cruz and Sasha Kapil and MPPDA co-chair recruitment committee, Ron Magliola for an article well done! If you want to read the article, check out our Med-Peds Cureus site ([Cureus | Evaluating the Impact of a Pilot Nationwide Webinar Series on National Med-Peds Residents' Association Membership](#)). What a whirlwind of activity!

The Section on Med-Peds (SOMP) has also been busy ranging from conference activities to our strategic goals. The SOMP successfully had another virtual AAP conference. The conference was a great collaboration with the Section on Integrative Medicine and Section on Osteopathic Pediatrics with discussions on integrative therapies for children and osteopathic approaches in pediatrics. There was a great discussion policies, advocacy and implications related to vaping and to cannabis. I learned so much from this Section meeting session.

The Physician Wellness Booth was also virtual. We updated the wellness apps handouts, updated the preventative care guidelines, and the Section on Integrative Medicine provided several updated handouts. Many of these handouts are available at the Section on Med-Peds AAP collaborative site ([Section on Medicine-Pediatrics \(Med-Peds\) Home \(aap.org\)](#)).

NMPRA and SOMP continue to push forward the DEI initiatives. The SOMP is working closely with the NMPRA DEI Committee to develop a list of underrepresented students and Med-Peds residents who have expressed an interest in DEI and working closely with affinity groups such as LMSA, SNMA, ANAMS, and Pride Alliance. We will definitely keep everyone posted as we get things finalized.

At our next Section meetings, I think having educational webinars can be a format to bring together medical students, Med-Peds residents, and Med-Peds primary care, hospitalists, and subspecialists. With a goal to have the first Webinar in 2022, topics could include diabetes, hypertension, preventative care, well-being, DEI, or other topics of interest. I recently read an article from the Alliance for Academic Internal Medicine summarizing an interview from former first lady Michelle Obama (www.vogue.com/article; Michelle Obama on "Imposter Syndrome", Empowering Young Women, and her own role models) which highlighted the aspects of motivation, the need to push past self-doubt and overcome imposter syndrome, to find our own path in our respective personal and professional goals, and to encourage others to do the same.

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Finally, remember to register for ACP 2022 which will be in Chicago, Illinois. Early registration ends January 31 (<https://annualmeeting.acponline.org>). The Section on Med-Peds Session will be highlighting "Transitions of Care in Sickle Cell anemia"!

As always, the Section on Med-Peds is here for all of Med-Peds. Keep in touch!

Med-Peds for Life,

Jayne

Jayne Barr MD MPH
Chair, AAP Section on Med-Peds

NMPRA Olympics

NMPRA SPIRIT WEEK

MED-PEDS MONDAY

TIE-DYE TUESDAY

WORKOUT WEDNESDAY

THROWBACK THURSDAY

FREAKY FRIDAY

VIRTUAL 5K SATURDAY

The 2nd annual NMPRA Olympics took place October 4th – 9th and featured a week full of incredible events. This year's fundraising efforts were geared toward the Sickle Cell Disease Association of America, for which a total of \$2523 was raised!

The competition this year was tougher than ever, which ultimately led to TWO winners being named: Geisinger and Spectrum Health/Michigan State University. We were able to catch up with the residents from Spectrum to discuss their epic victory. Keep reading to see how they pulled off this amazing win.

NMPRA: How did you feel when you saw that you were a co-winner? What was going through your head?

SPECTRUM: We were elated! Shout out to Geisinger too. They definitely brought their A game! 💪

NMPRA: How did you prepare for the week, mentally and physically?

SPECTRUM: Thanks for asking! We have been training hard all year! We scoured the finest pigments on the earth to use for tie dye Tuesday. Our interns were tasked with watching back to the future on repeat and creating an actual time machine for throwback Thursday. Needless to say, they delivered.

NMPRA: Is there anyone you'd like to give a shout-out to? Your fans or coaches or family?

SPECTRUM: Shout out to our alumni who got as into spirit week as we did. Shout out to our program director and program coordinator for being the best and most supportive people (on and off the court/field/wards 😊). This win is for you!! *bites gold medal*





NMPRA National Conference



The NMPRA National Conference was virtual for a second year in a row with audience members learning all about transition care! This year will focus on the important transition period from childhood to adulthood and beyond, and how we as Med-Peds physicians are uniquely equipped to help our patients navigate what can be a confusing and complicated time in their medical care.

