UROLOGY-NEPHROLOGY CLINIC LAUNCHED

Connecticut Children’s divisions of Urology and Nephrology are joining forces to hold regular, multidisciplinary clinics focused on conditions that often require the care of both specialties. One clinic already under way cares for children with posterior urethral valve disorder and chronic kidney disease.

Cynthia Silva, MD, division head and medical director of the Division of Pediatric Nephrology, runs this clinic jointly with Fernando Ferrer, MD, surgeon in chief and director of the Division of Urology. The clinic is held every other month. The multidisciplinary team also includes Jill Bernstein, MD, a board-certified pediatrician specializing in urology, physician assistant Molly Riemenschneider, PA-C, social worker Elizabeth Cameron, MSW, nutritionist Kyle Lamprecht, RD, CD-N, and fellows.

Dr. Silva says the multidisciplinary approach was begun because children need both urology and nephrology services to optimize care. Patients require ongoing surgical evaluation, as well as monitoring of renal dysfunction issues that include hypertension, proteinuria, chronic kidney disease and growth failure.

“The multidisciplinary approach improves their quality of life because they have a care team now,” Dr. Silva says. “People are communicating in front of them and with them. We make care plans with them as a team. It becomes a holistic approach to the child.”

Clinics such as this one are fairly rare, Dr. Silva notes. “There aren’t many medical and surgical specialties that unite around one medical issue, but where they do, everyone agrees that the care is far superior.”

The divisions of Nephrology and Urology are jointly live with Care Navigator, Connecticut Children’s electronic health record. So the team’s notes, including results of laboratory tests or imaging studies, go out to referring providers within 24 hours of the patient’s being seen.

This clinic, Dr. Silva says, “is the beginning of many joint ventures between the two divisions of Urology and Nephrology, the respective heads of the divisions of Nephrology and Urology, run the multidisciplinary clinic.”

services. We will collaborate on other diseases and conditions to improve the care of children with urologic and nephrologic problems in the state.”

A second multidisciplinary clinic, focusing on children who have or are at risk for kidney stones, is expected to launch early this year.

Patients may be referred to the joint clinic by contacting either the Division of Nephrology or the Division of Urology.

Don’t Miss These Stories Inside

Unusual pneumonia case, p.2
Lyme disease misconceptions, p.6

NEWEST FARMINGTON SITE FACILITATES COLLABORATION

Three Connecticut Children’s departments that collaborate frequently on the care of patients recently began offering expanded services at the Medical Center’s facility at 505 Farmington Ave., Farmington.

The Division of Otolaryngology-Head and Neck Surgery has opened a new outpatient office at the Farmington location. The office has state-of-the-art capabilities for evaluating airway, voice and swallowing disorders and has a comprehensive program for management of complex ear disease and cochlear implantation. According to Division Chief Scott Schoem, MD, “This expanded facility will enable us to enhance access and improve coordination of care with Audiology services, which have also moved to Farmington.”

Audiology now offers expanded services in Farmington. “Our experienced pediatric audiologists...”
A 6-month-old previously healthy female was transferred from a community hospital to Connecticut Children's Emergency Department with a three-day history of fever and increased work of breathing. Parents reported upper respiratory symptoms, decreased oral intake, fatigue and decreased urine output. Medical history revealed a full-term birth, no prior admissions or illnesses and up-to-date immunizations. The baby was exclusively breastfed.

In the emergency room, the infant was found to have an oxygen requirement of 6L via simple face mask. Examination revealed mild substernal retractions with clear breath sounds bilaterally. There was no cardiac murmur, and pulses and perfusion were appropriate for age. A chest radiograph at admission showed diffuse airspace opacities. The infant was admitted for further management.

**DIAGNOSIS/TREATMENT**

The infant was empirically started on ceftriaxone for presumed pneumonia. By day four of admission, the patient's oxygen requirement continued to increase and she was noted to be clinically worsening, with a persistent elevation in her respiratory rate, ranging from 70 to 80 respirations per minute. Her white blood cell count remained elevated at 30,000 with a lymphocytic predominance of 57%. Due to her worsening hypoxia, she was additionally started on azithromycin and clindamycin to cover for alternative pathogens. Additional subspecialists from Infectious Disease, Cardiology and Pulmonology were consulted for further evaluation.

