

The Wisper

March 2005

FROM THE PRESIDENT Carl Eisenberg, MD, FAAP

Moving On...

This will be my last article as president of the WIAAP. I appreciate all the active involvement by many members of this organization. It is really your involvement that has made our Chapter successful and my job fun.

Chapter accomplishments include:

Strengthening Chapter's structure by:

- * up-dating our By-laws,
- * formalizing a relationship with a bookkeeping/accounting service,
- * expanding the membership on our various committees (you are invited to contact the Chapter's office if you would like to become more involved.) Please visit the WIAAP's web page [<http://www.wisaap.org/>] to see a listing of Chapter committees.
- * creating new committees to meet changing needs, e.g., an Early Childhood Committee
- * assuring the financial stability of our Chapter by developing a budget process, using this process to determine our financial condition and raising dues to assure financial stability. Our membership did not decrease after the dues increase.
- * developing yearly goals using our e-mail distribution list, the WIAAP-NET (the WIAAP was one of the first Chapters in the nation to have a free e-mail distribution list for our members.)

Preparing our Chapter for the future by:

- * training future leaders of our organization by sending interested individuals to AAP Advocacy meetings where they gain expertise and meet the AAP's officers and staff
- * working to get WIAAP members appointed to AAP Committees where they can develop expertise
- * revitalizing our Chapter's strategic plan
- * fostering the incorporation and development of the WI Academy of Pediatrics Foundation (WAPF), our sister organization and a vehicle to allow for grant-based projects.

Providing Communications and Education for Members by:

- * Publishing the Chapter's newsletter, *The Wisper*
- * Maintaining e-mail distribution lists for members and leaders
- * Publishing seasonal safety handouts
- * Organizing an Annual CME Meeting at a resort location to attract pediatricians including those with young children
- * Collaborating with others to provide clinically useful tools, e.g., obesity-related materials, rural health information

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Wisconsin Newborn Screening Update: Compliance with National Recommendations

Gary L. Hoffman, PhD, Ronald H. Laessig, PhD,
Murray L. Katcher MD, PhD, FAAP

You may have read in the *New York Times* (Feb. 21, 2005) and elsewhere that the Advisory Committee on Heritable Disorders and Genetic Diseases in Newborns and Children (ACHDGDNC), established to assist the Secretary, U.S. Department of Health and Human Services, will soon be releasing recommendations for a "uniform panel" of 29 tests for state newborn screening programs. The Wisconsin newborn screening program routinely tests for all 29 of the recommended disorders. Since the 2003 addition of five aminoacidopathies, the Wisconsin program's official number of disorders has been listed as 26, but the practice of counting of disorders has been an issue since the implementation of tandem mass spectrometry (MS/MS) in newborn screening laboratories across this country.

The counting of disorders is a complex issue. Since many disorders utilize the same MS/MS markers, a particular disorder may have one or more variants, and several disorders have multiple names. Adoption of the uniform disorder panel will help reduce the ambiguity when comparing state screening programs. When the Wisconsin Newborn Screening Program adopts the national consensus counting system, we expect that our "count" will be more than 40 diseases. Please look for a more detailed description of our testing in an upcoming *Wisconsin Medical Journal*.

In spite of the current counting issues, Wisconsin physicians and parents can be assured that the Wisconsin newborn screening program is one of the most complete and comprehensive in the country. Our clear emphasis is on maintaining and providing Wisconsin newborns with testing that is state-of-the-art. The program is served and supported by physician consultants with contributions from the staffs at the Department of Health and Family Services, State Laboratory of Hygiene, health care systems, as well as concerned parents. This group of dedicated professionals and parents works to provide the best possible care for every newborn in the state of Wisconsin.

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(President's Report Continued)

Advocating for Children and Pediatricians by:

- * Sponsoring an Annual Residents' Advocacy Day to help teach pediatric residents from all three WI residency programs about advocacy processes.
- * Creating a Pediatric Council to work on issues with insurance companies and government
- * Working on a Legislative Study Committee in efforts to develop rational fireworks regulations
- * Working on a Task Force established by Governor Doyle to increase access to oral health
- * Working with the Office of the Commissioner of Insurance to assure that infants found to have hearing amplification needs will have insurance coverage for hearing aids
- * Working with State officials to develop and maintain newborn screening programs for genetic diseases and hearing loss
- * Spending time in the Capitol meeting with legislators on various issues including child passenger safety, bike helmets, the Injured Patients and Families Compensation Fund, boxing for children

We are currently facing issues that will impact the children in Wisconsin.

- * Governor Doyle's Task Force on Access to Oral Health will prepare a final report to the Governor's Office within the next few months. We have already recommended significant changes to the system regarding dental hygienists practice. Other topics of discussion include increasing the supply of dentists in Wisconsin by helping to fund more students at the Marquette Dental School, maintaining funding for loan forgiveness programs for dental students, changing Medicaid reimbursement for dentists, and urging the Governor to continue to support various oral health prevention programs.
- * There are possible changes being discussed in Washington to the way the Federal government funds Medicaid, i.e., block grants instead of the current system. Such a change probably would eventually reduce the total dollars available to states and would alter the way these monies are distributed likely reducing the number of children covered by medical assistance and/or reducing covered services in Wisconsin. Governor Doyle has been a friend of children's programs, but he may not be able to sustain the WI program at the current level should these changes come to pass — it depends upon what happens in Washington. Please keep in touch with the situation by visiting the Member Center on the AAP's web site (<http://www.aap.org/>) and don't hesitate to contact the Chapter's office (<cmewcaap@aol.com>) if you have questions.
- * Proposals to limit property taxes have been proposed by both the Republicans in the legislature and Governor Doyle. These proposals fall under the heading of TABOR, or a Taxpayer's Bill Of Rights. Social programs in other states, notably Colorado, have suffered as a result of the TABOR enacted there. The WIAAP's Legislative Committee and Pediatric Council will be working hard with the new Children's Champions Coalition and the Wisconsin Medical Society to influence this legislation. If you would like to be part of the effort, please contact the Chapter's office.

I have every confidence that your next leaders will continue to work on behalf of children and pediatricians to fulfill the Chapter's Mission: "... to (1) assure optimal health and safety for Wisconsin's Children and their families through advocacy and collaboration with other child interest groups (2) give support to Wisconsin pediatricians that enables them to continue to be the most effective providers of health care to children."

It has been an honor to serve you for the past three years. I leave the Chapter in good fiscal health and in good hands. Best wishes to all.

AAP District VI Chair Report

Kathryn Nichol, MD, FAAP

The recently concluded Advisory Committee and BOD meetings were very robust, and I wanted to share with you some of the highlights.

There were several updates on ongoing initiatives including:

Task Force on Obesity Update (TFOO): At the Academy Leadership Forum (ALF) in August of 2004 the TFOO identified 3 priority objectives to accomplish before their term ends: 1) development and implementation of a physician obesity kit, 2) reimbursement resources, and 3) a community advocacy kit. The target completion date for the physician obesity kit is no later than June 30, 2005. The TFOO has attempted to keep committees, sections and chapters apprised of their activities in a number of ways. In addition, there were as many as 7 obesity sessions sponsored by the TFOO and the Peds-21 Steering Committee at the 2004 NCE. Approximately 250 pediatricians and other pediatric health care providers attended the obesity symposium entitled "Fact, Fiction, or the Future of Pediatric Obesity" where pediatric obesity experts gave presentations on primary prevention, pathophysiology of obesity, physical activity basics, non-family environmental issues, office-based treatment, and alternative therapies/fad diets.

Mental Health Task Force: Held its first meeting Dec. 10-11, 2004 where the agenda included 1) a review of the task force directives, 2) mental health issues paper, 3) the periodic survey results, 4) Bright Futures and mental health commonalities, 5) issue of assisting AAP Chapters and 6) the development of a mental health tool kit. The mental health issues paper included evaluating the Pediatrician's Perspective, the Systems Perspective and the Children and Families Perspective.

Discussion of the Pediatrician's Perspective included that 1) pediatricians vary in experience with behavioral health practice, 2) emergency physicians often lack the knowledge and tools to manage mental health problems, 3) pediatricians lack the knowledge of referral sources in their community, 4) pediatricians cannot provide mental health services unless they are adequately reimbursed, 5) there is an inadequate evidence base for pediatric psychopharmacologic treatments, and complementary and alternative treatment. 6) pediatricians need skills/resources to address cultural linguistic barriers, 7) pediatricians have insufficient resources to assist families with basic parenting skills, 8) the mental health of a child's parents has a great psychosocial impact on the child.