NMPRA President, Dr. Sophia Urban, planned a three-day event filled with learning and fun. Conference attendees heard from a wide variety of speakers including Sneha Dave (founder of Health Advocacy Summit), Drs. Eleanor Floyd and Sam Robin (Colorado Med-Peds), and Dr.

Patience White (Co-Director of Got Transition). Check out our twitter or medpeds.org for highlights/full recordings of the conference.

When asked, “what does med-peds mean to you?”, these were the responses sent in by conference attendees!



Classifieds

Introducing the new Med-Peds Academic Channel (MPAC)!



- Forum created to promote scientific advancement and dissemination of knowledge in the field of Med-Peds
- *Peer-reviewed publications on various topics unique to the practice of Med-Peds*
- Open to submissions including original articles, review articles, case reports, technical reports, editorials, and posters!!

Check out more details on the website:

<https://www.cureus.com/channels/med-peds>

****Please submit under “academic channels” to submit to MPAC rather than to cureus.com****

Topics in Med-Peds

Dear Medical Student Without a Med-Peds Program

Dear Medical Student Without a Med-Peds Program,

As an aspiring Med-Peds physician at a school without a Med-Peds residency program, my journey has been a gradual patchwork from lucky encounters, elicited stories, and engineered experiences that I want to share with you. My hope is that this letter proves insightful for your own journey in discovering this career. With any success, I wish to provide a sense of comfort that, with Med-Peds, you can set out to do what you intended to do when you first applied to medical school.

I was fortunate to have an introduction to Med-Peds my first year of medical school. My clinical reasoning course was taught by a Med-Peds physician, one of the few at our school and the only one participating in the first half of the student curriculum. He was a stepwise person who always made us exhaust the patient interview before moving onto a focused physical exam, labs, and imaging, all of which we had to defend with evidence from the initial patient interview. I enjoyed this structure as I like to know the little details and think through deductive relationships, much a result of being raised by an engineer. At the time, I didn't know whether this methodology was every doctor's approach or particular to the Med-Peds mindset.

I went into the summer after my first year curious about this new career path. With my first google inquiry about Med-Peds, I found the NMPRA website and created a free student membership. I was incredibly lucky that this summer was the first NMPRA annual informational webinar series. I truly do not know if I would have gained such a sense of the Med-Peds community prior to the residency interview trail. I was met with inside jokes between program directors and residents enthusiastic to talk about their training and supports. As someone who opted for a smaller, more rural third year clinical site to get to know my faculty and cohort closely, finding the well-connected and easygoing culture in Med-Peds was key to me.

With the rest of my summer, I reached out to a local program director and talked to two Med-Peds trained subspecialists. Their personal stories and excitement about their careers showed me that the Med-Peds culture is sustained throughout various lengths of training. For the subspecialist that did not pursue a combined fellowship, having certain knowledge about one population (ex. antiarrhythmics for adults) went far in helping the other (ex. rhythm anomalies in kids). For the subspecialist who did a combined fellowship, the extra years of training were worth the readily available job opportunities and leadership positions. My takeaway was that it was the perfect field to subspecialize in, as the demand for Med-Peds expertise provides the flexibility to remain in your preferred location.

However, the most important part of my journey to Med-Peds came between my second and third year. Admittedly premature to rotations, I had started to question a career in medicine and thought a lot about whether my goals aligned better with a life in social work. During the clinical experience I had gotten, albeit COVID-limited, when I asked physicians about

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complicated patient situations some answers I received were “there’s nothing to do” or “they are already connected to a social worker.” I started to doubt whether caring for the whole patient - including each person’s social and environmental inequities - really happened in medicine. It seemed this type of participation took place in advocacy meetings outside of clinic time that did not necessarily address individual patient needs.

