A Young Life Saved

Injured infant’s case demonstrates the value of Connecticut Children’s Level 1 Trauma Program.

A 5-month-old baby girl recently presented in Connecticut Children’s Emergency Department. The child had fallen off a changing table at day care earlier in the day, but had seemed fine afterward. Her mother picked her up and brought her home. But when the baby woke from her nap, she was fussy and vomited. Sensing a problem, her mother rushed her to her pediatrician, Jerome Lahman, MD, of Vernon. Dr. Lahman immediately recognized signs of a serious head injury and called for an ambulance to rush the baby to Connecticut Children’s ED.

By the time the child arrived in the ED, she was pale and listless. Emergency Room physicians intubated the child, and pediatric neurosurgeon Paul Kanev, MD, and pediatric surgeon Christine Finck, MD, promptly evaluated her. A CT scan revealed a massive epidural hematoma, the result of a skull fracture that had torn the underlying middle meningeal artery. The baby was taken to the OR, where the surgical team—OR staff, nurses, the anesthesiologist and others—was ready to perform the emergency procedure.

About 30 minutes after the baby arrived at Connecticut Children’s, she was in the operating room undergoing life-saving surgery.

Dr. Kanev evacuated the large epidural hemorrhage and controlled the arterial bleeding site.

At the end of the procedure, while the patient was still under anesthesia, the physicians rescanned her head using the hospital’s CereTom portable CT scanner—the only one of its kind in the state—to make sure that the bleeding was controlled.

The baby went home four days later and has made a complete recovery.

“The mother’s fast action and the immediate recognition and response of the community pediatrician were critically important,” says Dr. Kanev. “The speed of the pediatrician’s evaluation and arranging for rapid transport set all the resources in motion.”

Dr. Kanev also commends the whole team at Connecticut Children’s.

“The baby was in so fragile a state when she arrived here that, had there been even a five-minute delay at any point, she may have died,” he says. “Thankfully, every asset of manpower and equipment here were all instantly available.”

CME News

Connecticut Children’s has plans to offer more continuing medical education programs in suburban locations, and one of the first will be held in Shelton this spring.

“Digestive Diseases Update: A Case-Based Discussion of Important Pediatric Problems” will be held on Wednesday, April 7, 2010, from 5:30 to 8:15 pm at Connecticut Children’s Specialty Care Center, 3 Corporate Drive, Tower 3, in Shelton. The program is geared primarily to pediatricians, family practitioners, pediatric nurse practitioners and physician assistants. For a list of presenters and registration information, see the Please Join Us column on page 5.

For more information, contact Diane Mouradjian at Connecticut Children’s: 860.610.4264 or dmouradjian@connecticutchildrens.org.
**CASE REVIEW**

**Mysterious Back Pain Clue to Rare Disease**

Natalie S. Bezler, MD, pediatric chief resident at Connecticut Children’s, prepared this issue’s case.

**Presentation**

A previously healthy 3-year-old male presented several times to his pediatrician in the Primary Care Center at Connecticut Children’s with back pain. The pain occurred daily and often awoke him from sleep. Physical exam was unremarkable. After two months of pain, X-rays of the lumbar spine and an abdominal ultrasound were obtained, both of which were unremarkable. Also at this time, a CBC was within normal limits and an ESR was elevated at 36 mm/hr. The pain persisted, and an MRI of the spine performed three months after the onset of the pain revealed a lytic lesion of the L1 vertebra with associated fracture. A follow-up CT scan revealed a similar lytic lesion in the posterior right 6th rib.

**Diagnosis**

A skeletal survey was performed next to identify any further lesions. In addition to the two lesions described above, he was found to have a 6 to 7 millimeter lucency in the distal left humerus. Additional blood work revealed a normal CBC, comprehensive metabolic panel, LDH, ESR, CRP, ferritin and urinalysis. A CT-guided biopsy of the rib lesion revealed Langerhans cell histiocytosis (LCH).

