NEW ICD-10 CODING SYSTEM TAKING EFFECT

During September 1-30, 2015, ICD-9 and ICD-10 codes will be required for applicable referrals to Connecticut Children’s. ICD-10 codes will become standard on October 1.

EARLY TREATMENT BEST FOR GENDER DYSPHORIA

Children and teens with gender dysphoria are at high risk for depression, anxiety and even suicide, especially as puberty sets in. But early intervention can significantly reduce those risks, says Priya Phulwani, MD, medical director of Connecticut Children’s Gender Identity Program.

“As early as the start of puberty, we can give puberty-suppressing hormones,” Phulwani says. “This pushes the pause button on puberty and gives the young person time to work through their gender dysphoria with a knowledgeable therapist.”

If, at age 16, the teenager wishes to transition to the desired gender, cross-sex hormones can be given to achieve that outcome. In the rare case where the individual decides he/she is comfortable with the biological gender, suppression can be stopped, and puberty will advance normally. “Suppression is a reversible option,” Phulwani notes.

Young people with gender dysphoria who receive puberty-suppressing hormones have better physical and mental-health outcomes, Phulwani says. Gender-specific physical changes that occur with puberty cannot be completely reversed later in life by cross-sex hormones. When those changes are prevented from happening in the first place, patients more readily achieve the appearance they desire once cross-sex hormone therapy takes place.

From a mental-health perspective, depression and anxiety are exacerbated when people see their bodies progressing during puberty to the gender with which they don’t identify. The attempted suicide rate in teens with gender dysphoria is estimated to be between 8 and 20 percent. “That rate decreases to less than 2 percent if patients are treated,” says Phulwani. Primary care providers, she says “can make a huge difference in their patients’ lives if they pick up on this early and refer them for treatment.”

Phulwani encourages primary care providers to take the opportunity at regular visits to ask patients how they feel about their gender. If a young child expresses unhappiness, a referral to a therapist is in order. Patients should be referred to an appropriate endocrinologist at age 10 or at the very first sign of puberty, whichever occurs first.

“The average age when I first see them is about 14,” Phulwani says. “But many children start puberty as early as 9. I’d like to see them earlier. Long-term outcomes are better if puberty-suppressing hormones are started at the first sign of puberty.”

More information, including referral and clinical practice guidelines and a list of support groups, is available at the Gender Identity Program section of connecticutchildrens.org.

Priya Phulwani, MD, is board-certified in pediatric and adult endocrinology and is an assistant professor of pediatrics at the UConn School of Medicine. She may be reached at 860.837.6700 or pphulwa@connecticutchildrens.org.
Failure To Thrive In A Teenage Boy
By pediatric gastroenterologist Wael N. Sayej, MD, and pediatric pulmonologist Melanie Sue Collins, MD

PRESENTATION
A 15-year-old boy presented to the gastroenterology clinic for evaluation of chronic intermittent abdominal pain for at least one year and poor weight gain for several years. The abdominal pain was periumbilical and non-radiating and frequently resolved after bowel movements. He had regular bowel movements every one to two days. He denied any nausea, reflux or heartburn symptoms, diarrhea or constipation. He had a long history of picky eating habits, poor appetite and poor weight gain attributed to his ADHD medications. High-calorie shake supplements, started by his mother, had not produced results.

His medical history was notable for moderate asthma, which had never required hospitalization, as well as several sinus infections and two episodes of pneumonia, which were treated with oral antibiotics. He had had a negative sweat test for cystic fibrosis (CF) (34 mEq/L) in 2008, and his mutational analysis in 2009 was negative for CF mutations found in his family members. He had been on multiple medications for ADHD and anxiety, starting in 2007, and was being treated with lamotrigine (Lamictal) for a possible seizure disorder.

The patient has a 13-year-old sister with a history of CF (ΔF508/unknown), constipation, and chronic abdominal pain, as well as a 17-year-old brother with asthma (without CF). There was no family history of any gastrointestinal disorders (i.e., celiac disease, Crohn’s disease or peptic ulcer disease).

