The AAP plays an important role to sustain our pediatric endocrine subspecialty. The AAP is an important source for education where our section helps determine what pediatricians learn about endocrine while in training and we have an important role in developing and reviewing AAP policy. However, in my opinion, the most critical role of the AAP is to provide us with a unified and informed voice of advocacy. Too often our “day jobs” leave us little energy to address and impact policies and to advocate for change. But there are several important issues to be aware of right now. I would like to share a few important examples.

First, I strongly believe that we do not deserve to be among the lowest paid pediatric subspecialties. We are typically paid below rates of general pediatricians who themselves currently ranked dead last at # 27th of the 27 most common fields of medicine with a 1% decrease in salary this past year. I am not complaining, I am among the majority in our field who love what we do. We overall rank ourselves as relatively happy and we continue to refuse to reject Medicaid.

Chairperson's Note: Please see the editorial Patient Advocacy – Yes, We Can All Do It! by our AAP superstar fellow, Dr. Brittany Bruggeman. She is actively engaged with us to sort out the detailed root causes for waning numbers of pediatric endocrine applicants in addition to her advocacy for affordable insulin as a PGY4 fellow!

Patient Advocacy – Yes, We Can All Do It!

When it comes to patient advocacy, I like to keep the AAP’s mantra “Be first, be right, be credible” in mind. First, identify an issue that is affecting your patients, such as the skyrocketing price of insulin. Don't be afraid to speak up about these issues- your voice is well respected in the community and can be incredibly impactful. Make sure to check your facts and be credible, but once you have done your research, don't be afraid to speak up. Be confident in your statements and be credible, but once you have done your research, don't be afraid to speak up. Politicians, pharmaceutical companies, and other stakeholders will take notice.

Continued on Page 2

Section on Endocrinology Newsletter Copyright © 2018 American Academy of Pediatrics
patients mostly out of principal despite the financial consequences. However, we need to advocate for ourselves and our trainees as they decide whether to follow in our footsteps in the midst of debt and burn out. But, we cannot afford to be passive.

Technology advances often outpace efficient clinic flow and documentation that impact billing. Pediatric endocrine time spent on diabetes self-management education, sensor/meter data interpretation, behavior changes, and pump technology downloads are time consuming. Our subspecialty currently is under-reimbursed for non-billable phone time spent talking to patients about BG and CGM patterns to titrate insulin doses or manning urgent phone call from patients, schools, parents for sick day management. Additionally, reimbursement for the staff time and training needed to download pumps, meters and sensors and do point of care testing for efficient clinic visits is currently underestimated.

On July 12, 2018, the Centers for Medicare & Medicaid Services (CMS) released a proposal to update Medicare reimbursement which could greatly impact Medicaid reimbursement rates for us. The AAP comment letter to CMS has been approved and submitted to CMS. The concern is that the payment policies introduced in Medicare are often adopted by the Medicaid program and private payers. It is important for pediatricians to be aware of the proposed changes to the E/M code proposals to determine if they fairly reimburse providers and adequately address our subspecialty needs.

Several aspects of the 2019 Medicare Physician Fee Schedule proposals for new E/M visit payment would negatively impact our outpatient practices. One of these CMS proposals is to pay with new, single blended payment rates that cover E/M level 99212-99215 visits with add-on G codes for non-procedural specialty services. We cannot allow policies that reduce the earning potential of pediatric endocrinologists. Conversely, the equivalent of “copied forward” past medical history and ancillary staff documentation is a welcome consideration in an era of unwieldy EMRs. CMS also proposes payment for services using communication technology, which is a potentially great fit for remote diabetes management. Our section is also reviewing new proposals for revisions for ICD-11 codes. Many ICD-10 codes “clump” inappropriate diagnoses into peculiar umbrella codes that can complicate or frustrate us when preauthorizing necessary therapy. Our AAP SOEn has been given an opportunity to voice concerns and work with the AAP ICD-10 representative to submit constructive

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**Patient advocacy – Yes, We Can All Do It!**

and the community at large need to hear your perspective when it comes to issues that affect you and your patient population. Prepare 2-3 key points and stay on message. Focus on the impact that policies have on your patients and what can be done to improve policy. “Far and away the best prize that life has to offer is the chance to work hard at work worth doing,” and I can tell you from experience that patient advocacy is one such rewarding endeavor.

