After months of dedicated work from passionate individuals driven to improve patient care, Connecticut Children’s announces the Connecticut Children’s Care Network as the first pediatric-specific clinically integrated network in the state. A clinically integrated network (CIN) is a collection of health providers, such as physicians, hospitals, specialists and community partners that join together to improve care and reduce costs. These networks share data, improve communication and rely on evidence-based guidelines to provide high-quality care across the care continuum. This new network allows for Connecticut Children’s Medical Center, their specialists and primary care physicians to collaborate in measuring and improving the quality of care delivered to children in an efficient and cost-effective manner.

The network started developing in March of 2018 and a steering committee of 12 pediatricians from across the state of Connecticut and into Massachusetts met monthly to create the network. The co-chairs for the steering committee of the network, Jennifer Schwab, MD, from Rocky Hill Pediatrics, and Chris Veale, MD, who has recently retired from Newington Pediatrics after 35 years of service, are exceptional pediatricians who worked closely with Care Network Senior Director, Ryan Calhoun, to make this a reality. "I am honored to work on this committee with him. Ryan is highly intelligent, intellectually curious, and deeply committed. Thankfully he worked on a similar venture in Colorado and so is quite knowledgeable about the process," said Dr. Schwab. When thinking about the future of the network, Dr. Veale exclaims, "I hope to see a robust interest in the Clinically Integrated Network from the independent pediatric practices as well as coordination with the existing larger networks across the state so that we can work together to provide the best quality of care, with the best outcomes and improved cost benefits to our pediatric patients." The number of pediatric-specific CINs across the country is rising quickly to fill a need in our ever-changing healthcare landscape. As Dr. Schwab observes, "I know that many of us [pediatricians] struggle to manage our patients with complex conditions, as well as some basic, but challenging to treat conditions, like Obesity and Mental Health Disorders. This unique pediatric network will work to build access to mental health providers, potentially even in our offices, and support us as we learn new and more practical and effective ways to help coordinate care for our difficult to treat patients. While initially the insurance companies may still choose what they think are important quality measures, we hope over time to work with the payers to create quality metrics that actually have meaning and value to our patients and practices."

With practices already beginning to sign on, the pediatrician-led board and committees of the Care Network are excited to integrate successful quality metrics into the pediatric practices throughout the state.

If you have any questions or interest in joining the Care Network, please contact Ryan Calhoun: Email: RCalhoun@ConnecticutChildrens.org Phone: 860.545.9632
Dear Colleagues,

Please enjoy this new issue of the Connecticut Children’s Medical News, as we welcome a gentle southern New England spring! Although I’m close to celebrating my 21st anniversary with Connecticut Children’s, I am more excited than ever to share with you the latest on our collective efforts to improve the health and well-being of all the children in this region. In return, please share with me your thoughts on these efforts and the Medical News, as well. I look forward to hearing from you.

Sincerely yours,
John Brancato, MD

Email Dr. Brancato: Jbranca@connecticutchildrens.org

A Message from Dr. John Brancato

Just a Reminder

The division of orthopedics has moved from 282 Washington Street to 31 Seymour Street, in Hartford, for patient care.

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New and Innovative Infusion Center

Anticipation continues to build as Connecticut Children’s new Infusion Center prepares for its grand opening on April 30th at 10 Birdseye Road in Farmington. With many updates, this site grows our total infusion capacity from a small 6 chair site, to a new 9 chair and 3 bed site, with the 282 Washington Street location remaining open and available. While the majority of infusions are done for gastroenterology, endocrinology, infectious disease, and rheumatology, multiple specialties will have access to the Infusion Center as well.

To maximize the patient-family experience, Connecticut Children’s has designed the new Infusion Center with a friendly, inviting interior. Patients will also have access to a special app, suitable for all ages, which allow them to create their own avatar and explore an outside world during their infusions.
Hearing impairment is more common than all other diseases screened for in the newborn period. The estimated incidence of congenital hearing loss is 1-3 per 1000 in neonates and doubles to 6 per 1000 by the time children enter school. Early identification and intervention of childhood hearing loss is essential for best outcomes in speech and language acquisition as well as cognitive, social and academic success.