DIAGNOSIS AND TREATMENT
On examination, the patient’s weight was 38.6 kg (<5th percentile) and height was 160.9 cm (8th percentile), BMI 14.9 kg/M2 (<5th percentile). He was small for age and thin. His physical examination was otherwise unremarkable except it was noted that he had significant digital clubbing of his upper extremities.

After the GI visit, he was started on a high-calorie diet and instructed to drink three high-calorie shakes per day. He was sent for an initial set of labs, including a complete blood count, a comprehensive metabolic panel, a sedimentation rate, C-reactive protein, thyroid studies and a celiac disease serology panel. He was also referred back to Pulmonary Medicine for re-evaluation/testing for possible CF.

Extensive blood work was completely within normal limits, however his initial sweat test was nearly positive with a level of 57 mEq/L (normal is <40 mEq/L, and borderline is 40-60 mEq/L) and a repeat sweat test was also positive with a level of 74 mEq/L. He had a stool pancreatic elastase that was normal with a level of 452 mcg/g.

DISCUSSION
Failure to thrive (FTT) is a common presentation to the pediatric GI clinic, with a broad differential diagnosis. Most children with FTT present in the first few years of life. In the younger age group, nutritional deficiencies, poor caloric intake or behavioral feeding issues are the most common reasons for FTT. Pathologic causes for FTT in the younger age group include celiac disease, allergic GI disorders, and rarely, inflammatory bowel disease (Crohn’s disease) or other causes of malabsorption. In older children with new onset of FTT or growth failure, pathologic causes of FTT play a bigger role than nutritional issues. Eating disorders, celiac disease and inflammatory bowel disease are high on the differential list.

While universal screening for CF now occurs throughout the United States and Europe, the possibility of late diagnosis of CF still exists. This patient had been tested previously but had only one sweat test performed. The Cystic Fibrosis Foundation recommends two sweat tests to confirm or refute a diagnosis of CF. However, given a known family history of CF with a known mutation, easily identifiable on genetic testing (ΔF508), it would seem that this patient did not have CF and no further testing was indicated. ΔF508 is a specific mutation on chromosome 7 for the cystic fibrosis transmembrane conductance regulator (CFTR) protein. It is of interest that this patient’s older brother had earlier carried a diagnosis of CF, and had been identified as having the familial known CF mutation (ΔF508), only to have two completely normal sweat tests and have his diagnosis changed to asthma/CFTR-related disease. Repeat genetic testing for our patient is pending to confirm that indeed no laboratory error has occurred. His older brother’s will be repeated at another time.

In this case, the growth failure and identification of digital clubbing prompted re-examination of this patient’s diagnosis of “non-CF,” and he will now get the aggressive care that he needs. While his current nutritional status is very worrisome for a patient with CF, further evaluation of his lungs with CT scan does not demonstrate bronchiectasis, and his lung function remains in the normal range. His stool pancreatic elastase was normal, which rules out malabsorption due to CF-related pancreatic insufficiency. Thus, his FTT is likely due to increased metabolic demands and poor nutritional/caloric intake.

This case nicely illustrates that pairing historical and physical exam findings with broad differential diagnosis is key to making an accurate diagnosis. Additionally, it reminds us of the critical importance of using TWO sweat tests to confirm/refute a diagnosis of CF.

REFERENCES

Have you had an interesting case involving Connecticut Children’s?
Contact Medical News Managing Editor Dennis Crean, RN, at 860.837.8024B or dcrean@connecticutchildrens.org.
Hospitalist Coverage Expands, continued from page 1

to examine the patient, get a sense of what the resident is thinking and come up with a plan together at the bedside rather than over the phone.*

The Medical Center has engaged two new physicians to provide the afternoon and evening coverage. They are Emilee Colella, MD, and Sumith Madhavarapu, D.O. “Both are very highly regarded,” says Sekaran. “Dr. Colella comes to us from the Children’s National Medical Center in Washington, D.C., and Dr. Madhavarapu trained in our own pediatric residency program.”

