Chairperson’s Report
Raeford Brown, MD, FAAP
This will be my last Chairperson’s report before handing off to Anita Honkanen, who will become our new Chair after the fall meeting. The opportunity to lead this group for the last two years has been a personal and professional highlight. The Section has accomplished much but, inevitably, time and the requirements of other professional responsibilities prevented further successes. The Section has focused on issues relevant to the health of all children, often in areas outside the perioperative world. By doing so, we have extended the stature of the Section within and outside the Academy.

There are several things that have been accomplished during the last two years that I would like to highlight. First, by establishing dues for the Section, we have been able to maintain a financial equilibrium while maintaining membership. Further, by taking this action, we have demonstrated the commitment of our members to the AAP and its work.

We have continued to make our mark within the Academy through the many statements that we write, edit, and reaffirm. This work is essential as medical knowledge and social thought changes and grows. It is critical that our Section, with a membership of experts in providing safe medical care to the sickest children, continues to have an active voice in pediatric patient safety. It is what we do.

We are near completion of statements concerning the treatment of acute and chronic pain in children. The Acute Pain statement, revised by a cadre of our colleagues and led by Dr. Corrie Anderson, represents the state of the art in the safe management of acute pain in children. The Chronic Pain Statement, a work that has allowed us to interact with organizations outside of the AAP, is also in its final prepublication stage. This statement will represent an essential declaration of the need for sophisticated chronic pain management for children.

We began the process for the development of board certification for Pediatric Pain Medicine. With this effort, we have been able to draw on the talents of other colleagues within and outside of the AAP. We have garnered support from the American Board of Pediatrics and the American Board of Anesthesiology. The leaders of this project have also been successful in obtaining a grant from the Mayday Fund for $165,000 over five years to defray, in part, the work required to prepare curricula, develop ACGME certified Fellowships, create an examination process, and much more.

Our association with the Society for Pediatric Anesthesia (SPA) has grown stronger. We have been invited to think strategically with the SPA leadership about the continued growth of the organization, and areas of common interest. Together we will grow and collaborate to ensure the perioperative safety of children.

Lastly, we have witnessed over the last half-decade an assault on U.S. public health in the form of increased gun violence, opioid misuse, and threats to immigrant health. As part of the AAP, we have joined the SPA and the ASA in decrying these affronts to our society and, in fact, have often led the discussion in the search for answers.

As Chair of the Section, I have spent the majority of my time advocating for child safety, and it has been a labor of love. I can only hope that, as I step away from my various

(Continued on page 2)
Dr. Anita Honkanen Assumes Role of Section Chairperson; Dr. Mary Landrigan-Ossar Becomes Chair-Elect

Dr. Anita Honkanen, who has served as a Section Executive Committee member since 2013 and as Chair-Elect since 2017 will transition into the role of Chairperson on November 1st. Dr. Mary Landrigan-Ossar will assume the role of Chair-Elect as Dr. Honkanen transitions into the Chairperson role.

About Our New Chairperson:
Dr. Anita Honkanen practices at Lucile Packard Children’s Hospital Stanford, where she was the Chief of Pediatric Anesthesiology and Pain Medicine from 2006 through 2019. She completed her medical training at Tufts University School of Medicine, followed by nearly 4 years on Active Duty in the Army, residency training at the Massachusetts General Hospital in Boston, and 6 months of fellowship time in Pediatric Anesthesia at Boston Children’s Hospital. After 4 years in research and clinical care at Massachusetts General Hospital, primarily in pediatrics and obstetrics, she spent 4 years in private practice. She completed a Masters of Science degree in Health Services Research at Stanford, with a goal of developing a better understanding of resources and policies related to pediatric perioperative and surgical care. She helped develop the in-situ pediatric simulation models used at Lucile Packard Children’s Hospital and now at other institutions, and assists with MOCA simulation courses for ABA recertification. Her current research interests relate to perioperative systems of care and outcomes for pediatric surgery and anesthesia.

She has been a member of the Executive Committee of the AAP Section on Anesthesiology and Pain Medicine since 2013, was a member of the ASA COPA from 2014 through 2016, and has assisted as a site surveyor for the American College of Surgeons’ Children’s Surgery Verification Program. She has 5 daughters and lives with her family near Stanford CA.

About Our New Chairperson-Elect
Mary Landrigan-Ossar, MD, PhD, FAAP, FASA is honored to be taking on the position of Chairperson-Elect of the AAP Section on Anesthesiology and Pain Medicine. She currently serves as the Section’s Newsletter Editor and as Chair of the Section’s Education Subcommittee. The Section’s mission to communicate with the general pediatrician community and the public at large about pediatric anesthesiologists’ priorities for delivering safe, high-quality care of children both in and outside the operating room is increasingly important in the changing health care environment. Physicians who can work comfortably and productively in multi-specialty settings will aid in the establishment of our specialty’s goals as our work continues to bring us outside the doors of the operating room.

Dr. Landrigan-Ossar is Senior Associate in Perioperative Anesthesia at Boston Children’s Hospital and Assistant Professor in Anesthesia at the Harvard Medical School. She received her MD and a PhD in molecular biology from Mt. Sinai School of Medicine (now Icahn School of Medicine) in New York, NY. She completed anesthesia residency at Mt. Sinai Medical Center and pediatric anesthesiology fellowship at Boston Children’s Hospital. Dr. Landrigan-Ossar is board certified in anesthesiology and pediatric anesthesiology. Her clinical practice focuses on non-operating room anesthesia and on patients with vascular anomalies. Dr. Landrigan-Ossar is director of anesthesia for Interventional Radiology, the Chair of the hospital’s Sedation Committee, and a member of the Boston Children’s Hospital Vascular Anomalies Center, roles that require a high level of interdisciplinary collaboration.

Dr. Debnath Chatterjee to Join Section Executive Committee This Fall

We are pleased to welcome Dr. Debnath Chatterjee to our AAP Section on Anesthesiology and Pain Medicine Executive Committee as of November 1, 2019. A little bit about our new leader...

Debnath Chatterjee, MD, FAAP
Dr. Chatterjee practices as a pediatric anesthesiologist at Children’s Hospital Colorado providing perioperative anesthesia care for children undergoing a wide variety of surgical and medical procedures. He is the program director for the pediatric anesthesiology fellowship at the University of Colorado School of Medicine and also serves as the director of the fetal anesthesia program at the Colorado Fetal Care Center. He is also an oral board examiner for the American Board of Anesthesiology and one of the pediatric anesthesia section editors of Open Anesthesia.