Chairperson’s Column  Continued from Page 2

suggestions for changes as this process evolves.

Secondly, we need to use our AAP power speak up for our patients as they attempt to receive respectful care and access to care. Our patients with diabetes are often restricted from technology options, limited by drug therapies by FDA age restrictions and now are also being hit with rising insulin and drug costs. An AAP SOEn resolution adopted during the 2018 AAP Annual Leadership Forum (#32SB) Medical Services at School for Children with Diabetes is being discussed among leadership of the SOEn and the Council on School Health this month. In another example, our outstanding SOEn Executive Committee member, Dr. Ximena Lopez, and I worked with the AAP State Advocacy Team and AAP Oklahoma Chapter leadership to develop an op-ed regarding a recent social media bullying, it was rewarding to craft a message of support for a family whose transgender child was unfairly threatened and disrespected in a school setting.

My third point is to emphasize our ability to advocate for our future Pediatric endocrine doctors. There are smart ways to address corporate support for training grants and early research to provide early exposure to endocrine experiences for medical students and pediatric residents (How about some Diabetes Camp staff scholarships?). Government loan repayment options should be similar to those available for primary pediatric trainees. The need to advocate for payment will then minimize the financial burden which influences trainees to seek careers in other fields. We must address finances as a factor that contributes to pediatric subspecialty shortages. We believe that the published data for future workforce pediatric endocrine needs were sorely underestimated. The AAP is supportive of our section's partnership with Pediatric Endocrine Society (PES) to attempt to accurately collect relevant data and to strategize a reversal of current workforce trends.

We would love to have our section members let us know of their individual interests to become involved, I have not had the energy to reach out and we need your help! Let us know how you would like to make a difference in a way that is personally convenient and meaningful. I will do my best to figure out a match for your interests and to connect you to resources. Please contact AAP staff at llaskosz@aap.org if you are interested in being involved and what your area of interest/expertise is. Our subspecialty depends on our self-advocacy and our patients depend on our ability to effectively use our unified voice of advocacy. Thanks for all you do!!

References:

New and Renewed Members

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As pediatric providers, fertility and sexual function are not topics we traditionally think about. In fact, many of us are focused on the opposite – constantly brainstorming new ways to counsel adolescents about prevention of unplanned pregnancies and sexually transmitted infections. Contraception and safe sex practices will always be paramount in the care of children, adolescents, and young adults – but an expanding body of literature now shows general pediatricians and pediatric subspecialists also need to begin addressing fertility and sexual function in many different patient populations.¹

Due to treatment advances, survival rates for pediatric conditions are steadily improving. For example, 5-year survival rates for childhood cancer now exceed 80%.² With a growing number of survivors approaching their reproductive years, it is essential to address and prevent cancer therapy related complications including fertility impairment and sexual dysfunction. Beyond cancer, therapies that threaten fertility and sexual function are often used in the management of hematologic, rheumatic, renal diseases, and in youth with gender dysphoria. Additionally, there are several congenital or acquired medical conditions such as genetic syndromes (e.g. Klinefelter syndrome, Turner syndrome, galactosemia), differences/disorders of sex development (DSD), and spinal cord anomalies/injuries where fertility and sexual function are mildly or severely impaired.