Thankfully, during my third year of medical school I was assigned my elective for my first rotation block. With a strong interest in Med-Peds but still with career uncertainty, I wanted to know if Med-Peds would allow me to address the complete range of patient needs on a day-to-day basis. I decided to create a unique elective to intensively explore Med-Peds. I contacted physicians at both my institution and nearby who worked in Med-Peds primary care, cancer survivor, diabetic, refugee, cystic fibrosis, congenital cardiology, sickle cell, and complex care clinics and requested to shadow them. Through my experience, I realized with relief that Med-Peds physicians do actively engage in patient inequities and they do it clinically every day.

During my time in a complex care clinic, a niche primary care setting for patients with challenging chronic diseases, I saw a teenage female with down syndrome who came in with her parents to establish care. Being very comfortable with this type of patient, the Med-Peds physician I was with was very excited to meet the family. She went into the room and enthusiastically addressed the patient directly, creating a welcoming and comfortable environment. The patient was very shy, but the physician made sure to create opportunities to keep including her in the conversation. She addressed the patient’s involvements in school and in the community and asked about the family’s use of resources. After hearing the family’s health concerns, the physician brought up upcoming health events to consider, such as the potential need for general anesthesia for the patient’s first pap smear. In another care setting, a pap smear for this individual may have just been ignored or resulted in a traumatizing experience without these extra efforts. The physician also spoke to them about guardianship, something the family hadn’t been counseled about before. Although it was not something the physician could do for them, she took the time to talk to the family about this knowing how it could impact their experiences later with healthcare and in other aspects of their life, and helped them initiate this process. During my time with complex care, I also learned how physicians connected their patients to adequate government funding and even went out to group homes to personally vaccinate staff and their patients against COVID-19.

This degree of involvement between physicians and patients was not only unique to the complex care clinic but was something I saw in almost every clinic I visited during my Med-Peds elective. The refugee clinic personally called cabs for their patient’s transportation needs and provided patients with the necessary documentation for green cards and exemption from citizenship exams. The sickle cell clinic ensured their patient’s access to the necessary pain medications, gave them books to test their own healthcare literacy, and provided them with blankets and gift-cards in recognition that most of their patients are low-income. The cancer survivor clinic fought for and received funding to support their patients with in vitro fertilization as many of them have fertility difficulties from chemotherapy treatments. Although the sickle cell and survivor clinics I visited are run by pediatricians, both expressed the ongoing need for additional Med-Peds providers in this field to fight the inequities that occur to their patients’ care during adult transitions.

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Ultimately, any specialty is what you make it to be, including what aspects of a patient's life you decide to address in the office. However, Med-Peds allows physicians to be exceptionally good at addressing a variety of issues from extensive training in both fields. Med-Peds can fill specific gaps in a community by being able to serve any population, and in doing so they often participate in the various social hardships their patients face in the process of providing care. Career flexibility from this type of training creates the foundation for Med-Peds providers to build unique programs and in turn expand their patients' access to necessary resources. Thus, for those of us without a Med-Peds program (and even those with) who are debating if Med-Peds is worth it compared to categorical programs, I would argue that this extra year alone is priceless in its ability to give years of opportunities and power to carry with us. If you need something more tangible to be convinced – reach out, start shadowing, ask questions, and fight for opportunities for yourself to get to know this awesome career.

All the best to you and your journey,

Danielle Cannon, MS3
SUNY Upstate Medical University

Essays

Clinic-ally Stable

Brian Schnettgoecke, PGY-3
Baylor College of Medicine

This is a 19 year-old man living with well-controlled HIV on Biktarvy with an undetectable viral load and recent CD4 of 630 who is here for routine clinic follow up. He has no new concerns today and reports 100% adherence to his antiretroviral therapy. He engages in insertive anal intercourse with multiple male partners and uses barrier protection during 100% of sexual encounters. No concerning findings on physical exam. His recent monitoring labs remain in normal range and STI testing was negative. He is up to date with his immunizations including COVID and influenza. Plan for follow up in 4 months with routine pre-clinic labs.

The above presentation would not be atypical for a patient presenting for a follow up appointment in an ambulatory HIV clinic. It is comprehensive and presents information relevant to the care of a patient living with HIV. No problems identified, continue with the current plan, and move on to see the next patient, right?

Until about one month ago, I would have already been in the room with my next patient. As part of my ambulatory HIV rotation, I had the privilege of participating in therapy sessions with patients and a psychologist who specializes in HIV-related care. It was my experience with this same 19 year-old patient and his psychologist who dramatically changed my perspective.

