The medical community has made huge strides when it comes to childhood, adolescent, and young adult cancers. With a survival rate of over 85%, Connecticut Children's is proud to offer a diverse team of providers in our Hematology/Oncology division. With progress moving steadily forward, the next issue to address is that of long-term side effects of treatment, including fertility and sexual health.

The Comprehensive Fertility and Sexual Health Program team, comprised of members from various departments including Urology, Reproductive Endocrinology, General Surgery, Nursing and Social Work, officially took on this challenge in March of 2019. Prior to the program's onset, Connecticut Children's was already interested in this area of medical care, and with the arrival of Natasha Frederick, MD previously of the Dana-Farber Cancer Institute in Boston, it has all come together under an umbrella of multidisciplinary team members.

One of the program's biggest concerns is spreading awareness of long-term fertility issues that could arise in patients treated for pediatric cancer. Dr. Frederick stresses the importance of addressing the potential of future fertility and sexual health issues in a timely manner so as to improve the overall quality of life of our patients. The Comprehensive Fertility and Sexual Health Program is well-staffed to explain and handle any procedures, experimental or otherwise, that patients and families may be exploring. Risk of infertility and related complications is determined by the patient's diagnosis, previous treatment, and pubertal status. The program offers both experimental and non-experimental procedures, including sperm banking, testicular biopsy, ovarian transposition, egg freezing, and more.

For more information please visit the program's official webpage at [www.connecticutchildrens.org/fertility](http://www.connecticutchildrens.org/fertility), or direct any questions to Dr. Natasha Frederick via email: Nfrederick@connecticutchildrens.org.
Dear Colleagues,

Fall in Connecticut is the best with its cool, crisp days and beautiful colors. It may be harvest time in our local farms but it is, indeed, growth time at Connecticut Children’s. Please enjoy this issue of the Medical News. I hope you find it interesting and informative. There are welcomes for our large number of new faculty. I hope you have the opportunity to welcome them in person soon, as well. As always, I look forward to hearing from you on our growth and the Medical News.

With Warm Regards,
John Brancato, MD
Email Dr. Brancato: Jbranca@connecticutchildrens.org

Understanding Sleep: Connecticut Children’s Sleep Center

Helping children sleep well is important to every provider. As you know, families in your practice often struggle with this but may not know where to turn. The Sleep Center at Connecticut Children’s can help in a variety of ways for a variety of issues. For example, if a parent is concerned that their child may have sleep-disordered breathing, such as sleep apnea, our expert sleep medicine physicians can sort out whether a sleep study is needed and treat any noted sleep disorders appropriately.

If a parent is concerned about his or her child having frequent parasomnias such as sleep walking, nightmares and night terrors, the Sleep Center can help evaluate and manage these as well. The experts at The Sleep Center can also help treat bedwetting in a child over age 7 with a gentle but effective behavioral plan.

The most common sleep issue a parent may report, however, is difficulty helping his or her child learn how to fall asleep quickly and easily at bedtime and stay asleep all night long. Our sleep psychologist is skilled at helping parents teach their children to reach this goal and for everyone to enjoy a good night’s sleep.

Connecticut Children’s Specialty Care – South Hadley: Moving into Massachusetts

Connecticut Children’s is excited to announce that James Moore, MD, PhD, is joining the Executive Management Team and will be moving into the role of Vice President, Clinical Network Development and Chief Clinical Network Development Officer, while also remaining the Division Head of Neonatology and overseeing our regional neonatal network of care. Within this role, he will be responsible for growing Connecticut Children’s regional partnerships and referral volume. Please join us in congratulating Dr. Moore on this well-deserved promotion.

James E. Moore, MD, PhD – Vice President, Clinical Network Development and Chief Clinical Network Development Office

Connecticut Children’s Specialty Care – South Hadley: Moving into Massachusetts

If families in your practice are struggling with any other sleep related issues, please consider referring them to the Connecticut Children’s Sleep Center. Our facilities are designed to make children feel as comfortable as possible while undergoing a sleep study, and our providers are specifically trained in the specialty care of kids and adolescents. We have locations in Hartford, Farmington, Glastonbury and Fairfield. You may call OneCall at 1-833-PEDS-NOW to request an appointment with one of our dedicated sleep specialists.