The American Academy of Pediatrics, American Society of Clinical Oncology, and American Society for Reproductive Medicine have published recommendations for offering fertility preservation to at-risk patient populations.³⁵ Recent Endocrine Society guidelines also highlight the importance of addressing infertility risk with gender diverse youth prior to medical and surgical interventions.⁶ However, discussions about fertility and sexual function remain inconsistent in at risk populations, with patients, parents, and providers reporting gaps in knowledge/training and a desire for more guidance. Specifically, in a recent national survey more than 90% of pediatric endocrinologists reported routinely seeing patients at risk for infertility, but only 36% felt adequately trained in fertility, and 25% felt adequately trained in sexual function.⁷ Further, nearly half of the providers surveyed (including pediatric endocrinologists, urologists, adolescent medicine specialists, and gynecologists) thought the primary responsibility for providing this counseling may belong to another provider group, such as another subspecialist or the primary care provider.⁷ The implications of these gaps are far reaching – multiple prior studies have shown high levels of distress, regret, and uncertainty in adolescents and young adults who are facing the possibility of infertility and sexual problems.⁸⁻⁹ Misconceptions have also resulted in unplanned pregnancies in those who erroneously assumed they were infertile. So, how can we do better?

First, gather key pieces of information. As in much of medicine, the first step is becoming informed about risk and management. 1) Is this a medical condition that impacts fertility and/or sexual function, or is there a medical or surgical intervention taking place that may impact future fertility or sexual function? 2) Is there an opportunity now to protect or preserve fertility (e.g. cryopreservation of eggs, sperm, reproductive tissue) or sexual function? 3) What information should be shared with the patient and family, both to facilitate decision making and also to prepare for the future, including other considerations such as risks associated with pregnancy or to future offspring? While some disease-specific guidelines have been established regarding infertility risk, sexual function concerns, and interventions, a literature search may be needed to answer these questions for lesser-known conditions.

Second, plan the discussion. 1) Is the family already aware of these issues? Counseling should begin as soon as the risk of infertility or sexual problems is identified, which may be in infancy in cases of DSD, or other anatomic or genetic conditions. 2) What might the child know/understand? The approach to counseling will vary considerably based on age and developmental stage. In younger children, general discussions (e.g. different options for parenthood) may be appropriate, whereas adolescents may have specific questions or concerns about their bodies, intimacy/sexuality, and fertility potential. In many cases, the patient may have been too young or ill to understand or prioritize these issues at the time of initial counseling; thus, repeated and ongoing discussions are necessary. Age-appropriate information sharing is essential to promote positive outcomes; non-disclosure for the purposes of “protecting the child” should be discouraged. Additionally, conversations about fertility and sexual function with adolescents may be uncomfortable and embarrassing, so planning part of the discussion with the parents and without is important.
Third, when possible, consider using an interdisciplinary approach. 1) In a given case, are there other medical and/or behavioral health specialists who could help address these issues, and who should relay which pieces of information? For example, different providers may address infertility risk (e.g. endocrinologist, oncologist, rheumatologist), potential interventions (e.g. gynecologist, urologist, and/or reproductive endocrinologist), decision making/psychosocial challenges (psychologist), and ethical/financial considerations. 2) Are there team members who can help address cognitive, developmental, and/or cultural differences that may impact counseling approaches? Additionally, in this process, details of these discussions should be clearly documented and shared within the team to optimize communication and ultimately facilitate a smooth transition to adult care.

In conclusion, fertility impairment and sexual dysfunction impact a wide range of pediatric populations. These important aspects of reproductive health have historically been overlooked. With emerging research underscoring the impact of these issues on psychosocial outcomes, general pediatricians, pediatric endocrinologists, and other pediatric subspecialists need to become well-versed in this area and work together to provide age-appropriate, ongoing counseling to at-risk youth and families.

The new AAP clinical report, “Counseling in Pediatric Populations at Risk for Infertility and/or Sexual Function Concerns,” describes numerous at-risk populations and offers guidance on how to address these issues. The report, from the Section on Endocrinology, is available at http://pediatrics.aappublications.org/content/early/2018/07/26/peds.2018-1435 and was published in the August 2018 issue of Pediatrics.