In today’s fiscally challenging health care environment, allocating additional resources is a major decision. Creating the two new positions, Sekaran says, “shows that Connecticut Children’s is committed to constantly improving the quality of care we provide for our patients.”

Anand Sekaran, MD, chief of Hospital Medicine, is also an associate professor of pediatrics at the University of Connecticut School of Medicine. He may be reached at asekaran@connecticutchildrens.org or 860.837-5506.

WEBINARS SCHEDULED

Upcoming webinars include:

CHDI Maternal Depression Screenings at Well-Baby Visits
October 2015

Lap Band and Gastric Sleeve Surgeries
Dr. Christine Finck, chief, Division of Pediatric Surgery; and Dr. Meghna Misra, pediatric general surgeon.
Nov. 10, 2015

Gender Dysphoria
December 2015

Seven previous webinars are archived and available for viewing. To access them, visit the For Health Care Professionals section of CONNECTICUTCHILDRENS.ORG.

TRANSITIONS

Pediatric cardiologist Derek Obayashi, MD, has relocated to California.

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Receive important news and information from Connecticut Children’s quickly and easily. Sign up for emails today by visiting connecticutchildrens.org/forhealthprofessionals/education/register for emails.
**SURGERY NOW OFFERED IN DANBURY**

Children who live in the Danbury area can now have outpatient surgical procedures performed by Connecticut Children’s physicians without having to travel far from home. Pediatric general surgeons and urologists from Connecticut Children’s now operate two days a week at Danbury Hospital.

Pediatric surgeons Drs. Christine Finck, Christine Rader and Richard Weiss and pediatric urologists Drs. Christine Kim and Eric Nelson perform a range of procedures that can be done on an outpatient basis with low-risk patients. These include procedures for hernias, abscesses and soft-tissue masses, as well as penile, testicular and routine kidney problems.

“Offering these services in Danbury keeps kids in their own community,” says Finck. “For relatively routine procedures, families don’t have to travel to Hartford or Farmington. They have good care delivered to where they live.”

“We see patients pre- and postoperatively in their home area, and we are building relationships with the Danbury team,” Nelson says. “We’re familiarizing them with care of routine postsurgical complications and complaints so they can handle those right there.”

The program is in the early stages and may expand as demand requires. In the meantime, says Finck, “We’re excited to be providing services to the community and to be collaborating with referring providers in that part of the state.”

Christine Finck is an associate professor of pediatrics and surgery at the University of Connecticut School of Medicine. She may be reached at cfinck@connecticutchildrens.org or 860.545.9520. Eric Nelson is an assistant professor of surgery (urology) at the UConn School of Medicine. Contact him at enelson@connecticutchildrens.org or 860.545.9520

**MORE SERVICES EYED FOR DANBURY**

Connecticut Children’s Center for Cancer and Blood Disorders is seeking to expand the services it offers in Danbury. Although the center already has a satellite clinic two to three times a month, “We are likely to increase that number, because the sessions are filling up,” says center Co-Director Michael Isakoff, MD. Co-Director Nehal Parikh, MD, says the center may also add new services. “We’re looking into opportunities to increase our capacity to do infusion and chemotherapy in Danbury to increase convenience for families who live in the region,” Parikh says.

**HONING SKILLS THROUGH SIMULATION**

*Attendings help clinicians practice for real-life situations.*

Two Connecticut Children’s subspecialists have teamed up to provide simulation training for the Medical Center’s otolaryngology and anesthesia residents and operating room staff. Pediatric otolaryngologist Katherine Kavanagh, MD, and pediatric anesthesiologist Michael Archambault, MD, conduct the training at Hartford Hospital’s Center for Education, Simulation and Innovation (CESI). They use CESI’s high-technology resources to enable participants to gain experience in both situation-based and task-based scenarios. “I had experience with it in my residency and fellowship, specifically for situation-based simulation,” says Kavanagh, “and I thought it would be a good addition to our residency program, as well.”