From a Systems Perspective: 1) separate medical and mental health silos exist, 2) lack of insurance and mental health parity are formidable barriers, 3) school systems are de facto providers of mental health services, 4) gaps exist between best practice and school policies, 5) there is a high turnover in the public mental health systems, 6) children in foster care and juvenile justice systems have significant need for mental health services.

From the Children and Families' Perspective, 1) social stigma may be associated with a child receiving mental health treatment, 2) faith-based organizations provide support and counseling to families, 3) material that is developed needs to be at lower

literacy level to effectively assist patients and their families, 4) war has created new threats to the psychosocial well-being of children.

There was discussion by the task force members on the development of a Chapter Resource Guide. They intend to assess existing mental health services, initiate discussion with mental health providers, educate chapter members on treatment of mental health problems, begin a dialogue with third party payers and advocate for an effective system. In developing a Mental Health Tool Kit, the task force intends to outline 1) patient engagement strategies, 2) clinician decision support, 3) information systems/tracking support and 4) organization/financing of care.

A topic of major concern at this meeting and probably for the next four years is the issue of **Medicaid and SCHIP**. It is expected that the President's proposed FY 2006 budget will include a sizable cut to Medicaid. The proposed cuts may be coupled with changes to the existing Medicaid financing structure, including capping federal financing of Medicaid in the states. There have been discussions with several states about waiver proposals that could lead to caps in Medicaid financing. Medicaid has become the program in most states that is the largest expense item, so states also are looking for ways to cut the cost of Medicaid, which is why the waiver is attractive to some states. The AAP's message on Medicaid is:

- Maintain the individual entitlement to Medicaid
 - Ensure appropriate/adequate physician payment under Medicaid
 - Protect the Medicaid benefits, critical for children (e.g. EPSDT)
 - Protect the SCHIP program and its' funding
- Do not substitute tax credits for the Medicaid program

The National Governors Association (NGA) does not want Medicaid reform to include shifts from the federal government to the states, nor do they feel such reform should be part of a federal budget reduction and reconciliation process. The AAP has sent a sample letter to Presidents of the Chapters encouraging them to write their governor to advocate for the Academy's position on Medicaid including that there be no diminution in eligibility, benefits or reimbursement for services rendered for the population we serve, reminding them of the cost effectiveness of caring for children who are enrolled in Medicaid and reminding them of the five key issues noted above. We need to continually point out that children, while making up over 50% of the Medicaid population, account for less than 25% of the cost of the program.

On another Medicaid related topic, the AAP continues to advocate for the establishment of a Medicaid Payment Advisory Commission that would advise CMS and Congress on physician coding and payment policies related to state Medicaid programs, in a similar fashion to the Medicare Payment Advisory Commission with respect to Medicare payment policies.

The AAP has joined forces with a number of advocacy organizations to present a united front on the Medicaid issue.

Newborn Screening

There was an extensive discussion on Newborn Screening (NBS). It was a topic worthy to be discussed because NBS is not universal, is not equitably distributed in the US, and is not uniform. (Continued Page 4)

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More than 1,000 newborns go undetected annually due to states not screening for identifiable conditions. The American College of Genetics (ACMG) is developing a report which is in the process of being reviewed by multiple agencies and organizations, including the AAP. The recommendations are likely to be:

- Mandate screening for all core panel conditions (29). These are conditions for which there are known treatments.
 - Mandate reporting of any clinically significant conditions identified while screening for core conditions (25). These are conditions which do not have known treatments at this time, but have genetic patterns of inheritance of importance in decision making for parents and families.
 - Maximize use of multiplex technologies and 2nd tier tests
- Recognize that the range of benefits from NBS go beyond infant mortality and morbidity.

There will be more on this topic if the ACMG report is endorsed by the AAP.

The BOD of the AAP after much work and input from committees, sections and chapters and review by legal counsel approved the Policy for Relationships with Industry and Other Organizations. I would encourage Chapters to refer to this document when you have questions about possible conflicts of interest.

AAP Member Attitudes, Awareness, Usage

The BOD heard a summary of findings of market research which studied AAP member attitudes, awareness and usage. The results were very interesting, and I'll try to summarize the main points.

First, there was high loyalty among members, with no statistically significant differences based on age. Women were more positive toward the AAP on all measures, and pediatricians in part time practice were more likely to view the AAP as a trusted resource, the later two findings being statistically significant but not a large difference. The market research study was able to identify five member segments with highly differentiated motivations: 1) the "strivers" (16%) who were driven by a love of pediatrics and unconcerned with a balanced life. There were relatively more males and fewer young females in this group. There were fewer part time members. 2) the "kids docs" (30%) who love pediatrics and thrive on day to day interaction with children. They resemble the overall population in terms of gender, age and part time/full time. 3) the "pragmatic pillars" (18%) who focus on the clinical aspects of pediatrics and enjoy the appreciation of families and status in the community. They represented slightly more part-timer than other segments. 4) the "counselors" (13%) who focus on psychological outcomes, value interpersonal skills over clinical knowledge. They enjoy the appreciation of families, but status is unimportant. This group represents relatively more women and slightly more part-timers. They also have the most positive attitude toward the AAP with no disenchanting members in this segment. 5) the "disenchanted" (21%) who experience low to moderate enjoyment of patient interaction and have dissatisfaction and/or doubt regarding their choice of pediatrics. The emotional and functional needs of these five groups vary, not surprisingly. Other findings included: 1) members are committed to a high value membership with a strong need to feel valued 2) being part of a respected organization is the strongest motivator across seg-

ments 3) feeling valued was the second most frequent motivator across segments 3) membership in additional societies was linked to higher ratings of the AAP.

The results of the market research were affirming that the importance of Academy membership is tied to the AAP's image as a respected organization involved in child advocacy and the advancement of pediatric research and science. The AAP needs to maintain this image. Feeling valued is very important to all members. Members seek value in their membership; not a bargain. The AAP needs to enhance and integrate communication, marketing and promotion re: the AAP image.

Jan Berger, the chair of the committee management committee, who resides in Chicago, gave an outstanding presentation on consumer driven health plans (CDH). It is predicted that by 2007 70% of employers will offer CDH as at least one option. CDH is presently being offered by Kaiser Permanente, Humana, United Health care etc. Physicians need to understand the types of models, need to develop marketing expertise, have a knowledge of cost of services and goods, have good billing systems and good liability systems. The AAP is committed to developing materials and educational offerings to help pediatricians negotiate this new territory.

Lastly, the Academy is in the process of developing a more comprehensive quality initiative than has previously existed. It will be cross departmental and include many areas the AAP is already working on such as the electronic health record, the results from PROS, the utilization of Pedialink and eQuip as quality educational tools. It will become more comprehensive, however. I hope to be able to expand on this in my May Newsletter.

Chapter Pediatric Council

John Meurer, MD, FAAP

The primary purpose of the WIAAP Pediatrics Council is to partner with and educate large purchasers of child health services, thereby influencing their policies and procedures to ensure that resources are provided for high quality and accessible pediatric care for patients and consumers in Wisconsin.

Our strategies include exchanging useful information, initially focusing on quality of care issues. WIAAP members may contact the Council Chair John Meurer, MD, MBA (414-456-4116, jmeurer@mcw.edu) with specific payer issues in their practices. We would like to ensure pediatrician representation in health plan review panels. When relationships with purchasers are established, we then will address reimbursement issues.

Pediatricians active in the Council include Carl Eisenberg, Tim Corden, Andrea DeMets, Tom Dunigan, Sharon Fleischfresser, Bob Miller, Nithya Sunder, and Michelle Urban. Our consultants include Mark Adams, Tom Gazzana, Mark Rakowski, Lou Terranova, and Carolyn Evenstad.

One major challenge is the Wisconsin Medicaid deficit of approximately \$230 million in fiscal year 2005. The number of Medicaid recipients has increased 64% since 2000. 70% of Wisconsin Medicaid covered individuals are children and families but they only account for 30% of Medicaid expenses. Wisconsin Medicaid reimburses only 58% of hospital costs according to (Continued Page 5)

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the Wisconsin Hospital Association. A 10% cut in Medicaid would cost 9,100 jobs, \$394 million in income, and \$30 million in tax revenue based on projections by the Wisconsin Council on Children and Families. Adding to the Medicaid challenges, implementation of the Badger-Care Employer Verification form was associated with a 17% decline in enrollment since May 2004.

