

# Georgia Chapter

American Academy of Pediatrics

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# The GEORGIA Pediatrician

A Publication of the Georgia Chapter of the American Academy of Pediatrics

## President's Letter



**Angela  
Highbaugh-Battle,  
MD, FAAP**

I hope you are enjoying the beautiful spring that Georgia is known for giving. Soon, I will get to see many of you in Amelia Island at our annual CME meeting, Pediatrics By the Sea. The meeting will have fantastic educational sessions.

It will also be a great time to network with colleagues and even relax with friends and family. I will officially pass the gavel to President-Elect Dr. Nicola Chin of Atlanta. I look forward to all of the festivities. Serving as your President has been the honor of my career. I love the practice of pediatrics. My involvement with the Georgia Chapter has enabled me to find fulfillment in pediatrics outside my office practice. I decided that I would use my last President's column to share with you why I became a pediatrician in the first place.

My "why" started 30 years ago as a high school freshman. I had broken my arm while cheerleading and had to stay overnight in the hospital after surgery. I shared a room with a much younger child. I did not rest well because I was in pain and woke up several times that night. My roommate's mother seemed worried and tended to him all night. She was awake each time I opened my eyes. The following morning, a group of hospital personnel came to talk to the mother. It was immediately clear that English was not her first language. She was being asked about their

**My term as President taught me that pediatricians have an incredibly important voice for all children. We already exercise that voice in our office and hospital interactions daily. We must also be heard throughout our communities, schools, and local, state, and federal policy-making bodies.**

insurance status. She seemed to try to explain that her husband, who worked out of town, managed that for their family. She insisted that they had insurance. She was informed that they would need to transfer her child to another hospital because she could not prove they had insurance.

As a 14-year-old kid, I was in disbelief. I was shocked and saddened that this could happen to a child. While I had always planned to be a doctor, I made up my mind at that moment that I would be a pediatrician. I thought that if I could be on the front lines, I could help make decisions to ensure children could get the care they needed. To my 14-year-old brain, it seemed simple enough: if children need care, give it to them. Provide the very best care right where they are.

I am quite proud to write that I have had the opportunity to make some patient-focused decisions in my career. I have gotten to exercise the power that comes with simply being at the table when making decisions. I am reminded of my "why" each time I see an unjust healthcare situation. At this stage in my

*Continued on next page.*

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career, it is clear that the solutions may truly not be easy, but they are possible.

My term as President taught me that pediatricians have an incredibly important voice for all children. We already exercise that voice in our office and hospital interactions daily. We must also be heard throughout our communities, schools, and local, state, and federal policy-making bodies. Pediatricians understand that one does not have to greatly impact one person, group, or agency. Even a small positive impact on a child can change the world for the better. I am proof of that. I do not think that I have changed the world (yet). Clearly, that one experience in the hospital determined the trajectory of my whole life and ultimately brought me to this moment!

**Pediatricians understand that one does not have to greatly impact one person, group, or agency. Even a small positive impact on a child can change the world for the better. I am proof of that.**

I appreciate the support that I have received during this Presidency. I hope you take the time to reflect on your own “why” that brought you to pediatrics. Please make sure that you continue to work to meet it. The fulfillment I get from it pays dividends to my soul, and I am optimistic it will do the same for you!



**Angela Highbaugh-Battle, MD, FAAP**





# Reach Out and Read



Catherine Turingan  
Mauer, MD, FAAP

Growing up in the Philippines, I usually spent my summer vacations at my grandparents' farm in the province, north of Manila. My family had limited means and my grandparents were the cheapest destination when school was out. The farm of my grandparents, however, was a fun place. I always looked forward to visiting them and my relatives.

I fondly remember how I enjoyed my time there, playing outdoors with my cousins, helping in the farm, riding the carabao, swimming in the pond - with the carabao - and just immersing myself with the farmers' life in rural Philippines.

One day I was bored and just curiously looking around in the living room when I found something truly exciting - a comic book! I opened the cover and started reading. I loved it instantly and read it several times. Then I looked everywhere to see if there was more hidden stuff to read. To my disappointment there were none. In my young mind I thought that was unfair. I wished so much I had more books to read.

This is the story I shared when I applied to be a site for the Reach Out and Read program. A child should not feel deprived of the wonderful world of reading.

First, I was hesitant to apply as there were added logistics and changes in the workflow in the clinic required to implement the program. I was also concerned about the funding needed to buy the books. Eventually I decided it was the right thing to do. I realized it has a high return on investment in several ways.



**Several large US and international studies showed that early reading has a measurable positive effect on a child's cognitive abilities and psycho-social development. A child who is read to is smarter and more successful in school.**

When we did get approved as a Reach Out and Read site, we were the first practice to start it in our county. Initially we found it a bit awkward to incorporate the books in the well check visits, given the time constraints we have in our day-to-day operations. However, with training and support from the entire Reach Out and Read team and growing routine, we became efficient Reach Out and Read jugglers. While presenting the book to the child and parents, we observe the response and interaction as part of the examination, where we are assessing growth as well as development. Anticipatory guidance includes sharing with parents the importance of reading to their child at a critical time of brain development. Several large US and international studies showed that early reading has a measurable positive effect on a child's cognitive abilities and psycho-social development. A child who is read to is smarter and more successful in school. Especially in households where both parents are working and squeezed for time for themselves and their children, reading is quality time spent together. It is also fun for all involved and creates trust between child and reader.

In the light of the increasingly excessive time our children spend on using digital media, with all its negative consequences, it is even more important to encourage our families to read with their kids.

We have been in practice long enough that we now see our second-generation patients. For these parents, they know the "drill" when we share the book with their child, reminiscing about their own childhood filled with books and how it has positively shaped their own lives.