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Services Offered in Additional Locations:
• Pain & Headache – Fairfield
• Weight Management – Fairfield
• Sports Medicine – Glastonbury

Connecticut Children’s Specialty Care – South Hadley:
Moving into Massachusetts

Providers of Western Massachusetts – you spoke, and we listened. Beginning September 10th, Connecticut Children’s began providing care in South Hadley, Massachusetts at 84 Willimansett Street, Suite 3. While offering services with Gastroenterology and Nephrology, the effort to expand care and accessibility across state lines is improving. As a health system, Connecticut Children’s believes that it is important to provide care close to home and where access may be limited. Additional specialties will be offered in the near future.

Please call OneCall at (833) PEDS-NOW to request an appointment.

Email Lynelle Schneeberg, PsyD: Lschneeberg@connecticutchildrens.org

John Brancato, MD
Connecticut Children’s Medical Center
105-A Newtown Road, Danbury, CT 06810

New Specialty Care Center in Danbury has opened! 105-A Newtown Road

Lynelle Schneeberg, PsyD
Connecticut Children’s
Medical News

Services Offered in Additional Locations:
• Pain & Headache – Fairfield
• Weight Management – Fairfield
• Sports Medicine – Glastonbury

Connecticut Children’s Specialty Care – South Hadley:
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Please call OneCall at (833) PEDS-NOW to request an appointment.

Email Lynelle Schneeberg, PsyD: Lschneeberg@connecticutchildrens.org
What Should I Do About This Umbilical Hernia?

Brendan T. Campbell, MD, MPH

Problems with the umbilicus are common in clinical practice. Most problems related to the umbilicus are benign and do not require urgent surgical treatment. This article will briefly review the most common umbilical problems seen in pediatric practice, describe those requiring more urgent surgical evaluation, and discuss the evidence-based management of umbilical hernias.

The differential diagnosis of umbilical problems can be narrowed based on whether there is an umbilical bulge, drainage from the umbilicus, or signs of inflammation present. A bulge at the umbilicus that does not reduce with gentle pressure suggests that there could be incarcerated bowel, or more commonly omentum. Umbilical drainage can occur with a granuloma or omphalitis, but it can also be a clue that an underlying congenital anomaly is present – clear or yellow fluid (i.e., urine) may be associated with a patent urachus and bilious or feculent drainage suggests a communication with the ileum through a patent vitelline duct. The most common clinical signs to suggest that there is an underlying problem that should be investigated are non-reducible swelling, localized tenderness, and umbilical drainage.

The most common conditions related to the umbilicus that can cause acute problems would include soft tissue infection at the umbilicus (i.e., omphalitis), an infected urachal remnant, lower GI bleeding or bowel obstruction related to a connection between the umbilicus and a Meckel’s diverticulum (i.e., vitelline duct remnant). In infants it can be difficult to distinguish between an umbilical granuloma and a congenital anomaly of the umbilicus because there is not always a patent communication between the umbilicus and underlying GI and GU structures, and each of these conditions can have overlapping symptoms.

**Umbilical Hernia Management**

Umbilical hernias are one of the most common reasons children are referred to pediatric surgeons for evaluation. The incidence of umbilical hernias in infants is approximately 20%, and they develop when the fascia of the rectus abdominis fails to fuse at the umbilical ring where the umbilical vessels passed through it to form the umbilical cord. When the umbilical ring fails to close, an umbilical hernia may develop. Protrusion of viscera back and forth through the umbilical defect rarely causes pain. However, parents sometimes perceive that their child is crying because the hernia is protruding, when in fact the converse is true. There are no stringent guidelines on how to manage pediatric umbilical hernias. An estimated 80% of umbilical hernias will close spontaneously so in the vast majority of cases, it is safe and appropriate to wait until children are three to five years of age before considering surgical treatment. Unless an infant or toddler has signs of bowel obstruction or incarceration, the child can be observed until they are older because the risk of complications from an un repaired umbilical hernia is very low.

Consensus-based recommendations for surgical repair of umbilical hernias in children older than 3 years includes the following:

• Umbilical fascial defect larger than 2 cm
• An “elephant trunk” appearance
• The child develops symptoms related to the hernia
• The hernia increases in size after 1-2 years of age

The repair of an asymptomatic umbilical hernia is an outpatient procedure, and involves closure of the fascial defect usually with absorbable sutures. Mesh is rarely indicated in children. Excellent postoperative pain control can be achieved with intravenous local anesthetic combined with postoperative ibuprofen and acetaminophen. Activity restriction is generally limited to 7 days of no submersion.