After completing medical school at Jawaharlal Institute for Postgraduate Medical Education and Research in Pondicherry, India, he moved to the United States to pursue anesthesia residency at SUNY Upstate Medical University in Syracuse, NY followed by a pediatric anesthesiology fellowship at Boston Children's Hospital. His clinical interests include anesthesia for fetal interventions and adolescent bariatric surgery. He represents the AAP Section on Anesthesiology on the National Button Battery Task Force, a multi-disciplinary group made up of representatives from relevant organizations in industry, medicine, public health and government to develop, coordinate and implement strategies to reduce the incidence of button battery ingestion injuries in children. He is looking forward to getting further involved with the AAP as a leader within the AAP Section on Anesthesiology and Pain Medicine.
A Tribute to Jay Deshpande for the 2020 Robert M. Smith Award

By Eugenie Heitmiller

I first laid eyes on Jay Deshpande when he arrived at Johns Hopkins as a newly-hired Assistant Professor of Pediatrics and Anesthesiology in September 1985. He had just finished a research fellowship in the Laboratory for Experimental Brain Research at University of Lund, Sweden, where he was studying cerebral ischemia. I was introduced to this tall, handsome guy who was so friendly and approachable. I would see him in the hallway, always smiling and excited to hear what you had to say. Everyone loved him. It wasn’t long after that he was recognized as an outstanding teacher and physician, winning the Teacher of the Year Award for the Department of Anesthesiology and Critical Care Medicine in less than two years after joining the department. As I recall, part of the prize was a trip to Hawaii — and well deserved. Since then, Jay has continued to accumulate honors and achievements for his tireless work on behalf of children for his institutions, for the Society for Pediatric Anesthesia and for the American Academy of Pediatrics. I will attempt to touch on many of his accomplishments over the years, realizing there are far more than I can include in this tribute.

Starting with his education, Jay graduated from Boston University majoring in chemistry and went on to the University of Tennessee in Memphis for his medical degree, during which time he received the CIBA Distinguished Service Award. He stayed in Memphis for his internship and residency in anesthesiology at LeBonheur Children’s Medical Center and while there received the Outstanding PL-3 Faculty Award for the Department of Pediatrics. He then traveled up to Philadelphia for his residency in anesthesiology and fellowship in pediatric anesthesiology & critical care at Children’s Hospital of Philadelphia, after which he was off to Sweden for a year of research. Upon his return, he was recruited by Mark Rogers, who was the Department Chair at Johns Hopkins; there he joined his good friends and colleagues David Nichols and Myron Yaster (Figure 1; Page 4).

While at Hopkins, Jay was twice awarded the W.M. Keck Clinician Scientist Award. He received institutional and American Heart Association funding for his research in cerebral ischemia and Maryland state funding for comprehensive emergency medical services for children. He published more than 25 papers and chapters during his years at Johns Hopkins, focusing on the treatment of cerebral ischemia, traumatic brain injury and pain management in children. After just three years as an attending, he became the Associate Director of the Johns Hopkins Pediatric Intensive Care Unit (PICU).

Jay’s accomplishments caught the attention of the leadership at Vanderbilt and, after six years at Hopkins, he was offered and accepted the position of Medical Director of the PICU at Vanderbilt University Medical Center. The following year, he was named the Anesthesiologist-In-Charge, and then added to that a title of Medical Director of Performance Management and Improvement. He continued to advance at Vanderbilt, becoming the Executive Physician for Pediatric Quality and Safety at Monroe Carell, Jr. Children’s Hospital. He was promoted to Professor of Anesthesiology and Pediatrics and became Vice Chair for Pediatric Affairs for the Department of Anesthesiology AND the Vice Chair for Clinical Affairs for the Department of Pediatrics. Yes, that’s right — Vice Chair in two departments! He then moved up to become the Vice Chair for Faculty Affairs for the Department of Anesthesiology and was, during that time, also Interim Director of the Division of Pediatric Pulmonary Medicine. He was instrumental in growing their Sedation Program, designing and opening the new Monroe Carell, Jr. Children’s Hospital, building their International Program, starting the Tennessee Emergency Medical Services for Children, and establishing programs in Pediatric Critical Care, Anesthesia and Quality and Safety. His amazing organizational skills also allowed him to complete the Master of Public Health program at Vanderbilt in 2003 and to co-edit editions of “The Pediatric Pain Handbook,” and “Pediatric Pain Management for Primary Care”.

After nine very productive years at Vanderbilt, Jay was offered and accepted the position of Senior Vice President/Chief Quality Officer/Associate Medical Director for Arkansas Children’s Hospital in Little Rock. He received The Harvey and Bernice Jones Endowed Chair in Pediatrics and The Jonathan Bates, MD Endowed Chair of Improving Children’s Health and became the Director of The Jonathan Bates, MD Center for Improving Children’s Health. He spent eight years at Arkansas Children’s and was recognized as a true advocate for pediatric patients. A Twitter feed from the hospital read: “Proud of our SVP and CMO, Dr. Jay Deshpande for championing children at @archildrens and serving on the board at @RMHCArkansas. Dr. Deshpande has an unyielding commitment to provide the best care for patients and families in Arkansas. Thanks for all you do! #Championsforchildren.” Then in 2018, Jay was offered and accepted his current position as the Nemours Children’s Hospital Chief of Quality, Safety and Clinical Analytics in Orlando, Florida, and Professor of Pediatrics at the University of Central Florida.

As though he wasn’t busy enough with his academic work and his hospital leadership activities, Jay found time for a multitude of national committee work. I’ll highlight a few. He spent three years as the Coordinator of the Pediatric Critical Care Fellowship Directors Group for the Society for Critical Care Medicine (SCCM), two years as the Medical Director for Pediatric Advance Life Support (PALS) Course for the American Heart Association (AHA), two years on the Advisory Committee (Elected Member at Large), Pediatric Section for SCCM, four years on the Peer Review Committee (Grants) for the AHA Executive Committee, four years on the Executive Committee of the American Academy of Pediatrics (AAP) Section on Anesthesiology and Pain Medicine, and four years as Editor of the Society for Pediatric Anesthesia (SPA) Newsletter & Chair of the SPA Publications.

(Continued on page 4)
Committee. In 2000, Jay was elected Treasurer for the SPA Executive Committee and over the next six years served on the Executive Committee as Vice President and then President of SPA from 2006-2008. As a founding member of Wake Up Safe, Jay was a member of the Steering Committee for three years and was President of Wake Up Safe from 2012-2013.

Advocacy has always been a high priority for Jay. Jay was an FDA Consultant and Member of the Anesthetic and Life Support Drugs Advisory Committee for the Division of Anesthesia, Analgesia and Rheumatology Products from 2008-2012, and since 2014, has been working with the American College of Surgeons Committee on Optimum Resources for Children’s Surgical Services. Over the course of his career, Jay has lectured and taught extensively, both national and internationally, on many topics in pediatric anesthesia, most notably on pediatric advanced life support and quality and safety in pediatric anesthesia.

Believe it or not, Jay has actually also been able to make time to raise a family over the course of his career, but we all know that Patti, his wife of over 38 years with a career of her own, also deserves a tribute for that! (Figure 2). He has two sons, Neel and Shyam. Neel, who after managing special programs with Metro Parks and as serving as deputy director of the Metro Office of Economic and Community Development in Nashville, TN, is now campaign manager at the Calvert Street group, a nationally-recognized political consulting firm that specializes in crafting local campaigns to win land-use battles and nonpartisan elections across a wide variety of industries and communities. Shyam, who after finishing his year as the Chief Resident in Pediatrics at Boston Children’s, is now in the Anesthesiology Residency / PICU Fellowship Program at Seattle Children’s Hospital. Jay is deeply proud of his family; his true passion is being a Dad. He loves sharing stories about his family and I will share one with you. One day Shyam brought home a class mate, who was one of nine siblings and fatherless. Over time, this boy started sleeping over at Jay’s and eventually moved in to become Jay and Patti’s “3rd” son. This young man is now an attorney in Seattle. Recently, Jay took all three of his sons to the BMW Auto Racing School for more “bonding.” And the family continues to grow. Jay and Patti became grandparents on Jan 2, 2019 with the arrival of the beautiful Araya Lorraine Neel Deshpande.

