FALL 2020 ISSUE

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Georgia Chapter

The GEORGIA Pediatrician

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President's Letter

Pediatricians Tackle a Pandemic

Hugo Scornick, MD, FAAP

By the time you read this, I imagine most of you will know someone who has been afflicted by the SARS-CoV-2 virus. During this devastating and protracted pandemic, pediatricians are tasked with watching over the smallest amongst us, the nation's children. They have been affected in multiple ways. We pediatricians care for the 7-year-old boy with a fever and a rash who has a case of coronavirus associated MIS-C. We listen to the 13-year-old with autism who is feeling increasingly anxious when he watches the news. We notice the 4th grader who stopped all virtual schooling because of poor internet access and the twelve-year-old girl who, due to the pandemic, waited for three additional days before coming to the office with appendicitis. We explain to families the importance of wearing masks and keeping social distance to help stop the spread of the virus. As President of the AAP Dr. Sally Goza has said, what we are doing now "may be the most important work of our lives."

As the Covid-19 crisis began to unfold in March, the Georgia Chapter of the AAP became a flurry of activity. Under the leadership of immediate past president Dr. Terri McFadden, the Executive Committee began to meet weekly. A Georgia Covid-19 Task Force was created comprising pediatric infectious disease specialists, CDC physicians, public health officials, and community pediatricians from throughout the state. This distinguished committee advises Chapter leaders of the medical situation on the ground. The Chapter increased email communications to members (currently weekly) and shared messages through social media. Topics have included everything from proper infection control procedures in the pediatric office to breastfeeding guidance for the Covid-19 positive mother to educational opportunities for pediatricians.

During this devastating and protracted pandemic, pediatricians are tasked with watching over the smallest amongst us, the nation's children.

Our amazing Chapter staff works with urgency every day to distribute these communications, coordinate a multitude of committee meetings, and to respond to physician members' questions and concerns.

Simultaneously, the health crisis rapidly became an urgent financial crisis for many practices around the state (including my own) due to a steep drop in patient volume. We developed a communications strategy that included press releases and media interviews encouraging families to continue their child's routine health care. We partnered with the Georgia Department of Public Health to create a social media campaign that encouraged childhood wellness exams and worked with the school system to keep immunization and sports physical requirements in place. We disseminated to pediatricians all the details of the new federal small business loans and the provider relief fund. We also urged government officials to allocate scarce PPE for pediatricians and children's hospitals. Chapter leaders have been engaged with all levels of state government, meeting with the commissioner of Public Health Dr. Kathleen Toomey, the Chief of Medicaid Services Blake Fulenwider, the State School Superintendent Richard Woods, and with Governor Brian Kemp as we continuously advocate for children's health issues.

Many of our Chapter's committees have become more active during this crisis. The Legislative Committee, led by Dr. Melinda Willingham, navigated a challenging legislative session interrupted by the coronavirus and facing budget shortfalls due to a steep drop in state revenues. Remarkably, they were able to secure important wins for children that included a small increase in the Medicaid rate, an expansion of Medicaid

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benefits to mothers for six months postpartum (previously was sixty days), the passage of a state law raising the age of nicotine purchase to 21, and an increase in taxes on vaping products. The School Health Committee received national attention for creating an innovative school reopening toolkit and webinar. Our Telehealth committee became a valuable resource for pediatricians learning about this new care delivery model. They produced two webinars on telehealth and advocated for adequate payment from insurers for this service. The Emergency Preparedness Committee, the Medicaid Task Force, the Infectious Diseases Committee, the Immigrant Child and Family Committee, the Medical Home Task Force, the Communications Committee, the Bioethics Committee, the Committee on Child Abuse and Neglect, the Breastfeeding Committee, and others have all been engaged in important work during the pandemic.

Seemingly overnight, we deep cleaned our offices, gowned up in personal protective equipment, and radically altered our workflows. We stayed open, treated the sick, and counseled families through this stressful event.

Looking back over the past few months, I am proud to say that Georgia's pediatricians have risen to an incredible challenge. Seemingly overnight, we deep cleaned our offices, gowned up in personal protective equipment, and radically altered our workflows. We stayed open, treated the sick, and counseled families through this stressful event. We have kept calm, stayed sane, and supported each other. I would like to thank our state's children's hospitals for stepping up during this crisis with their leadership, resources, and expertise. And, of course, I would like to thank all of you, our state's pediatricians, for your service to your young patients and for frequently putting their needs in front of your own. Although this is a difficult time, I have never been more proud to be part of the physician community, to be a practicing pediatrician, and to be a loyal member of our organization, the Georgia Chapter of the American Academy of Pediatrics.

Hugo Scornick, MD, FAAP

Making This Up as We Go

Sylvia Washington, MD, FAAP

"Resilience: the capacity to recover quickly from difficulties; toughness"
- Oxford Language Dictionary

I am amazed at the parents, grandparents, and children I see in my practice. I've taught virtual New Mommy Classes and found these new Mamas are fierce! They have been to Obstetrics appointments alone, given birth with one partner present, and attended pediatrician office visits with masks for themselves and their children (over age 2 years). They breastfeed and they bottle-feed. They work on the frontline or work at home with various childcare issues. Many have been dealing with the decision to send children to school in-person or virtual this school year.