**Treatment**

The patient is undergoing both chemotherapy and radiation therapy. The radiation consists of a total of three sessions and is localized to the vertebral lesion. It is not standard therapy for LCH, but is being administered to promote healing due to the associated fracture. He had a port placed for chemotherapy administration and is receiving a regimen consisting of intravenous vinblastine and oral prednisone. During the six-week chemotherapy induction period, the vinblastine is administered weekly, and the prednisone is administered daily. If future imaging reveals improvement, he will enter the maintenance phase of his therapy, during which the vinblastine and prednisone will be administered every three weeks. The total duration of therapy will be approximately eight months.

**Discussion**

Langerhans cell histiocytosis is a clonal accumulation and proliferation of abnormal bone-marrow-derived Langerhans cells. The nomenclature of this disease has changed significantly as it was once divided into three subsets: eosinophilic granuloma, Hand-Schuller-Christian disease, and Letterer-Siwe disease. When it was discovered that these were actually a single entity, they were united as Histiocytosis X. The name was later changed to Langerhans cell histiocytosis to reflect the pathophysiology of the disease.

The documented incidence of LCH is about five per million. The male-to-female ratio is about 1.5:1. The disease can occur at any age, from neonates to the elderly. However, there is a peak between ages 1 and 3. LCH is now classified based on number of lesions, number of organs involved, and whether or not “risk” organs such as bone marrow or liver are involved. Multisystem disease, especially involving “risk” organs, portends a poorer prognosis, and diffuse disease, especially in neonates, can be life-threatening.

Our patient has multifocal bone disease. Bone is the single most common organ involved in LCH, and the majority of patients present with a single lesion. Multiple lesions are seen in 18 to 30% of patients at the time of presentation. The bones most commonly affected are the skull, ribs, pelvis, long bones, mandible and vertebrae. The skull is the most common location overall, particularly the frontal bone. The typical presentation is painful swelling at the site of the lesions. Pathologic fractures can also occur, and additional symptoms may be due to an effect on nearby structures. Examples include vertebral involvement that causes spinal cord compression, jaw involvement that leads to loose teeth, and skull involvement that causes diabetes insipidus when in proximity to the pituitary gland.

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Conventional radiographs are used to identify and follow lesions. The classical X-ray finding is a punched-out lytic lesion. Due to the malignant conditions in the differential diagnosis of such a lesion, histologic confirmation is needed to make the diagnosis of LCH. Biopsy in LCH demonstrates a granulomatous lesion with pathologic Langerhans cells alongside normal inflammatory cells and multinucleated giant cells. Immunohistochemistry reveals positivity for CD1a and Langerin (CD207).

Surgical curettage has been used with good success in individuals with solitary skull or long-bone lesions, but management of individuals with multifocal or multisystem disease is primarily medical. The Treatment Protocol of the Third International Study for Langerhans Cell Histiocytosis uses vinblastine and oral prednisone as the mainstay of therapy. In those with higher risk disease, therapy is often augmented with methotrexate and 6-mercaptopurine. Duration of therapy ranges from six to 12 months.

Prognosis for LCH is generally very good, with survival rates ranging from 80% in those with multisystem “risk” disease to 100% in those with bone and skin-only disease. Although the survival rate is good, the reactivation rate is as high as 50% in some groups, and many patients will have permanent sequelae from their disease.

The most common is diabetes insipidus, but depending on the location of lesions, patients may be left with orthopaedic problems, loss of teeth and facial asymmetry, among others. Early treatment improves survival in those with high-risk disease and can reduce the permanent consequences of localized disease.

**Learning Point**

Although rare, Langerhans cell histiocytosis does occur in children. In our case, the patient was diagnosed and able to start treatment in a timely manner because his pediatrician continued to closely monitor and evaluate symptoms that were unusual for a child.