References:
On the Horizon for Achondroplasia

Nadia Merchant, MD, FAAP (Pediatric Endocrine Fellow)

Achondroplasia is the most common skeletal dysplasia. Approximately 80% of individuals with achondroplasia are born to parents of average stature. Parents often embark on a journey to find ways to maximize their child’s height because the most obvious description of these individuals is their short stature with disproportionate arms and legs. These individuals are also at risk for other medical issues (e.g., foramen magnum stenosis, sleep apnea, recurrent ear infections that can lead to conductive hearing loss, chronic pain) that require screening and treatment.

As a physician, it is our responsibility to provide families and patients with appropriate and sufficient information regarding their child’s medical diagnosis to aid them in making a decision regarding treatment options. Information should include complications, outcomes, and realistic expectations for the treatment options. For example, a child may grow with growth hormone, but it may also lead to disproportionate growth. Similarly, there are concerns with limb lengthening, especially as it decreases a child’s mobility for several years. Thus, parents will often not pursue these treatment options and focus on maximizing a child’s potential.

Vasoritide (BMN-11) is a new drug shown to significantly increase height velocity for children with achondroplasia in phase 2 trials. Growth velocity increased by approximately 50% without worsening disproportionate growth, and with no major side effects. The drug has not been studied for a long enough period of time to determine if the risk of other medical issues would decrease. Therefore, as physicians, we need to discuss the risks and benefits with parents.

Little people are independent and functional in society and, as a physician, it is important to emphasize to parents/families that they should maximize their child’s potential with or without treatment for height. Parents may decide to pursue the new drug, but they need to be aware that it has only been studied for a limited period of time. As a parent, it is difficult to decide the best option for their child, but we have to decide on an individual basis instead of collectively deciding that only one option is best. Some parents with a child born with impaired hearing may decide on a cochlear implant, whereas others may decide against it. For a child with idiopathic short stature, some parents will decide on daily growth hormone injections and others will decide against it.

As healthcare providers, we have to provide families and patients with information to make the best decision on a case by case basis. Overall, it would be considered ethical for parents to decide to pursue vasoritide to help normalize bone growth in children with achondroplasia, as long as it is done safely with minimal complications and realistic expectations. However, it would also be ethical for them to decide against it.

Aromatase Inhibitors for Growth Promotion

Mitchell E. Geffner, MD

As pediatric endocrinologists, we are frequently referred children with short stature whose predicted adult heights are less than acceptable to their parents. Such children may have been born small-for-gestational age or appear to have idiopathic short stature (ISS). In the former case (for unknown reasons albeit likely related to some facet of intrauterine programming), an additional “whammy” that may occur is slightly early and/or rapidly progressive pubertal status with advanced bone age and, hence, reduced adult height potential. In children with ISS, pubertal status is expected to be normal. In another group of short children, some start out with a delayed bone age suggesting a diagnosis of constitutional delay of growth and puberty (CDGP) followed later by an inexplicable (often familial) forward bone-age flip resulting in a much lower adult height prediction than was calculated at the time of original presentation. Other scenarios with initial tall stature, but advanced bone age, and, hence, poor adult height prognosis, include late-diagnosed congenital adrenal hyperplasia and many forms of precocious puberty. Our therapeutic armamentarium until about 15 years ago was to treat any underlying disease if a discrete one could be identified, prescribe growth hormone (GH) to maximize the number of inches grown per year of bone-age advancement, and/or to inhibit puberty with gonadotropin-releasing hormone agonists (GnRHa) if central in origin or with other pharmacotherapy and/or surgical means in cases of peripheral puberty.