At CESI, the physicians use a high-fidelity mannequin to simulate a real patient. The mannequin has human-like qualities that include a heart rate, breathing sounds and an airway. Using the center’s sophisticated software, they create a scenario during which participants have to respond as if the mannequin were a real patient.

For the situation-based or “crisis resource management” training, Kavanagh and Archambault create a scenario involving low-frequency, high-acuity events such as an airway problem or operating room emergency. While participants must make decisions regarding what to do for the “patient,” much of the training focuses on communication among team members. “Miscommunication can be the root cause of errors,” Kavanagh says. “We practice how to work together in teams to achieve the best outcomes. Our focus is creating a culture of safety, teamwork and good communication to create the safest environment we can for our patients at Connecticut Children’s.”

Crisis resource management practices were originally drawn from the airline industry. Its principles include flattening the hierarchy, making sure all team members feel comfortable speaking up, using “closed-loop” communication in which a team member repeats what another team member has said, knowing what resources are available, calling for help as soon as a concern arises and alerting the team to changes in patient status.

Kavanagh and Archambault also lead task-based simulations to allow ENT and anesthesia residents to practice bronchoscopy, laryngoscopy, airway management, foreign-body removal and temporal-bone surgery. Kavanagh and pediatric otolaryngologist Tulio Valdez, MD, are developing other simulation models that give residents experience in procedures such as microlaryngeal surgery.

For both crisis situations and demanding tasks, Kavanagh says, “It’s best to have experience before you face these things in real life.”

Katherine Kavanagh, MD, may be contacted at kkavanaugh@connecticutchildrens.org or 860.545.9650
ADDITIONAL PROVIDERS JOIN EXPANDING SLEEP CENTER

Two experienced clinicians have joined Connecticut Children’s Sleep Center in Farmington to provide additional expertise and meet the growing demand for the center’s services.

Keith Dixon, MD, is an internal medicine specialist who is fellowship trained and board-certified in sleep medicine and has extensive clinical experience in pediatric sleep medicine. He was the regional medical director of a large sleep medicine program in the state. In addition to seeing patients and interpreting sleep studies, “We are looking to Dr. Dixon to help us enhance systems and processes as the program expands,” says Jay Kenkare, MD, the center’s medical director. “We want to be sure we are meeting the needs of our patients and referring providers in a timely manner. We are excited about establishing new programs such as a CPAP program to ensure adequate follow-up of our sleep apnea patients.”

Lynelle Schneeberg, PhD, is a board-certified sleep psychologist and former director of a behavioral sleep medicine program. Kenkare notes that there are very few board-certified sleep psychologists in the state. “We are excited to have on board with us a psychologist who specializes in sleep medicine with a strong pediatric background,” Kenkare says. Schneeberg will focus on children with insomnia, circadian rhythm disorders and behavioral sleep issues. “This adds another dimension to our sleep center,” says Kenkare.

The two new providers will work closely with Kenkare and Craig Schramm, MD, who heads the Medical Center’s Pediatric Pulmonary Division.

Connecticut Children’s Sleep Center is on track to perform approximately 1,000 sleep studies this year, more than double the number done in 2014. Kenkare attributes the growth to an increase in awareness of pediatric sleep issues, availability of a high-quality testing environment and an increase in the number of children whose sleep is negatively affected by factors such as early school start times, overscheduling, academic and social pressure and a rise in pediatric obesity.

Jay Kenkare, MD, may be reached at jkenkare@connecticutchildrens.org or 860.837.6643.

PARTNERSHIP WITH BAYSTATE ANNOUNCED

Connecticut Children’s and Baystate Children’s Hospital have established a new partnership in pediatric neurosurgery. Under the arrangement, Connecticut Children’s pediatric neurosurgeon Jonathan Martin, MD, will see patients at Baystate’s Springfield facility. The partnership advances a clinical collaboration the hospitals began in late 2014 with the goal of increasing the availability, sophistication and coordination of pediatric services throughout the Connecticut River Valley.