The personal and professional traits of Robert M Smith were nicely described in Dr. Smith’s obituary (written by his colleagues): “… a well-mannered, soft-spoken gentleman … his presence in the operating room always had a calming influence even in the most trying circumstances. His quiet demeanor and great clinical competence inspired those around him to do their best …” Jay clearly embodies these traits. The Robert M. Smith Award is presented annually to honor an individual who has made outstanding contributions to the field of pediatric anesthesiology, and I can think of no one more deserving of this very special and prestigious recognition for a life spent in service to his profession and to the care of children than Jay Deshpande.

Figure 1. Jay (far right) with Dave Nichols (far left), and Myron Yaster (center).

Figure 2. Jay (far left) and Patti (far right) with Lynne Maxwell (center), the 2016 Robert M Smith Awardee, at a wine tasting in Napa Valley, 2018.

Attend the 2020 AAP Legislative Conference

Registration for the 2020 AAP Legislative Conference is officially open! The conference will take place April 5 – 7 in Washington, DC. Join us and learn how to be a strong advocate for children’s health!

Each year, the conference brings together pediatricians, pediatric medical and surgical specialists, residents and medical students from across the country who share a passion for child health advocacy. Participants attend skills-building workshops, hear from guest speakers, learn about policy priorities impacting children and pediatricians and go to Capitol Hill to urge Congress to support strong child health policies.

For the fifth year, the conference will feature a Pediatric Subspecialty Advocacy Track with specific legislative and skills building workshops uniquely focused on the interests and needs of pediatric medical subspecialists and surgical specialists.

For more information and to register, please visit aap.org/legcon. We hope to see you in April!
AAP Names Mark Del Monte as Chief Executive Officer/Executive Vice President

The AAP Board of Directors has named Mark Del Monte, JD, as the organization’s next Chief Executive Officer (CEO) and Executive Vice President. Mr. Del Monte has served as interim CEO since July 2018 and before that, served as the AAP’s Chief Deputy and Senior Vice President for Advocacy and External Affairs, directing the organization’s communications, public relations and advocacy activities. The AAP serves 67,000 pediatrician, pediatric medical subspecialist, and pediatric surgical specialist members.

“Mark Del Monte’s commitment to the mission, members and future of the American Academy of Pediatrics is well known to AAP members across the country,” said AAP president Kyle E. Yasuda, M.D., FAAP. “A longtime trusted leader within the organization, Mark has a unique understanding of the challenges and opportunities facing the profession of pediatrics today, and his background in advocacy gives him much-needed insight into how we can best advance our agenda for children. Mark has led the organization well over the last year and I can think of no one more capable of leading the AAP at this moment than Mark.”

“I am honored to serve as the ninth CEO of the American Academy of Pediatrics,” said Del Monte. “Having spent the last 14 years at the Academy, I understand and appreciate how vital pediatricians are to their patients, not just in the clinical setting, but as champions for children in communities. Pediatricians understand what children need and they are compelling messengers to articulate those needs, whether in groundbreaking policy statements, meetings with elected officials or in the media. The Academy’s staff are incredibly talented, hard-working and mission driven. Their efforts help ensure the Academy remains a leading voice for children. I look forward to leading such an impactful organization during such an important time for children’s health. The Academy has never been more relevant or necessary.”

When he joined AAP in 2005, Mr. Del Monte was an Assistant Director in the organization’s Washington, DC office, overseeing a portfolio of issues including pediatric drugs and devices, tobacco prevention, pediatric AIDS and children with disabilities. In 2010, Mr. Del Monte was named Director of the AAP’s DC office, following the retirement of longtime director Elizabeth Jackie Noyes, MA, FAAP. He then advanced to Chief Public Affairs Officer in 2013 before becoming Chief Deputy and Senior Vice President of Advocacy and External Affairs in 2016. He also served as Interim Development Director from 2015-2017.

Prior to joining the Academy, Mr. Del Monte served as Director of Policy and Government Affairs for the AIDS Alliance for Children, Youth & Families, a national organization advocating for children and families with HIV/AIDS. Before moving to Washington, DC, Mr. Del Monte worked as a lawyer in his home state of California, providing direct legal services to HIV-positive, low-income children and families.

Mr. Del Monte holds a law degree from the University of California (Berkeley) and a bachelor’s degree from Gonzaga University.

Reflections from the 72nd World Health Assembly

By Mark Del Monte, JD, CEO/Executive Vice President, Senior Vice President, Advocacy and External Affairs

“The people of the world are looking at us to deliver results. And the people of the world will hold us accountable for these results.”

– Dr Tedros Adhanom Ghebreyesus, WHO Director General

In my time at the Academy, I have spent countless hours in Washington, DC advocating, speaking and listening to elected leaders and government officials. Together with AAP members, we have made the case for the unique needs of all children and youth. In many ways, advocacy at the WHA felt very much like work we do every day in the United States, but there are key, complex differences. In addition to our government, each Member State (i.e., the countries who make up the Assembly) makes its appeal based on how the WHA agenda impacts their individual country. Conditions across the world vary greatly and the health needs of many populations need urgent attention. Discussions run long, politics interfere too often, and much like with our government, we worry that we are not seeing enough progress fast enough.

But then, like what you see in DC, we work alongside the advocates (known as civil society organizations), speaking up for children and families, the health care system, and equity. We stood with the International Pediatric Association and its president, Dr. Errol Alden, NCD Child (chaired by Dr. Mychelle Farmer), and many other groups with children as the key focus. The Academy, as a member of the Global Health Council (GHC), led the development and supported six statements in response to the WHA agenda. This was our opportunity to try to influence the debates and to ensure the unique needs of children and youth were considered across the agenda.

- Primary health care towards universal health coverage
- Polio transition – the GHC was the only civil society organization to make a statement on polio transition
- Health, environment and climate change
- Access to medicines and vaccines
- Promoting the health of refugees and migrants
- Strengthening synergies between the World Health Assembly and the Conference of the Parties to the WHO Framework Convention on Tobacco Control

(Continued on page 6)
Reflections on the WHA (Continued from page 5)

Like advocacy in the US, there were moments of true inspiration and hope. I was especially awestruck by the many youth who travelled from all over the world to Geneva to tell their story, speak truth, and demand change. Where government officials and advocates can see overwhelming complexity and challenges, the young people articulated a clear vision of the future where they are prioritized, and resources are sufficient to meet their needs across the life course. It was an honor to participate in events where young people took center stage and changed the conversation.

In addition to youth, there was also a powerful group of government officials from the US and elsewhere who don’t need convincing about the needs of children. US DHHS Secretary Alex Azar, Assistant Secretary for Health ADM Dr. Brett Giroir, CDC Director Dr. Robert R. Redfield, and many other officials attended WHA to lead conversations on infectious diseases, sickle cell disease, non-communicable diseases, and other topics directly affecting children and families. The AAP creates an important link between children and families, pediatricians, and government.