Just like them, my life has been filled with worry and angst about the COVID-19 pandemic. The first time I donned PPE and swabbed a pediatric patient for COVID-19, both the mother and I cried due to the uncertain future. In another case, I hospitalized a pediatric PUI (patient under investigation) for possible COVID-19 with a chest x-ray positive for pneumonia, and the parents were forced to close their local business. My entire schedule is different: my temperature is taken prior to entering the hospital for morning rounds in the newborn nursery. I have separate PPE for inpatient versus outpatient settings. I see wellness visits in the morning and sick visits in the afternoons. For months, I've worked, come home, and disinfected myself.

The first time I donned PPE and swabbed a pediatric patient for COVID-19, both the mother and I cried due to the uncertain future.

My career is on an up-ward trajectory: I serve as Chair of the Department of Pediatrics at my local hospital. I attend executive meetings and help determine critical care interventions for our hospital's sickest patients. I have studied the COVID-19 guidelines daily and managed to educate families in my community about this new illness. I also teach resident physicians, medical students, and nurse practitioner students in my office. I've seen positive cases and given guidance about quarantine and self-isolation. I've grown and it feels like I've been to medical school all over again.

Life moves on, and there are new sources of joy for my family. We've attended online church services and had "Zoom" birthday parties. My husband surprised me with a private boat tour for our wedding anniversary! My 5th grader had a sweet drive-through graduation ceremony. We cancelled our Disney Cruise and opted for a quiet beach trip instead. I've read several good books and had really heart-felt conversations with my sisters. My staff and I are in this boat together; we are "Team Popsicles" for our company's wellness challenge. I've been walking 2 miles 3-4 days a week with a friend to keep my sanity and my health intact.

After much debate, my husband (college professor) and I decided to send our children back to school at a smaller private school, which has mandatory masking requirements, temperature checks, and desks spaced 6 feet apart. I pray every day for their safety. I am amazed at my children's resilience: they wear their masks, they play outdoors with friends, and swim with ease.

The world has changed and will never be the same. Some of you are doing telemedicine. Some are working in the office and struggling to make ends meet. Some are in the hospital, struggling with potential exposure and treatment of various other childhood ailments. Some have family members with COVID-19, and some have COVID-19 themselves. So, be encouraged my fellow pediatricians: we are resilient, and we will continue to fight for the safety and wellbeing of children! I am with you, and I am sending you a virtual hug.

Sylvia Washington, MD, FAAP
Floyd Pediatrics
Early Career Physicians Committee Chair
Rome

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Orthopaedics and Sports Medicine

Dell McLaughlin, MD, will join Children's as a pediatric orthopaedic surgeon in October. Dr. McLaughlin completed a pediatric orthopaedic fellowship at The Hospital for Sick Children in Toronto, Ontario, Canada, as well as a fellowship in musculoskeletal oncology at Memorial Sloan Kettering Cancer Center in New York. Prior to her fellowship training, she completed her residency at the University of California San Francisco and received her medical degree at Emory University School of Medicine. Her interests include musculoskeletal tumors, complex limb reconstruction and general pediatric orthopedic conditions. She will see patients at the Center for Advanced Pediatrics, Children's at Fayette and Children's at Old Milton Parkway in Alpharetta.

Saji Azerf, MD, MPH, will join Children's as a pediatric orthopedist in October. Dr. Azerf recently completed his non-operative pediatric fellowship training at the University of Wisconsin School of Medicine and Public Health. He attended the Helen Devos Children's Hospital for his residency training after receiving his medical degree at the University of Alabama School of Medicine. His areas of focus include club foot, fracture care and nonoperative musculoskeletal. Dr. Azerf will care for patients at Children's at Forsyth and Athens.

Otolaryngology (ENT)

Clarice Brown, MD, joined Children's in September as a pediatric otolaryngologist. Dr. Brown attended the University of Texas Southwestern Medical Center for her pediatric otolaryngology fellowship training. Prior to her fellowship, she completed her residency training at the University at Buffalo and received her medical degree from Morehouse School of Medicine. Her clinical areas of interest include general pediatric otolaryngology, head and neck masses, pediatric sinonasal disease, pediatric obstructive sleep apnea, and dysphagia. Dr. Brown sees patients at Children's at Satellite Boulevard in Duluth.

Sean Evans, MD, joined Children's as a pediatric otolaryngologist following the completion of his complex pediatric otolaryngology fellowship training at Seattle Children's Hospital. Prior to his fellowship, he completed his residency training at the University of Alabama at Birmingham and received his medical degree at Tulane University School of Medicine. His clinical areas of interest include general pediatric otolaryngology, head and neck masses including tumors and vascular malformations, congenital deformities, diseases of the sinuses and nose, airway abnormalities, speech difficulties, and ear infections and disease. Dr. Evans sees patients at Children's at Fayette.

Pediatric General Surgery

Allison Linden, MD, MPH, will join Children's as a pediatric general surgeon in October. Dr. Linden recently completed her pediatric surgery fellowship training at the Sidney Kimmel Medical College at Thomas Jefferson University/Al duPont Hospital for Children. Prior to her pediatric surgery fellowship, Dr. Linden completed a pediatric surgery critical care fellowship at Children's Hospital Los Angeles and an ECMO fellowship at the University of Chicago Comer Children's Hospital. She finished her general surgery residency at Georgetown University Hospital and received her medical degree from Georgetown University School of Medicine. Dr. Linden's areas of interest include neonatal surgery, minimally invasive surgery, surgical critical care, ECMO and global surgery. She will hold clinics at the Center for Advanced Pediatrics and Children's at Satellite Boulevard.