On the one hand, members of the Wisconsin legislature are promoting a Taxpayer Bill of Rights (TABOR) similar to Colorado to limit government expenditures. On the other hand, neither the Governor nor legislative leaders are willing to increase the cigarette tax from \$0.77 to \$1.92, which would raise \$225 million annually and reduce youth smoking by 15%.

The top priority Council objective is to improve medical and dental home access, especially for children with special health care needs. One major private sector objective is to strengthen the safety net and to ensure needed health care, medications, and preventive services for children covered by high-deductible, catastrophic private insurance and health savings accounts. We support the Governor's KidsFirst agenda including improving health care coverage, immunizations, fitness and nutrition to reduce obesity, injury prevention (especially passenger vehicle safety), oral and mental health, home visiting, care coordination and case management, and Wisconsin Regional Centers for CSHCN.

During the past year, members of the Council met with the Governor's health policy aide and plan follow-up with other staff. We submitted influential comments to the Medicaid Pharmacy Prior Authorization Committee about asthma and allergy medications. We submitted a letter to the State to ensure all Medicaid plans follow AAP Synagis guidelines to prevent RSV complications. We used talking points from Covering Kids and Families-Wisconsin to influence legislators. We plan to meet with the Assistant Deputy Commissioner of Insurance who regulates plans covering 40% of residents.

We also met with a health plan and secured reimbursement for ADHD care by pediatricians. We met with a representative of Wisconsin Manufacturers and Commerce whose members employ 25% of the Wisconsin workforce, and plan a WIAAP article in their newsletter and a survey of their members about preventive care and vaccine coverage. We plan to meet with Wisconsin Association of Health Plans to establish common legislative priorities. We also will meet with Wellpoint to follow-up on our counseling campaign to prevent and treat obesity.

Legislative Update

The WI Chapter AAP and CCW: Where do We Stand?

LuAnn Moraski, MD, FAAP

As reflected in office discussions, the media, and the talk around the kitchen table, issues regarding firearms and their utilization are everywhere. Wisconsin is one of 4 remaining states without existing legislation regarding concealed carry weapons. Legislation in Wisconsin was defeated by a veto by Governor Doyle in the last session, but the Republican-led Assembly and Senate are certain to revisit the issue this term.

Where does that leave us - the pediatricians of the state? From the perspective of a pediatrician, I recognize that guns and kids are a dangerous combination. Yet I also married an avid sportsman who owns several firearms. At the WIAAP meeting in January, Dr. Stephen Hargarten, MD, MPH, joined us to help understand alternative viewpoints to the existing "pro and con" discussion previously tabled. As you know, CCW (concealed carry weapons) refers to the ability of private citizens, after registration and training, to obtain a license to carry a handgun on their person in public places with limited exceptions (schools, hospitals, designated public buildings).

Concealed Carry as an issue of Crime?

As physicians, we are driven by data. The WMS altered their position on CCW because of a lack of sufficient data. Governor Doyle echoed this sentiment in the Wisconsin Medical Journal – there is a need for more data. But we have some data. Wisconsin has a lower youth homicide rate (27% lower) than the national rate. Same for robbery (44% lower than national rate). The National Academies of Science just published an exhaustive review on this subject. Their findings: CCW does not have a measurable impact on crime. Unfortunately, Wisconsin's youth suicide rate is 36% above national averages (60% of which involve someone else's gun; 83% a parent or guardians'). Given that CCW does not increase or decrease crime, that our crime rate is low and our suicide rate is high, is crime a prime mover for decisions regarding CCW?

CCW and its role in Safety.

As pediatricians, we understand and respect the role of safety in maintaining our patients' health. Safety involves the protection of those who may not understand the ramifications of actions. Can we reexamine CCW through the safety lens?

Should CCW include only firearms that are truly safe to carry? Dr Hargarten related a personal story about a serious injury that occurred in a restaurant he visited: a gentleman accidentally dropped his concealed handgun and it discharged, seriously injuring two bystanders. There are a number of firearms that have design flaws that make them more likely to unintentionally discharge (as if dropped from a pocket or jacket). California has a "drop safety" provision written into their CCW legislation. Should Wisconsin include this up front in new CCW legislation?

How do we get the data to understand the safety ramifications of CCW legislation? Wisconsin has in place a violent death reporting system (WVDRS), but it lacks the financial support necessary to adequately evaluate the impact of CCW. Issues regarding data collection (tracking licensure; accurate reporting of citizens as either perpetrators or victims of crime) also need to be examined as part of the drafting of CCW legislation. Both arguments exist: CCW increases and decreases danger. Without the data, we cannot know with certainty which is true.

CCW is controversial; even amongst our group with the strongest of commitments to the health of children. In order for the WIAAP to contribute to good legislative policy and protect the health and safety of Wisconsin children, we need your thoughts on CCW and will present them at our upcoming regional meeting. As the WIAAP, we can contribute to a policy less about politics and focused on advancing the health and safety of children.

Please respond to lmoraski@mcw.edu

BREASTFED INFANTS WITH JAUNDICE:**REVIEW OF BREASTFEEDING and BREASTMILK JAUNDICE**

Karen Pletta, MD, IBCLC, FAAP

Case #1: A breastfed baby presents at the fourth day of life for hospital follow-up. He was born at term, without complication. Mom is 0+, no fever or risk factors from delivery. His weight is 10% below birthweight. Mom felt that he is breastfeeding "well but seems restless". He is clearly clinically jaundiced. Bilirubin is 18.0/0.4. Is this a concern? What is the likely cause of this jaundice?

Case #2: A breastfed baby is seen at the 2-week well child check. He is thriving – well above birthweight and has all normal exam except that he is clearly clinically jaundiced. Bilirubin is 16.0/0.4. Is this a concern? What causes are possible for this height of jaundice at this age?

Besides the usual causes of jaundice in newborns and infants (e.g. physiologic, ABO incompatibility, liver abnormality), there are two types of jaundice that are related to breastfeeding and breastmilk itself. The cases above are most likely caused from Breastfeeding jaundice (Case #1) and Breastmilk jaundice (Case #2). The causes and treatment (or not) of breastfeeding and breastmilk jaundice are briefly reviewed below.

"Breastfeeding jaundice" is defined as that jaundice seen in newborn infants in the first 5 days of life that is caused by inadequate breastfeeding/breastmilk intake. It has been named by some as "breast- non-feeding jaundice". Although it is known that all infants will lose some weight initially, it is felt that weight loss >8% for breastfed newborns is usually a sign of insufficient milk intake either from poor latch/position or breastmilk supply. Insufficient calories will cause jaundice even in healthy adults. The development of increased indirect bilirubin in breastfed infants with significant weight loss (>8%) is felt to be due to insufficient calories just as if they were not taking in sufficient formula. Therefore, if a breastfed baby in the first 5 days of life has significant jaundice, close attention must be paid to their weight and breastmilk intake besides the other factors that can cause jaundice in this period. Management should include evaluation of breastfeeding and breastmilk intake as well as usual evaluation/treatment for jaundice as per AAP guidelines and individual clinical practice. Supplementation of breastmilk with formula can be necessary until the baby is taking in sufficient breastmilk.

"Breastmilk Jaundice" is defined as the "normal prolongation of physiologic jaundice in breastfed infants, which has its onset after the fifth day of life." It may last up to 3 months of age. Studies currently suggest that this is due to a yet-to-be-determined factor that causes increased reabsorption of indirect bilirubin from the intestine. This factor seems to be made in mature milk (usually produced at 3-5 days post-delivery). Babies with breastmilk jaundice have elevated indirect bilirubin but are otherwise thriving with normal direct bilirubin, appropriate weight gain and normal exams and output. While formula fed infants, have a normal physiologic peak of bilirubin (avg. 5.5) at 4-5 days of life and then drop to adult values by 2 weeks of age, breastfed babies have the normal physiologic peak at 4-5 days and then an even higher peak at about 10 days of life (average peak bilirubin at 10 days is 8.0, note: jaundice clinically seen approx. bilirubin = 5). Breastfed infants then have a more gradual drop of bilirubin with as many as 60% of healthy, breastfed infants having serum bilirubins above adult value at 2-3 weeks of life and as many as 30% of infants having clinical jaundice (bili >5) as this age in some studies. High bilirubins (e.g.20-25%) have been reported for breastmilk jaundice although this is rare (<1%) and it is recommended to then also evaluate breastmilk intake as well as other pathological

etiologies for jaundice. Most clinical jaundice resolves by 2 months of age for breastfed babies, although indirect bilirubin levels may not decrease to adult levels until 3 months of age.