Nasopharyngeal cultures for RSV, metapneumovirus, influenza, parainfluenza, adenovirus, pertussis and HSV were negative. Blood cultures, urine cultures and serum quantiferon to evaluate for tuberculosis were negative. Cardiac echocardiogram revealed a structurally normal heart with normal function.

Ultimately, bronchoscopy was performed, which revealed the definitive diagnosis. Fluid culture stained positive for *Pneumocystis jiroveci* (*camii*), and the patient was diagnosed with *p.jiroveci* pneumonia (PCP). She was started on trimethoprim-sulfamethoxazole (TMP-SMX), and her clinical status eventually improved.

**DISCUSSION**

*Pneumocystis* infection is classified as an atypical fungus, based on DNA analysis. PCP is the most common opportunistic infection in the HIV population. It is rarely pathologic in healthy individuals, but should be suspected in immunocompromised patients. Studies show that children acquire antibodies to *pneumocystis* by 20 months of age.

Symptoms are nonspecific, including fever, cough, tachypnea, dyspnea and cyanosis. The intensity of symptoms can vary.

Chest radiograph typically shows bilateral reticular or alveolar infiltrates. There is no definitive laboratory test to detect infection. PCR assays have been trialed but are not yet commercially available. Histologic stain on tissue or fluid from bronchoscopy is the gold standard method of diagnosis. An alternative, less specific method for diagnosis is to measure serum Beta-D glucan levels. This is a cell wall component of many pathogenic fungi. Our patient screened positive for Beta-D glucan; however, results were not available until after the culture diagnosis was made. Antifungals are not effective in treating pneumocystis infection. Intravenous pentamidine or intravenous TMP-SMX can be used for treatment. Oral TMP-SMX is reserved for mild cases. However, comparative studies have shown that oral TMP-SMX is just as effective as IV pentamidine. Mortality ranges from 4 to 40% and is close to 100% without treatment.

The diagnosis of an opportunistic infection in the patient prompted further work-up, which revealed an underlying immunodeficiency as her primary diagnosis. HIV testing was conducted with negative results. Immunoglobulin levels were obtained, which showed normal IgM levels and substantially decreased levels of IgG and IgA. In healthy children, passive immunity from the mother is lost and intrinsic IgG peaks at approximately six months of age. The timing of this infant's infection, along with the abnormal immunoglobulin levels, indicates that she was unable to produce normal levels of IgG.

Cytogenic analysis confirmed the diagnosis of hyper IgM syndrome. This disorder is characterized by a defect at the molecular level, which prevents the ability to switch from the production of IgM antibodies to antibodies of the IgG, IgA or IgE types. Patients with this immunodeficiency are susceptible to recurrent infections, including opportunistic infections. Our patient was started on immunoglobulin replacement therapy with IVIG as a bridge to bone marrow transplant, which she received within a year of her diagnosis.

Respiratory infections are ubiquitous in the pediatric population and in many cases require minimal intervention. However, when the course of illness is outside the expected norm or fails to respond to conventional therapy, additional details of the case should be used to guide the differential diagnosis. The age of our patient coincided with the loss of passive immunity and subsequent infection with this opportunistic organism.
in Farmington provide a full range of audiological assessment and intervention services, utilizing state-of-the-art audiology technology,” says Audiology services Manager Nancy Bruno, Au.D. Assessment services include diagnostic audiological follow-up for infants referring on newborn hearing screening assessment, as well as ongoing assessment and monitoring of hearing for patients with risk factors for or symptoms of hearing loss. The team offers a full range of audiological intervention services to optimize outcomes for families and children who use hearing aids or cochlear implants. “Our expansion increases timely, direct access to services for patients referred by their physicians,” says Dr. Bruno. “It also increases access to the care we provide in collaboration with Connecticut Children’s Specialty Group’s ENT physicians.”

Connecticut Children’s Speech-Language Pathology group has also expanded services at 505 Farmington Ave. The expansion includes additional space for treatment of patients on the autism spectrum. “We consider the Farmington office to be the main location for our growing Autism Spectrum Assessment Program because of the proximity to the future main offices of Developmental-Behavioral Pediatrics and to autism research colleagues at UConn,” says Virginia McGoeys-Radshaw, MEd, manager of Speech-Language Pathology services. The group will continue to offer specialty clinic programs with ENT, such as voice and swallow clinics, and will collaborate with ENT on caring for older children and adolescents who have exercise-induced voice and respiratory problems.