At the AAP, we proudly say that the organization is dedicated to the health of all children. Our mission calls on us to advocate for children wherever they are and in whatever communities they live and grow. I have always been impressed by the power of the pediatrician voice. Even if we know that advocacy is a marathon not a sprint, the AAP has a unique and important role to play at WHA and in many countries outside the US. It can be challenging to keep up the momentum but backed by the expertise and passion of our members, the skills and expertise of our staff, and the urgency of our mission, I know we can make progress together.
Updated AAP Guidelines on Dental Sedation Address Concerns Over Safety for Pediatric Patients

The AAP has updated its guidance on sedation for dental procedures in children in a clinical report written by Dr. Charles Coté and Dr. Stephen Wilson in conjunction with the American Academy of Pediatric Dentistry.


The guidelines recommend that at least two people with specific training and credentials should be present with a pediatric patient undergoing deep sedation or general anesthesia for dental treatment in a dental facility or hospital. The report also clarifies that the sedation should be administered by a qualified anesthesia provider. The 2019 guidelines define a role of a qualified anesthesia provider, who may include a medical anesthesiologist, certified registered nurse anesthetist, dentist anesthesiologist or second oral surgeon.

“Sedation for dental procedures in children and teenagers is generally safe,” said Charles J. Coté, lead author of the clinical report, who is a pediatrician and a pediatric anesthesiologist. “However, we are aware of adverse outcomes when a single dental provider simultaneously performs the procedure and administers deep sedation or general anesthesia for dental procedures. These guidelines ensure the safety of patients who undergo these procedures.”

Under the 2019 guidelines, one of the two trained people required for sedation must be an independent observer who is not involved with performing or assisting with the dental procedure. The observer’s sole responsibility is to constantly observe the patient’s vital signs and to be skilled to assist with any medical emergency. Both the independent observer and the operating dentist must be certified in Pediatric Advanced Life Support.

The prior guidelines had called for the presence of at least one trained person with the Pediatric Advanced Life Support certification.


In a joint statement, the American Society of Anesthesiologists (ASA), the Society for Pediatric Anesthesia, the American Society of Dentist Anesthesiologists, and the Society for Pediatric Sedation join the AAP and the American Academy of Pediatric Dentistry in endorsing guidelines that recommend that at least two people with specific training and credentials should be present with a pediatric patient undergoing deep sedation or general anesthesia for dental treatment in a dental facility or hospital.

The six health organizations recommend that pediatric patients requiring deep sedation or general anesthesia for dental procedures require a second, well-trained professional capable of monitoring the patient, managing the airway, establishing venous access for the administration of rescue medications, and resuscitation. This approach, called the multi-provider team-based safe practice model, requires that the dental surgeon and the professional who is monitoring and sedating the patient are two distinct individuals with separate tasks.

“We are pleased with the support from these influential health organizations on dental sedation guidelines, which take into account the unique vulnerabilities of children,” said Kyle Yasuda, M.D., president of the AAP. “As health care providers, we share a desire for children to receive close supervised care led by a team of skilled professionals.”

“We’re excited to be working with these important health care groups to take an important step in furthering the safety of children who undergo deep sedation and general anesthesia for dental procedures,” said ASA President Linda J. Mason, M.D., FASA. “There are real risks associated with one dental provider doing both the procedure and monitoring the patient’s vitals. Our collective endorsement of the guidelines illustrates the necessity of having a dedicated, qualified anesthesia provider monitor the child to reduce the risk of adverse events and to manage any complications.”

Do you want to improve your teaching skills but don’t necessarily know how? Would you like to join a nationally recognized cohort of teachers in pediatrics? If so, the APEX Teaching Program is the place for you.

The application period is now open for the Advancing Pediatric Educators eXcellence (APEX) Teaching Program’s brand new cohort scheduled to start at the Pediatric Academic Societies (PAS) Conference in 2020. This track is being offered to general pediatricians, pediatric subspecialists, and pediatric surgical specialists. The Teaching Program welcomes physicians as well as advanced practice providers. Deadline: November 15, 2019.

The APEX Teaching Program is a unique longitudinal national program that offers highly interactive learning opportunities and fosters an ongoing exchange of ideas and best practices. Participants will learn new teaching techniques, enhance current skills, and work with a local mentor along with leaders in the field of pediatrics to build a new set of capabilities. To learn more about the APEX Teaching Program visit http://aap.org/apexteachingprogram. Questions? Please contact APEXTeachPrgm@aap.org.
Joint Program: Section on Integrative Medicine, Section on Anesthesiology & Pain Medicine, and Section on International Child Health

**Integrative Approaches to Pain: Non-pharmacologic, Non-Invasive Options Amid the Opioid Crisis**

This program will focus on integrative approaches to acute and chronic pain in children amid the era of an opioid crisis. Topics covered will be non-pharmacological, non-invasive integrative therapies including the integration of acupuncture, mind-body skills, hypnosis, massage, distraction and others into clinical practice, approaches to pain in low resource environments, and also the psychology of pain and pain memory. All are invited to attend.

**LEARNING OBJECTIVES**

1. Identify integrative approaches to both acute and chronic pain.
2. Recognize the psychology of pain and impact of pain on mental health, in order to integrate methods into practice that minimize and address psychiatric components of pediatric pain and pain memory.
3. Recognize useful approaches to pain in low resource environments.
4. Determine opportunities to incorporate integrative therapies into clinical care of patients with pain.

**SATURDAY, OCTOBER 26, 2019**

2:00-2:30pm   Hey Doc- why do I hurt? The psychology behind pain
   Melanie Noel PhD; University of Calgary

2:30-3:00pm   Stop the Pain! An Overview of Integrative Options
   Stefan Friedrichsdorf, MD, FAAP; Children’s Minnesota Pain & Palliative Care

3:00-3:30pm   Treating Pain in Low Resource Environments
   Anjana Kundu MBBS, MD; Dayton Children’s Hospital

3:30-3:45pm   Panel/Roundtable Discussion

3:45-3:55pm   Mindfulness Moment
   Erica Sibinga, MD

4:00-6:00pm   Abstract Posters and Networking

**SUNDAY, OCTOBER 27, 2019**

8:00am   Welcome
   Abby Nerlinger, MD, MPH, FAAP

8:10am   Presentation of Pediatric Hospital Medicine Abstract Research Award

8:15am   Abstract Viewing Session

9:00am   Evidence-based Approaches to Pediatric Acute Pain Management
   Anjana Kundu, MD, ABIHM, FAAP

10:00am   Break

10:15am   Goals of Care and Symptom Management at End-of-Life
   Carly Levy, MD, FAAP

11:15am   A Multidisciplinary Approach to Pediatric Chronic Pain Management
   Neil Schechter, MD

12:15pm   Break

12:30pm   Section on Hospital Medicine Business Luncheon

1:00pm   Laura Mirkinson, MD, FAAP Lecture:
   Social Determinants of Health and Pediatric Hospital Medicine: Do the Missions Align?
   Veronica Gunn, MD, MPH, FAAP

2:00pm   A Panel Discussion on Neonatal Abstinence Syndrome Management
   Matthew Grossman, MD, FAAP,
   Scott Wexelblatt, MD, FAAP
The opioid crisis reaches across all age, socioeconomic, and ethnic divides. This program will focus on how pediatricians and pediatric specialists can provide optimal pain management after surgery, injury, and in other clinical situations, while minimizing side effects and complications of opioid use. Attendees will learn how they can confront the opioid epidemic in their communities.