The management of breastmilk jaundice depends on the age and level of bilirubin. Bilirubin is an anti-oxidant so that some feel that the more gradual drop of bilirubin with breastmilk may have advantages for infants. Individual practice may always vary, however Dr. Larry Gartner, (a pediatrician who has studied breastfeeding and breastmilk jaundice and is involved with several national breastfeeding committees), has recommended the following guidelines.

Assuming a healthy, thriving infant, one can expect that the breastfed infant will have a slower drop of bilirubin over the first 3 months compared to a formula fed infant. Most breastfed infants will not have clinical jaundice (bili >5) at the two week check, although up to 30% may. If a baby is obviously clinically jaundiced at the two week checkup, Dr. Gartner suggests checking labs at least once to rule out other causes of clinical jaundice at this age (e.g. liver abnormality) including Total/direct bilirubin, CBC d/plt and retic count. The baby with breastmilk jaundice will be thriving with normal weight gain and exam and will have high indirect bilirubin but normal direct bilirubin, normal smear and retic count. Dr. Gartner noted that a high bilirubin (>20), is unusual for breastmilk jaundice (<1%) and would lead him to further evaluate breastmilk intake, hemolysis, G6PD etc. At these levels, some practitioners may wish to observe/follow for drop, some may wish to complement breastmilk with formula for 24-48 hours to reduce bilirubin absorption or some may begin treatment with phototherapy as per AAP guidelines. If the bilirubin rises toward 25, use of phototherapy while continuing breastfeeding or interruption of breastfeeding and giving formula for 24 hours may be indicated. (Most full-term breastfed babies who develop kernicterus have weight loss of >10% suggesting that those infants may have breastmilk and breastfeeding jaundice.) If the bilirubin is 15-20, bilirubin can be repeated, and if dropping with direct bili still normal, the baby should have follow-up to evaluate for clinical jaundice at 1-month old and then the usual 2 month well baby exam.

If the baby has no obvious clinical jaundice at the 1-month and 2 month visits, the bilirubin does not need to be re-checked. If clinical jaundice is seen at 1 month of age, the total/direct bilirubin should be checked to exclude other developing liver abnormalities e.g. biliary atresia, neonatal hepatitis. If the indirect bilirubin is dropping and the direct bilirubin is normal, the baby can then return at the 2-month visit unless parents note a worsening of jaundice sooner.

(Continued Page 7)

(Breastfed Infants Continued)

Most breastfed babies will not have visible, clinical jaundice by the 2-month check, although it has been reported. If the baby is still clinically jaundiced at the 2-month visit, the total/direct bili are done. If indirect/direct bili are still dropping/normal, the baby can then be re-checked at the 3-month visit, where jaundice should have resolved. Along the way, if parents are very concerned, a trial of formula for 24 hours should show a rapid decrease of bilirubin, but this is not necessary if the clinical jaundice resolves or total/direct bilirubins are dropping as above.

In summary, breastfed infants can develop breastfeeding and/or breastmilk jaundice in addition to other causes of infant jaundice. Evaluation of age, weight, feeding, clinical exam and bilirubin can help determine the significance of the jaundice and treatment options. Two good review articles can be found at: "Breastfeeding and Jaundice", Gartner LM, J Perinatol 2001;21:S25-29 and "Jaundice and Breastfeeding" Gartner and Hershel, Peds Clinics of North America 2001;48 (2):389-399. Please feel free to email me for further references at karen.pletta@uwmf.wisc.edu.

Antidepressant Treatment of Children and The Black Box Warnings

James Meyer, MD, FAAP

After a dramatic increase in the prescribing of antidepressants to children from 1987 to 2003, there has now been a steady decline in treatments written since the FDA warnings last year. As of October 2004 all manufacturers of antidepressants must place the black-box warning on their drugs. Hearing the often dramatic news stories of behavior changes, suicide and now even cases of homicide being attributed to use of Selective Serotonin Reuptake Inhibitors(SSRI's), many young patients have stopped their medications often at the request of their parents. Many primary care providers who are often the first contacts of patients with mental health problems, may feel even more uncomfortable prescribing these meds and yet access to Child/Adolescent Psychiatrists is poor in most areas of Wisconsin. Withholding treatment from truly depressed children and teens may make things worse for these families. What is a practitioner to do?

The facts: 1) Depression in Western Cultures affects 20% of teens and that is the greatest factor placing teens at risk for suicide especially in the face of perceived sudden loss (dating relationship, peer ridicule, family dynamics, legal issues, etc.).

2) Fluoxetine(Prozac) is the only antidepressant that has proven efficacy in placebo-controlled trials in children. Even older meds like amitriptyline were never proven to be more effective than placebo in children with depression. Zoloft has been shown effective in children for the treatment of Obsessive Compulsive Disorder(OCD).

3) The CDC meta-analysis performed on prior clinical studies of SSRI treatment of 4700 children for depression, anxiety, OCD, etc. found that 2% showed increased agitation, suicidal thoughts and worrisome behavioral changes compared to 1% who had been treated with placebo. This risk was elevated

for all study populations not just in kids being treated for depression. NO suicide occurred in the study subjects.

Recommendations: 1) Openly discuss the above facts as you continue to see and assess children with mental health problems. They already trust your opinion and are more likely to listen to your recommendations.

2) Use accepted screening tools to confirm your clinical diagnosis. A simple clinical screen the Center for Epidemiologic Studies-Depression(CES-D) Scale is available at http://www.perinatalweb.org/association/topic_depressionlink.html. A score over 16 is significant and it is easy to score.

3) Connect your patient to psychological/counseling services where ever possible in your community including County Mental Health Services, Children Service Societies, and especially the local school psychologist as often these children are already exhibiting difficulties in the school setting. The more they work on issues that trigger self-doubt, low self esteem, miscommunication, anger and stress management the less they will need to rely on antidepressants or street drugs over time. Helping the patient formulate a list of goals they want to work on/accomplish with the therapist will make that referral go smoother.

4) Practice quick office-based interventions to help your patient and family identify stressors, feelings and lifestyle habits that may add to the depression and for which problem solving techniques can be applied to improve the situation. Poor sleep hygiene, diet, misunderstandings or preconceived false ideas all are quite amenable to change. It can be rewarding to help an impulsively angry teen identify ways that they can stop feeling bad/regretting what they did/said and days filled with negativity by learning simple calming techniques and a plan for what they will do when they next get upset.

5) Use medication appropriately with documentation of diagnostic criteria, plan for counseling and patient/parent education including the black-box warning and need for vigorous monitoring over the first 3 months. Until further efficacy studies show benefits of other SSRI's in Children, fluoxetine should be the medication of choice for children with significant depression, OCD or functionally impairing anxiety. As a generic it is also the cheapest SSRI available. Starting slow at 5-10mg will decrease the chance of tremor, nausea, or diarrhea. 4/5 of patients do better taking the meds in the am. Increase by 5-10mg every 1-2 weeks until some improvement is noted or if a side-effect occurs. Most of those will improve over a week or so. Weekly monitoring is needed for the first month of treatment of all patients and then every 2 weeks for the next 2 months. These can be quick office visits to assess for increased agitation, sleep disturbance, suicidal thoughts or major behavior deterioration, but for reliable families may be a combination of visits and phone follow-ups. Queries would include adequacy of sleep, better or worsening mood and specifically any increased agitation, thoughts or statements of self harm or threats to others, functional impairment(going to school, family interactions, peer contact,etc), and side-effects.

Hopefully this article has provided primary caregivers a little more of the info they need to comfortably see and help their pediatric patients and their families who experience mental health problems.

Post-traumatic Stress Disorder Within a Primary Care Setting: Effectively and Sensitively Responding to Sexual Trauma Survivors

Serena Clardie, MSW, LCSW

It is estimated that 1 in 4 females and 1 in 6 males have experienced sexual assault or abuse before the age of eighteen¹. Research suggests that assault and rape are the most frequent traumas associated with the development of post-traumatic stress disorder (PTSD)^{2,3,4} and studies show that almost half of rape survivors will develop PTSD⁵.