The co-location of these services at 505 Farmington Ave. will allow clinicians to collaborate directly to serve children with combined hearing and language disorders.

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**A NEW APPROACH TO PSYCHIATRIC EMERGENCY CARE**

Connecticut Children’s Emergency Department is reconfiguring the way children presenting with psychiatric issues are evaluated and managed. Steven Rogers, MD, the department’s coordinator for emergency behavioral health services, says the change grew out of discussions he had with Emergency Mobile Psychiatric Services (EMPS), the Department of Children and Families and other state agencies about “what we consider to be a behavioral health crisis in the ED because of the overwhelming number of patients.”

Last year, the roughly 2,300 psychiatric/behavioral health patients who came to Connecticut Children’s ED were evaluated by staff from the Institute of Living. The Medical Center long has contracted with the IOL to provide evaluations for this high-risk group of patients.

“Over time, we have realized that we should provide different levels of service,” Dr. Rogers says. “Many of our patients can be managed on an outpatient basis. Instead of trying to figure out how to get them inpatient care, we’re trying to get them home and get them all the services they need without having a lengthy ED stay or unnecessary inpatient care.”

The new approach calls for several innovations. One is having an EMPS representative dedicated to the Emergency Department to help coordinate care for complex patients and those patients who don’t require inpatient care. Another involves having a dedicated ED social worker to determine what level of service the patient requires and direct the patient to the appropriate level of service.

“We’re also exploring the possibility of telepsychiatry services, with a psychiatrist on call 24 hours a day via computer to help us determine if a patient is safe to go home or needs a higher level of care,” Dr. Rogers says. “Every patient who comes to the ED with a behavioral health emergency should have an assessment and care provided that is appropriate for their individual needs,” says Dr. Rogers. “We are changing our processes to ensure that we meet those needs in the most efficient way possible.”

Dr. Rogers is an assistant professor at the University of Connecticut School of Medicine. He may be reached at 860.837.5435 or scrogers@connecticutchildrens.org.
When pediatric critical care specialist Heather Schlott, MD, joined Connecticut Children’s in 2008, she brought with her a special interest in extracorporeal therapies. Since then, Dr. Schlott has played a key role in developing the hospital’s programs in continuous renal replacement therapy (CRRT) and extracorporeal membrane oxygenation (ECMO) therapy. The CRRT program began in late 2009, while the ECMO program launched in 2011.

Meeting Community Need
While the volume of patients who need ECMO isn’t terribly large, Dr. Schlott says it’s important to have it available at Connecticut Children’s so patients don’t have to be transported to distant hospitals. Transport itself can carry risk for patients who are already unstable, and having a loved one far away puts an extra strain on families. Plus, sometimes patients who appeared to be getting worse would be transferred but then not go on to need the therapy, leaving the sending provider and the family further frustrated. For these and other reasons, Dr. Schlott says, “It’s very nice to be able to provide ECMO at Connecticut Children’s.” She notes that it was a family whose child was in the NICU who helped fund the ECMO program. “Families don’t want to be far from support networks, their other children and family members. It was families who asked that we offer these things closer to home.”

Focus on the Child
Dr. Schlott knows from experience that at some centers with leading-edge therapies, providers, with the best of intentions, may offer patients such extreme therapies even though the therapies are unlikely to benefit the patient.

“One reason I love practicing at Connecticut Children’s is that here the focus is on making sure that we choose patients for whom this is medically appropriate therapy and always consider whether this is the right thing for the child and whether they’re suffering too much,” Dr. Schlott says. “There’s a good balance of trying to advance our medical knowledge and therapies and get better every day, yet not create unnecessary suffering in patients for the sake of trying.”

Additional Interests
Other areas Dr. Schlott is interested in include septic shock resuscitation and resuscitation of diabetic ketoacidosis, two conditions quite common in the ICU.

Giving fluid and antibiotics in a timely way in septic shock cases causes patients to improve “right before your eyes.” On the other hand, resuscitation of patients with diabetic ketoacidosis must be done very slowly to minimize the brain swelling that, in the past, often led to death.

Dr. Schlott has a keen interest in medical mission work. She has traveled to numerous countries and, this spring, will be in Malawi working to find clinical markers of cerebral brain volume in patients with malaria and helping with a project aimed at developing a surgical ICU.

Dr. Schlott is also assistant professor of pediatrics at the University of Connecticut School of Medicine. She may be contacted at hschlott@connecticutchildrens.org or 860.837.5451.