Universal newborn hearing screening started in the mid-1990s and slowly gained traction nationally. Over the past 20-30 years with great improvement in management of maternal infections and close monitoring of intravenous aminoglycoside antibiotic use, the most common cause of newborn hearing loss has become genetic inheritance rather than infectious causes, ototoxic medications, hyperbilirubinemia or other perinatal causes.

In Connecticut, the Early Hearing Detection and Intervention (EHDI) task force meets monthly to work toward ensuring infants are screened by one month, receive audiological evaluation by 3 months and are referred for intervention by 6 months of age.

Connecticut’s most recent EHDI data (2016) found that 98.8% of infants born received a hearing screening. Connecticut hospitals and clinics use a two stage hearing screening with two different screening methods, both with automated interpretation. They are Otoacoustic Emission (OAE) screening and Auditory Brainstem Response (ABR) screening. Otoacoustic emissions (OAE) screening measures an emission created by the outer hair cells of the cochlea and can be impacted by factors in the external auditory canal, tympanic membrane, middle ear and hair cells of the cochlea. However, OAE does not assess the inner hair cells of the cochlea or cochlear nerve. Automated auditory brainstem response (ABR) assesses the hearing pathway from the external auditory canal through the level of the auditory brainstem, with sensitivity down to 35 dB (normal hearing is < 20 dB). One type of hearing loss called auditory neuropathy or auditory dys-synchrony may not be detected by using OAEs. In this disorder sound enters the inner ear normally but the transmission of sound via the cochlear nerve to the processing centers of the brain is abnormal. Two stage hearing screening with the second stage being automated ABR is the standard in Connecticut. Children who do not pass Connecticut’s two stage hearing screening should receive a full diagnostic audiology evaluation including a full brainstem auditory evoked response (BAER) test. In Connecticut, 82.7% of infants who referred on hearing screening received a diagnostic evaluation and 18.5% of those were confirmed to have hearing loss.

The greatest challenge currently for EHDI is ensuring children identified with hearing loss connect with intervention services. Connecticut’s most recent EHDI data (2016) found 61.8% of children identified with hearing loss were enrolled in early intervention. Convincing families of the value intervention services can provide in monitoring hearing and developmental progress as well as intervening with amplification, as indicated, is essential to ensuring the best outcomes possible for children with hearing loss. Additionally, children confirmed to have hearing loss by diagnostic audiology evaluation should be seen by an otolaryngologist well versed in evaluation and management of newborn and infant hearing loss.

Otolaryngology evaluation includes assessment for possible syndromic hearing loss versus isolated hearing loss with no other abnormalities. In the short-term, the 2 most important tests for children with at least bilateral mild to moderate hearing loss include electrocardiogram and an evaluation by an ophthalmologist who understands the developmental relationship in utero between the eyes and ears and the over 200 named syndromes involving disorders of eye and ear development. The electrocardiogram is to assess for the presence of the prolonged QT interval that can lead to sudden death.

Even though this is a very rare syndrome called Jervell and Lange-Nielsen syndrome, the test is cheap, easy and is potentially lifesaving, especially if there is a family history of syncope or sudden death.

So what is new? It has long been suspected but never really proved that congenital cytomegalovirus (CMV) has been the primary cause of non-genetically inherited congenital hearing loss with estimates from 7% to 25%. Since CMV is so prevalent in healthy populations a confirmatory test to link congenital hearing loss to congenital CMV requires a urine sample to be obtained within the first 3-4 weeks after birth. In the past, most suspected cases of CMV related hearing loss could not be verified and therefore not treated. However, recent laws in CT and other states mandate CMV testing in all children who refer on hearing screening testing. Some states have passed legislation on CMV education of pregnant women and targeted newborn screening.

Connecticut Children’s is one of many sites in a recently launched NIH-sponsored multi-institutional study gathering data nationally on the incidence of CMV-mediated congenital hearing loss and effectiveness of antiviral treatment using valganciclovir for hearing loss due to CMV with no other known clinical manifestations. Referring providers with CMV positive newborns with hearing loss are encouraged to contact either Christopher Grindle, MD or Scott Schoem, MD from Otolaryngology, and Nicholas Bennett, MD from Infectious Disease to discuss patient candidacy for this study.