Post-traumatic responses can persist for years and may impact a patient's experience of medical care. Unfortunately, consistent inquiry around sexually traumatic experiences is not implemented in primary care settings. Many who suffer from post-traumatic symptomatology do not seek, or have access to, appropriate treatment. In response, many trauma survivors attempt to get their physical, emotional, and mental health needs met through a primary care setting. Even if mental health symptoms are assessed in a primary care setting, post-traumatic stress disorder can be misdiagnosed as depression or anxiety, due to a similar clinical presentation. If post-traumatic syndromes are misdiagnosed, the patient will likely receive care that is not trauma-focused, which is inconsistent with best practice guidelines for the treatment of PTSD. Screening for sexual trauma and gaining an understanding of how to respond empathically to post-traumatic responses enable primary care physicians to provide sensitive care and appropriate referrals to trauma survivors.

Many health care providers would acknowledge the importance of addressing abuse issues in their practice, but are unsure how to phrase the questions or how to approach the subject during a visit. The following is an example of how the topic could be raised with patient:

“Because abuse is so common in people's lives,
I've begun to ask patients about these experiences to ensure that
I can help them in the best way possible.”

After a disclosure, a sensitive and effective response is critical in supporting a patient's choice to share their experience. The following statement is an example of an appropriate response to an abuse disclosure:

“Thank you for trusting me with such an important and private experience.
What happened was not your fault and you
deserve help in dealing with something so difficult.
Would you like me to connect you with someone you could talk to about this?”

Sexual trauma can also affect how a person experiences touch from others, even years after they were victimized. Gynecological/male genital examinations, rectal examinations, and conscious sedation are examples of procedures that could be potentially revictimizing or uncomfortable for survivors of sexual abuse or assault. When a person has identified as a survivor, a physician can empower the patient by creating opportunities for the expression of discomfort during procedures and openly discussing ways to modify and enhance care they provide to survivors of sexual trauma. Examples of such modifications include asking permission prior to touching the patient, keeping patient informed as to what is being done as it happens, and checking in regularly as to how the patient is feeling.

Providing care that is sensitive to trauma survivors also includes referral for appropriate treatment, which can include education, psychosocial treatment, and/or psychopharmacologic treatment⁶.

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Postpartum Depression and the Pediatrician

Ruth Rademacher, MD,CLC

Postpartum depression is a common occurrence after pregnancy, having an estimated prevalence of 5% to 25%. Many pediatricians may not feel responsible for recognizing it, or intervening if it is suspected. However, it has potential negative effects for the mother and child, both short-term and long-term. These effects can be on personal, social, and cognitive development.

The mothers may commonly see their obstetrician only once during the first postpartum year (usually for a six week checkup). As symptoms of depression can improve during the pregnancy and peripartum period, they may be missed at that visit. The mother usually sees the pediatrician for the child's visits five to seven times during that first year for well child-care; more often if the child has illnesses. Despite the multiple contacts with medical professionals during that time, puerperal mood disorders may never be diagnosed or addressed. Pediatricians can have a critical impact in recognizing and intervening in postpartum mood disorders, thus playing another important role in the health of the child and family.

Postpartum mood disorders are divided into three categories based on timing and significance of symptoms: postpartum blues, postpartum depression, and postpartum psychosis. Postpartum blues or "baby blues" are the most common and least serious. They are said to occur in up to 85% of postpartum women in the first three to seven days after birth. Signs are mood swings, tearfulness, anxiety, irritability and feeling overwhelmed. Symptoms should resolve by ten days; if they resolve, treatment is not indicated.

Postpartum depression (PPD) is the most common of these disorders to need treatment, and according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), postpartum major depression is not distinguished from its nonpostpartum form. Postpartum depression may occur from two weeks to twelve months after delivery. Signs and symptoms are similar to those of major depressive disorder and include depressed mood, lack of pleasure or interest, sleep disturbance, irritability, crying, appetite disturbance, anxiety, weight changes, loss of energy, psychomotor agitation or retardation, feeling overwhelmed, feelings of worthlessness, or inappropriate guilt, diminished concentration or indecisiveness, and frequent thoughts of death or suicide. Depression caused by other medical conditions needs to be excluded (such as thyroid dysfunction or anemia).

Postpartum psychosis is the most serious of these disorders and is considered a psychiatric emergency that requires immediate intervention. Most women develop symptoms within the first two weeks and it is most often found in women with bipolar disorder. Symptoms include an acute onset of psychotic symptoms with rapidly changing depressed or elevated mood, disorientation and delusional thinking, often centered on the newborn. Suicide and infanticide can result, and many women relapse with subsequent pregnancies and many experience nonpregnancy related psychotic episodes.

The exact pathogenesis is unknown—the postpartum period is marked by hormonal fluctuations, lifestyle changes, and other stressors, both physical and environmental.

Untreated postpartum mood disorders result in poor out-

comes for mother and child, as well as other children in the home. The neonatal period is important for the development of the maternal-infant bond, and neonates and young infants are incredibly sensitive to the emotions of their caregivers. They alter their behavior in response to changes in maternal affect; these changes become learned and can be seen later. Some mothers have a flat affect, speak less often to their child and are more critical, more withdrawn, and less engaging with their infants. Other mothers are more "intrusive," speak with more hostility and express more anger towards their infants, touch their infants less and touch more negatively.

In some studies, infants reacted with more anger and sad faces, appeared less interested, had lower activity levels, vocalized less and spent less time playing. They showed insecure attachment and performed poorly on later cognitive function tests. Long-term effects include decreased developmental scores, cognitive scores, decreased IQ scores and more special needs in educational settings, as well as a higher rate of accidents and maltreatment, and decreased duration of breastfeeding.

Because of the high prevalence of postpartum depression, screening all postpartum women is crucial. Identifying women at risk includes awareness of the risk factors: a previous history of any depression, lower occupational status, stressful life events preceding the prenatal period or during the pregnancy, psychological stress late in pregnancy, perceived social isolation and high parity. Multiple office visits or emergency room visits for minor complaints, more than one "problem oriented" visit, or visits for apparent nonmedical concerns, may be signs of anxiety or depression in the mother. Women who experience postpartum blues may be at more risk for postpartum depression later, especially if the symptoms were severe. Women with infants in the NICU are thought to be at especially high risk for postpartum depression.

Pediatricians see barriers to screening for postpartum depression including unfamiliarity with the disease, time pressures, and discomfort with screening or approaching the mother about herself. The Edinburgh Postnatal Depression Scale (EPDS) is easily used and well validated, is sensitive and specific. It is a brief questionnaire that can be filled out by the mother in about five minutes, and has a simple method of scoring. Mothers who score above a threshold of 12 or 13 are likely to be suffering depressive symptoms that warrant referral. The incidence of detection using the EPDS has been shown to be significantly higher than spontaneous detection during routine evaluation. The key is to screen all postpartum women because the prevalence of PPD is high and the rate of detection without screening is low. Screening can be repeated multiple times in the postpartum year if necessary. Women with infants in the NICU should be screened on a regular basis throughout the course of the infant's NICU stay. The pediatrician should let the mother know of the concerns and refer her to her own physician, and supply a list of resources for the mother, and help identify her own supports. Frequent follow up whether by office visits or phone calls about the infant and other children in the household are important. They insure that the child/children are doing well and that the mother is receiving treatment. It is appropriate to see the children of depressed mothers frequently for weight checks because poor growth (along with personal, social and cognitive effects) is among the identified risks to the infant.

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IMMUNIZATION and INFECTIOUS DISEASE NEWS

February, 2005

Tom Saari, MD, FAAP

Pertussis in Wisconsin: The unofficial total number of pertussis cases identified in Wisconsin for all of 2005 now stands at 5070. There are over 100 additional patients who are suspected to have had pertussis during the later part of the year but official confirmation has not yet been established. Southern Wisconsin (including Dane County) has seen the most intense activity (123 cases / 100,000 population) with southeastern Wisconsin counties (including Milwaukee) close behind at 101/100,000. Incidence was greatest in infants under 6 months of age at 525/100,000 with a secondary peak in children 10 to 14 years of age at 310 / 100,000. Cases were identified in several patients over 70 years of age. Over 110 patients required hospitalization for pertussis complications with nearly one half of these patients under 6 months old. This level of hospitalization is more than 5 times greater than an average year and confirms that the increase in cases is not a testing artifact due to primary reliance on the PCR technique.