EHR IMPLEMENTATION MILESTONE – FOURTH COMPLETE, BIGGEST ON DECK FOR APRIL

As Connecticut Children’s continues the staggered implementation of its electronic health records (EHR) program, Care Navigator, which began in October 2012, it is pleased to announce the success of its fourth rollout to ambulatory areas including Nephrology, Orthopaedics, Rheumatology, Sports Medicine and Urology. The late-January Go Live was met with enthusiasm and determination by providers and clinical staff alike.

Jeff Thomson, MD, president of Connecticut Children’s Specialty Group and division head of Orthopaedics, shared his thoughts during the launch: “We have a lot to gain by electronic health records, because the record will be available to every provider at any location, at any time. Everybody is excited by Care Navigator. Everybody wants it to be successful.”

Next up, in April, will be the largest launch to date, which is scheduled to include Inpatient; Pharmacy; Emergency Department; Operating Room; Hospital Billing; Admission, Discharge, Transfer; and Coding/Abstraction. Essentially, the entirety of hospital services will be brought online with EHR. Training has already begun for all providers and staff.

“Building on previous success and the lessons we learned the past four Care Navigator rollouts, I’m confident that this next Go Live, our largest one, will also be successful,” says Chief Medical Information Officer Richelle deMayo, MD. “We have so many bright and dedicated analysts, educators and project managers working on this effort. Our clinical staff understands how important this transition is. They are equally committed to its success.”

Dr. deMayo adds: “We are looking forward to sharing our EHR with our community providers. EpicCare Link, the Web-based portal for referring providers, is in the planning stages; we’ll be sure to share more details when they are available.”

Dr. deMayo invites community providers who want to learn more about the EHR to contact her at rdeMayo@connecticutchildrens.org.
NEW SLEEP MEDICINE CENTER AND NEURODIAGNOSTIC LAB ENHANCE THE PATIENT EXPERIENCE

Patients who need sleep studies, EEGs or EMGs on an outpatient basis will have them done in greater comfort when Connecticut Children's opens its spacious new Sleep Medicine and Neurodiagnostic Center this spring at 505 Farmington Ave., Farmington.

“The Farmington site is really exciting,” says Jennifer Madan Cohen, MD, pediatric neurologist and medical director of the hospital’s Epilepsy Center. “The new space will be greatly expanded. The equipment will be state-of-the-art, and there will be space for technologists and physicians to meet. It will be more comfortable for everyone—patients, families and staff.”

William Agostinucci, Connecticut Children’s director of clinical support services, notes that the Farmington center has the distinction of being the only dedicated pediatric sleep medicine program and center in Connecticut. “This is the best place for children throughout the state to be seen when they need these services,” Mr. Agostinucci says.

QUALITY, COMFORTABLE CARE
One notable innovation associated with the Farmington location is that the Sleep Medicine Center will be totally operated by Connecticut Children’s, rather than by a contracted, outside provider as in the past. All the sleep technologists hired will be experienced in pediatrics. Craig Schramm, MD, head of Connecticut Children’s Pulmonary Division, is medical director of the Sleep Medicine Center while the hospital recruits additional sleep specialists.

“Good sleep of sufficient duration is essential to a child’s development,” Dr. Schramm says. “Many things can interfere with children’s sleep, including nighttime fears, poor sleep habits, and sleep apnea. In addition to causing medical problems, inadequate sleep can result in daytime sleepiness, attention problems and poor school performance. Our new Pediatric Sleep Medicine Center will allow us to identify and treat these sleep problems throughout childhood.”

The Farmington space will have five rooms, versus the two now in Hartford. This will allow staff to do up to four sleep studies at night. During the day, it can accommodate up to three patients for EEGs, one for EMG and one for daytime sleep studies such as multiple sleep latency tests (MSLTs). One room is specially designed for bariatric patients. The rooms are larger to allow a parent to stay with his or her child. Rooms have comfortable features such as iPod docking stations, flat-screen TVs, DVD players, iPad minis, private bathrooms and locking closets. The rooms are furnished to look more like hotel rooms than hospital rooms. Each room has a nature-related decorative theme. Rooms are equipped with high-definition cameras operated from the control room. Bedside equipment is available for patients who need bedside monitoring for greater safety.

In addition to on-site EEGs, the center will offer ambulatory EEG services for selected patients.