Meet Dr. Anna Kuo: 2019 Board Chair, American Board of Pediatrics

Anna Kuo, MD, FAAP

Starting as a volunteer question writer with the American Board of Pediatrics (ABP) in 2000, I am about to complete a seven-year term on the Board of Directors, having served as Chair in 2019 and as Immediate Past Chair in 2020. Under the leadership of Dr. David Nichols, President and CEO, and with the vision of "inspiring a lifetime pursuit of learning to improve child health," the ABP has launched major innovations in pediatric education and certification, including the new assessment platform MOCA-Peds and the popular learning tool Question of the Week. This year, the American Board of Pediatrics administered its first certifying exam in Pediatric Hospital Medicine (PHM), the fifteenth subspecialty in the field of pediatrics. The ABP is also committed to addressing the epidemic of behavioral and mental issues by working with training programs to ensure residents and fellows are better equipped to manage common issues in these areas, and by providing diplomates self-assessment (Part 2) and quality improvement (Part 4) opportunities as well.

Understanding that the coronavirus pandemic was significantly affecting diplomates and trainees, the ABP acted quickly to make adjustments in requirements. This summer, diplomates automatically received Part 2 and Part 4 points in their portfolios, acknowledging the tremendous learning and practice improvements pediatricians were making in response to the crisis. The ABP also granted the ability to drop two quarters in 2020 for those enrolled in MOCA Peds, recognizing that keeping up with the assessment program may be difficult for some diplomates. A COVID-19 Improvement Project application was also developed to credit the innovative care delivery efforts that practices put into place in response to the pandemic. The ABP is actively working on ways to accommodate pediatricians who continue to face significant financial hardship through the end of the year. As a reminder, the annual payment option for MOC is $280, and will not be increased in 2021. For more details on these changes, I invite diplomates to log onto their portfolios at abp.org.

The ABP is also regularly communicating with residency and fellowship directors, reviewing and adjusting training requirements that might be difficult to meet during the pandemic. Four subspecialty exams that were originally scheduled in the spring were quickly rescheduled for August. Because some hot spots continued to exist in different parts of the country, the ABP also offered fellows the opportunity to defer their eligibility for two years, and to take those exams when they are next scheduled to occur.

I am very grateful for the opportunity to work with the ABP and want to especially thank the American Academy of Pediatrics and our very own Dr. Sally Goza for the Academy's continued collaborative efforts. I also want to thank the many Georgia pediatricians who have donated their time to work on an ABP committee, and enthusiastically encourage office-based pediatricians to consider volunteering with the Board – it has been a true highlight of my career!

Anna R. Kuo, MD
Peachtree Park Pediatrics, Atlanta
akuo@peachtreeparkpeds.com

More about Dr. Kuo

Education: Emory School of Medicine 1989, University of Maryland, Pediatric Residency & Chief 1989-1993

Current position: Partner, Peachtree Park Pediatrics, Atlanta

Hometown: Connecticut originally

Family: Terry Feng, MD and OB/GYN, and three children

Inspiration: Nature

Guiding principles: Remembering to look at the glass half full, not half empty.

Greatest Accomplishment: Three awesome kids!

Why is Georgia Chapter membership important to me: Lobbying on behalf of Georgia's children

Why is the AAP important to me: Representing children and families in policy making

Roles in the AAP or other pediatric or medical organizations: Chair, American Board of Pediatrics (2019), Immediate Past Chair (2020)

Hobbies: Outdoor adventures, new cuisines

Pet Peeves: Having all of my heaviest groceries placed into one bag at the supermarket

If you could have dinner with any one person, who would it be?: Michelle Obama (or her husband if she's too busy)

Child Abuse and COVID:
Child Abuse Pediatrician's Perspective

Yameika Head, MD, FAAP

Imagine this scenario: Kayla is on her computer doing her classwork online since COVID has shut down her school. She is really hating life right now. Ughh! She hates virtual learning, she misses her friends, and she is at home alone with her mom's creepy boyfriend since her mother has to work to help support them. She snacks on Ramen noodles, which is the only thing they have in the house because her mom had to sell their EBT card to help pay bills since work hours have been cut. While doing her homework, a cute picture of a boy pops up in her DMs. Who is this? He's a "meal" (meaning cute in slang). Little does Kayla know that the cute boy is really Chester, a middle-aged man who lives in California who preys on young girls to "hook up" with and solicits illicit photographs. Unfortunately, Kayla trusts him and the relationship continues.

Kayla's story reflects the effects of our current environment and should raise concerns for all of us. On April 3, 2020, Governor Brian Kemp declared a Shelter-In Place Order for the state of Georgia. Everything was shut down and life as we knew it changed. COVID-19 and its effects on society took over and we in the medical field kicked into high gear trying to manage the steady flow of patients ravaged by this novel virus. This pandemic has magnified risk factors similar to those we see that propagate child abuse. Although we are seeing an overall suppression in child abuse reports and fewer children are being taken into care, simultaneously there is an increase in admissions for severe physical abuse and domestic violence.

Many studies support a positive correlation between disasters and elevated risk for trauma. In the midst of our current evolving chaos, I worry about our children. Our eyes are not on them as before. Schools are closed and they are not protected by common reporters such as educators, counsellors, home visitors and medical providers. Medical offices are incorporating virtual visits, diminishing essential personal contact with children and their caregivers. Additionally, new virtual platforms for learning and more time online expose our children to predators. How can we keep our children safe?