Personally, I made it a point to practice what I preach and read early on with our own child.

As for me, and the child in me, it is never too late to catch up with the wonderful world of reading with its imaginable adventures!

**Catherine Turingan Mauer MD, FAAP**  
The Kids Specialists – Henry Pediatrics, LLC





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# American Academy of Pediatrics Advocacy Conference

Washington, D.C., April 14–16, 2024



**Alice Little Caldwell,  
MD, MPH, IBCLC, FAAP**

Thirteen members of the Georgia Chapter AAP, along with Dr. Melinda Williams-Willingham, Chair of the AAP Committee on Federal Government Affairs and Co-Chair of the conference, attended the AAP Advocacy Conference 2024 in Washington, D.C. We represented all levels of training from Pediatric residents and fellows to Sub-Specialty pediatricians and Pediatric faculty at Emory, Morehouse and the Medical College of Georgia. After two days of instruction about advocacy on the national level, our group set out for Capitol Hill. Our mission was to talk with Georgia members of the Senate and House of Representatives about three upcoming pieces of legislation:

- The Children's Online Safety Act (KOSA), which deals with design elements of social media, which can lead children to compulsive use and direct them to unsafe sites
- Children's Online Privacy Protection Act 2.0 (COPPA 2.0), which updates and expands protections of data collection from children without consent, bans data-driven targeted advertising, and creates an "Eraser Button," which allows children and teens to access, correct and delete personal data held by companies on them.
- Emergency Medical Services for Children (EMSC), which allocates funding to each state and territory to meet the needs of children that are tailored to their unique emergency care needs - children need different dosages of medicine, as well as specially designed or differently sized medical devices. It is a reauthorization bill that expires on 9/30/24.



Our meeting with Georgia Senator Raphael Warnock.

Front row: Dr. Celese Beaudreau, Dr. Heather Hirsch, Dr. Swati Chandhoke, Senator Warnock, Dr. Nicola Chin, Dr. Alice Little Caldwell, Dr. Nadine Najjar

Back row: Dr. Amanda Kuhn, Dr. Terri McFadden, Dr. Anna Rodenbough, Dr. Alexandra Collins, Senator Warnock, Dr. Keisha Fraser Doh, Dr. Shuai Hao, and Dr. Andrew Potter.



Our meeting with Representative Rick Allen from the 12th Congressional District from Georgia.

From left to right: Dr. Shuai Hao, Dr. Alice Little Caldwell, Rep. Rick Allen, Dr. Celese Beaudreau, Dr. Keisha Fraser Doh, and Dr. Nadine Najjar.



Our meeting with Iyana Kollock, the House Legislative Assistant for Rep. Nikema Williams of the 5th Congressional District of Georgia.

Front row: Dr. Hirsch, Ms. Kollock, Dr. Collins and Dr. Chin

Back row: Dr. Chandhoke, Dr. Rodenbough, Dr. Potter, Dr. Kuhn, Dr. McFadden

## **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**





# Dairy Foods and the African American Diet



**Winston Price**  
MD, FAAP

Health disparities, along with the millions of children in America who go to bed every night with hungry stomachs or poorly nourished bodies, continue to plague our nation. The National Medical Association (NMA) and the American Academy of Pediatrics have been strong advocates to address this issue from the grassroots level to the halls of Congress. Over the last several years, the increasing number of additional children, resulting from the international conflicts abroad, has added to the burden in our communities. There are many ways to address the root causes, the least of which are the myriad social determinants of health. The bottom line is helping families and communities meet economic challenges effectively and to widen access to the most cost-effective food choices to achieve good nutrition through the lifecycle, especially the 1st 1000 days of life.

Through the more than 20 years of research analysis conducted by the NMA, we are proud to promulgate the findings of our fourth and most recent Supplement of the Journal of the NMA entitled, "The role of dairy food intake for improving health among Black Americans across the life continuum."<sup>1</sup> Black Americans share greater burdens of discrimination, socioeconomic inequities, and health disparities compared to other racial or ethnic groups in the US.<sup>6</sup> Decades of health data show major health disparities occur at every life stage for Black Americans, beginning with greater maternal and infant mortality rates among Black mothers and their offspring and culminating in a higher burden of chronic disease and a significantly lower life expectancy.

A growing body of research shows that a healthy dietary pattern is one of the most important factors associated with increased longevity, improved mental health and immunity, and decreased risk for obesity and chronic disease.<sup>5,7-10</sup> Black populations tend to consume inadequate amounts of dairy foods relative to Dietary Guidelines for Americans (DGA) recommendations and simultaneously tend to consume excessive amounts of fast foods and sugar-sweetened beverages to a greater degree than most other racial or ethnic groups.<sup>5,11-13</sup> Given the complex relationships that Black populations have with dairy foods due to issues with lactose intolerance, and/or negative perceptions about the health effects of dairy foods, there is a need to examine the role that this food group plays in the health and well-being of Black Americans.

