Recognizing An Emerging Disorder

Eosinophilic esophagitis manifests differently at different ages.

Eosinophilic esophagitis (EE) is a newly recognized gastrointestinal allergic inflammatory disease that has been seen with increasing frequency in children over the past five to 10 years. It is characterized by the presence in the esophagus of a large number of eosinophils—a specific type of white blood cell important to the immune system, usually seen with allergy.

While the incidence of EE is definitely on the rise, diagnosis is often delayed, says Jeffrey Hyams, MD, director of the Division of Digestive Diseases, Hepatology and Nutrition at Connecticut Children’s. This delay is due partly to a lack of awareness of the disorder and partly to how the disorder manifests itself.

“EE presents with very age-specific symptoms, and this can lead to confusion when dealing with young patients,” says Dr. Hyams. “It often resembles GERD. In infants and toddlers EE presents with symptoms including vomiting, abdominal discomfort, feeding aversion and failure to thrive. In older children, it often presents with difficulty swallowing, heartburn, regurgitation and sometimes with a piece of food becoming impacted in the esophagus.”

Referral and Diagnosis

Dr. Hyams recommends that primary care providers refer any patient with persistent vomiting, feeding issues or swallowing problems to a digestive diseases specialist for further evaluation.

“We look for anatomical abnormalities first, performing an upper GI series and then endoscopy looking for typical findings of... Continued on page 3

Revisiting Lyme

New developments in Lyme disease include affirmation of treatment guidelines and studies showing that 10 days of antibiotic are as effective as 20.

Perhaps nowhere is Lyme disease discussed and debated more than here in the state that gave the disease its name. Primary care providers are on the front lines of care, so a periodic review of what’s new in Lyme disease is appropriate.

“One of the new things in Lyme disease is that, this past year, a national review panel supported existing guidelines previously published by the Infectious Disease Society of America,” says Connecticut Children’s pediatric rheumatologist Lawrence Zemel, MD.

The panel, comprising mostly infectious disease physicians with strong academic credentials, strongly rebuked a challenge by Connecticut’s attorney general. “The message to pediatricians,” Dr. Zemel says, “is to continue to follow those guidelines in terms of treatment.”

Pediatric infectious disease specialist Henry Feder, MD, has published several studies on Lyme disease. He notes that, while three to four weeks of antibiotics are usually recommended, recent studies show that 10 days of doxycycline are as effective as 20 days in treating the rash of Lyme disease (erythema migrans).

“If I see my patient on... Continued on page 4

We’re Tops In Orthopedics!

This summer, Connecticut Children’s was named one of America’s top children’s hospitals in the specialty area of orthopedics. The ranking, by U.S. News and World Report, qualifies Connecticut Children’s program as one of the top 30 in the country. Our Department of Orthopaedics received especially high marks in four categories: infection prevention activities, patient volume, non-surgical volume and advanced clinical services. Final rankings are online at www.usnews.com/childrenshospitals.
**Presentation**

TP is a previously healthy 12-year-old girl who presented with lethargy and a purpuric rash. Two days prior to admission, she had returned from a trip to Wisconsin for an academic competition. On the day prior to admission, she had attended school, but had come home on the bus complaining of nausea, sore throat and headache. That night, she was restless and febrile. The morning of admission, she was “crabby” and lethargic, and could barely open her eyes. Her father noticed the emergence of a diffuse petechial rash with some areas of purpura, and recognized this as purpura fulminans. She was rushed to Marlborough Health Care Center, where an IV was placed. She was given IV antibiotics and fluid resuscitation, and transported by LIFE STAR helicopter to Connecticut Children’s.

**Diagnosis/Treatment**

I met TP on her arrival at the Emergency Department of Connecticut Children’s. At that time, she was barely conscious and was febrile and hypotensive. Initial blood work disclosed significant anemia (hematocrit of 15%) and severe lactic acidosis (pH 7.17). Fluid resuscitation was continued with crystalloid and O negative packed red blood cells. She was given stress hydrocortisone and taken to the PICU where she was emergently intubated and central venous access was obtained.