You can e-mail Dr. Schoem at: sschoem@connecticutchildrens.org
Partnership with the Department of Public Health – Newborn Screening

Connecticut Children’s Medical Center recently partnered with the Connecticut Department of Public Health to form the “Connecticut Newborn Diagnosis and Treatment Network”. This partnership includes specialty clinical care teams at both Connecticut Children’s and Yale-New Haven Hospital, as well as birthing hospitals throughout the state. Through this development with two of the hospitals in the state, Connecticut Children’s creates a database to ensure a continuum of care for the children with positive screens in Connecticut. Newborn screening is a simple blood test that is usually done in the hospital when a baby is 1-2 days old. The blood is sent to the state public health lab where it is tested for over 60 health conditions. The network will respond to all reports of infants who screen positive through CT NBS, and will, in coordination with the infant’s PCP or hospital-based provider, begin the diagnostic workflow and provide support to the family. Through Epic-based workflows, centralized coordinators will respond to initial positive screens from the Department of Public Health. Coordinate next steps for confirmatory screenings, arrange appointments with specialists, and ensure treatment is underway when needed. Specialty providers for Hematology, Genetics, Immunology, and Endocrinology will partner with EPIC resources to develop protocols for patient care, develop content for discrete documentation, and define performance metrics to track their patient population. The new workflows and data capturing method will support a Newborn Registry that enables reporting back to the state and performance transparency across the network.

Debra Ellis, RN, Coordinator for the Connecticut Newborn Diagnosis and Treatment Network, enthusiastically comments on the future of this program. “Pediatricians and healthcare providers that work with families have indicated that they would like additional guidance, not only in educating families about some of these rare conditions, but in how to deliver results, and how to explain newborn screening. We are putting a lot of effort into developing tools to assist with this.” Ellis said. “This can be a very stressful experience for families, even if the follow up testing determines that their baby is healthy.” Ellis added that families are anxious when they are informed their screen is out of range. This network is here to calm their fears by answering their questions and directing them to the appropriate resources and support. “We’re hoping to provide a streamlined workflow with supportive communication between all parties. If we can achieve that, we will have an improved experience for both families and providers,” Ellis said.

The network aims to awareness and knowledge of newborn screenings, support families and act as a resource throughout the process. They also aim to support physicians who care for families before, during and after a child’s birth, and improve verbal and nonverbal communication with parents about newborn screening at multiple junctures, from preconception through adulthood.

Clinical Nutrition Services’ New Digs

Connecticut Children’s Clinical Nutrition Counseling Services moved from 111 Founders Plaza in East Hartford to the Hartford Campus on 100 Retreat Ave 5th floor this past November, creating better accessibility for patients and more convenience for coordination with additional services. Patricia Esposito RD, manager of clinical nutrition, leads a team with more than 20 years of pediatric experience. Specialties include weight management, allergies, sports nutrition, home tube feedings and overall childhood nutrition. Esposito drives the point that if a primary care provider sees a patient with failure to thrive or another urgent need, Clinical Nutrition will coordinate those appointments to fit the patient’s needs. This new center is handicapped-accessible and bariatric-friendly to accommodate for all patient-family necessities.

Clinical Nutrition can be contacted by phone: 860.837.6286 or by fax: 860.837.6283
The Dangers of Vaping: What Parents and Patients Need to Know

The past few years have seen a marked increase in the use of vaping devices among teens. Dr. Alyssa Bennett, Division Head of Adolescent Medicine, discusses the dangers and facts patients and parents need to know. “Nicotine is just as addictive as heroin,” Dr. Bennett states. “Nicotine use affects the developing adolescent brain and can increase the risk of addiction to other drugs in the future.” Nicotine can harm parts of the brain that control attention, learning, mood and impulse control. Additionally, studies show that the vaporization of the liquids in these devices produces carcinogens and may also include heavy metals, volatile organic compounds and flavorings, such as diacetyl, that has been linked to serious lung disease. Dr. Bennett goes on to discuss the drastic increase in e-cigarette usage among teens. According to the National Youth Tobacco Survey, an alarming 3.6 million middle school and high school students were current (within the past 30 days) e-cigarette users in 2018, more than double the number in 2017. At the same time, a 2018 National Academy of Medicine report found that there was some evidence that e-cigarette use increases the frequency and amount of cigarette smoking in the future. Dr. Bennett explains that it’s important for providers to screen all adolescents for substance use, including vaping. One option is the CRAFFT 2.1, which can be used as a self-administered patient questionnaire or a clinician interview. Research has shown that adolescents may disclose riskier behaviors via a self-administered questionnaire compared to face-to-face interviews. Dr. Bennett also suggests SBIRT training (Screening, Brief Intervention, and Referral to Treatment) to help providers improve their clinical skills in assessing adolescents with possible substance use disorders. Local to the area is Rushford by Hartford Healthcare which provides a continuum of substance use treatment for adolescents. From a provider standpoint, consistent screening and prevention education is vital to reduce the number of adolescents using substances, including nicotine.