**Summary**

Pediatric umbilical hernias are commonly seen in clinical practice. Children with a non-reducible umbilical bulge, drainage or pain at the site should be evaluated by a pediatric surgeon to determine if the child has an incarcerated hernia, underlying congenital anomaly, or omphalitis that warrants surgical treatment. For umbilical hernias, the decision to proceed with surgical repair should be deferred until children are 3 to 5 years of age due to their high likelihood of spontaneous closure. Small (<1 cm fascial defect), asymptomatic hernias rarely produce clinical symptoms and can be safely observed.

**DIFFERENTIAL DIAGNOSES OF PEDIATRIC UMBILICAL CONDITIONS**

<table>
<thead>
<tr>
<th><strong>Diagnosis</strong></th>
<th><strong>Clinical Features</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Asymptomatic Umbilical Hernia</td>
<td>umbilical bulge reduces with gentle pressure, non-tender non-reducible umbilical bulge, tenderness, may have SBO round, moist, non-tender, often pedunculated</td>
</tr>
<tr>
<td>Incarcerated Umbilical Hernia</td>
<td>umbilical pain, obstructive symptoms, bilious drainage, fever, inflammatory changes, clear/yellow drainage, UTI inflammatory changes, tenderness, purulent or bloody drainage</td>
</tr>
<tr>
<td>Umbilical Granuloma</td>
<td>a round, moist, nontender, often pedunculated</td>
</tr>
<tr>
<td>Vitelline Duct Remnant</td>
<td>Omphalitis</td>
</tr>
</tbody>
</table>

**MULTI-SPECIALTY VASCULAR ANOMALIES PROGRAM**

The Vascular Anomalies Program is made up of care specialists from Cardiology, Hematology/Oncology, Plastic Surgery, Radiology, Craniofacial, Interventional Radiology, Otolaryngology, Pediatric Surgery, and more. The team treats malformations such as hemangiomas, lymphangiomas, arteriovenous malformations, and other rare anomalies. These anomalies usually show up either at birth or within a few weeks of age, initially entering the rapid proliferation phase at 2-6 months before ceasing growth in the involution phase at 8-12 months, lasting 5-7 years. They may be recognized early on by parents or primary care providers as a red mark on the child.

What can be most concerning regarding hemangiomas and other malformations is the possibility of complications such as vision or airway obstruction, as well as the destruction of normal tissue, especially in anomalies located on the face or head.

The Vascular Anomalies team aims to consult and treat patients quickly, preferably before 2 months of age if possible, as conditions respond immediately to treatment. When reaching out with any questions or concerns, please note that the phone number for the program will bring providers to the Center for Cancer and Blood Disorders line. A staff member or provider from the department will be able to provide more information or schedule an appointment if necessary.

For more information, please contact Dr. Alex Golden or Dr. Michael Isakoff through OneCall at 833-PEDS-NOW.
Rapidly Progressing Lyme Carditis: A Case of Disseminated Disease with Negative Serologies on Presentation

Dr. Scott Treece, a resident at Connecticut Children’s, authored this case in collaboration with Dr. Nicholas J. Bennett. The patient was referred to Richard Segool, MD of Pioneer Valley Pediatrics in Enfield, CT.

PRESENTATION

A 16-year-old boy with a history of mild intermittent asthma presented to the Connecticut Children’s Emergency Department (ED) in early July complaining of chest pain and dyspnea that was not responsive to albuterol. Two days prior, he had presented to an urgent care with fever, chills, and a dark, erythematosus rash on his right ankle after a recent camping trip to northern Massachusetts. At that time, he had Lyme serologies drawn (later resulted as indeterminate) and he was started on doxycycline for empiric treatment of Erythema migrans (EM). Upon his presentation to the ED, he had received two doses of doxycycline. In the ED, he was afebrile, but still complaining of chest pain.

The EM rash was still apparent on the right ankle, with localized swelling. Lab work was significant for CRP of 4.5 mg/dL, and mild hyperbilirubinemia at 1.3 mg/dL. ECG and chest X-ray were unremarkable.

DIAGNOSIS AND TREATMENT

On the floor, he continued on doxycycline therapy, and had serial follow up to return to the ED. At this visit, he was found to have elevated troponin I to 2.45 ng/mL (reference < 0.30 ng/mL), CK-MB at 10.0 ng/mL, and CK 429 U/L. ECG that night found abnormal repolarization with mild ST elevations and intraventricular delay. The aforementioned viral tests all resulted as negative. He underwent repeat Lyme serologies approximately 6 weeks after his admission, and EIA elevated from 0.32 to 1.46, with two positive IgM bands and two positive IgG bands on Western blot, meeting recommended diagnostic criteria for Lyme disease.