Over the next several hours, she developed increasingly unstable blood pressure with steadily rising serum lactates (to as high as 16 mmol/L), requiring further fluid resuscitation and increasing inotropic support with epinephrine and milrinone infusions. She developed disseminated intravascular coagulation with a prothrombin time as high as 30 sec, and the Hematology consultant recommended treatment with vitamin K and fresh frozen plasma. For the first 24 hours, her prognosis was uncertain, and she required near-constant presence by a critical care attending at her bedside in order to manage her rapidly changing condition.

She improved almost as rapidly as she had initially progressed. Her respiratory and hemodynamic status stabilized during the next day. Blood cultures from the Marlborough facility were positive for *Neisseria meningitidis*. The state Department of Public Health was notified, and prophylactic antibiotics were given to close contacts. Her respiratory and cardiac insufficiency quickly improved and, within two days, she was extubated and no longer needed cardiovascular support. Although the Plastic Surgery Department had been consulted, she did not require tissue debridement for her purpura.

After four days, she was transferred to the ward for continued care led by Dr. Richard Johnson. After seven days, she was discharged home with rehabilitation follow-up for physical and occupational therapy.

**Discussion**

Meningococcemia is a well-deserved frightening reputation in the medical community. Frequently worried about but rarely seen, meningococcemia can kill more rapidly than any other infectious disease. Irreversible shock and death can occur within hours of the onset of symptoms. Skin manifestations are the most important first clue to the diagnosis. Early recognition and rapid treatment are key, and prompt antibiotic therapy and supportive care are critical to survival. In a recent review, the mortality for meningococcemia in children was 23%, with 82% of deaths occurring within the first two days of admission, and 7.5% of the survivors had skin necrosis and limb ischemia requiring grafts or even partial or full amputations of extremities.

Meningococcemia is caused by *Neisseria meningitidis*, a Gram-negative diplococcus. Humans are the only natural reservoir for this bacterium, and it is spread from asymptomatic carriers. Children under 5 years of age and adolescents are the most likely populations to be infected. The incubation period is typically less than four days, but can range from one to 10 days. A vaccine is available and typically given to children at 11 to 12 years of age. Antibiotic prophylaxis with either rifampin or ciprofloxacin is recommended for those with direct and close contact with infected individuals.

The symptoms of acute meningococcemia can mimic a viral-like illness with pharyngitis, fever, myalgias, weakness and headache. The characteristic rash is either macular or papular, and can start as petechial before progressing to the more severe purpura fulminans. With systemic infection, children also commonly develop shock, acidosis, adrenal insufficiency, disseminated intravascular coagulation, altered mental status and coma. Despite the organism’s name, meningal infection occurs only in slightly more than half of affected children. In this particular case, a lumbar puncture was not performed due to the risk from her bleeding diathesis. Patients with asplenia or specific complement deficiencies (C3, C5-9) are more susceptible to severe disease. Young age and absence of meningitis, coma, hypotension, leukopenia, and thrombocytopenia are associated with a worse prognosis.

Infection is the leading killer of children worldwide. Delays in administering antibiotics can increase mortality by six-fold, and failure to provide early, aggressive fluid...
resuscitation and inotropic support increases the probability of death by 40% with each hour that passes. In this case, the care provided at each stage was exemplary. TP’s sepsis was recognized promptly, her treatment was begun rapidly, she was transported quickly and she received aggressive resuscitation by in-house subspecialists. At any point, there were ample opportunities for delays. Lack of recognition of purpura fulminans, failure of the outside hospital to give immediate IV antibiotics, weather factors that could have prevented LIFE STAR from flying – any of these could have dramatically changed the outcome. Fortunately, none of these occurred, and remarkable coordination in care resulted in a positive outcome.

A Physician Father’s Perspective

John Peng, MD, a pediatric emergency medicine specialist at Connecticut Children’s, is the father of the patient in the Case Review. Dr. Peng wrote of his experience at the invitation of Medical News.

When you are a physician and your own child becomes ill, you are always walking the tightrope between overreacting and underreacting. When my daughter developed fever, sore throat and headache, the thought of meningococcemia crossed my mind, but I dismissed it rapidly, as I didn’t have enough signs at that point to substantiate that concern. When I went to check on her in the morning before going to work, she had a half-dollar-sized purpuric lesion on her right hip, and I knew that my worst nightmare was reality. At this point, I knew that I had to get her antibiotics started quickly. We are fortunate to live within several miles of an emergency center. I scooped her up and ran, not even pausing to put on her shoes.