Part of Connecticut Children’s Neurology Department is also moving to 505 Farmington Ave., just upstairs from the EEG lab. Dr. Madan Cohen says this is especially beneficial. “Since neurology physicians are the ones who read EEGs, it’s helpful to have everyone working in one place,” she says.

GROWING EPILEPSY CENTER
Dr. Madan Cohen notes that the expanded EEG lab is part of Connecticut Children’s growing Epilepsy Center. In addition to the outpatient lab and inpatient EEG services, the Epilepsy Center includes the Epilepsy Monitoring Unit, comprehensive care for patients with epilepsy, the state’s only Ketogenic Diet Program and collaboration with Neurosurgery on potentially curative surgery for epilepsy.

In late 2013, Dr. Madan Cohen and Neurosurgery Chief Paul Kanev, MD, along with other team members, collaborated to treat a patient who was experiencing epileptic seizures. In the operating room, the team implanted electrodes onto the part of the brain suspected of causing the seizures. After being monitored for a week, the patient returned to the operating room, and Dr. Kanev removed the part of the brain that was the source of the seizures. Today, Dr. Madan Cohen says, “The patient is seizure free.”

For more information about services available at the Sleep Medicine and Neurodiagnostic Center, contact Alex Rivera, ASM, RD-EEG, NREMT, manager, at 860.545.9485 or arivera13@connecticutchildrens.org.
“CDC estimates 300,000 U.S. cases of Lyme Disease annually,” read the headline in newspapers and in the Sept. 13, 2013, issue of JAMA. We all knew that the official incidence rate of 30,000 cases of Lyme disease per year represented underreporting, but had no idea that the true rate would be this high. Or is it? Reading the fine print, this is probably overreporting. The number 300,000 came from a few dubious sources: 1) insurance claims listing Lyme disease, 2) surveillance of laboratories, and 3) results of a national survey.

Insurance claim data may be misleading, since there are a number of “maverick” physicians who make a livelihood from diagnosing (or overdiagnosing) Lyme, and will fill out insurance claims with an incorrect diagnosis. Labs may be overreporting, because of the well-recognized phenomenon of false positive IgM Western blots, which still register as “positive” on the official result (we know that these are false positives, since most of these patients have chronic complaints, but no IgG sero-positivity to support those chronic complaints). Finally, in a survey, many people think they have Lyme, but don’t really (earlier studies have shown that as many as 50 percent of patients showing up at a Lyme disease clinic do not have Lyme!).

There are still many misconceptions about Lyme disease, nearly 40 years after Lyme was first described in this country, and 100 years since Afzelius first described erythema migrans in Sweden. An excellent summary of these misconceptions by John Halperin and colleagues can be found at http://www.ncbi.nlm.nih.gov/pubmed/23321431, which can be shared with your patients as well. Some of the misconceptions discussed relate to testing for Lyme.

Another headline that appeared in papers in December 2013 alerted readers to three recent cardiac deaths attributable to Lyme. These were, in fact, three well-documented cases of unrecognized carditis secondary to Lyme, all in adults. (See the CDC’s Morbidity and Mortality Weekly Report of Dec. 13, 2013.) This report highlights the potentially serious nature of Lyme, and documents the few rare deaths from this common disorder.

There are times when Lyme arthritis looks like septic arthritis; several investigators, including our own Dr. Matthew Milewski of Orthopedics, studied over 600 children who presented to two institutions with monoarthritis (Deanehan JK et al. Distinguishing Lyme from septic knee monoarthritis in Lyme disease endemic areas. Pediatrics 131:e695-e701. 2013). One important conclusion was that Lyme disease is much more common than septic arthritis: There were 19 children with septic arthritis, and 341 had Lyme. Also, every child with a septic knee had a sed rate >40, and peripheral WBC with an ANC > 10,000. Of course, fever is generally required before considering a diagnosis of septic arthritis, so that lack of fever safely excludes sepsis in most cases. ■

Lyme disease reminder: A child with chronic non-specific complaints, such as arthralgias and fatigue, with only two positive IgM bands on Western blot, does not have Lyme disease (at least five IgG bands are required).