**References:**


Connecticut Children’s Names Chief Information Officer

With opportunities and challenges in the information technology arena on the rise, especially in connection with the technology provisions of the Federal Stimulus Act, Connecticut Children’s has appointed a Chief Information Officer to its management team. Kelly R. Styles, formerly the Chief Information Officer at Children’s Medical Center in Washington D.C., joined Connecticut Children’s this past fall.

Styles will be leading the development of an information services strategic plan that defines resources and structures that will best enable the Medical Center to improve and enhance timely access to relevant information and help achieve meaningful use of electronic medical records in accordance with the provisions of the Stimulus Act.

*With all of the exciting new developments in information services and the possibilities they create, we felt this was the right time for Connecticut Children’s to recruit a chief information officer,” said Wendy Warring, Executive Vice President and Chief Operating Officer at Connecticut Children’s. “We are very excited about Kelly’s depth of expertise and his commitment to children’s health and we look forward to continuing to advance our ability to use information technologies to improve the quality of care we provide.”

For the last ten years, Styles served as Vice President and Chief Information Officer at Children’s National Medical Center in Washington, D.C. Kelly began his information technology healthcare career at Wilson N. Jones Health System in Sherman, TX, where he served as the Chief Information Officer for six years. He was also a member of the Air Force for 14 years, where he developed and utilized various technologies in support of the Air Force’s analytical capabilities.

New Display Honors Medical Staff

Francisco Sylvester, MD, is first annual honoree.

A new Physician Recognition Display was installed in Connecticut Children’s Washington Street lobby this past November. The eye-catching display features the names of past presidents of the medical staff, as well as names of members of the honorary staff—physicians who made outstanding contributions to the past and present pediatric staff of Newington Children’s Hospital, the Institute of Living and Connecticut Children’s. A third panel will be used to honor a different individual physician annually.

The project was the brainchild of the current president and vice president of the medical staff, Drs. Donald Hight and Ann Milanese.

“Ann and I first conceived this project in 2008,” Dr. Hight says. “We wanted to do something to recognize the contributions made by past and present members of the medical staff of Connecticut Children’s.”

“Our people are our most valuable resource,” says Dr. Milanese. “We thought this was an important thing to do as part of our term.”

The first physician to be singled out for recognition was pediatric gastroenterologist Francisco Sylvester, MD. The display features his photo and a tribute that praises him for his contributions to the hospital’s clinical, educational and research missions, his outstanding reputation in the field of pediatric gastroenterology and his research on how chronic childhood disease affects bone growth.

The award was presented to Dr. Sylvester at the medical staff annual meeting in November. Be sure to take a look at the display the next time you visit Connecticut Children’s.

New Year, New Name

As we begin a new year, you will soon notice a change in name for our specialty care pediatric practice. Formerly the CCMC Faculty Practice Plan, the group will now be called the Connecticut Children’s Specialty Group.

The decision to rename the practice group was largely based on two reasons: first, to be consistent with the Medical Center’s preferred name and, second, to provide greater clarity for patients and families.

With its recent branding campaign, the Medical Center has made a concentrated effort to be known as Connecticut Children’s rather than CCMC.

“As the only medical center in the state dedicated exclusively to children, Connecticut Children’s is clearly different from every other hospital in the region,” said Bob Fraleigh, Connecticut Children’s director of corporate communications.

“Referring to ourselves as Connecticut Children’s rather than CCMC allows us to remind everyone of this important distinction everywhere our name appears.”

In conjunction with the change to Connecticut Children’s, a second opportunity arose to reconsider the rest of the practice’s name.

“The name Faculty Practice Plan has always accurately described the role our physicians play as faculty and the important research and medical education they provide,” according to Dean Rapoza, president, Connecticut Children’s Specialty Group. “It was not particularly helpful, however, in describing what the practice was from an external or patient/family perspective. The new name, Connecticut Children’s Specialty Group, will offer more opportunities to promote the breadth and depth of the specialty care services we provide, and it better connotes our relationship with patients and families.”