When I arrived at the emergency center, the dilemma faced me of knowing what she needed, but trying not to be an overbearing parent. They responded quickly, establishing IV access and starting the first dose of antibiotic and fluids. I was grateful that they were receptive to my suggestions on giving the fluid more quickly. Transport was quickly arranged via LIFE STAR. I drove to Connecticut Children’s, arriving before LIFE STAR, and was met in the Emergency Department by the emergency medicine attending, the intensive care attending and the nursing staff. I presented the situation to them. On arrival at Connecticut Children’s, my daughter was still coherent and her blood pressure had normalized with fluids. I knew that the ICU attending was being respectful of my status as a physician when he reviewed the treatment options with me. But I also agreed with him that we were going to have to be aggressive with her management and gave him the green light to do what he needed to do. Five to 10 minutes after arrival, my daughter’s blood pressure bottomed out, and we transported her to the ICU to establish an airway and central line access.

Three intensive care attendings and a team of nurses worked several hours to establish the lines that were needed and to stabilize her blood pressure. During this time, I purposefully stayed out of the room. I knew that she was in good hands, and that in my current state of mind, I would have nothing to contribute. I did not want my presence to distract them from the task at hand. Sometimes, I think that treating the child of a physician can also cause an overreaction or underreaction on the part of the treating staff. Sitting outside the room was hard since, as a physician, I knew the marginal likelihood of successful recovery. However, thanks to the PICU team, she will heal with perhaps only a few residual scars. Without their expertise, she would have died, or at least suffered more extensive injury. I am grateful to say that things could not have happened any faster when it came to the treatment of my daughter.

“Biopsy is crucial as we look for an increased number of eosinophils along with other signs of inflammation. At times there is overlap with reflux esophagitis, making a diagnosis more difficult. Usually, however, the number of eosinophils is so great that the diagnosis is straightforward”

Once the child has been definitively diagnosed with EE, Dr. Hyams and his colleagues manipulate the child’s diet.

“About 80 percent of children will have complete resolution by removing six foods: milk, soy, egg, wheat, fish and nuts. They’re not necessarily allergic to all six, but if you eliminate all six, you’ll see complete resolution,” Dr. Hyams says.

Repeat endoscopy is performed in two to three months, and if the child has clinically improved and the biopsy normalized, physicians will gradually add back one food at a time. Upon re-challenge with food, they repeat the endoscopy to see if the inflammation has returned. While a child may have an allergic response to more than one food, milk is far and away the most likely not to be tolerated. Though the process of identifying offending foods by trial and error is tedious and time-consuming, there is no other way, since standard allergy testing is typically not helpful in predicting which foods are the problem.

Dr. Hyams notes that the disorder tends to run in families, more commonly on the father’s side.

TREATMENT

While a small percentage of very young children may outgrow the disease, for most of them and for older children, EE is a chronic condition that must be treated with dietary restriction. If symptoms do not improve with diet, then a treatment approach in which the child swallows anti-inflammatory medications (corticosteroids) to coat the esophagus can be used, but the condition returns as soon as the medication is stopped. Given potential long-term toxicity of this approach, it is not generally used as first-line treatment in many centers.

If left untreated, EE can result in progressive scarring of the esophagus and the formation of strictures, requiring dilation on an ongoing basis.

Primary care physicians wishing to discuss a patient may contact the Division of Digestive Diseases, Hepatology, and Nutrition at 860.545.9560.
Revisiting Lyme, continued from page 1

day 16 and he or she is having an allergic reaction to the antibiotic, I can stop it," says Dr. Feder. "There's nothing magical about 20 days"

**POST-LYME SYNDROM E**

Dr. Zemel says it bears repeating that physicians must correlate lab findings with clinical findings in order to diagnose Lyme disease.

"We often see positive IgM antibodies in children who do not have Lyme disease," Dr. Zemel says.