## FINDINGS

Compared to other food groups, dairy foods are some of the most accessible and affordable sources of essential nutrients like vitamin A, vitamin D, vitamin B12, calcium, magnesium, potassium, selenium, and zinc in the food supply,<sup>14,15</sup> as well as being some of the primary sources of several

health-promoting bioactive compounds, including polar lipids, bioactive proteins and peptides, prebiotic oligosaccharides, and live and active cultures in fermented products.<sup>16-23</sup> Given their distinctive combination of nutrients and bioactive compounds, the benefits of dairy foods are difficult to replace in healthy dietary patterns. The nutritional quality of plant-based alternatives is regarded as inferior to dairy foods<sup>24</sup>, and exclusive intake of these alternatives instead of dairy foods may carry serious health risks unless special care is taken to ensure adequate diet quality.<sup>25-30</sup> Likewise, dairy avoidance due to lactose intolerance may put Black populations at higher risk for inadequate intake of multiple micronutrients and several preventable diseases. Severely limiting or eliminating dairy foods from the diet is considered a poor management option for lactose intolerance as there are many options for individuals with lactose intolerance to meet dairy intake recommendations, such as selecting lactose-free products and fermented dairy products, regularly consuming small amounts of dairy foods throughout the day, consuming milk with meals, and/or by taking supplements that contain the lactase enzyme and/or lactic acid bacteria. The research findings from the extensive body of evidence on dairy and health outcomes over the last 10 years confirm the same benefits as those published a decade prior, indicating that higher total dairy intake, and especially higher fermented and fortified dairy intake, is consistently associated with reduced risk for many of the commonly occurring chronic diseases that impact Americans as well as those that disproportionately impact Black Americans.<sup>31-32</sup>

## CONCLUSIONS

As a nation we must do better to address the core elements responsible for our health disparities, which include factors such as systemic racism, low socioeconomic status, food insecurity, poor access to healthcare, and unhealthy dietary habits. While many of these inequities must be addressed at the state or national level, there are certain modifiable risk factors, such as improving dietary patterns, that hold massive potential for improving health and well-being across the life course. Important dietary modifications for Black Americans, such as improving adherence to DGA recommendations for dairy food and nutrient intakes, limiting intake of fast foods and sugar-sweetened beverages, and properly diagnosing and managing lactose intolerance, can help reduce health disparities and lead to improvements in health span and life span. Therefore, evidence-based, and culturally appropriate strategies for addressing barriers to healthy eating, especially for dairy foods, are gravely needed to improve health equity for this population. We should support AAP in efforts to assure that patients are screened for food insecurity.

## Winston Price, MD, FAAP

Associate Professor, Department of Pediatrics  
Philadelphia College of Osteopathic Medicine

Sources: <https://www.sciencedirect.com/science/article/pii/S0027968424000178> & <https://publications.aap.org/aapnews/news/22384/White-House-spotlights-AAP-initiative-to-reduce>



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# Nutrition-GI Update

## SPRING 2024



Jay Hochman,  
MD

Important nutrition information has been published recently which may be of interest to Georgia pediatricians.

### 1. Increasing Prevalence of Steatotic (Fatty) Liver Disease and New Terminology

*P Hartmann et al. Hepatology 2023; 78: 1168-1181.*

**Open Access! Global and national prevalence of nonalcoholic fatty liver disease in adolescents**

The Global Burden of Disease (GBD) Study is the most comprehensive and long-standing effort to collate data systematically and scientifically on hundreds of diseases and injuries across the globe, including related clinical outcomes. Beginning in 1990, the GBD Study initially collected data on 106 conditions and 10 risk factors, across 5 age groups. Key finding: The global prevalence of NAFLD in adolescents shows no sign of abating, rather it has continued to increase steadily from 3.7% in 1990 to 4.7% in 2019.

*M Rinella et al. Hepatology 2023; DOI: 10.1097/HEP.0000000000000520.*

**Open access! A multi-society Delphi consensus statement on new fatty liver disease nomenclature**

Steatotic liver disease (SLD) was chosen as an overarching term to encompass the various etiologies of fatty liver disease.

#### Key Recommendations:

- The name chosen to replace NAFLD was metabolic dysfunction-associated steatotic liver disease (MASLD).
- Metabolic dysfunction-associated steatohepatitis (MASH) is the replacement term for NASH.
- Those with no metabolic parameters and no known cause were deemed to have cryptogenic SLD (steatotic liver disease).
- A new category, outside pure MASLD, termed MetALD was selected to describe those with MASLD who consume greater amounts of alcohol per week.

Currently, there are no approved treatments for MASLD/MASH. There are, however, several promising therapeutics including GLP-1 receptor agonists (e.g., semaglutide, liraglutide, and tirzepatide) and resmetirone (SA Harrison et al. NEJM 2024; 390: 497-509), which is a thyroid hormone receptor beta-selective agonist.

### 2. Stunting in Cystic Fibrosis Patients in Later Diagnosis Cohort (even 1 month makes a difference)

*SL Martiniano et al. J Pediatr 2023; 262: 113595.*

**Late Diagnosis in the Era of Universal Newborn Screening Negatively Affects Short- and Long-Term Growth and Health Outcomes in Infants with Cystic Fibrosis**

Using the U.S. Cystic Fibrosis Foundation patient registry (CFFPR), the authors examined children born between 2010-2018 who were diagnosed based on newborn screening (NBS). Age at first event (AFE) serves as a proxy for when CF care was likely initiated. Patients were divided into 3 cohorts based on AFE: <14 days (early cohort), 14 days to <33 days, and 33 days or more (late cohort).

#### Key Findings:

- Pulmonary exacerbations were reported as the reason for hospitalization in 59.1% of late cohort compared with 4.8% of early cohort with hospitalization as their first CF event.
- Height-for-age z-scores were consistently lower in the late cohort. At 1 year and 5 years, median z-scores were -0.6 (vs. -0.42) and -0.26 (vs. -0.12 in early group) respectively.

The authors note that the early and late groups had differences in parental education attainment which “may be evidence that the late cohort had lower socioeconomic status that could have resulted in barriers to timely evaluation.” This study confirms the following:

1. NBS/early identification has clear benefits.
2. There is a need to quickly get suspected patients seen by CF centers. A 1-month delay in diagnosis can result in early hospitalization and stunted growth for at least 5 years.

### 3. Cow's Milk Protein Intolerance Education

There is a pediatric GI podcast called “Bowel Sounds.” The episode with Victoria Martin is a terrific update on cow's milk protein intolerance for pediatricians and pediatric gastroenterologists.