Lawrence Zemel, MD, heads Connecticut Children’s Division of Rheumatology. He is a professor of pediatrics at the UConn School of Medicine. Dr. Zemel may be reached at lzemel@connecticutchildrens.org or 860.545.9390.
NEW LEADERSHIP STRUCTURE IN HEM/ONC

At the end of 2013, the Division of Hematology and Oncology saw the departure of two veteran physicians—Dr. Arnold Altman, who retired after 40 years of service, and Dr. Nathan Hagstrom, who has left Connecticut Children’s to become the chair of pediatrics at Lehigh Valley Health Network.

As the Division of Hematology/Oncology continues to grow, a new leadership model has been developed to support the broad expansion that will continue to take place in the areas of clinical care, program development, and research.

Michael Isakoff, MD, and Nehal Parikh, MD, have transitioned into joint leadership roles as co-directors of the Division of Hematology and Oncology. Dr. Isakoff has taken on the role of medical director and will lead the clinical operations of the division, and Dr. Parikh has taken on the role of the research and academic director and will lead program development and the broadening of research. The two share administrative duties in collaboration with Nursing and Practice Manager Sarah Matney, RN, and Assistant Practice Manager Jenn Hann.

With the new leadership structure, Dr. Isakoff says “We hope to continue the clinical growth of our division while providing the highest level of service to the patients and families in our region. We are very excited about the challenges that lie ahead. Patients in our region who are diagnosed with cancer or blood disorders deserve world class care, and that is what we will strive to provide.”

Dr. Isakoff says that the division will continue to serve as a referral center for primary care and subspecialty providers across the state and will be available to providers for phone consultations. “Patients and families will continue to receive the highest level of care possible,” he says.

The division has recruited an additional hematologist/oncologist, Natalie Bezler, MD, who will start in April 2014. A top graduate of the UConn School of Medicine, Dr. Bezler did her residency at Connecticut Children’s, served as chief resident, and recently completed a fellowship in pediatric hematology and oncology at the Dana Farber Cancer Institute and Boston Children’s Hospital. Dr. Isakoff notes that to complete the new leadership structure the division aims to “recruit a senior-level scientist with national stature to take over the division chief position. We are hopeful that we will have the opportunity to recruit a scientist with expertise in genomic research that will help expand our collaborations with the Jackson Laboratories and UConn Health Center to help bring the most cutting-edge research and therapies to patients in our region.”

CLINICAL AND RESEARCH PLANS

Dr. Parikh says that the division will continue to build on several clinical programs, including those in late effects of chemotherapy, palliative care, solid tumor, sickle cell, hemophilia and advanced therapeutics.

“Each of our faculty is integral to our specialized programs, and identifying ways to support them is critical. We would like our faculty to continue program development that sets the standard that is recognized not only within our community and region, but perhaps even nationally and internationally,” says Dr. Parikh.

Genomic research is at the early stages of impacting clinical cancer care. The Division of Hematology and Oncology is collaborating with Jackson Laboratories to help develop the next phase of individualized, intelligent therapies that are guided by genomic abnormalities in a patient’s tumor. Through this collaboration, Dr. Parikh says, “We will be able to identify very, very specific types of treatments that are highly individualized and targeted, in hopes of improving responses while minimizing toxicities.”

The division is also working with surgical colleagues Christine Finck, MD, and Fernando Ferrer, MD, to develop early understanding of cancer biology in hopes of designing new therapies for pediatric tumors.

The division is part of several national consortiums, which allows it to bring the most novel therapies to patients under its care. Its advanced therapeutics program offers multiple Phase 1 and 2 trials for patients who seek novel treatments for recurrent cancers. One current trial guides treatment based on the molecular abnormalities in the individual patient tumor. Patients travel across the country to enroll in many of the division’s novel therapeutic trials. Dr. Parikh notes that these and other initiatives benefit patients and the community as a whole.

“As we continue our development of expertise within these programs, we will continue to expand the level of care we can offer,” he says. “Doctors in the region can be comfortable knowing that, when they refer to the Division of Hematology/Oncology at Connecticut Children’s Medical Center, their patients will be treated and cared for by experts in the field, not only in Connecticut, but nationally and internationally.”

Dr. Isakoff may be reached at misakoff@connecticutchildrens.org or 860.545.9630. Dr. Parikh may be contacted at nparikh@connecticutchildrens.org or 860.545.9630.
INVESTIGATORS RECEIVE GENOMICS INSTITUTE GRANTS

The Institute for Systems Genomics at the University of Connecticut recently awarded $1 million to four collaborative research programs, three of which include researchers from Connecticut Children’s. The programs, called Affinity Research Collaboratives, or ARCs, are based on a similar initiative developed at Boston University. They are designed to spur cross-disciplinary and cross-institutional research programs. In addition to Connecticut Children’s, investigators represent the Jackson Laboratory for Genomic Medicine and UConn.