NEW NICU CHIEF NAMED

James E. Moore, MD, PhD, has joined Connecticut Children’s as chief of the Neonatal Intensive Care Unit and head of the Division of Neonatology in the Department of Pediatrics at the UConn School of Medicine. Moore was selected after a national search.

A graduate of Syracuse University, Moore earned his PhD in neurophysiology from Emory University. He completed his medical training at Emory, followed by a residency in pediatrics at UTSW Medical Center in Dallas and a Neonatal-Perinatal Medicine Fellowship at Boston Children’s. He returned to Emory University and Children’s Healthcare of Atlanta as assistant professor of pediatrics and director of the Neonatal-Perinatal Medicine Fellowship. He was recruited to UT Southwestern in July 2011 as associate professor of pediatrics and medical director of the NICU at Dallas Children’s. During his four years in Dallas, he spearheaded the expansion of the NICU, developed a groundbreaking regional neonatal telemedicine service and contributed to the growth of the ECMO program.

Moore replaces retiring NICU Chief Vic Herson, MD. Herson will stay on part time in the division.

WELCOME ABOARD

We’re delighted to announce these additions to our medical staff.

Henry Chicaiza, MD
Emergency Medicine
• Clinical assistant professor, Stony Brook Children’s Service, UFPC
• Attending physician, Lawrence and Memorial Hospital
• Fellowship in pediatric emergency medicine, Connecticut Children’s Medical Center
• Residency in pediatrics, Baystate Medical Center/Tufts University School of Medicine
• MD, New Jersey Medical School
• BA, chemistry, Hamilton College

Clare O’Keefe, DO
Cancer and Blood Disorders
• Chief resident, Connecticut Children’s Medical Center
• DO, Philadelphia College of Osteopathic Medicine
• BA, biological sciences, University of Delaware

Peter Townsend, MD
Digestive Diseases, Hepatology & Nutrition
• Fellowship, Hasbro Children’s Hospital
• Residency in pediatrics, Tufts Medical Center Floating Hospital for Children
• MD, University of Massachusetts Medical School
• BS, biology, University of Massachusetts at Amherst
CONTINUING MEDICAL EDUCATION PROGRAMS
All programs are held at the Pond House Café, 1555 Asylum Ave., West Hartford, Connecticut, and begin at 5:30 p.m. with registration and buffet dinner.

PEDIATRIC EVENING LECTURE SERIES

Sept. 17, 2015
Hernias, Hydroceles & Undescended Testicles

Nov. 12, 2015
Common Neurosurgical Problems Seen in Primary Care

Feb. 11, 2016
More Than Meets the Eye: Common Problems in Pediatric Ophthalmology

April 7, 2016
The 5 E’s to an Exceptional Eczema Experience

To register or obtain more information, contact:
Diane Mouradjian – 860.837.6264, dmouradjian@connecticutchildrens.org
Deidre Palmer – 860.837.6281, dpalmer01@connecticutchildrens.org

ANDRULONIS CHILD MENTAL HEALTH EVENING LECTURE SERIES

Oct. 15, 2015
Psychiatry for the Primary Care Physician: A Toolkit for Pediatric Health Care Providers

Jan. 12, 2016
Addressing Postpartum Mood and Anxiety Disorders in Primary Care: From Screening to Triage

March 1, 2016
Assessment and Treatment of Autism and Transition to Adulthood

May 10, 2016
Gender Nonconformity and Dysphoria in Childhood & Adolescence: Clinical Issues for the Primary Care Pediatrician

FREE “LUNCH & LEARN” TALKS FOR YOUR PRACTICE

Would you like to learn more about clinical issues you may encounter in your practice? Connecticut Children’s can help. Our specialists will visit your office to present information on topics you choose and engage in informal discussions with you and your colleagues. The talks are free of charge. Lunch is provided for physicians, APRNs and PAs. To schedule a talk, contact Trish Masse at tmasse@connecticutchildrens.org or 860.837.6251.