Supported in-part by the Conrad N. Hilton Foundation

**Sponsors:** Committee on Drugs; Committee on Substance Use and Prevention; Council on Injury, Violence, and Poison Prevention; Section on Anesthesiology and Pain Medicine; Section on Integrative Medicine; Section on Neonatal-Perinatal Medicine

*please note lunch will not be provided

**Agenda**

1:00PM | Poster session
1:30PM | Welcome  
AAP President Kyle E. Yasuda, MD, FAAP
1:35PM | Introduction  
Rita Agarwal, MD, FAAP
1:40PM | Exposed in the Womb: Managing Neonatal Abstinence Syndrome in the NICU and Beyond  
Matt Grossman, MD, FAAP
2:00PM | Toddlers and Up: Unintentional Exposure, Prevention and Treatment  
Kevin Osterhoudt, MD, MS, FAAP
2:20PM | Youth at Risk: Understanding Co-Occurring Diseases, Recognizing High-Risk Populations, and Screening for Opioid Use Disorder  
Lucien Gonzalez, MD, MS, FAAP
2:40PM | Q&A
3:00PM | Break with posters
3:30PM | Addiction and Dependence: One Patient’s Story
4:00PM | Acute Pain and Multimodal Analgesia  
Stephen Hays, MD, FAAP
Anjana Kundu, MBBS, MD, ABIHM, FAAP
4:40PM | The Mind-Body Connection and Biobehavioral Techniques That Everyone Can Use  
Melanie Brown, MD, FAAP
5:00PM | Q&A
5:30PM | Adjourn

For full conference details and to register, visit AAPexperience.org  
#AAP19
A set of updated recommendations on critical care for infants and children – including criteria for admission and discharge and levels of care in the pediatric intensive care unit (PICU) – have been jointly released by the Society of Critical Care Medicine (SCCM) and the AAP. The recommendations define new categories for levels of PICU care, in an effort to improve critical care for children.

“We have created a new practice statement and guidance that will enable hospitals, institutions, and individuals to develop the appropriate PICUs for the needs of their communities,” according to the report by a task force of nationally and internationally recognized clinical experts in pediatric critical care medicine. The full evidence-based statement – which updates the 2004 American Academy of Pediatrics/Society for Critical Care Medicine PICU guidelines – was published in the September issue of Pediatric Critical Care Medicine. An executive summary was also published in the journal Pediatrics (published online Sept. 5).

“This new guidance is extremely important, as it reflects the changes in pediatric critical care over the past decade,” said task force chair Lorry R. Frankel, MD, FCCM, of California Pacific Medical Center, San Francisco.

Dr. Frankel also participated in an SCCM iCritical Care Podcast interview (also released on Sept. 5) to explain the recommendations in depth. The podcast is available at sccm.org/iCriticalCare.

**Statement Recommends New Categories for Level of PICU Care**

The task force identified and evaluated research evidence on the organizations and outcomes of PICU care for critically ill infants and children. Because separate guidelines exist, the practice statement did not address newborns, except those requiring complex cardiovascular surgery. A research review identified only 21 studies evaluating patient outcomes related to pediatric level of care, specialized PICUs, patient volume, or personnel. Due to the lack of high-quality evidence, consensus recommendations were developed based on expert opinion, following a formal voting process.

The updated statement specifies characteristics for ascending levels of PICU care, including team structure, technology, education and training, academic pursuits, and indications for transferring patients to a higher level of care. Building on previous classifications, the statement proposes three levels of units providing care for critically ill infants and children:

- Community-based PICUs (previously categorized as level II), mainly located in general hospitals. Community PICUs are further classified as rural, suburban, or urban and academic versus nonacademic.
- Tertiary PICUs (previously categorized as level I), capable of providing advanced care for critically ill children with a wide range of medical and surgical conditions.
- Quaternary PICUs, a new category of PICUs providing comprehensive care to all children with complex conditions. These units may be found in children’s hospitals and in specialized general hospitals. Some quaternary PICUs provide specialized care for conditions such as cardiovascular disease, transplantation, trauma, and cancer.

For each level of care, the statement addressed the populations served, types of diseases treated, necessary healthcare team members and support services, coverage responsibilities, equipment and technology, quality measurement and patient safety, relationships with other ICUs, and patient transport and transfer. “The emergence of specialized PICUs to care for critically ill children with organ-specific needs has evolved. Tertiary PICUs are able to provide complex care to a specific segment of the pediatric population, while community PICUs continue to provide a very important resource to patients and their families with more common pediatric critical illnesses. These three levels of PICUs will provide the best possible care to the critically ill pediatric patient in an environment that is most appropriate for the medical or surgical issues facing the child and his/her family,” noted Dr. Frankel.

Recommendations for ICU structure and provider staffing include the statement, “Expertise in the care of the critically ill child is required in all PICU levels of care.” An important focus is determining the appropriate level of care associated with improved outcomes. The statement includes recommendations for transfer to a higher level of care and criteria for discharge from the PICU, including patient follow-up and support.

The updated statement acknowledges the lack of evidence addressing many or most of the areas addressed, including ICU structure and staffing models. The authors conclude: “Despite this limitation, the members of the task force believe that these recommendations provide guidance to practitioners in making informed decisions regarding pediatric admission or transfer to the appropriate level of care to achieve the best outcomes.”
New AAP Policies Address the Health Impact of Racism and Provide Guidance on Caring and Advocating for Immigrant Children and Families

AAP Addresses Racism and Its Health Impact on Children and Teens

Racism has a profound impact on children’s health. With the goal of helping all children reach their full potential, the American Academy of Pediatrics (AAP) has published new recommendations on ways to lessen the impact of racism on children and teens.

In the policy statement, “Racism and Its Impact on Child and Adolescent Health,” the AAP calls on pediatricians to create welcoming, culturally competent medical practices, to advocate for policies that advance social justice, and to engage leaders in their communities to reduce health disparities. The policy was published in the August 2019 issue of Pediatrics.

“While progress has been made toward racial equality, the impact of racism on communities of color is wide-reaching, systemic and complex,” said Maria Trent, MD, MPH, FAAP, FSAHM, lead author of the policy statement. “A combination of strategies will be needed to begin untangling the thread of racism throughout the fabric of our society, and to improve the health of all children.”

Children can experience the effects of racism from other individuals, as well as through the places they live and learn, through limited access to resources and economic opportunity, and how their rights are enforced or exercised. A growing body of research has found that racism harms children’s mental and physical health.

For example, children and teens who are the targets of racism are impacted the most, but bystanders are also harmed. Studies have found that young adults who were bystanders to racism as a child experience profound physiological and psychological effects when asked to recall the event -- comparable to the effects experienced by first responders after a major disaster. Research has also examined the impact of racism on specific health measures, such as pre-term birth, low birth weight and mental health.

“As a pediatrician, I know that when children are stressed, it impacts their health and development,” said Jacqueline Dougé, MD, MPH, FAAP, co-author of the statement. “When children experience chronic stress, they are flooded with stress hormones such as cortisol that, after prolonged exposure, leads to inflammatory reactions. This can harm children’s health in the short term, but also creates long-term health problems like heart disease, diabetes, and depression.”

The AAP believes pediatricians share a role in helping improve the conditions where children live, learn and play, by listening to families, creating culturally safe medical homes and advocating within their communities.