Laboratory confirmation occurred in 52% of all documented cases with PCR used almost 90% of the time as the confirming test. Pertussis PCR was determined to be 94% sensitive compared to less than 50% for culture. 8 % of all PCR tests performed in 2004 were positive for pertussis. Over half of patients will still be PCR positive a week or more after treatment has started but none will be culture positive. This demonstrates the ability to still document a case even after intervention has occurred. Slightly more than 40% of cases included in the state total were recorded as "probable" based on clinical grounds alone. Between 81% and 91% of the cases of all age groups reported a paroxysmal cough and only between 26% and 53% of cases described a classic "whoop" as an ongoing symptom. Only children under 1 year of age were more likely to have a history of a "whoop" than not. Coughing leading to a sleep disturbance was also found in the majority of patients in all age groups. School and household settings accounted for 75% of where transmission took place. A review of the pertussis immunization status of infected children under the age of 15 years showed that 72% of victims under 1 year of age had three doses of DTaP on board, the rest had only two of the three recommended doses. Only 38% of pertussis cases age 1 to 2 years old had the required 4 doses given on time, the rest being underimmunized. Azithromycin or clarithromycin were the treatments of choice in nearly 80% of those infected. 9% of those receiving an original course of antibiotics ended up being treated a second time.

An expert panel was convened by the State Health Department for an all day meeting on February 2, 2005 to analyze in depth the effect the pertussis outbreak had on all of us being asked to control the spread Bordella pertussis in Wisconsin. Certain truths were clear. 2004 represented a real increase of disease that could not be explained solely on improved techniques for identifying infected individuals. The natural cycling of pertussis activity every 2 to 4 years has not been altered by mass immunization efforts directed toward infants and children. Adolescents continue to be a significant reservoir of infection in the community and improved physician recogni-

tion cases in adolescents with a variable presentation of symptoms not considered "classic" contributed to better overall case identification. Efforts in the spring of 2004 to encourage practitioners to do PCR testing of suspect cases was well received and acted upon resulting in a better approximation of pertussis activity that is closer to real time disease incidence. National and international data suggests that between 1 and 3 million new cases of pertussis should occur each year in a country with our population base. This makes pertussis a particularly ubiquitous infection during peak cycles. Questions were raised as to what extent efforts made to blunt outbreak surges can be in truly controlling the spread of this infection. The tremendous manpower expended, particularly by the public health nursing services and the private practitioners, is often to the detriment of other public health activities and was the reason the panel was created. The State of Wisconsin felt obligated to follow CDC guidelines when forming policy for pertussis control this past year. This philosophy coupled with the superior epidemiologic expertise in our state and the uniqueness of the close cooperation that exist between the Wisconsin private and public sector providers resulted in the capacity to initiate a maximal effort but strained the ability of all of us to sustain that effort.

Planning is going forward to re-examine Wisconsin's overall approach when responding to a repeat threat of pertussis disease in 2005, should it occur. The practitioner's point of view was clearly heard during the panel discussion and centered around the nature of the physician's role in responding to the public health service's requests for case management. Practitioners want more clinical discretion, particularly when making treatment decisions regarding suspect cases, and they question if the broad-brush approach to disease control advocated by the CDC is appropriate in every setting. Infants, particularly those under a year of age and underimmunized, represent the most risky patients when placed in an environment where transmission is likely to occur. Perhaps a more focused set of criteria for case finding and prophylaxis is more appropriate when attempting to reduce pertussis morbidity and mortality in select populations. Additional concerns with the massive use of a class of antibiotics likely to enhance more antimicrobial resistance in respiratory pathogens were forcefully expressed. The WARN (Wisconsin Antibiotic Resistance Network) has published a set of judicious antibiotic guidelines during pertussis outbreaks on their web site www.warnwisconsin.org that may help in your decision making about who to treat and isolate when considering certain clinical scenarios.

Pertussis-Containing Vaccines for Adolescents and Adults:

Two acellular pertussis vaccines combined with diphtheria and tetanus toxoid, Boostrix and Adacel, were simultaneously submitted to the FDA last summer with the hope for a summer 2005 release. Boostrix (GSK) is for patients 11 thru 19 years old and would be primarily targeted as a booster for middle schooler's age 11-12 years of age. It has the same 3 acellular pertussis antigenic components found in GSK's Infanrix. Aventis is seeking approval for their Adacel to be used in patients 11 thru 64 years old and uses the same five acellular components contained in their Daptacel vaccine. Both vaccines have a reduced strength diphtheria toxoid in it to reduce

vaccine side effects, therefore they are designated dTaP with the little “d”. Neither vaccine will be approved for primer doses and are meant to be given only for patients previously primed with either DTaP or DTwP vaccines. The intent would be to give a dTaP booster every 10 years starting in middle school.

Meningococcal Conjugate Vaccine: The FDA gave approval of the quadrivalent (A,C, Y, W 135) conjugated vaccine (MCV4 Menactra^R) in February. Recent release of recommendations for the control of meningococcal disease in the USA by the CDC (ACIP) includes the routine vaccination of all children 11-12 years of age as a part of the regularly recommended health maintenance visit for that middle school cohort. Adolescents entering high school at age 15 years would be a secondary group where immunization would be beneficial in accelerating the coverage for the total adolescent cohort. There has been a clear reluctance, however, to extend the recommendation for catch up vaccination with MCV4 for those 13 to 18 years of age because of concerns for a limited vaccine supply and the impact the high overall cost of the MCV4 vaccine (\$82) would have on clinic and government vaccine budgets. College freshman in dorms represent another higher risk group where routine MCV4 vaccination can be considered. In states where meningococcal vaccine is required for matriculation, MCV4 is the preferred vaccine. Wisconsin Law 61 does not require college freshmen in our state to be vaccinated for the prevention of meningococcal disease, just that students be informed about it and that there is a vaccine available to potentially prevent it. I have never been enthusiastic for the widespread use of the previous meningococcal polysaccharide vaccine (MPSV4) because it had serious shortcomings in antibody durability, cost and outbreak control.

MCV4 manifests all the more desirable characteristics of conjugated vaccines (HiB, PCV7) we are more familiar with. In contrast to MPSV4, MCV4 induces T-cell cellular immunity that produces brisk anamnestic responses on future encounters with the meningococcal strains contained in the vaccine. There is a good booster response without signs of the hypo-responsiveness (tolerance) characteristic of MPSV4 when previous recipients of either MCV4 or MPSV4 receive MCV4 down the road. Hence MCV4 gives longer term protection which contributes to the herd immunity necessary for true outbreak control. Also, only MCV4 reduces nasal carriage of meningococcal strains which is important for reducing spread in close quarters like dorm rooms and households.

The cost / benefit profile for MCV4 is still poor but ACIP (and probably the AAP-COVID which will decide on the AAP recommendations this spring) has decided that the performance of MCV4 in preventing a rare but devastating infection is worth the cost to society. The dollars spent on MCV4 (@ \$82 a dose) per case prevented in college freshmen living in dorms is around \$1.5 million and \$15 million per death averted. Money spent on MCV4 to prevent a case of meningococemia in a 11 year old is about \$1 million and \$5 million to prevent a death in the same age group. The adverse event profile shows a bit more injection site swelling and post vaccination headache following MCV4 when compared to MPSV4. It is expected that the Vaccines For Children (VFC) program will eventually include MCV4 for eligible 11-12 year old children some-

time this year. Vaccine supplies should be adequate for the limited middle school cohort plus college freshmen but questionable for groups beyond that. The published national immunization schedule may be modified this summer to reflect the addition of MCV4 on the purple adolescent bar. Clinic systems will be expected to include MCV4 as a vaccine benefit for 11-12 year old patients.

Wisconsin Influenza Prevention Survey Preliminary Results: 131 of you responded to the 250 surveys that were sent out to randomly selected WIAAP members early last fall and, as promised, the preliminary results are as follows. Keep in mind that nearly all of our surveys were returned before the flu vaccine shortage was made public last fall. This puts your responses in the context of your agreement or disagreement with the new AAP recommendations for routine flu vaccine for all healthy 6 to 23 month old infants assuming adequate vaccine supplies. Almost 90% of you would aggressively push inactivated influenza vaccine (TIV) for most of you high risk patients but only 57% would be actively pursue giving TIV to > 75% of your healthy infants 6 to 23 months of age. 54% of you would recommend giving flu vaccine to the majority of the household contacts of your high risk children and only 27% would be advising household family members with healthy children under 24 months to get protected and prevent influenza spread to these vulnerable patients. There was very little interest at this time (< 10% of respondents) in providing universal protection from influenza for every child 2 to 18 years of age.