If a child 9 years of age or older has been bitten by a deer tick and the tick was attached for more than 24 hours, the child can receive a double dose of doxycycline (200 mg) to prevent Lyme disease from occurring.

Diagnosing the disease is fairly straightforward. What's more challenging is determining whether the infection has been eradicated. The blood antibody test is the only one available, yet once someone has had Lyme disease, these antibodies may be present for years or even decades.

After treatment, 10 to 20 percent of people will have a recurrence of not feeling well. With the initial infection, patients may have fever, headache, malaise and rash. With treatment, the fever and rash resolve within 48 hours and the person usually feels better in a few days.

But, after stopping therapy, he or she may complain of subjective symptoms, such as headache and malaise. These may continue for many months. This is known as post-Lyme syndrome.

"Sometimes the best thing to do is wait it out. People may have persistence of subjective symptoms following treatment of Lyme disease. Treating Lyme disease longer doesn't make persistence of symptoms less likely," says Dr. Feder. He likens post-Lyme syndrome to the fatigue that often follows mononucleosis.

**WHEN TO REFER**

Dr. Zemel says that patients should be referred to a pediatric infectious disease specialist or rheumatologist for evaluation if they continue to have symptoms beyond initial treatment. They should also be referred if there is a question of Lyme meningitis. Symptoms of this condition may be subtle. They may include severe headache with only mild neck stiffness.

Children suspected of having Lyme arthritis, characterized by marked swelling of the knee or other joint, should be referred to a pediatric rheumatologist.

Erroneous information on the Internet, coupled with the views expressed by a tiny minority of physicians, often cause people to be convinced that their child has chronic Lyme disease, despite the primary care physician's determination that Lyme disease is not present. Dr. Feder says that referral to a pediatric infectious disease specialist with expertise in Lyme disease may help alleviate fears.

"I can sometimes get the patient thinking in the right direction and get them to move on with their lives," Dr. Feder says.

The physicians note that a number of popular Lyme disease websites contain grossly inaccurate information. They suggest directing patients to the websites of the Centers for Disease Control and Prevention (cdc.gov), the American Lyme Disease Foundation (aldf.com) or the National Institutes of Health (nih.gov).

Referring Provider Project Update

Connecticut Children's subspecialty divisions are continuing to develop referral guidelines, as part of an initiative prioritized by the Referring Provider Advisory Board. This first series of referral guidelines will be completed and available on the website by Sept. 30.

Each division's guideline is reviewed by primary care pediatricians and ultimately approved by the Connecticut Children's Specialty Group Quality Committee.

Community pediatricians who have volunteered to review the guidelines include Drs. Gerald Calnen, Jody Terranova, Harry Weinerman, Carrie Streim and Maury Luxemburg.

Karen Rubin, MD, physician champion of the hospital's Referring Provider Relations Program, says that the rigorous process of developing the guidelines, which are intended to benefit primary care providers, also benefits specialists.

"Guidelines must reflect the best available, most current evidence, so it's an opportunity for the whole division to do a literature review," Dr. Rubin says. "This learning experience enables specialists to be even more comfortable in making recommendations to the referral community. The process elevates the standard of care for everyone involved."

**CO-MANAGEMENT WORKSHOPS AND RESEARCH STUDY**

CME workshops have been held on the five conditions selected for inclusion in the Co-Management pilot study. To extend the Co-Management training to providers in other parts of the state, a combined workshop on pediatric voiding dysfunction and chronic fatigue syndrome/fibromyalgia will be held on Wednesday, Oct. 13, at 6 p.m. at Connecticut Children's Shelton Specialty Care Center at 4 Corporate Drive, Suite 282. (For more information, see page 9. To register, e-mail dmouradjian@connecticutchildrens.org.)

Referring providers can obtain CME credit for any of the five Collaborative Co-Management CME workshops by accessing them on the referring provider page of Connecticut Children's website. Laura
Asthma Clinical Pathway Developed
This clinical tool aims to make the inpatient stay more efficient and evidence-based while maximizing the patient’s continued improvement after discharge.

Connecticut Children’s now has in place a clinical pathway for the inpatient management of asthma. The pathway is the result of months of work by a multidisciplinary team led by Anand Sekaran, medical director of Inpatient Services at Connecticut Children’s.