This patient had been diagnosed about one year prior and he had intentionally not divulged his diagnosis to his mother. However, his mother had recently found his medication, which he typically kept well-hidden. She knew, it was a big deal. He knew it would be, and was why he feared this day. Almost immediately, it had created a tragic divide between mother and son. He wasn't quite sure how he should proceed, or how he could possibly mend a now fractured relationship. What tormented him most was now feeling "dirty" or "stained" having had his secret inadvertently escape him, now leaving him vulnerable to the judgement and vilification that often accompanies this diagnosis. He was debating whether it was worth it to continue taking his medication. His tone and body language were telling – he was struggling.

The above encounters tell two very different stories. He seemed "clinically stable", but was psychosocially decompensating. Not knowing this as a clinician, future clinical

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scenarios that may have been anticipated or even preventable quickly become reality. Perhaps in light of his new relational turmoil, medication adherence suffers, his viral load increases, and his CD4 count drops precipitously leading to a life-threatening opportunistic infection.

I was struck by how dramatically different a clinic visit and a therapy visit could be if psychosocial factors are not routinely addressed during each clinical encounter. Admittedly, though I did not see this patient in clinic, I realized the above presentation would have been similar to my own and I easily may have allowed his struggles to go undetected. This prompted me to reflect. How often had I framed patients as stable, reassured myself, and unknowingly sent them home to an environment that may ultimately lead to a medical unraveling? I am not the first to note the importance of obtaining a psychosocial history or the impact of a patient's environment on his health. Though I do contend that of all the components of a typical medical encounter, assessing relevant social factors perhaps requires the most intention to do so consistently and is often first to be sacrificed for the sake of time in a busy practice. For me, this experience served as yet another poignant reminder. Take the extra few minutes.

Just as any other screening method, a psychosocial assessment must be applied consistently and broadly. With intentional focus on this assessment patients may be more promptly linked to appropriate services, thereby proactively limiting or preventing the potential deleterious health effects of environmental or psychosocial stressors. Without it, well, we may see more "stable" patients slowly slipping away.



Ugly Feelings from a Jellyfish

Stephanie Cedeño, PGY-2
Jackson Memorial Health System

I fluently speak 2 languages; I even speak a little of a third, but I don't advertise that too often. I grew up in a close-knit Latin community with an even closer family. Despite being perpetually surrounded with people I love and speaking with them on a daily basis through many different modalities and languages, something has changed.

I am convinced that at some point in my training my arms became gelatinous tentacles with microscopic stingers. My face blurred into a soft, translucent dome, one day splitting into two and completing the final, fantastic process. In a matter of several years, the skills I possessed of communication with those who raised me have vanished. It began with some soft pauses and slightly awkward moments, and ballooned into (shamefully) avoiding some conversations for the sake of maintaining a peaceful dinner.

My lifelong friends — my absolute best friends — who are not involved in medicine are likely some form of aquatic creature too, as conversations with them have only gotten easier with each passing year. Our life experiences, maturity-levels, and everything else may be polar opposite, but speaking with and comforting each other through it all has never been an issue. My experience with my family, however, is not something I speak about often because it is both strange and difficult to admit.

Honestly, It really hurts. Talking about my mental health, or any aspect of my health really, is grounds for discussing instead of comforting. From the day I entered medical school, the texts and calls I received carried a different tone. Initially, the questions seemed to seek my valued opinion. Then, it became apparent that a specific response was being sought — a specific opinion they wanted to hear from me.

To paint a picture, imagine you receive a call from a family member asking what you think about their insulin use. You discuss with them their diet, exercise, and long history of insulin use, only to eventually have them insist they don't truly believe they need insulin. Namely, because medications are poison anyways, and they just need to exercise more. They end each sentence with, "...you know this is true, right? I'm doing the right thing, right?" You're backed into a corner, and now you have to break it to them that their A1C of 13 is going to need a bit more help. As if by magic, you're suddenly the cold doctor who doesn't believe in them, is being too harsh, and shouldn't be involved. The terminal damage on your relationship with them is now palpable. You ask, "what did I do wrong?"