Respondents strongly believed that their decision to provide influenza vaccine to healthy children will ultimately be influenced by recommendations from the AAP and the CDC and to a slightly lesser extent by parental demand. Professional concerns about the safety of thimerosal containing TIV vaccine were minimal but pediatricians would bow to parental concerns about mercury containing vaccine preservatives and use thimerosal-free TIV if it meant getting a child vaccinated. WIAAP pediatricians estimated that an average of 19% of the 6 to 23 month old patients in their practice received a thimerosal-free TIV vaccine in the 2003-04 flu season and that was likely to increase to 31% of that cohort this season. (2004-05).

Most Wisconsin pediatricians have a solid knowledge base concerning the risk of hospitalization to children under 2 years of age who become infected with influenza. There is also a very good understanding of the role younger children play in the spread of influenza to others in the community. There was somewhat less enthusiasm for the idea of universal influenza immunization for healthy children of all ages.

Although there is a growing understanding of some of the advantages in parental acceptance and effectiveness of the live attenuated intranasal vaccine (LAIV) in providing better durability and cross protection for drifted influenza strains, many of you retain some doubts about the overall safety and transmissibility of this new flu vaccine. LAIV storage requirements and reimbursement issues will also need to be overcome before wider acceptance can occur. Most of you were hesitant to consider LAIV as an option at this time, even if it were approved for routine use in healthy children down to age 12 months. (Continued Page 12)

(Immunization News Continued)

This survey points out a significant education effort will need to be made to solidify the concept of universal yearly influenza immunization for all healthy children and their household contacts as the future strategy in the USA for more effective pandemic influenza control. It is also becoming more clear that childhood influenza prevention will be instrumental in protecting the elderly, a population that does not respond particularly well to the current TIV vaccine.

As always, I welcome your comments and questions on immunization matters: Tom Saari, MD, FAAP
tsaari@wisc.edu (608) 263-9733

(Postpartum Depression Continued)

If the mother is receiving psychotropic medications, it is important for the pediatrician to be aware of this while caring for the infant, especially if the infant is breastfeeding.

In conclusion, postpartum depression is a common reaction, and has a variable onset after birth of the infant. Women should be screened routinely and at multiple times in the first year after birth, and risk factors identified. Since the pediatrician in general is the physician with whom the mother has the most contact, and since postpartum depression has short and long-term effects on the child and family, it falls upon the pediatrician to screen all mothers, and refer the mothers who show signs of postpartum depression. In doing this, pediatricians can have a crucial, sometimes, critical, impact on many children and their families.

Chapter Opportunities for Young Pediatricians

Cami Matthews, MD, FAAP
 Co-Chair, Young Pediatricians Committee

The Young Pediatricians Committee of the Wisconsin Chapter is made up of AAP members who are under the age of 40 and / or within the first five years of completion of training. We are continually looking for new ways to involve more members in activities and ongoing projects and we welcome all members who are interested in participating within this section. Additionally, we would like to hear from people as to what activities would be most beneficial for young pediatricians regarding CME activities, advocacy projects, or even networking among each other for support and ideas about career questions, parenting support, or getting involved within the AAP.

The WIAAP Annual Meeting on April 23, 2005 at the Kalahari Resort in Wisconsin Dells is not only highlighting many topics of interest to the general pediatrician, but can be a great way to meet others within Wisconsin. ***We would like to reserve a table at the noon luncheon specifically for young pediatricians so that you can meet one another. Please include a note on your registration form, or contact Chapter Executive Director, Carolyn Evenstad (CMEWCAAP@aol.com) if you would like to join other young pediatricians at the noon lunch.***

Also, young pediatricians are always welcome at the chapter executive committee meetings that are held three times throughout the year. This meeting brings together the leaders of the various chapter committees and is a great opportunity to meet people who are doing amazing work within Wisconsin and the nation for kids and families. Highlights vary from Breastfeeding, Medical Education, Legislative advocacy, School Health, Dental Health and many others. If you are interested in attending, please let Carolyn Evenstad know so that you will be contacted regarding future dates.

Keeping up to date via the chapter's email distribution list, WIAAP-NET, is great! You can subscribe to the group by contacting Jeff Britton (jeffrey.w.britton@aurora.org), or the chapter president, Carl Eisenberg (CEisenberg@AAPSCOT.ORG). Also, general information about the chapter that highlights committee chairs, safety handouts, and past newsletters, is available on the chapter website at <http://wisaap.org>. The Young Physicians Section through the national AAP office also has a website at www.aap.org/sections/youngphys.

Please feel free to contact me, or Lorelle Manion with any comments, questions, or suggestions for the Young Pediatricians Committee. The more input we receive, the better we can direct activities towards the needs of the group. My email address is ckmatthews@wisc.edu and Lorelle can be reached at lmanion@voyager.net. We look forward to hearing from you.

Chapter Dues Deduction for Taxes

Dues remitted to the Wisconsin Chapter are not deductible as a charitable contribution, but may be deductible as an ordinary and necessary business expense. Ten percent, or \$9.00 of the dues, is not a deductible business expense because of the chapter's lobbying activity.

Chapter E-Mail Distribution List Update Subscribe Now!

The Chapter's e-mail distribution list, WIAAP-NET, currently has 238 subscribers. If you did NOT receive a message from WIAAP-NET dated 2/14/05 with the "TEST" in the subject line and believe you are a subscriber or would like to be a subscriber please contact either Jeff Britton (<jeff.britton@sbcglobal.net>) or me (<CEisenberg@AAPSCOT.ORG>) with your most current e-mail address. Please remember this service is a free membership benefit and serves to keep you up to date on many WIAAP activities. The officers as well as board and executive committee members frequently use this e-mail distribution list to post announcements or to solicit input. We welcome and encourage all WIAAP members to subscribe.

Pediatric Externs Report on Summer Experiences

Natascha Wathne

In the summer of 2004, between my first and second years of medical school, I had the pleasure to work with Dr. Selkurt at the Gunderson Lutheran Clinic in Whitehall, Wisconsin. Dr. Selkurt serves this small town of 1,651 residents as a pediatrician and in many other ways. My schedule consisted of seeing pediatric patients with Dr. Selkurt in the mornings and/or afternoons and rotating for a few hours at a time through other departments such as radiology, surgery, physical therapy, the nutrition office and labs. After regular clinic hours, I often went to urgent care/emergency room. I also had a chance to talk to several administrators of the adjacent Tri-County Memorial Hospital, which was very interesting based on my MBA background and previous administrative fellowship at the University of Wisconsin Hospital and Clinics. This arrangement gave me an overview of how patient care is delivered in a rural setting.

In the clinic, I especially enjoyed seeing our young patients for their well-child visits and talking to young mothers and fathers. I like that the focus of well-child visits is on preventing injuries and illness by talking about themes such as safety precautions and nutrition. I also enjoyed seeing teenagers and earning their trust. One day, I had the pleasure of learning from a young Amish girl and her mother (who had come to town in their horse-drawn carriage) about their everyday chores, lifestyle and medical beliefs. It meant a lot to me to see them open up. The girl was more mature than any 13-year-old girl that I had ever met. It showed me how important it is to understand a patient's background and to earn their trust to be an effective physician. Furthermore, I had fun studying rashes. We had a little guessing game (research media allowed of course) every time someone came in with a rash. I learned so much from Dr. Martin and his fabulous books! The list of educational encounters goes on and on: allergies, asthma, physicals, strep infections, fractures, etc. I could have never wished for a better experience between my first and second years of medical school.

In addition to seeing pediatric patients in the clinic, I visited the Department of Health of Trempealeau County twice and observed how nurses took care of young mothers and children who were part of The Special Supplemental and Nutrition Program for Women, Infants and Children (WIC). WIC provides nutrition education and nutritional foods to families who qualify with children up to age 5. One evening, I accompanied a nurse to check up on a newborn and his mother in their home. To see how they lived made me realize how many challenges people face in their everyday life. As a practitioner, it is not enough to write a prescription or push for a treatment when the patient is unable to follow the advice due to limited resources, time or other reasons. We also saw a young mother with her little son who did not have health care. I am very troubled by the lack of universal access to health care in this country.

Building relationships is very important to me and I can definitely see myself serving a smaller community as a pediatrician someday. I would like to make a difference in my patients' lives by acknowledging their diversity and beliefs, earning their trust, and offering my support to provide for the well-being of the youngest members of our society.

Kristin Lyerly

First year medical students cherish the idea of "the last summer." Beyond anatomy and biochemistry, our minds are filled with questions about how to best fill these final few weeks before the profession takes over – will it be research, clinical work or...dare I say, nothing? As the mother of two small children (and a frequent flyer at my own pediatrician's office), I knew that a clinical experience in pediatrics would fit the bill. What I didn't know was that the three short weeks that I was to spend in rural Whitehall, would become such an important part of my practical medical education.