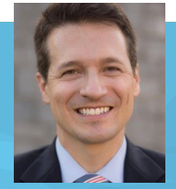
We must remember that not all homes are safe. The majority of school districts have gone to virtual platforms. While revolutionary in many ways, these platforms mean more time is spent at home and, with many parents still working, children are being left with unsafe or distracted caregivers. School may have been the only safe place for a child to have reprieve from the abuse that is occurring at home. With confinement to the home, abusers have more access to them. Additionally, online predators are becoming more aggressive during the pandemic. More than 500,000 predators are online every day. One in seven youth are contacted by an internet predator with girls making up 78% of child victims. This situation is why education regarding online predators should be discussed with families.

We should also not forget about food poverty as one in four Georgia children live in food insecure homes. School may provide their only meals for the day and, although many schools have made it possible for families to obtain food, there are associated risks for infection exposure with these programs as well. All of these factors are concerning for the physical and mental health of our children.

Child abuse is a major concern during this pandemic. We as pediatricians must be exquisitely vigilant about checking on our families and offering support and resources. We are not alone in our stewardship over our patients. Even though life as we know it has changed, our resources are the same. If a pediatrician has concerns for abuse, the Division of Family and Children's Services (DFCS) has the 1-855-GA-CHILD (1-855-422-4453) hotline and are continuing to perform investigations and offer services. Prevent Child Abuse Georgia has a hotline (1-800-CHILDREN) that offers support to families and has multiple resources. There are 52 Children's Advocacy Centers throughout Georgia that have local resources to help families provide direction. Local law enforcement continues to provide welfare checks for families if there are concerns. Child Abuse Pediatricians located in Macon, Atlanta, Savannah and Augusta are available to offer support and information. The National AAP and Georgia AAP also have resources to help families and pediatricians. In short, we can and must to continue to be available for our children and families to ensure safety and protection so we can keep them safe.

Yameika Head, MD, FAAP
Child Abuse Pediatrician
Chair, Committee of Child Abuse and Neglect
Beverly Olson Children's Hospital
Macon

Child Abuse and COVID:
A Resident's Perspective



Ryan B. Davies, MD
PGY-III Chief Resident

In our resident clinics we collectively see hundreds of thousands of children. They come smiling and playful or apprehensive and screaming. We talk about sports, school, friends, and joke about what we find in their ears or hear in their bellies. As we transition to teen years our questions become more serious and conversations can become more embarrassing. These discussions, however, are essential to their evolving care.

There is danger in letting these conversations become routine because they, like the patient, change. Questions about school performance can quickly lead to talks about bullying, problems at home, or disclosure of abuse. I recall a conversation with a patient of mine who admitted that her father often choked and slammed her against the wall. Afterwards, she begged me not to tell anyone because she feared repercussions and asserted it was her fault for provoking him. On exam, there was evidence supporting her accusation and I was left with the dilemma of how to ensure my patient's safety with the accused abuser, who was unaware, literally waiting on the other side of the door.

There is danger in letting these conversations become routine because they, like the patient, change. Questions about school performance can quickly lead to talks about bullying, problems at home, or disclosure of abuse.

In the midst of the stressors of the current global pandemic, probing questions and frank conversations with our patients are more important than ever. The CDC estimates at baseline that at least 1 in 7 children is a victim of abuse or neglect and that those from lower socioeconomic populations are 5 times more likely to suffer abuse than their more financially secure peers. The pandemic environment expands this at-risk population by compounding financial stressors of underemployment and employment-related infection risks with preexisting relationship discord. Infection-control measures, while necessary, disturb access to social support institutions (family, school, child care, community and religious organizations), leaving at-risk families or individuals with limited access to resources. Confinement augments the concern for limited disclosure opportunities and more online time with distracted or absent parental supervision gives sexual predators broader access to potential victims.

The AAP recently published a call to action on childhood sexual abuse, which begins with the line, "Every one of my doctors failed me." This is a powerful and somber statement regarding our stewardship. Asking appropriate open-ended questioning, building rapport, and using the physical exam as an opportunity to identify abuse and educate about body safety are all resources we have in this fight. Additionally, mentioned in this call to action is the use of a 17-item screener tool (currently undergoing randomized controlled trial) that we may potentially use to identify Adverse Childhood Events and thereby better advocate for our patients.

Despite current societal challenges, we cannot fail our patients. We must figuratively, through serious screening and patient education, and, when necessary, literally stand at the door between our patients and their abuser with the solemn responsibility to allow no harm.

Ryan B. Davies, MD
PGY-III Chief Resident, Pediatrics
The Medical Center Navicent Health
Macon

Nutrition Update – Fall 2020

Jay Hochman, MD

Several important nutrition articles have been published recently which may be of interest to Georgia pediatricians.

1. **<u>"Doggie Bag" Study for Celiac disease.</u> JA Silvester et al (Gastroenterol 2020; 158: 1497-99)** examined the gluten-free diet (GFD). 12 of 18 were exposed inadvertently to gluten within the 10-day study period due to food contamination. 25 of 313 (8%) of food samples from 9 participants had detectable gluten with a median of 11 parts per million. This study shows that a "GFD may be more aspirational than achievable, even by highly committed and knowledgeable individuals."