“Health care has become increasingly complex, resulting in greater fragmentation of care, greater risk of medical errors and an increasing need for safety and quality systems,” says Dr. Sekaran. “Use of tools such as pathways and checklists help ensure that we use best practices, provide evidence-based care and do the right thing for the right patient at the right time.”

A clinical pathway may be described as an evidence-based algorithm linked to a standardized order set. When the patient with asthma is admitted, he or she is placed on the pathway, which describes specifically what should be done for the patient by different providers. It outlines what the resident should order for the initial plan, what nurses, respiratory therapists and others should do and how the patient will be cared for through to discharge.

Improving Communication
Dr. Sekaran says the pathway will also extend beyond discharge.

“We need to make sure we do better with patient and family education and with communication with primary care providers,” Dr. Sekaran says. “We are now going to track as a quality measure not only whether a home treatment plan was done, but whether it was given to the family and faxed to the primary care provider.”

Since PCPs have said the handwritten portions of the faxed document are sometime illegible, the team is working with Clinical Informatics to computerize the entire asthma home treatment plan.

Better patient/family education and improved communication with PCPs typically help the patient complete the initial discharge plan of care and avoid exacerbations and readmissions in the future.

Merits of Pathways
One of the features that make pathways so valuable is that, in the process of creating one, each step is discussed, debated and decided upon by a multidisciplinary group. It is the result of a rigorous, multifaceted process and is based on evidence and outcomes, as much as those are available.

Dr. Sekaran stresses that, far from being “cookbook” in nature, the pathway is a guide that allows for variation, depending on the patient.

“It is vital that providers realize that variation from the pathway is not only OK, but contributes to making the pathway better,” he says. “Our job as pediatric providers is to use our minds and experience to the fullest to determine how we should vary from the usual approach, given that patient’s specific needs.”

Pathways are subject to change. Dr. Sekaran and his team will meet monthly and will look at pathway use and quality measures. They are asking that providers document on the front page via a “variance” when patient care requires deviation from the usual approach.

“If we see the same variances occurring repeatedly, we will change the pathway, so that over time we will shape it to be optimal,” says Dr. Sekaran. “The pathway is a living, evolving document, not something written in stone.”

Referring providers with questions or comments related to the asthma pathway may page Dr. Sekaran at 860.220.1992 or e-mail him at asekar@connecticutchildrens.org.
Radiology Upgrades Enhance Care

New technology means superior imaging and expanded capabilities, but the commitment to every child’s comfort and safety remains the same.

Connecticut Children’s Radiology Department upgraded its MRI scanner this summer and is adding a new 64-slice CT scanner this fall. Both improve image resolution and cut scanning time. The new CT scanner is the only one in the industry to have a unique Dose Shield that eliminates radiation exposure from areas that are not relevant to the study. In some cases, radiation exposure may be decreased by up to 40 percent.

Tim Brown, MD, the department’s medical director, says that the upgraded MRI will be especially helpful when imaging small joints and will allow for better, faster diagnoses. The MRI’s increased speed will also make possible two additional studies: MR enterography, which will allow examination of the small bowel without the radiation exposure of a CT scan, and MR urography, which allows for anatomical and functional imaging of the kidneys and genitourinary tract. The upgraded software also includes motion compensation software that may reduce the need for sedation.

The new CT scanner offers many benefits to patients.

“Our new CT scanner will allow patients to have specialized studies right here at Connecticut Children’s,” says Suzanne Czerwinski, RTR, CT, radiology clinical educator. “We will have the capability to perform interventional studies such as abscess drainages and biopsies, as well as advanced dynamic studies including CTA and renal studies. The shorter scan times will also contribute to the reduction in the use of sedation for some patients.”

Diane Jay, RTR, CRA, radiology manager, says “This technology will afford us more comprehensive imaging capabilities and provide a platform for future technological enhancements.”

Minimizing Radiation
Connecticut Children’s is aggressive in efforts to keep radiation exposure to a minimum when a child must have a CT scan. The hospital participates in the national Image Gently campaign and has procedures to guarantee the child receives the lowest possible dose. The department is also accredited by the American College of Radiology for both CT and MR.