I'm one of the first medical professionals in the family with a career in two specialties, but I haven't been able to shake off the feeling of being a black sheep. Excuse me -

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black jellyfish. I thought I was doing “good”, but my version of “good” never involved feeling so isolated. I have a good support system and manage my health as appropriately as a resident could. I am trying so hard for a simple goal: happy and healthy. This goal I aim for with all my patients haunts me as just out of reach for myself.

This is not my 24/7 state of being. This is, however, a reflection on the isolation professionals may feel when they reflect on the life they had lived compared to the life they now live. The way my mind ruminates on certain patients at night or how some encounters bring me to joyful tears in the hospital hallways do not entirely translate over in words. The love, anger, and outright depression I feel for complete strangers is understood without question by my colleagues — we all shed similar blood, sweat, and tears. Be it Spanish, English, or bubbles from a jellyfish, there’s a language I’ve lost with some people I love. It permeates my holidays, birthdays, and simple Sunday gatherings. I feel the love and respect from my family for what I have been able to achieve with their support, just at an arms distance.

Feelings of isolation, depression, guilt, and even anger are my own ugly feelings. Feelings that seemingly came as a consequence of my achievements. I can’t talk about it daily, and attempts to talk about it with my nuclear family have failed several times over. This ugliness is real, and despite its crude nature, I am not ashamed. I know I shouldn’t let some of these feelings seep into how I perceive myself, but pretending I don’t have these thoughts at all only causes more harm. As I process my internal dichotomy of these difficult emotions towards and my sheer, unconditional love for the very same people, I must emphasize that I don’t think of myself as a bad person. I also don’t think my ugliness is unique at all. So to all children of immigrants, for those with blended families, for the first medical professionals in their home, for any and every single human who can relate: we are still beautiful, even when we feel so freaking ugly.

Sincerely,
The friendly two-headed jellyfish

A Matter of Time

Tuong Phan, PGY-4
UT Houston

“Until she makes a decision, we keep going.” My attending’s words rang loudly at 7 a.m.. I placed the orders for blood transfusions, for antibiotics, for pressors—whatever was needed to keep her alive. I looked at the clock, thinking to myself: “Three more hours.”

Just 24 hours prior, I met Jada while caring for her mother in the ICU. Her mother had been admitted for acute liver failure from a rapidly progressive malignancy. She was a single mom, who had just delivered her third baby girl two months prior, and had been attributing her abdominal pain as post-partum pain. When she became confused and jaundiced, Jada’s aunt Tiana brought her to the hospital, and now she laid in our hospital bed, unresponsive to everyone’s cries.

I walked into the dark ICU room with Jada and her extended family. It was time for a goals of care discussion, a conversation I was all too familiar with. I began to discuss what we knew and the prognosis. I looked at Tiana, who returned a sympathetic look and understood where I was going. She cried, “She looked so good at Jada’s 18th birthday I just didn’t think to worry.” It took me a moment for it to sink in. I had walked in believing that Tiana was the legal decision-maker, but it wasn’t. It was Jada, who had just turned 18.

I turned my attention to the sobbing young girl next to her mother. Jada appeared frail—her shoulders shrunken from the weight of the world collapsing in on her. She had not said a word since I began talking. I crouched down next to her, but unexpectedly found myself speechless. I uttered what felt comfortable to me: “I’m sorry Jada. I’m so sorry. What questions do you have?” She simply continued to cry. I felt a heaviness on my chest and a queasy feeling in my stomach. I had come in with an agenda, knowing that Jada’s mother was decompensating fast, and it was just a matter of time. I wanted to give her mom what I had considered a “dignified passing,” and help her family transition to comfort care, but did Jada understand that? If she did, could she make the decision?

I spoke softly, “Jada, I’m sorry, but from a legal perspective, I have to ask you, not your aunt or anyone else, about some decisions for your mom.” Tiana held Jada tightly as I described what comfort care would be like, and the risks and benefits of continuing current treatment. The more words I said, the more uncomfortable I felt. Jada tried her best to respond and asked questions in between her tears, but as she tried to make the clinching decision to withdraw care, her face scrunched up and only tears came out. She tried again, and again no words came out. Tiana caressed her hair and said “Jada, he’s only trying to do what’s best for your mom. He just needs to hear it from

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you.” I stood up and excused myself; it was too much for me. I pictured myself at 18. What did I know at 18? Would I even be able to do what she is attempting to do? How can I be asking so much of this young girl, when I knew that if she had been a patient in my pediatric clinic, we would be waffling over simpler decisions such as what acne treatment to use?