To complete the name change, Connecticut Children’s four major specialty care offices in Hartford, Farmington, Glastonbury and Shelton will now be called Connecticut Children’s Specialty Care Centers.

Grand Rounds Online

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

For more information, contact Diane Mouradjian at dmouradjian@connecticutchildrens.org or 860.610.4264 or fax 860.610.4261.
**Youth in Psychiatric Crisis? Call 211**

Connecticut’s revamped Emergency Mobile Psychiatric Service, accessed through 211, is an alternative to ED referrals or calling law enforcement.

When a child or adolescent patient is experiencing a psychiatric emergency at home, at school or right there in your office, what do you do? Until recently, children were most often brought to Connecticut Children’s Emergency Department or the police were called. But now, more parents and professionals are becoming aware of another, often better choice: the improved and expanded Emergency Mobile Psychiatric Service (EMPS).

EMPS is a state-funded program that provides for teams of trained mental health professionals to respond immediately—either to the child’s location or by phone—when a child is in crisis. Its intent is to serve children in their homes and communities, reduce the number of children presenting to EDs for behavioral health emergencies and divert them from hospitalization if a lower level of care is a safe alternative.

EMPS is accessed by dialing 211 and, at the prompt, pressing 1 for “crisis.” The program serves all 169 cities and towns in the state and is available to help anyone 18 or younger, regardless of their insurance status or ability to pay. Anyone—parent, school staff member, health care provider or others—concerned about a youth in crisis can call EMPS.

The service is available 24 hours a day, 365 days a year. Teams are able to go mobile weekdays from 9 am to 10 pm and weekends from 1 pm to 10 pm. At all other times, teams are available to provide consultation, guidance and assistance by phone.

**What to Expect**

Callers to 211 are first connected to a crisis specialist who obtains information and performs triage. Appropriate calls are transferred to a local EMPS provider with access to all information collected. The EMPS provider performs an evaluation and determines whether the child can safely be maintained where he/she is to await a response team or should be transported to the Emergency Department.

If emergency transport is not required, a mobile team is then dispatched to the child’s location. Each team is overseen by a licensed, master’s-level clinician. At least one person with a master’s degree in behavioral health or human services will respond, often with an experienced paraprofessional with expertise in supporting families in crisis.

Teams work with the child and family to address the initial crisis, then work to link them with the services and ongoing support they need to deal with whatever issues are causing the crisis.

**Focus on Quality**

The EMPS program was completely revamped last year, says Robert Plant, PhD, of the Department of Children and Families, with an eye toward ensuring consistent quality statewide. The reconstituted service now consists of three components: the agencies contracted to respond, the call center at 211 and a performance improvement center that monitors quality across the system.

“We provide standardized training in state-of-the-art crisis assessment, violence intervention and more—all the background you need to provide crisis stabilization,” says Dr. Plant. “We also monitor and track performance to ensure the highest quality service.”

Lisa Namerow, MD, child and adolescent psychiatrist with Hartford Hospital and Connecticut Children’s, did not design the program, but has high praise for it.

“EMPS delivers what it says it will deliver,” Dr. Namerow says. “While other aspects of the mental health care system need to be addressed, this piece is working beautifully well. EMPS can help children get fast, appropriate care, without hospitalizations or prolonged ED visits, as long as schools, families and primary care providers know of and take advantage of this option.”

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**Lead-Control Project Receives Grant**

Connecticut Children’s LAMPP (Lead Action for Medicaid Primary Prevention) lead hazard control program was the only program in Connecticut to receive funding in the federal Department of Housing and Urban Development’s (HUD’s) latest round of grants for its Lead Hazard Control and Lead Reduction Demonstration grant programs.

LAMPP received $6 million to continue its work of educating families and property owners on the dangers of lead poisoning, providing relocation assistance for tenants during the lead remediation and abatement construction process and providing property owners with the financial assistance necessary to make homes lead safe.