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Aromatase Inhibitors for Growth Promotion  Continued from Page 6

With the reports in 1995 of two unusual male patients with very tall stature, continued growth into their late 20's, and ~10-year delays in their bone ages, one of whom had a mutation in his estrogen receptor-[\(\text{ESR1}\)] gene\(^1\) and the other a mutation in his aromatase enzyme (\(\text{CY19A1}\)) gene\(^2\), a critical role for estrogen regulation (in both sexes) of epiphyseal maturation and fusion was discovered. These observations then led to the hypothesis that pharmacological inhibition of the aromatase enzyme might slow epiphyseal maturation and increase adult height potential. Conveniently, aromatase inhibitors (AI's) were already FDA-approved as adjunctive therapy for the treatment of estrogen-sensitive breast cancer in post-menopausal women\(^3\). Despite this limited indication, AIs started to be prescribed by pediatric endocrinologists for height preservation/augmentation in boys on a fairly widespread, off-label basis with only a modicum of scientific investigation showing efficacy and safety.

In 2008, I wrote a “For Debate” piece entitled: “Aromatase Inhibitors to Augment Height: Have We Lost Our Inhibitions?” wherein I summarized all of the available studies up to that time point to which the reader can refer\(^4\). Over the last decade, surprisingly few additional studies have been undertaken and, as in the past, only very few with solely AI treatment, and almost none to near-adult or adult height. The majority of published studies have been done either in Sweden (AI’s + testosterone in boys with CDGP) or at Nemours Children's Specialty Care in Jacksonville, Florida (AI’s ± GH in boys with GH deficiency or ISS). Below, I will briefly describe the relevant studies performed since 2008.

2010

In a prospective, double-blind, randomized, placebo-controlled clinical trial\(^5\), 91 boys with CDGP (between 12.6-14.6 years of age) with predicted short stature were treated with letrozole, oxandrolone, or placebo. Unlike treatment with oxandrolone or placebo, letrozole significantly increased predicted adult height (\(p < 0.05\)), and slightly but significantly decreased HDL-cholesterol. Compared to placebo, oxandrolone and, to a lesser degree, letrozole significantly increased the height standard deviation (SD) score and bone age.

2012

A 14.5-year-old boy with ISS was reported\(^6\) with a height of 142.7 cm (-2.79 SD), a bone age of 13.5-14 years, and a predicted adult height (using the Bayley/Pinneau tables) of between 154 cm (-3.77 SD) and 158.2 cm (-3.15 SD. After 5 years of letrozole treatment, his adult height was 169 cm (-1.57 SD) representing a difference between predicted and adult height of between 10.8 and 15 cm. There were no permanent side effects observed from the letrozole, although there was a transient occurrence and a spontaneous recovery of decreased bone mineral apparent density seen on dual-energy X-ray absorptiometry and spinal magnetic resonance imaging showed no vertebral abnormalities.

2014

In a comparative study of different third-generation AI's, Neely, et al reported that letrozole was more potent than anastrozole in terms of hormonal effects, but anastrozole treatment resulted in a greater height prediction after one year\(^7\). In a retrospective study from Columbia University\(^8\), anastrozole was administered to 27 boys with short stature (height ≤ -2 SD or < 2 SD below the mid-parental target height) or with rapid pubertal progression and bone age ≥ 13 years for 21 months on average, with no significant increase in predicted adult height.

2015

In the report from Rothenbuhler, et al\(^9\), 24 older boys were studied (mean age 15.2 years and mean bone age 14.5 years) with adult serum testosterone levels, height velocities <3.5 cm/year, and a predicted adult height <2.5 SD. Boys were treated with either anastrozole + GH or GH alone. Treatment was stopped when height velocity was <0.1 cm in 6 months or when height was close to 170 cm. Mean treatment duration was 19 months in the anastrozole + GH group and 11.5 months in the GH-only group. Adult height reached 168.4 ± 2.6 cm in the anastrozole + GH group versus 164.2 ± 5.6 cm in the GH only group (\(P < 0.02\)); adult height was 160.1 ± 2.8 cm in a historical control group.