As I drove home that evening, I thought about what I would say the next day. I fell asleep frustrated and exhausted. I walked into our ICU the next morning only to find my team rushing to her bedside. There was blood being suctioned from her nasogastric tube, and her hemoglobin had precipitously dropped. Just like that, time was up. I called Jada and her family, and they said they would be there at 10 a.m. I looked at the clock—it was 7 a.m.

They came promptly at 10 a.m. Jada cried as we updated them. After a few minutes, she wiped away her tears, looked at me, and spoke slowly between her sniffles: “It’s ok... for you... to let... my mom... go.” My heart broke. It was the decision that I had prayed for, yet it didn’t feel right. It felt as if I had forced Jada to make this cruel decision, that it was my agenda that drove her, my silence that pushed her, my wake-up phone call that delivered the final blow. As we excused ourselves from the room, I asked my attending to excuse myself from rounds. I walked to the bathroom. My hands shook, my breathing became shallow and rapid; this was the first time in residency I had felt such a visceral shock.

In reflection, I still do not know what the correct answer was. However, I knew that I was wrong in assuming an agenda prior to my conversation with Jada. I had been complacent, normalizing death in my mind from all my accumulated patient experience, yet to every patient and their families, this was their first time. I had inadvertently created unnecessary pressure on myself, that there was no time, and that Jada had to make a decision. In the end, Jada was the physician, not me. She made the difficult decisions. She acted on her mother’s interest. She showed kindness to her mother and me.

That day as Jada’s family left the ICU, Tiana gave me a hug. “Thank you for your kindness. Thank you for giving us time.” To my surprise, I cried.



The Standard of Care

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When I met N, she was slumped in her wheelchair and wearing scrubs too big for her emaciated frame. She had lost 60 pounds after the onset of unremitting dysphagia 4 months before and had completed all possible medical testing: rigorous labs, a swallow study, EGD, and colonoscopy to name a few. There was no medical cause of her symptoms, so she was admitted for inpatient psychiatric evaluation. Her voice was barely audible, and I had to lean in close to listen as she dozed off in the middle of sentences. She couldn't explain the events leading up to her admission nor give a detailed history. When we asked her to consent to an NG tube to gain back some of the weight, she refused the procedure and all medications. "I just want to go home," she whispered.

I knew it would be difficult to help N without medications, so I approached her with compassion and patience. I kept my interviews focused on her concerns and we would often sit in silence as she processed questions and crafted responses. When applicable, I explained how treatment could alleviate some of her symptoms then repeated these explanations the next day when she forgot our conversation. Occasionally she would consent to NGT placement but would change her mind by the time a nurse arrived with the equipment. A probate hearing occurred a week after admission and the court determined it was in her best interest for treatment to be administered without consent. Her weight improved over the next few days with an NGT, but she became more upset and despondent. "Why is this happening?" she would mumble during our interviews. I did my best to explain, but she would only shake her head and repeat herself.

I left clinic on the last day of my rotation worried about N. Discharge would not be an option for her anytime soon and I wondered if she would be affected by my leaving. How would she respond to someone else taking over her care? Will they be as patient as I was? Will she feel that her concerns are being heard? The last two weeks I had learned everything I could about her, completing extensive chart review on her multiple times and writing her progress notes every day. I advocated on her behalf to lower medications she felt were sedating and asked nurses to give her extra time to shower. During rounds, I knew exactly how much Boost she had received the night before and could tell you the results of any lab or failed medication trial. I was her one consistent provider as attendings switched on and off the service, and my knowledge of her history prevented the repetition of unnecessary tests. While N's voice was quiet, I did my best to be loud on her behalf.