“It’s important, as child health professionals, that we examine our own biases and work with families to gain their trust and confidence,” Dr. Dougé said. “We must be prepared to counsel families of all races on the effects of exposure to racism. That includes talking with victims, bystanders and perpetrators about managing their circumstances and health.”

Adds Danielle Dooley, MD, MPH, FAAP and co-author of the statement, “In pediatric practice I care for children and families who are exposed to racism in the school system, the justice system, the public benefits system, the immigration system and other environments. We must advance practices and policies that empower pediatricians to engage with families and communities on this critical challenge for child health.”

“Upending deep-rooted racial disparities to improve children's health will require a great investment, but the United States has developed ingenious solutions to significant societal problems in the past. For instance, the Food Stamp program, developed in the 1930s and revived in the 1960s, led to higher birth weights in babies whose mothers were at risk of nutritional deficiencies. When provided with food stamps three months prior to giving birth, the pregnant women gave birth with babies who had better odds of surviving, as a result. Similarly, expansion of child health insurance improved health care access for children, with significant gains for black and Hispanic children.”

“As a nation, we have made great strides in tackling other major challenges, and this one should be no different. This is an area where we can – and must – make a difference,” said Dr. Trent.

In the policy statement, AAP recommends that pediatricians:

• Create a culturally safe medical home, using evidence-based tools to improve their communications with families and training clinical and office staff in culturally competent care.
• Engage community leaders to create safe playgrounds and healthy food markets to reduce disparities in obesity and undernutrition in neighborhoods affected by poverty.
• Advocate for federal and local policies that support implicit bias training in schools and robust training of educators to improve disparities in academic outcomes and disproportionate rates of suspension and expulsion.
• Encourage community-level advocacy to develop policies that advance social justice.
• Collaborate with first responders and community police and share expertise on child and teen development and mental health, considering potential differences in culture, gender and background.

AAP has taken steps as an organization and advocate for children to address racism and be at the forefront of positive change. In August 2017, AAP formed a task force to address racism as a core social determinant of health for children and adolescents. The Task Force on Addressing Bias and Discrimination is charged with developing a plan to address common types of bias across a broad spectrum. The group will develop materials for pediatricians and parents, promote partnerships, and develop a policy agenda to build inclusive communities and health care systems.

AAP also formed a provisional Section on Minority Health, Equity, and Inclusion that aims to advance health equity among children and promote greater inclusion and diversity in the pediatric workforce. In April 2018, the academy published a policy statement, “AAP Diversity and Inclusion Statement,” that committed to using policy, advocacy, and education to encourage inclusivity and cultural effectiveness for all.

“This work is incredibly important for the AAP, for pediatricians, and for children, and it will remain a priority for our organization,” said AAP President Kyle Yasuda, MD, FAAP. “As a pediatrician, I know that when we help children grow up healthy and with equal access to opportunities, we improve all of society.”

(Continued on page 12)
AAP Policy Statement Provides Guidance on Caring and Advocating for Immigrant Children and Families

Urging health equity for immigrant children, the AAP has published a policy statement that describes how compassionate care and cultural understanding strengthens families, builds individual resilience and enriches society at large.


“Like all children, when children in immigrant families are healthy, happy and empowered to help others, they enrich and enliven our communities,” said Julie M. Linton, MD, FAAP, lead author of the policy statement. “Children’s strengths are most evident when they are able to be as healthy as possible, and pediatricians are able and willing to help make that happen.”

In the statement, the AAP addresses how federal immigration policies can harm immigrants’ health, access to care, and long-term health outcomes. Increased fear about the use of public programs and immigration status has deterred some families from accessing programs, regardless of their eligibility.

Detaining and separating families are counterproductive and threaten the short- and long-term health of children, according to the AAP. Keeping families together and protecting those who are most vulnerable – such as children without parents or a guardian – must factor into comprehensive immigration reform, according to the report. “One in every four children in the United States were born in another country or have a parent who was born outside the U.S.” said Andrea Green, MDCM, FAAP, co-author of the statement. “All children should receive equitable health care that is sensitive to cultural difference, mindful of global health concerns and supports resilience and integration into the community.”

AAP urges pediatricians to start in their own offices, by first examining their own inherent biases. AAP also recommends:

• Integrating services for mental health, social work, patient navigation and legal concerns within the medical practice or locating the office near these services.
• Providing trained interpreters who can assist in person or by phone or video, to help communicate with families. AAP advises against having the patient’s family, friends or children serve as interpreters.
• Offering staff training on working effectively with language services and offering professional development in immigrant health and related competencies.
• When working with patients, the physician should look for signs of trauma and screen for social determinants of health, such as access to nutritious food, safe housing and education.

The AAP calls for the federal government and private and community-based organizations involved with immigrant children to adopt policies that protect and prioritize the children’s health, safety and well-being.

AAP recommends that:

• Health coverage should be provided for all children, regardless of immigration status.
• Private and public insurance payers should pay for qualified medical interpretation and translation services.
• Immigrant children should not be detained or separated from parents.
• Immigration enforcement activities should not occur at or near sensitive locations, such as hospitals, schools, childcare facilities or places of worship.
• Children in immigration proceedings should have free legal representation provided by medical-legal partnerships such as Kids in Need of Defense (KIND) and the Refugee and Immigrant Center for Education and Legal Services (RAICES).

“All children deserve to be treated with compassion and respect, to be given a healthy start and an education to help them reach their full potential,” Dr. Linton said. “By creating partnerships with families and other professionals in our communities, we can provide services that help lift families up. As we improve our understanding of different cultures, we all become stronger in the process.”

WELCOME NEW MEMBERS!!

Augusto Machado, MD, Brasilia, BRAZIL
Denise Lo, MD, São Paulo, BRAZIL
Alberto González-Márquez, MD, Santiago, CHILE
Javier Varela, MD, ÑUÑOA, CHILE
Mohammad Arshi Khan, MD, Jabalpur, INDIA
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Sacha Al Hassan, MD, Boston, MA
Bobbie Riley, MD, FAAP, Newton, MA
Sepeedeh Kermalli, DO, Champlin, MN
Lisa Einhorn, MD, FAAP, Durham, NC
Stephen Perhac, MD, FAAP, Asheville, NC
Ingrid Fitz-James Antoine, MD, FAAP, New York, NY
Lieu Tran, MD, FAAP, Pittsburgh, PA
Teenagers on Birth Control and Sugammadex – Are We Doing Enough?
Meera Gangadharan MBBS aJenny Pennycuff, MDa, Destiny Chau, MDb

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Sugammadex, which was approved by the Food and Drug Administration (FDA) in December 2016, is a reversal agent for neuromuscular blocking agents which contain a steroid nucleus. Currently, rocuronium and vecuronium are the most commonly used of these agents.1 Since its approval, use has rapidly increased due to its ability to reverse NMB agents quickly and completely. Anecdotally, its popularity is such that many residents in training have used sugammadex exclusively and have little experience with alternative methods of pharmacological reversal. Because of its cyclodextrin structure, sugammadex is capable of binding to progesterone and may produce a decrease in the circulating level and the clinical efficacy of hormonal contraceptive methods. With perfect use of some oral contraceptive pills (OCP) the failure rate has been reported to be 0.3% in the first year of use. With typical use, the rate could be as high as 8%.2 With exposure to sugammadex, the efficacy rate decreases as much as 34%, which is equivalent to taking an OCP 12 hours too late.3 The sugammadex package insert states that patients who use hormonal contraceptives should use an additional non-hormonal method of contraception for the 7 days following sugammadex administration.4 To some, the use of an alternative contraceptive method may not be of relevance, but for adolescent females, this may represent a significant public health issue. Teenagers are less likely to consistently use any form of contraception when compared to adults.5 The 2013 CDC Youth Risk Behavior Surveillance Survey revealed that 44% of females ages 15-19 are sexually active. Thus, simply recommending the use of another form of contraception likely will be inadequate for this population.5 In added efforts to reduce unplanned pregnancies, the American Academy of Pediatrics (AAP) recommends emergency contraception be available to teens.6 Despite these actions, it may be prudent to use neostigmine and glycopyrrolate for NMB reversal in adolescent females unless there is a compelling reason to use sugammadex.