DISCUSSION

Lyme carditis is generally considered to be a presentation of early disseminated Lyme disease, and usually occurs weeks to months after initial infection. By that time, patients typically have a robust serologic response. Our patient developed a myocarditis within days of onset of the primary EM rash, when disease was early enough to be seronegative. A recent case report details the presentation of a 66-year-old man from Syracuse, NY that presented to the ED in early July complaining of chest pain and dyspnea that was not responsive to albuterol. Two days prior, he had presented with an EM in the area of the right ankle, with localized swelling. Lab work was significant for CRP of 4.5 mg/dL, and mild hyperbilirubinemia at 1.3 mg/dL. ECG and chest X-ray were unremarkable.

The Infectious Disease team was consulted. His exam was largely benign, save for the rash on his right ankle, which was already improving based on prior photographs provided by the family. His fevers, malaise, EKG changes, and laboratory findings focused the differential on an infectious myocarditis. Lyme titers that evening resulted as negative. A viral work up of enterovirus PCR, CMV culture, RSV EIA and DFA, influenza A/B PCR, as well as culture for adenovirus, influenza A/B, parainfluenza (types 1, 2, and 3), and RSV was collected. Given the initial presentation very consistent with acute localized Lyme disease, and some case reports of early presentations of Lyme carditis, decision was made to continue doxycycline therapy for a 14 day course of therapy. After continued improvement in his clinical symptoms and cardiac enzymes, he was allowed to leave and was discharged the following day. Over the coming weeks, symptoms resolved entirely. The aforementioned viral tests all resulted as negative.

While this patient’s presentation was unusual, it is important to keep Lyme disease on the differential when considering infectious myocarditis. Among these patients, 6 of them had either QTQT prolongation or ST changes, rather than the typical AV block (2). Most of these patients have very good outcomes, but some may have persisting ECG changes. According to the CDC, at least 9 fatalities related to Lyme carditis have been reported in literature since 1985 (3). Children from Lyme-endemic areas with infectious myocarditis and any features of Lyme disease should promptly be treated, with the knowledge that some of these children may initially have negative serologies. Convalescent titers may help make the diagnosis in these cases.
Upcoming CME Events

PEDIATRIC GRAND ROUNDS:
2019-2020 Series kicked off on Tuesday,
September 3rd, 2019
Where: Gilman Auditorium, Conklin Building, Hartford Hospital
7:30am-8:00am - Breakfast with the Chair
8:00am-9:00am - Lecture

PEDIATRIC EVENING SERIES LECTURES:
THURSDAY, OCTOBER 17, 2019 | 5:30-8:30PM
2 AMA PRA CATEGORY 1 CREDIT™
TITLE: Diagnosis and Management of Childhood Musculoskeletal Complaints for the Primary Care Pediatrician
SPEAKERS: Barbara Edelheit, MD; Blaine Lapin, MD
OBJECTIVES: 1. Distinguish between mechanical and inflammatory musculoskeletal symptoms
2. Describe the workup and first line management techniques for children with Juvenile Idiopathic Arthritis
3. Identify effective non-pharmacologic treatment measures for non-inflammatory musculoskeletal pain with particular attention paid to amplified musculoskeletal pain syndrome

THURSDAY, JANUARY 16, 2020 | 5:30-8:30PM
2 AMA PRA CATEGORY 1 CREDIT™
TITLE: Adolescent Idiopathic Scoliosis: Diagnosis and Management
SPEAKERS: Mark Lee, MD; Jeffrey Thomson, MD
OBJECTIVES: 1. Identify characteristics of an atypical scoliosis in an adolescent patient
2. Outline treatment options for scoliosis in a growing adolescent
3. Describe “red flag” symptoms in the evaluation of a pediatric patient with back pain

THURSDAY, MARCH 19, 2020 | 5:30-8:00PM
1.5 AMA PRA CATEGORY 1 CREDIT™
TITLE: Updates in Pediatric Constipation
SPEAKERS: Corey Baker, MD
OBJECTIVES: 1. Discuss components of constipation pathophysiology
2. Identify types of medications used for constipation and the patients whom it would benefit
3. Recall available advanced diagnostic techniques for constipation