When students write about their meaningful patient experiences, they tend to highlight how their patient was special and easy to connect with. N was not one of those patients. She sat in her wheelchair staring straight ahead; too tired to worry about being relatable and incapable of realizing how her refusal of treatment frustrated her medical providers. Many on the team seemed to lose interest in N as time went on, but I remained invested in her care and continued to follow her progress. It was troubling for me to log into the EMR and read about her many setbacks, but those feelings paled in comparison to the joy I felt when N was finally discharged after over a month of inpatient care.

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Every time I checked on N, I thought about a phrase I've heard often in medical school: "If you care too much about your patients, you won't make it in medicine." Preceptors use this advice to prepare their students for the harsh realities of healthcare. Emotional investment can lead to heartbreak and burnout; however, I feel this defense mechanism is often confused with indifference and leaves providers aloof and jaded. Compassion should be considered a standard of care when treating patients in any setting, even for those who make it difficult to see them as more than a disease process. N expanded my capacity to care as my "difficult" patient and inspired me to go outside my comfort zone. When I found myself at a loss for how to proceed, taking on the role of the advocate helped close the gap. It motivated me to repeat chart reviews, research treatment options, and maintain patience during interviews. Some might say I cared "too much" at times, but I feel telling medical students to care cautiously prevents them from using their most powerful tool to become thoughtful, compassionate physicians. Choosing to care for N allowed me to give her the best treatment I was capable of, and the lessons I learned from her will make me a better medical student and physician for all the patients that follow.



Are we the heroes?

A life that is chosen,
Is it true that we choose,
Or are we called in the silence
No place to refuse?

To sacrifice our youth
To a cause with such worth;
The dedication and training
From it comes our birth.

New knowledge and skills
We come forth from those years,
But with such abuse to our minds
Was it worth all those tears?

Are we the heroes
For the pain we went through,
To become ripe for this fight
For a cause some deem true?

When we trained we were told
Is it a privilege, not a right,
But the suffering we felt
Made it feel like a rite.

The hours of suffering
Late nights, early days,
Pushed to our limits
Most time was a haze.

Then we fight at the frontlines
For these never-ending wars.
We co-work with death
Always at these doors.

Are we the heroes
Because life is on the line?
We're terrified, but keep going
Hoping all will be fine.

It's so well and good
When you're on the outside.
We hope you never see
All that we never confide.

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We actually truly hope
That you never understand
The sense of real dread
Of holding the dead's hand.

But those moments of triumph
When you look someone in the eye,
And you know that you did it
And no one had to die.

Are we the heroes
That you have come to believe,
Or are we just people
That you simply misconceive?

Deanna Peterangelo , MS4
Lake Erie College of Osteopathic Medicine



The Mask

Passionate **p**hysicians **e**mpower,
So **a**dvantageously **v**ia **e**fficacious **s**olace;
Lovingly **i**lluminating **v**aliant **e**ndearing **s**ouls.

Wyleen Bohomol

MS3 Trinity School of Medicine

Cases

Poor Insulin Absorption in an 11-Year-Old with Insulin Edema

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Background

Insulin edema is a rare and underreported adverse effect in patients initiating insulin therapy. First described in adults in 1927, one review found 24 published pediatric cases since 1979. Affected pediatric patients are typically lean, and more likely to be female.¹ One case series of 31 pediatric and adult, the mean onset of edema in cases of insulin initiation or intensification 9.2 days later. Insulin edema is often transient and self-limiting. However, complications can be as severe as congestive heart failure, hepatomegaly, ascites, pleural effusions or generalized massive anasarca.²

Case

Our patient was an 11-year-old male with Type 1 Diabetes Mellitus (T1DM) who presented with lower extremity edema. Nine days prior to the current admission, the patient was admitted with diabetic ketoacidosis and diagnosed with T1DM. His insulin was titrated to a discharge regimen of insulin lispro Target 100, Correction Factor 40, Carb Ratio 10; glargine 17 U at bedtime. After discharge, the patient was in his normal state of health, adherent to his regimen with well-controlled glucose, without hypoglycemic events. On the day of the current admission, the patient's father noticed that his legs were more swollen after a bike ride, and blood sugar over 400. In the ED, vital signs were stable. Exam was significant for swelling of bilateral legs and feet. Glucose was 442, with normal HCO₃, pH and anion gap; hemoglobin 10.5, albumin 3.2.