Dr. Martin emphasized the importance of challenging patients receiving restricted diets earlier and that prolonged restrictions can increase the risk of life-long food allergies (as well as costs). In those with mild symptoms, it may be reasonable to watch without intervention, especially in breast-fed infants.

Find the episode at: <http://buzzsprout.com/581062/12503492>



## Nutrition-GI Update

Continued from previous page.

### 4. Best Diet for Irritable Bowel Syndrome

*A Rej et al. Clin Gastroenterol Hepatol 2022; 20: 2876-2887.  
Open Access! Efficacy and Acceptability of Dietary Therapies  
in Non-Constipated Irritable Bowel Syndrome: A Randomized  
Trial of Traditional Dietary Advice, the Low FODMAP Diet,  
and the Gluten-Free Diet*

The “traditional dietary advice” (TDA) group: “Its principles include adopting healthy, sensible eating patterns such as having regular meals, never eating too little/too much, maintaining adequate hydration, and reducing the intake of (1) alcohol/caffeine/fizzy drinks, (2) fatty/spicy/processed foods, (3) fresh fruit to a maximum of 3 per day, (4) fiber and other commonly consumed gas-producing foods (e.g., beans, bread, sweeteners), and (5) addressing any perceived food intolerances (e.g., dairy).” This study randomized 99 adult patients with non-constipation IBS to one of three diets.

#### Key findings:

- All three diets resulted in improvement. The primary end point of  $\geq 50$ -point reduction in IBS-SSS (IBS-symptom severity score) was met by 42% (n = 14/33) undertaking TDA, 55% (n = 18/33) for low FODMAPS diet, and 58% (n = 19/33) for gluten-free diet (P = .43) (which allowed for cross-contamination).

### 5. Arching in Infants is Not Likely Due to Reflux

*M Njeh, S Jadcherla et al. J Pediatr 2024; 264: 113760.  
The Irritable Infant in the Neonatal Intensive Care Unit: Risk  
Factors and Biomarkers of Gastroesophageal Reflux Disease*



This study analyzed “pH impedance testing in the NICU in 516 infants with symptoms of arching and irritability. A nurse was assigned to document episodes of arching and irritability during the study.”

#### Key findings:

- Acid reflux and impedance bolus characteristics were not significantly different between infants with  $>72$  and  $\leq 72$  arching/irritability events (P  $\geq .05$ )
- Arching/irritability events had an 8% sensitivity for reflux (3062/39,962). The specificity of arching/irritability for NOT being reflux was 94% (246,462/262,534)

This study indicates that empiric treatment should not be used when arching/irritability is present. Furthermore, reflux medications have NOT been shown to be effective in infants (despite increasing usage).

Contact [jhochman@gicareforkids.com](mailto:jhochman@gicareforkids.com) with questions and suggestions.

#### Jay Hochman, MD

Vice Chair, Committee on Nutrition, Georgia Chapter AAP  
Blog site: [gutsandgrowth.com](https://gutsandgrowth.com)



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# Preventing Measles



Iyabode Akinsanya-Beysolow,  
MD, MPH, FAAP

Globally and nationally, we have seen a recent surge in measles cases. In the U.S., over 60 measles cases have been reported in 2024 (data<sup>1</sup> accessed March 29, 2024). This number of cases has not been seen since the 121 cases reported in 2021 and the 1274 cases during measles outbreaks in the U.S. in 2019. Per CDC's Health Alert Network<sup>2</sup> (HAN) report in March 2024, of the 58 cases reported thus far in 2024, 54 (93%) were linked to international travel, and most cases had been among children aged 12 months and older who had not received measles-mumps-rubella (MMR) vaccine. Declines in measles vaccination rates globally have increased the risk of measles outbreaks worldwide, including in the U.S.



Measles on the face

The AAP<sup>3</sup> and CDC ask providers to remain vigilant as measles cases increase across the US. One of the ways to do so is to remind ourselves of what measles looks like.

Measles is an acute viral respiratory illness. It is highly contagious and can lead to a febrile rash illness. Characteristics include a prodrome of



Measles on the trunk

fever (stepwise increase in fever to 103°F -105°F), malaise, the three “C”s - cough, coryza, and conjunctivitis, and a pathognomonic enanthem (Koplik spots – tiny blue-white spots on the bright red background of the buccal mucosa). The prodrome is followed by a maculopapular

rash, which begins on the head and face and then spreads downward over the trunk, arms, legs and feet and lasts for 5 to 6 days. The rash may become confluent as it spreads. The rash usually appears about 14 days after a person is exposed. The rash fades in the order it appears, from the head down to the extremities. However, some patients (e.g., immunocompromised) may not develop a rash.

Patients are considered contagious from 4 days before to 4 days after the rash appears. Measles is highly infectious. The virus is transmitted through direct contact with infectious droplets or through airborne spread when infected people breathe, cough or sneeze. It has a more than 90% secondary attack rate among exposed susceptible persons in close-contact settings. Measles virus can remain infectious in the air for up to two hours after an infected person leaves an area.<sup>6</sup>

Patients sometimes develop diarrhea or otitis media with measles. However, more severe complications such as pneumonia, encephalitis, subacute sclerosing panencephalitis (SSPE) or even death can occur. Patients at most risk of serious complications include children under 5 years of age, adults 20 years and older, pregnant people and people who are immunocompromised.