MENTAL HEALTH EVENING LECTURE SERIES:
THURSDAY, NOVEMBER 12, 2019 | 5:30-8:30PM
2 AMA PRA CATEGORY 1 CREDIT™
TITLE: Beyond the Couch – Pediatric Psychology at the Front Lines of Medical Care (TED TALK)
SPEAKERS: Bradley Jenson; Emily Wakefield, PsyD; Christine Nunes, MD; Lisa Namerow, MD; Barbara Rzepecki; Melissa Santos, PhD
OBJECTIVES: 1. Illustrate the use of psychosocial assessments in youth with comorbid medical and mental health concerns
2. Summarize a biopsychosocial formulation in pediatric psychology
3. Explain how brain-body connectivity pathways are involved in the bidirectional relationship between physical and psychiatric symptoms

TUESDAY, FEBRUARY 18, 2020 | 5:30-8:30PM
2 AMA PRA CATEGORY 1 CREDIT™
TITLE: Suicide & Cutting
SPEAKERS: Lisa Namerow, MD; Steven Rogers, MD, CPST
OBJECTIVES: 1. Review screening tools and their role in the assessment of suicide utilizing a clinical pathway developed to address suicide screening
2. Recall the Zero-suicide initiative at Connecticut Children’s
3. Distinguish suicidal and non-suicidal self-injury and identify the possible contributing factors

TUESDAY, APRIL 28, 2020 | 5:30-8:30PM
1.5 AMA PRA CATEGORY 1 CREDIT™
TITLE: Digital Media and Early Childhood: The Good, The Bad, and the Unknown
SPEAKERS: Jenny Radesky, MD
OBJECTIVES: 1. Explain the developmental effects of digital media in early childhood (the good and the bad)
2. Examine concepts important to addressing novel media issues in the office (the unknown)
3. Apply these concepts for addressing media use during clinical encounters using patient centered approaches

In Memory of Dr. Jeffrey Bartlett
Jeffrey Bartlett, DO, a Connecticut Children’s neonatologist, passed away unexpectedly on August 3rd. A graduate of both our residency in pediatrics and fellowship in neonatology, Dr. Bartlett was the medical director of the Connecticut Children’s NICU at Danbury Hospital. As a few of you know, Dr. Bartlett was recently nominated for and was awarded the Melville G Magida Award by the Fairfield County Medical Association. He was the first neonatologist to receive this honor in its 38 year history. Jeff’s compassion, honesty and support for those with the ‘tiniest and most fragile lives’ will outlast us all. In his free time, Jeff volunteered for both local non-profits and international agencies to improve neonatal resuscitation, nutrition, and survival. Jeff was clearly very loved by both his team and the families he cared for. This is not idle praise.

There have been letters from parents whose children Jeff cared for: “Dr. Bartlett’s remarkable medical expertise, heartfelt concern for our babies and family as a whole, as well as the NICU community in its entirety speaks to the heart”. Dr. Bartlett worked to have Human Breast Milk supplemented with Human Milk fortifier, thus reducing the rates and illness from NEC (Necrotizing EnteroColitis) in his NICUs.

One of his co-workers recently wrote that “despite the rapid pace,he strolls into each family NICU room, pushes the computer aside, sits in a chair and talks with the parents. He begins by asking them how they feel things are going. It doesn’t matter if the baby is the most or least critical in the NICU, he treats each family as though they are the most important”. A physician who was also a parent in the NICU commented, “Dr. Bartlett was there for me every step of the way. It is apparent that he cares deeply not only for the babies in his care, but for the families that come with his patients. As tough as those 3 months were, I could not have asked for a better doctor.”

To honor his memory, we can only suggest that we do for our patients as Dr. Bartlett did for his.
Understanding Concussions

Markus Bookland MD - Neurosurgery | William Graf MD - Neurology | David Wang MD – Sports Medicine

"Concussion" and "Post-Concussion Syndrome: two diagnostic terms that are often misunderstood or incorrectly used interchangeably. This is important because the management of these two conditions is different. The ability to make the correct diagnosis early and provide appropriate treatment can lead to improved outcomes and quicker recovery times.

Concussion (also known as mild traumatic brain injury symptoms) is a clinically-defined relatively mild head injury that temporarily affects brain function. Beyond the description of the actual injury, signs and symptoms of concussion may include some alteration (or loss) of consciousness; memory deficits and other symptoms of cognitive impairment; headaches; poor concentration; difficulty with balance; nausea; blurred vision; sleep disturbances; and mood changes. Any of these symptoms may begin immediately, or appear within hours or days after the injury. Symptoms often peak 24-48 hours after the injury and typically last 1-4 weeks.