8:00-8:15AM Welcome Remarks with Dr. Raul Arguello
8:15-9:00AM Cleft Lip and Palate with Dr. Charles Castiglione
9:00-9:45AM Glycogen Storage Disease with Dr. David Weinstein
10:00-10:45AM Esophageal Defects due to Atresia with Dr. Christine Finck
10:45-11:30AM Eating Disorders with Dr. Alyssa Bennett
11:30-12:15PM Updates to the Diagnosis and Management of Pediatric Tuberculosis with Dr. Nicholas Bennett
1:00-1:45PM Discussion with Dr. Angela Verardo
1:45-2:30PM Cystic Fibrosis Newborn Screening with Dr. Melanie Sue Collins
2:30-3:15PM Discussion with Dr. Alicia Briggs
As part of the Elite Sports Medicine Division at Connecticut Children’s, I often see knee pain referrals. While sports medicine can be complex, there really are only a few things on the differential of a young athlete presenting with knee pain to keep in mind. Here are a few of the scenarios we see and some tricks on helping to differentiate them. Also, make sure you don’t forget about the hip. In kids, hip issues can present as knee pain, so if you are ever not sure, make sure to get an x-ray of the hip so you don’t miss anything.

Scenario 1: “Both my knees hurt in the front” aka bilateral knee anterior knee pain. No specific injury occurred. This is rarely surgical. Usually the patient presents with central knee pain centered around or just below the patella. He or she may have tenderness at both medial and lateral joint lines which usually means the knee is irritated from something more central. A meniscus tear, for example, would usually be tender on only one side of the joint line, not both. Rotational maneuvers such as the McMurray or Thessaly maneuvers coupled with unilateral joint line tenderness have a higher sensitivity and specificity for meniscus tears. If that’s the case, you can get an MRI. But if it’s just anterior knee pain, the usual first line treatment for this problem can be NSAIDs, (topicals like Voltaren gel can help), as well as PT. PT focuses on helping the patella to track better in its groove by strengthening the medial-sided quadriceps, stretching the lateral knee structure like the IT band, and strengthening the external rotators of the hip to keep everything well-aligned.

Scenario 2: “I was playing a sport when I pivoted and felt a pop.” This is a classic story for an ACL tear, but don’t forget about patella dislocations. Patients can have a traumatic patella dislocation that involves a pop and an effusion, just like an ACL. One way to tell on exam is to try and push the patella laterally with knee extended. If the patient doesn’t like that or has apprehension, it may have been a patella dislocation. Note that it is a kneecap dislocation and not a true knee dislocation. An actual knee dislocation is where several ligaments of the knee tear and that’s a much worse injury. If the patella isn’t the issue, then check the Lachman exam. The Lachman exam is a much better test for the ACL than the anterior drawer we all learn in medical school. Also, I like to ask if the athlete could finish the game. If they couldn’t, it’s likely a more significant injury like an ACL tear or patella dislocation. Finally, if x-rays are normal, you can differentiate an ACL tear from a patella dislocation on MRI.

Scenario 3: “My one knee swells and hurts but it’s hard to pinpoint the pain.” This is one where if even as the examiner you can’t find the tender spot, you might look for things like Lyme disease, but the easiest thing to do is get an x-ray to rule out an osteochondritis dissecans, or OCD lesion. OCD lesions are where the bone underneath the cartilage in a specific spot starts to pull away from the rest of the knee bone. The cartilage stays attached to this piece. If missed, this could lead to the piece becoming dislodged and potentially significant cartilage loss in the future. Early identification is critical, as it can help the surgeon to start with less invasive options.