Continued on Page 8
2016
In a prospective multi-center study of the impact of AIs ± GH on near-final height, Mauras, et al\textsuperscript{10} studied 25 boys with ISS treated with AI’s (anastrozole or letrozole) and 26 patients with ISS treated with AI’s + GH. The authors found, after 2 years of treatment, a height SD increment (for chronological age) of 0.5 and 1.0 with AI’s alone or AI’s + GH, retrospectively. Assessment by specific type of AI was not provided.

2017
In our own retrospective study of AI use in boys with either short predicted adult stature and/or rapid-tempo puberty\textsuperscript{11}, predicted adult height did not significantly change in boys who, at study entry, either had Tanner genitalia stage 1-2 or 3-5. Approximately one-third of the subjects also received GH. Of note, mean peak serum testosterone levels significantly increased from baseline to $650 \pm 458$ ng/dL in the former group and to $1156 \pm 302$ ng/dL in the latter group. In the boys with more advanced puberty, we also found significant increases in hematocrit and acne scores. In yet another more recent, non-controlled, retrospective analysis of 96 pubertal boys from two centers in Brazil who were “selected” because of an “idiopathic decrease in predicted adult height” and treated randomly with anastrozole or letrozole with or without GH\textsuperscript{12}, 15/21 (76 %) of the participants followed to adult height attained a height similar to or above their target heights. That said, the subjects in this study had predicted adult heights very close to their mean target heights that ranged from -0.3 to -0.7 SD, so that the indication for treatment in the first place was unclear. Importantly, in the letrozole-only group, mean serum testosterone levels reached $1099.8 \pm 298.3$ ng/dL.

A Cochrane review in 2015\textsuperscript{13} on AI usage for growth promotion included four randomized clinical trials involving 207 males with constitutional delay of growth, ISS, or GH deficiency (84 receiving interventions). Three of the four trials had overall low or unclear risk of bias for primary outcomes. Predicted adult height based on extrapolation from short-term results improved in all trials. However, just one trial reported primary outcome of final and near-final height as an extension under non-randomized conditions and none of the trials assessed health-related quality-of-life. Only one publication provided detailed information regarding incidence of adverse events. Of concern was the report that a significant proportion (45%) of prepubertal boys with ISS treated with letrozole developed mild morphological abnormalities of their vertebrae, compared with none in the placebo group. Other potential safety concerns that bear further attention include effects of AIs on bone density given the “desired” reduction in estrogen (along with vertebral body morphology), metabolic parameters (e.g., reduction in HDL cholesterol and elevation in triglycerides as has been reported with letrozole), and spermatogenesis/fertility. No adverse effects to date of elevated testosterone/reduced estradiol have been found in terms of cognition and insulin resistance. Lastly, one study\textsuperscript{14} has reported the use of AI’s + a GnRHa in girls with early puberty and compromised growth, compared to a GnRHa alone. Twenty girls were treated with a GnRHa + anastrozole and 20 with a GnRHa alone for 2 years or until age 10 years. Reduction in rate of bone age advancement was significantly greater in the former and predicted adult height almost doubled by 24 months versus the latter [+1.21 ± 0.45 SD (7.51 cm) versus +0.31 ± 0.37 SD (1.92 cm, p = 0.001), respectively]. The group treated with a GnRHa + anastrozole had no clinical or biochemical hyperandrogenism, unchanged normal bone density, and normal lumbar spine X-rays.

Furthermore, in a number of reviews on growth promotion since 2010 written by international experts in the fields of growth and puberty (two of whom participated in the early AI trials), further research study was universally recommended as was caution regarding the wide-scale clinical use of AIs for the purpose of height augmentation\textsuperscript{15-18}. This is a rational viewpoint that I fully endorse, but I also realize that there may be select cases with the potential for severe short stature with limited or no other options.

References:


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**Announcement!**

The AAP and PES Leona Cuttler Quality Improvement Award

Congratulations Mackenzie Dean for receiving the 2018 Leona Cuttler Quality Improvement Award for the abstract entitled “Redesigning Testosterone Prescribing in the Doernbecher Gender Clinic: Interdisciplinary Process Improvement Results in Enhanced Patient Experience”.