“CT is a powerful imaging tool that can really help in diagnosis,” says Dr. Brown. “Because of the significant radiation exposure, we use it only when necessary. For this reason, having an advanced, lower-dose CT scanner is very important for us.”

Focus on the Child
Like all of Connecticut Children’s, Radiology is committed to delivering expert care while ensuring each child’s comfort and safety.

Child Life staff members are available to explain procedures to patients and families, allay concerns and provide distractions during IV starts or other slightly uncomfortable procedures. Rebecca Haynes, certified child life specialist, says “These services help increase a patient’s understanding, encourage them to be more cooperative and reduce anxiety or fear.”

The Radiology Department regularly uses the medical center’s Sedation Service and Anesthesiology Department to reduce a child’s anxiety and enhance his or her comfort. This also reduces radiation exposure by preventing the need for repeat scans.

“Our repeat rate is extremely low,” Dr. Brown says. “With Sedation, Anesthesia and Child Life, we can do the scan once and do it properly.”

To schedule an outpatient appointment, call 860.545.9556 for MRI or 860.545.9120 for CT.

Neurology Access Expected To Improve

The addition of two new full-time pediatric neurologists to Connecticut Children’s Neurology Division this summer and fall should mean patients won’t have to wait as long to see a subspecialist in this field. Cristian Ionita, MD, joined the department in August, and Gyula Acsadi, MD, PhD, will come on board in early November. Dr. Acsadi will also serve as chief of the division.

The new physicians will join Drs. Francis DiMario, Carol Leicher, Jennifer Maden-Cohen and Richard Young in seeing patients with a range of conditions, including epilepsy, seizures, headache and muscle disease. Drs. Acsadi and Ionita are both board-certified muscle-disease specialists.

Dr. Leicher has announced her plans to retire effective Dec. 31, 2010, after 14 years with Connecticut Children’s.

“Carol has been a wonderful colleague, as well as an excellent and caring physician,” says Physician-in-Chief Paul Dworkin, MD. “We will miss her, but we all wish her well in this new chapter in her life.”

The division’s pediatric neurologists see patients in Hartford and at Connecticut Children’s Specialty Care Centers in Glastonbury and Farmington.

To refer a patient, please access the online referral system at www.connecticutchildrens.org.
Can using a safety checklist before and after every surgical procedure reduce morbidity and mortality? A recent worldwide World Health Organization study of adult patients answered with a resounding “yes,” with some sites reporting a 40 percent reduction in surgical morbidity. Now Connecticut Children’s and more than two dozen other sites in this country are participating in a study to gauge the impact on pediatric patients.

The study, initiated by Children’s Hospital Boston, got under way at Connecticut Children’s in early 2009, after Perioperative Clinical Education Specialist Kathleen Doyle, BSN, RN, CNOR, and her colleagues talked with the Boston researchers and obtained permission for Connecticut Children’s to take part.

“The Boston people gave us a template and asked us to modify it to our practice,” Ms. Doyle says. “Over two to three months, we made modifications and incorporated AORN and Joint Commission standards. We’ve been using the same checklist since June 2009.”

The checklist is used in every OR and endoscopy suite for every patient and every case. Physician champions for the study include Drs. John Makari, Elizabeth Weber and Richard Weiss.

**CHECKLIST IN PRACTICE**

An initial timeout is held prior to each procedure. The OR team follows universal protocols and the “red rule” for using two identifiers for each patient. They verify the patient’s procedure and the position for surgery, see that any implants needed are on hand, and identify whether the patient needs antibiotics or available blood. Once the patient is prepped and draped, team members hold a second timeout. They re-verify the patient’s name and procedure, talk about any special equipment, review any imaging studies or labs, verify that antibiotics have been given, consent matches the stated procedure, and medications are labeled. After discussing fire risks, each person in the room introduces him- or herself. Only then do they proceed with the procedure.

After the procedure, they have a final “sign out”. The surgeon verifies the name of the procedure to be recorded. The team verifies that the final count is correct and that specimens are labeled. They discuss any concerns or issues they need to share with the PACU. Finally, they use SBAR (situation, background, assessment, recommendation) to complete handoff to the PACU.