**Prevention of measles: what vaccines are recommended to prevent measles, and when measles is more likely to spread and cause outbreaks in U.S. communities where groups of people are unvaccinated.**

Measles is nearly entirely preventable through vaccination (2 doses being 97% effective and one dose 93% effective against measles<sup>6</sup>). CDC reports:<sup>2</sup> “When more than 95% of people in a community are vaccinated (coverage >95%), most people are protected through community immunity (herd immunity). However, vaccination coverage among U.S. kindergartners has decreased from 95.2% during the 2019–2020 school year to 93.1% in the 2022–2023 school year, leaving approximately 250,000 kindergartners susceptible to measles each year over the last three years. Thirty-six states plus the District of Columbia (DC) had less than 95% MMR coverage among kindergartners during the 2022–2023 school year. Of states with less than 95% MMR coverage, ten reported more than 5% of kindergartners had medical and nonmedical exemptions, highlighting the importance of targeted efforts at increasing vaccine confidence and access.”

**Routine vaccination for children<sup>7</sup>:**

- CDC recommends that providers administer a 2-dose series to children, with the first dose at 12 through 15 months old and the second dose at 4 through 6 years old.



# Measles

Continued from previous page.

- MMR or MMRV may be administered.

**Note:** For the first dose in children 12–47 months old, it is recommended that MMR and varicella vaccines be administered separately. MMRV may be used if parents or caregivers express a preference. The minimum interval between doses of MMR vaccine is 4 weeks. If MMRV is used, the minimum interval between MMRV doses is 3 months.

## Catch-up vaccination for children and adolescents<sup>7</sup>:

Unvaccinated children and adolescents: Administer a 2-dose series; administer doses at least 4 weeks apart.

**Note:** If MMRV is used, the minimum interval between doses is 3 months. The maximum age for using MMRV is 12 years.

## Special Situations<sup>7</sup>:

### International travel

- Infants 6–11 months old: Administer 1(one) dose before departure. However, doses of MMR vaccine administered before 12 months old should not be counted as part of the routine 2-dose series. Children vaccinated before 12 months old should be revaccinated with a 2-dose series, with a dose at 12–15 months old (12 months for children in high-risk areas) and dose 2(two) as early as four weeks later. (Note: If MMRV is used, the minimum interval between MMRV doses is 3 months.)
- For unvaccinated children, 12 months and older, who are traveling internationally, administer a 2-dose series (doses at least four weeks apart) before departure. (Note: If MMRV is used, the minimum interval between MMRV doses is 3 months.)

### Persons without evidence of measles immunity<sup>6</sup>:

- People born in 1957 or later who do not have evidence of immunity against measles should get at least one dose of the MMR vaccine.
- Two doses of the MMR vaccine are recommended for students entering colleges, universities, technical and vocational schools, and other post-high-school educational institutions who do not have evidence of immunity against measles, with the second dose administered no earlier than 28 days after the first dose.

Healthcare personnel should have documented evidence of immunity against measles, according to recommendations from the ACIP.

Per the CDC<sup>6</sup>, acceptable presumptive evidence of immunity against measles includes at least one of the following:

- written documentation of adequate vaccination
- serologic evidence of immunity
- laboratory confirmation of measles
- birth before 1957 (Note: Healthcare personnel<sup>8</sup> should follow CDC recommendations)<sup>9</sup>.

Healthcare providers and health departments should not accept verbal reports of vaccination without written documentation as presumptive evidence of immunity. For additional details about evidence of immunity

## What to do if you suspect a case of measles in your setting

- Immediately mask and isolate the patient in a room with a closed door (negative pressure room if available). Follow standard and airborne precautions.
- Only healthcare workers with presumptive evidence of measles immunity should attend to the patient; they must use N-95 masks.
- Evaluate the patient and perform collections for measles confirmatory testing (collect a throat or nasopharyngeal swab for RT-PCR and serum for IgM measles testing).<sup>4</sup>
- Contact infection control if available at your facility or your local hospital.
- Contact your local and/or state health department and report this suspected case immediately.

Source: <https://www.cdc.gov/measles/downloads/Measles-fact-sheet-508.pdf>

criteria, see Table 3 in Prevention of Measles, Rubella, Congenital Rubella Syndrome, and Mumps, 2013: Summary Recommendations of the Advisory Committee on Immunization Practices (ACIP).

### Resources

- Contraindications and precautions to use of MMR/MMRV vaccine: <https://www.cdc.gov/vaccines/vpd/mmr/hcp/recommendations.html>
- Post-exposure prophylaxis guidelines for people exposed to measles: <https://www.cdc.gov/vaccines/vpd/mmr/hcp/recommendations.html>
- CDC: Video, Measles Clinical Features and Diagnosis <https://www.youtube.com/watch?v=3HFeQEciDVY>
- ACIP: Measles Vaccine Recommendations <https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/mmr.html>
- CDC: Provider Resources for Vaccine Conversations <https://www.cdc.gov/vaccines/hcp/conversations/index.html>

### Sources

1. CDC: Measles Cases and Outbreaks: <https://www.cdc.gov/measles/cases-outbreaks.html>
2. CDC: HAN Report Measles March 18, 2024: <https://emergency.cdc.gov/han/2024/han00504.asp>
3. AAP: Red Book Online Outbreaks: Measles: <https://publications.aap.org/redbook/resources/15187/Red-Book-Online-Outbreaks-Measles>
4. CDC: Specimen Collection, Storage and Shipment: <https://www.cdc.gov/measles/lab-tools/rt-pcr.html>
5. CDC: Fact Sheet, Measles: <https://www.cdc.gov/measles/downloads/Measles-fact-sheet-508.pdf>
6. CDC: Measles Information for Healthcare Providers: <https://www.cdc.gov/measles/hcp/index.html#vaccination>
7. CDC: Childhood Immunization Schedule: <https://www.cdc.gov/vaccines/schedules/hcp/imz/child-schedule-notes.html#note-mmr>
8. CDC: The Pink Book, Measles Chapter: <https://www.cdc.gov/vaccines/pubs/pinkbook/meas.html>
9. CDC: Immunization of Healthcare Personnel: <https://www.cdc.gov/mmwr/pdf/rr/rr6007.pdf>