2. **<u>Milk consumption and health.</u> WC Willett et al (NEJM 2020; 182: 644-54)** Provide a provocative review on why a healthy diet may not need milk, especially in adolescents and adults. All the nutrients in milk can be obtained from other sources (including calcium and vitamin D). If the diet quality is low, especially for children, dairy foods can improve nutrition. However, "if diet quality is high, increased [milk] intake is unlikely to provide substantial benefits, and harms are possible."

3. **<u>Nutritional risks in adolescents after bariatric surgery.</u> S Xanthakos et al (Clin Gastroenterol Hepatol 2020; 18: 1070-81)** completed a multicenter prospective cohort study with 226 adolescents (mean age 16.5 years, mean BMI of 52.7) who had either Roux-en-Y bypass (RYGB, n=161) or vertical sleeve gastrectomy (VSG, n=67). Key findings:
   - After 5 years, 59% of RYGB and 27% of VSG had ≥2 nutritional deficiencies
   - The most prevalent deficiency was hypoferritinemia, which affected nearly twice as many RYGB recipients by Year 5 compared with VSG.
   - Vitamin B12 status likewise worsened disproportionately after RYGB, despite similar trajectories of weight loss after VSG

   Overall, this study shows that adolescents undergoing VSG had fewer nutritional deficiencies than RYGB and provides data supporting nutritional monitoring after bariatric surgery.

4. **<u>Reducing gastrostomy tube placement in children after failed swallow study.</u> M McSweeney et al (Pediatrics. 2020, 145: e20190325; DOI: https://doi.org/10.1542/peds.2019-0325)** developed a strategy to treat children <1 year of age conservatively who failed a video fluoroscopic swallow study (VFSS). If a VFSS was abnormal, then the child either was admitted to the hospital for a trial of nasogastric (NG) breastmilk or oral thickened formula with NG breastmilk. The patient then continued to work with a speech language pathologist (SLP). If a repeat VFSS showed improvement in the swallowing mechanism, then working with SLP and trialing with thickened feeds continued until the aspiration had resolved as demonstrated by VFSS. If a repeat VFSS still showed aspiration, however, a child was considered a candidate for gastrostomy placement. **Gastrostomy placement in this patient population fell from 10.9% at the beginning of the study to 5.2% at the end.** The patient group without gastrostomies had significantly less emergency room visits and hospitalizations compared to those children who had undergone gastrostomy placement.

5. **<u>Dave Stukus: Eczema rarely due to food allergies</u> Blog post: https://www.nationwidechildrens.org/family-resources-education/700childrens/2020/06/eczema-separating-fact-from-fiction** "About 40% of children with eczema have a mutation in a protein called filaggrin, which is important in reducing the gap between skin cells. If the skin barrier is disrupted then irritants and allergens are more likely to pass through and cause irritation, itching, and rash, but this is not the 'cause'…In rare instances, specific foods may be a major contributor to a child's eczema, but this is the exception and typically affects infants less than one year of age with truly unmanageable, severe eczema, despite good daily skin care… Breastfeeding mothers everywhere are incorrectly told to stop eating dairy or other foods to 'treat' their baby's eczema. Not only is this unnecessary for most mothers but can lead to significant problems."

6. **<u>Long-term outcome of celiac disease.</u> S Kroger et al (JPGN 2020; 71: 71-7) (n=906 children, from 1966-2014).** Key findings:
   - With more recent diagnosis (after 2006) children had milder histologic lesions, more often diagnosis due to screening (rather than symptoms) 30% vs. 25%, less anemia (16% vs 21%), less growth disturbances (22% vs. 36%), and lower TTG-2 titers (mean 64 U/L vs 120 U/).
   - Among adults, severity of villous atrophy at childhood diagnosis did not predict complications, persistent symptoms, quality of life, or adherence with gluten-free diet
   - Thus, severe villous atrophy due to celiac disease can respond fully to a gluten-free diet. (As an aside, children with IgA deficiency should not be offered a "no-biopsy diagnosis" **JPGN 2020; 71: 59-63.)**

Finally, one timely additional reference: **CV Almario et al (Am J Gastroenterol 2020 (pre-print posted online July 7, 2020)** found an increased risk of acquiring COVID-19 infection among users of proton pump inhibitors; the risk with once a day was 2.2-fold and with twice a day it was 3.7-fold.

Please contact me at jhochman@gicareforkids.com with questions and suggestions.

Jay Hochman, MD
Vice Chair, Committee on Nutrition, Georgia Chapter AAP
Blog site: gutsandgrowth.wordpress.com

AAP Names E-Cigarette Champions

Alice Little Caldwell, MD, MPH, IBCLC, FAAP

In response to the growing epidemic of youth e-cigarette use among youth and young adults, the American Academy of Pediatrics has appointed an E-Cigarette Champion for each of the 59 chapters in the U.S. The purpose of this network of E-Cigarette Champions is to educate pediatricians on the extent of the vaping epidemic, advise them on screening for smoking and vaping in clinical settings, give them the means to educate patients and their parents of the harms of vaping and help those to quit who have become regular users. Half of these newly installed Champions underwent two days of virtual training in July. The other cohort will have their training in November. I am currently the Georgia E-Cigarette Champion and the editor of the AAP Section on Tobacco Control newsletter. Please contact me at alicelittlec@gmail.com if you would like to work on this project.