Connecticut Children’s LAMPP Project will also provide families and property owners with free visual assessments for environmental health hazards such as mold, pests, radon and other asthma triggers. LAMPP is offering these visual assessments to position itself as a resource for future HUD funds focused on the new Green and Healthy Homes Initiative that HUD is promoting.

The LAMPP Project is available in 14 municipalities: Bridgeport, Danbury, East Haven, Enfield, Hartford, Manchester, Meriden, New Britain, New Haven, Norwalk, Stamford, Torrington, Waterbury and West Haven. However, LAMPP can also link residents of other communities to statewide programs to address lead hazards.

For more information, call the LAMPP Project director at 860.610.4241 or visit connecticutchildrens.org/lampp.
A Record-Breaking Year In The ED

Connecticut Children’s Emergency Department had a record 50,000 visits in 2009, as the volume continues to grow at 5 to 7 percent annually.

“In emergency medicine, 50,000 visits is a milestone,” says M.C. “Cub” Culbertson III, MD, director of Emergency Medicine at the center. “If you’re over 50,000 visits, you’re in an entirely different category.”

The ED continues to grow and innovate to meet the increased needs of referring providers, patients and families. In December 2009, the department instituted a new, three-track system that will help minor-emergency cases be seen more quickly. It is also adding a physician and mid-level providers.

Reminder: Shelton Site Open

Area physicians have responded enthusiastically to Connecticut Children’s new Specialty Care Center at 3 Corporate Drive in Shelton, which opened last fall.

Practice Director Karen Koprose is tracking referrals to determine which specialties to expand.

*Surgery began seeing patients in January, and

we plan to add more cardiology sessions in the spring* she says.

See the Please Join Us column for information about an April 7 CME event in Shelton.

To refer a patient to the Shelton facility, call the specialty’s main number in Hartford or complete the referral form available at www.connecticutchildrens.org.

Managing Sports-Related Concussion

Highlights from recent lecture.

Late last year, Michael Collins, PhD, one of the country’s leading researchers on concussion, made a presentation as part of Connecticut Children’s Pediatric Evening Lecture Series. His talk, entitled “Sports-Related Concussion: What Every Pediatrician Must Know,” focused on current thinking in diagnosis and treatment of this all-too-common injury.

Mark McCarthy, ATC, LAT, director of Connecticut Children’s Sports Concussion Program at Elite Sports Medicine, was instrumental in bringing Dr. Collins to Hartford and recently offered some highlights from the presentation.

Awareness is key – Parents, coaches, physicians and athletes themselves need to recognize concussion as a serious issue for student athletes.

Diagnosis – Headache, dizziness, fatigue and inability to concentrate are some of the chief symptoms of concussion, but others, such as short-term memory dysfunction, sensitivity to light/noise and emotional changes are also possible indications of concussion.

Individualized care – The standard of care for concussion is moving to an individualized treatment model, rather than a grading model.

Every concussion is different, and management must be tailored to each child.

Rest as treatment – Adequate rest—from both physical and mental exertion—is critical to the brain’s recovery. The child should take a break from sports activities, both for healing and to prevent risk of a second injury. He or she may need to stay out of school for a while to allow time for the brain to rest and heal.

Gauging recovery – Before the child returns to normal activities, he or she should have no cognitive or physical symptoms, either at rest or on exertion. A neurocognitive testing tool should be used to see whether the child has achieved return to pre-injury neurocognitive status.

Gradual return to play – Once neurocognitive testing indicates recovery, the child may return to light activities, then gradually increase activity levels over a five- to six-day period.

To refer a patient to Connecticut Children’s Sports Concussion Program, call Elite Sports Medicine at 860.284.0252. To get more information on concussion, view an educational video and more, visit www.elitesportsmedicine.org. Information on concussion and the ImPACT neurocognitive testing tool is available at Dr. Collins’ site, www.impacttest.com.