**The Way of the Future**

To generate enthusiasm for using the checklist approach, Ms. Doyle and others put together a four-minute video showing an OR team completing the three timeouts and stressing that the process takes less than three minutes in total. They showed the video in the medical center’s cafeteria on National Timeout Day and during Risk Management Week, both in June.

Although it will be some time before Boston analyzes all the data and reports results, Ms. Doyle is already seeing improvement. Compliance with antibiotic administration improved dramatically with the checklist’s implementation, rising from 80 to nearly 100 percent. Already-low infection rates are now even lower – well below national averages.

Ms. Doyle maintains that checklists such as this one are the way of the future.

“*I’ve been an OR nurse for 24 years, and I can see the writing on the wall,*” she says, noting that the approach reflects Joint Commission recommendations. “It works. It prevents errors and saves lives. It will be mandated in the future.”
Accessing Clinical Information Online

Referring providers with a pressing need to obtain view-only access to Connecticut Children’s clinical information system can make arrangements for it by contacting the medical center’s Medical Staff Office. The office is onboarding physicians on a case-by-case basis.

“Once the physician has view access, he or she can log on from any location to see if a patient was admitted, view lab and other reports and read the discharge summary,” says Practitioner Informatics Analyst Nikki Daigneau, RN, BSN, CPN, who coordinates arrangements.

She notes that Connecticut Children’s is working to improve the process for transmitting discharge summaries to primary care providers.

Before receiving access to Sunrise Clinical Manager, physicians go through about an hour of online modules on how to access and navigate the system, and then attend an hour-long, in-person class led by Ms. Daigneau.

To request access to the system, contact Katherine Arbuckle at 860.545.8123 or karbuckle@connecticutchildrens.org.

Special Program in Waterbury

Nurses and other health care providers who care for children are invited to register for “Current Issues in Pediatric Healthcare,” an educational program being held on Saturday, Oct. 2, 2010, from 7:15 am to noon at Connecticut Children’s Waterbury campus, 56 Franklin Street.

Nursing continuing education credits are offered. For a brochure and more information, contact Deborah Martin, MSN, RN at 203.709.3549.

Grand Rounds Online

Earn CME credit from your home or office by accessing selected Grand Rounds presentations online. Go to www.connecticutchildrens.org to register and obtain a password.

NOW ONLINE
Directory Of Programs And Services

In the interest of ensuring up-to-date information — and being kind to the environment — we’re now publishing our Directory of Programs and Services exclusively online. You’ll find the 2010-2011 edition by clicking on the link on our homepage, www.connecticutchildrens.org.
Cardiac Surgery Expands

Agreement with Boston Children’s creates a regional resource.

Connecticut Children’s ability to provide comprehensive pediatric cardiovascular surgical care is expanding significantly, thanks to a recently finalized collaborative arrangement with Children’s Hospital Boston.

In the short term, the agreement calls for a pediatric cardiac surgeon from the Boston center to provide services at Connecticut Children’s up to five days per month while Connecticut Children’s recruits a full-time pediatric cardiac surgeon. But the relationship will ultimately be long term.

“The surgeon who is ultimately hired will be a full-time employee of our practice, says Dean Rapoza, president of Connecticut Children’s Specialty Group, “and will also have an affiliation with Boston Children’s to share clinical and research protocols.”

Children’s Hospital Boston is one of only a handful of centers that perform a very high volume of sophisticated pediatric cardiac surgical procedures. The new relationship is expected to enable Connecticut Children’s to perform even the most complex procedures, such as hypoplastic left heart repair, by drawing on the resources and experience of a regional quaternary center. Hartford- and Boston-based surgeons could, for example, collaborate to perform procedures at Connecticut Children’s.

“This relationship gives us the opportunity to deliver pediatric cardiac surgery of the highest quality and, at the same time, be able to provide more surgical care locally,” says Mr. Rapoza. “It is a partnership that will provide regional resources for this service.”