## Iyabode Akinsanya-Beysolow, MD, MPH, FAAP

Chair, EPIC Immunization Advisory Committee,  
Chapter Immunization Representative, AAP



# Welcome New Members

**Welcome to these new members, which includes medical students too, who have recently joined the Chapter. Your commitment to quality pediatric care enriches our team, and your support of the AAP mission is invaluable. Together, we'll positively impact children and families across Georgia. Thank you for joining the Georgia AAP family!**

Toycina Aguilh-Figaro MD *Acworth*  
 Isabelle Aldridge *Lebanon*  
 Rana Al-Jaberi MD *Atlanta*  
 Sarah Amaris *Moultrie*  
 Mary Lovett Anderson NP *Toccoa*  
 Sheba Antony MD *Acworth*  
 Lucy Avant *Acworth*  
 Adebisi Bamidele *Powder Springs*  
 Cia Bishop MD *Decatur*  
 Charlz Bisong *Jacksonville*  
 Jeana Bush MD *Macon*  
 Iagn Nino Kenji Cabahug *Pooler*  
 Emily Chu *Atlanta*  
 Jerrica Davis *Atlanta*  
 Dawn Embers MD *Fayetteville*

Nina Fainberg MD *Atlanta*  
 Joseph Felder *Atlanta*  
 Deshon Fisher *Far Rockaway*  
 Matthew Fults DO *Richmond Hill*  
 Hannah Gordon *Bartlesville*  
 Warren Grupe MD *Acworth*  
 Meena Gurbani MD *Sandy Springs*  
 KaBrea Jones *Fairburn*  
 Marvin Kolb MD *Atlanta*  
 Vidya Krishnamurthy MD *Alpharetta*  
 Valentina Larrivey *Owosso*  
 Jamie Lawson DO *Warrenville*  
 Emily Leshen MD, BS, MS *Brookhaven*  
 Kelly Montgomery *Fayetteville*  
 Jackson Montrym MD *Columbus*  
 Ayanna Muhammad *Atlanta*

Sridevi Narayanan MD *Cumming*  
 Apurva Nemala *Albany*  
 Marshall Newman MD *Martinez*  
 Chiagoziem Ohamadike *Atlanta*  
 Veena Ramachandran MD *Atlanta*  
 Gabriel Rosenberg MD *Madison*  
 Sarah Samaranayake *Decatur*  
 Holland Schell *Macon*  
 Brittany Sheffield *North Augusta*  
 KJoy Simms *Clarkston*  
 Janya Sims *Stone Mountain*  
 Kailen Turner *Smyrna*  
 Hitesh Vashi MD *Marietta*  
 Haritha Vellanki MD *Atlanta*  
 Christopher Watson MD *North Augusta*



**Are you a member of the Georgia Chapter - American Academy of Pediatrics?**

**Are you an Outpatient Pediatrician?**

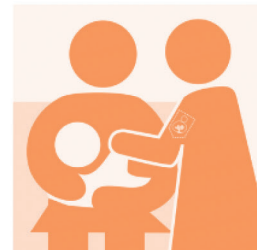
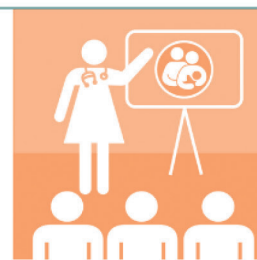
**Do you want to increase breastfeeding rates in your practice and in Georgia?**

**This program is for you!**

**Certification Program** Scan the QR code to fill out an interest form to see if you're eligible to join our upcoming cohort!

Become certified as a  
**Breastfeeding-Friendly Pediatrician!**

Learn more at [www.GaAAP.org/breastfeeding](http://www.GaAAP.org/breastfeeding)  
Follow us on Instagram and Facebook @GaBfPeds







# Georgia Mental health Access in Pediatrics (GMAP) Teleconsultation Line Expands Coverage

The Georgia Mental health Access in Pediatrics (GMAP) program, of which the Georgia Chapter is a part, is focused on improving mental health care for pediatric patients statewide. GMAP is collaboration between the Chapter, the Georgia Department of Behavioral Health and Developmental Disabilities and the Medical College of Georgia (MCG). GMAP launched in 2022 and offers ECHO's and other training sessions to enhance the general pediatrician's capabilities to provide mental health care to patients. As a second phase, a teleconsultation advice line for pediatricians began last August. Four child & adolescent psychiatrists (C/AP) at MCG staff the line: Sameera Azeem, MD, Eric Lewkowicz, MD, Dale Peeples, MD and Sandra Sexson, MD. They provide pediatricians with expert advice and support in addressing mental health conditions among their patients.

Recently, the Chapter expanded the teleconsultation line to cover all the counties in the southern half of the state, roughly from Columbus to Macon and Augusta, reaching over 300 more Chapter members. This expansion facilitates increased access to C/AP expertise for pediatricians. By leveraging teleconsultation services, pediatricians can readily connect with a C/AP.

**How It Works:** The Teleconsultation Line operates on weekdays, offering two time slots: 12 noon -1:30pm and 3:30-4pm. To reach a child/adolescent psychiatrist, pediatricians can call (404) 594-6518 during these

**This service has been wonderful to have. I feel very strongly that GMAP is essential in helping community pediatricians integrate mental health in their practice.**

**Priya Thomas, MD, Chapter member, Johns Creek**

hours. Alternatively, appointments can be scheduled at the pediatrician's convenience through <https://GMAPTeleconsultationLine.as.me>. There is no charge for Chapter members to utilize the line.