These are just some of the issues the athlete may encounter with knee pain, but they are important to understand and think about. If ever any concerns, x-rays are a good start and of course we are happy to see your patients at Elite Sports Medicine at Connecticut Children’s Medical Center.

To make a referral, please call 1-833-PEDS-NOW.

Expanded Services in Danbury, Shelton and Fairfield

- The division of endocrinology expands into Danbury, allowing for more accessibility and availability in Fairfield County.
- Urology expands its services in Fairfield with Dr. Jeffrey Small and in Bridgeport with Dr. Carlos Medina. The department of urology also provides evening hours to better accommodate patient family schedules.
- The division of gastroenterology expands its services in Shelton, allowing for quicker turnover times for appointments and better availability. All referrals will be seen within one week.
Neonatal Jaundice: Straight to the Lights

Neonatal jaundice results from deposition of bilirubin in the skin, sclerae and mucous membranes, and is present in about two-thirds of all newborns. In most cases, this common condition is benign and self-limited, but at very high bilirubin levels, newborns are at risk for bilirubin toxicity and even neurologic sequelae. It is therefore critical to ensure prompt treatment when this condition is recognized.

At Connecticut Children’s, we utilize a neonatal hyperbilirubinemia clinical pathway to promote high quality, evidence-based care for these infants. This is one of over 30 pathways we have implemented at our institution, with increasing use of pathways at our satellite units across the state as well. Clinical pathways have been shown to improve quality outcomes while reducing unnecessary variation and cost. The hyperbilirubinemia pathway has been a particularly successful one. In 2009, it was recognized that mothers of babies admitted for this condition were not receiving consistent lactation support. Through education, lactation services consultation, consistent use of breast pumps, and close follow up, we were able to increase the rate of continued breastfeeding a week after discharge, from an initial 60% to a current remarkable 100%! This high success rate, including a high rate of continued breastfeeding at a full month after discharge, has been sustained for over two years.

We now want to tackle the issue of time to intensive phototherapy to decrease delays in delivery of this definitive treatment. The Emergency Department has implemented the use of a bilirubin blanket for patients with neonatal jaundice and has developed a system to initiate more rapid initial bilirubin testing. Yet there is another important step we can take. Our data shows that by bringing these babies in as “direct admits” (admitting directly to the inpatient unit and avoiding the ED stay), we can decrease the time to start of intensive phototherapy by up to 2.5 hours! We encourage this approach when the infant has been seen by the PCP in the past 24 hours, is well appearing with no signs of sepsis, has had a serum total bilirubin level done within 8 hours of admission, does not require immediate (<30 minute) intervention, and has an accepting physician.

Coordinating a direct admission may seem a daunting task during a busy office day. To help with that concern, Connecticut Children’s has implemented a new and already highly successful service, called the OneCall Access Center. When a PCP has identified an otherwise well-appearing infant in the outpatient setting who requires phototherapy, the first step is to call 1-833-PEDS NOW. The OneCall Center transfer coordinator will loop in the attending hospitalist, while staying on the line and documenting the recorded call. The hospitalist will obtain the necessary clinical information and accept the patient as a direct admission, provided that the usual criteria are met. The OneCall Center operator will update the PCP when a bed is ready, and the family can then be sent in to receive prompt care.

As with all of our clinical pathways, we will continue to track the data and share our outcomes with the front line providers. It is our hope that increasing the use of our new direct admit/OneCall Center process will improve care for infants with neonatal jaundice by decreasing time to intensive phototherapy, while enhancing both the provider and family experience.