ARCs involving Connecticut Children’s researchers are:


• Use of Diversity Outbred Mice to Study Cardiotoxicity of Chemotherapeutic Agents – Drs. Olga Toro-Salazar, Michael Isakoff, Eileen Gillan and Andrea Orsey.

• Early Life Physiological and Psychosocial Stress Imprints Gut Microbiome in Preterm Infants – Drs. Adam Matson and Naveed Hussain.

RESEARCH: TAKING A GLOBAL PERSPECTIVE

Connecticut Children’s pediatric urologist John Makari, MD, is engaged in research aimed at obtaining a global view of trends in his specialty. Using large, administrative databases such as that maintained by the Child Health Corporation of America, he is looking at utilization of health care services related to select procedures on a national level.

“One shortcoming of research in general is that it’s usually limited to the case series of a single institution or a single surgeon,” Dr. Makari says. “This approach lets us get a 30,000-foot view of what’s happening nationally among people performing these procedures.”

Using information assembled through his research, Dr. Makari recently published an article in the Journal of Urology on the need for additional procedures in patients undergoing proximal hypospadias repair. Having abundant data on additional procedures performed after complex hypospadias repair, Dr. Makari says, “helps us understand on a global level what’s going on and gives us reference points as to whether we fall within the expected range. We can judge an individual series against a broader context.”

Analyzing accumulated data for this and other procedures reveals information about trends in utilization of services over time, regional variations in utilization of health care, and long-term complications from different procedures. It also shows trends such as the rate at which new procedures are replacing older ones.

Dr. Makari also used administrative databases in a study he conducted to see whether children who underwent deflux for vesicoureteral reflux went on to require additional procedures.

“We found that despite success rates reported in the literature, not only is the incidence of additional surgical intervention lower than expected, but also that wide variation exists in the incidence of additional procedures among hospitals nationwide,” he says. “This is a different way to look at trends in utilization of care to better understand what’s going on nationwide.”

Dr. Makari is an assistant professor of surgery (urology) at the University of Connecticut School of Medicine and a Fellow of the American Academy of Pediatrics and the American College of Surgeons. He may be contacted at jmakari@connecticutchildrens.org or 860.545.9520.
NEW MOC MANAGER ON BOARD

Eminet Feyissa, MPH, has joined the maintenance of certification program as program manager. Ms. Feyissa’s responsibilities include managing Connecticut Children’s MOC portfolio, including coordinating development of community- and hospital-based quality improvement projects that meet MOC credit requirements.

The MOC program implements quality improvement initiatives within the Medical Center and bridges sustained improvements in the delivery of care to community pediatricians. As an American Board of Pediatrics Portfolio Sponsor, Connecticut Children’s evaluates and approves its own QI projects. The program is a valuable resource for pediatricians looking to receive credit for the Performance in Practice component of MOC.

Ms. Feyissa has been a research associate for Connecticut Children’s Co-Management program and grant developer for the Office for Community Child Health.

Ms. Feyissa may be reached at efeyissa@connecticutchildrens.org or 860.837.5712.

GRANT TO IMPROVE ACCESS TO QUALITY CARE

United Healthcare has provided a $1 million grant for Connecticut Children’s Medical Center’s Office for Community Child Health to help enhance care delivery and address critical public health issues for children. These issues include child development, wellness, and chronic conditions such as asthma and obesity.

The grant will help OCCH create a Maintenance of Certification program to train primary care pediatricians in management of diseases such as asthma and obesity. OCCH will also provide 600 primary care doctors at more than 1/2 U practices in Connecticut with training to enhance children’s health care quality.

GRAND ROUNDS Online

Remember that Grand Rounds Online is now FREE of charge.

Earn CME credit from your home or office by accessing selected Grand Rounds presentations online.

To register and obtain a password, call Deirdre Palmer at 860.837.6281.

CONINUING MEDICAL EDUCATION PROGRAMS

All programs are held at the Pond House Café, 1555 Asylum Ave., West Hartford, Conn.