Since its launch, the GMAP teleconsultation line has seen 86% of consults related to medication advice and 14% concerning behavioral issues. The top patient concerns reported are: 50% ADHD, 42% depression, 35% anxiety, 21% autism, 14% OCD, and 7% suicidality/self-harm.

In addition to the teleconsultation advice line, GMAP provides free Project ECHO®s for pediatricians and pediatric nurses focusing on pediatric mental health. To stay informed about upcoming GMAP offerings, visit the Chapter website. They'll also be posted on our bi-weekly Member Updates.

For more information, contact the Chapter Behavioral Health Coordinator, Hannah Smith, MS at [hsmith@gaaap.org](mailto:hsmith@gaaap.org) or (404)881-5089.

## Pediatrics By the Sea

**A CME Conference  
in Practical Pediatric Topics and a  
Coding & Practice Management Seminar**

**June 12-16, 2024  
Ritz-Carlton Hotel  
Amelia Island, Fla.**

**For information or to register visit  
[www.gaaap.org](http://www.gaaap.org) or call 404-881-5091**

## In Memoriam: Thomas W. Ellison, MD



Dr. Thomas Ellison passed away on April 6 in Columbus. He was born in Corbin, KY on August 24, 1952. He

grew up in Oak Ridge, Tennessee and received his undergrad degree from the University of Tennessee, and went to Medical School in Memphis, where he developed his love of pediatrics.

He entered the U.S. Army which sent him to posts around the country, and finally to Ft. Benning in Columbus where he and his wife settled permanently. He retired from the Army as a Lt. Colonel. In 1985, he joined the practice of Dr. Abraham Kravtin & Louis Levy, and then with Rivertown Pediatrics in Columbus. He is survived by his wife of 52 years Charlene, three children, and six grandchildren.



# Youth Suicide Prevention Efforts in Georgia



**Shreeti Kapoor**  
MD, FAAP

Mental health concerns among youth continue to rise throughout the United States and within the state of Georgia. In 2021, a National Emergency in Child and Adolescent Mental Health was declared by the American Academy of Pediatrics, the American Association of Child and Adolescent Psychiatry, and the Children's Hospital Association. Suicide and suicidal behavior among youth have been on the increase as well and are a major public health crisis. During the period of 2017-2019, there was a significant increase in suicide completion among youth 10-24 years of age, with suicide being the second leading cause of death for 10-24-year-olds in the United States. In Georgia, the number of children who visited emergency departments for suicide related reasons nearly tripled between 2008 and 2021. In 2022, 73,000 students report having seriously considered harming themselves and 43,905 students reported having harmed themselves (Voices for Georgia Fact Sheet on Youth Suicide)

There are many factors contributing to these increasing numbers of youth and families impacted by suicide. The AAP released a clinical report in the January 2024 issue of Pediatrics outlining these factors as well as the role of pediatricians and other health care providers in addressing suicide risk. Pediatric providers are essential in identifying risk as well as promoting protective factors in their patients. The AAP's commitment to youth suicide prevention includes the Blueprint for Youth Suicide Prevention. The Blueprint was developed in 2022 by the American Academy of Pediatrics and the American Foundation for Suicide Prevention (AFSP), in collaboration with experts from the National Institute of Mental Health (NIMH). It translates suicide prevention research into strategies that are feasible, pragmatic, and actionable across all contexts in which youth live, learn, work, and play. It follows a public health framework, outlining a multi layered prevention approach to support youth in clinical and community settings, as well as partnering with community resources.

The AAP continued its efforts in youth suicide prevention in 2023 by identifying the first cohort of Youth Suicide Prevention Ambassadors in various states throughout the United States to work in partnership with the American Foundation for Suicide Prevention (AFSP) to commit to an action plan for their state towards this goal. The program was expanded in 2024 to include additional participants from states that were not part of the original cohort. The Georgia Chapter of the AAP is proud to be participating in the 2024 cohort. The Suicide Prevention Ambassadors from Georgia are Dr. Evan Brockman, Dr. Ann Contrucci, and Dr. Shreeti Kapoor, who have been involved with the GA AAP Mental Health Committee for several years.

As representatives for Georgia, we want our action plan to reflect the needs of our very diverse state and the services available throughout the state. Our overarching goal is to increase pediatric provider involvement in youth suicide prevention in Georgia, and to improve provider confidence and competence in using evidence-based, best practice standard of language when discussing suicide with patients, families and stakeholders.

To achieve this goal, we have partnered with the Georgia Chapter of the AFSP as well as the youth-suicide prevention specialists of the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) to offer information on resources available throughout the state to pediatric provider offices. The three ambassadors will provide these resources, as well as information around language when discussing youth suicide, to pediatric practices in their respective geographic areas, which include the Atlanta metro area, the Augusta area and North Georgia. There will also be information available regarding these resources at the Pediatrics By the Sea conference in June sponsored by the Georgia AAP.



As the Youth Suicide Prevention Ambassadors for Georgia, we hope to highlight the efforts that are going on throughout the state in preventing youth suicide. Pediatric providers are at the forefront of care for the youth in our state and are well positioned to be a part of the movement to address and prevent youth suicide in Georgia. Please feel free to reach out to us with events in your communities on suicide prevention in youth as well as resources that can be shared with pediatric colleagues in this effort.

If you have questions, comments or suggestions please send them to Hannah Smith at [HSmith@gaaap.org](mailto:HSmith@gaaap.org) or at (404) 881-5089.