The vaping epidemic has taken a back seat to the Coronavirus pandemic. Fortunately, the number of cases of E-cigarette or Vaping Associated Lung Injury (EVALI) has decreased, although they have not disappeared completely. There is no current data on e-cigarette use among youth and young adults during the pandemic; however, a recent article in the *Journal the of Adolescent Health* showed that young people (ages 13-24) who have ever used e-cigarettes have a 5 times greater chance of being diagnosed with SARS-CoV-2 and those who have ever been dual users of cigarettes and e-cigarettes have a 7 times greater chance.

(Gaiha et al. Association Between Youth Smoking, Electronic Cigarette Use, and Coronavirus Disease 2019)

To learn more about E-cigarettes & Vaping, plan to join me as I present, Webinar: *Update on E-Cigarettes & Vaping*, on Wednesday, October 14, 2020 from 12:30 – 1:30 pm.

Alice Little Caldwell, MD, MPH, IBCLC, FAAP
Associate Professor of Pediatrics, Medical College of Georgia
Member, Executive Committee, AAP Section on Tobacco Control
AAP Georgia E-Cigarette Champion
Augusta

Pocket Guide for E-cigarette Screening & Cessation

Below are some resources you can use to assist your patients.

Screen youth using the 5As Model:
Ask, Advise, Assess, Assist, Arrange follow-up
Discuss hazards of e-cigarette use: nicotine addiction, aggravation of asthma, effect on athletic performance, expense, EVALI, potential for more serious disease with COVID infection

Discourage experimentation and encourage cessation with the following aids:
<u>Georgia Tobacco Quit Line</u>: 1-877-270-STOP (7867) or for Spanish speakers: 1-877-2NO-FUME (1-877-266-3862) - free professional tobacco cessation for Georgia adults, pregnant women and teens (ages 13 and older) + 4-week supply of free Nicotine Replacement Therapy (ages 18 and older)

<u>This is Quitting</u>: www.thetruth.com/articles/hot-topic/quit-vaping (Text DITCHJUUL to 88709)

<u>Smokefree Teen</u>: sponsored by the National Institute of Health (Go to teen.smokefree.gov/)

Nicotine Replacement Therapy (NRT):
AAP policy recommends consideration of off-label use of NRT for moderately to severely nicotine addicted youth (may require prescription < 18 years of age)

- Patches come in 3 concentrations: 7 mg, 14 mg, 21 mg – can combine patch with short-acting form of NRT such as gum or lozenge; consider preloading with nicotine patch prior to quit date
- Nicotine gum (OTC 2 or 4 mg) – park and chew, avoid acidic beverages for 15 minutes before and during chewing gum
- Lozenge (2 or 4 mg) – allow to dissolve slowly in the mouth over about 30 minutes; do not chew or swallow – use every 1-2h for first 6 wks, then every 2-4h for 3 wks, then every 4-8h for 3wks

For more information: www.cancer.org/healthy/stay-away-from-tobacco/guide-quitting-smoking/nicotine-replacement-therapy.html

The Evolution of ECMO and Further Training in Advanced Technologies

Matthew Paden, MD

Lisa Lima, MD

Before the current coronavirus pandemic few people outside of the intensive care unit had heard of Extracorporeal Membrane Oxygenation (ECMO). In recent months, however, ECMO has been making the national spotlight on a routine basis with stories ranging from how care is rationed to ECMO to supporting a woman requiring a double lung transplant after COVID-19 severely damaged her lungs.

ECMO utilization has been increasing in adult patients since the early 2000's but initially made its foothold as a feasible life support technology in neonatal and pediatric patients. The pediatric intensive care unit at Children's Healthcare of Atlanta at Egleston is one of two pediatric and neonatal ECMO centers providing care for critically ill children in the state of Georgia. (The other is the Medical College of Georgia in Augusta.) Children's Healthcare of Atlanta is one of eleven Children's Hospitals in the United States to be awarded the Platinum Center of Excellence by the Extracorporeal Life Support Organization, an award signifying commitment to high level performance, innovation and quality care.

Children's Healthcare of Atlanta is one of eleven Children's Hospitals in the United States to be awarded the Platinum Center of Excellence by the Extracorporeal Life Support Organization, an award signifying commitment to high level performance, innovation and quality care.

Patients are considered for ECMO candidacy when their risk of mortality approaches 80% with conventional treatment and if the process leading to respiratory failure, cardiac failure or both is considered reversible. Early consideration of transfer to an ECMO center, however, is suggested in cases of severe illness or where a rapid escalation in supportive medical therapy is needed in order to facilitate safe transport and allow time for evaluation by the ECMO center. Egleston's ECMO program can support patients needing cardiac support (venoarterial ECMO), bypass of the lungs (venovenous ECMO generally) or support of both the heart and lungs. Our cardiac ECMO program has approximately 30 ECMO cases per year with survival rates of close to 50%. Indications for cardiac ECMO include myocarditis or cardiomyopathy, uncontrolled arrhythmia, and failure to separate from cardiac bypass post-surgery for congenital heart disease, among others. Our pediatric respiratory failure patients generally require ECMO due to viral or bacterial pneumonia. Other less common indications include pulmonary hemorrhage, asthma non-responsive to conventional therapy, and pulmonary emboli. Survival rates are around 75% or higher depending on the underlying indication. We also care for neonates who most frequently require ECMO for congenital diaphragmatic hernia, meconium aspiration syndrome and persistent pulmonary hypertension of the newborn (or persistent fetal circulation). These patients also have varying survival rates depending on the underlying indication, ranging from 50-90%.