Please Join Us

Pediatric Evening Lecture Series
Feb. 11, 2010
Pond House Café, 1555 Asylum Ave., West Hartford, CT.
5 pm – Registration
5:30 pm – Buffet Dinner
6:30 to 8:15 pm – Lecture
8:15 to 8:45 pm – Q&A

Antimicrobial Resistance in the Pediatric Office: Management Strategies for Health Care Providers™

Speakers: Michael Gerber, MD, director of Continuing Medical Education and director of Clinical Care and Teaching, Division of Infectious Disease, Cincinnati Children’s Medical Center; professor of pediatrics, University of Cincinnati Department of Pediatrics.

Robert Baltimore, MD, attending pediatric physician and associate physician of epidemiology, Yale-New Haven Hospital; professor of pediatrics and epidemiology, Yale University School of Medicine; director of the Pediatric Tuberculosis Clinic, Yale-New Haven Hospital.

Juan Salazar, MD, (moderator), chief, Division of Infectious Disease, Connecticut Children’s Medical Center; assistant professor, pediatrics, University of Connecticut School of Medicine.

April 7, 2010
Connecticut Children’s Shelton Specialty Care Center, 3 Corporate Dr., Tower 3, Shelton, CT.
5:30 pm – Registration and Buffet Dinner
6:15 pm – Lecture
7:45 to 8:15 pm – Q&A

Digestive Diseases Update: A Case-Based Discussion of Important Pediatric Problems

Speakers: Jeffrey Hyams, MD, director, Division of Digestive Diseases, Hepatology and Nutrition, Connecticut Children’s Medical Center; professor of pediatrics, University of Connecticut School of Medicine.

Karan Emerick, MD, Division of Digestive Diseases, Hepatology and Nutrition, Connecticut Children’s Medical Center; associate professor of pediatrics, University of Connecticut School of Medicine.

Donna Zeiter, MD, Division of Digestive Diseases, Hepatology and Nutrition, Connecticut Children’s Medical Center; assistant professor of pediatrics, University of Connecticut School of Medicine.

April 27, 2010
Pond House Café, 1555 Asylum Ave., West Hartford, CT.
5 pm – Registration
5:30 pm – Buffet Dinner
6:30 pm – Lecture
7:30 to 8 pm – Q&A

Practical Approaches to Anemia and Bleeding During Childhood and Adolescence

Speakers: Stuart Goldman, MD, assistant professor of psychiatry, Harvard University School of Medicine; co-director, Mood Disorder Program, Children’s Hospital Boston.

Andrulonis Child Mental Health Evening Lecture Series
March 11, 2010
Pond House Café, 1555 Asylum Ave., West Hartford, CT.
5 pm – Registration
5:30 pm – Buffet Dinner
6:30 pm – Lecture
7:30 to 8 pm – Q&A

Bipolar Disorder: Category or Dimension?

Speakers: Stuart Goldman, MD, assistant professor of psychiatry, Harvard University School of Medicine; co-director, Mood Disorder Program, Children’s Hospital Boston.

For up-to-the-minute information, visit www.connecticutchildrens.org/professionals/education.asp or call 860.610.4264 or fax 860.610.4261.
Referring Provider Program Update

Connecticut Children’s Referring Provider Relations Program is making steady progress on many fronts, thanks to close collaboration between hospital- and community-based physicians and strong staff support. The new referring provider section of the hospital’s Web site was created in the spring of 2009 with input from the referring community and will continue to be refined in 2010. The referral form for the medical specialties has been updated to make it easier to use, while only a telephone call is needed for referrals to the surgical specialties. Several co-management protocols are either completed or close to completion.

Co-Management Plans and Pilot Study
The development of collaborative co-management plans for five relatively common, lower-acuity conditions has been one of the initiative’s most significant achievements to date. The plans are being rolled out as part of a two-year pilot study funded by an Innovation Grant from the Children’s Fund of Connecticut.