For every 1,000 adolescent females aged 15-19 in the US, there were 18.8 births in 2017. One in six of those births were to females who already had one or more births.7 The teen birth rate has been steadily declining in recent years. The increased use of effective contraceptives by teens is thought to be a contributing factor in this decline. Still, the United States has significantly higher teen birth rates than many other developed countries, including Canada and the United Kingdom.8 Nearly 80% of adolescent pregnancies are not intentional.9 Barriers to contraception include concerns about health risk, weight, and effects on future childbirth.10 Adolescents between 15-19 years of age accounted for 9.8% of all legal abortions in 2015. Legal abortion rates are 9.6 and 10.3 per thousand adolescents aged 18 and 19 years respectively and 0.5 per thousand adolescent in the less than 13 or 14 years old age group according to the Center for Disease Control (CDC) in 2015.11 Abortion ratios (abortions per thousand live births) were highest among adolescents in the same report. Most strikingly, complications during pregnancy and childbirth serve as the second leading cause of mortality in 15-19-year-olds worldwide.9

Our responsibility as physicians is “primum non nocere” (first, to do no harm). We have a responsibility to aid in the efforts of the CDC’s Healthy People 2020 goal to help reduce pregnancy in young women between 15-19 years of age.12 A renewed focus on the risks and benefits of sugammadex could prevent the occurrence of unintentional pregnancies secondary to non-compliance with discharge instructions for backup methods of contraception. Neostigmine has been in use since 1931 and is effective. The benefits of sugammadex (stronger reversal, one drug) should not lead us to abandon neostigmine altogether as there are populations that may benefit from this formulation of NMB reversal.

References:
Venous thromboembolic events (VTE) are relatively uncommon in pediatrics, with Canadian registry data suggesting an incidence of around 0.07 per 10,000 children or 5.3 per 10,000 pediatric hospital admissions. However, the rate of VTE in hospitalized children is increasing, most likely a reflection of the increased acuity of illness and the increasing use of indwelling vascular lines. These acquired risk factors for thrombosis often occur in conjunction, which further increases the likelihood of a thrombotic complication during hospitalization. In the adult literature, there is good evidence for the use of thromboprophylaxis, both mechanical and pharmacological, but the corresponding data in pediatrics is lacking.

As a general strategic approach in the adult literature, all medical and surgical patients require thrombotic risk assessment and should be considered for prophylaxis. Patients who are particularly at risk are those with prolonged hospitalization, reduced mobility, heart or respiratory failure, acute infection or inflammatory illness, or cancers. In those at-risk patients, heparins were traditionally considered effective pharmacological prophylaxis, with a preference for the low-molecular-weight heparins for ease of administration and dosing. The advent of the direct oral anticoagulants is changing the approach to thromboprophylaxis in adults, as these agents are demonstrating equivalent efficacy and safety with even simpler administration. Mechanical prophylaxis should also be considered for all patients.

Despite increasing interest in the development of clinical guidelines for pediatric anticoagulation, the issue of thromboprophylaxis is not well evaluated. The 2012 Chest guidelines on pediatric anticoagulation generally confines the discussion of prophylaxis to central vascular access devices and specific indications such as total parenteral nutrition and Kawasaki disease. The more recent 2018 guidelines from the American Society of Hematology are focused on therapeutic anticoagulation, with the comment that future guidelines should consider prophylactic use.

In pediatrics, there is more variability in use of pharmacological thromboprophylaxis. Adolescents are generally more likely to receive thromboprophylaxis, but still at a lower rate than adults. In general, prophylaxis patterns in children reflect the recognized risk factors for VTE, but a lack of evidence of risk and benefits of thromboprophylaxis and misconceptions of the burden of illness of VTE in children and adolescents limits their uptake. At Children's Hospital of Philadelphia, a quality improvement initiative was started after a noted increased incidence of hospital-acquired VTE. Their thromboprophylaxis algorithm was developed by consensus opinion, with the final treatment decision left to the discretion of the primary physician. The guidelines were promoted and implemented with active compliance measures and follow-up; this did not reveal an increase in the amount of anticoagulation prescribed but did reveal an increased appreciation of the risk of thrombosis, particularly among nursing staff.

The Children's Hospital, Health Sciences Centre in Winnipeg, Manitoba is the primary pediatric hospital for the province of Manitoba with 127 beds, including a Pediatric ICU and Level 4 Neonatal ICU. All anticoagulation for in-patients requires consultations with the Pediatric Hematology service. There was an interest from both the surgical and intensive care services and the Pediatric Hematologists in developing a process for prophylactic anticoagulation that would not require this direct involvement of Hematology while still being appropriate and safe. The guidelines developed at CHOP were taken as a baseline for modification to the specific needs of our center and population.

Development of the thromboprophylaxis guidelines was initiated as a quality improvement initiative, and a working group was assembled under the Child Health Quality Team. The group included representation from Pediatric Hematology, Orthopedic and General Surgery, Intensive Care, Physiotherapy, Occupational Therapy, Nursing, and Quality. Initial meetings established the need for the guidelines and the available supporting evidence, which was admittedly limited. From the CHOP guidelines, an algorithm was developed by group consensus which incorporated the risk of development of VTE and the risk of complications from anticoagulation. The working group also felt it was important to include mechanical as well as pharmacologic measures.
During the development of the guidelines, there were frequent meetings of the working group, whose members reviewed the interval drafts within their individual medical and allied health groups for their input. The Quality Team also engaged other groups likely to be impacted, such as Anesthesia. Those discussions were particularly helpful in defining absolute and relative contraindications to prophylactic anticoagulation. The final versions were taken under review by the hospital’s clinical program management team, and ultimately by the administrative leadership for final approval.

Child Health Thromboprophylaxis Algorithm

Permission to publish this Algorithm was provided by the Winnipeg Health Sciences Centre.

The final algorithm is shown in the figure, and a formal institutional policy and standard order set were created. It starts with the decision on whether or not the patient is able to ambulate; if so, mobilization is encouraged. Those who are unable to mobilize and aged greater than 14 years are evaluated for established risk factors for thrombosis, including acute trauma, obesity, presence of a central venous catheter, and chronic inflammatory conditions. Where a risk factor is present, contraindications to anticoagulation are assessed, such as active bleeding or coagulopathy or anticipated surgical intervention in the immediate future. In the absence of risk factors, pharmacologic prophylaxis is recommended. The requirement for approval for thromboprophylaxis by Hematology was waived for those patients meeting the recommendation for anticoagulation. Guidance was also provided for those patients who did not qualify, including the consideration of Hematology consultation for anticoagulation outside of the guidelines.