There have been many advances in the ECMO field that have improved the circuit technology, improved quality of life and family interactions while on ECMO, in addition to improving patient outcomes. Innovative cannula design allowing easier patient mobilization, more compact ECMO pumps and increased provider experience have promoted protocols affording decreased sedation and neuromuscular blockade utilization resulting in increased mobilization of patients. These advancements have allowed patients who would previously be lying in bed with minimal to no interaction with their family for potentially weeks at a time while on ECMO to be more alert and interactive. Additional benefits include improved physical strength and conditioning which ultimately lead to faster recovery and decreased rehabilitation needs after ECMO support is no longer required.

ECMO is a rapidly evolving and increasingly complex field with a human mechanical interface leading to nuances in management not generally accounted for in critically ill patients. For example, a child's temperature is artificially regulated (the blood needs to be heated for the child to maintain a normal body temperature) due to the volume of blood outside of the patient in the ECMO circuit. There is also an inflammatory component with altered immunoregulatory effects due to contact of the patient's blood with the plastic circuit. These two factors make accurately detecting infection while a patient is on ECMO more challenging. From a surgical

The Evolution of ECMO

Continued from previous page.

standpoint, proper cannula placement and securement in tiny vessels is a technical procedure requiring finesse and precision. As the adoption of ECMO continues to increase and its utilization evolves, the Emory University School of Medicine saw a window to contribute to the knowledge and training of future critical care and surgical physicians by implementing a 1-year ECMO and advanced technologies fellowship starting this year in 2020. This fellowship will be offered to surgical, pediatric critical care, and neonatology fellows to include training on the intricacies of ECMO cannulation and patient management on ECMO in addition to other advanced technologies including continuous renal replacement therapy and plasma exchange.

Lisa Lima, MD
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Children's Healthcare of Atlanta

Matthew Paden, MD
Associate Professor of Pediatrics
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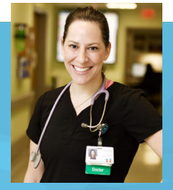
Safe Sleep Corner:
Since there's no back to school, let's go back to sleep…



Sarah Lazurus, DO

The Center for Disease Control and Prevention (CDC) defines sudden unexpected infant death (SUID) as "the sudden death of an infant under 1 year of age that cannot be explained after a thorough investigation." SUID is routinely classified as one of these: 1) sudden infant death syndrome (SIDS), 2) accidental suffocation and strangulation in bed (ASSB), or 3) death from unknown causes. Each year, around 4,000 U.S. babies die from SUID, making it an important topic to understand and effect change. In Georgia, there are three deaths every week from SUID. Between 1990 and 1999, the SUID rate drastically declined following numerous safe sleep campaigns, the most notable being the "Back to Sleep" campaign in 1994. In 2012, the AAP expanded their focus to include environmental recommendations (such as sleep location and environment) and renamed it the "Safe to Sleep" campaign. Since 1997, SIDS deaths have become less common; however, rates of infant death due to unknown causes and ASSB are stagnant. With proper safe sleep education and adherence to the American Academy of Pediatrics (AAP) safe sleep recommendations, the risk of sleep-related infant death can be reduced.

To reduce sleep deaths, the AAP's ABCs of sleep are paramount:
A = place infants **Alone**, **B =** on their **Back,** and **C =** in a clear **Crib** with only a firm mattress and a tight-fitting sheet.

In 2016, the AAP updated their sleep recommendations as follows:

1) Back to sleep for every sleep: Head of bed elevation has not been found to be protective against reflux, so it is no longer recommended!

2) Use a firm surface covered by a fitted sheet: no soft bedding, no bumpers, and cribs must meet CPSC requirements. NO sleeping in car seats, swings, or carriers.

3) Breastfeed: At least until 6 months if possible; 12 months is even better!

4) Room-sharing without bed sharing: A child's crib should be in the caregiver's room, ideally until 12 months (but if you can make it to 6 months, that's great!)

5) Keep everything out of the crib: no blankets or pillows, place in a sleep sack. Swaddling has not been found to be protective against SUID.

6) Consider offering a pacifier: they are protective against SUID. The mechanism is unclear, but even if they fall out, they are still protective.

7) Avoid smoking, drug use and alcohol during pregnancy and the newborn period (AND bed-sharing is strictly prohibited).

8) Avoid over-heating and head-covering in newborns: once the newborn can regulate temperature, stop covering the head and avoid over-bundling (no more than one layer over what parents are wearing).

9) Pregnant women should get routine prenatal care.

10) Vaccinate per the CDC/AAP guidelines.

11) Avoid use of devices that go against these regulations (bumpers/dock-a-tots).

12) Do no use cardio-respiratory monitors because they do not prevent SIDS (owlets).

13) Recommend supervised tummy time.

14) Always model safe sleep: NICU's should model these recommendations as soon as the patient is stable. Nurseries should model immediately. All daycares should model with every sleep.

Question: Which of the following has not been found to be protective against SUID?

A) Pacifiers **B)** Breast-feeding
C) Hats **D)** Routine vaccinations
E) Room-sharing without bed-sharing

Answer is C:
All but hats have been found to be protective. We recommend not overheating babies, and although hats may be used in the immediate newborn state, once babies are regulating their temperatures well, head coverings are not necessary and may lead to overheating, or can tug over the nose, which can put at risk for suffocation.