## **Shreeti Kapoor, MD, FAAP**

**Vice Chair, Child & Adolescent Mental Health Committee, Georgia AAP  
Suicide Prevention Ambassador for Georgia Chapter of the AAP**





# The Georgia Audiology Shortage – A Pediatric Public Health Crisis

Nearly 2,500 children in Georgia are classified as deaf or hard of hearing.<sup>1</sup> In 2020, 215 children were diagnosed with permanent hearing loss, though only 132 received the diagnosis prior to 3 months of age.<sup>2</sup> Nearly 40% of children in the state of Georgia with hearing loss are not diagnosed before pre-K, which limits their access to early intervention services. Without such a diagnosis, they are ineligible for most private, federal, and state-supported early intervention programs. Preventable language delays occurs in 68% of infants who do not receive a diagnosis or who receive a late diagnosis of hearing loss.<sup>3</sup> Studies have shown that children who receive timely intervention tend to catch up quickly and demonstrate language skills and cognitive abilities that are on par with their peers.<sup>4</sup> A major contributor to these delays is the lack of access to audiology services due to a shortage of Audiologists in the state of Georgia.

Georgia ranks near the bottom at 43rd in the nation for the ratio of certified audiologists to the population, with only 3.<sup>4</sup> audiologists available for every 100,000 people. Georgia also lacks audiology graduate programs so every fully trained audiologist practicing in the state, had to be recruited from training programs in other states.

In contrast, our neighboring state of Tennessee ranks 7th in the nation with a nearly double ratio of 6 certified audiologists per 100,000 residents and has 430 certified audiologists in total. Tennessee also has 6 CAA\* certified audiology programs. In a similar vein, our neighbor to the west, Alabama has 372 certified audiologists, resulting in 5.2 audiologists per 100,000 residents and 2 CAA\* certified audiology programs, and ranks 18th nationally in audiology services. Colorado currently carries the #1 rank with 448 audiologists in 2022 and 7.7 audiologists per 100,000 residents.<sup>5</sup> This access is more than double that for children in Georgia.

The nationwide standard from the American Academy of Pediatrics (AAP) Early Hearing Detection and Intervention (EHDI) are as follows:

- Ensure every child with hearing loss is diagnosed and receives appropriate, timely intervention.
- Enhance knowledge for pediatricians, other physicians, and non-physician clinicians knowledge about the EHDI 1-3-6 guidelines—screening by 1 month of age, diagnosis of hearing loss by 3 months of age, and entry into early intervention (EI) services by 6 months of age.
- Ensure newborn hearing screening results are communicated to all parents and reported in a timely fashion according to state laws, regulations, and guidelines.
- Incorporate EHDI into an integrated, medical home approach to child health.

Georgia has yet to meet these guidelines.

The rate of infants with a documented audiologic diagnostic evaluation varies greatly across Georgia's public health districts, with some school districts only achieving a 20% diagnostic rate, while others reach over 80%. This disparity in outcomes highlights the urgent need to improve access to audiological services statewide. There are currently 103 healthcare facilities that provide audiology services to children in Georgia. There are, however, no pediatric audiologists available south of Macon, GA, a region that includes 83 south Georgia counties where children must travel to pediatric audiology services.

To address these pressing issues and improve the lives of Georgia's children with hearing loss, we advocate for the establishment of the first Doctor of Audiology (AuD) program in the state. This initiative is imperative to bridge the gap in on-time diagnosis, improve access to audiological services, and ensure that all children in Georgia have a fair chance to achieve age-appropriate language and literacy skills.

#### References:

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  2. 2020 CDC EHDI Hearing Screening & Follow-up Survey (HSFS)
  3. Georgia DPH 2016-2020 HSFS Data for PHIP referenced by Georgia Commission for the Deaf or Hard of Hearing Language and Literacy Report (2021)
  4. Mary Pat Moeller; Early Intervention and Language Development in Children Who Are Deaf and Hard of Hearing. Pediatrics September 2000; 106 (3): e43. 10.1542/peds.106.3.e43
  5. American Speech-Language-Hearing Association. (2022). Member and Affiliate Profile: 2022 ASHA-certified audiologist- and speech- language pathologist-to-population ratios. www.asha.org
- \* Accreditation held by The Council on Academic Accreditation in Audiology and Speech-Language Pathology (CAA) of the American Speech-Language-Hearing Association (ASHA).

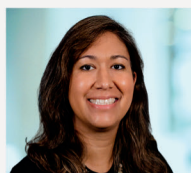
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Article by the Medical College  
of Georgia- Department of  
Otolaryngology, Augusta, GA



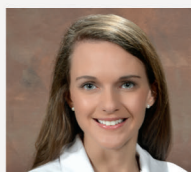
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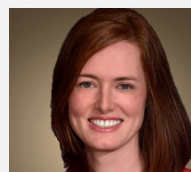
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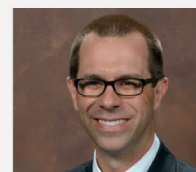
**Jason May, MD**



**Sarah King, AuD**



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MD, MMHC**



**Drew Prosser, MD**

# Georgia Chapter

American Academy of Pediatrics

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## Looking Ahead: Join us for our upcoming events!

### Pediatrics by the Sea Summer CME Meeting

June 12-16, 2024  
Ritz-Carlton Hotel  
Amelia Island, FL

### AAP Experience National Conference & Exhibition

September 27 – October 1, 2024  
Orlando, FL

### Georgia Pediatric Nurses & Practice Managers Association Fall Meeting

September 20, 2024  
Cobb Energy Centre,  
Atlanta

### Pediatrics on the Parkway Fall CME Meeting

October 24 – 26, 2024  
Cobb Galleria Centre,  
Atlanta

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The Georgia Chapter of the American Academy of Pediatrics is incorporated in the state of Georgia.

Visit the Chapter Website for details on Chapter events. [www.GAaap.org](http://www.GAaap.org)  
Call (404) 881-5020 for more information.