While the pilot study is small, Connecticut Children’s plans to expand the Co-Management Program to more patients and more conditions once it proves satisfactory to physicians and patients. The first two co-management plans were developed over several months last year. Pediatric urologist John Makari, MD, and Rocky Hill pediatrician Jennifer Schwab, MD, collaborated to develop the plan for pediatric voiding dysfunction. Pediatric rheumatologist Lawrence Zemel, MD, and Torrington pediatrician Michael Curi, MD, designed the plan for co-managing chronic fatigue/fibromyalgia. The physician teams presented CME workshops on their topics in the fall.

Materials from both workshops are available on the Referring Providers section of Connecticut Children’s Web site.

Referring Providers Are Key
Dr. Karen Rubin, physician champion of the Referring Provider Relations Program and the principal investigator for the study, gives high praise to the community physicians who volunteered to co-author the co-management plans with Connecticut Children’s specialists.

Speaking of Drs. Curi and Schwab, who collaborated on the two plans launched so far, Dr. Rubin says, “Both physicians did a yeoman’s job. Their valued input and hard work were essential to the quality, usefulness and success of these two co-management plans.”

Dr. Rubin notes the important role that Drs. Curi and Schwab played throughout the process: “They provided critical feedback to the specialists on what aspects of co-management were feasible in a busy pediatric practice. They specified the diagnostic and management support tools needed to co-manage patients in real time in their offices. They drafted the pediatric office visit templates, suggested realistic intervals between each visit and shared in the development of additional co-management tools. They also contributed to and participated in the CME presentations.”

Community Physicians’ Perspectives
Dr. Schwab says she originally became involved in the development of protocols to improve her patients’ access to specialists at Connecticut Children’s and because it was an exciting way to learn how to manage problems that in the past had to be referred to the hospital. She especially enjoyed the research aspect of the undertaking, and she is pleased with the guidelines, templates and other co-management materials the process produced.

“These materials make co-managing patients with pediatric voiding dysfunction easy for me,” she says. “Because I have these useful handouts and extra training, the care I’m providing to my patients is improved.”

Dr. Curi agrees: “This has taken a clinical condition that can be both intimidating and exhausting and organized it in a way that makes care coordination very manageable,” he says. “It provides a level of sophistication and attention to detail that is going to greatly improve care coordination and, hopefully, outcomes.”

See page 7 for upcoming co-management workshop.

Orthopaedic Offerings Expand

Connecticut Children’s Department of Orthopaedics continues to expand its services to meet the needs of the region’s children and adolescents.

The department now offers a comprehensive Adolescent Hip Service. Many children who have had pediatric illnesses need surgical treatment for hip-related problems. By age 16 or 17, a child is usually skeletally mature, but adult practitioners may not be comfortable treating children or the unusual problems that exist in a post-disease hip. The orthopaedics team at Connecticut Children’s combines expertise in both pediatric care and state-of-the-art surgical procedures to meet the needs of these young people. Services they offer include surgical hip dislocation for labral repairs, femoral neck osteoplasty, acetabuloplasty and total hip arthroplasty.

The department also now offers radiofrequency ablation (RFA) for treatment of benign tumors of the bone. Performed under CT scan guidance, RFA removes lesions that can cause intense pain, without the need for a major, open procedure.

For more information, or to refer a patient, contact the Department of Orthopaedics at 860.545.9100.
Dr. Carroll Honored

Christopher Carroll, MD, FCCP, of Connecticut Children’s Critical Care Department received the Alfred Soffer award at the American College of Chest Physicians Annual Meeting (CHEST 2009) in December. This award is given to the top abstract at the meeting. In addition, two of his studies from 2009 were featured in the Journal of Pediatrics’ list of the Best Articles Relevant to Pediatric Allergy and Immunology as selected by members of the Section on Allergy and Immunology of the American Academy of Pediatrics.