Once admitted, the patient was started on his home insulin regimen and patient's glucose nadired to 82 and peaked at 426. As the patient was sitting or lying in a hospital bed, the medical team instructed further insulin not to be administered to lower abdomen or legs if those areas were edematous. Insulin glargine was switched to insulin degludec. Thereafter, glucose was controlled. Albumin levels nadired to 2.8, recovering the following days to 3.5. An echocardiogram was normal. Edema markedly improved. Patient was discharged on a tweaked insulin regimen, most notable for long-acting insulin degludec.

Discussion

Our case is unique for a few reasons. Insulin edema is a rare and underreported adverse effect of insulin. It may affect a much larger number of patients starting insulin therapy and thus Med/Peds clinicians, who see patients with insulin-dependent diabetes of all ages, should be aware. The patient's fluctuations in glucose were likely due to impaired insulin

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absorption in edematous tissue. Switching glargine to degludec may have improved edema. His anemia and hypoalbuminemia recovered as edema improved; quick introduction of insulin and fluids can cause sodium and water retention, leading to intravascular repletion despite low albumin.

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A Case of a Missing IVC: Always Absent or an Adverse Event?

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Introduction

When taking care of the adolescent or young adult patient, it is important to consider both pathologies of childhood and adulthood. In this case, a patient was found to have significant thrombosis secondary to extensive venous collateralization. The formation of these collateral vessels may represent complications of central catheter placement in childhood or congenital anomaly of the inferior vena cava (IVC). While congenitally absent structures are often expected to show symptoms during childhood, an adult male patient has been reported in the literature to have an absent IVC not diagnosed until age 54 with first deep vein thrombosis (DVT) occurrence.¹ Congenital absence of the inferior vena cava is extremely rare and may present with DVT presumably related to abnormal venous flow. In many patients it is not well understood whether an absent IVC is the consequence of an anomaly of fetal development or a complication of central catheterization in infancy.

Case Description

A 16-year-old male was admitted with 1 month of worsening hip and left lower extremity pain with erythema and edema of the left lower extremity (LLE). Past history revealed a possible aortic arch abnormality and a reported history of a left femoral venous catheter which had become “kinked” during his NICU stay. He had no personal history of immobilization, surgery, DVT, or pulmonary embolism (PE). His exam was significant for nonpitting edema of the LLE to the mid-thigh accompanied by pain with dorsiflexion of the left foot and varicose veins on the left anterior thigh. LLE ultrasound revealed an extensive and occlusive DVT involving the left femoral, profunda, and left common femoral veins extending down through the left popliteal and posterior tibial veins. Subsequent CT venograms of the pelvis revealed no visible IVC with extensive venous collaterals. After undergoing lytic catheterization and femoral venoplasty, he was discharged on therapeutic enoxaparin and aspirin (later transitioned to aspirin and rivaroxaban) with plans for lifelong anticoagulation. It remained unclear if his extensive collateralization was secondary to a congenitally absent IVC or complications of his prior central catheterization.

Discussion/Conclusion

This is a case of a patient with a common presentation of DVT with an extremely rare finding of extensive venous abnormalities of unclear etiology. While multiple embryologic events leading to IVC absence have been proposed, no single event fully explaining the agenesis has been identified.² At the same time, a significant number of young patients with

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IVC thrombosis have had prior catheterization procedures, proposing the possibility of catheter-induced thrombosis as a cause of eventual agenesis of the IVC.³

Take Home Points

- Iatrogenic interventions can have lifelong impacts on patient health and anatomy. Consequences of birth history can become apparent for the first time in late adolescence and even adulthood, and a patient's birth history may hold the key to unexpected or rare medical findings and diagnoses.

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NMPRA Notes

New Initiative! Calling all interested residents and medical students!

All residents and medical students interested in advocacy are invited to join NMRPA's Advocacy Task Force as we work to develop and execute advocacy projects on issues relevant to Med-Peds providers and our patients.

Our next meeting will take place on Thursday December 9 at 7pm at: meet.google.com/ogi-wnci-xyv.

Please reach out to nicole.danit.damari@gmail.com with any questions or for additional information.

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This newsletter is published as a collaborative effort between the following organizations:



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