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The national midterm elections are Tuesday, November 6, 2018. All 435 seats in the U.S. House of Representatives and 35 of the 100 seats in the U.S. Senate will be contested. In addition, 36 governors, more than 6,000 state legislators, and many other state and local officials across the country will be elected.

From clinics to state capitals to Congress, the AAP has one message for our elected leaders: put children first. The Academy's Get Out the Vote campaign, #VoteKids, encourages pediatricians and others who care for children to vote with kids in mind in November.

It is important to note that the last day of the AAP National Conference & Exhibition in Orlando, Tuesday, November 6, is Election Day. If you are attending the conference and plan to vote in the midterm elections, there are steps you will need to take in advance to ensure you can cast your ballot.

Here are some steps you can take to ensure you're prepared for Election Day, especially if you’ll be at the National Conference:

• Check your voter registration status to ensure it is up-to-date.
• Register to vote. Don't delay! While some states allow registration closer to Election Day, most require this process to be complete 30 days before an election. See your state's voter registration deadlines for details.
• Check voter ID requirements. If you’ve recently relocated, you may need to obtain the correct state identification required at your polling place.
• Vote! If you will be at the National Conference on Election Day, here's how you can cast your ballot in advance:
  o Take advantage of early voting options.
  o Request an absentee ballot.
• If you are voting in-person, remember to bring required identification and get to your polling place during hours of operation.
• Voting assistance for service members, their families, and overseas citizens is available from the Federal Voting Assistance Program.

Thank you for all you do for children every day. Voting with children in mind is a small act that can make a big difference!

Not a Member? Joining is Easy!

Current members of the Academy in good standing are eligible to join the Section on Endocrinology by contacting the AAP Customer Service at 866/THE-AAP1 (866-843-2271).
Technical Review of Policy

The Section on Endocrinology has been busy serving as expert technical reviewers for draft Academy policy, manuals, and consumer publications.

The following documents have been reviewed:

- Clinical report, “Drugs Used to Treat Pediatric Emergencies”
- AAP Pediatric Environmental Health, 4th Edition Manual- Chapter on Obesity
- Policy Statement – Public Policies to Reduce Sugary Drink Consumption in Children and Adolescents
- Birth to Age 5 Consumer Publication – Chapter on Chronic Conditions and Diseases
- Birth to Age 5 Consumer Publication – Chapter on Developmental Disabilities
- Healthychildren.org article – Melatonin and Sleep

Measure What Matters:
Advancing Multidisciplinary Care Coordination in Primary and Subspecialty Care Settings
Webinar Recording, Faculty Presentations, and Answers to Audience Questions Now Available

Presented by the National Center for Medical Home Implementation (NCMHI) and the National Center for Care Coordination Technical Assistance, this 2-part recorded webinar series showcases real-world experiences from diverse health care providers with the common goal of capturing the value of care coordination using the Care Coordination Measurement Tool (CCMT)*. Webinar faculty describe their objectives for measuring care coordination, experiences in implementing the tool, and the implications of capturing the value of care coordination. Webinar recordings, faculty presentations, and answers to audience questions are now available on the NCMHI Web site.

*An accompanying CCMT Adaptation and Implementation Guide is also available in the public domain.
Endocrinology Meeting Schedule

88th Annual Meeting of the American Thyroid Association
October 3-7, 2018
Marriott Marquis
Washington, DC

AAP National Conference & Exhibition
November 2-6, 2018
Orange County Convention Center
Orlando, FL

ENDO 2019 – The Endocrine Society Annual Meeting
March 23-26, 2019
Ernest N. Morial Convention Center
New Orleans, LA

AAP Legislative Conference
April 7-9, 2019
Washington, DC

Pediatric Endocrine Society Annual Meeting
April 27-30, 2019
Baltimore, MD

American Diabetes Association 79th Scientific Sessions
June 7-11, 2019
San Francisco, CA