On-Site Rehab For Children With Brain Injury

Children with traumatic or acquired brain injury don’t have to leave Connecticut Children’s to receive prompt, comprehensive rehabilitation therapy, thanks to the hospital’s unique Acute Inpatient Rehabilitation Program. Inpatient rehabilitation offers numerous benefits to children and families. It eliminates the stress and disruption of transferring the child to a separate rehabilitation facility. It allows children to be treated by professionals who get to know them well right from the start. And it enables children to stay in the hospital, where they have immediate access to all medical and surgical subspecialists, should the need arise.

As soon as a child is diagnosed with brain injury, staff members call in the program’s multidisciplinary team. Ann Milanese, MD, division head of Developmental Pediatrics and medical director of Education and Rehabilitation Services, heads up the team, which also includes occupational, physical and speech therapists; a nurse; a psychologist and a teacher. Team members meet with the family and the child right away, sometimes even in the ICU, to get to know them and to explain what to expect. They also develop a plan for therapy.

Rehabilitation begins as soon as the child is medically stable. The timing is critical. “When someone has had brain injury, there is a period of rapid recovery, followed by a period of slower recovery,” says Dr. Milanese. “We try to maximize the period of rapid recovery with as much intense therapy as possible.” Therapy is typically scheduled for about three hours a day. The duration depends on each child’s condition. The shortest is about two weeks, and the longest is about two months. The multidisciplinary team meets twice a week. Parents are encouraged to attend meetings and to join them on rounds.

By the time the child is discharged, the team will have arranged for the outpatient services the child will need and been in touch with providers and the child’s school, in order to achieve a smooth transition.

“Our goal is to support families and maximize children’s recovery,” Dr. Milanese says.

For more information about the Acute Inpatient Rehabilitation Program, contact Anne Riley, MSN, at 860.610.4200.

Patients May Apply For Scholarship

Graduating high school seniors who are current or former patients of Connecticut Children’s or Newington Children’s and are going on to postsecondary education are eligible to apply for funds from the Isidore Wise Scholarship Program. Completed applications are due by March 31, 2010.

The longstanding program was established through a bequest from Isidore Wise, who served on the board of Newington Children’s Hospital for 45 years. It provides grants to qualifying students who plan to attend accredited postsecondary undergraduate institutions.

If you have a patient who will graduate in 2010, please alert him or her to this opportunity. Students may obtain an application by calling Jean Boza at 860.610.5717.

Welcome Aboard!

A warm welcome to the newest member of our medical staff.

Bella Zeisler, MD
Gastroenterology

• Fellowship in pediatric gastroenterology, Cincinnati Children’s Hospital Medical Center
• Residency in pediatrics, New York University Medical Center
• MD, State University of New York, Stony Brook School of Medicine
• MS, physiology and biophysics, Georgetown University
• BA, political economy, Barnard College, Columbia University

Upcoming Co-Management Workshops

All will be held in Hartford Hospital’s Jefferson Building, room 118, from 5:30 to 8:30 pm Buffet dinner is included. For more information or to register, contact Diane Mouradjian at 860.610.4264 or dmouradjian@connecticutchildrens.org.

Hematuria
February 25, 2010
Pediatric nephrologist Majid Rasoulpour, MD, and Carol Erickson, APRN, of Dr. Gerald Calnen’s office in Enfield.

Lyme Disease
April 25, 2010
Pediatric infectious disease specialist Melissa Held, MD, and Bloomfield pediatrician Lee Hoffman, MD.

Migraine
May 12, 2010
Pediatric neurologist Carol Leicher, MD, and South Windsor pediatrician Jody Terranova, DO
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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 • Endocrinology • Gastroenterology • Hematology/Oncology • Occupational Therapy • Orthopaedics • Physical Therapy • Pulmonary Medicine • Radiology • Speech-Language • Sports Medicine • Surgery • Urology

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

Madison, 1347 Boston Post Road
- Cardiology

Manchester, 71 Haynes Street
- Cardiology

Middletown, 520 Saybrook Road
- Cardiology

New Britain, 100 Grand St.
- Cardiology • 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, 516 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.”