For patients without a risk factor for thrombosis or those with contraindications to anticoagulation, early mobilization and mechanical thromboprophylaxis with graduated compression stockings are encouraged, and these measures are also recommended when anticoagulation is given. For patients younger than 14 years, where the evidence for prophylactic anticoagulant was most limited, mechanical prophylaxis and Hematology consultation are recommended when two or more risk factors for thrombosis are present. Other children excluded from the guidelines are those with known abnormalities of coagulation, neonatal patients, patients with significant cardiac conditions, solid organ transplant recipients, patients on hemodialysis, and those with a history of stroke; Hematology consultation was recommended where prophylactic anticoagulation was being considered outside of the guideline.
Following the approval of the policy and standard order set, nursing education was carried out on key impacted wards, and information also provided to the hospital attending staff and residents in Pediatrics, Intensive Care, and the surgical specialties. The algorithm and order set were made available on all the wards in an accessible location. While awareness of the guidelines was very high following their initial introduction, it did wane over the subsequent months, and was significantly affected by the turnover in house staff, particularly surgical residents on their Pediatrics rotation. Fortunately, nursing support remains strong, and appreciation of the patients at risk of thrombosis and the need for monitoring, mobilization, and mechanical measures is proactively considered. Where pharmacological thromboprophylaxis is necessary, the process for obtaining anticoagulation is much smoother.

While there were plans to audit the guidelines as part of ongoing quality improvement, this part of the initiative has unfortunately not yet taken place. Still, our experience shows the value in developing a specific policy for pediatric thromboprophylaxis which is adapted to the unique needs and abilities of the individual center.

References:

When you think about that prior sense of purpose and direction, what is different now? Elements that may have changed include the actual job you were performing, and also the setting, the people, your support system, technology, time constraints, call schedule, sleep schedule and so on.

Once you have identified some of the differences between then and now, write them down. These are your clues: potential obstacles, speed bumps, closed doors blocking your way to regaining meaning and purpose in your work life.

The next important question to ask when considering your perceived obstacles is this, which elements of the situation are actually in your control and which are not?

Research shows that a strong sense of ‘locus of control’, i.e., an inner ‘can-do’ perspective, is a recognized trait of highly resilient people.1 It is not that these people don’t recognize the obstacle, it is that they simultaneously recognize it, maintain an attitude of realistic optimism, and begin to problem solve without fear of failure.

One of things I’ve observed when talking with some colleagues about burnout is a profound sense of loss of control, a feeling that medicine has changed for the worse and there is little they can do about it. This concerns me because I have seen many colleagues make deep and significant shifts in their outlook, turn events in their favor, seek out new opportunities, connect with broader networks and open doors to solutions not previously considered.

If you need to refuel your sense of meaning in medicine, it may be worthwhile examining an area where you feel stymied, stuck, or stagnant. Take some time to consider these questions:

- Can you clearly bring to mind a time you felt a strong sense of meaning and purpose at work?
- Which elements resonated with you then?
- If you’ve lost your sense of purpose, what is different now?
- Does the change involve elements that are, in fact, in your control?
- If so, focus on one small area where you can realistically make a change.
- Then make it.

Each time you follow the breadcrumbs and act, whether it’s a step towards physical self-care or in seeking out a new job opportunity, you enhance your inner locus of control, refining a perspective that will help you reengage with the powerful sense of purpose that drew you to medicine in the first place, providing welcome relief from feeling burned out, off course, and out of control.

1 Stress in America: Paying with Our Health. American Psychological Association, 2015

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Delay or proceed? What to do when patient gets URI before undergoing anesthesia

by Justin B. Long M.D., FAAP

Pediatricians commonly are the first call parents make when their child develops an upper respiratory infection (URI) before a procedure requiring anesthesia due to concerns that the procedure may need to be cancelled.

URIs are the most common cause of procedure cancellation among children due to the increased risk for perioperative respiratory adverse events (PRAE). These events include laryngospasm, bronchospasm, breath holding, desaturation and unexpected need for oxygen supplementation postoperatively, which can lead to prolonged admission or unexpected escalation in care, such as admission to the intensive care unit.

Historically, anesthesiologists have considered the period of increased risk for PRAE in children with a recent URI to be up to six weeks after symptom resolution. However, a large observational investigation suggests the period of increased risk generally is limited to two weeks (von Ungern-Sternberg BS, et al. Lancet. 2010;376:773-783).

Risk factors for PRAE

Viral URIs are among the risk factors for PRAE. They are the most common infectious ailment of childhood, with children under age 6 experiencing an average of one URI per month during fall and winter.

No two URIs are the same, and some features of severe URI are especially concerning preoperatively: fever, wet cough, thick or green nasal discharge, and malaise. Testing for the infective virus is not done routinely in pediatric patients with URI. That said, influenza or respiratory syncytial virus (RSV) may increase the risk of PRAE compared to other viral infections, even when severe URI symptoms are not present (Spaeder MC, et al. BMC Anesthesiol. 2011;11:16).

Suspicion of a bacterial cause of symptoms such as strep throat may prompt delay of some procedures such as cardiac surgery or catheterization and orthopedic implants due to the risk of bacteremia.

Additional preoperative risk factors for PRAE in the setting of ongoing or recent URI include passive smoke exposure, history of reactive airway disease, history of prematurity or parental concern that the child is unusually sick.

Risk of PRAE varies depending on the type of surgery or procedure being performed as well as the anesthesia plan.

The risk of PRAE in children without ongoing or recent URI who are undergoing sedation for nonsurgical procedures is 6.3%. Children with URI within two weeks, current URI with clear secretions or current URI with thick secretions have a PRAE risk of 9.1%, 14.6% and 22.2%, respectively (Mallory MD, et al. Pediatrics. 2017;140:e20170009).

Among children having elective surgery, risk of PRAE in those without ongoing or recent URI is 12% vs. 29% among those with URI less than two weeks prior to the procedure and 25% among those with an ongoing URI (von Ungern-Sternberg BS, et al. Lancet. 2010;376:773-783).

Guidance for pediatricians

So how should a pediatrician counsel a family whose child has a URI before a planned procedure?
Recurrent URIs, the effect of rescheduling the procedure on the family, the relative risk of proceeding vs. delaying the procedure, severity and cause of illness, and the nature of the procedure all affect the decision to delay.

History and physical examination are all that are required for most patients with generic URI symptoms. However, suspicion of strep throat, RSV or influenza may prompt diagnostic testing. Additionally, reactive airway disease that manifests with a URI may require intervention such as steroids or bronchodilators. While some clinicians empirically prescribe steroids or antibiotics before a procedure to reduce the risk of cancellation, this is not recommended.

Most children with perioperative URI can be anesthetized safely. However, it is optimal for the pediatrician to collaborate with an anesthesiologist to determine whether a patient can proceed with elective surgery. Most centers have on-call anesthesiology resources or preoperative evaluation clinics that can answer questions prior to the day of the procedure.

Dr. Long is a member of the AAP Section on Anesthesiology and Pain Medicine.

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