Standard Schedule:
5:30 p.m. to 6:00 p.m. – Registration
5:30 p.m. to 6:30 p.m. – Buffet Dinner
6:30 p.m. to 7:30 p.m. – Lecture
7:30 p.m. to 8:00 p.m. – Q&A

Expanded Schedule:
5:30 p.m. to 6:00 p.m. – Registration
5:30 p.m. to 6:30 p.m. – Buffet Dinner
6:30 p.m. to 8:00 p.m. – Lecture
8:00 p.m. to 8:30 p.m. – Q&A

ANDRULONIS CHILD MENTAL HEALTH EVENING LECTURE SERIES
May 6, 2014**
Psychopharmacology: Update for 2014

PEDIATRIC EVENING LECTURE SERIES
April 3, 2014**
Co-Management of Premature Adrenarche

To register or obtain more information, contact Diane Mouradjian at 860.837.6264 or dmouradjian@connecticutchildrens.org or Deirdre Palmer at 860.837.6281 or dpalmer01@connecticutchildrens.org
Inside Glance...

A Breathtaking Illness: Misconceptions still swirl around Lyme disease..............6
A New Approach to Psychiatric Emergency Care..............................................3
Got Decal?.................................................................................................3
Lunch & Learn Talks....................................................................................3
Featured Subspecialist: Heather Schlott, MD..................................................4
EHR Implementation Milestone – Fourth Complete, Biggest On Deck For April......4
New Sleep Medicine Center And Neurodiagnostic Lab....................................5
News from Rheumatology - Misconceptions still swirl around Lyme disease........6
New Leadership Structure In Hem/Onc..............................................................7
Investigators Receive Genomics Institute Grants.............................................8
Research: Taking A Global Perspective.............................................................8
New MOC Manager On Board..........................................................................9
Grant To Improve Access To Quality Care......................................................9
Grand Rounds Online......................................................................................9
Connecticut Children’s American Board of Pediatrics (ABP) Maintenance of Certification (MOC) Portfolio Program........9
Continuing Medical Education Programs......................................................9

Connecticut Children’s Medical Center At Your Service

Connecticut Children’s provides a variety of services at locations statewide and beyond. Here’s a summary:

**HOSPITALS**

**Hartford**
Connecticut Children’s Medical Center
282 Washington Street
Hartford, CT 06106

**Waterbury**
Connecticut Children’s - Waterbury
Saint Mary’s Hospital
56 Franklin Street
Waterbury, CT 06706

**NEONATAL INTENSIVE CARE UNITS (NICU)**

**Hartford**
Connecticut Children’s NICU
Hartford Hospital
80 Seymour Street
Hartford, CT 06106

**Farmington**
Connecticut Children’s NICU at UCONN Health Center
263 Farmington Avenue
Farmington, CT 06032

**AMBULATORY SURGERY CENTER**

**Farmington**
505 Farmington Ave., 3rd Floor
Farmington, CT 06032

**SPECIALTY CARE CENTERS**

**The Children’s Health and Wellness Center**
79 Sandpit Road
Danbury, CT 06810

**95 Reef Road**
Fairfield, CT 06824

**399 Farmington Avenue**
Farmington, CT 06032

**310 Western Boulevard**
Glastonbury, CT 06033

**4 Corporate Drive, Suite 282**
Shelton, CT 06484

**OTHER LOCATIONS**

**East Hartford**
111 Founders Plaza
East Hartford, CT 06108

**Farmington**
11 South Road
Farmington, CT 06032

**Hartford**
100 Retreat Avenue
Medical Arts Building
Hartford, CT 06106

**New Britain**
The Hospital of Central Connecticut
100 Grand Street
New Britain, CT 06050

**New London**
Lawrence & Memorial Hospital
365 Montauk Avenue
New London, CT 06320

**Putnam**
Day Kimball Hospital
320 Pomfret Street
Putnam, CT 06260

**Stamford**
Stamford Hospital – Tully Hill Health Center
32 Strawberry Hill Court
Stamford, CT 06902

**Torrington**
Charlotte Hungerford Hospital
157 Litchfield Street
Torrington, CT 06790

**Waterbury**
Waterbury Hospital
64 Robbins Street, 3rd Floor
Waterbury, CT 06708

**Springfield, MA**
Shriners Hospital for Children
576 Carew Street
Springfield, MA 01104

To make an appointment, call the specialty’s main number found at

WWW.CONNECTICUTCHILDRENS.ORG

**BEST CHILDREN’S HOSPITALS**

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**NEONATOLOGY**
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