Expansion in Developmental Pediatrics

As of January 7th, 2019, Connecticut Children’s Division of Developmental and Behavioral Pediatrics has opened a facility on 761 Main Ave, Building D, Suite 203 in Norwalk, expanding our services in Fairfield County. This expansion is a direct result of the exciting partnership between Connecticut Children’s and WCHN. The goal of this new center is to “improve access to diagnostic services for young children” says Ann Milanese, MD, Division Head of Developmental and Behavioral Pediatrics. Dr. Milanese also goes on to explain the importance of early intervention when the brain is most receptive. “Neurologically speaking, young children’s brains are developing and most susceptible to communication gains at 2-6 years of age.” Early intervention also allows for informed family planning for parents around the genetics and recurrence risk implications for future pregnancies. For those who choose to have another child, with previous developmental challenges in the past, clinicians will integrate more intensive screenings to offer early diagnosis and management. Developmental and Behavioral Pediatrician Susan Dellert, MD, is the new center’s medical director and will work alongside a clinical psychologist and an APRN. Though newly opened, staff is committed to the goal of increasing access early on and improving overall care and quality of life for their patients.
A 29-year-old female with an extensive past medical history including several years of mild hypoxemia (92-93% in room air) was referred for evaluation of worsening fatigue and shortness of breath with exertion. She had a notable past medical history including asthma, anxiety, arthritis, depression, GERD, Lyme disease, migraines, obstructive sleep apnea and morbid obesity. She was the mother of a toddler, delivered by uneventful Caesarian section. In early 2018, the patient presented to an outside hospital ED complaining of acute chest pain and upper abdominal pain. A CT scan was performed at that time to rule out pulmonary embolism. The scan was negative but did have an incidental finding of a persistent left superior vena cava (SVC) draining to the left atrium. She was discharged from the ED with the diagnosis of pleurodynia. Her pain did resolve. The patient was referred to an adult cardiologist who did an echocardiogram revealing an enlarged coronary sinus, persistent left SVC to the left atrium and no other structural defects. She was then referred to a pulmonologist. The pulmonologist conducted a 6-minute walk test which demonstrated a drop in the patient's oxygen saturation to 88% after 2 minutes, accompanied by shortness of breath. An ABG done at this time revealed a PO2 of 67. Methemoglobinemia was ruled out. She was started on around-the-clock oxygen supplementation by nasal cannula and her saturations improved from mid-80’s to 90’s. After starting the oxygen therapy, the patient noted improvement in sleep, though shortness of breath with minimal exertion persisted. The patient was then referred to the Adult Congenital Heart Disease Program at Connecticut Children’s. At the time of her visit with the adult congenital cardiologist, she was experiencing syncopal episodes around 1-2 times/week. These improved by preoperative evaluation due to better hydration but she was also still complaining of focal, left-sided chest pain. Initially sharp, the pain had become dull in nature. She denied radiation of the pain, nausea and vomiting associated with the pain, diaphoresis, and ameliorating or relieving factors.

In the fall of 2018, the patient underwent surgical repair of the persistent left SVC. This consisted of removing the left superior vena cava from the left atrium and using an 18mm Gore-Tex interposition graft to translocate it to drain into the right superior vena cava. A small coronary sinus type ASD (unroofed coronary sinus) was not repaired due to its small size. Her post-operative course was uneventful and she was discharged on the fourth postoperative day without supplemental oxygen. Her oxygen saturation after walking only drifted to 92%. In follow up with the adult congenital cardiologist, she continues to do well off of oxygen with saturation around 96%. The small residual decrease in her saturation results from some coronary veins which still drain into the left atrium.

Persistent Left Superior Vena Cava (LSVC) is a normal variant. It is found in 0.3-0.5% of the general population though there is a 12% incidence in patients with congenital heart disease. In most cases, a right superior vena cava is also present but there are cases where the right SVC is absent. A persistent left superior vena cava occurs due to failure of the left anterior cardinal vein to involute during fetal life. In 80 to 90% of cases, the persistent LSVC drains to the coronary sinus. If the coronary sinus is normal, the coronary sinus will be enlarged and the blood will return to the right atrium. If the coronary sinus is unroofed or the LSVC drains directly to the left atrium, cyanosis will occur. Persistent LSVC may also be associated with abnormalities of the pacemaker and conduction tissues, on occasion resulting in dysrhythmias. It may present technical challenges to the placement of intracardiac catheters or pacemakers. Indeed, the radiographic appearance of a central line ending behind the heart instead of across in the right SVC may be surprising. An additional notable consequence of the LSVC draining into the left atrium is that air bubbles and clots that enter an IV in the left arm go directly to the left heart and may cause a stroke. IV filters are recommended to manage this. While the presence of a LSVC is important to know for cardiac surgery, it does not always require repair. Indeed, only situations of hemodynamic consequence, such as desaturation require repair.