Question: What type of reflux precautions are recommended?

A) Holding upright for 30 minutes after feeds
B) Putting books under infant mattress to keep the head of bed inclined
C) Putting infants to sleep in an inclined sleeper or car seat
D) Putting infants to sleep in an infant swing
E) Elevated head of bed to prevent reflux is no longer recommended due to higher risk of SUID

Answer is E.

Sarah Lazurus, DO
Pediatric Emergency Medicine Physician
Children's Healthcare of Atlanta
Atlanta

Create a **Safe Sleep Environment** for Baby

Did you know that the features of your baby's sleep area can affect his/her risk for **Sudden Infant Death Syndrome (SIDS)** and other sleep-related causes of infant death, such as suffocation?

Reduce the risk of SIDS and other sleep-related causes of infant death by **creating a safe sleep environment** for your baby.

How can you make a **safe sleep environment**?

- Always place baby **on his or her back** to sleep for all sleep times, including naps.

- Have the baby **share your room, not your bed.** Your baby should not sleep in an adult bed, on a couch, or on a chair alone, with you, or with anyone else. Try room sharing—keeping baby's sleep area in the *same* room next to where you sleep.

- Use a **firm sleep surface**, such as a mattress in a safety-approved* crib, covered by a fitted sheet.

- Keep soft objects, toys, pillows, crib bumpers, and loose bedding **out of your baby's sleep area.**

- Dress your baby in **no more than one layer of clothing more than an adult would wear** to be comfortable, and leave the blanket out of the crib. A one-piece sleeper or wearable blanket can be used for sleep clothing. Keep the room at a temperature that is comfortable for an adult.

Safety-approved* portable play yards can also provide a safe sleep environment for your baby. When using a portable play yard, always place baby to sleep on his or her back and keep toys, pillows, and blankets out of the play yard. These actions help reduce the risk of SIDS and other sleep-related causes of infant death.

***Visit** the U.S. Consumer Product Safety Commission website for more information about safety-approved baby sleep areas: http://www.cpsc.gov/en/Safety-Education/Safety-Education-Centers/cribs/

NIH *Eunice Kennedy Shriver* National Institute of Child Health and Human Development

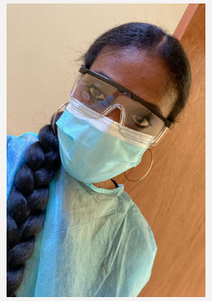
20th Anniversary SAFE TO SLEEP

Learn more about ways to reduce the risk of SIDS and other sleep-related causes of infant death at http://safetosleep.nichd.nih.gov

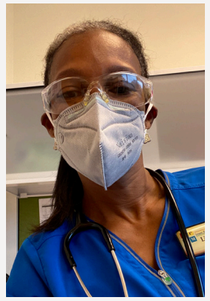
We asked you all to send your pictures/ selfies in PPE. Here are our members in their PPE taking care of Georgia's children!

Rebecca Reamy, MD,
Columbus

Don Batisky, MD,
Atlanta



Fiona Blair, MD,
Stone Mountain



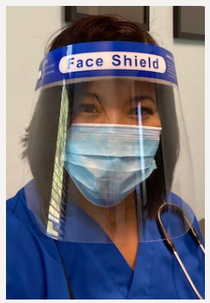
Lisa Roberts, MD,
Lawrenceville

Maria Coleman, MD,
McDonough

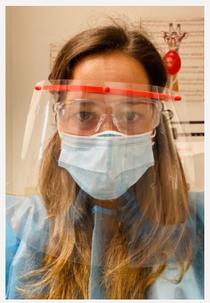
Jessie Brutus-Darius, MD,
Dunwoody

Amanda West, APRN, CPNP-PC
& Juliana Nahas, MD, Covington

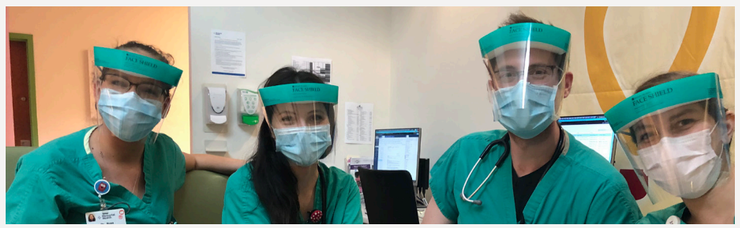
Keyana Washington, MD,
Dacula



Melinda Williams-Willingham,
MD, Clarkston



Natalia Benza, MD,
Dunwoody



Memorial residents:
L to R: Katie Ross MD, Lydia Davidson MD, Chris McConnell MD, Trish McLaughlin DO

Pediatrics and Genetics,
Alpharetta

Sylvia Washington, MD,
Rome

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Looking Ahead:

Join us for our upcoming virtual events!

Pediatrics on the Virtual Parkway:
Halloween Edition, Virtual Fall CME Meeting
October 31- November 1

To register for upcoming webinars, visit:
www.gaaap.org/upcoming-webinars

The Georgia Pediatrician is the newsletter of the Georgia Chapter/American Academy of Pediatrics
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Visit the Chapter Website for details on Chapter events. www.GAaap.org
Call (404) 881-5020 for more information.