From the beginning, I was made to feel at home in Whitehall. I was greeted at the door by an enthusiastic nurse, who explained that medical students were a common and valued sight at their facility. Following a thoughtful tour and round of introductions, Dr. Joanne Selkurt revealed the detailed schedule of activities that she had created especially for me. From then on, I spent half days working primarily with Dr. Selkurt, but also darting in and out of rooms served by various clinicians as interesting cases presented themselves. The physicians and physicians' assistants were kind and eager to teach me, and I was fortunate to meet and examine many patients personally. The other half-day was always an adventure, whether it was ophthalmology, ENT or lab work.

In addition to the rich clinical experiences, Dr. Selkurt wisely integrated community outreach into the externship. I spent a day with the Trempealeau County coordinators and clients of the WIC program and another with inspectors from the county health department. These, however, paled in comparison to the week that the Girl Scouts schooled me in campfire talk as I attempted to help them earn their first aid badges!

All in all, my Whitehall adventure was ripe with clinical, community and interpersonal experiences that I will always fondly remember. I enjoyed the opportunity to apply some of the skills that I had learned during my first year, but that wasn't what I took away from Whitehall. What I will always remember is the way Dr. Selkurt and her colleagues cared for the people in their community, both medically and as neighbors. This is the stuff that they don't teach in medical school and, ironically, that which makes us better physicians.

I would like to express my most sincere gratitude to the members of the Wisconsin Chapter of the American Academy of Pediatrics for sponsoring the summer externship program for medical students and extending me the opportunity to participate. The experience was unique and wonderful, to say the least.

The production of this newsletter is supported, in part, by an unrestricted grant from the Ross Products Division of Abbott Laboratories

***WIAAP-Net Responds to
Pediatrician Member's Request
For Resources***

Parent Diagnosed with Cancer

One of our Chapter members has a family with elementary school-aged children whose father was recently diagnosed with Cancer. He posted a request for resources to the WIAAP-Net and received a wonderful response.

Many members responded with the following recommendations:

****McCue, Kathleen.** 1994. "How to Help Children Through a Parent's Serious Illness" - New York, St. Marten's Press.

Written by a child life specialist, this book contains practical ways to address issues at all stages of treatment, and helpful ways to talk with your children.

****Harpham, Wendy Schlessel,** 1997. "When a Parent Has Cancer: A Guide to Caring For Your Children" - Harper-Collins Publishers.

Written by a physician being treated for cancer, this book is also well-received by parents. It contains a children's book, "Becky and the Worry Cup" to be read together with your children.

Additional resources are available from your Regional Children with Special Health Care Needs (CSHCN) center.

A map of Centers with links and contact information is available at: http://dhfs.wisconsin.gov/DPH_BFCH/cshcn/WI_CSHCN_MAP.htm

Listed below is the contact information for each Center and First Step, a 24/7 information hotline and website for families and providers.

Northern Region - Family Resource Center - Rhinelander
Phone: (715) 361-2890 or (888) 266-0028,
Fax: (715) 361-2892
<http://www.familyresourceconnection.org/cshcn.htm>

Northeastern Regional CSHCN Center - St. Vincents Hospital - Green Bay
Phone: (920) 433-8296 (Green Bay Area) or 1-800-236-3030 ext. 8296
Fax: (920) 431-3055
<http://www.northeasterncshcn.org/>

Southern Regional CSHCN Center - University of Wisconsin - Waisman
Resource Center - Madison
Phone: (800) 532-3321 or (608) 263-5890
FAX: (608) 263-0529
www.waisman.wisc.edu/cshcn

Southeastern Regional CSHCN Center - Special Needs Family Center- Children's Hospital of Wisconsin- Milwaukee
Phone: (414) 266-NEED or toll free at (800) 234-KIDS
FAX: (414) 266-2225
<http://www.specialneedsfamilycenter.org/>

Western Regional CSHCN Center - Chippewa County Health Department - Chippewa Falls
Phone: (715) 726-7900 or 1-800-400-3678
Fax: (715) 726-7910
<http://www.co.chippewa.wi.us/CCDPH/CSHCN/>

The Wisconsin First Step Hotline (24 hours a day/7 days a week with language line) supports the Regional CSHCN Centers by providing statewide information and referrals for providers and families. For more information go to: www.mch-hotlines.org or call the toll-free: 1-800-642-7837 Voice/TTY.

This information was provided by Chapter pediatricians and Executive Committee Members. For further questions please contact the Chapter Office at:

Phone, Fax: 608.222.7751 — E-mail cmewcaap@aol.com

**WIAAP Annual Meeting:
From Head to Toe: Important Issues
In General Pediatrics**

Mark Your Calendars

The WIAAP Annual Meeting will be held on Saturday, April 23rd, 2005 at the Kalahari Resort in Wisconsin Dells. The one day CME program will consist of a variety of speakers focusing on common issues in the practice of general pediatrics.

Topics and Presenters

Morning topics:

- “Post Partum Depression” - Ruth Rademacher, MD, CLC
- “Getting “Docs” Into the Loop on Disaster Preparedness” - Joanne Selkurt, MD
- “Oral Risk Assessment” - Lori Barbeau, DDS
- “Children’s Health and the Environment in Wisconsin”
Leonardo Trasande, MD

Afternoon topics:

- “Childhood Depression, Child and Adolescent Psychiatry” - Eric Schwietering, MD
- “Addressing Pediatric Hip Dysplasia—The Importance of Development” - Blaise Nemeth, MD, MS
- “Update in Amblyopia and Strabismus” -
Mark Ruttum, MD
- “Food Allergy: Different Tastes of Case Presentations”
Mark Moss, MD
- “Acne Update” - Sheila Galbraith, MD

Residents Posters

Residents from Madison, Milwaukee and Marshfield have been invited to present posters during meeting breaks, and following the noon lunch. Contact Carolyn at the Chapter office.

Social Hour

As in previous years, following the final program presentation, all attendees and families are invited to attend a light hors d’oeuvre buffet .

We look forward to seeing you there!

—Program Co-Chairs:
Lorelle Manion, MD, Cami Matthews, MD

Hotel Reservation Information
Please Note: Participants are responsible for their own hotel reservations. To make reservations, please call the Kalahari Resort (1-877-253-5466), by Tuesday, March 22, 2005, to guarantee a room and receive the Chapter group rate of \$149.00. If you have questions regarding rooms or reservations contact Carolyn Evenstad, 608.222.7751, or

REGISTRATION (Please Print)

Name: _____

Address: _____

PHONE _____

E-Mail _____

(E-mail for registration confirmation)

| | Fee Prior | Fee After |
|----------------------------------|------------------|------------------|
| Register Early & Save | 4/4/05 | 4/4/05 |
| Member WI Chapter AAP | \$35.00 | \$55.00 |
| Non-Member | \$90.00 | \$110.00 |
| House Officer | No Charge | No Charge |
| Medical Students | No Charge | No Charge |
| Pediatric Nurse Practitioner | \$45.00 | \$65.00 |
| Nurse, Educators, Spouses | \$45.00 | \$65.00 |
| Luncheon | Yes #____ | No |
| (Please circle Yes, or No) | | |
| Hors d’oeuvre Buffet | Yes #____ | No |
| (Please circle Yes, or No) | | |

Total Amount Enclosed \$ _____

Registration Fees Include Lunch & Social Hour Buffet.

Make Checks Payable to WI CHAPTER AAP

Mail to: Carolyn Evenstad
WI Chapter American Academy of Pediatrics
330 E. Lakeside Street, PO Box 1109
Madison, WI 53701

**Refunds: For a full refund, cancellations must be received by April 15, 2005; requests after that date will not be accepted.

**Special Needs: Any participant of the WIAAP Meeting requiring special accommodations should call (608) 222-7751, and identify the special need.

***Speakers may change due to unplanned absences

If you have not received your complete brochure, please contact
Carolyn Evenstad at the Chapter Office

608-222-7751
E-mail: cmewcaap@aol.com

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Mark Your Calendars

WIAAP Board of Directors
Executive Committee Meeting
Friday, April 22, 2005
10:00 AM
Kalahari Resort
Wisconsin Dells, WI

WI Chapter Annual Meeting
Saturday, April 23, 2005
Kalahari Resort
Wisconsin Dells

WAPF Foundation Meeting
Friday, April 22, 2005
8:30 AM
Kalahari Resort
Wisconsin Dells