Video Filmed At Connecticut Children’s Available Nationwide

Connecticut Children’s got a little taste of Hollywood recently, when a video aimed at easing children’s fears of surgery was recently filmed on-site. Titled Small Tales, the video uses puppets to explain basic pre-op procedures in a way children can understand. Produced by Little Engine Media and supported by Care.com, the video is available for purchase by hospitals nationwide. The video features four puppet characters who travel through the pre-operative area a children’s hospital, learning about topics such as check-ups, blood tests and anesthesia. Along the way, they meet real-life caregivers from Connecticut Children’s, including staff from Child Life, Nursing and Anesthesia.

Among those attending the “Small Tales” premiere that took place at Connecticut Children’s were (from left) producer Melissa Roja Lawlor, puppeteer Peter Linz and Connecticut Children’s Child Life Specialists Mary Welker, CCLS, and Colleen Brown, MS, CCLS. The puppets featured in the video are (from left) Piper, Jojo and Bailey.
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  - University of Iceland School of Medicine
  - University of Iceland, history, Latin

- **Vineetha Joseph, DO**
  - University of Medicine and Dentistry of New Jersey School of Osteopathic Medicine
  - The College of New Jersey, BS biology

- **David Kram, MD**
  - Sackler School of Medicine
  - University of Florida, BA Jewish studies

- **Christopher Nitkin, MD**
  - Mount Sinai School of Medicine of New York University
  - Dartmouth College, BA chemistry

- **Amisha Parikh, MD**
  - Pennsylvania State University College of Medicine
  - Boston University, BA biochemistry/molecular biology

- **Richard Pierce, MD**
  - University of Illinois College of Medicine
  - University of Illinois, MS organic chemistry
  - Oberlin College, BA chemistry, biochemistry, biology

- **Sarah-Jo Stimpson, MD**
  - University of Massachusetts Medical School
  - Union College, BS biochemistry

- **Ricka Messer, MD, PhD**
  - University of Connecticut School of Medicine MD/PhD
  - University of Texas, BA biology/linguistics

- **Victoria Martin, MD**
  - University of Massachusetts Medical School
  - Harvard University, BA biology

- **Leana May, DO, MPH**
  - Michigan State University College of Osteopathic Medicine DO/MPH
  - University of Michigan, BS biopsychology and cognitive neuroscience

- **Richard Uluski, MD**
  - Jefferson Medical College
  - Union College, BS biochemistry
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:

**Avon**, 120 Simsbury Road
- Audiology • Ear, Nose and Throat • Speech-Language

**Farmington**, 399 Farmington Avenue
- Center for Motion Analysis • Digestive Diseases • Endocrinology • Hematology/Oncology • Occupational Therapy • Orthopaedics • Physical Therapy • Pulmonary Medicine • Radiology • Speech-Language • Sports Medicine • Surgery • Urology

**Glastonbury**, 310 Western Boulevard
- Audiology • Cardiology • Digestive Diseases • Ear, Nose and Throat • Endocrinology • Hematology/Oncology • Neurology • Occupational and Physical Therapy • Orthopaedics • Pulmonary Medicine • Radiology • Rheumatology • Speech-Language

**Manchester**, 71 Haynes Street
- Cardiology

**Middletown**, 520 Saybrook Road
- Cardiology

**New Britain**, 100 Grand St.
- Pulmonary Medicine

**New London**, 365 Montauk Avenue
- Rheumatology

**Norwich**, 44 Stott Avenue
- Genetics

**Putnam**, 320 Pomfret Street
- Cardiology

**Shelton**, 4 Corporate Drive
- Cardiology • Digestive Diseases • Endocrinology • Hematology • Nephrology • Orthopaedics • Pulmonary Medicine • Rheumatology • Surgery • Urology

**Southbury**, 22 Old Waterbury Road, Suite 201
- Cardiology

**Stamford**, 32 Strawberry Hill Court
- Endocrinology • Orthopaedics • Rheumatology

**Torrington**, 157 Litchfield Street
- Cardiology • Endocrinology

**Waterbury**, 64 Robbins Street
- Cardiology

**Massachusetts, 616 Carew Street, Springfield**
- Rheumatology • Neurosurgery

To make an appointment, call the specialty’s main number as listed in the Directory of Medical Programs and Services.