CONNECTICUT CHILDREN’S MEDICAL CENTER
LOCATIONS AND PARTNERSHIPS

Ambulatory Surgery Centers
Farmington, 505 Farmington Avenue
Trumbull, 112 Quarry Road
(Urology Partnership)

Inpatient Units
Danbury, Danbury Hospital
Hartford, Connecticut Children’s Medical Center
Norwalk, Norwalk Hospital
Waterbury, Saint Mary’s Hospital

Newborn Care
Bridgeport, St. Vincent’s Medical Center
Danbury, Danbury Hospital
Farmington, UConn Health Center
Hartford, Hartford Hospital
Norwalk, Norwalk Hospital

Nurseries
Bridgeport, St. Vincent’s Medical Center

Hartford, Hartford Hospital
Manchester, Manchester Memorial Hospital
Meriden, Midstate Medical Center
New Britain, Hospital of Central Connecticut
Norwich, Backus Hospital
Putnam, Day Kimball Hospital
Vernon, Rockville General Hospital
Willimantic, Windham Hospital

Primary Care Centers
East Hartford, 800 Connecticut Boulevard
Hartford, 76 New Britain Avenue
West Hartford, 65 Kane Street

Specialty Care Centers
Bridgeport, 4695 Main Street
Danbury, 79 Sand Pit Road
(moving soon to 107 Newtown Road)
Fairfield, 95 Reef Road
Farmington, 11 South Road
Farmington, 366 Colt Highway
Farmington, 399 Farmington Avenue
Farmington, 505 Farmington Avenue
Glastonbury, 131 New London Turnpike
Glastonbury, 310 Western Boulevard
Glastonbury, 676 Hebron Avenue
Hartford, 85 Seymour Street
Hartford, 100 Retreat Avenue
Hartford, 282 Washington Street
Hartford, 31 Seymour Street
Norwalk, 761 Main Street
Shelton, 2 Ivy Brook Road
Shelton, 4 Corporate Drive
Springfield MA, 50 Wason Avenue
Stamford, 32 Strawberry Court

Welcome Aboard!
We’re pleased to announce these new additions to our medical staff.

Patrick Ryan, MD, FAAP
GLYCOGEN STORAGE
• BS, West Virginia University, 1996
• MD, West Virginia University, 2004
• Residency at Charleston Area Medical Center/WVU-Charleston, 2004-2008

Jeffrey Small, MD
UROLOGY
• BS, Tufts University, 1982
• MD, New York Medical College, 1987
• Residency in Urology at University of Connecticut, 1987-1991
The partnership between Connecticut Children’s and Western Connecticut Health Network celebrated its one-year anniversary on January 1, 2019. When asked what has improved with regard to care because of the partnership, James Moore, MD, Division Head of neonatology, simply replies, everything. “Having access to the Level 4 NICU in Hartford [through] the partnership allows for babies to be returned to their home hospitals when they don’t need high level care anymore,” Dr. Moore said. “In 2018, 12 babies were transferred from Danbury to Hartford, of which 7 went back to their original hospital.”

John Brancato, MD, Pediatric Emergency Medicine liaison of the partnership, says the two systems are developing strong relationships. “This is a process but we are building good relationships. The ED faculty at all three hospitals have been really welcoming and appreciative of our work together. We will continue sharing more pathways and protocols going forward.” In recognition of the work so far, the Connecticut Emergency Medical Services for Children Advisory Committee awarded a Certificate of Recognition to Dr. Brancato for representing Danbury and Norwalk Hospitals on the committee and helping them raise the bar for kids.

Beth Natt, MD, Director of Pediatric Hospital Medicine and Regional Programs, exclaims that the new OneCall center has improved the care and allowed more streamlined communication with colleagues in Hartford. Dr. Natt also reports that pediatricians in the area have already been vocalizing that they notice a difference since last year. Going forward, Dr. Natt plans to continue to implement more clinical practice guidelines, pathways and best neonatal practices; improve ‘rapid response’ systems, and increase collaboration with the ED.