Acute concussion recovery is typically divided into three phases:
1) Acute rest; 2) Relative rest; and 3) Graduated exertion/Return to sports or life activities. Following a brief period of cognitive and physical rest, athletes may gradually resume their normal daily activities as tolerated. Proper management in the acute setting is essential to ensure that a timely and safe return to sport and academics is achieved.

Post-concussion syndrome is a condition is often a more complex disorder that includes various neurological symptoms (such as headaches, dizziness, and sleep problems) as well as other psychological symptoms that last for weeks and sometimes months after the injury that caused the concussion. Post-concussion syndrome is often associated with signs and symptoms similar to those often experienced by people diagnosed with depression, anxiety, post-traumatic stress disorder, significant life stressors, poor social support systems or a lack of coping skills. In many cases, both physiological effects of brain trauma and emotional reactions to these effects play a role in the development of post-concussion syndrome symptoms. It is often unclear why some persons who have had recent concussion(s) develop persistent post-concussion symptoms while others do not, and there is usually no direct correlation between the severity of the injury and the likelihood of developing persistent post-concussion symptoms.

Treatment of post-concussion syndrome is non-specific and depends on the individual and the details of the person’s symptoms. There are no medications that effectively treat specific cognitive problems after mild traumatic brain injury—and it appears to be the best therapy for these post-concussion syndrome symptoms. Certain forms of cognitive therapy (including cognitive-behavioral therapy, or CBT), may be helpful, including focused cognitive rehabilitation. Some individuals may benefit from occupational or speech therapy. Stress can increase the intensity of cognitive symptoms and learning stress management strategies/relaxation techniques may be helpful to decrease some cognitive symptoms. Medication trials to treat anxiety or depression (such as low dose amitriptyline or fluoxetine) are only occasionally indicated.

If you would like a consult with a concussion specialist, please call OneCall at (860) PEDS-NOW.

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

Corey Baker, MD
GASTROENTEROLOGY
• MD, UAB University School of Medicine
• Fellowship in Pediatric Gastroenterology, Hepatology and Nutrition, The University of Alabama at Birmingham

Allison Elizabeth Crepeau, DO
SPORTS MEDICINE
• DO, Tufts University School of Medicine
• Fellowship in Sports Medicine, Rush University Medical Center

Veronica Fabrizio, DO
NEONATAL INTENSIVE CARE
• DO, Temple University School of Medicine
• Fellowship in Neonatal-Perinatal Medicine, Rush University Medical Center

Dr. Hughes joined our team in August and brings with him a concussion specialist, Dr. Christopher Hughes, MD, MPH, and Plastic Surgery Division to Connecticut Children’s.

Christopher Hughes, MD
PLASTIC SURGERY
• MD, Johns Hopkins University School of Medicine
• Fellowship in Plastic Surgery, University of Texas Southwestern Medical Center
• Fellowship in Pediatric Plastic Surgery, Boston Children’s Hospital, Harvard Medical School

Global Concussion Research Fellowship, Harvard Medical School

New Program: Plastic Surgery
We welcome Dr. Christopher Hughes, MD, MPH, and Plastic Surgery Division to Connecticut Children’s. Dr. Hughes joined our team in August and brings experience and expertise in pediatric plastic surgery. His clinical interests include cleft and craniofacial surgery, vascular abnormalities, body contouring, trauma care and global health.

Ancillary Service Referrals Consolidated into OneCall
Beginning in October, all referrals and orders to Connecticut Children’s, including clinical support referrals, such as PT/OT, nutrition, radiology, sleep medicine, audology, speech therapy and more, will be sent directly to OneCall. This gives our community providers the luxury of simplicity in referring to Connecticut Children’s—all referrals go to one number. For more information, please contact OneCall at 1-833-PEDS-NOW.
The Curbside Consult: Connecticut Children’s Newest Podcast

Change up your daily commute to work and subscribe to Connecticut Children’s podcast – The Curbside Consult. With Patricia Garcia, MD, on the mic each month, she interviews a different specialist to discuss a variety of relevant issues and an array of topics that community pediatricians, patients and families can all benefit from hearing.

Please feel free to email CurbsideConsult@ConnecticutChildrens.org if you would like more information or have a topic suggestion.